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Training Guidelines for New Staff in a Community Integrated Living Arrangement (CILA) Program

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Training Guidelines for New Staff In A

Community Integrated Living Arrangement (CILA) Program
(TITLE)

BY
Michael R. Finney

THESIS

SUBMITTED IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE OF

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I HEREBY RECOMMEND THIS THESIS BE ACCEPTED AS FULFILLING THIS PART OF THE GRADUATE DEGREE CITED ABOVE

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ABSTRACT

Adequate staff training prior to working with developmentally disabled individuals in a Community Integrated Living Arrangement program is a state requirement. This study gives some background information and suggestions for such training requirements in concise blocks of time.

A training period before new staff begin working with clients is important because it enables staff to understand various facets of their job. It is important that all new staff understand the types of individuals with whom they will be working and what is expected of them in regard to working with the agency's clientele.

To ensure that staff comprehend the rationale of training and perform the skills properly, role-playing and video taping can be utilized in the training plans. Simulations can be set up in which staff role-play actual situations with a resident and demonstrate the skills they have learned.

Individual reading of selected materials is another way staff can learn more about and be prepared for working with individuals who are developmentally disabled. This affords new staff with adequate time to ask questions before actually beginning work with clients.

While basic skills are fairly generic when beginning a training program for new staff, unique needs do arise in each residence. The training system should address the ongoing needs of staff in the particular program. Staff training should be applicable to the day-to-day realities of the job and should teach concrete skills to help staff work more effectively with clients.

Without training, members rendering services to individuals who have developmental disabilities will be ill- prepared to do their jobs. Consequently, the individuals for whom services are to be rendered will suffer by not receiving the quality of services to which they are entitled. Furthermore, failure to abide by the Illinois Department of Mental Health and Developmental Disabilities Community Integrated Living Arrangement guidelines could result in loss of licensure and in turn, loss of funding for agencies providing such programs.

In order to rectify this problem, a training curricula which satisfies state requirements has been developed. Hopefully, the fulfillment of these requirements will enhance the performance of staff members in their delivery of services. By the same token, the individual's lives to whom staff render services will be improved as well.

DEDICATION

I would like to dedicate this study to the staff and clients at the Coles County Association for the Retarded, Charleston, Illinois.

ACKNOWLEDGEMENTS

Putting together a comprehensive study is no easy task. There are months of planning, conferences and researching involved. Then a curricula has to be developed. At last the curricula is in place and ready to act upon. The cast of characters is set into writing, scripts are written and hours of video taping is done.

There have been a tremendous amount of people involved in this study and I would like to acknowledge them here for all their hard work and dedication.

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To all of you, a heart-filled thanks for a job well done!

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CHAPTER I
INTRODUCTION

A Community Integrated Living Arrangement (C.I.L.A.) program is based on the fundamental recognition that persons receiving services are first and foremost unique individuals with basic human needs, aspirations, desires and feelings. They are citizens of a local community with all rights and privileges, opportunities and responsibilities accorded other citizens. Only secondarily do these persons have a disability.

On August 30, 1988, the Community Integrated Arrangement Act became a reality. The bill marked the beginning of a re-designed community based customized service system for persons with disabilities. These individualized services are known as C.I.L.A. (Community Integrated Living Arrangements).

C.I.L.A. is an array of customized support services - including supervision, skills training, personal assistance, employment-related services and transportation. These services include provision of a permanent home in the community, if the individual does not choose to remain in his/her existing home. All services are designed to meet each individual's needs, preferences and strengths regardless of "programmatic categories." As a system of services, C.I.L.A. can be provided to persons living in a wide variety of residential settings including family homes, private apartments or houses, and agency operated group homes.

C.I.L.A. services are developed jointly with the individual and family or friends. Carefully selected, positive choices are offered in order to ensure adequate support and assistance. In this way the individuals have the experience of taking risks and making decisions for themselves. At the same time, it is a team approach which offers optimal interpersonal contact with a variety of others.

The "team" consists of developmental services agency staff under the leadership of a qualified mental retardation professional. Once the individual's

needs are assessed with the involvement of the individual, the family and others, an integrated services plan is designed. This plan defines the specific support services requested by or required for that individual. The team arranges for natural support networks of non-paid persons in the community as well as advocacy and assistance with generic community services. This coordinated team approach is crucial: It provides staffing flexibility and responsiveness and ensures optimal interpersonal contact with a variety of community members.

FUNDING

Funding is linked to the individual, rather than a program "slot": If that individual needs or wishes to move, or to receive a different combination of support services, the funding follows that person to provide the desired services.

When a licensed C.I.L.A. agency (Illinois Department of Mental Health and Developmental Disabilities, 1989) identifies a person in need of services, a designated amount of money is allocated for services for that person. Should additional funding be required, the agency may make a special request to the department. Otherwise funding does not change. It may increase, will not decrease, and stays with the individual.

PURPOSE

The underlying principles of C.I.L.A. go beyond physically placing persons with mental disabilities into a neighborhood residence. The purpose of C.I.L.A.'s specialized array of services is to help clients remain at home and establish feelings of permanency and security. They are involved in productive activities with the goal of becoming personally and economically self-sufficient.

C.I.L.A. clients learn to be good neighbors. They learn to use community resources that most of us take for granted, such as banks, grocery stores, self-service laundries, and parks. They learn to make new friends and build informal support groups with people other than mental health providers or caregivers and volunteers. Furthermore, participants in C.I.L.A. learn to be

interdependent. While dependent upon their family, their friends, their community, and their environment, they also contribute in turn by working and participating in community activities.

C.I.L.A. is a significant departure from our usual way of thinking about clients, services, and funding. It has required substantial innovative administrative changes in the way we do business. While we struggle with those changes, it is important to keep in mind the primary C.I.L.A. value: the client comes first (Taylor, et al., 1987).

EDUCATION

This study is intended to address the training needs of individuals who are considered professionally qualified to work in the field of developmental disabilities. In order to be an acknowledged Qualified Mental Retardation Professional (QMRP), one must have at least one year of experience working directly with persons with mental retardation or other developmental disabilities and in addition is one of the following: a doctor of medicine or osteopathy, a registered nurse, or a person who holds at least a bachelor's degree in a professional category such as human services field which includes, but is not limited to sociology, special education, rehabilitation counseling and psychology. Also included in this area are individuals who hold at least a bachelor's degree in an academic discipline associated with the study of human behavior, human skill development, humans and their cultural behavior, or any other studies of services related to basic human care needs (Federal Regulations with Interpretive Guidelines for Intermediate Care Facilities for the Mentally Retarded, October, 1988).

Essentially, any individual with a bachelor's degree remotely related to the broad category of "human services" who has worked in the field of developmental disabilities for one year may be considered a QMRP. Physical education, English, art education, history, political science and home economics are common examples of major fields of study for QMRP's. The question of qualification looms over the field of developmental disabilities and

rehabilitation in general (Hansen, 1971; Walker & Myers, 1988). In fact, in the rehabilitation field, types and level of degrees and corresponding success or job effectiveness have been a source of concern (Hershenson, 1988; Szymanski & Parker, 1989).

