ASSESSING THE EFFECTS OF TRAINING ON THE ATTITUDES OF STAFF WORKING WITH PEOPLE WHO HAVE DEVELOPMENTAL DISABILITIES

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TABLE OF CONTENTS

LIST OF FIGURES

LIST OF TABLES

CHAPTER ONE

INTRODUCTION

"At the end of the twentieth century we are in a boundary situation. We can transform ourselves, or not." (Doll, 1994, p. 15)

A profound transformation in the general mind-set of a society, a transformation in what constituted legitimate knowledge for a particular set of values or attitudes held by members of that society, was defined by Pinar, Reynolds, Slattery and Taubman (1995) as a societal paradigm shift. Historically, such paradigm shifts did not occur without controversy, did not occur painlessly, and certainly did not occur without serious inquiry into the reasoning behind the current and prevailing belief systems of a culture.

Kuhn (1962) further defined paradigms as shared ways of viewing certain realities. He believed that changes in the perception of social realities were necessary before cultural and social changes could occur. Polloway, Patton, Smith, and Smith (1996) also stated "Paradigm shifts may be critical to growth, change and improvement in any field" (p. 11).

Traditional shared views were often so powerful within a culture that in order for a paradigm shift to happen, sudden and often dramatic changes or events were required before the shift could occur. These primal changes redefined reality and not only facilitated the initial paradigm shift but strengthened resultant cultural movement (Apple, 1996).

The beginnings of such societal paradigm shifts in the treatment of devalued groups could be seen at work in the United States during the desegregation of the public schools as a result of Brown vs. School Board in the late 1950s, and in the formation of the National Organization for Women (NOW) for the furtherance of women's rights in the 1960s. Both of these catalytic events initiated shifts in the way society viewed rights toward specific groups who were socially devalued and marginalized. Without such events, the chances for changing social paradigms decreased dramatically and often resulted in cultural stagnation (Apple, 1996).

Paradigm Shifts In The Provision of Services to People with Developmental Disabilities

Such a cultural paradigm shift, one that had been initiated in Denmark during the 1950's and gathered momentum in the United States a few years later, was the shift away from the institutionalization of people with developmental disabilities (Nibert, 1995). The institutional philosophy recommended congregating large numbers of people who had developmental disabilities together, preferably in a calm and peaceful country setting, in order to provide professional, educational and habilitative services in the most efficient manner possible. The institutional congregate care system was viewed as both economically sound and ideologically effective (Kugel & Wolfensberger, 1969).

The model of warehousing large numbers of people with developmental disabilities in institutions was inherently flawed, however. Samuel Gridley Howe, one of the first champions of the out-of-home, residential settings which later evolved into the institutional system, warned of the dangers of that same system, "Society, moved by pity for some special form of suffering, hastens to build up establishments which sometimes increases the very evil which it wished to lessen" (p. 64) (Howe, Richards, & Sanborn, 1906). The institutional system had sought to change social abuse of the individual, including loss of individual rights and the inability of communities to provide appropriate habilitation and health care. Yet, these same incidents occurred with alarming frequency within large congregate care settings. Something was missing in the basic epistemology of the institutional concept.

Two catalytic events, Senator Robert Kennedy's negative reactions in 1965 after visiting several institutions for the "mentally retarded" and Blatt and Kaplan's (1966) expose of institutional life in Christmas in Purgatory, set the stage for social change in the United States. The viability of the institutional system as the best possible option for providing services to people with developmental disabilities in the United States had begun to be questioned. Parents and family members wondered whether putting their loved ones who had developmental disabilities into an institutional setting with hundreds, if not thousands, of other people with similar disabilities really provided the quality of life they wished for that person (Skarnulis, 1980).

Skarnulis (1980) also noted the beginnings of a paradigm shift away from institutional services for people with developmental disabilities. He stated that "even the President's Committee on Mental Retardation reflected the emotional mood at the beginning of the deinstitutionalization movement in its review of the history of mental retardation" (p. 4). A decade later, as momentum of the paradigm shift away from large congregate care institutions accelerated, Meyer and Peck (1991) stated:

> The myth of the protective environment of congregate living for persons with mental retardation would seem to have been shattered forever, particularly as subsequent investigations continued to document intolerable conditions, depersonalization, and even abuse in these large hospitals in various parts of the world. Before long, a growing consensus emerged that such facilities by their very nature were incapable of being habilitative, and "deinstitutionalization" movement began. In their place, professionals and advocates called for the development of community services that would support persons with disabilities in a manner that was more reflective of the way that others who did not have disabilities chose to live, work, and spend their leisure time. (p. 107)

Paradigm Shifts Toward Community Inclusion in Oklahoma

The Hissom Memorial Center (THMC), an institution for the "mentally retarded" in Sand Springs, Oklahoma, was at the heart of a similar social paradigm shift within the state of Oklahoma. Opened in March of 1964, THMC in its early years was believed to be a state-of-the-art program for the treatment of people with developmental disabilities. Hissom's buildings and programs were used as models for institutional development throughout the country during a period when the growth in the number of institutions housing people with developmental disabilities was at its peak. By 1972, 634 people with developmental disabilities, most from the northeast area of the state, were in residence at THMC. (State of Oklahoma, 1993).

But THMC suffered from the same flaws as many other institutions around the country — devaluation and disregard for the individual. This flaw resulted in abuses of the very people THMC was meant to serve.

In 1981, a small group of parents of children with developmental disabilities consolidated their efforts and began to "advocate for family support services and more community options" (Homeward Bound Review Panel, 1995, pg. 1). Challenging the political and cultural systems managing THMC, parents urged administrators to move their children out of the institution and into more appropriate community residences. Unfortunately, their early efforts failed and with no other options available and no monies for support, parents were forced to continue placing their children at THMC. They did, however, band together to form a support and advocacy group, Homeward Bound, Inc., for the purpose of continued political lobbying.

In partial response to those lobbying efforts, the federal government in 1984 threatened to cut $25 million dollars in Medicaid funding to the state unless major changes were made at the Hissom institution. At the same time, a series of exposes by reporters from the Tulsa Tribune World newspaper in Tulsa, Oklahoma revealed that residents of Hissom lived under conditions that were neglectful and antiquated. Worse, the reports disclosed evidence of over-medication, lack of treatment and possible incidents of abuse. The Tribune's reports (Homeward Bound Review Panel, 1995) further asserted that

> Oklahoma's lack of community programs led families to place their children with mental retardation in state-operated institutions which prevented many of them from being released. Findings at THMC found rows of toilets without seats, open showers, doors to rooms locked with aides with keys having the only access to locks mounted six feet off the floor, stark surroundings void of stimulation and personalization, shelves empty (toys were kept locked up in living units), televisions mounted high on the walls, etc. They found staffing levels three to four times less than those levels reported in national surveys. There was evidence of over-medication and neglect. (p. 1)

Parents once again hoped that public outrage over the conditions existing at Hissom would force administrators to move their children into community settings with appropriate support services. Unfortunately, the newspaper articles did not generate as much of a public outcry as they had hoped. Disappointed but determined to make changes in the system, parents activated and strengthened their advocacy organization "Homeward Bound." They began once again to lobby for reform but, again, efforts seemed to fail. Worse yet, several incidents occurred in which children were injured while in residence at Hissom. Driven by concern for the safety and well-being of their children, parents and their attorneys filed a class action suit in Federal District Court on May 2, 1985 (Homeward Bound, et. al. v. The Hissom Memorial Center, et. al., 1985).

Defendants named in the suit included The Hissom Memorial Center (THMC), the Governor of Oklahoma, members of the Oklahoma Commission for Human Services, the Oklahoma Department of Human Services (DHS), the director of DHS, and the Oklahoma Department of Education.

The class action suit heralded the beginnings of a paradigm shift in the way people with developmental disabilities were treated in Oklahoma. The suit alleged that "Hissom was a dangerous place for people with developmental disabilities to live and requested that the state provide services to all plaintiffs and members of the class in the least separate, most integrated community setting appropriate to their needs" (Homeward Bound Review Panel, 1995, pg. 2). The term "class" referred to those people who were living, or had lived, at Hissom while the lawsuit was going on 1985. (Homeward Bound, et. al. v. The Hissom Memorial Center, et. al., 1985).

In 1986, the Court ordered the development of a comprehensive plan by the defendants that provided for community-based services. A guardian ad litem was appointed for class members and a former employee of the U.S. Public Health Services was retained to inspect conditions at THMC.

The Homeward Bound Review Panel (1995) wrote:

> Reports on the sanitary inspection of THMC revealed that a deterioration in compliance with the court's order and numerous sanitation and housekeeping problems were found recurrent in a worse degree" than in previous inspections. The conditions, according to the inspector presented a potential for adverse health consequences to THMC residents." (p. 3)

On July 24, 1987, the Court issued its Findings of Fact and Conclusions of Law and the Court Plan and Order of Deinstitutionalization (1987). This document defined the members of the class, set out a comprehensive plan of community services, and established a four-year timetable for placing all Hissom residents into the community. On October 21, 1987, the Court entered the judgement in favor of the plaintiffs (Homeward Bound, et. al. v. The Hissom Memorial Center, et. al., 1987a). The State of Oklahoma filed an appeal of the judgement.

In 1988, a Court Monitor was appointed to oversee actions concerning class members at Hissom. The Court Monitor was later replaced by a three-member Review Panel. Review Panel members were professionals in the field of developmental disabilities, each of whom had extensive experience in the "development of community services and deinstitutionalization" (Homeward Bound Review Panel, 1995, pg. 4).

In 1989, the Court adopted a Consent Decree that outlined seven areas for goal and objective achievement (Homeward Bound, et. al. v. The Hissom Memorial Center, et. al., 1989). These areas included Community Living Arrangements; Case Management/Family Support/Leisure; Employment Services; Infrastructure; Community Involvement; Advocacy; and Systematic Communication.

Each of the seven areas were defined by a guiding principle with the overall purpose of assuring that people with developmental disabilities who were currently living at THMC, or who had previously lived there, were provided the supports and resources necessary for their successful transition into community environments. Additionally, the guiding principles outlined plans for the provision of community services, limited case manager case loads, provided a schedule for placing the class in appropriate community settings by October 1, 1993, and targeted the discharge of the balance class (those individuals living in nursing homes and ICF's/MR's (intermediate care facilities/mental retardation) by October 1, 1994 (see Appendix A).

The provisions found in the Consent Decree also applied to approximately 400 people who had once resided at Hissom but who were living in nursing homes, intermediate care facilities and other state-operated facilities. These members of the suit were also given the opportunity to move into community homes with appropriate supports.

A Notice of Non-compliance was filed against the state in 1991 which listed allegations of non-compliance in six areas: (1) failure to meet the court-ordered movement schedule; (2) failure to provide residential, vocational and professional services; (3) failure to provide required training; (4) failure to provide court-ordered independent case managers; (5) failure to provide necessary safeguards; and (6) failure to support the community program. In 1992, the State submitted a response to the allegations and in December, 1992, the Court found significant noncompliance in the following areas: (1) training, (2) vocational services; (3) THMC downsizing; (4) segregated medical services in the community; (5) challenging behavior management; and (6) foster home and adult companion program development.

In 1993, the Court ordered that the State develop and/or expand services in 19 areas to comply with the Consent Decree. The State projected April 15, 1994 as the date THMC would be closed. On April 22, 1994, THMC transitioned the last of its 530 residents into the community and officially closed its doors (Homeward Bound Review Panel, 1995).

While the Hissom case only affected people currently or previously residing at Hissom, it was nevertheless a significant factor in Oklahoma's shifting paradigm away from congregate care institutional settings and heralded a concurrent social shift in attitudes toward people with developmental disabilities.

Provisions for the Development of a State-Wide Comprehensive Training System in Oklahoma

The importance of training in relation to supporting people with developmental disabilities was addressed by the Court in the first of its areas: Community Living Arrangements. Goal Number 11 stated "By December 31, 1989, design and implement a system to train staff for provision of community living support services" (Homeward Bound, et. al., p. 7). Six objectives were outlined to address this goal. They were:

1. By September 30, 1989, design a statewide system for training direct care staff;
2. By November 30, 1989, develop a long-term system for training case managers and contract providers;
3. By December 30, 1990, develop a long-term system for educating management staff for community programs;
4. By June 30, 1990, develop an ongoing system for staff development;
5. By December 30, 1989, train providers of community living services to administer the Inventory for Client and Agency Planning (ICAP); and

6. Train providers of community services in use of the Ongoing Behavior Monitoring System (OBMS). (p. 8)

The State, under the auspices of a Review Panel member with extensive experience in training, instituted the beginnings of a tiered level of training curriculum consisting of five training levels. Each level addressed a specific major training program area within the state's service delivery system (see Figure 1). A development committee consisting of members drawn from across the state who had expertise in developmental disabilities, aided in the design the initial training program, Foundation Training. In late 1992, and in the spring of 1993, the State offered the first training classes of Foundation Training, the basic level of the five-tiered training curriculum system.

Figure 1: DDSD TRAINING CURRICULUM LEVELS

A brief overview of the five levels of training, major training program areas, and who was required to attend are presented in Figure 2:

Figure 2: TRAINING REQUIREMENTS

Training Levels	***Description***	***Who Attends***	***Time Required For Completion***
Foundation Training	Traces the history, myths and perceptions surrounding people with developmental disabilities. Defines disabilities and presents the Principle of Normalization as a guiding concept. Explores the service delivery system in Oklahoma and offers a view of future developments in the field. Trained by state trainers.	All persons working for the Developmental Disabilities Services Division or provider agencies in any capacity, from support staff to professionals.	Before beginning work
Job Specific Training	Five Training Programs including: Residential, Vocational, Case Management, Administrative, and Support Staff. Trained by staff working in the job specific areas.	All persons working in any of the job specific areas.	60 days after Foundation Training is completed.
Specialized Needs Training	Training designed specifically for specialized needs, i.e., Behavioral or Physical needs. Trained by staff in the specific professional field.	Only those staff working with people with specific needs.	To be completed as soon as Foundation and Job Specific training levels are completed.
Client Specific Needs Training	To be provided on-site, one-on-one based on needs identified in the individual's IP. Trained by staff in the specific professional field.	Only those staff working with people with specific needs.	To be completed as soon as Foundation and Job Specific training levels are completed.
Annual In-Service Training	Refreshers, Introduction to new materials and policies. Trained by a variety of instructors and using a variety of methods including distance education, agency training, and state training programs.	All staff as required.	On-going -- 40 hours per year.

(State of Oklahoma, 1993)

Training curriculum levels were broken down dependent upon the status of the staff member and the needs of the individuals being served. Individuals entering as first-time employees of the Developmental Disabilities Services Division (DDSD), division of the Oklahoma Department of Human Services, or as employees of private agencies providing contract services through DDSD, must have attended and passed Foundation Training before serving people with developmental disabilities. Then, dependent upon their area of specialization, employees must have attended and passed the second tier training course designed for their specialty area within a specific time frame. In other words, if they were residential direct care staff, they must have attended Residential training. If they intended to become case managers, they must have attended Case Management Training and, if they were job coaches or intended to work in a center-based, vocational program they must have attended Employment Training.

For staff who worked with people with severe physical or behavioral issues, the third tier -- Individualized Specialized Needs Training -- was required before actually working with individuals with specific needs. The same held true for staff who worked with Individualized Client Specific Needs, the fourth training level. Finally, annual in-service training was required at all staffing levels with the number of required hours dependent upon the individual's employment position.

Foundation Training

Foundation Training was developed to meet the primary training needs of staff who work with people with developmental disabilities in state-supported situations. The training placed heavy emphasis on the issues, attitudes, and values surrounding people with developmental disabilities and their families. Foundation Training's primary objectives (State of Oklahoma, 1993) were to:

- Provide all staff with a shared vision of what Oklahoma's system of services will look like.
- Provide a consistent information, knowledge, and skill base for all individuals who serve people with developmental disabilities.
- Prepare staff to become more effective members of the teams that provide assessment, planning, and the delivery of services for individuals with developmental disabilities.
- Improve the quality of communication and social interaction skills of staff who provide services.
- Provide a functional definition of developmental disabilities and help staff understand common types of developmental disabilities.
- Provide an understanding of historical issues influencing individuals with developmental disabilities and how they influence today's attitudes.
- Provide staff and individuals with an understanding of the Principle of Normalization.
- Provide a philosophy of services that is consistent with current state and national trends in service delivery.
- Provide staff and individuals with a better awareness of the individual's with developmental disabilities rights and legal issues surrounding service delivery.
- Provide staff and individuals with an understanding of the services available within the State of Oklahoma and specifically, through the Developmental Disability Services Division.
- Provide an understanding of mistreatment\maltreatment, reporting measures for suspected abuse and neglect, and the importance of the use of non-aversive techniques.
- Provide an introduction to future technological trends that may influence the quality of life of individuals with developmental disabilities.
- Provide an awareness of the role of the State and the Statement of Beliefs that influence the State in its performance of services for individuals with developmental disabilities. (pg. 1-2)
-

Consisting of four modules, the training curriculum challenged traditional social and cultural views of people with developmental disabilities and provided attitudinal guides and fundamental information concerning philosophy, ethics, the Oklahoma service system and views of future trends in services affecting people with developmental disabilities (State of Oklahoma, 1993). These modules included:

> - Module One - "People Are People"
>   Defined the term, developmental disability, and described some of the disabilities included in that term. Emphasis was placed on the concept of looking at individuals as *people rather than products of their disability.*
> - Module Two - "Changing Times"
>   Traced the historical events that influenced how services for people with developmental disabilities developed, and emphasized an understanding of what didn't work and why it didn't work so that the mistakes of the past are not repeated. Also introduced the Principle of Normalization and the importance of role models.
> - Module Three - "Systems And Policies"
>   Provided a snapshot of the State of Oklahoma service delivery system today, including public and private service providers, families, advocates, etc. Reaffirmed the importance of individuals who work most closely with people with developmental disabilities.
> - Module Four - "The New Frontiers"
>   Provided a "Vision of the Future," a blueprint which logically emerged from the previous three modules. Emphasized the vital importance of all staff sharing a common vision and focused energies in that direction. It also provided a look at future technological trends that might influence the lives of individuals with developmental disabilities. (pg. 6-7)

Foundation Training was developed by the Developmental Disabilities Services Division (DDSD) using an advisory committee whose members were drawn from across the state and from all areas of the developmental disabilities service system. A review panel member with expertise in the field of training served as advisor and editor of materials and an outside curriculum consultant provided technical assistance with instructional design. The training curriculum was designed to be transformational in nature (Pinar, Reynolds, Slattery, & Taubman, 1995). As such, the curriculum not only presented specific information about developmental disabilities and the DDSD system, but was highly interactive, encouraged individual and group participation, and facilitated the exploration of individually held beliefs and attitudes toward people with developmental disabilities.

But was the development and adoption of such informational curriculum in the form of Foundation Training enough to influence staff attitudes toward people with developmental disabilities? Could training curriculum alone, defined in this instance as informational in nature, independently help staff achieve a paradigm shift in attitudes toward people with developmental disabilities? Or was something more needed?

Changing Attitudinal Paradigms

Anthony (Marinelli & Dell Orto, 1984) talked about changing attitudes and engaging in societal rehabilitation through three methods: (1) contact; (2) information; and, (3) information plus contact. Contact was defined as arranging meetings between the general public and members of the devalued group, (in Anthony's research, people with developmental disabilities.) While Anthony stated that contact alone could result in slightly more favorable results in increased positive attitudes, contact alone "consistently have found no changes in the subjects' attitudes as a result of their contacts with disabled persons" (p. 119).

On the other hand, attempts to change attitudes strictly through the dissemination of positive information only increased the person's knowledge concerning people with disabilities and did not result in any increased positive attitude trends. However, the combination of contact experience with information concerning the disability resulted in remarkable consistency regarding favorable impact on the person's attitudes toward people with disabilities. Anthony (1972) emphasized the word "consistent." Regardless of the disability examined, information plus contact resulted in consistent positive attitude changes.

As Oklahoma's service system for people with developmental disabilities moved from an institutional model to a community inclusive model and people moved out of state institutions and into their home communities, it became critical that staff providing support services adopted attitudes that reflected positive perspectives toward people with developmental disabilities. It was especially important to recognize that Direct Care staff, those individuals who provided everyday services in residential settings, were the people who most influenced the success, or failure, of community living options (Skarnulis, 1984). The Developmental Disabilities Services Division's Foundation Training was designed to assist with these attitudinal changes by allowing participants attending training to explore previously held belief systems concerning people with developmental disabilities.

But why was Foundation Training important? And why should concern be expressed in regard to the effectiveness of the curriculum in influencing staff's attitudes toward people with developmental disabilities? Hastings (1997) stated that research on the change in beliefs of new staff from their first days of work would "help to identify the effects of experience and the impact on staff support for client skills" (p. 786). The lack of such information and its positive effects on attitude formation might, either directly or indirectly, influence direct care and support of people with developmental disabilities in Oklahoma who had moved into the community and were trying to become independent and productive members of that community. Also:

- Staff needed the positive attitudes presented in Foundation Training to (1) recognize that all people are just people, regardless of any disability that might be present; (2) prevent incidents of abuse and neglect; (2) promote individual rights; and (3) advocate for independence and inclusion for the people they work with.
- With between 8,000-12,000 people entering the DDSD service system as staff every year, consistency and the need for everyone to “sing from the same hymnal” (Skarnulis, 1984) became increasingly necessary.
- Ensure the continuing provision of high quality services by all staff, whether provided by private agencies or DDSD, to people with developmental disabilities.

Statement of the Problem

At the present time there was insufficient evidence to indicate that information presented in Foundation Training had been effective in positively influencing staff's attitudes, awareness, and agreement concerning people with developmental disabilities.

Purpose of the Research

The purpose and central focus of this study was to determine, using quantitative methods, if (1) the Department of Human Service's Developmental Disabilities Services Division's Foundation Training program had been effective in positively influencing attitudes of staff, and (2) if information plus contact as represented by at least three months on-the-job experience after attendance in Foundation training resulted in positive attitudinal agreement in staff working with people with developmental disabilities. In a period in state government when training was often the first area to experience budget reductions, such information would be critical in establishing the need for Foundation Training and in continuing financial and administrative support of the program.

Research Questions

The following questions guided the research:

1. To what extent had Foundation Training positively affected the awareness of and agreement with the desired attitudes of Direct Care staff measured by pre and post-tests before and after attending Foundation Training using scores on the Scale of Attitudes toward Disabled People (SADP) as the measurement instrument?
2. To what extent had at least a three month contact with people with developmental disabilities through on-the-job experience positively influenced agreement with the desired attitudes of Direct Care staff toward people with developmental disabilities using scores on the Scale of Attitudes toward Disabled People (SADP)?
3. To what extent were there correlations in the reported agreement of SADP scores between the Control Group (CG), Foundation Training Only (IO) pre and post-test groups, and the Foundation Training plus on-the-job experience (IC) group between (1) all staff, and (2) direct care staff only?
4. To what extent were there differences in attitude scores on the SADP between the independent variables of Prior Contact, Prior Training, and

Prior On-the-job experience, and the reported agreement levels between the Control Group (CG), Foundation Training Only (IO) pre and post-test groups, and the Foundation Training plus on-the-job experience group (IC)?

Scope and Limitations

The Developmental Disabilities Services Division of the Oklahoma Department of Human Services currently provides a wide range of services and programs to people with developmental disabilities. Limitations of the study included:

1. Participants were limited by the criteria given in the research design;
2. The study was considered a pilot study designed to pave the way for a more comprehensive future evaluation of Foundation Training; and
3. The study was limited by the time frame of twelve weeks during which the population attending state scheduled training classes was assessed.

Assumptions

The following assumptions are made:

1. Participants attending Foundation Training were doing so for the first time and had little or no exposure to current accepted attitudes and trends in the field of developmental disabilities.
2. Respondents answered survey questions honestly and to the best of their ability.