The particular issue of qualifications has been magnified by the prolific growth in community residential facilities serving developmentally disabled persons. This movement towards providing less restrictive housing options to persons with developmental disabilities has created a demand which far exceeds the supply of qualified professionals (Ebert, 1979; Jacobsen & Janicki, 1984).

One might well question whether or not a single year of experience is sufficient to provide the QMRP with adequate qualifications to deal professionally with individuals who are developmentally disabled. The issue is complex because retention of personnel is a major problem in the field of developmental disabilities. Along with personnel issues such as recruitment of qualified personnel or staff training and development issues, staff turnover was considered to be the major problem in an extensive survey of administrators (Bruininks, Kudla, Wieck, & Hauber, 1980). Thus, such limited experience requirements may seem somewhat more plausible under such extenuating circumstances.

Among major factors contributing to low retention or higher turnover is lack of training (George & Baumeister, 1981). Indeed, lack of training and brevity of experience compound the issue of qualification. Furthermore, the field of human services has been slow to develop training and education programs for employees (Tropman, 1984). Staff training needs have been identified as a substantial deficit area and may well be one of the greatest challenges confronting administrators in the field of developmental disabilities (Repp, Felce & deKock, 1987; Slater & Bunyard, 1983).

Presumably the resultant gaps attributed to lack of qualification and lack of experience, no matter how formidable, could be bridged by training. Expanded

training and "professionalization" of direct service staff are frequently cited as the key to quality programming (Friorelli, 1982; Singer, Close, Irvin, Gersten & Sailer, 1984). Development and implementaton of associate degree curricula through junior colleges specifically oriented to the field of developmental disabilities, is a possible solution for filling the training void. In fact, Lake Land College in Mattoon, Illinois offers a program in Human Services that was developed with the C.I.L.A. program in mind.

In short, qualifications, lack of experience and lack of training are three intricately connected issues facing those in the field of providing services to persons with developmental disabilities. For example, eighty-five percent of approximately two thousand administrative respondents to an extensive and elaborate mail survey indicated that personnel issues, including recruitment of qualified personnel, retention of experienced personnel and staff training were the most significant problems facing the field of developmental disabilities (Bruininks, et al, 1980). As a point of reference; funding, which was identified as the second most pressing problem, had twenty percent fewer responses (Bruininks, et al, 1980).

Most community agencies do not have specified personnel whose primary function is to deal with staff training and development. Many inservice training sessions are conducted by in-house staff who are not necessarily qualified to do so. Inadequate funding is the major obstacle to provision of adequate staff training. Agencies can neither afford to engage experts to conduct proper inservice training sessions, nor can most agencies afford to send many staff persons to training sessions where attendance fees are charged (Slater & Bunyard, 1983).

The other major funding source in the field of developmental disabilities, the Department of Public Aid (DPA), has training requirements for paraprofessionals but has none for professionals other than the QMRP standard. Presumably, QMRP status is sufficient unto itself.

Ultimately, the most important beneficiaries of an investigation of issues

pertaining to the qualifications of professionals within the field of developmental disabilities are the recipients of services rendered by these qualified professionals. In other words, developmentally disabled individuals stand to derive the greatest benefit from a study such as this.

HISTORY

Since the late 1960's many adults with developmental disabilities have left state institutions to move to smaller residential settings in the community such as intermediate care facilities for the mentally retarded or developmentally disabled, group homes, supervised apartments or supported apartments. People with the most severe disabilities, however, often remained in state institutions or moved to a nursing home, private institution or large intermediate care facility (Fiorelli, 1982).

In the past few years, it has become increasingly clear that all people with developmental disabilities, including people with severe disabilities and chronic health needs, can be supported in the community. The current issue is not whether a person should live in an institution or in the community but how best to provide supports for people with the most complex needs in the community (Taylor, Racino, Knoll, and Lutfiyya, 1987).

The most exemplary practices in supporting adults with severe disabilities in the community represent a new way of thinking about "residential services." Unlike the traditional approach of establishing residential programs fitting people into the program, and then individualizing within the context of the program, innovative service agencies are now starting with the person first and developing the supports and housing around the person (Fiorelli, 1982).

The issue of size of homes in the community for people with disabilities continues to be a key issue in some states. For example, New York State still promotes a prototype home for twelve people with severe disabilities. Most intermediate care facilities, a common living arrangement for people with medical needs, have at least eight people. In contrast, innovative service

systems and agencies have already recognized the importance of size of the home to the quality of people's lives and have moved or are moving toward smaller size homes from one to four people. Examples include:

1. Maryland has developed three person alternative living units across the state and supports people with severe disabilities in these settings.
2. Since 1982, Connecticut has increased the number of homes for one to three people, particularly for people with challenging behaviors or extensive medical needs.
3. In 1983, Wisconsin limited the size of living arrangements under their home and community-based deinstitutionalization waiver, to four people unless an exception was granted.
4. Minnesota, under their home and community-based medicaid waiver, limits supported living services for adults to places where no more than six people reside and supports many adults in even smaller homes.
5. Nebraska is moving away from homes of five or six people to smaller homes (Knoll & Pacino, 1988).

Smaller homes are particularly important for people with more severe disabilities. From the perspective of service providers, small size is valuable because it enables people with disabilities to feel more secure and to have a greater sense of control over their lifespace. It also enables staff to get to know people as individuals versus an emphasis on "group management." In interviews with innovative service providers, the general consensus was "as the problems associated with supporting a person increased, the need for the person to live with a few people or even alone, increased" (Knoll & Pacino, 1988).

At the same time, it is important to realize that small size alone is not enough since it does not necessarily involve more individualized supports for

people. When based on the same "model of services" as larger facilities, smaller settings can also become highly routinized and "home-like" instead of homes. The issue is not just one of size but also involves a change in the basic approach to supporting adults with severe disabilities (Taylor, et al., 1987, Racino, 1988).

Throughout the past half dozen years there has been an increased emphasis on the importance of heterogeneity (i.e., a mix of people) in homes as opposed to people with the same type and level of disability living in the same home. Still many states and communities continue to group people on the basis of similar "needs or disabilities." It is common to find homes where all the people in the home have "challenging behaviors" or "medical needs" or "social emotional problems." This practice of grouping people on the basis of similar disabilities has often extended to even the smaller homes.

In such homes, it would be preferable to have a group with a range of needs (i.e., a heterogeneous group). This could enhance people's acquisition of skills and competencies (Ford, et al., 1982) as well as their integration in the community (Wolfensberger, 1972). In a recent study, most innovative service providers stressed that the nature of the grouping was as important as the size of the group. "They universally testified to problems with the common practice of creating a specialized setting where all the most difficult people were grouped" (Kroll & Pacino, 1988).

Taking an individualized approach to residential supports, however, is a "quantum" leap past the heterogeneity/homogeneity issue. Instead of matching people on the basis of their disability, either common or different, an individualized approach enables us to view people as people first and recognizes the disability as a relatively minor aspect of the matching process. For adults, the process involves supporting people in deciding with whom they will live and whether they will live alone or with others. The major decisions then revolve around issues such as the desire of people to live together, common interests, or basic compatibility.

In an individualized approach, neither the location nor the number of people is predetermined. Therefore, there is greater flexibility in how many people will live together. The option of living alone, at least for a period of time, is an important one for some people. Individualized, however, does not mean that a person will always live alone or with one other person. People may also live with roommates whom they select. Because supports are not tied to a certain setting, one can live with a variety of people, including "typical" people, family, people with other labels or alone and still receive the needed intensity of supports. This approach recognizes the critical importance of the people we live with and the impact they may have on our lives.

Therefore, staff working with people who have developmental disabilities, must be adequately trained in order to handle the complexities that occur in the clients' lives that they serve. Not only is initial training important before staff begin working with clients, but on-going training throughout the year is a must.

Training does not have to be complex. In fact, it should be developed in such a way that staff of all educational levels can understand and remember the material content. Training should be presented in a way whereby staff can work independently for the most part. The reason for this is that the staff are not centrally located. That is they are spread throughout the community and work different schedules. It is impossible to get them all together for any type of training after they begin working with clients.

A limitation of this study was the number of staff used for data collection. It was felt by the author that only staff working in the residential services program should be studied which limited the number to sixty respondents. The results were based only on this one group of people and compared to no one else. The study is strictly based on one agency program (Residential Services, Coles County ARC, Charleston, Illinois).

The intention of this study is to determine that by watching video tapes as opposed to just reading printed material, more learning takes place. The Null Hypothesis is that there is no significant difference between the two.

DEFINITION OF TERMS

Education level - degree held by the professional, conferred by college or university.

Major - particular discipline studied to obtain the degree.

Inservice training - training sessions held within the place of employment for its employees presumably to enhance their knowledge and/or performance.

Professional - employee who holds a degree conferred by a college or university.

Paraprofessional - employee who is non-degreed.

Mental Retardation - significant subaverage general intellectual functioning which exists concurrently with impairment in adaptive behavior and which originates before the age of 18 years.

Developmental Disabilities - a disability which is attributable to mental retardation, cerebral palsy, epilepsy or autism; or to any other condition which results in an impairment similar to that caused by mental retardation and which requires services similar to those required by mentally retarded individuals. Such disability must originate before the age of 18 , be expected to continue indefinitely, and constitute a substantial handicap.

Community Agency - agency licensed by Illinois Department of Public Health or by the Department of Mental Health and Developmental Disabilities to provide support services to developmentally disabled and/or mentally retarded persons. This term may refer to a community mental health or developmental services agency which is a sole proprietorship, association, partnership, corporation or organization, public or private, either for profit or non-profit.

CHAPTER II

REVIEW OF LITERATURE

This review has focused on the problems and means of training staff to work within a residential program agency. An agency must first have an organizational philosophy to guide its work with its clientele and employees. Second, an agency must have staff supervision, recruitment and retention practices that enhance its ability to attract and retain capable staff.

A sound organizational philosophy allows senior management to influence decisions at all levels and provides a framework both for the development of concrete objectives and for a corporate personality. An effective management style is one that involves all levels of the organization to the greatest degree possible. The crucial link in this organizational structure is the director of the program , who bridges the gap between administration and program.

In order to strengthen this structure, a proposal to develop and implement a training curricula which satisfies the requirements for a Community Integrated Living Arrangement (C.I.L.A.) program established by the Department of Mental Health/Developmental Disabilities (DMH/DD), is being made. Presumably, the fulfillment of these requirements would enhance the performance of staff members in their delivery of services. By the same token, the individual's lives to whom they render services, would be improved as well.

The following requirements taken from the document Standards and Licensure Requirements for Community Integrated Living Arrangements, (October, 1989) are specifically what needs to be met.

Staff and Volunteer Training:

1. Training for direct-service staff shall include but not be limited to the following areas:
    a. Cardiopulmonary resuscitation (CPR), Heimlich maneuver and first aid;
    b. Concepts of treatment, habilitation and rehabilitation

including behavior managment, normalization, age appropriateness and psycho-social rehabilitation depending on the needs of the individuals served or to be served;

c. Safety, fire and disaster procedures;

d. Abuse, neglect and unusual incident prevention, handling and reporting;

e. Individual rights in accordance with Chapter 2 of the Code (Ill. Rev. Stat. 1987, ch. 91 1/2, par. 2-100 35 seq) and maintaining confidentiality in accordance with the Act (Ill Rev. Stat. 1987, ch. 91 1/2, par. 801 et seq.);

f. The nature and structure of the individual integrated services plan;

g. The type, dosage, characteristics and side effects of medications prescribed for individuals; and

h. Screening for involuntary muscular movement, which may be indicative of tardive dyskinesia.

2. Direct-service staff shall receive at least 40 hours of training prior to direct involvement with individuals;

3. Following completion of training requirements in subsection 2 above, direct-service staff shall be provided training in the following areas of not less than 40 hours, to be completed within six months of assignment to specific individuals living in C.I.L.A.'s;

a. Development and implementation of an individual integrated services plan; and

b. Formal assessment instruments used and their role in the development of the services plan; and

c. Other training which relates specifically to the type of disability or treatment and intervention techniques being

used specific to individuals living in C.I.L.A.'s geared toward assisting staff execute objectives contained in services plans; and

4. Upon completion of training specified in subsection 2 and 3 above, each direct-care staff member shall participate in not less than 40 hours of training per year designed to enhance his or her ability to deliver services to individuals which promotes independence in daily living and economic self-sufficiency;
5. All training shall be documented in each employee's personnel record and shall be readily available for review by DMH/DD surveyors;
6. This agency shall implement a written training plan which describes each formal course offered to meet the requirements of this part, the methods used to provide training and to determine pass or fail and or completion of any required training;
7. The agency shall provide a training program for volunteers prior to their working with individuals. For those volunteers providing direct service, training shall include subsections 1a, 1c, 1d and 1e above and may include subsection 1b as required by the agency.

PROCEDURE

The requirements can be met in the following manner. Due to the nature of C.I.L.A.'s, it is virtually impossible to bring all staff members together in any one place at any given time. Therefore, in order to fulfill these requirements, it is necessary to create a variety of training modules which can lend themselves to the uniqueness of C.I.L.A. staffing patterns. Video cassettes will be developed in some instances so that individuals or small groups can have access to them for their training. A reading curricula can be developed as a means to meet some of the training needs which again can be done on an individual basis. The shadowing techniques can be used in which new employees follow veteran employees around daily.

Presently, many facilities providing C.I.L.A.'s have no formal training procedures. By implementing a training program in one department in order to meet specified guidelines, the door will be opened to implement other training programs unique to the needs of each department within an agency.

Presently, many facilities providing C.I.L.A.'s have no formal training procedures. By implementing a training program in one department in order to meet specified guidelines, the door will be opened to implement other training programs unique to the needs of each department within an agency. Eventually, all staff members who are employed would be required to go through formal training pertinent to their particular function. Thus, staff members will become more developed and better prepared to more effectively deliver services to those individuals for whom they were hired to serve. The individuals receiving services will benefit from the enhanced knowledge of the staff persons who deliver services to them.