3. The content of the attitude items on the survey instrument, the Scale of Attitudes toward Disabled People, were representative of the positive attitudes promoted by the Developmental Disabilities Services Division in Foundation Training.

Significance and Outcomes of the Study

The significance of this study was based on outcomes in four areas:

1. Clients — People with developmental disabilities receiving services would be better served by direct care staff who adopted desired attitudes;
2. Staff — Staff's ability to provide supports within the service system would be enhanced by greater awareness of their attitudes toward people with developmental disabilities;
3. Institutional — The Developmental Disabilities Services Division would have an increased awareness of the attitudes currently held by staff providing supports. This knowledge would in turn allow them to increase the effectiveness of their Foundation Training program and curriculum.
4. Funding — Increased effectiveness of Foundation Training in providing staff with positive attitudes toward people with developmental disabilities would aid in justifying continued funding of the Foundation Training program.

Definitions

To ensure clear and concise understanding of the issues discussed throughout this research, the following definitions from the Dictionary of Developmental Disabilities Terminology (Accardo & Whitman, 1996), Handbook of autism and pervasive developmental disorders (Donnellan & Paul, 1987), and Foundation Training (State of Oklahoma, 1993) were provided.

Americans With Disabilities Act of 1990 — Federal legislation providing fundamental rights protection to people with disabilities in the areas of public access, services and accommodations, telecommunications, and employment.

Attitude — an individual's mental position in regard to a fact or belief.

Developmental Disability — Any mental and/or physical impairment, which;

- starts before age 22;
- continues indefinitely or for an extended period of time;
- results in a functional limitation in 3 or more life areas (described below), and;
- the person needs an individually planned or coordinated combination or sequence of services.

Developmental Disabilities Services Division — The division within the Oklahoma Department of Human Services responsible for identifying, providing, and coordinating services to people with developmental disabilities.

Foundation Training — Basic training program required by the Developmental Disabilities Services Division for all people employed on some level, public or private provider agencies, for the provision of services to people with developmental disabilities.

Life Area — Seven major activities of daily living including:

- Self-care activities are the things people do daily to meet their basic life needs, including eating, personal hygiene, and grooming.
- Receptive and expressive language are the verbal and nonverbal skills a person uses to understand others and to express his/her ideas and feelings.
- Learning is the ability to acquire new behaviors, perceptions, and information; the ability to apply past experiences to new situations.
- Mobility is the ability to move from one place to another with or without mechanical aids.
- Self-direction is the ability to take care of oneself. The person is able to make sound personal decisions and protect his/her self-interest.
- Capacity for independent living describes a person's ability to live without extraordinary support in a way that is age-appropriate.
- Economic self-sufficiency describes a person's capacity to maintain adequate employment and financial support.

Oklahoma Department of Human Services — Division of Oklahoma state government responsible for social welfare issues.

People First Language — Language that emphasizes the individual over his or her disability. *Example: "A boy with mental retardation" rather than "that mentally-retarded boy" or "that retard."*

Support Services — Services and supports provided by the Developmental Disabilities Services Division in the three areas of vocational, residential, and health.

CHAPTER II

REVIEW OF LITERATURE

This chapter reviews the literature in the following areas: (1) definitions of the most common developmental disabilities; (2) historical trends in attitudes toward people with developmental disabilities; (3) trends in the provision of services to people with developmental disabilities; (4) the importance of direct care staff in providing services; and (5) effects of information and contact in the form of training programs on attitudinal change.

Definition of the Term "Developmental Disability"

Accardo and Whitman (1996) define a developmental disability as physical or mental disabilities (or a combination of both) occurring during an individual's developmental years before the age of 22. The definition was not always so clearly cut. Originally, in order to facilitate communication funding and treatment, mental retardation, epilepsy, autism, muscular dystrophy, spina bifida, cystic fibrosis and several other disabilities affected fairly large numbers of people were clustered together under the umbrella term of "developmental disabilities" (Van Hasselt, Strain, & Hersen, 1988).

The Development of a
Standardardized Definition of Developmental Disability

Before 1984, children and adults with mental retardation, epilepsy, autism, cerebral palsy, or other disabilities were eligible for governmental funding on a *categorized* basis. In other words, if a disability affected a large number of people, e.g. mental retardation, and had vocal advocates who lobbied for services and programs, the broad category of "mental retardation" received program funding. However, if a disability was a rare condition that only affected a relatively small number of people, such as spinal bifida, only a small number of family or friends could lobby (State of Oklahoma, 1993). The need for help was just as great as more prevalent conditions but the category was not large enough to attract broad funding. The concern grew that small groups were not receiving enough services, even though their needs were just as important (Trent, 1994).

Also, legislators, policymakers, and the general public -- who were not specialists in the field of disabilities -- often believed everyone's needs were being met when they voted for a program designated "disability." They had little education on what constituted the various "disability" programs and therefore had difficulty making knowledgeable decisions (State of Oklahoma, 1993). In an attempt to correct this, the Developmental Disabilities Services and Facilities Construction Act of 1975 (PL 91-517) of 1970 introduced the concept of "developmental disability" and created a program of state formula grants to support government activities related to service delivery (Accardo & Whitman, 1996).

In order to bring about fairness in the distribution of government funding and reduce confusion, four groups (mental retardation, autism, epilepsy, and cerebral palsy) collaborated and lobbied to expand the definition. Their efforts resulted in the Developmental Disabilities and Bill of Rights Act Amendments of 1987. The definition was later expanded to include other groups beyond the original four. Accardo and Whitman (1996) specify that the Federal legislation defined a developmental disability as:

> A severe, chronic disability of a person 5 years of age or older, which is attributable to a mental or physical impairment or combination of mental and physical impairments; is manifested before the person attains age 22; is likely to continue indefinitely; and results in substantial functional limitations in three or more areas of major life activity; 1) self care, 2) receptive and expressive language; 3) learning; 4) mobility; 5) self direction; 6) capacity for independent living; and 7) economic self-sufficiency; and reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services that are lifelong or extended duration and are individually planned and coordinated. (p. 87)

The seven major life areas component of the federal definition was important in clarifying what constituted a developmental disability. People with physical disabilities did not necessarily have mental disabilities and vice versa (Tyor, 1984). For example, a person with cerebral palsy might have a developmental disability because of extensive physical disabilities and yet be extremely intelligent. Conversely, a person with a learning disability might not fall into the developmental disabilities category since they were not severely limited in three out of the seven life areas. Others might not qualify because their disability occurred after the age of 22. The seven life areas are described in Figure 3.

Figure 3: Seven Major Life Areas

Seven Major Life Areas

- Self Care Activities — activities completed in the course of a typical day including eating, personal hygiene and grooming.
- Receptive and expressive language — verbal and nonverbal skills needed to understand others and to express ideas and feelings.
- Learning — the ability to acquire new behaviors, perceptions and information and to apply past experiences to new situations.
- Mobility — the ability to move from place to place with or without mechanical aids.
- Self-direction — the ability to make sound personal decisions and to protect self interests.
- Capacity for independent living — the ability to live without extraordinary support in a way that is age appropriate.
- Economic self-sufficiency — the capacity to maintain adequate employment and financial support.

(State of Oklahoma, 1993)

Types of Common Developmental Disabilities

According to Van Hasselt, Strain and Hersen (1988) some of the more common developmental disabilities included:

- Mental retardation — The term, mental retardation, refers to substantial limitations in mental functioning. It is characterized by significantly subaverage intellectual functioning which existed concurrently with related limitations in two or more of the following adaptive skill areas; communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests itself before age 18 and could stem from literally hundreds of causes, including:

(1) Genetic/chromosomal or inherited traits (Down Syndrome); (2) Infections (encephalitis or meningitis) and metabolic problems (diabetes or hyperthyroidism); (3) Environmental influences during pregnancy; including (a) lack of oxygen to the brain at birth, (b) chemicals and drugs (including alcohol) ingested during pregnancy, (d) exposure to radiation, and (e) high body temperature in the mother during early pregnancy; and (4) other environmental factors (inadequate stimulation and love, or abuse, neglect, or other trauma during early childhood).

People with mild levels of mental retardation often have no known cause for their mental retardation. The vast majority of people (90 percent or more) with mental retardation have only mild limitations and require either limited or no additional assistance. People with mild to moderate levels of mental retardation often need only minimal support and have few or no additional handicapping conditions, such as epilepsy, physical disabilities, etc. People with more severe mental retardation might have additional handicapping conditions and are likely to need support in various areas of their life.

- Epilepsy — Epilepsy is a chronic brain disorder characterized by seizures which include uncontrolled body movements, unusual sensations, altered perceptions, or various mixtures of movements and sensations which interfere with a person's normal functioning and behavior. Seizures occur in approximately one to two percent of the general population. Only a very small number of people with epilepsy have conditions so severe as to be classified as developmentally disabled. An individual with more severe psychomotor epilepsy may be able to perform normal activities but may also exhibit amnesia or loss of awareness during a seizure. Although the disease itself is not inherited, recent research suggests that, in some cases, predisposition to the disease might be a hereditary trait. Epilepsy can often be controlled by medication in a large percentage of individuals but those, in turn, may involve restrictions from certain activities such as driving.

- Cerebral Palsy — Cerebral palsy is a result of physical damage to the brain that, in turn, affects muscle coordination. This damage may be so mild that it involves only fine motor skills, such as writing or sewing, or it may be severe enough to make all motor activity, such as walking, talking and taking care of personal needs, difficult. Motor activity limitations usually result from damage to the brain either before, during, or after birth. They develop due to a variety of reasons including inherited metabolic conditions and diseases such as Rubella or toxemia during pregnancy or oxygen deficiency and trauma during delivery. Evidence of brain damage may not show up until several months after birth or, in some cases, may not be recognized for several years.
- Autism — Autism is the inability to compile information from the environment effectively and to communicate responses. Autism is characterized as a disturbance in the areas of (1) speech and language; (2) rate of development; (3) ability to relate to people and things; (4) perception of the environment; and (5) exaggerated use of mannerisms.

> Autism is usually present at birth but is often not diagnosed before the age of three. Children with autism may appear withdrawn and unresponsive and may use constant self stimulation activities. They may, however, also possess exceptional ability in specialty areas such as music or mathematics. The cause or causes of autism are still under investigation but it is known that autism is <u>not</u> caused by specific types of parenting as was once suggested. (State of Oklahoma, 1993)

Although the conditions just discussed — mental retardation, epilepsy, cerebral palsy, and autism — made up the largest proportion of people with developmental disabilities, other conditions such as muscular dystrophy, spina bifida, cystic fibrosis, hearing impairment, and vision impairment were also classified as disabilities that could interfere with an individual's physical development and ability to learn. If these conditions were sufficiently severe enough to result in substantial functional limitations in three of the major life areas, they could then be classified as developmental disabilities as previously defined (Van Hasselt, Strain, & Hersen, 1988).

Environmental factors could also result in developmental disabilities. The misuse of psychotropic drugs, inadequate physical therapy, and emotional frustration that developed from the inability to communicate could also result in additional behavioral, as well as physical disabilities (Van Hasselt, Strain, & Hersen, 1988).

Historical Trends in Societal Attitudes toward People with Developmental Disabilities

Historically, societal beliefs have been culturally dependent and have ranged from complete acceptance (perceiving people with developmental disabilities as innocent children of God), to total aversion and rejection (people viewed as monstrous and as a danger to society). These beliefs could be classified into two subgroups; attitudes and related concepts (Antonak & Livneh, 1988).

Attitudes

Zimbardo and Leippe (1991) defined attitudes as

> An evaluative disposition toward some object. It's an evaluation of something or someone along a continuum of like-to-dislike, our affinities and aversions, the way we evaluate our relationship to our environment. An attitude is a disposition in the sense that it is a learned tendency to think about some object, person, or issue in a particular way. (p. 31)

Attitudes were created in the individual as part of a complex set of reactions to social factors. These reactions included: (1) intentions, (2) behaviors, (3) cognitions, and (4) affective responses (Zimbardo & Leippe, 1991). All combined in some fashion to form an individual's attitudinal belief system toward specific social factors. Livneh (1982) offered a classification of socially negative attitudes toward people with disabilities. He categorized attitudes by sources which combined process (psycho dynamic mechanisms) and content (sociocultural factors). Those sources included:

- Sociocultural conditioning — This attitude was characterized by: (1) concepts such as personal appearance, youth, health, "body beautiful," wholeness, and athletic prowess; (2) emphasis on personal productiveness and achievement as well as the ability to be competitive in society; (3) prevailing socioeconomic level; (4) a "sick role" model in which the longer the individual was viewed in the disabled role, the greater the negative societal perception; and (5) marginal group status arising from physical, behavioral and attribution-based characteristics.

- Psycho dynamic mechanisms — Social mechanisms related to childhood including: (1) people with disabilities were expected to "grieve" appropriately over their misfortune; (2) conflicts with the approach/fascination - avoidance/repulsion conflict associated with the sight of a person who had disabilities; (3) the generalization of one perceived characteristic (mental retardation) to other, unrelated characteristics (physical characteristics); (4) the individual with a disability being held "responsible" for that disability which in turn resulted in social management approaches involving control, punishment, correction, or rehabilitation; (5) fear of social ostracism in which persons associating with people who have disabilities feared they would also be seen as maladjusted; and (6) guilt of being "able-bodied" leading to attempts to "atone" or distance themselves from people who have disabilities.
- Disability as punishment for sin — This attitude stressed: (1) the source of a person's disability was attributed to a personal evil act or wrong doing; (2) the individual with a disability was viewed as dangerous and as capable of future evil; (3) the feeling of guilt by a nondisabled person for past misdeeds which in turn resulted in avoidance of the person with disabilities

through fear of retribution; and (4) self-punishment which arose from association with the person with disabilities.

- Anxiety provoking unstructured situations — Situations in which the non-disabled person was faced with an unstructured situation in which social roles and rules were not well-defined and which in turn, resulted in the creation of anxiety. Unstructured situations included: (1) the lack of factual knowledge about the disability which in turn created anxiety; and (2) lack of contact and experience with people who have disabilities which in turn contributed to fearful and negative reactions.
- Aesthetic aversion — Feelings of repulsion and discomfort felt by nondisabled people when they came into contact with people with certain physical disabilities.
- Threats to body image integrity — Sexual-related attitudes which revolved around: (1) threats to personal body image though feelings of discomfort; (2) revival of archaic "castration" fears when presented with the sight of an individual who has lost a body part or function; (3) fear of loss of self-control and fear of bodily harm; (4) separation anxiety resulting from unresolved narcissistic concerns and infantile anxieties; and (5) fear of contamination through social intercourse or in-depth relationships.
- Minority group compatibility — Attitudes toward people with disabilities similar to those attitudes toward other marginal or minority groups.
- Disability as a reminder of death — Anxiety associated with death was also associated with sight of persons with disabilities.

- Prejudice inviting behaviors — Behaviors of persons who have disabilities provoked, in turn, discriminatory responses toward those same people. These responses included: (1) prejudice by invitation in which certain behaviors such as dependency, acting fearful, or inferiority created and strengthened by prejudicial behaviors; and (2) prejudice by silence in which lack of interest, advocacy, or involvement by the nondisabled person fostered stereotypic and negative attitudes.
- Influence of disability-related factors — Several individualized factors affected the formation of attitudes. These factors included: (1) disabilities involving decreased functionality were more negatively perceived than disabilities not involving functionality; (2) the more severe the disability, the more negatively it was perceived; (3) the more visible the disability, the more negatively it was perceived; (4) the more negative the cosmetic aspects of the disability, the more negatively it was perceived; (5) the more contagious a disability, the more negatively it was perceived; (6) the greater the importance of the body part affected, the greater the reaction to the disability; and (7) the more predictable the disability, the less negatively it was perceived. (pp. 181-189)

Livneh (1982) also related several demographic and personality variables to the formation of attitudes, including:

- Sex — Females generally displayed more positive attitudes toward individuals with disabilities than males.
- Age — Late childhood and adulthood displayed more positive attitudes.

Early childhood, adolescence, and old age displayed generally more negative attitudes.

- Socioeconomic status — Higher income groups displayed generally more positive attitudes than lower economic groups.
- Educational level — In general, the greater the educational level of the individuals providing services, the more positive their attitudes were toward people with disabilities.
- Ethnocentrism — In general, the more negative the attitude of the individuals providing services toward ethnic and religious groups, the more negative their attitudes were toward people with disabilities.
- Authoritarianism — Less aggressive, less authoritarian individuals generally expressed more positive attitudes toward people with disabilities.
- Self-insight — A moderate relationship existed between the need for introspection in individuals providing services and their empathetic understanding of people with disabilities.
- Anxiety — High levels of anxiety were positively correlated with rejection of disabilities.
- Self-concept — Correlations were found between positive self-concept and positive attitudes toward people with disabilities.
- Ego strength — Weak relationships were found between ego weakness and rejection of people with disabilities.
- Body and self-satisfaction — People with positive self-concepts were more accepting of people with disabilities.

- Ambiguity tolerance — The ability to tolerate ambiguity positively correlated positively with acceptance of people with disabilities.
- Social desirability — The need for social approval and acceptance was positively correlated with acceptance of people with disabilities.
- Alienation — Individuals who felt alienated by society generally had more hostile and rejecting attitudes toward people with disabilities. (pp. 190-191)

In the case of developmental disabilities, social factors resulted in a broad array of social attitudes. Wolfensberger (1972) placed common societal attitudes toward people with developmental disabilities into nine groups:

- Subhuman Organism — This attitude classifies individuals who have developmental disabilities as "non-persons." People with developmental disabilities are compared with animals, vegetables, or other non-human organisms and are perceived as not having the feelings or needs that other people have. There is, therefore, no need for basic human necessities. This perception results in impersonalization of social and environmental surroundings and minimal care conditions.
- Object of Pity — This attitude allows people with developmental disabilities to be viewed with compassion but little else. Limited expectations result in the assumption that people can grow and develop only at the most limited range of capabilities.
- Object of Ridicule — This attitude views people with developmental disabilities as creatures to be made fun of, or to taunt and torment, and is

often the springboard for aggressive or abusive treatment by caregivers or by people in social settings.

- Unspeakable Objects of Dread — This attitude is most commonly characterized by public fear or paranoia centered around "controlling the uncontrollable." People with disabilities are often confined and treated as criminals by their caregivers in settings reflective of prisons.
- Holy Innocents — The belief that God will reward people if they are kind to people with developmental disabilities is the central focus of this attitude. Above all else, dependency and inequality, as well as the belief that people who cared for individuals who had developmental disabilities would one day receive divine reward for their work, is the focus.
- Eternal Child — This attitude views the adult with developmental disabilities as a child, no matter the age of that adult. Adults are encouraged to play with childish toys and to wear childish clothing. Lifelong dependency is promoted under the assumption that adults with developmental disabilities are unable to: (1) make decisions without guidance; (2) care for themselves; or (3) live independently.
- Sick Person — This attitude revolves around a medical model that asserts all people with developmental disabilities are ill and need constant medical care. This attitude results in both reduced contact with the normal world and in environments constructed and run like hospitals. There is an emphasis on "therapy" in order to "fix," "treat," or "cure" the person.
- Menace to Society — This attitude encourages the belief that people with

mental retardation and other developmental disabilities will reproduce millions of "defective" people which, in turn, would destroy society. This attitude was responsible for the deaths of thousands of people with developmental disabilities during the Holocaust.

- Object of Charity — This attitude is characterized by the subjection of people with developmental disabilities to humiliating charitable drives or other fund raising media events. It also assumes life-long dependency and promotes feelings of pity in nondisabled people. (State of Oklahoma, 1993)

Whatever the attitude's label, the classification of someone as mentally retarded or developmentally disabled carried with it a stigma which deeply discredited both the character and the place in society of people with developmental disabilities. This, in turn, created a self-fulfilling prophecy in which people who had mental retardation or other developmental disabilities played social roles that rewarded them for fulfilling social expectations and punished them for behaviors that did not conform to those expectations. People often portrayed the perception they believed best fit their role in society. Wolfensberger (1972) wrote:

> When a person is perceived as deviant, he is cast into a role that carries with it powerful expectancies. Strangely enough, these expectancies not only take hold of the mind of the perceiver, but of the perceived person as well. . . Generally, people will play the roles they have been assigned. This permits those who define social roles to make self-fulfilling prophecies by predicting that someone cast into a certain role will emit behavior consistent with that role. (pp.15-16)

Skarnulis (1974) also summed up societal perceptions:

> Historically, the mentally retarded have been perceived as creatures to be pitied, feared, abhorred, or treated as inconsequential. At the opposite end of the spectrum, they have been perceived as holy innocents, objects of pity, burdens of charity, or eternal children. Such stereotypes strip the mentally retarded of their dignity as human beings. Worse, the constitutional rights accorded to all United States citizens are selectively denied to mentally retarded citizens. (p. 57)

Related Concepts: Misconceptions

While not actually constituting attitudes, the following misconceptions toward people with developmental disabilities have been historically perpetuated. The perpetuation of misconceptions in turn facilitated the formation of damaging attitudes and aided in the continued denial of constitutional rights to millions of individuals with developmental disabilities. Wolfensberger (1972) described these misconceptions as:

- *People with developmental disabilities were destined to lead a life of complete dependency.*

  Historically, it was a common belief that people with developmental disabilities did not have the capability to learn even simple tasks and would always be dependent upon their care givers.
- *Mental retardation equaled mental illness.*

  People often equated mental retardation with mental illness. While it was true people with mental retardation could also have a mental illness, the percentage of occurrence in people with developmental disabilities was no greater than the percentage in the general population.
- *All people with mental retardation acted alike.*

People who had mental retardation often appeared to behave in similar ways which led to the common misconception that all people with mental retardation acted alike. However, a more probable cause of similar behaviors was the common sharing of an institutional environment in which all individuals experienced the same conditions and so often responded to those conditions using similar methods of behavior.

- *A person with developmental disabilities could only function to the extent of his/her mental age or IQ score.*

  The label of an IQ score was probably the greatest disservice given to people with developmental disabilities. The ability to learn to function in an environment was not dependent upon the level of an IQ score, no matter what that score implied. Before the development of the Intelligence Quotient, people functioned successfully within their environments.

- *People with developmental disabilities needed "special" environments.*

  This subtle yet pervasive misconception resulted in the development of segregated surroundings such as “special education” classes that separated children, “special” workshops or vocational settings that kept adults with developmental disabilities out of the mainstream workforce, and “special” living arrangements that congregated adults with developmental disabilities together in large institutions and segregated them from the community. (State of Oklahoma, 1993)

Attitudes and Paradigm Shifts

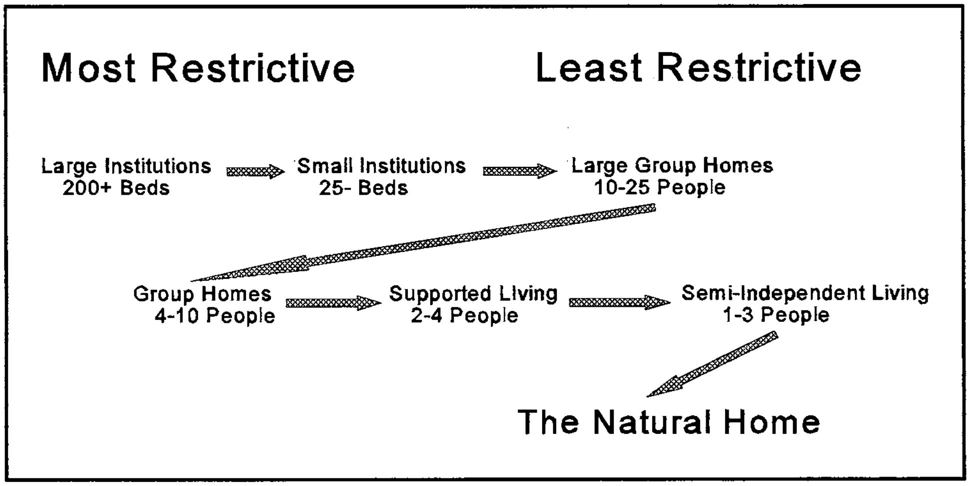
Polloway, Patton, Smith, and Smith (1996) compared shifting societal attitudes toward people who had developmental disabilities with the following three societal paradigm shifts in the provision of services; (1) facility-based; (2) services-based; and (3) supports-based. The facility-based paradigm existed from the early 1900s to the mid 1900s. Institutions, facility residential programs and, to a lesser extent, special schools were constructed under the premise that "the needs of individuals could best be met if they were grouped together, and isolated from other individuals" (p. 4). While caring individuals worked within these settings and while there were numerous attempts to provide the best possible services for the people residing in institutional settings, this paradigm resulted in "the warehousing, involuntary sterilization, and generalized poor treatment of many persons with mental retardation" (p. 4).

Merely twenty-five years have passed since this paradigm was at its highest point. Although there were still people classified as mentally retarded who lived in such facilities, a dramatic decline in facility-based services occurred in the late 1960s and early 1970s as the public became more aware of the conditions that existed within those facilities.

In response to public outcries against the facility-based period, a "service-based" paradigm developed in an attempt to provide "special" services to "special" people. Such services were designed to assist people in developing the skills seen as necessary for successful transition and integration into the community. The shortcomings of this model became evident when it was seen that while many people entered these services, few exited.

This model was also called a “readiness” model. In other words, when a person was “ready,” he or she got to live in the community, or work at a real job, or attend regular school classes with typical children. Movement was in a continuum, step-by-step, whether or not the individual needed the step. The problem was that not many people reached the end of the steps, or the end of the process (Polloway, et. al., 1996). Movement from one environment to the next within a continuum was an "earning" process based upon how outside observers rated the individual's merit. Continuums also legitimized the use of large, segregated environments as necessary stops along the way to the ultimate goal of an individual living independently within a community. This continuum in the area of residential services is illustrated in Figure 4:

Figure 4: Residential Continuum

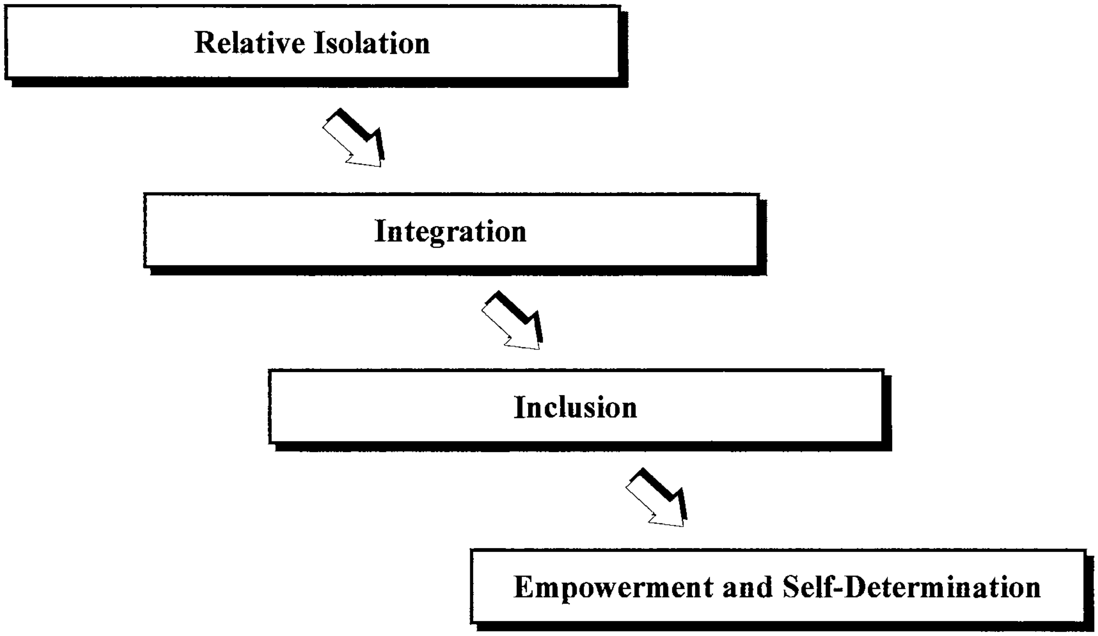


(State of Oklahoma, 1995)

Social perspectives shifted away from the continuum-based paradigm toward a supports-based, inclusion paradigm in the 1980s and 1990s. Under this model, people with developmental disabilities not only lived in a community but were included in that community's activities and had a voice in the workings of that community. Individuals were seen as empowered people, capable of making choices and determining the directions of their lives (Skarnulis, 1984).

Success was insured through the use of appropriate and necessary supports in which the level of support was based upon the need and desires of the individual being served. This shift placed emphasis on levels of support rather than levels of disability. Polloway, Patton, Smith, and Smith (1996) graphically represent historical societal changes toward treatment of people with developmental disabilities in Figure 5.

Figure 5: Historic Changes



(Polloway, Patton, Smith & Smith, 1996)

The Development of Community Living Options

The above attitudes were seen at varying times and in varying degrees throughout history; but perhaps nowhere else were they as evident as in the area of living arrangements. From segregated, enormous institutions housing up to thousands of people with developmental disabilities to family homes in community neighborhoods, the influence of historic paradigm shifts in societal attitudes could be vividly portrayed in the movement of people into the community. Figure 6 provides a brief overview of historic trends in societal attitudes from the era of the institutions to movement toward inclusive community living in the United States.

Figure 6: Trends in Attitudes Toward Community Living in the United States

HISTORICAL OUTLINE

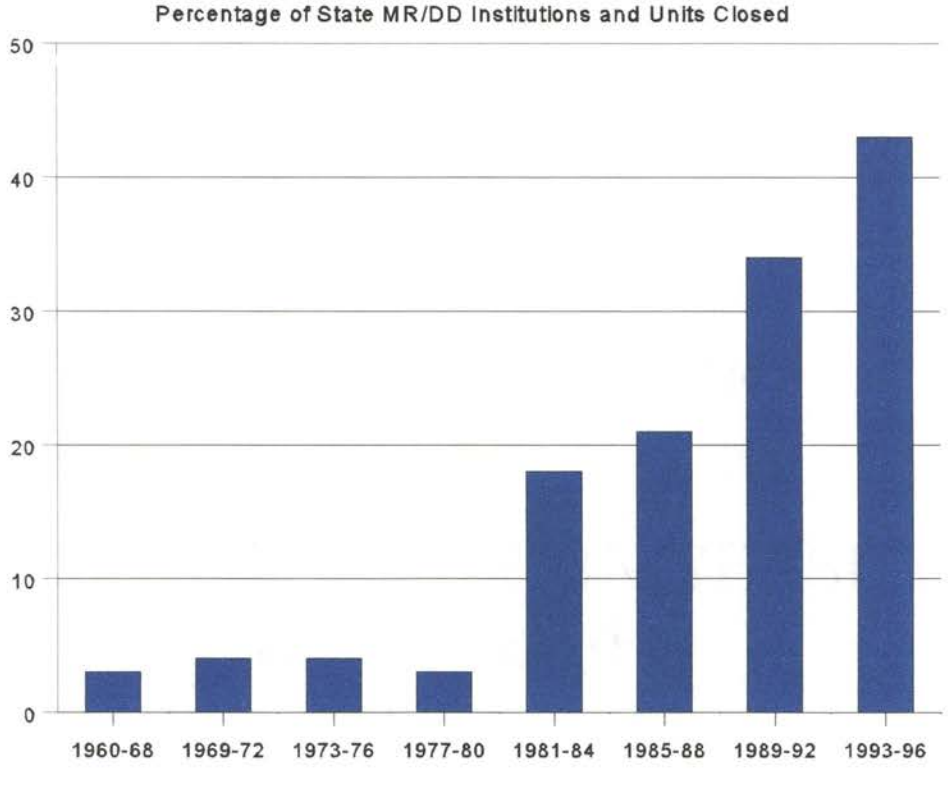
1790 -- 1850	Positive attitudes, optimistic outlooks on the future.
1850 -- 1890	The attitude of "We Need To Protect Them" begins. Institutions start, become custodial.
1890 -- 1910	Backlash organized against immigrants, Native Americans and others, including people with developmental disabilities who are seen as "different."
1910 -- 1930-40s	Negative images persist. Development of huge institutions -- warehousing of people in "snake pits." Horror movies popular depicting individuals with developmental disabilities in "villain" roles.
1940-50s--1950s,	Parent groups begin and start small "activity" centers.
Early 60s	Famous parents lend support. Parents get upset about conditions in institutions and the lack of community services.
Mid 60s — Mid 70s	Parents agitate. Institution exposes (Willowbrook in New York, Partlow in Alabama, Pennhurst in Pennsylvania, etc.)-- helped by professionals in the field (superintendents, etc.)
1970s -- 1980s	The result of the previous events: 1) More resources flowed into institutions (more staff, clothing, food, etc.). Environment improved. 2) Resources didn't solve problems. Downswing in attitude (disillusionment) -- movement toward deinstitutionalization. 3) Start of new community services -- for both people coming into the community and enlargement of services. Much voluntary parent effort.
Late 70s — early 80s	1) Improvements in institutions. 2) Excitement about community programs. • Institutional returnees "blossoming." • Families glad to have people back in their own communities. • Success stories concerning jobs, schools, places to live, etc. • Community agencies becoming more skilled at serving <u>all individuals</u>, even the medically involved, behaviorally challenged, etc. Demonstrating that everybody can be served with skilled staff.

(State of Oklahoma, 1995)

Lakin, Prouty, Anderson and Sandlin (1997) stated:

> Between the first “era of deinstitutionalization” (post-1960) closure in 1962 and the end of the Calendar Year 1996, a total of 130 of those MR/DD institutions and units were closed. This is more than one third (37.4%) of all state institutions operating since 1960. With fourteen closures currently underway and projected to be completed by the end of 1998 (excluding those presently “under consideration”), by December 1998 over 4 in 10 (41.0%) of all MR/DD institutions and units operating since 1960 will have been closed. By December 1998, 8 states will have closed all state MR/DD institutions and units. (See Figure 7)

Figure 7: State MR/DD Institutions and Units Closed



(Lakin, Prouty, Anderson & Sandlin, 1997)

As institutions and other large congregate care facilities closed and as more people moved into the community, the fourth paradigm discussed by Polloway, et al. (1996) became increasingly important to understand. This supports-based paradigm emphasized a normal environment in which people with disabilities lived and worked in settings that were typical for any individual in society. Skarnulis (1975) defined this concept in regard to habilitative settings as “Support, not supplant, the natural home” (p. 62). Bengt Nirje’s (1969) concept of normalization also stated the intended goal of normalized living quite elegantly:

> Normalization means sharing a normal rhythm of day, with privacy, activities and mutual responsibilities; a normal rhythm of week, with a home to live in, a school or work to go to, and leisure time with a modicum of social interactions; a normal rhythm of year, with the changing modes and ways of life and family and community customs as experienced in the different seasons of the year." (p. 181)

According to Nirje (1969), conditions that characterized normalization and normalized environments included: (1) conditions of everyday living; (2) normal rhythms; (3) normal activities; (4) culturally appropriate teaching strategies; (5) integrated lifestyles; and (6) positive images. The principle of normalization focused on helping people enjoy typical activities, in typical settings, at typical times and with typical people. It promoted facilitating opportunities for people with developmental disabilities to enjoy social relationships, play valued roles in the community and build not only self-esteem but self-empowerment as well (Bradley & Knoll, 1990). Normalization provided the framework with which to build supports for people as they moved from the institutions into the community and became citizens with all the rights and responsibilities associated with that role (Lakin, Hayden, & Abery, 1994).

Contiguous with the movement into the community, the role of support staff also changed. Direct care staff moved from making sure people simply were clothed and had places to sleep and eat, to a much more diverse role in which they assisted people with developmental disabilities to lead self-directed and empowered lives. Where once staff viewed the people they served from as dependent and in needed of care or treatment, they now cultivated normalization and inclusion, as well as encouraged self-empowerment and decision-making (Hewitt, O'Nell, & Lawson, 1996).

The Importance of Direct Care Staff in Providing Services

As services for people with developmental disabilities moved from large congregate care facilities to smaller community settings, the role of direct care staff also moved from a facility-based, medical care model to that of individual support and advocacy of people with whom they worked (Leff, Mulkern & Leff, 1996). Bradley and Knoll (1990) characterized this shift in the roles of direct care staff to include six areas for provision of services: (1) identification and removal of barriers to full inclusion within the community; (2) development of social connections that aids the individual in integrating successfully into the community; (3) the development and cultivation of natural supports; (4) essential and integral components in the individual planning process; (5) aiding the individual in the making informed choices about daily and long-term life issues; and, (6) making sure that a wide variety of meaningful choices were available to the individuals they serve.

The changing paradigm in support services also required that direct care staff provide services in a wide variety of settings (Hewitt, 1997). Staff's increasingly demanding jobs were essential in assisting the individual to lead self directed and integrated lives within the community rather than within an insulated institutional setting

(Hewitt, 1997). As such, staff were pivotal in assuring the quality of services provided to the individual. Indeed, they were often the key people who knew the individual on a daily basis, who often knew the individual better than anyone else except perhaps family members.

In order to be effective, however, direct care staff needed the ability to recognize, develop, and display attitudes toward people with developmental disabilities that were supportive of normalization, community inclusion, and the paradigms of social change that were sweeping the field of developmental disabilities (Fiske, 1997).

Transformation of Attitudes

Social paradigm shifts in the delivery of supports to people with developmental disabilities did not automatically imply that direct care staff delivering those services and supports would necessarily display the positive attitudes advocated by the new philosophies. The philosophy of normalized and inclusive environments hinged on five concepts; (1) independence, (2) physical and social integration, (3) an array of services available to meet individual needs rather than a continuum of services through which an individual passes, (4) real jobs in the community, and (5) empowerment to make life decisions. But whether or not these concepts actually succeeded in providing people with inclusive lifestyles depended upon the attitudes of staff providing supports (Henry, Keys, Balcazar, & Jopp, 1996b).

Wolfensberger (1988a, 1988b) voiced concerns about staff working in community living supports who either did not adopt, or did not espouse, the attitudes defined by the philosophies of their parent agencies or organizations. Henry, et al. (1996b) further emphasized the importance of commitment to the values espoused by the agency or organization in the following:

> Without the attitudinal commitment of personnel at all levels to the goal of implementing agency missions concerning community living, there is little reason to believe that progressive philosophies will have much noticeable impact in the everyday lives of people with mental retardation. (p. 368)

Negative attitudes held by staff toward people with developmental disabilities could contribute to a decline in progress toward community inclusion goals. They might even halt or slow the provision of necessary services and supports. On a larger social level, detrimental attitudes might also affect funding and public policy decisions regarding people with developmental disabilities (Henry, Keys, Jopp, & Balcazarr, 1996a).

To prevent such outcomes, positive attitudinal outlooks in staff needed to be cultivated through a variety of methods, including support, encouragement, and more pragmatically, carefully designed training programs that encouraged the exploration of personally held belief systems. This exploration in a training setting, especially included personal attitudes of staff toward people with developmental disabilities (Smalley, Certo, & Goetz, 1997).

But how could staff's attitudes toward people with developmental disabilities, attitudes that had deep social and cultural roots, be influenced toward more positive outlooks? Perhaps by supplying people with knowledge and information through training courses that emphasized the basic values of the organization or agency? Or by encouraging contact between staff and people with developmental disabilities on some personal level? Should they be viewed as separate autonomous entities or as dependent and contiguous?

Those questions could not be quickly nor easily answered. Neither knowledge nor experience alone was considered sufficient in influencing the development of new attitudes (Marinelli & Dell Orto, 1984). Karlins and Abelson (1970) contended that knowledge alone was almost never effective in changing an individual's definition of reality, except perhaps under very specialized conditions. This change could only occur in two circumstances; (1) if the individual had already adopted the belief systems as reality then the provision of knowledge might serve to strengthen them, or (2) if knowledge allowed the individual a method of expressing his beliefs and thereby exploring the realities he had constructed for himself. Essentially, the adoption of an attitude into a personal belief system was dependent upon both knowledge and experience.

The Role of Knowledge and Experience in Attitude Formation

It might be too simplistic to encapsulate learning into the triad of knowledge, skills, and attitudes. On the surface, these domains might be viewed as separate entities that only interact at specific points in the learning process. Yet the complexity of this interaction between the triad, as well as the interaction with the learner, the environment, and the socio/political culture, demanded a more holistic approach when discussing attitude formation and curriculum development. In this vein, any study of the acquisition of individual attitudes within the context of what was meaningful and what was meaningless should be done with the realization that attitude formation was not a static phenomena (Jarvis, 1987).

Pinar, Williams, Taubman and Slattery (1995) contended that knowledge and understanding came through actual lived experiences. The learner could not be separated from the object of the learning; reality was recognized and explored and then adapted into the experience of the learner. This encounter, person to person, went beyond theory. Huebner (1975) also observed that:

> For some, the encounter of man with man is seen as the essence of life, and the form that this encounter takes is the meaning of life. The encounter is not used to produce change, to enhance prestige, to identify new knowledge, or to be symbolic of something else. The encounter *is*. The [person] is not viewed as an object, an *it*, but as a fellow human being, another subject, a *thou,* who is to be lived with in the fullness of the present moment or the eternal present. (pp. 227-228)

In this situation, experience defined reality. The combination of experience plus knowledge positively influenced what the learner adopted into his belief system. The person must be viewed as a person above all else and then experience became reflective of all human experiences. Paul Williams (State of Oklahoma, 1995) put this person-centered philosophy into perspective for people with developmental disabilities and the staff who supported them:

> We have a need for somewhere homelike to live, for fulfilling occupations, for affection and appreciation, for a chance to give of our best. We have emotions of sadness, happiness, anger, shame, joy. We believe we have the same rights as you to adequate housing, security, a fair day's pay for a fair day's work, and a right to determine the pattern of our own lives. We believe that we exercise responsibility to the same extent as you do. We do not abuse our freedoms any more than you do; we believe that our record of irresponsible, criminal or violent behavior, of divorce, drunkenness, ill-treatment of our fellow human beings, selfishness, cruelty or dishonesty, when compared with yours, reflects credit on us rather than the reverse.
>
> It is often said that we like being with people of our own kind, that we need the company of our peers, that we enjoy living in communities of people with similar disabilities. Some of us do, because it is what we are used to, but we often do not feel that we have anything in common with

> other people with disabilities, nor do we particularly want them as close friends, nor do we want to live with them. We are rarely offered any real choice as to whom we mix with, so we are very often thrown into the company of other people with developmental disabilities and we develop skills of mixing with each other and accepting each other's company -- we probably have greater skills than you in accepting people with disabilities in our environment. However, given a choice of mixing with people with disabilities or with you, we will very often choose you -- just as you choose you.
>
> We are delighted when you respect us as adults and take the trouble to listen to our verbal or non-verbal communications. One of the best ways in which you can do this is just to be with us sharing experiences with us. We generally respond very well when you are just sitting with us, talking to us, or engaging in everyday things with us like washing up or watching television or working or eating. We are very grateful to you when you teach us new things or organize special events for us, but really we would often prefer that you became our friends rather than our teachers or our leisure organizers. We want to be involved in individual relationships with ordinary people doing ordinary things. Take us to the seaside by all means, but come back and sleep in the next bed afterwards. Teach us how to button our clothes, but please come and share a meal with us also. By all means assess our abilities and interests, but sit and tell us about yours as well. Only in this way will our disabilities be reduced -- and your disabilities be reduced, too. (pp. 17-18)

The Role of Curriculum in Influencing Attitude Change and Social Paradigm Shifts

When discussing broad, and often complex, social issues, the field of curriculum theory, development, and practice had been viewed as both recursive and reflective in nature. Doll (1993a) defined recursion as “the process of reflecting on one’s work — to explore, discuss, inquire into both ourselves as meaning makers and into the text itself (p. 178)”. In an ongoing transformative process: “Recursion aims at developing competence--the ability to organize, combine, inquire, use something heuristically” (p. 178). Hand in hand with this, reflective knowledge of curriculum allowed the educator to look back at what had come before and acknowledge the process as well as the result.

Recursive and reflective practices in developing curriculum became the standards by which critical evaluators designed training programs that "eventually lift the curriculum away from texts and materials [and] give it an independent existence" (Doyle, 1992, p.499). These two educational adjectives helped define a balance between the individual and society, between the perceived and actual needs of each in relation to the acquisition of knowledge, and between what had been in the past, what was currently, and what will happen in the future.

Historically, curriculum often was, and continued to be, involved in the reproduction of existing social standards by promoting the continuation of the values and attitudes held by dominant groups within that society rather than those of less valued or marginalized entities (McLaren, 1989). Pinar, et. al. (1995) acknowledged the endurance of reproductive systems replicated within a curriculum in maintaining the dominant value system of a culture:

> To the extent the curriculum reproduces or resists a status quo, it is "lifted out" out of its passages, and bores crevices in the mind, creating ruts and rituals that decrease movement, and produce inauthentic knowing and static, bureaucratic knowledge. (pp. 857)

This knowledge, if not always synonymous, was certainly often linked with power in discussions of curriculum theory. The acquisition of knowledge, and thereby power, might be viewed as a social process in which historic cultural practices became institutionalized and social movements rather than social cultures were the forces which shaped change. Pinar, et. al., (1995) stated that "In this view, curriculum *is* power, not only reproductive of power. It is social movement" (p. 303). Wexler (1990) also noted that social movement was the basis of legitimate thought.

Knowledge viewed from this perspective then became the tool of choice for social movement and eventually, as cultural values and belief systems changed, social transformation. Baier (in Meizerow, 1996) argued that an individual's ability to acquire knowledge was dependent upon cultural reference points which were reproduced generation to generation through socialization. The ability to learn became a process of dialogue and discourse in which knowledge was shaped by the learner's perceptions of reality. When these perceptions were challenged and a resultant shift led to something "fundamentally different in structure," a transformation in understanding and attitudes toward the social structure and the learning situation occurred (Robertson, 1996).

Kolb (1984) defined learning as the process whereby knowledge is created through the transformation of experience. Mezirow (1996) called this event *transformational learning*. Transformative learning allowed adults to create and change their belief structures through reflection and active participation in the learning process. Robertson (1996) related transformative learning to curriculum and to the educator in a highly personal sense:

> Transformative learning is a complicated, intensely emotional process that takes considerable skill and knowledge to facilitate effectively and responsibly. Paradigm shifts, whether in individuals or in communities, appear to have a clear pattern. A new paradigm emerges only after the old one becomes overtly dysfunctional. (pg. 45)

He further stated:

> Initially, preparatory curriculum can help raise awareness of the issues and generate some beginning frameworks (in which transformative learning can occur). (pg. 38)

At the same time, curriculum acted as a tool which provided individuals with an opportunity to engage in critical thinking about social issues, helped develop new perspectives about existing social value systems, and encouraged the adoption of alternative methods of individual behavior based upon the adoption of new attitudes (McLaren, 1991). In order for transformational learning to occur and in order for the learner to be able to examine his or her personal belief systems, curriculum could not separate subject from the object or the learner from the reality (Doll, 1993b). To do so would be to lose the essence of that reality and consequently fail to transform the social structure. Bowers (1984) related curriculum to knowledge as a means of connecting the learner with the reality defined by culture and to changing mutually-shared attitudes of learners within a system. He wrote:

> The curriculum, whether it deals with the nature of work, time, metaphorical thinking, poverty, or ways of knowing, should be judged, in part, on the basis of whether it helps the student understand how the content area relates to the broader, overarching belief system of the culture that influences the existential questions faced in the course of everyday life.. . If the curriculum is designed to reinforce the taken-for-granted beliefs that represent historically outmoded ways of responding to today's problems, the curriculum will serve to undermine the student's growth... . (p. 80)

Transforming attitudes came about through a reorganization of personal beliefs that revolved around an entirely new cultural vision (Pinar, et. al., 1995) This new way of viewing reality — of forming a new meaning for reality — might be frightening for staff who work with people with developmental disabilities in that it required learners to become dependent during the learning process, to open their minds to new information that may refute previously held beliefs, and to rethink earlier actions and decisions (Kidd, 1973). Curriculums had to be designed that recognized these issues and helped staff explore new definitions for long-held beliefs toward people with developmental disabilities.