For each training session conducted via video cassette or assigned readings, trainees will be quizzed to ascertain whether or not they have gained any learning from the training session. For the shadowing part of the training, roles will be reversed whereby the veteran employee trainer will shadow the new employee trainee in order to ascertain what the new employee has learned.

Improvement in the development of the individuals being served will in turn be monitored to determine whether the training has effectively been translated to their benefit.

In order to protect the rights of residents on an ongoing basis, an agency should undertake certain specific actions and procedures. First among these is staff training, both at the administrative and direct service levels. Unless the nature and scope of the legal rights of residents within the program and community is well understood by the persons charged with their protection, nothing positive can result.

A training period before new staff begin working is important because it

enables staff to understand various facets of their job. A number of aspects of work within a residential program need to be covered within a inservice training program. These include an orientation to the agency's clientele, the basic philosophy of providing services, the agency's mission, health and safety issues, sexuality, and service provision practices.

It is important that new staff understand the types of individuals with whom they will be working and what is expected of them in regard to working with the agency's clientele. Staff may have little, if any, experience with a disabled person and may need to both confront their own attitudes and values related to disablement, as well as understand the capabilities and potentials of disabled persons. This is very important, as it sets a constructive tone for staff attitudes and expectations. However, it is also vital to address residents' limitations so as not to engender staff frustrations when residents who are more severely impaired do not display rapid progress in acquiring new skills.

BASICS

The foundation for the agency's practices - its philosophy of care - should be grounded in a belief system that holds all persons in high esteem, no matter how severe their disabilities, and promotes experiences and activities that are typical of the community. Human management belief systems such as those espoused within the tenets of the normalization principle (Wolfensberger, 1973) are used by many residential program agencies to orient staff in the philosophy of care. A fundamental understanding of the principles of normalization will serve as a good foundation for staff practices within the community residence.

Health and safety issues are also important, and should be covered with staff as soon as possible after beginning their employment. All staff should be required to take first-aid and cardiopulmonary resuscitation (CPR) training; they should also be taught how to deal with serious injuries and seizures. Frequently, because residents of a residential program may often have difficulty exercising independent judgment, staff also need to be trained in decision making and in exercising good judgment in situations where residents may be

endangered and need protection (Illinois Department of Mental Health & Developmental Disabilities, October, 1989). Residents in a typical community are exposed to certain dangers in everyday situations such as crossing streets, riding buses, cooking and cleaning, and using electric or power equipment. Staff in a community-based home must be aware of the inherent dangers of community living, while also helping residents to take advantage of as many opportunities in the community as possible. Staff should be trained to lessen the risks as much as possible while allowing for "dignity of risk."

Another issue, that of human sexuality, is often laden with profound emotional overtones. Many agencies debate whether to even bring up the issue of sex education because of the fear of negative reaction from family members of the residents. However, sexuality is an integral part of any individuals' life and requires an open discussion to result in accurate knowledge and sound judgment. Many agencies want to be clear that while they neither encourage nor discourage sexual activity, they seek to facilitate a resident's understanding of sexuality. Staff are told that the resident should receive counseling and teaching regarding the privacy and appropriateness of various behaviors (Slater & Bunyard, 1983). Staff also come to the job with their own values, attitudes, and prejudices concerning sexuality. It is constructive to have them contend with both their own feelings about sexuality, and the sexuality of the residents. Consequently; including the topic of sexuality within the inservice training program can prevent misunderstanding and problems once the staffperson is on the job.

To reiterate, an inservice training program should include, at minimum, the philosophy of a given agency, an understanding of who the residents are and of how the agency's philosophy affects the treatment and care of the residents, and basic health and safety topics. If the inservice training is conducted at a site other than the community residence, the director of the home should review this information with the new staff, including any aspects specific to the resident, before the staff begins work.

Many residential program agencies operate a number of homes, each of which has a different mix of residents' age, sex, level of intellectual impairment, or physical handicap. Since, in many instances, the major differences that staff must adapt to are those attributed to variations in intellectual impairment, some agencies conduct separate training programs for staff who work with severely and profoundly impaired residents and for those who work with mildly and moderately impaired residents (Ebert, 1979).

SKILLS

When training staff to work with severely and profoundly retarded residents, agencies need to first stress that these residents can learn and achieve. Gold (1975), in his Try Another Way techniques, clearly demonstrated that severely handicapped individuals can perform complex tasks through proper training. Similarly, it has been shown that persons with severe handicaps can perform in competitive job settings, given the proper conditions (Brown, et al., 1983). Also, any training must concentrate on those skills that are critical for residents to learn in order to better negotiate their environment (Adams & Sternberg, 1982).

In addition, staff who work with severely and profoundly retarded persons require a different level of skills than those who work with mildly retarded persons, because of the severity of the disabilities (Foxx, 1982). In working with severely and profoundly retarded individuals, staff need extensive training in behavioral techniques, as well as in the use of feedback or reinforcement procedures and in prompting and fading techniques to strengthen positive behavior (Foxx, 1982; Van Houten, 1980).

To ensure that staff comprehend the approach and perform the skill properly, role-playing and video tapes can be utilized in the training sessions. Simulations can be set up in which staff role-play working with a resident and demonstrate the skills they have learned (Cooper, 1974).

When training staff to work with residents who have mild or moderate

retardation, staff should be adept at enhancing behavioral, affective, and cognitive abilities. Consequently, staff should be trained to motivate the residents by utilizing proper behavioral feedback techniques and should also understand the emotional needs of residents.

Mildly handicapped residents need to learn how to better solve problems by developing new adaptive skills. Valuable techniques are those that teach residents strategies to think through problems, not merely to perform the task at hand (Feuerstein, 1980). For example, to teach a resident to vacuum a room, staff first have to train the resident to understand that a problem exists by utilizing all their senses to interact with the environment. They then teach the resident to label the various parts of the room and to plan a strategy for vacuuming, and finally to be precise in checking his or her work.

New staff need to understand that mildly impaired residents may often need more emotional support because they have a greater understanding of who they are and what their handicap is than does a severely profoundly handicapped person. Because mildly impaired residents sometimes are more aware of the negative attitudes of nonhandicapped people, staff also need training in providing sensitive counseling to help them cope with this problem.

The combination of staff working at three training levels leads to a definable outcome, as reflected in evaluation. If a number of staff do not exhibit a given skill, then the system needs to be reevaluated in terms of how the skill was taught and whether staff practice time was sufficient.

While basic skills are fairly generic when beginning to teach staff to work with residents, unique needs do arise in each residence. A training system should address the ongoing needs of staff in the particular program. Many agencies in the mental retardation field do have continuing inservice training programs. Nevertheless, in this author's experience, numerous complaints are heard from staff that the inservice training is irrelevant and that it contains too much lecturing. Staff training should be applicable to the day-to-day

realities of the job, and should teach concrete skills to help staff work more effectively with residents (Bittel, 1978).