In that context, training of support staff who worked with people who had developmental disabilities became increasingly important. When training was absent or ineffective and when the curriculum did not address the formation of new attitudes, individuals entered support roles without the necessary knowledge, skills, or attitudes necessary to provide quality support services (Henry, Keys, Balcazar, & Jopp, 1996b).

The development of transformative curriculums and the subsequent training of support staff had been identified as a significant challenge for agencies providing services (Larson, Hewitt, & Lakin, 1994). If training did not focus on inclusion, the rights of the individual, and professionalism, staff were often unable to develop the positive attitudes necessary to provide supports and other advocacy measures within the changing social systems. Such positive attitude development was necessary if staff were to successfully achieve their most important goal — the support of people with developmental disabilities as they entered the new social paradigm of becoming active and involved members of their communities.

Summary

People with developmental disabilities have historically been subjected to a wide range of societally-held beliefs. These beliefs, and their accompanying individually-held attitudes, directly affect the place of people with developmental disabilities in society. This concept holds special importance for direct care staff, those people who work with people with developmental disabilities on a daily basis and who are responsible for issues involving the individual's care and integration into society. Attitudes can be influenced by exposure to knowledge, deciminated through carefully-designed transformative training programs, in conjunction with contact with people who have developmental disabilities.

CHAPTER III

METHODOLOGY

The purpose and central focus of this study was to determine, using quantitative methods, if (1) the Department of Human Service's Developmental Disabilities Services Division's Foundation Training program had been effective in positively influencing attitudes of staff toward people with developmental disabilities; and (2) if information plus contact, as represented by attendance in Foundation Training (information) plus at least three months on-the-job experience working with people with developmental disabilities (contact), resulted in positive attitudinal agreement of staff. In a period during which training was often the first area to experience state budget reductions, such information would be critical in (1) establishing the need for Foundation Training, and (2) in continuing financial and administrative support of the Foundation Training program. The following questions guided the research:

1. To what extent had Foundation Training positively affected the awareness of, and agreement with, the desired attitudes of Direct Care staff as measured by pre and post-test scores on the Scale of Attitudes toward Disabled People (SADP) measurement instrument before and after attending Foundation Training?
2. To what extent had at least three-months contact with people with developmental disabilities through on-the-job experience positively

influenced agreement with the desired attitudes of Direct Care staff toward people with developmental disabilities as measured by scores on the Scale of Attitudes toward Disabled People (SADP)?

3. To what extent were there correlations in the reported agreement of SADP scores between the Control Group (CG), Foundation Training Only (IO) pre and post-test groups, and the Foundation Training plus on-the-job experience (IC) group between (1) all staff, and (2) direct care staff only?
4. To what extent were there differences in attitude as measured by scores on the SADP between the four tested groups (CG, IO pre and post, and IC), and the independent variables of Prior Contact, Prior Training, and Prior On-the-job experience?

This Chapter explains the (1) Design of the Study; (2) Population and Sample Selection; (3) Instrumentation; (4) Methods of Data Collection; and (5) Analysis of the Data.

Design of the Study

Descriptive research was useful in determining the current status of variables (Key, 1974). Descriptive statistics in this study assigned numerical values to phenomena that might otherwise have been hard to characterize. Such statistics also enabled the exploration of any relationships that might exist between those variables.

An Ex Post Facto Group Design was used. Three groups representing a Control Group (CG), Information Only -- pre and post tests (IO pre and IO post) and Information plus Contact (IC) had already been formed. In this context, the degree of association between the groups could be examined but could not be used to determine causation.

Population and Sample Selection

The population consisted of all people attending the Developmental Disabilities' Services Division's (DDSD) statewide Foundation and Residential Training statewide between the dates of July 15, 1998 and October 31, 1998. It was attempted to sample the entire population attending statewide training programs during that period using nonrandom, systematic sampling. The population sample was (1) drawn from private agencies and Department of Human Services Developmental Disabilities Services Division staff attending Foundation and Residential Training, (2) from across Oklahoma, and (3) representative of the three geographic areas of the DDSD service delivery system (see Appendix B). Because of population and the influence of the federal court case, Area II had the largest number of private provider agencies and therefore, the largest number of participants attending training.

A total of 597 surveys were distributed across the state. Of this, the total returned population sample size consisted of 439 surveys. This total population sample of 439 was composed of two groups: (1) 263 sets returned for participants attending Foundation Training; and (2) 176 sets returned for participants attending Residential Training (Table I).

TABLE I

Population Numbers and Sample Sizes for all Groups

	Information Only (CG, IO pre and post)	Information plus Contact (IC)
Distributed	347	250
Returned	263	176
% Return	76%	70%
Discarded	58	17
Final Sample	205 (150/IOpre&post, 55/CG)	159

Using Anthony's (1972) descriptors, the sample population was classified into two groups: (1) information only (IO) -- staff attending Foundation Training for the first time, and (2) information plus contact (IC) -- staff attending Residential Training after being on-the-job working with people who have developmental disabilities for at least three months. A control group consisting of five randomly drawn classes from the Information Only group was also defined.

The following criterion was applied for selection of the information only (IO) sample subgroup:

1. Participants had not previously attended Foundation Training.

Rationale: Prior Foundation Training in the field of developmental disabilities would constitute information acquisition which might influence attitude development.

The second sample subgroup consisted of the information plus contact (IC) group. This group was staff who had attended Foundation Training and then had worked for at least three months on-the-job with people who had developmental disabilities. They were surveyed at the beginning of DDSD's Residential Training classes. As with the first group, participants were drawn from across the state of Oklahoma and were representative of the three geographic areas of service provision for DDSD. Participants were mainly direct care staff working with people with developmental disabilities in either private or public facilities supported by DDSD. Direct care staff included any private or state employed staff who provided habilitative services and/or assistance with daily living skills to people with developmental disabilities within the Oklahoma service system.

The following criteria was applied for selection of the second sample subgroup — information plus contact (IP) participants:

1. Participants had attended Foundation Training within a three-six month time frame.

Rationale: Attendance of Foundation Training constituted the information acquisition requirement for the study.

2. Participants had participated in on-the-job direct care service at either a state-sponsored or private provider facility working directly with people with developmental disabilities for a period of at least three months.

Rationale: Participation in on-the-job direct care service constituted the contact requirement for the study.

Instrumentation

The use of a psychometrically sound instrument to measure attitudes of direct care staff's awareness of and agreement with the desired attitudes toward persons with mental retardation could not be emphasized strongly enough. Such quantitative measures were important in aiding the movement towards empowerment and community living (Antonak, 1982; Henry, Keys, Balcazar, & Jopp, D., 1996; Yuker, Block, & Campbell, 1960). Antonak and Livneh (1988) stated that negative attitudes toward people with disabilities displayed by teachers, neighbors, and employers might constitute barriers to complete integration and acceptance of disabled people. Early identification of these negative attitudes by people developing training programs could result in more efficient and effective programming. Antonak and Livneh (1988) also wrote:

> Knowledge of the development and structure of attitudes toward people with disabilities is considered to be necessary for changing them, and thereby increasing the integration of disabled people into larger society. (Jones and Guskin, 1984, pp. 1-20)

The Scale of Attitudes toward Disabled People (SADP) attitude measurement instrument demonstrated "psychometrically sound and reliable" results for measuring attitudes toward people with disabilities (Antonak & Livneh, 1988) (see Appendix C). Antonak and Livneh (1988) further stated that "practitioners will find the Scale of Attitudes toward Disabled Persons useful in applied settings, such as measuring the effectiveness of professional training programs and attitude change programs" (p. 162).

The scale's item statements were derived by Antonak (1982) from a review of literature, examination of previously published scales, and from analysis of interviews with experts in the field of special education and rehabilitation. During revision, items were edited by a panel of ten experts and then randomly arranged onto a composite scale (Antonak & Livneh, 1988).

Each of the 24 item statements on the SADP contained a six-point Likert-type response scale. Responses ranged from a -3 (Very Unfavorable) to a +3 (Very Favorable). Respondents were required to rate each item based on their agreement or disagreement with the item statement. Higher scores on the scale indicated favorable attitudes toward people with disabilities and, conversely, lower scores indicated unfavorable attitudes.

Reliability analysis of the SADP yielded "Spearman-Brown corrected reliability coefficients ranging from +.81 to +.85, and alpha coefficients ranging from +.88 to +.91" (Antonak & Livneh, 1988, pg. 160). Validity was investigated through analysis of the relationship between the SADP and other attitude scales and through multidimensional scaling analysis (Chan, Hua, & Lam, 1984). Results suggested convergent validity of the SADP as well as the assurance that the factorial structure was compatible across at least two cultures.

Threats to internal validity of the SADP in this research study might include: (a) prior attitudes of subjects toward training and/or people with developmental disabilities; (b) data collector bias; (c) loss of subjects (mortality); (d) location (three statewide areas); and (e) testing/practice effects (pre and post-tests using same scale).

The threats in this research study were addressed by: (a) standardizing the conditions under which the scales were given including the use of standardized trainer "scripts" to maintain consistent administration (see Appendix D); (b) obtaining demographic information for use in analyzing and interpreting the study's results; (c) collecting information prior to training as far as location, times, participant characteristics, etc., to minimize extraneous events from occurring; and (d) using a control group (Information Only).

The Demographics Survey used in data collection was developed using a similar survey by Fiske (1997) as a model (see Appendix E). To aid in establishing validity, the instrument was reviewed by three professionals in the field of developmental disabilities who were chosen because of their expertise in both the field of developmental disabilities and their knowledge of the Developmental Disabilities Services Division. Professionals included the state training director, a review panel member, and an experienced Foundation trainer. The demographics survey was pre-tested and revisions made to aid in establishing item validity.

Methods of Data Collection

All participants attending Foundation Training (staff receiving information only) and Residential Training (staff who have previously received Foundation Training and have at least three months on-the-job experience) were administered the pre and post-tests as part of the normal class routine. All participants were told that the pre and post tests were necessary for judging the effectiveness of DDSD's training programs. Participants were asked to sign a consent form agreeing to participate in the study (see Appendix F).

For the sample groups of information-only (IO) and the Control Group (CG), DDSD staff trainers at 13 training sites across the state of Oklahoma administered the Scale of Attitudes toward Disabled Persons to 347 respondents at the beginning of the four-day long Foundation Training classes from August, 1999 to November, 1999. At the beginning of the Foundation Training class, trainers handed each participant an envelope containing the Demographics Survey, the blue pre-test SADP #1, and the yellow post-test SADP #2. Then using the pre-developed script, trainers described the testing procedure to participants. Participants were asked to answer the blue pre-test SADP #1 at the beginning of the first day of Foundation Training with the caution to "Please respond to every statement."

At the end of the Foundation Training class, participants were asked to rate their responses for the second time using the yellow post-test SADP #2. Responses were returned to the researcher for evaluation. 263 survey sets were returned for a seventy-six percent return rate. There was no attempt to follow up those surveys not returned because participants had left class after the first day and were no longer a part of the training system. Respondents generally completed the pre and post-test SADP's in approximately 15 minutes. Of the 263 returned packets, 58 were not used because of previous attendance in Foundation Training, incompleteness of answers, illegibility, or because the individual indicated they not be used. As a result, a total of 205 surveys (150 in the Information Only group and 55 in the Control Group) were analyzed.

The green SADP-R was administered by Residential trainers across the state of Oklahoma to a second group of participants from August, 1999 through November, 1999. This group, information plus contact (IC), consisted of staff who had attended Foundation Training and then worked in a direct care position for a period of no less than three months. The SADP was administered before the beginning of Residential Training classes and took approximately 15 minutes to complete. 176 out of 250 demographic questionnaires and surveys were returned to the researcher by mail for a 70 percent return rate. There was no attempt to follow up those surveys that were not returned as participants had left class after the first day and were no longer a part of the training system. Out of the 176 returned packets, 17 were discarded because of incompleteness of answers, illegibility, or because the individual indicated they not be used. As a result, a total of 159 useable surveys were returned to the researcher and analyzed.

All returned instruments were hand scored and the raw scores entered into a computer statistical analysis database using the Statistical Package for the Social Sciences (SPSS) software program.

Analysis of Data

Data collected from the two sample groups was formatted to identify the variables of (1) scores on the SADP for each group; and (2) demographic variables including the area of specialization, prior contact with people with developmental disabilities, prior training (other than Foundation Training) in the field of developmental disabilities, and prior on-the-job experience working with people with developmental disabilities. These variables were then analyzed by using descriptive statistical methods including measures of central tendency, *t* tests, Pearson's *r* correlational coefficient and ANOVA.

Measures of central tendencies included percentages, frequency distributions, means, and standard deviations and were used for quantitative description of the population. Independent and paired samples *t* tests were used to compare means to determine if observed differences between two sample means arose by chance or represented a true difference between the IO and IC groups. The means of the independent variables of prior contact, prior training, and prior on-the-job experience between direct care staff and all other areas of specialization were also examined using *t* tests.

Pearson's *r* was used to look at relationships between direct care staff and all other areas of specialization on attitude scores. A one-way Analysis of Variance (ANOVA) was used to compare means between the areas of specialization groups as well as to test the effects of the independent variables of area of specialization, prior contact, prior training and prior on-the-job experience within and between groups. Least Significant Difference (LSD), Scheffe and Tukey post hoc comparisons were conducted to determine if overall significance arose by chance. A confidence level of $p=.05$ was used.

CHAPTER IV

RESULTS

The following questions guided the research:

1. To what extent had Foundation Training positively affected the awareness of, and agreement with, the desired attitudes of Direct Care staff as measured by pre and post-test scores on the Scale of Attitudes toward Disabled People (SADP) measurement instrument before and after attending Foundation Training?
2. To what extent had at least three-months contact with people with developmental disabilities through on-the-job experience positively influenced agreement with the desired attitudes of Direct Care staff toward people with developmental disabilities as measured by scores on the Scale of Attitudes toward Disabled People (SADP)?
3. To what extent were there correlations in the reported agreement of SADP scores between the Control Group (CG), Foundation Training Only (IO) pre and post-test groups, and the Foundation Training plus on-the-job experience (IC) group between (1) all staff, and (2) direct care staff only?
4. To what extent were there differences in attitude as measured by scores on the SADP between the four tested groups (CG, IO pre and post, and IC),

and the independent variables of Prior Contact, Prior Training, and Prior On-the-job experience?

This chapter discusses findings in the following areas: (1) demographics; (2) staff's attitudes toward people with developmental disabilities; and (3) analysis of data. The demographics section included total percentages in each of the demographic categories broken down by sample groups. The section on staff's attitudes toward people with developmental disabilities consisted of group score data for the Scale of Attitude toward Disabled People measurement instrument, and the third area, data analysis, contained statistical results of *t* tests, Pearson *r* correlational coefficients, ANOVA, and post-hoc tests.

DEMOGRAPHICS

A total of 439 staff participated in this research study. Of the original 439 returned surveys, 66 were discarded due to participants attending Foundation Training more than once, the failure to complete Foundation Training if they had enrolled in Residential Training, the failure to complete the survey form, or individual requests not to use survey results. The final sample size consisted of 373 participants in three groups. Group IO (Information Only -- IO pre and post) consisted of 150 participants who were attending Foundation Training for the first time. Group IC (Information plus Contact — IC) consisted of 159 participants who had attended Foundation Training and then been on-the-job for at least three months. Group CG (Control Group -- CG) was a control group of 55 participants who received only the post-test after completion of Foundation Training. Demographic information for the three groups is summarized in Table II.

TABLE II

DEMOGRAPHICS

Demographics	Group IO		Group IC		Group CG	
	f	%	*f*	%	*f*	%
Gender:						
Male	36	24.0	27	17.0	13	23.6
Female	112	74.7	122	76.7	40	72.7
No Response	2	1.3	1	.6	2	3.7
Totals	150	100	159	100	55	100
Age:						
18-25	52	34.7	38	23.9	18	32.8
26-35	36	24.0	46	28.9	13	23.6
36-45	32	21.3	45	28.3	13	23.6
46-55	18	12.0	20	12.6	9	16.4
Over 55	12	8.0	6	3.8	1	1.8
No Response			4	2.5	1	1.8
Totals	150	100	159	100	55	100
Area:						
Area I	54	36.0	19	11.9	11	20.0
Area II	79	52.7	98	61.6	44	80.0
Area III	17	11.3	42	26.4	0	0
No Response						
Totals	150	100	159	100	55	100
Area of Specialization:						
Direct Care/HTS	105	70.0	143	90.5	46	83.7
Vocational	20	13.3	3	1.9	2	3.6
Case	1	.7	0	0	0	0
Management	1	.7			0	0
Professional	10	6.7	0	0	1	1.8
Admin/Super.	4	2.7	5	3.2	1	1.8
Support	9	6.0	1	.6	5	9.1
Other			6	3.8		
No Response			1	.6		
Totals	150	100	159	100	55	100

Prior Contact:						
Family Member or Friend	54	36.0	66	41.5	19	34.5
Previously Worked	66	44.0	73	45.9	26	47.3
No Prior Contact	30	20.0	20	12.6	10	18.2
No Response						
Totals	150	100	159	100	55	100
Prior Training:						
Lecture	39	26.0	92	57.9	11	20.0
Experiential	35	23.3	41	25.8	15	27.3
Distance Education	2	1.3	1	.6	1	1.8
No Prior Training	74	49.3	25	15.7	28	50.9
No Response						
Totals	150	100	159	100	55	100

Group IO — Information Only — consisted of 112 (74.7%) females, 36 (24%) males, and 2 (1.3%) non-respondents. Respondents ranged in age from 18 years to age 55 or over. Over one half (58.7%) of the sample ranged between the ages of 18 - 35. Area demographics included 54 (36%) respondents from Area I, 79 (52.7%) from Area II, and 17 (11.3%) from Area III. Direct Care Staff comprised 70% of the sample (105 respondents). Eighty percent of the respondents (120) had some form of prior contact with people with developmental disabilities, either having a family member or friend with developmental disabilities or having previously worked with people with developmental disabilities. Half of the respondents (50.7%) had prior training in the field of developmental disabilities in the form of lecture, distance education, and experiential or work-related training.

Group IC — Information plus Contact — consisted of 122 (76.7%) females, 27 (17%) males, and 1 (.6%) non-respondents. The group ranged in age from 18 years to 55 or over. Over half (58.7%) the sample ranged between the ages of 18 - 35. Area demographics included 19 (11.9%) respondents from Area I, 98 (61.6%) from Area II, and 42 (26.4%) from Area III. Direct Care Staff comprised 90.5% of the sample (143 respondents). One hundred and thirty-nine respondents (87.4%) had some form of prior contact with people with developmental disabilities, either having a family member or friend with developmental disabilities or having previously worked with people with developmental disabilities. Over two-thirds of the respondents (83.7%) had prior training in the field of developmental disabilities in the form of lecture, distance education, and experiential or work-related training.

The information only control group (CG) consisted of 40 (72.7%) females, 13 (23.6%) males, and 2 (3.7%) non-respondents. Respondents ranged in age from 18 years to 55 or over. Over half (56.4%) the sample ranged between the ages of 18 - 35. Area demographics included 11 (20%) respondents from Area I, and 44 (80%) from Area II. Direct Care Staff comprised 83.7% of the sample (46 respondents). Forty-five respondents (81.8%) had some form of prior contact with people with developmental disabilities, either having a family member or friend with developmental disabilities or having previously worked with people with developmental disabilities. Twenty-seven respondents (49.1) had prior training in the field of developmental disabilities in the form of lecture, distance education, and experiential or work-related training.

Summarized, demographics revealed that most respondents were female, between the age of 18-35, worked in Area II, and specialized as direct care staff. Most respondents had prior contact with people with disabilities either in the form of a family member or friend with developmental disabilities or on-the-job experience working with someone with developmental disabilities. Those respondents attending Foundation Training for the first time were split almost equally in half concerning prior training — half had prior training in the field of developmental disabilities and half had not. Almost all of the respondents attending Foundation Training and then working at least three months on-the-job with people who had developmental disabilities had prior training in the field of developmental disabilities.

Staff's Attitudes Toward People with Developmental Disabilities

The Scale of Attitudes toward Disabled People (SADP) was scored by summing the total responses on the instrument, reversing the sign to positive of the negatively worded questions (1, 3, 4, 7, 8, 9, 10, 14, 17, 18, 19, 22) to eliminate negative values and then adding the constant value of 72. Possible scores could range between 0 and 144 (median = 72) with the higher the score the more favorable the person's attitude toward people with developmental disabilities. The SADP had been extensively tested for both validity and reliability but there were no numerical group norms for scores on the instrument (Antonak & Livneh, 1988).

Within, and between, the three groups tested, scores ranged from a low of 51 to a high of 144. The lowest score, 51, indicated a negative attitude toward people with developmental disabilities and the highest score, 144, indicated a very positive attitude. Mean group scores for the sum of all items and standard deviations are given in Table III.

TABLE III

Mean Group Scores and Standard Deviations
for all Groups

	Group CG	Pretest — IO — Posttest		Group IC
Mean	106.31	105.09	117.12	110.02
SD	19.33	19.05	17.94	18.36

Group IO (Information Only) had a mean score of 105.09 (standard deviation of 19.05) on the pre-test given before attending Foundation Training and a mean score of 117.12 (standard deviation of 17.94) on the post-test after attending Foundation Training. Group IC (Information plus Contact) was administered the SADP after attending Foundation Training and working with people with developmental disabilities for at least three months. The mean score for this group was 110.02 (standard deviation of 18.36). Group CG (Control Group) was not pre-tested to aid in eliminating practice effects, but was administered the SADP as a post-test after attending Foundation Training. The mean scores of Group CG was 106.31 with a standard deviation of 19.33, nine and a half points (9.56) lower than the post-test scores of the IO group.

Little difference in means existed between the Control Group (106.6) and the pre-test Information Only Group (104.6). A larger increase in mean scores was observed in the post-test Information Only Group (115.6) and the Information plus Contact Group (112.6). However, there was a small decrease the post-test IO Group (115.6) and the IC Group (112.6). The mean scores of all three groups were above 70% indicating a positive attitude toward people with developmental disabilities. Responses of the three groups to the 24 questions on the SADP are illustrated in Table IV.

TABLE IV

Answers To Scale of Attitudes toward Disabled People (SADP)

SADP Responses: -3=Disagree very much -2=Disagree pretty much -1=Disagree a little 1=Agree a little 2=Agree pretty much 3=Agree very much		Groups							
		Pretest --(IO)-- Post test				(IC)		(CG)	
	Value	*n*	%	*n*	%	*n*	%	*n*	%
1. Disabled children should not be provided with a free public education.	-3	112	74.7	131	87.3	123	77.8	48	87.3
	-2	11	7.3	5	3.3	10	6.3	3	5.5
	-1	7	4.7	3	2.0	5	3.2	1	1.8
	1	3	2.0	0	0	4	2.5	1	1.8
	2	6	4.0	2	1.3	3	1.9	0	0
	3	11	7.3	9	6.0	13	8.2	2	3.6
Mean Score		-2.11		-2.50		-2.18		-2.62	
Mode		-3		-3		-3		-3	
% Disagree		86.7		92.6		87.3		94.5	
2. Disabled people are not more accident prone than other people.	-3	34	22.8	22	14.7	25	16.1	13	24.1
	-2	31	20.8	17	11.3	18	11.6	14	25.9
	-1	30	20.1	33	22.0	24	15.5	10	18.5
	1	16	10.7	20	13.3	21	13.5	6	11.1
	2	20	13.4	21	14.0	28	18.1	5	9.3
	3	18	12.1	37	24.7	39	25.2	6	11.1
Mean Score		-.56		.27		.38		-.80	
Mode		-3		3		3		-2	
% Disagree		63.7		48.0		46.2		68.5	
3. A disabled individual is not capable of making moral decisions.	-3	69	46.0	96	64.4	99	62.3	26	47.3
	-2	25	16.7	20	13.4	28	17.6	11	20.0
	-1	24	16.0	15	10.1	13	8.2	12	21.8
	1	21	14.0	7	4.7	9	5.7	4	7.3
	2	6	4.0	8	5.4	6	3.8	1	1.8
	3	5	3.3	3	2.0	4	2.5	1	1.8
Mean Score		-1.55		-2.09		-2.09		-1.87	
Mode		-3		-3		-3		-3	
% Disagree		78.7		87.9		88.1		89.1	

4. Disabled people should be prevented from having children.	-3	58	38.7	80	53.3	76	48.4	23	41.8
	-2	18	12.0	23	15.3	26	16.6	7	12.7
	-1	35	23.3	21	14.0	26	16.6	11	20.0
	1	23	15.3	15	10.0	16	10.2	6	10.9
	2	12	8.0	9	6.0	5	3.2	3	5.5
	3	4	2.7	2	1.3	8	5.1	5	9.1
Mean Score		-1.24		-1.79		-1.63		-1.22	
Mode		-3		-3		-3		-3	
% Disagree		74.0		82.6		81.6		74.5	
5. Disabled people should be allowed to live where and how they choose.	-3	9	6.0	7	4.7	16	10.1	4	7.3
	-2	7	4.7	10	6.7	11	6.9	6	10.9
	-1	21	14.0	8	5.3	8	5.0	5	9.1
	1	26	17.3	9	6.1	16	10.1	5	9.1
	2	26	17.3	17	11.3	30	18.9	12	21.8
	3	61	40.7	98	66.0	78	49.1	23	41.8
Mean Score		1.33		2.38		1.46		1.25	
Mode		3		3		3		3	
% Disagree		24.7		16.7		22.0		27.3	
6. Adequate housing for disabled people is neither too expensive nor too difficult to build.	-3	19	12.7	26	17.4	26	16.7	8	14.8
	-2	15	10.0	14	9.4	11	7.1	7	13.0
	-1	24	16.0	12	8.1	21	13.5	6	11.1
	1	21	14.0	13	8.7	17	10.9	6	11.1
	2	30	20.0	20	13.4	38	24.4	11	20.4
	3	41	27.3	64	43.0	43	27.6	16	29.6
Mean Score		.62		.85		.65		.59	
Mode		3		3		3		3	
% Disagree		38.7		34.9		37.3		78.2	
7. Rehabilitation programs for disabled people are too expensive to operate.	-3	88	59.5	87	58.0	77	49.7	11	20.0
	-2	25	16.9	21	14.0	46	29.7	7	12.7
	-1	13	8.8	18	12.0	12	7.7	7	12.7
	1	11	7.4	12	8.0	9	5.8	11	20.0
	2	6	4.1	5	3.3	10	6.5	8	14.5
	3	5	3.4	7	4.7	1	.6	11	20.0
Mean Score		-1.95		-1.85		-1.95		-1.78	
Mode		-3		-3		-3		-3	
% Disagree		85.2		84.0		87.1		45.4	

8. Disabled people	-3	16	10.7	56	37.3	40	25.2	11	20.0
are in many ways	-2	15	10.0	24	16.0	14	8.8	7	12.7
like children.	-1	12	8.0	15	10.0	28	17.6	7	12.7
	1	41	27.3	31	20.7	44	27.7	11	20.0
	2	40	26.7	15	10.0	17	10.7	8	14.5
	3	26	17.3	9	6.0	16	10.1	11	20.0
Mean Score		.73		-.95		-.31		.11	
Mode		1		-3		1		-3	
% Disagree		28.7		63.3		51.6		45.4	
9. Disabled people	-3	52	36.4	68	47.2	82	53.2	24	44.4
need only the proper	-2	15	10.5	14	9.7	21	13.6	7	13.0
environment and	-1	23	16.1	16	11.1	12	7.8	7	13.0
opportunity to	1	29	20.3	17	11.8	24	15.6	8	14.8
develop and express	2	9	6.3	12	8.3	5	3.2	4	7.4
criminal tendencies.	3	15	10.5	17	11.8	10	6.5	4	7.4
Mean Score		-.82		-1.08		-1.53		-1.20	
Mode		-3		-3		-3		-3	
% Disagree		63.0		68.0		74.6		70.4	
10. Disabled adults	-3	92	61.3	109	73.2	116	73.4	29	52.7
should be	-2	18	12.0	16	10.7	16	10.1	8	14.5
involuntarily	-1	23	15.3	15	10.1	17	10.8	9	16.4
committed to an	1	12	8.0	5	3.4	4	2.5	6	10.9
institution following	2	4	2.7	1	.7	2	1.3	1	1.8
arrest.	3	1	.7	3	2.0	3	1.9	2	3.6
Mean Score		-2.08		-2.40		-2.41		-1.78	
Mode		-3		-3		-3		-3	
% Disagree		88.6		94.0		94.3		83.6	
11. Most disabled	-3	3	2.0	2	1.3	3	1.9	1	1.9
people are willing to	-2	5	3.3	4	2.7	1	.6	2	3.7
work.	-1	5	3.3	9	6.0	8	5.0	3	5.6
	1	25	16.7	10	6.7	20	12.6	6	11.1
	2	44	29.3	36	24.2	40	25.2	20	37.0
	3	68	45.3	88	59.1	87	54.7	22	40.7
Mean Score		1.95		2.17		2.15		1.89	
Mode		3		3		3		3	
% Disagree		8.6		10.0		7.5		11.2	

12. Disabled individuals are able to adjust to a life outside an institutional setting.	-3	6	4.0	1	.7	4	2.5	1	1.8
	-2	6	4.0	2	1.3	1	.6	1	1.8
	-1	3	2.0	1	.7	5	3.1	0	0
	1	21	14.0	6	4.0	12	7.5	8	14.5
	2	40	26.7	28	18.7	31	19.5	18	32.7
	3	74	49.3	112	74.7	106	66.7	27	49.1
Mean Score		1.93		2.60		2.35		2.18	
Mode		3		3		3		3	
% Disagree		10.0		2.7		6.2		3.6	
13. Disabled people should not be prohibited from obtaining a driver's license.	-3	20	13.5	16	10.7	15	9.5	3	5.5
	-2	17	11.5	14	9.4	14	8.9	7	12.7
	-1	22	14.9	15	10.1	23	14.6	13	23.6
	1	32	21.6	27	18.1	32	20.3	15	27.3
	2	23	15.5	28	18.8	31	19.6	7	12.7
	3	34	23.0	49	32.9	43	27.2	10	18.2
Mean Score		.43		.93		.80		.42	
Mode		3		3		3		1	
% Disagree		39.9		30.2		32.0		41.8	
14. Disabled people should live with others of similar disability.	-3	35	23.6	75	50.0	66	41.8	18	32.7
	-2	27	18.2	22	14.7	34	21.5	12	21.8
	-1	29	19.6	18	12.0	20	12.7	6	10.9
	1	25	16.9	15	10.0	14	8.9	12	21.8
	2	20	13.5	8	5.3	14	8.9	6	10.9
	3	12	8.1	12	8.0	10	6.3	1	1.8
Mean Score		-.59		-1.47		-1.35		-1.04	
Mode		-3		-3		-3		-3	
% Disagree		61.4		76.7		76.0		65.4	
15. Zoning ordinances should not discriminate against disabled people by prohibiting group homes in residential districts.	-3	8	5.4	15	10.1	9	5.7	5	9.3
	-2	3	2.0	4	2.7	5	3.2	2	3.7
	-1	4	2.7	3	2.0	8	5.1	3	5.6
	1	18	12.2	9	6.0	9	5.7	2	3.7
	2	25	17.0	16	10.7	13	8.3	10	18.5
	3	89	60.5	102	68.5	113	72.0	32	59.3
Mean Score		2.05		1.95		2.10		1.78	
Mode		3		3		3		3	
% Disagree		10.1		14.8		14.0		18.6	

16. The opportunity for gainful employment should be provided to disabled people.	-3	2	1.4	3	2.0	5	3.2	1	1.8
	-2	1	.7	2	1.4	0	0	1	1.8
	-1	2	1.4	1	.7	4	5.7	4	7.3
	1	14	9.5	6	4.1	8	5.1	3	5.5
	2	34	23.0	18	12.2	22	13.9	11	20.0
	3	95	64.2	117	79.6	119	75.3	35	63.6
Mean Score		2.41		2.58		2.47		2.20	
Mode		3		3		3		3	
% Disagree		3.5		4.1		5.7		10.9	
17. Disabled children in regular classrooms have an adverse effect on other children.	-3	50	33.8	71	48.6	72	45.6	23	41.8
	-2	23	15.5	27	18.5	26	16.5	9	16.4
	-1	18	12.2	15	10.3	20	12.7	6	10.9
	1	33	22.3	13	8.9	25	15.8	11	20.0
	2	13	8.8	11	7.5	12	7.6	4	7.3
	3	11	7.4	9	6.2	3	1.9	2	3.6
Mean Score		-.82		-1.51		-1.46		-1.24	
Mode		-3		-3		-3		-3	
% Disagree		61.5		77.4		74.8		69.1	
18. Simple repetitive work is appropriate for disabled people.	-3	25	16.9	49	33.3	48	30.6	12	21.8
	-2	14	9.5	11	7.5	34	21.7	8	14.5
	-1	20	13.5	16	10.9	21	13.4	3	5.5
	1	37	25.0	24	16.3	20	12.7	11	20.0
	2	25	16.9	27	18.4	21	13.4	10	18.2
	3	27	18.2	20	13.6	13	8.3	11	20.0
Mean Score		.30		-.32		-.84		.16	
Mode		1		-3		-3		-3	
% Disagree		39.9		40.7		65.7		41.8	
19. Disabled people show a deviant personality profile.	-3	54	37.0	73	49.7	79	52.3	23	41.8
	-2	22	15.1	20	13.6	25	16.6	12	21.8
	-1	27	18.5	23	15.6	22	14.6	7	12.7
	1	28	19.2	19	12.9	14	9.3	8	14.5
	2	7	4.8	8	5.4	6	4.0	2	3.6
	3	8	5.5	4	2.7	5	3.3	3	5.5
Mean Score		-1.14		-1.60		-1.77		-1.44	
Mode		-3		-3		-3		-3	
% Disagree		70.6		78.9		83.5		76.3	

20. Equal employment opportunities should be available to disabled individuals.	-3	2	1.4	0	0	3	1.9	3	5.5
	-2	1	.7	1	.7	4	2.6	1	1.8
	-1	2	1.4	3	2.0	2	1.3	1	1.8
	1	17	11.5	10	6.8	9	5.8	2	3.6
	2	25	16.9	18	12.2	20	12.8	12	21.8
	3	101	68.2	116	78.4	118	75.6	36	65.5
Mean Score		2.43		2.63		2.46		2.22	
Mode		3		3		3		3	
% Disagree		3.5		2.7		5.8		9.1	
21. Laws to prevent employers from discriminating against disabled people should be passed.	-3	8	5.5	6	4.1	12	7.5	4	7.3
	-2	0	0	1	.7	3	1.9	1	1.8
	-1	5	3.4	2	1.4	5	3.1	2	3.6
	1	13	9.0	4	2.7	11	6.9	6	10.9
	2	17	11.7	15	10.2	14	8.8	4	7.3
	3	102	70.3	119	81.0	114	71.7	38	69.1
Mean Score		2.23		2.51		2.10		2.04	
Mode		3		3		3		3	
% Disagree		8.9		6.2		12.5		12.7	
22. Disabled people engage in bizarre and deviant sexual activity.	-3	79	54.5	96	65.8	99	63.1	35	63.6
	-2	22	15.2	18	12.3	20	12.7	8	14.5
	-1	20	13.8	15	10.3	14	8.9	5	9.1
	1	17	11.7	7	4.8	13	8.3	4	7.3
	2	6	4.1	7	4.8	8	5.1	2	3.6
	3	1	.7	3	2.1	3	1.9	1	1.8
Mean Score		-1.86		-2.12		-1.99		-2.09	
Mode		-3		-3		-3		-3	
% Disagree		83.5		88.4		84.7		87.2	
23. Disabled workers should receive at least the minimum wage established for their jobs.	-3	8	5.4	3	2.0	10	6.3	5	9.1
	-2	2	1.4	4	2.7	5	3.1	1	1.8
	-1	7	4.8	6	4.1	3	1.9	1	1.8
	1	13	8.8	14	9.5	16	10.1	3	5.5
	2	22	15.0	12	8.2	15	9.4	7	12.7
	3	95	64.6	108	73.5	110	69.2	38	69.1
Mean Score		2.09		2.31		2.09		2.05	
Mode		3		3		3		3	
% Disagree		11.6		8.8		11.3		12.7	

24. Disabled individuals can be expected to fit into competitive society.	-3	6	4.1	3	2.0	7	4.5	3	5.5
	-2	9	6.2	4	2.7	6	3.8	2	3.6
	-1	23	15.8	13	8.8	14	9.0	4	7.3
	1	31	21.2	18	12.2	32	20.5	11	20.0
	2	45	30.8	31	21.1	33	21.2	14	25.5
	3	32	21.9	78	53.1	64	41.0	21	38.2
Mean Score		1.08		1.93		1.56		1.55	
Mode		2		3		3		3	
% Disagree		26.1		13.5		17.3		16.4	

* Percentages calculated using absolute values

Individual item statements on the SADP with mean values greater than -1 and less than +1 indicated attitudes that were more neutral in nature and not as well defined as means with values less than -1 or greater than +1 (Fiske, 1997). Item statements 2, 6, 8, 13, and 18, contained neutral values across all group means and perhaps signified areas of the Foundation Training curriculum that needed either clarification or emphasis. These item statements were respectively: (1) Item 2 — Disabled people are not more accident prone than other people; (2) Item 6 — Adequate housing for disabled people is neither too expensive nor too difficult to build; (3) Item 8 — Disabled people are in many ways like children; (4) Disabled people should not be prohibited from obtaining a driver's license; and (5) Simple repetitive work is appropriate for disabled people.

The SADP contained questions that examined attitudes toward people with developmental disabilities in three areas: (1) general beliefs about characteristics of people who have developmental disabilities; (2) societal attitudes and community living options; and (3) vocational and employment issues (Antonak & Livneh, 1988). The means for each of these categories for all groups tested are given in Table V.

TABLE V

Group Mean Attitude Scores for all Groups
on Categories of the SADP

Categories	Means			
	Group CG	Group IO (pretest)	Group IO (posttest)	Group IC
1. General Attitudes: (1,2,3,4,7,8,9,10, 13,17,19,22)	1.36	1.01	1.56	1.48
2. Societal and community options: (5,6,12,14,15,24)	1.40	1.27	1.86	1.58
3. Employment and vocational issues: (11,16,18,20,21, 23)	1.64	1.72	2.00	2.00

Twelve questions on the SADP (1, 2, 3, 4, 7, 8, 9, 10, 13, 17, 19, 22) asked respondents to rate their general beliefs about characteristics of people with developmental disabilities. The group means for these questions for all four groups ranged from a low of +1.01 (IO pretest) to a high of +1.56 (IO posttest). The Control Group scored a +1.36 and the Information plus Contract Group scored a +1.56. Mean scores indicated positive attitudes for all groups toward general characteristics of people with developmental disabilities.

Societal and community living options (5, 6, 12, 14, 15, 24) was the second category addressed on the SADP. Mean scores for all groups on questions regarding societal and community living options for people with developmental disabilities ranged from a low of +1.27 (IO pretest) to a high of +1.86 (IO posttest) signifying respondents believed that people with developmental disabilities were able to live, and be integrated successfully into both social and community settings. The control group (CG) scored 1.40 and the Information plus Contact (IC) group scored 1.58.

The third and last category addressed on the SADP was vocational and employment issues (11, 16, 18, 20, 21, 23). Means for all groups ranged between a low of +1.64 (Control Group) and +1.82 (IO pretest) to a high of +2.00 (IO posttest and IC) indicating that respondents firmly believed that people with developmental disabilities should be able to hold regular jobs in the community as well as be paid competitive wages for their work.

Total scores on the SADP were generally positive across all groups. Five SADP questions revealed areas in Foundation Training that needed to be strengthened. In general, all three categories of the SADP revealed positive attitudes across all groups tested.

Data Analysis

The total attitude scores of each of the four groups were used to compare attitudes between groups, as well as examine the influence of demographics on attitudes. Statistical tests included measures of central tendency, *t* tests, Pearson's *r*, and ANOVA,

Normal Distribution of Data

The positive linear relationships between the four groups and the norm are portrayed in Figures 8 — 11.

Figure 8: Normal Distribution of IC

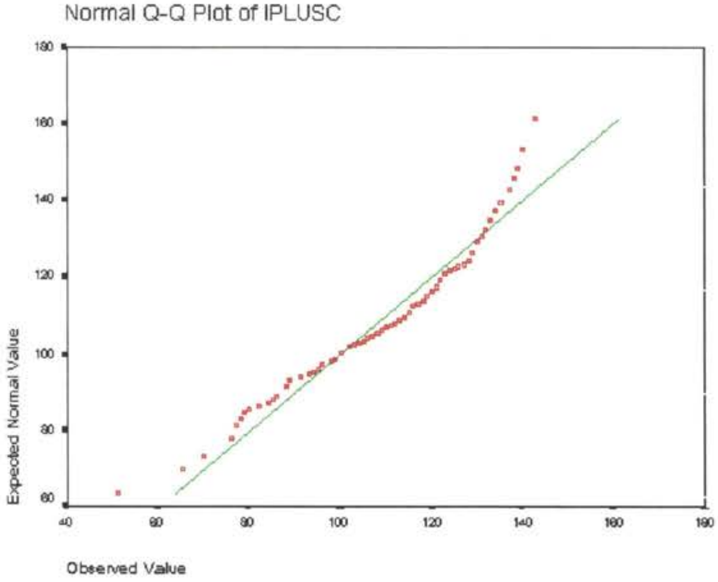


Figure 9: Normal distribution of CG

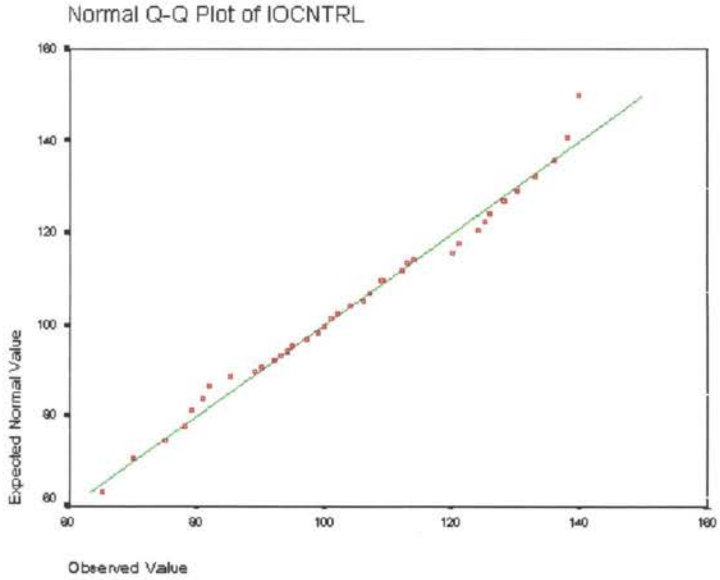


Figure 10: Normal distribution of IO pretest

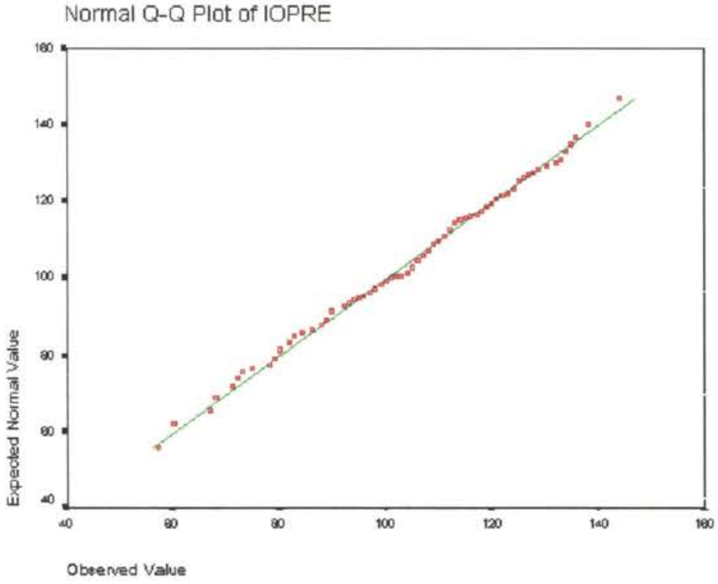
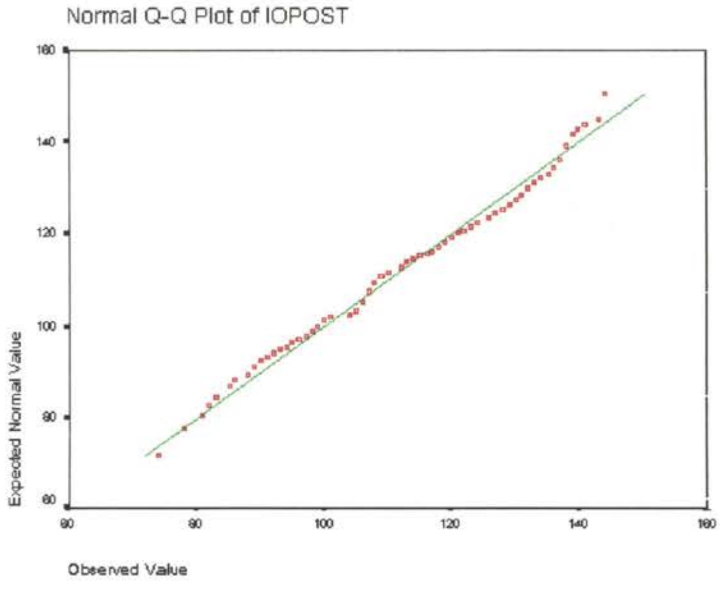


Figure 11: Normal distribution of IO posttest



t Tests and Pearson's *r*

A paired samples two-tailed *t* test was used to determine if there was a significant effect between pre and post-test scores for those participants attending Foundation Training for the first time (IO pre and post) (see Table VI).

Table VI. Pre and post-test attitude scores (SADP) and area of specialization (paired samples *t* tests)

Variable	n	M	sd	*t*	df	*p*
All areas of specialization staff — (IO)						
IO pre	130	105.09	19.05			
IO post	130	117.12	17.94			
IO pre / post	130	-12.03	15.96	-8.595	129	.000*
Direct care staff — (IO)						
IO pre	90	105.17	18.10			
IO post	90	115.72	16.29			
IO pre / post	90	-10.56	14.70	-6.810	89	.000*

* *p* significant at .05

The paired samples *t* test indicated that the mean of the post-test scores of Group IO (116.61) differed significantly from the mean of the pre-test scores of Group IO (105.09) with a significant *p* value of .000 (*p* significant at .05) indicating that attitudes had been positively influenced at the conclusion of Foundation Training. This test was also run using the filtered variable of direct care staff under the Area of Specialization variable. Direct care staff's mean for pre-test scores was 105.17 ($p = .000$) which also differed significantly from the mean of the pre-test scores of the direct care staff's IO post test scores of 115.72.

Pearson's product-moment correlation coefficient (Pearson's *r*) measured the strength of association between two variables, described a linear relationship between two variables, and provided an index of the strength of a relationship as well as the direction, either positive or negative, of that relationship (Shavelson, 1988). Pearson's *r* was used to examine the relationship between pre and post test groups of Information Only (IO pre and IO post), Information Only post (IO post) and the control group (CG), Information Only post (IO post) and Information plus Contact (IC), and the Information Only pretest (IO pre and the Control Group (CG) for both direct care staff and all other areas of specialization (Table VII).