It is only recently that the Illinois Department of Mental Health and Developmental Disabilities (DMH/DD) has begun to address training requirements. In the document, Standards and Licensure Requirements for Community Integrated Living Arrangements (CILA), (October, 1989), requirements have been established for forty hours of training for new staff prior to their working with clients. An additional forty hours are required during the next six months of their employment and forty hours each year thereafter. Unfortunately, these standards and licensure requirements are still only in draft form while C.I.L.A. has been in existence for a year and a half. Furthermore, DMH/DD offers no funding mechanism to assist agencies in fulfilling the staff training requirements. Nonetheless, the point to be made in this context is that DMH/DD is finally acknowledging the need for training persons who work with individuals who are developmentally disabled.

C.I.L.A.'s are DMH/DD's newest concept for delivering services to individuals who have developmental disabilities and/or mental illness. The C.I.L.A. concept represents a dramatic departure from previous methods of service delivery. Previously, mentally disabled individuals were expected to graduate through a continuum of congregate living residential models. Large state institutions are the most restrictive, community based Intermediate Care Facilities for Developmental Disabilities (ICF/DD) such as the ninety-one bed Heritage House in Charleston, Illinois represented the next step in the continuum. Smaller fifteen bed ICF/DD's represent the next step and so on. In short, a cumbersome and stifling residential system has been created which restricts the rights and development of those individuals for whom they were created.

The C.I.L.A. concept in theory takes the individual who is developmentally disabled, lets him or her choose where he/she will live and then makes it

incumbent upon the service provider to deliver an array of services to that individual at times and in places that are convenient to him or her. The idea is to break away from the concept of creating programs and then sticking individuals into these programs fully expecting the individual to be molded into the program. In other words, all services are to be molded to meet the individual's needs. Simply put, the individual's choices are maximized and operationalized. The C.I.L.A. concept's brillance lies in its simplicity. Nonetheless it represents a dramatic departure from the way services have been delivered in the mental health field. This marked departure and the major emphasis DMH/DD is placing on C.I.L.A. are further reasons necessitating the development of a training curricula.

What will happen if adequate training is not provided is that staff members rendering services to individuals who have developmental disabilities will be ill-prepared to do their jobs. Consequently, the individuals for whom services are to be rendered will suffer by not receiving the quality of services to which they are entitled. Furthermore, failure to abide by DMH/DD's C.I.L.A. guidelines could result in loss of licensure and in turn, loss of funding for agencies providing C.I.L.A.'s.

Although training is a problem endemic to the field of developmental disabilities, for agencies providing C.I.L.A.'s the most pressing issue is to create a training curricula to meet C.I.L.A. standards. Therefore, C.I.L.A. will be the focus of this project.

CHAPTER III
METHODOLOGY

BACKGROUND

This author and the Director of Residential Services determined that a formal guide needed to be developed. This guide was to be used by each new staff member coming into the program before working with individuals who are developmentally disabled. It is to be used again to establish training needs after staff have been on duty for six months and then annually thereafter. This guide can be reproduced as needed, to fit the needs of the program (Finney and Patton, 1991).

As a result of determining a need for inservice training, the following goals will be met;

Goal 1. Curricula will be established to meet the 40 hours of training required for each new trainee prior to direct involvement with the individuals they are hired to serve in accordance to Community Integrated Living Arrangement (C.I.L.A.) program guidelines.

Intended Learning Outcomes:

a. the trainee will learn to perform cardiopulmonary resuscitation (CPR) through a 4 hour group training module conducted by a certified CPR instructor.
b. the trainee will learn to perform basic standard First Aid procedures and the Heimlich maneuver through a 4 hour group training session conducted by a certified First Aid instructor.
c. the trainee will learn basic safety, fire and disaster procedures which are applicable to the various C.I.L.A.'s in the agency's cachement area through a 2 hour video taped training module presented by a local fire authority.
d. concepts of treatment, habilitation and rehabilitation

including behavior management, normalization, age appropriateness and psychosocial rehabilitation depends on the needs of the individuals served, will be learned by trainee through a combination of assigned readings and video tapes to be conducted by qualified professional staff persons with experience in the field. This training should account for approximately 8 hours of training time.

e. trainee will learn handling and reporting of abuse, neglect and unusual incidents via video tapes depicting these types of scenarios through role playing. This should account for approximately 2 hours of training time.

f. trainee will learn about individual rights and maintaining confidentiality along with other orientation information through one-on-one orientation to be conducted by Director of Human Resources. Orientation sessions take approximately 6 hours.

g. trainee will learn about the nature and structure of the individual integrated services plan through use of video cassettes which also will depict a meeting in which a plan is being put together. Trainee will have copies of the forms used to follow along with the video. This training module will take approximately 2 hours.

h. trainee will learn the type, dosage, characteristics and side effects of medications prescribed for individuals through video in which a pharmacist will review commonly used medications and explain how to use the Physicians Desk Reference and the Drug Information for the Health Care Professional (volumes 1A and 1B). This training module will take approximately 2 hours.

i. trainee will learn to screen for involuntary muscular

movement, which may be indicative of tardive dyskinesia through training conducted by someone qualified to conduct this training and certify staff upon completion. This will be an 8 hour training session.

j. trainee will learn about the positioning and handling of individuals who have special needs through video and hands on group training. This will take approximately 2 hours.

Goal 2. Curricula will be established to meet the 40 hours of training required for each trainee during their first six months of employment in accordance to C.I.L.A. guidelines.

Intended Learning Outcomes:

a. trainee will learn to develop and implement an individual integrated services plan in conjunction with training on the nature and structure of the individual integrated services plan. This will be done by having the trainee acting as a silent partner in a role model of the interdisciplinary process as depicted on a video cassette. Based on information provided in the depicted meeting, trainee will write an individual integrated services plan. This training session will last approximately 2 hours.

b. trainee will learn about the formal use of assessments and their role in the development of the services plan through videos in which qualified instructors will teach the trainee to perform basic assessments such as the Inventory for Client and Agency Planning (ICAP) and the mid-Nebraska. Trainee will learn to interpret other assessments such as psychologicals and various vocational and personality

assessments. Trainee will learn how to apply assessment information in the development of services plans. This will be approximately an 8 hour training session.

c. trainee will learn documentation and record keeping requirements with reference to the services plan through videos in which step-by-step instructions and practical filling out of forms will be conducted. Trainee will also have a veteran staff person assigned to help in filling out required forms during the first month of employment. A total of 12 hours will be committed to this training module.

d. trainee will learn about the nature of developmental disabilities through assigned readings which he or she will be required to discuss in small discussion groups. This will take a total of 9 hours of training time.

e. trainee will learn about working with individuals who have developmental disabilities through videos of caseworkers working with individuals in their home environments and other natural community settings. This training will be supplemented with shadowing techniques in which the trainee follows the experienced worker daily. This will take approximately 9 hours to complete.