Table VII. Attitude scores (SADP) and
area of specialization (Pearson *r* Correlation Coefficient)

Variables	N	*r*	Sig. (two-tailed)
All areas of specialization			
IO post / IO pre	130	.649	.000*
IO post / CG	46	.015	.919
IO post / IC	121	-.220	.015**
IO pre / CG	48	-.104	.483
Direct Care Staff only			
IO post / IO pre	34	.706	.000*
IO post / CG	36	.016	.928
IO post / IC	111	-.203	.033**
IO pre / CG	39	-.012	.944

* p significant at .05 for IO post/ IO pre for (1) all staff, and (2) direct care staff only
** p significant at .05 for IO post and IC for (1) all staff, and (2) direct care staff only

Pearson's *r* indicated a strong correlation in both direct care staff and all areas of specialization between the pre and post-test IO scores (.000/.000)) as well as the IO post and the Information plus Contact (IC) (.000/.033). A *p* value of .05 was used to determine significant correlation.

The independent variables of (1) prior contact with people with developmental disabilities, (2) prior training in the field of developmental disabilities, and (3) prior on-the-job experience working with people with developmental disabilities were also examined using the independent samples *t* test for post-test scores of Group IO and for Group IC. A second test, using a filtered variable for direct care staff, determined relationships between direct care staff and all other staff in Group IO and IC and the three independent demographic variables. The variance of the means of the three independent variables and their relationship to each case was examined for significance using Levene's Test of Equality of Error variance for both the IO and IC groups (Table VIII and IX).

Table VIII. IO post Attitude scores (SADP) and demographic variables (independent samples *t* test)

Variable	n	M	sd	*t*	sig 2-tailed	Levene's Test for Equality of Variances (Equal variance assumed)	
						F	Sig
IO post — all areas of specialization							
Prior Contact							
Prior contact	95	115.41	17.09	-.144	.886	.088	.767
No prior contact	49	115.84	16.29				
Prior Training							
Prior training	66	113.92	16.92	-1.075	.284	.095	.759
No prior training	78	116.94	16.62				
On-the-job Experience							
Prior experience	61	114.02	15.62	-.996	.321	1.69	.196
No prior experience	81	116.86	17.74				
IO post — Direct Care staff only							
Prior Contact							
Prior contact	59	114.17	17.19	-.006	.995	.014	.905
No prior contact	42	114.19	16.22				
Prior Training							
Prior training	51	113.69	16.38	-.297	.767	.001	.976
No prior training	50	114.68	17.19				
On-the-job Experience							
Prior experience	47	113.68	15.58	-.331	.742	1.093	.298
No prior experience	52	114.81	18.07				

Table IX IC Attitude scores (SADP) and demographic variables (independent samples *t* test)

Variable	n	M	sd	*t*	sig 2-tailed	Levene's Test for Equality of Variances (Equal variance assumed)	
						F	Sig
IC — All areas of specialization							
Prior Contact							
Prior contact	77	109.75	19.71	-2.017	.046	1.401	.239
No prior contact	59	116.51	17.47				
Prior Training — (other than Foundation)							
Prior training	20	117.70	13.97	1.305	.194	2.992	.086
No prior training	116	111.72	19.64				
On-the-job Experience							
Prior experience	11	112.00	18.55	-.132	.895	.044	.834
No prior experience	124	112.79	19.11				
IC — Direct Care staff only							
Prior Contact							
Prior contact	72	109.18	19.76	-2.006	.047	2.086	.151
No prior contact	52	115.96	16.79				
Prior Training —							
(other than Foundation)	20	117.70	13.97	1.481	.141	2.721	.102
Prior training	104	110.93	19.46				
No prior training							
On-the-job Experience	10	113.30	19.02	.199	.843	.076	.784
Prior experience	113	112.06	18.88				
No prior experience							

Levene's Test for Equality of Variances examined the assumption that the variance of each dependent variable was the same as the variance of all other dependent variables by conducting an ANOVA on the differences between each case and the mean for that variable (George & Mallery, 1999). Neither the independent *t* tests nor Levene's Test for

Equality of Variances revealed any significant relationships between the demographic variables of prior contact, prior training and prior on-the-job experience, and IO post or IC scores.

One-Way Analysis of Variance

One-Way Analysis of Variance (ANOVA) was used to compare sample means to determine if there was evidence inferring that the means of the corresponding population distributions also differ. The ANOVA differed from *t* tests in that it could compare many distributions at once while *t* tests only compared two distributions. One-way ANOVA was used to examine the differences in mean scores of levels of the independent variable, Area of Specialization. It was also used to examine levels of the independent variables of Prior Training, Prior Contact and Prior On-the-job Experience. Levels of the independent variables that contained two or fewer respondents were deleted in order to perform the post hoc tests, Least Significant Difference, and Tukey HSD (Table X, Table XI, Table XII, and Table XIII).

Table X. Attitude scores (SADP) and
Area of Specialization independent variable (One-Way ANOVA)

	CG Control Group	IO Pre-Test Group	IO Post-test Group	IC Information plus Contact
Direct Care	n=46	n=100	n=101	n=124
Mean	107.28	104.36	114.18	112.02
Standard Deviation	19.16	18.34	16.71	18.80
Vocational	n=3	n=17	n=18	
Mean	115.00	102.53	114.28	NV
Standard Deviation	9.85	24.03	19.47	
Case Management				
Mean	NV	NV	NV	NV
Standard Deviation				
Professional				
Mean	NV	NV	NV	NV
Standard Deviation				
Admin/Supervisory		n=9	n=10	n=5
Mean	NV	110.89	127.90	116.00
Standard Deviation		12.71	6.12	17.52
Support Staff		n=5	n=4	
Mean	NV	115.00	130.75	NV
Standard Deviation		15.18	13.84	
Other	n=5			n=5
Mean	101.4	NV	NV	120.60
Standard Deviation	20.23			25.44

NV = values≤ 2

Table XI. One-Way ANOVA of Area of Specialization

Variable	Sum of Squares	df	Mean Square	F	Sig.
CG — Control Group					
Between Groups	350.974	2	175.487	.488	.617
Within Groups	18342.526	51	359.657		
Total	18693.500	53			
IO — Information Only Pre-test Group					
Between Groups	956.767	3	318.922	.905	.441
Within Groups	44762.164	127	352.458		
Total	45718.931	130			
IO - Information Only Post-test Group					
Between Groups	2664.654	3	888.218	3.248	.024*
Within Groups	35282.053	129	273.504		
Total	37946.707	132			
IC — Information plus Contact Group					
Between Groups	417.365	2	208.683	.578	.563
Within Groups	47308.127	131	361.131		
Total	47725.493	133			

* Post hoc tests (LSD and Tukey) reveal a significant differences between groups at the .05 level

Table XII. One-Way ANOVA of Levels of Independent Variables of Prior Contact, Prior Training and Prior On-the-Job Experience and Information Only (posttest)

Variable	Sum of Squares	df	Mean Square	F	Sig.
Prior Contact					
Between Groups	75.076	2	376.038	1.160	.316
Within Groups	45708.94	141	324.176		
Prior Training					
Between Groups	546.982	2	273.491	.840	.434
Within Groups	45913.96	141	325.631		
Prior On-The-Job Experience					
Between Groups	425.207	2	425.207	1.312	.254
Within Groups	46035.731	141	324.195		

Table XIII. One-Way ANOVA Contrast Tests of Levels of Independent Variables of Prior Contact, Prior Training and Prior On-the-Job Experience and Information Only (posttest)

Variable	Value of Contrast	Std. Error	t	dt	Sig. (2-tailed)
Prior Contact					
Assume equal variance	-8.14	7.71	-1.056	141	.293
Does not assume equal variance	-8.14	6.57	-1.239	49.961	.221
Prior Training					
Assume equal variance	7.66	6.05	1.266	141	.207
Does not assume equal variance	7.66	5.90	1.299	139.424	.196
Prior On-The-Job Experience					
Assume equal variance	-3.48	3.04	-1.145	142	.254
Does not assume equal variance	-3.48	2.93	-1.185	140.985	.238

For the CG (control) group, none of the levels of Area of Specialization differed significantly from each other at the $p = .05$ level. Levene's test for Homogeneity of Variance also indicated that variances in scores for each of the areas of specialization did not differ significantly (.384). Post hoc tests of LSD (Least Significant Difference) and Tukey HSD also showed no significant differences between pairwise comparisons.

The IO (information only — pre-test) group also revealed no significant differences between areas of specialization on attitude scores. Levene's test for Homogeneity (.292) and post hoc tests (LSD and Tukey HSD) also indicated no significant differences between the areas of specialization. However, the IO (information only — post test) scores revealed a significant difference (.024) between areas of specialization and SADP post-test scores. Levene's test also indicated a significant variance in means (.011). The post hoc LSD revealed a significant difference between Direct Care staff and Administrative/Supervisory staff (.014) and Vocational (.039) on SADP scores.

The IC (information plus contact) group scores indicated no significant difference between the means of areas of specialization. Levene's test and post hoc tests also revealed no significant differences between areas of specialization.

The levels of the independent variables of the IO posttest group of Prior Contact, Prior Training, and Prior On-the-job Experience indicated no significant difference in between or within group comparisons. Contrast tests also showed no significance between levels of each of the independent variables.

Summary

Overall mean scores on the SADP revealed positive attitudes toward people with developmental disabilities in all groups tested. Means of individual questions revealed five questions that contained essentially neutral scores perhaps indicating areas of the curriculum that need strengthened. Positive attitudes across all groups also remained consistent within the three subject categories of the SADP.

Data analysis of the normally distributed groups revealed a significant difference in scores between pre and post test scores for (1) all staff; and, (2) direct care staff only. A strong positive relationship also existed between pre and post test scores and between post test scores and information plus contact scores. Examination of the independent variables of (1) prior contact with people with developmental disabilities; (2) prior training in the field of developmental disabilities; and (3) prior on-the-job experience working with people who had developmental disabilities revealed no significant differences between any of the three variables and the information only post test group or the information plus contact group. There were also no significant differences between all staff and direct care staff only.

ANOVA results using the independent variable of area of specialization indicated significant differences existed between direct care staff, administrative/supervisory staff, and vocational staff on SADP scores. ANOVA results and contrast of the IO post test group only revealed no significant differences in the independent variables of Prior Contact, Prior Training, and Prior On-the-job experience either between groups or within groups. Contrast levels within each variable also revealed no significant differences.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

Few of us have the courage to follow our thoughts wherever they might lead. We all fear the dark at some level of our being.
(Philip Jackson, 1994, p.24)

This study permitted insights into the attitudes of staff who worked with people who had developmental disabilities in the Oklahoma Developmental Disabilities Services support system and how those attitudes, in turn, were influenced by information about, and contact with, people who had developmental disabilities. The purpose of this research grew out of a need to assess the attitudes of individuals working in the Oklahoma service delivery system and to determine if training (in the form of Foundation Training) had been effective in influencing the formation of positive attitudes. During a period in which training was often the first area to experience budget reductions, such information would be helpful in establishing the need for Foundation Training, continuing both financial and administrative support of the program, and providing quality support services to individuals with developmental disabilities. The following questions guided the research:

1. To what extent had Foundation Training positively affected the awareness of, and agreement with, the desired attitudes of Direct Care staff as measured by pre and post-test scores on the Scale of Attitudes toward Disabled People (SADP) measurement instrument before and after attending Foundation Training?

2. To what extent had at least three-months contact with people with developmental disabilities through on-the-job experience positively influenced agreement with the desired attitudes of Direct Care staff toward people with developmental disabilities as measured by scores on the Scale of Attitudes toward Disabled People (SADP)?
3. To what extent were there correlations in the reported agreement of SADP scores between the Control Group (CG), Foundation Training Only (IO) pre and post-test groups, and the Foundation Training plus on-the-job experience (IC) group between (1) all staff, and (2) direct care staff only?
4. To what extent were there differences in attitude as measured by scores on the SADP between the four tested groups (CG, IO pre and post, and IC), and the independent variables of Prior Contact, Prior Training, and Prior On-the-job experience?

Conclusions

Based on the data analyzed in this research study, conclusions were drawn in three areas: (1) demographics; (2) attitudes of staff toward people with developmental disabilities; and (3) statistical analysis of data.

Demographics

Most participants in the study were female, between the ages of 18 - 35, and worked as direct care staff. Area II had the largest number of participants and, consequently, the largest number of private provider agencies. Most respondents had prior contact with people with developmental disabilities before they attended Foundation Training, either having family members or friends with developmental disabilities or having worked with an individual who had developmental disabilities. Of the respondents attending Foundation Training for the first time, half had some form of prior training in the field of developmental disabilities. Most respondents who had attended Foundation Training and then worked on-the-job with people with developmental disabilities for at least three months had training in the field of developmental disabilities other than Foundation Training.

Attitudes

Attitudes of staff were measured by scores on the Scale of Attitudes toward Disabled People (SADP). Responses of the three groups (CG, IO pre and post, and IC) tested indicated that the majority of individuals came into Foundation Training with positive attitudes on the individual item statements toward people who have developmental disabilities. Positive attitudes toward people with disabilities were most commonly found in female adult staff between the ages of 18-35 which supported Livneh's (in Marinelli, & Dell Orto, 1984) assessment.

The SADP contained three categories of item statements: (1) general attitudes toward people with developmental disabilities; (2) societal and community living options; and (3) employment and vocational issues. The mean scores of all three groups indicated positive attitudes in all categories toward people with developmental disabilities. Scores significantly increased between pre and post testing indicating that Foundation Training had influenced positive attitude formation. A slight decrease in mean scores, although still positive, was evidenced in the IC group which indicated that perhaps three month's on-the-job experience had resulted in a slight decline in staff's positive attitudes. Although this decrease was not statistically significant it possibly indicated a future trend and was something that should be watched closely. Researchers agreed that a deterioration in positive attitude formation occurs over time if newly acquired belief systems are not reinforced (Fiske, 1997; Hewitt, 1997; Holford, 1995; Jarvis, 1987; Karlins & Abelson, 1970; Pinar, Reynolds, Slattery & Taubman, 1995; Zimbardo & Leippe, 1991).

Five questions on the SADP revealed mean scores of a more neutral nature (values between -1 and +1) on both post-test scores and after three month's on-the-job experience. This indicated the need to strengthen Foundation Training curriculum in the areas of: (1) physical abilities and/or limitations of people who have developmental disabilities; (2) housing costs; (3) perception of childlike characteristics toward people who have developmental disabilities; (4) individual rights in relation to such issues as the ability to drive and obtain a driver's licenses; and (5) work and vocational options.

Overall, it was concluded that information in the form of Foundation Training influenced positive attitude formation in new staff toward individuals with developmental disabilities as well as in staff who had been on-the-job working with individuals who had developmental disabilities for at least three months. This finding also supported Karlins and Abelson's (1970) contention that knowledge was only effective in changing an individual's definition of reality and supporting attitudinal change if: (1) the individual had already adopted the belief systems as reality; and (2) knowledge allowed the individual to explore realities already constructed. Pre-test scores on all groups revealed positive attitudes coming into training indicating previously adopted belief systems. Secondly, Foundation Training was a highly interactive and individualized training program which encouraged the exploration of individual attitudes meeting Karlins and Abelson's second provision for attitudinal changes resulting solely through knowledge acquisition.

Statistical Analysis of Data

Statistically significant increases between pre and post test scores in the Information Only group indicated Foundation Training had positively influenced the formation of attitudes toward people with developmental disabilities. That difference did not arise by chance. A positive increase in attitudes was also observed between post test scores and after three month's on-the-job experience. Foundation Training could not be said to be solely responsible for the difference in attitude scores — other extraneous factors such as training times and locations, trainers' competence, and social make-up of the classes may have contributed to the rise in scores. Overall, it was concluded that Foundation Training had a positive affect on all staff's attitudes toward people with developmental disabilities and that the effect was still present and did not decrease significantly over a three month period of time.

There was no significant difference between the tested groups and the areas of specialization within the service system. This indicated that all staff benefitted equally from attending Foundation Training. And, even after three month's on-the-job experience, positive attitudes were still evident at about the same level across all areas of specialization which also indicated continued benefits over time for all staff.

The independent variables of (1) Area of Specialization, (2) Prior Contact with people who have developmental disabilities, (3) Prior Training in the field of developmental disabilities, and/or (4) Prior On-the-job Experience working with people who have developmental disabilities, had no significant effect on attitude on any of the tested groups (CG, IOpre, IOpost, or IC). This was also true within groups. Groups who had no prior training, no prior contact, or no prior on-the-job experience were not significantly different than those groups that had prior training, prior contact or prior on-the-job experience with people who had developmental disabilities. Overall, it was concluded that the independent variables of prior contact, prior training, and prior on-the-job experience were not a factor in influencing attitude formation in staff who worked with people with developmental disabilities in this study.

Recommendations

Affecting attitudes in staff toward people who have developmental disabilities is a complex and intricate task but one that has to be taken seriously by those providing services. Negative attitudes can result in a host of problems including lack of respect for the individual, failure to advocate for the rights of people with developmental disabilities, and most seriously, incidents of abuse and neglect. With this in mind, and based on the review of the literature and the results of this study, the following recommendations are made:

1. Realizing the importance of the positive attitudes addressed in Foundation Training and that course's influence in shaping those positive attitudes, the training course should be continued to be trained across the state of Oklahoma in its present form, as well as supported both financially and administratively.

2. Realizing the importance of the positive attitudes addressed in Foundation Training and that course's influence in shaping attitudes, *all* staff who work with people with developmental disabilities should be required to attend Foundation Training. No one, either public or provider staff, should be "grand fathered" into the DDSD system because they have attended previous courses.

3. Qualitative studies should be conducted to obtain information on training programs not addressed by quantitative studies.

4. Research needs to be conducted to determine why there are differences in attitudes between direct care staff, administrative/supervisory staff, and vocational staff.

5. The Foundation Training curriculum should be revised to address weak areas identified by item analysis.

6. Studies should be conducted on the attitudes of staff attending the job-specific levels of training (Residential, Vocational, and Center-based) to determine if results similar to this study are obtained and if attitudes are being influenced by those training programs.

7. A monitoring system should be developed and implemented that assures that courses are taught in the manner in which they were designed and that participants are attending within the specified time periods. Time periods within which training is to be attended should be as short as possible to prevent declines in positive attitude formation.

8. Revisions of existing training programs and development of new training programs should be conducted on a timely basis and should include information from a broad variety of both qualitative and quantitative sources.

Implications for Further Research

Based on the review of literature and the results of this study, the following implications for further research are offered:

1. It is recommended that further quantitative research is needed in the job-specific areas (Residential and Employment Training) of the Developmental Disabilities Services Division to determine if those training programs are effective in influencing attitudes and providing staff with the skills necessary to do their jobs effectively.

2. It is recommended that qualitative research in the areas of staff, people receiving services and their families be conducted through the use of valid and reliable survey instruments to determine if staff are providing services in respectful, efficient and effective manners.

3. It is recommended that both quantitative and qualitative research be conducted on the DDSD SATTRN (Satellite Training Network) to see if distance education training programs have been effective in providing training that influenced staff's attitudes and job skills.

4. It is recommended that a search be made for training programs from other states to determine if there are techniques that may be adapted to fit into the DDSD training system.

Final Words

The movement of people who have developmental disabilities from institutions into their communities is one that has achieved success on many levels. There is, however, a long way to go. People who have developmental disabilities are still often bound by societal constraints. It is our job as educators to use knowledge, often in the form of curriculum, to begin the process of loosening those bonds and helping people we work with to be seen as people, not as people who have a disability. As Holford (1995) states:

> ...social movements are important phenomena in the learning process of the individuals (and even collectively of the groups and organizations) which compose them, to a view that they are central to the production of human knowledge itself. The forms of knowledge which exist in any society are, it is held, the products in part of social movements which have emerged in, or had impact on, that society.

Bowers (1984) relates this production of knowledge to curriculum:

> The curriculum, whether it deals with the nature of work, time, metaphorical thinking, poverty, or ways of knowing, should be judged, in part, on the basis of whether it helps the student understand how the content area relates to the broader, overarching belief system of the culture that influences the existential questions faced in the course of every day life. (p. 80)

With the closing of The Hissom Memorial Center, Oklahoma stepped into a new paradigm shift. That shift away from institutionalization and toward community living requires reconceptualization of the way Oklahoma provides services to people with developmental disabilities. It also requires concurrent shifts in the attitudes of staff providing those services. People with developmental disabilities are no longer viewed as needy and dependent but as simply people, people with the same strengths, weaknesses, rights, and responsibilities as anyone else in our society.

Since curriculum is often reproductive of the society within which it is developed, Foundation Training now becomes critical as a transformational agent for insuring positive attitudinal development in staff providing services to people with developmental disabilities. It is also becomes a central factor in supporting the concurrent societal paradigm shift in Oklahoma.

The message is simple. Until we understand the importance of social movements such as those now occurring in the field of developmental disabilities, and embrace their importance as much as we embrace anything else in our lives, we will continue to fail future generations. Until we develop training programs that are effective in providing people the opportunity to address the attitudes they have formed toward devalued groups, and to aid them in transforming negative attitudes, we will continue to fail future generations.

We do not fail when we give people the ability to not only imagine a better world than the one they live in, but a better world for all people, regardless of disability, race, gender, or any other societal constraints. We do not fail when we allow people to explore their own belief systems in relation to new paradigms. Nor do we fail when we give people the tools, both physical and attitudinal, to actively take part in shaping those paradigms.

There are certainly struggles left and questions still unanswered as Oklahoma continues shaping its service delivery system, but the path ahead is clear and there is a sense of direction. We need only to keep to the journey.

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APPENDIXES

APPENDIX A

CONSENT DECREE

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF OKLAHOMA

HOMEWARD BOUND, et al.,)
Plaintiffs,)
v.) Case No. 85-C-437-E
THE HISSOM MEMORIAL CENTER, et al.,)
Defendants.)

APPENDIX

CONSENT DECREE

1989 PLAN

COMMUNITY LIVING ARRANGEMENTS

Principle: **Individuals have the right to live in a home of their choice and with friends, if they so choose.**

GOAL 1: **BY JUNE 30, 1990, DEVELOP PROCEDURES APPLICABLE TO COMMUNITY LIVING ARRANGEMENTS.**

OBJECTIVE 1:

By April 1, 1990, establish and refine policies and procedures for Supported Living.

OBJECTIVE 2:

By December 1, 1989, review and refine policies and procedures for Specialized Foster Care living.

OBJECTIVE 3:

By February 1, 1990, establish policies and procedures for an Adult Companion Program.

OBJECTIVE 4:

By April 30, 1990, review and refine policies and procedures for Group Homes.

OBJECTIVE 5:

By December 1, 1990, develop an ICF/MR program (small 4 - 6 beds) as a residential option.

GOAL 2: **BY APRIL 1, 1990, DESIGN, DEVELOP AND PROVIDE SUPPORT SERVICES FOR COMMUNITY LIVING ARRANGEMENTS.**

OBJECTIVE 1:

By April 1, 1990 provide Adaptive and Therapeutic Equipment Services for individuals in community living.

OBJECTIVE 2:...

By April 1, 1990, provide Architectural Modification Services for individuals in community living.

OBJECTIVE 3:...

By April 1, 1990, provide Transportation Services for individuals in community living.

OBJECTIVE 4:...

By April 1, 1990, establish Respite Care as a residential support.

OBJECTIVE 5:...

By April 1, 1990, contract to provide In-Home Workers (Habilitation Training Specialist, Homemaker) for individuals in community living.

OBJECTIVE 6:...

By April 1, 1990, contract to provide Family Training and Counseling for individuals in community living.

OBJECTIVE 7:...

By April 1, 1990, contract with professionals for Behavior Management Services for individuals in community living.

GOAL 3: **BY JUNE 30, 1994, COMPLETE TRACKING FORMS FOR CLASS MEMBERS IDENTIFIED TO MOVE INTO COMMUNITY LIVING ARRANGEMENTS.**

OBJECTIVE 1:...

By December 1, 1989, tracking forms for individuals identified to move before June 30, 1990, will be in use.

OBJECTIVE 2:...

By June 30, 1990, tracking forms for individuals identified to move before June 30, 1991, will be in use.

OBJECTIVE 3:

By June 30, 1991, tracking forms for individuals identified to move before June 30, 1992 will be in use.

OBJECTIVE 4:

By June 30, 1992, tracking forms for individuals identified to move before June 30, 1993 will be in use.

OBJECTIVE 5:

By June 30, 1993, tracking forms for individuals identified to move before June 30, 1994 will be in use.

OBJECTIVE 6:

By June 30, 1994, tracking forms for individuals identified to move before June 30, 1995 will be in use.

PREAMBLE TO GOALS 4-10

Capacity numbers are projections based on current assessment of client needs subject to change based on client needs as program progresses.

GOAL 4: **BY JUNE 30, 1994, DEVELOP CAPACITY TO SERVE UP TO 81 INDIVIDUALS IN AN INDEPENDENT LIVING ARRANGEMENT.**

OBJECTIVE 1:

By June 30, 1990, develop capacity to serve up to 10 individuals in an Independent Living Arrangement.

OBJECTIVE 2:

By June 30, 1991, develop capacity to serve up to 12 individuals in an Independent Living Arrangement.

OBJECTIVE 3:

By June 30, 1992, develop capacity to serve up to 12 individuals in an Independent Living Arrangement.

OBJECTIVE 4:...

By June 30, 1993, develop capacity to serve up to 25 individuals in an Independent Living Arrangement.

OBJECTIVE 5:...

By June 30, 1994, develop capacity to serve up to 22 individuals in an Independent Living Arrangement.

GOAL 5: **BY JUNE 30, 1992, DEVELOP CAPACITY TO SERVE UP TO 53 INDIVIDUALS IN THE NATURAL HOME.**

OBJECTIVE 1:...

By October 21, 1989, develop capacity to serve up to 4 individuals in his/her Natural Home.

OBJECTIVE 2:...

By June 30, 1990, develop capacity to serve up to 13 individuals in his/her Natural Home.

OBJECTIVE 3:...

By June 30, 1991, develop capacity to serve up to 18 individuals in his/her Natural Home.

OBJECTIVE 4:...

By June 30, 1992, develop capacity to serve up to 18 individuals in his/her Natural Home.

GOAL 6: **BY JUNE 30, 1994, CAPACITY WILL BE DEVELOPED TO SERVE UP TO 273 INDIVIDUALS IN SUPPORTED LIVING ARRANGEMENTS BASED ON THEIR IHP RECOMMENDATIONS.**

OBJECTIVE 1:...

By October 21, 1989, develop capacity to serve up to 22 individuals in a Supported Living Arrangement (Individualized, Shared Living, Group Homes).

OBJECTIVE 2:...

By June 30, 1990, develop capacity to serve up to 45 additional individuals in a Supported Living Arrangement (Individualized, Shared Living, Group Homes).

OBJECTIVE 3:...

By June 30, 1991, develop capacity to serve up to 57 additional individuals in a Supported Living Arrangement (Individualized, Shared Living, Group Homes).

OBJECTIVE 4:...

By June 30, 1992, develop capacity to serve up to 59 additional individuals in a Supported Living Arrangement (Individualized, Shared Living, Group Homes).

OBJECTIVE 5:...

By June 30, 1993, develop capacity to serve up to 50 additional individuals in a Supported Living Arrangement (Individualized, Shared Living, Group Homes).

OBJECTIVE 6:...

By June 30, 1994, develop capacity to serve up to 40 additional individuals in a Supported Living Arrangement (Individualized, Shared Living, Group Homes).

GOAL 7: **BY JUNE 30, 1992, CAPACITY WILL BE DEVELOPED TO SERVE 49 INDIVIDUALS IN SPECIALIZED FOSTER CARE LIVING ARRANGEMENT.**

OBJECTIVE 1:...

By October 21, 1989, develop capacity to serve 2 individuals in a Specialized Foster Care living arrangement.

OBJECTIVE 2:...

By June 30, 1990, develop capacity to serve 11 individuals in a Specialized Foster Care living arrangement.

OBJECTIVE 3:...

By June 30, 1991, develop capacity to serve 15 individuals in a Specialized Foster Care living arrangement.

OBJECTIVE 4:...

By June 30, 1992, develop capacity to serve 21 individuals in a Specialized Foster Care living arrangement.

GOAL 8: **BY JUNE 30, 1994, CAPACITY WILL BE DEVELOPED TO SERVE 81 INDIVIDUALS IN AN ADULT COMPANION LIVING ARRANGEMENT.**

OBJECTIVE 1:...

By October 21, 1989, develop capacity to serve up to 0 individuals in an Adult Companion living arrangement.

OBJECTIVE 2:...

By June 30, 1990, develop capacity to serve up to 3 individuals in an Adult Companion living arrangement.

OBJECTIVE 3:...

By June 30, 1991, develop capacity to serve up to 9 individuals in an Adult Companion living arrangement.

OBJECTIVE 4:...

By June 30, 1992, develop capacity to serve up to 10 individuals in an Adult Companion living arrangement.

OBJECTIVE 5:...

By June 30, 1993, develop capacity to serve up to 20 individuals in an Adult Companion living arrangement.

123

OBJECTIVE 6:..

By June 30, 1994, develop capacity to serve up to 39 individuals in an Adult Companion living arrangement.

GOAL 9: **BY JUNE 30, 1992, DEVELOP CAPACITY TO SERVE 13 INDIVIDUALS IN AN ICF/MR LIVING ARRANGEMENT.**

OBJECTIVE 1:..

By June 30, 1990, develop capacity to serve up to 4 individuals in an ICF/MR living arrangement.

OBJECTIVE 2:..

By June 30, 1991, develop capacity to serve up to 7 individuals in an ICF/MR living arrangement.

OBJECTIVE 3:..

By June 30, 1992, develop capacity to serve up to 2 individuals in an ICF/MR living arrangement.

GOAL 10: **BY DECEMBER 31, 1992, DEVELOP CAPACITY TO PROVIDE 3986 DAYS OF RESPITE SERVICES.**

OBJECTIVE 1:..

By June 30, 1990, develop capacity to provide 430 days of Respite Service for individuals with unusual medical challenges.

OBJECTIVE 2:..

By June 30, 1991, develop capacity to provide an additional 1335 days of Respite Service for individuals with unusual medical behavior challenges.

OBJECTIVE 3:..

By June 30, 1992, develop capacity to provide an additional 2221 days of Respite Service for individuals with non-specialized needs.

GOAL 11: **By December 31, 1989, design and implement a system to train staff for provision of community living support services.**

OBJECTIVE 1:...

By September 30, 1989, design a statewide system for training direct care staff.

OBJECTIVE 2:...

By November 30, 1989, develop a long-term system for training case managers and contract providers.

OBJECTIVE 3:...

By December 30, 1990, develop a long-term system for educating management staff for community program.

OBJECTIVE 4:...

By June 30, 1990, develop an ongoing system for staff development.

OBJECTIVE 5:...

By December 30, 1989, train providers of community living services to administer the ICAP.

OBJECTIVE 6:...

Train providers of community services in use of the Ongoing Behavior Monitoring System (OBMS).

GOAL 12: **By June 30, 1995, 870 additional paraprofessional staff will be trained and/or certified to support community living services.**

OBJECTIVE 1:...

By October 21, 1989, 69 paraprofessional staff will be trained and/or certified to support community living services.

OBJECTIVE 2:...

By June 30, 1990, 100 additional paraprofessional staff will be trained and/or certified to support community living services.

OBJECTIVE 3:..

By June 30, 1991, 142 additional paraprofessional staff will be trained and/or certified to support community living services.

OBJECTIVE 4:..

By June 30, 1992, 142 additional paraprofessional staff will be trained and/or certified to support community living services.

OBJECTIVE 5:..

By June 30, 1993, 135 additional paraprofessional staff will be trained and/or certified to support community living services.

OBJECTIVE 6:..

By June 30, 1994, 152 additional paraprofessional staff will be trained and/or certified to support community living services.

OBJECTIVE 7:..

By June 30, 1995, 130 additional paraprofessional staff will be trained and/or certified to support community living services.

CASE MANAGEMENT/FAMILY SUPPORT/LEISURE

PRINCIPLE: THE CASE MANAGER IS THE KEY PROFESSIONAL IN THE LIFE OF THE INDIVIDUAL TO INSURE THE INDIVIDUAL'S RIGHT TO PARTICIPATE IN A FULL ARRAY OF EXPERIENCES AVAILABLE TO OTHERS IN THEIR COMMUNITY. CASE MANAGERS ARE INDEPENDENT IN THEIR ROLE AS ADVOCATE AND SERVICE COORDINATORS FOR PERSONS THEY SERVE.

GOAL 1: **Case managers will enhance their ability to function independently as advocates, brokers of resources, coordination and monitoring of services, and leaders of interdisciplinary teams.**

Objective 1 . . . .

Case managers will be provided the regular training curriculum that has been developed.

Objective 2 . . . .

Case managers will be trained to lead an interdisciplinary team at the level required by the Employee Performance Development Procedure Standards through additional training in habilitation leadership as developed by Therapeutic Concepts, Inc.

GOAL 2: **DHS will enhance the quality and integrity of independent case management services through revision of selection procedures, periodic evaluation of case managers, increased capability of case management supervisors, and inclusion of competency based testing in all case management training modules.**

Objective 1 . . . .

By December 15, 1989, DHS will develop revised hiring practices and procedures.

Objective 2 . . . .

The DDSD Area Management Staff will evaluate case managers periodically to identify strengths and serious deficiencies. Areas for improvement will be addressed through retraining and/or redeployment.

Objective 3 . . . .

DDSD will train and support Case Management Supervisors, enabling them to function more effectively to the level required by the Employee Performance Development Plan Standards as job coaches and mentors to their assigned case managers.

Objective 4

DDSD will develop a competency based evaluation procedure for each training module.

GOAL 3: **Case managers and case management supervisors will insure the development and implementation of appropriate, coherent, and comprehensive IHPs.**

Objective 1

By October 15, 1989, DDSD will produce written guidelines for IHP development for use by case managers.

Objective 2

DDSD will train all new case managers in the IHP process in accordance with written guidelines.

Objective 3

Administrative/management staff will review all IHPs to meet client needs.

Objective 4

By January 31, 1990, DDSD will develop an administrative appeals procedure to enable clients to appeal IHP provisions and/or treatment decisions.

Objective 5

By November 15, 1989, DDSD will revise the transition process to increase coordination between the institutions and Area Offices.

Objective 6

When the interdisciplinary team identifies the need, the case manager will arrange for community living arrangements, support services, habilitation services and employment services in accordance with the IHP.

GOAL 4: **DDSD will establish a comprehensive system of family supports and services to support full community integration of all class members.**

Objective 1

When the interdisciplinary team identifies the need, the case manager will refer the family to counseling.

Objective 2

When the interdisciplinary team identifies the need, the case manager will procure adaptive equipment in accordance with Department policy.

Objective 3 . . . .

When the interdisciplinary team identifies the need for architectural modification, the resource developer will initiate procedures to contract with a vendor capable of design, construction and delivery in accordance with Department policy.

Objective 4 . . . .

When the interdisciplinary team identifies the need for transportation services, the case manager will initiate procedures to obtain generic transportation services.

Objective 5: . . . .

Case managers will assist clients to access an array of leisure and recreational opportunities in the communities.

GOAL 5 DDSD will provide professional and paraprofessional services to clients to support full community integration and participation.

Objective 1 . . . .

DDSD practices will support the utilization of generic services.

Objective 2 . . . .

DDSD will identify professional service providers in relevant disciplines to serve class members including: psychologists; health care specialists (including, but not limited to physicians, nurses, dentists and pharmacists); professional habilitation services (including, but not limited to occupational therapy, physical therapy, speech therapy, nutrition, and recreation therapy).

Objective 3 . . . .

DDSD will contract with agencies to provide Habilitation Training Specialist and/or Homemaker Services.

GOAL 6: The DDSD Area Office will develop a system for record keeping and documentation.

Objective 1 . . . .

By December 1, 1989, the DDSD Area Office will develop policy/protocol for record administration.

Objective 2 . . . .

By February 1, 1990, DDSD will train staff in use of record maintenance system.

EMPLOYMENT SERVICES

Principle: DHS will provide values-based Employment Services for Hissom class members that are responsive to individual needs through coordinated service delivery system. Employment Services include where appropriate: employment evaluation, screening and assessment, counseling and referral; training, placement, and time limited follow-up in competitive employment; supported employment; time limited pre-employment training in the community; community integrated employment programs; facility based employment training services provided through sheltered workshops and work activity centers.

GOAL 1: ESTABLISH A COORDINATED EMPLOYMENT SERVICES DELIVERY SYSTEM FOR HISSOM CLASS MEMBERS.

Objective 1 ....

By December 30, 1989, establish and implement a coordinated Employment Services Delivery System within DHS for Hissom class members.

Objective 2 ....

Develop appropriate policies, procedures and laws (as needed) to implement the system.

Objective 3 ....

Facilitate maximum utilization of non-DHS employment related services available to Hissom class members.

Objective 4 ....

Coordinate DDSD and RSD resources to effectively implement the Plan of Employment Services for members of the Hissom class.

GOAL 2: PROVIDE APPROPRIATE EMPLOYMENT SERVICES FOR HISSOM CLASS MEMBERS THAT ARE RESPONSIVE TO INDIVIDUAL NEEDS.

Objective 1 ....

By August 31, 1989, establish a referral and assessment process that meets client needs.

Objective 2 ....

By December 1, 1989, establish capacity to provide appropriate Employment Services for members of the Hissom focus class exiting the institution.

Objective 3 ....

Secure contracts and initiate the capacity to provide appropriate Employment Services for Hissom class members, serving individualized needs at a minimum of 10 individuals per month as they exit to the community.

Objective 4 ....

Arrange or provide as needed, pre-employment and transition (school-to-work) services for Hissom class members, ages 14-17.

Objective 5 ....

Provide technical assistance, training and professional support to providers of Employment Services for Hissom focus class members.

GOAL 3: **ASSURE THAT INDIVIDUAL CLIENT EMPLOYMENT NEEDS ARE MET.**

Objective 1 ....

Set minimum requirements for service delivery within annual contracts with providers.

Objective 2 ....

Establish community progress reporting procedures.

Objective 3 ....

Insure administrative appeal procedures are in place and educate provider/class members/ families about same.

Objective 4 ....

Review program effectiveness with respect to measurement of class member outcomes.

INFRASTRUCTURE

GOAL 1: TO ESTABLISH AN AUTOMATED DATA SYSTEM TO PROVIDE INDIVIDUAL CLIENT TRACKING; LINES OF SERVICE PER CLIENT; EXPENDITURES FOR SERVICES PER CLIENT AND MANAGEMENT REPORTING SYSTEM.

Objective 1 ....

By July 1, 1990, have in place an automated data system performing substantial functions of individual client tracking, lines of service per client, expenditures for services per client and management reporting system.

GOAL 2: DHS WILL ESTABLISH SYSTEMS WHICH ASSURE PROPER AND TIMELY REIMBURSEMENT TO PROVIDERS OF SERVICES TO CLASS MEMBERS.

Objective 1 ....

By January 1, 1990, DDSD will develop a standardized contract for services to class members.

Objective 2 ....

By January 1, 1990, develop contract addendums which delineate program requirements for the specific services to be provided to class members.

Objective 3 ....

By November 1, 1989, DDSD will develop a tracking system for contracts from the time negotiated by a resource developer until it is signed and returned to provider.

Objective 4 ....

DDSD will negotiate and submit to the Office of Public Affairs contracts of continuing providers to assure no break in reimbursement.

GOAL 3: DHS WILL PURSUE LEGISLATIVE FUNDING AND FEDERAL FINANCIAL SUPPORT SUFFICIENT TO PROVIDE FUNDS REQUIRED TO SERVE CLASS MEMBERS IN ACCORDANCE WITH THE CONSENT DECREE.

Objective 1 ....

DDSD will submit budget proposals to DHS Director in time for submission to the legislature which will contain funds sufficient to provide services to the Homeward Bound class.

Objective 2 ....

DHS will seek to obtain the maximum amount of federal funds available to fund the activities required by the Consent Decree.

GOAL 4: DHS WILL ASSIST EMPLOYEES OF THE HISSOM MEMORIAL CENTER TO TRANSITION TO OTHER EMPLOYMENT.

Objective 1 ....

DDSD will inform THMC employees of opportunities for employment in government and related services.

Objective 2 ....

DHS will provide cutplacement services to staff at THMC including counseling on retirement and other benefits.

Objective 3 ....

DHS, as appropriate, will offer training and other services to assist THMC employees in obtaining new employment.

Objective 4 ....

DHS will close the Infirmary, and reduce/reassign staff accordingly.

Objective 5 ....

DHS will complete closure and staff reductions at THMC.

COMMUNITY INVOLVEMENT

GOAL 1: CLASS MEMBERS AND THEIR FAMILIES WILL HAVE ACCESS TO ACCURATE AND TIMELY INFORMATION REGARDING POLICIES, PROGRAMS AND SERVICES RELATED TO DEVELOPMENTAL DISABILITIES.

Objective 1:. . . . .

Develop a system of information sharing to be used with class members and families at a public readability level.

ADVOCACY

Principle: The advocacy, Safeguard and Quality Assurance plan develop systems which promote independence, choice and rights for people served. Rights protection and advocacy will be primary considerations in developing DHS Regulations, Accreditation, systematic communications, procedural Protection and Transitional safeguards. Quality Assurance activities shall assure that service contracted for or rendered by the Department of Human Services are responsive to the needs of class members, comply with ethical standards of practice, produce outcomes prescribed in each class member's IHP, are modified to meet the changing needs of class members and comply with standards of public and fiscal accountability.

REGULATION

GOAL 1: ALL AGENCIES SERVING CLASS MEMBERS WILL CONFORM TO RELEVANT REGULATORY STANDARDS.

Objective 1. . . . .

The Department of Human Services will assure that services rendered class members conform to norms of community practice through contract stipulations requiring applicable professional licensure.

ACDD COMPLIANCE

GOAL 2: CLASS MEMBERS WILL BE SERVED BY AGENCIES COMPLYING WITH ACDD STANDARDS; 1987 EDITION.

Objective 1. . . . .

Class members will be served by agencies complying with ACDD standards, 1987 edition, by July 1, 1992, or accredited by a DHS approved accreditation agency.

Objective 2. . . . .

DHS will implement policies and procedures requiring provider compliance with ACDD standards.

SYSTEMATIC COMMUNICATION

GOAL 3: **CLASS MEMBERS/PARENTS/GUARDIANS WILL BE PROVIDED AN OPPORTUNITY TO PARTICIPATE IN THE PLANNING AND DESIGN OF POLICIES AND PROCEDURES RELATING TO SERVICE DELIVERY.**

Objective 1. . . . .

Planning, and the development of policies and procedures required for the delivery of services will occur with class member/parent/guardian participation.

Objective 2. . . . .

Class members, advocates and guardians shall be informed of provisions of the Consent Decree.

PROCEDURAL PROTECTIONS

GOAL 4: **DHS WILL ASSURE RECOGNITION AND EXERCISE OF CLASS MEMBER RIGHTS THROUGH THE DEVELOPMENT OF SELF-ADVOCACY SKILLS AND OPPORTUNITIES.**

Objective 1. . . . .

DHS will provide class members the opportunity to participate in the interdisciplinary team process.

Objective 2. . . . .

Citizenship and rights information will be provided to class members, parents, guardians, and family members.

Objective 3. . . . .

DHS will facilitate the development of self advocacy groups for class members statewide.

GOAL 5: **DHS WILL ASSURE RECOGNITION AND EXERCISE OF CLASS MEMBER RIGHTS THROUGH DEVELOPMENT OF A VOLUNTEER ADVOCACY AND MONITORING SYSTEM.**

Objective 1. . . . .

Each class member's need for representation by an advocate or guardian will be assessed by his/her interdisciplinary team at least annually with findings/recommendations reflected in the IHP.

Objective 2. . . . .

By June 30, 1990, DHS will contract with an independent agency to recruit and train volunteer advocates in sufficient quantities to assure availability of an advocate for class member selection when recommended by the interdisciplinary team or on class member request.

Objective 3. . . . .

Case managers will provide opportunities for class members to select an advocate when needed or requested by the class member.

Objective 4. . . . .

By June 30, 1990, DHS will contract with an independent agency to recruit and train guardians to assist class members in the exercise of rights.

Objective 5. . . . .

All class members shall be served by a Human Rights Committee, and as needed, a Behavior Review Committee.

GOAL 6: DHS WILL DEVELOP AND IMPLEMENT PROFESSIONAL ADVOCACY SERVICES.

Objective 1. . . . .

Each focus class member will be assigned a case manager who will serve no more than 10 individuals during the transition process.

Objective 2. . . . .

Ombudsman staff (Office of Client Advocacy) will provide independent advocacy services to class members residing at public ICF/MR facilities (THMC, ESS, PVSS).

Objective 3. . . . .

Ombudsman staff will provide independent advocacy services to focus class members residing in the community.

Objective 4. . . . .

DHS will maintain internal investigative procedures designed to address and reduce abuse, neglect or mistreatment of class members residing at public ICF/MR facilities (THMC, ESS, PVSS).

Objective 5.

DHS will assist class members through referral to the Protective and Advocacy Agency to obtain legal counsel and legal advocacy services.

GOAL 7: **SAFEGUARDS WILL BE INCLUDED IN THE IHP PROCESS TO ASSURE CLASS MEMBER PARTICIPATION AND THE DEVELOPMENT AND IMPLEMENTATION OF AN INDIVIDUALIZED PLAN OF SERVICES TO ADDRESS CLASS MEMBER'S NEEDS.**

Objective 1.

Safeguards shall be developed that ensure the development of an appropriately constituted interdisciplinary team for each class member.

Objective 2.

Class members and parents/guardians or other individuals on behalf of the client may appeal disagreements with a class member's IHP through the Department's current grievance procedure.

QUALITY ASSURANCE

GOAL 8: **DDSD WILL DEVELOP A PLAN FOR QUALITY ASSURANCE WITH THE ASSISTANCE OF NATIONAL EXPERTS.**

Objective 1.

A nationally recognized advocate with Quality Assurance expertise will assist in the development of plans for the DDSD Quality Assurance Program.

Objective 2.

DDSD will contract with a national expert to annually review plans and implementation of the DDSD Quality Assurance Program. A national expert shall evaluate plans for the DDSD Quality Assurance Program.

GOAL 9: **DDSD WILL DEVELOP AN AUTOMATED DATA BASE TO ANALYZE ON AN ANNUAL BASIS CHANGES IN CLASS MEMBER ADAPTIVE SKILLS, SATISFACTION WITH SERVICES AND QUALITY OF LIFE BASED UPON STANDARDIZED MEASURES.**

Objective 1.

DDSD will implement, by July 1, 1991, an information system assessing changes in class member adaptive behavior and quality of life based upon defined indicators.

Objective 2.

All class members shall be provided, at least annually, an opportunity to evaluate services they have received.

Objective 3.

A sample of families of class members will be provided at least annually an opportunity to express their level of satisfaction with service system and their family member's status within the system.

GOAL 10: **SERVICE OUTCOMES FOR EACH CLASS MEMBER WILL BE ASSESSED MONTHLY BY CASE MANAGERS.**

Objective 1.

Case managers will assess class member service outcomes to determine consistency with individual need.

TRANSITIONAL SAFEGUARDS

GOAL 11: **DHS WILL DEVELOP AND IMPLEMENT A SYSTEM OF INTERNAL SAFEGUARDS TO ASSURE THE AVAILABILITY OF SERVICES TO MEET EMERGENCY NEEDS OF CLASS MEMBERS.**

Objective 1.