Goal 3. Curricula will be established to meet the 40 hour per year training requirement designed to enhance the trainee's ability to deliver services to individuals which promotes independence in daily living and economic self-sufficiency. Trainees will be allowed to choose from among the following training modules to meet their 40 hours per year requirement (this curricula will be continuously expanded upon).

Intended Learning Outcomes:

a. trainee will become familiar with C.I.L.A. guidelines and

rules and other C.I.L.A. information put forth by the Department of Mental Health/Developmental Disabilities (DMH/DD) by reading this information.

b. trainee will learn about communication skills through a video session conducted by a qualified speech pathologist.

c. trainee will keep abreast of current trends in the field of developmental disabilities by reading materials on topics including but not limited to the following:

    1. integration
        a. housing
        b. employment
        c. community involvement
    2. sex education
        a. sexually transmitted diseases
        b. appropriate sexual expression
        c. marriage, dating, etc.
    3. recreational/leisure
        a. age appropriateness
        b. small groups

d. trainee will learn about Management by Objective (MBO) concepts as they pertain to C.I.L.A.

e. trainee will receive yearly training in CPR and training every three years in First Aid.

f. trainee will be provided opportunities to attend training conferences provided outside of the agency confines depending on budgetary constraints.

Other than the breakdown into three, forty hour segments, there is no particular order by which each training segment must be completed. Sequential order is irrelevant. Instead, each trainee must complete each forty

hour segment within their respective time frames. Thus, during the first forty hour segment to be completed in the first week of employment, topics covered will include CPR, First Aid training, fire safety and disaster procedures, concepts of treatment, handling and reporting of abuse, neglect and unusual incidents, individual rights, confidentiality and orientation, nature and structure of individual integrated services plan, type, dosage and side effects of medications, tardive dyskinesia and positioning and handling of individuals.

During the second forty hour segment which will occur over the next six months of employment, the following topics will be covered: development and implementation of individual integrated services plan, formal use of assessments, documentation and record keeping requirements, nature of developmental disabilities and working with individuals who have developmental disabilities.

The final forty hour segment, which occurs over the following year and each year thereafter, includes but will not be limited to the following topics: C.I.L.A. guidelines/rules, etc., communication skills, current trends in the field of developmental disabilities and CPR.

The primary mechanism for ascertaining whether or not goals have been met will be simple quizzes and written exercises. Furthermore, enhancement of programs and development of individuals to whom services are rendered will serve as evidence as to whether training goals have had their intended impact. This can be determined through program evaluation over a period of five years.

PROCEDURE

Of the 40 hours of training, this study focused on one specific section of training. This one section was developed into a video presentation to help the viewer have a better understanding of the content as opposed to reading the material in text form.

This study has examined the relationship of learning using two types of media: video tape and reading material. The video tape contained 8 vignettes depicting incidents that could likely occur in clients' lives and how staff should

or should not respond. The reading material contained global information regarding people with developmental disabilities.

The focus of this study was on new staff who had no exposure to the clients they would be serving in the program. The population which was studied consituted a total of 60 participating subjects (20 males and 40 females). The staff whose participation was solicited were members of the Residential Services program at the Coles County Association for the Retarded (C.C.A.R.) in Charleston, Illinois. This particular group was fairly homogeneous in intellectual ability, previous experience in the field of rehabilitation, ethenticity, and socioeconomic class. They varied in age. The mean age was 40 for both females and males. The range of ages was 19 to 56 for both females and males.

A pre-test and post -test were developed totally from the video. The tests and the video were reviewed by the Executive Director and Director of Residential Services at C.C.A.R., Charleston, Illinois and two university instructors, both Ph.D's at Eastern Illinois University, Charleston, Illinois. The above mentioned C.C.A.R. staff served as the pilot for the test. Two revisions were made of the tests. The pre-test and the post-test were given to both the experimental and control group. The experimental group reviewed the video and the control group read the reading material.

Pre-tests were given to both groups. It was stated to each that the test was being given to all new staff in the Residential Services program to be used at a later date to measure the value of the inservice training that they were about to receive. Staff in the experimental group and the control group were randomly assigned. The experimental group received the video tape. The control group was given printed material to read. This material consisted mainly of an overview on fire and safety procedures, first aid and CPR techniques, medications, etc. After completion, both were given a post-test which was the same as the pre-test except the questions had been randomly placed in a different order. The tests were hand scored by the author.

None of the instruments used in this study had been standarized. (It should be noted that follow-up on search for a standard measurement tool should be a recommendation for further study). They were developed or adapted specifically for this study. Furthermore, since little previous research had been done investigating the relationship of learning using video instruction versus reading material, there was little evidence on which to base hypothesis concerning this relationship. For these reasons, the hypothesis presented here was, for the most part, based on intuition gained from this one study rather than prior knowledge gathered by previous studies.

What the author is trying to determine in this study is whether the use of video taped information is a better learning tool for new staff members to use as opposed to reading printed material.

The population sampled in this study were new staff members hired for the Residential Services Program between the period of January 1 through October 30, 1991. All of them had no previous formal training in the area of developmental disabilities. These new staff members were hired to provide direct support services to clients who are living independently in the community.

The video was made as a result of a review of some of the typical incidents that have occurred historically in the program, incidents that could reoccur in the future. The purpose of the video is to instruct new staff in the proper way of handling such incidents . By watching the video, the new staff member should be able to remember the proper procedures better as opposed to reading about the proper procedures.

The instrumentation used to measure the results was a pre-and post- test. This test addressed issues, concerns and procedures associated with working with adults who are developmentally disabled. The tests were compiled by the author and consists totally of multiple-choice items. Two professors at Eastern Illinois University read the preliminary test design and made suggestions where appropriate. The design was also reviewed by the Executive Director and the Director of Residential Services at C.C.A.R..

The procedure for data collection was that all individuals in the experimental and control groups were given a pre-test individually. The tests were given out and collected by the secretary. The tests were scored by the author. For the experimental group, the video was presented to them for viewing and for the control group, the reading material was presented to them for reading and study. After this, both groups were given a post-test. Both groups were given identical tests in both situations. The tests were compared for each group to determine which group scored higher.

The analysis of this study was a direct result of the scores of the tests (see Chapter IV). The number of correct responses were compared between the two groups and were analyzed.

This chapter has been an overview of the methodology used in this study. The population sample and selection were described. Instruments used in the study were detailed, and methods of data collection were reported.

The remainder of this study will focus on the findings and conclusions resulting from analysis of the data.

CHAPTER IV
RESULTS

This chapter will focus on the analysis of the questions used to gather the data for this study. As this author studied the responses each subject made on each test, it was found that some questions were missed more than others and some questions were not missed at all. This could be indicative of poor question design.

Both groups responding to the pre-test answered two questions correctly (15 and 25). On the post-test, both groups responded to question 6 correctly, which is the same as question 25 on the pre-test.

#15. The police department calls you down to the station because they are holding two of your clients for shoplifting. You go down to the station and both clients deny the charges. Do you:

A. Call your supervisor.
B. Call the shopkeeper a liar.
C. Talk to the clients privately to get their side of the story and their view of what happened.
D. Reprimand the clients publicly.
(the answer is C).