By June 30, 1990, DHS will have procedural safeguards that assure that there is a continuity of services on a 24-hour basis.

Objective 2.

By June 30, 1990, DHS will develop emergency residential back-up resources to address the needs of clients in his/her current living status including, but not limited to emergency respite care, emergency professional and technical assistance, and in-home services.

Objective 3.

By June 30, 1990, DHS will develop emergency residential back-up resources for emergency out-of-home residential services including emergency foster care, emergency mental health services, and emergency out-of-home respite care.

Objective 4. . . . .

By June 30, 1990, DHS will have technical and professional resource persons to address the emergency needs of class members, including medical and behavior management services.

Objective 5. . . . .

By January 1, 1990, assure that a point of contact is available to class members, parents and providers on a 24-hour basis.

APPENDIX B

MAP OF THE DEPARTMENT OF HUMAN SERVICES' GEOGRAPHICAL AREAS OF SERVICE DELIVERY


CIMARRON
TEXAS
BEAVER
HARPER
WOODS
ALFALFA
GRANT
KAY
OSAGE
WASHINGTON
NOWATA
CRAIG
OTTAWA
ELLIS
WOODWARD
MAJOR
GARFIELD
NOBLE
PAWNEE
ROGERS
MAYES
DELAWARE
AREA I
DEWEY
BLAINE
KINGFISHER
PAYNE
LOGAN
LINCOLN
AREA II
CREEK
TULSA
WAGONER
CHEROKEE
ADAIR
ROGER MILLS
CUSTER
CANADIAN
OKLAHOMA
OKUSKEE
OKMULGEE
MUSKOGEE
McINTOSH
SEQUOYAH
BECKHAM
WASHITA
CADDO
GRADY
CLEVELAND
McCLAIN
POTTAWATOMIE
SEMINOLE
HUGHES
HASKELL
PITTSBURG
GREER
KIOWA
HARMON
JACKSON
COMANCHE
GARVIN
PONTOTOC
LATIMER
LeFLORE
COAL
STEPHENS
TILLMAN
COTTON
MURRAY
JOHNSON
ATOKA
PUSHMATAHA
CARTER
JEFFERSON
LOVE
MARSHALL
BRYAN
CHOCTAW
McCURTAIN
AREA III

APPENDIX C

SCALE OF ATTITUDES TOWARD DISABLED PEOPLE

IO pre-test -- Foundation Training: SADP #1

Scale of Attitudes Toward Disabled Persons

Directions:

The statements presented below express opinions or ideas about people who are disabled. There are many differences of opinion; many people agree and many people disagree with each statement. We would like to know your opinion about them. Put an "X" through the appropriate number, from -3 to +3, which best corresponds with how you feei about the statement. There are no right or wrong answers. You should work as quickly as you can, but don't rush. There is no time limit. Please respond to every statement.

Key

-3: I disagree very much
-2: I disagree pretty much
-1: I disagree a little
+1: I agree a little
+2: I agree pretty much
+3: I agree very much

1	Disabled children should not be provided with a free public education.	-3	-2	-1	+1	+2	+3
2	Disabled people are not more accident prone than other people.	-3	-2	-1	+1	+2	+3
3	A disabled individual is not capable of making moral decisions.	-3	-2	-1	+1	+2	+3
4	Disabled people should be prevented from having children.	-3	-2	-1	+1	+2	+3
5	Disabled people should be allowed to live where and how they choose.	-3	-2	-1	+1	+2	+3
6	Adequate housing for disabled people is neither too expensive nor too difficult to build.	-3	-2	-1	+1	+2	+3
7	Rehabilitation programs for disabled people are too expensive to operate.	-3	-2	-1	+1	+2	+3
8	Disabled people are in many ways like children.	-3	-2	-1	+1	+2	+3
9	Disabled people need only the proper environment and opportunity to develop and express criminal tendencies.	-3	-2	-1	+1	+2	+3
10	Disabled adults should be involuntarily committed to an institution following arrest.	-3	-2	-1	+1	+2	+3
11	Most disabled people are willing to work.	-3	-2	-1	+1	+2	+3
12	Disabled individuals are able to adjust to a life outside an institutional setting.	-3	-2	-1	+1	+2	+3

(Continued)

13	Disabled people should not be prohibited from obtaining a driver's license.	-3	-2	-1	+1	+2	+3
14	Disabled people should live with others of similar disability	-3	-2	-1	+1	+2	+3
15	Zoning ordinances should not discriminate against disabled people by prohibiting group homes in residential districts.	-3	-2	-1	+1	+2	+3
16	The opportunity for gainful employment should be provided to disabled people.	-3	-2	-1	+1	+2	+3
17	Disabled children in regular classrooms have an adverse effect on other children.	-3	-2	-1	+1	+2	+3
18	Simple repetitive work is appropriate for disabled people.	-3	-2	-1	+1	+2	+3
19	Disabled people show a deviant personality profile.	-3	-2	-1	+1	+2	+3
20	Equal employment opportunities should be available to disabled individuals.	-3	-2	-1	+1	+2	+3
21	Laws to prevent employers from discriminating against disabled people should be passed.	-3	-2	-1	+1	+2	+3
22	Disabled people engage in bizarre and deviant sexual activity.	-3	-2	-1	+1	+2	+3
23	Disabled workers should receive at least the minimum wage established for their jobs.	-3	-2	-1	+1	+2	+3
24	Disabled individuals can be expected to fit into competitive society.	-3	-2	-1	+1	+2	+3

Reprinted with permission of the author; from Antonak, R. F. (1981). Development and psychometric analysis of the Scale of Attitudes Toward Disabled Persons. (Technical Report No.1). Durham, NH: University of New Hampshire, Education Department.

IO post-test -- Foundation Training: SADP #2

Scale of Attitudes Toward Disabled Persons

Directions:

The statements presented below express opinions or ideas about people who are disabled. There are many differences of opinion; many people agree and many people disagree with each statement. We would like to know your opinion about them. Put an "X" through the appropriate number, from -3 to +3, which best corresponds with how you feel about the statement. There are no right or wrong answers. You should work as quickly as you can, but don't rush. There is no time limit. Please respond to every statement.

Key

-3: I disagree very much
-2: I disagree pretty much
-1: I disagree a little
+1: I agree a little
+2: I agree pretty much
+3: I agree very much

1	Disabled children should not be provided with a free public education.	-3	-2	-1	+1	+2	+3
2	Disabled people are not more accident prone than other people.	-3	-2	-1	+1	+2	+3
3	A disabled individual is not capable of making moral decisions.	-3	-2	-1	+1	+2	+3
4	Disabled people should be prevented from having children.	-3	-2	-1	+1	+2	+3
5	Disabled people should be allowed to live where and how they choose.	-3	-2	-1	+1	+2	+3
6	Adequate housing for disabled people is neither too expensive nor too difficult to build.	-3	-2	-1	+1	+2	+3
7	Rehabilitation programs for disabled people are too expensive to operate.	-3	-2	-1	+1	+2	+3
8	Disabled people are in many ways like children.	-3	-2	-1	+1	+2	+3
9	Disabled people need only the proper environment and opportunity to develop and express criminal tendencies.	-3	-2	-1	+1	+2	+3
10	Disabled adults should be involuntarily committed to an institution following arrest.	-3	-2	-1	+1	+2	+3
11	Most disabled people are willing to work.	-3	-2	-1	+1	+2	+3
12	Disabled individuals are able to adjust to a life outside an institutional setting.	-3	-2	-1	+1	+2	+3

(Continued)

13	Disabled people should not be prohibited from obtaining a driver's license.	-3	-2	-1	+1	+2	+3
14	Disabled people should live with others of similar disability.	-3	-2	-1	+1	+2	+3
15	Zoning ordinances should not discriminate against disabled people by prohibiting group homes in residential districts.	-3	-2	-1	+1	+2	+3
16	The opportunity for gainful employment should be provided to disabled people.	-3	-2	-1	+1	+2	+3
17	Disabled children in regular classrooms have an adverse effect on other children.	-3	-2	-1	+1	+2	+3
18	Simple repetitive work is appropriate for disabled people.	-3	-2	-1	+1	+2	+3
19	Disabled people show a deviant personality profile.	-3	-2	-1	+1	+2	+3
20	Equal employment opportunities should be available to disabled individuals.	-3	-2	-1	+1	+2	+3
21	Laws to prevent employers from discriminating against disabled people should be passed.	-3	-2	-1	+1	+2	+3
22	Disabled people engage in bizarre and deviant sexual activity.	-3	-2	-1	+1	+2	+3
23	Disabled workers should receive at least the minimum wage established for their jobs.	-3	-2	-1	+1	+2	+3
24	Disabled individuals can be expected to fit into competitive society.	-3	-2	-1	+1	+2	+3

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IC: Residential Training: SADP

Scale of Attitudes Toward Disabled Persons

Directions:

The statements presented below express opinions or ideas about people who are disabled. There are many differences of opinion: many people agree and many people disagree with each statement. We would like to know your opinion about them. Put an "X" through the appropriate number, from -3 to +3, which best corresponds with how you feel about the statement. There are no right or wrong answers. You should work as quickly as you can, but don't rush. There is no time limit. Please respond to every statement.

Key

-3: I disagree very much
-2: I disagree pretty much
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+2: I agree pretty much
+3: I agree very much

1	Disabled children should not be provided with a free public education.	-3	-2	-1	+1	+2	+3
2	Disabled people are not more accident prone than other people.	-3	-2	-1	+1	+2	+3
3	A disabled individual is not capable of making moral decisions.	-3	-2	-1	+1	+2	+3
4	Disabled people should be prevented from having children.	-3	-2	-1	+1	+2	+3
5	Disabled people should be allowed to live where and how they choose.	-3	-2	-1	+1	+2	+3
6	Adequate housing for disabled people is neither too expensive nor too difficult to build.	-3	-2	-1	+1	+2	+3
7	Rehabilitation programs for disabled people are too expensive to operate.	-3	-2	-1	+1	+2	+3
8	Disabled people are in many ways like children.	-3	-2	-1	+1	+2	+3
9	Disabled people need only the proper environment and opportunity to develop and express criminal tendencies.	-3	-2	-1	+1	+2	+3
10	Disabled adults should be involuntarily committed to an institution following arrest.	-3	-2	-1	+1	+2	+3
11	Most disabled people are willing to work.	-3	-2	-1	+1	+2	+3
12	Disabled individuals are able to adjust to a life outside an institutional setting.	-3	-2	-1	+1	+2	+3

(Continued)

13	Disabled people should not be prohibited from obtaining a driver's license.	-3	-2	-1	+1	+2	+3
14	Disabled people should live with others of similar disability	-3	-2	-1	+1	+2	+3
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17	Disabled children in regular classrooms have an adverse effect on other children.	-3	-2	-1	+1	+2	+3
18	Simple repetitive work is appropriate for disabled people.	-3	-2	-1	+1	+2	+3
19	Disabled people show a deviant personality profile.	-3	-2	-1	+1	+2	+3
20	Equal employment opportunities should be available to disabled individuals.	-3	-2	-1	+1	+2	+3
21	Laws to prevent employers from discriminating against disabled people should be passed.	-3	-2	-1	+1	+2	+3
22	Disabled people engage in bizarre and deviant sexual activity.	-3	-2	-1	+1	+2	+3
23	Disabled workers should receive at least the minimum wage established for their jobs.	-3	-2	-1	+1	+2	+3
24	Disabled individuals can be expected to fit into competitive society.	-3	-2	-1	+1	+2	+3

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APPENDIX D

TRAINER SCRIPTS FOR ADMINISTERING THE SADP

Foundation Trainer Script for Administering the Scale of Attitudes toward Disabled Persons

Steps in Administering the Foundation Training Scale of Attitudes toward Disabled Persons:

1. Explain to the group that we are in the process of evaluating our training programs and we would appreciate their participation. If they consent to participate in the evaluation, they will be given two short surveys before they begin Foundation Training: (1) A brief demographic survey, and (2) the "Scale of Attitudes toward Disabled Persons" (SADP) survey. Total time to fill out the two surveys should be less than 15 minutes. They will be asked to fill out a similar survey at the end of Foundation Training. **Emphasize that participation in the survey is voluntary. Responses will only be labeled by numbers on the outside of their packet. Identifying numbers will only designate the area of the state and the date data was collected. No specific reference to the participant's identity or the organization they work for will be made at any time. All records of the research will be kept exclusively by the researcher under lock and key. After the research has been collected and the report approved, all records will be destroyed.**

2. Pass out evaluation packets. Each packet contains:
   (A) Survey #1 — "Consent to Evaluate," "Demographics" and "SADP #1"
   (B) Survey #2 — "SADP #2"

3. Ask participants to fill out and sign the "Consent to Participate" and the "Demographics" part of Survey #1 if they are willing to participate in the evaluation. ASK PARTICIPANTS TO BE SURE AND FILL OUT THE AREA # AND THE CLASS DATE ON THE FRONT OF SURVEY #1.

4. Please read the following statement after participants have completed the "Consent to Participate" and "Demographics" forms and BEFORE they have started the SADP #1:

> ***"The statements presented in the following survey express opinions or ideas about people who are disabled. There are many differences of opinion; many people agree and many people disagree with each statement. We would like to know your opinion about them. Put an "X" through the appropriate number, from -3 to +3, which best corresponds with how you feel about the statement. There are no right or wrong answers. You should work as quickly as you can, but don't rush. There is no time limit. Please respond to every statement. We appreciate your help. Your responses will help us evaluate the effectiveness of the Developmental Disabilities Services Divisions' training programs."***

5. Once the SADP #1 have been completed, ask participants to place them back in their envelopes and keep them until the end of Foundation Training. They will be completing the second survey, the SADP #2 at the end of Foundation Training.

6. At the end of Foundation Training — BEFORE THEY TAKE THEIR LAST TEST — have them open their envelopes and complete Survey #2 (SADP #2). ASK THEM TO FILL OUT THE AREA # AND THE CLASS DATE ON THE FRONT OF SURVEY #2.

7. Have them put the completed survey into the envelopes and pass them to you. Place all class envelopes into the large main envelope MAKING SURE THE AREA # AND THE CLASS DATE ARE ON THE OUTSIDE.

8. Turn your completed survey packets into either your supervisor, Michaela Bishop (405) 521-6264, or to Shari Villani (405)364-1601, WITHIN ONE WEEK OF THE END OF THE CLASS.

9. Thank you for your help. Hopefully, we should be able to get some good sound information from the study.

Residential Trainer Script for Administering the Scale of Attitudes toward Disabled Persons

Steps for Administering the Residential Training "Scale of Attitudes toward Disabled Persons"

1. Explain to the group that we are in the process of evaluating our training programs and we would appreciate their participation. If they consent to participate in the evaluation, they will be given two short surveys before they begin Residential Training: (1) A brief demographic survey, and (2) the "Scale of Attitudes toward Disabled Persons" (SADP) survey. Total time to fill out the two surveys should be less than 15 minutes. **Emphasize that participation in the survey is voluntary. Responses will only be labeled by numbers on the outside of their packet. Identifying numbers will only designate the area of the state and the date data was collected. No specific reference to the participant's identity or the organization they work for will be made at any time. All records of the research will be kept exclusively by the researcher under lock and key. After the research has been collected and the report approved, all records will be destroyed.**
2. Pass out the Survey Packet that contains
    (A) "Consent to Evaluate,"
    (B) "Demographics"
    (B) "Scale of Attitudes toward Disabled People" (SADP)
3. Ask participants to fill out and sign "Consent to Participate" and the "Demographics" part of the survey packet if they are willing to participate in the evaluation.
4. Once they have finished, ask participants who have consented to participate to FILL OUT THE AREA # AND THE DATE OF THE CLASS ON THE FRONT OF THEIR PACKET.
5. Please read the following statement after participants have completed the "Consent to Participate" and "Demographics" forms and BEFORE they have started the SADP survey.

> ***"The statements presented in the following survey express opinions or ideas about people who are disabled. There are many differences of opinion: many people agree and many people disagree with each statement. We would like to know your opinion about them. Put an "X" through the appropriate number, from -3 to +3, which best corresponds with how you feel about the statement. There are no right or wrong answers. You should work as quickly as you can, but don't rush. There is no time limit. Please respond to every statement. We appreciate your help. Your responses will help us evaluate the effectiveness of the Developmental Disabilities Services Division's training programs."***

6. Once the SADP survey has been completed, ask participants to turn the packet into you.
7. Place all class surveys into the original large envelope MAKING SURE THE AREA # AND THE CLASS DATE ARE ON THE OUTSIDE.
8. Turn the completed surveys in their envelope into John Wingard, ECU, (580)332-8000, WITHIN ONE WEEK OF THE END OF THE CLASS.
9. Thank you for your help. Hopefully, we should be able to get some good sound information from the study.

APPENDIX E

DEMOGRAPHIC SURVEY

Demographic Information

Directions: Please place an X in the appropriate spaces.

1. I work in Area ________I _______II _______III

2. Age:
_______18-25
_______26-35
_______36-45
_______46-55
_______+55

3. Gender:
________Male
________Female

4. Ethnic Background:
_______African American
_______Asian / Pacific Islander
_______Caucasian
_______Hispanic / Latino
_______Native American
_______Other (please specify)__________________
_______Prefer not to answer

5. Area of Specialization:
_______Direct Care/HTS
_______Vocational
_______Case Management
_______Professional (OT's, PT's, Physicians, Psychologists)
_______Administrative/Supervisory
_______Support staff (Clerical, Transportation, Maintenance)
_______Other (please specify)__________________

6. Foundation Training:
_______I HAVE previously attended Foundation Training.
_______I HAVE NOT previously attended Foundation Training.

7. Prior Contact with People with Developmental Disabilities:
_______I have a family member or friend who has developmental disabilities
_______I have worked previously with people who have developmental disabilities
_______I have had No prior contact with people who have developmental disabilities

8. Prior Training on Developmental Disabilities OTHER THAN FOUNDATION TRAINING
______I have attended previous lecture-based training program(s)
______I have attended previous hands-on, experience or work-based training
______I have attended previous distance education (televised or computer) training program(s)
______I have No prior training in developmental disabilities

9. On-The-Job experience:
______I have NO previous on-the-job experience working with people with developmental disabilities.
______I have at least THREE MONTHS on-the-job experience working with people with developmental disabilities.

APPENDIX F

CONSENT FORM

CONSENT FORM

I, ____________________________, hereby agree to participate in the research project that assesses the attitudes of direct contact staff towards people with developmental disabilities. I understand the research is part of a graduate research project. To maintain confidentiality, all information obtained in the process will be reported in aggregate and/or by code. No specific reference to my identity nor to that of the organization for whom I work will be made at any time. All records of this research will be kept exclusively by the researcher under lock and key. After the research has been concluded and the report approved, all records will be destroyed.

This is done as part of an investigation entitled "Assessing the Effects of Training and Contact on the Attitudes of Direct Care Staff Working with People with Developmental Disabilities."

The purpose of the procedure is to gather insightful information regarding particular attitudes of staff who currently work with, or will work in the future with, people with developmental disabilities in Oklahoma. This information will then serve as survey data to reach meaningful findings, conclusions, and recommendations for those involved in the development of the Oklahoma Department of Human Services' Developmental Disabilities Services Division's staff training programs.

I understand that participation is voluntary, that there is no penalty for refusal to participate, and that I am free to withdraw my consent and participation in this project at any time without penalty after notifying the project director. I may contact Ms. Shari Villani at telephone number (405)364-1601. I may also contact Gay Clarkson, IRB Executive Secretary, 305 Whitehurst, Oklahoma State University, Stillwater, OK 74078; telephone (405)744-5700.

I have read and fully understand the consent form. I sign it freely and voluntarily. A copy will be supplied to me upon request.

Date:______________ Area:__________________ Time:______(a.m./p.m.)

Signed:___________________________________
(Signature of Subject)

I certify that I have personally explained all elements of this form to the subject or his/her representative before requesting the subject or his/her representative to sign it.

Signed:___________________________________
(Project Director or his/her authorized representative)

APPENDIX G

INSTITUTIONAL REVIEW BOARD
APPROVAL FORM

OKLAHOMA STATE UNIVERSITY
INSTITUTIONAL REVIEW BOARD
HUMAN SUBJECTS REVIEW

Date: 08-18-98 **IRB #:** ED-99-003

Proposal Title: ASSESSING THE EFFECTS OF TRAINING AND CONTACT ON THE ATTITUDES OF DIRECT CARE STAFF WORKING WITH PEOPLE WITH DEVELOPMENTAL DISABILITIES

Principal Investigator(s): Reynaldo Martinez, Shari Villani

Reviewed and Processed as: Exempt

Approval Status Recommended by Reviewer(s): Approved

ALL APPROVALS MAY BE SUBJECT TO REVIEW BY FULL INSTITUTIONAL REVIEW BOARD AT NEXT MEETING, AS WELL AS ARE SUBJECT TO MONITORING AT ANY TIME DURING THE APPROVAL PERIOD.
APPROVAL STATUS PERIOD VALID FOR DATA COLLECTION FOR A ONE CALENDAR YEAR PERIOD AFTER WHICH A CONTINUATION OR RENEWAL REQUEST IS REQUIRED TO BE SUBMITTED FOR BOARD APPROVAL.
ANY MODIFICATIONS TO APPROVED PROJECT MUST ALSO BE SUBMITTED FOR APPROVAL.

Comments, Modifications/Conditions for Approval or Disapproval are as follows:

According to the reviewer, the following might be considered a risk potential. Attitudes could be regarded as inappropriate for working with clients. What if, a respondent is the only African American from a region of the state? Can this person be adequately protected? If so, OK. Can respondents refuse to answer some demographics?

Signature: Thomas C. Collins

Interim Chair of Institutional Review Board
and Vice President for Research

Date: August 18, 1998

cc: Shari Villani

VITA

Shari L. Villani

Candidate for the Degree of

Doctor of Education

Thesis: ASSESSING THE EFFECTS OF TRAINING ON THE ATTITUDES OF STAFF WORKING WITH PEOPLE WHO HAVE DEVELOPMENTAL DISABILITIES

Major Field: Occupational and Adult Education

Biographical:

Personal Data: Born in Meade, Kansas, July 1st, 1951, the daughter of Lester A. and Barbera Black, Alva, Oklahoma; Betty J. Black of Norman, OK. Married to Robert Anthony Villani, August 4, 1973. Three sons, Christopher, Travis, and Ryan.

Education: Graduated from Alva High School, Alva, Oklahoma, in May, 1969; received Bachelor of Science Degree in Education from Northwestern Oklahoma State University, July, 1972; received a Master of Education Degree in Occupational and Adult Education from the University of Central Oklahoma in Dec., 1993. Completed requirements for the Doctor of Education degree from Oklahoma State University, Stillwater, Oklahoma in May, 1999.

Professional Experience: High School Science Teacher, Western Heights High School, Oklahoma City, Oklahoma, June 1972 - May 1974; Curriculum Development Specialist, Moore-Norman Vocational-Technical School, Norman, Oklahoma, December 1989 - August 1990; Contract Instructional Designer, Oklahoma State Department of Vo-Tech, November 1990 - September 1991; Senior Instructional Designer, Baptist/Integris Medical Center, Oklahoma City, Oklahoma, September 1990 - April 1991; Consultant in Curriculum Development and Distance Education, The Nigh Institute, University of Central Oklahoma, August 1991 - June 1995; President, Villani & Associates, Inc., January, 1996 to present; Consultant, Instructional Development and Design, State of Oklahoma, Department of Human Services, 1991 - Present.

Professional Organizations: American Society of Training and Development, National Organization, Central Oklahoma Chapter; American Association on Mental Retardation; Adult Education and Research Association; Gamma Chapter, Phi Delta Kappa, Oklahoma State University; Oklahoma Writers Federation; Norman City Council, City of Norman Sub-committee, Sutton Urban Wilderness Area