#25. You have a client that you have hot heard from is several days. You know he had been sick and you begin to worry. You cannot reach him by telephone. You decide to talk with your supervisor about this for guidance as to what to do. Should you:

A. Keep trying to phone.
B. Call the police.
C. Call family and friends.
D. Go over to his house.
(the answer is D).

All groups on all tests missed question 17 (21 on the post-test) the most. The choices of correct responses were all good ones and are all things one would probably do in the situation. The choices for this question need to be re-worked.

#17. A female client reports that a male client made her do something that she did not like and she does not want to see him anymore. The two have been friends for a long time and you see this report as being unusual. You suspect the male client may have forced himself on her sexually. Do you:

A. Call the police and make a report.
B. Encourage the female client to call the police and file a complaint.
C. Go to the male client's caseworker and discuss the issue.
D. Call the male client in and confront him.
(the answer is C).

The control group missed question 21 (22 on the post-test) as a group. Like question 17, the choices were all good and it would be difficult to decide what to do first. These choices need to be re-worked as well.

#21. You make a home visit and find the client to unconscious. Do you:

A. Take his pulse.
B. Try to wake him up.
C. Call your supervisor.
D.. Call an ambulance.
(the answer is A).

Experimental Group

On the pre-test, all subjects answered questions 1, 11, 15, and 25 correctly. Questions 1, 11, and 25 were identical to questions 23, 5, and 6 respectively on the post-test. (On the post-test, subjects answered 5, 6, 12, 17, 19, and 23 correctly).

Control Group

On the pre-test, subjects answered questions 15, 22, and 25 correctly. Questions 15, and 25 were identical to questions 4, and 6 respectively on the post-test. (On the post-test, subjects answered 4, 6, and 7 correctly).

The correlation between watching a training video and reading training material was significant in measuring learning. The data show that there is twice as much learning taking place by viewing the video as opposed to reading.

Statistical Analysis

This study is an illustration of a basic two-group study. In such a study, the author manipulated the conditions under which subjects were tested, treating members of one group in one way (reading the text) and members of another group in another (watching the video).

The statistical analysis of findings from this study in which the effects of two

conditions are compared was an analysis of variance. It was then necessary to test the significance of the differences among the $\bar{X}$'s obtained with the several conditions. With this information about the shape of the sampling distribution, and its mean and standard deviation, the author was able to determine the probability of obtaining any given differences between $\bar{X}$'s of a given size or larger.

Since only one basic variable is being studied, this method is identified as a one-way analysis of variance.

For the Experimental Group, with df=29, the critical value of t is 1.699 for p=.05. Since the obtained t=3.88 exceeds the critical value, we can conclude that watching the video did really affect learning.

For the Control Group, with df=29, the crtitical value of t is 1.699 for p=.05. Since the obtained t=1.49 is less than the critical value, we can conclude that reading the material did not affect learning.

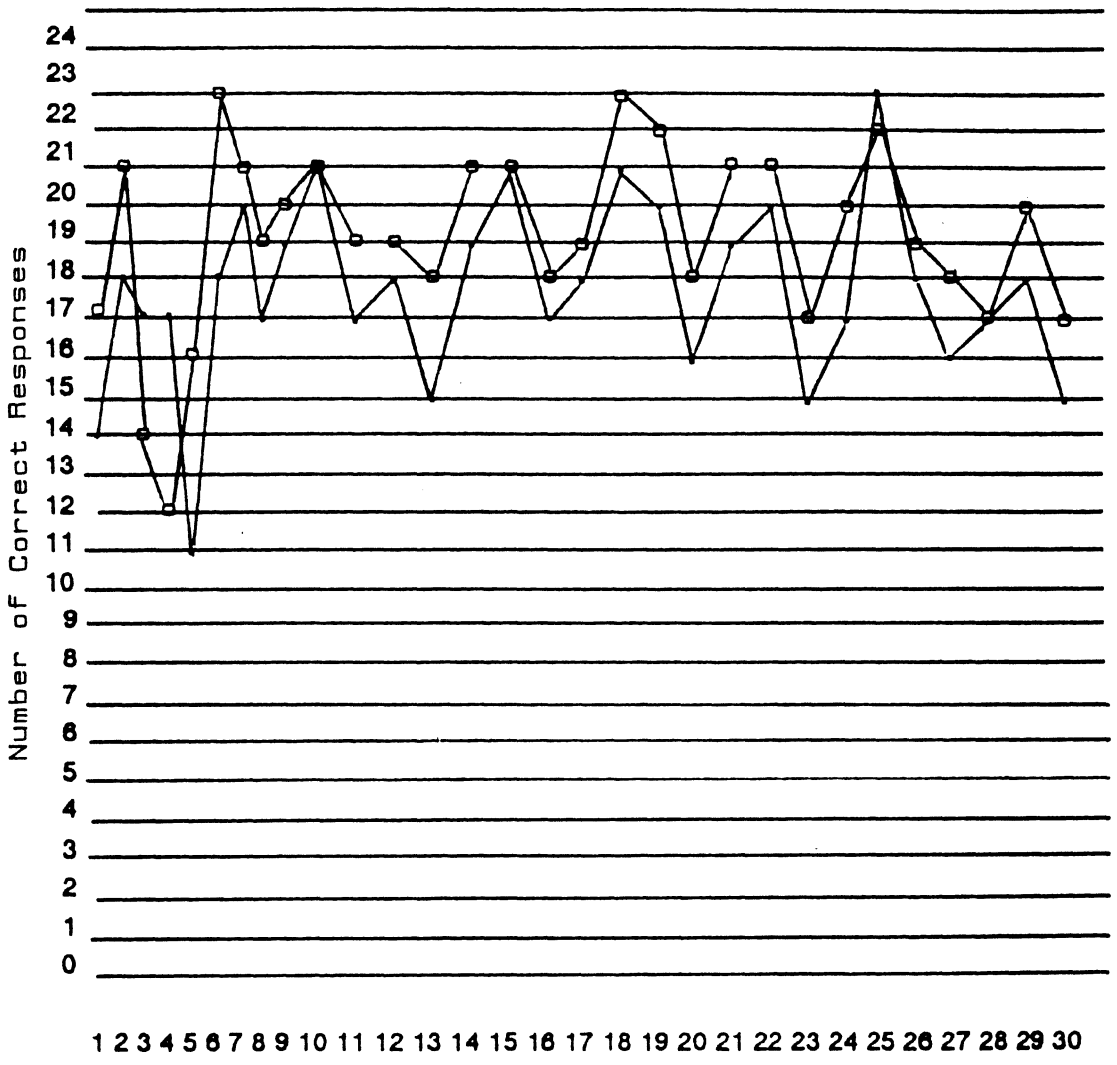
In doing a confidence interval of 95% comparing the difference in learning between both groups, this author makes a statistical inference that of all people in the field of rehabilitation, 95% of those taking the pre-and post-tests, and being equally represented in both groups, would score in the range that this study's population fell.

The Null Hypothesis states that there is no difference between the two population means. The findings of this study reject the Null Hypothesis.

Table 1 ANOVA SUMMARY TABLE FOR STUDY COMPARING EFFECTS OF TWO CONDITIONS

SOURCE	df	SS	MS	F	p=.05
Experimental	29	1.93	15.03	.518	3.88
Control	29	13.14	2.21	.076	1.49

VIDEO
TABLE 2

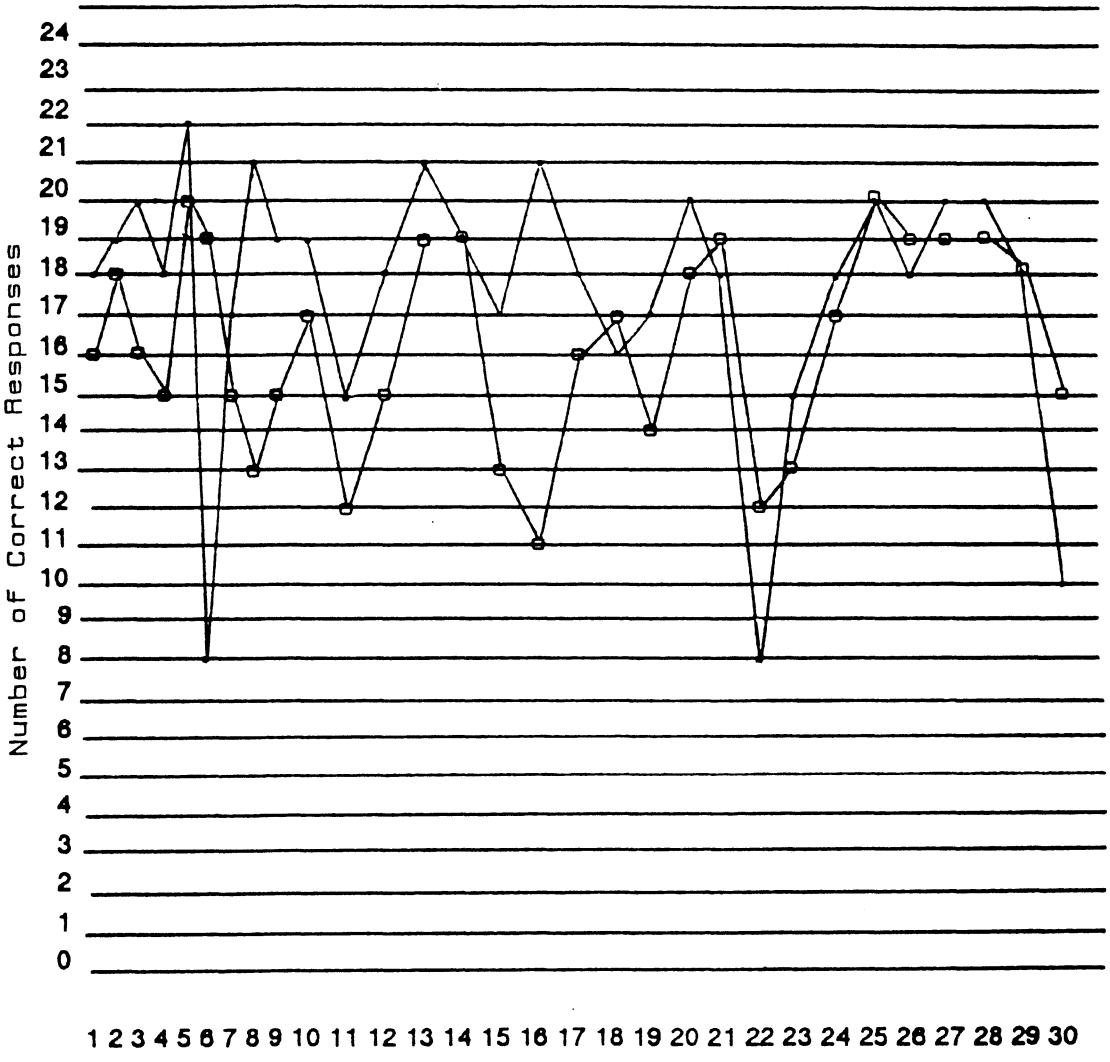


• = pre-test average Correct Responses (17.73)

o = post test average Correct Responses (19.13

Amount of improvement (+1.40)

READING
TABLE 3



• = pre-test average Correct Responses (17.69)

o = post test average of Correct Responses (16.30)

Amount of Improvement (-1.37)

CHAPTER V
CONCLUSIONS AND IMPLICATIONS

The purpose of the study was to examine the best form of media to present to new staff for inservice training to gain optimal learning and content retention. The main question was: Is there any significant difference in learning by using video taped material or serveral pages of reading material?

Sixty new staff members from similar educational backgrounds and socioeconomic areas comprised both the experimental and control groups (thirty in each group). Twice as many females than males (40 and 20) were involved but there did not appear to be any significant difference between the two sexes. It can be stated here that using video taped material for staff training has a direct effect on learning retention as opposed to having staff read several pages of printed material.

This author speculates that the scores on the Control Group's post-tests were worse than the pre-test because of boredom of reading and trying to get the test finished as rapidly as possible. Also, most subjects had not been in a school-like setting for sometime and were not accustomed to sitting and reading for a long period of time.

The design for this study appears to merit further improvement and expansion. This preliminary investigation was designed to determine any significant difference between the two means of inservice training, thus allowing for continuation of the study or not. Many different comparable variables could be measured such as sex, age, educational level, job title, etc. This information would help even further in setting up a video training program more specific to each group.

Relative to the addition of a more explicit conceptualization of the study and additional measurable variables, the results were conclusive enough to warrant a statement which can lead to further research. It appears that using video taped material does enhance learning.

The state of Illinois has now mandated that agencies providing Community

Integrated Living Arrangements for persons with developmental disabilities conduct forty hours of concentrated inservice training to all staff hired to work in the program before they ever begin working with clients. Then, during the first six months on the job, another forty hours of training must be completed. Thereafter, annually each staff person has to complete forty hours of training. There are no training manuals in existence that provide a curricula to follow for such training as of this study.

Therefore, this study has been developed to hopefully fill that need and to determine which method of inservice presentation had the most learning value. Video presentations on relevant and required topics of training seem to be an excellent way of communicating information to staff. These videos are paired with reading material and actual supervised on-the-job field training with seasoned staff. This combination seems to work well. It allows the staff to maintain their interest and reduces the boredom of just viewing videos, or just reading printed material, or just shadowing veteran staff.

The topics covered in the video were specified by the state as being required training (Appendix D). Since that video, several other videos have been developed covering such issues as fire and safety, normalization, aggression management, and developing individual service plans. Plans are on the drawing board for more interesting videos. The search for relevant reading material (journal articles, etc.) is ongoing to supplement the videos and add an element of variety to training.

As the video has been in use since February, 1991, this author has found that some vignettes need some revamping and plans are being made to do that. As with any mode of training, keeping up with the changes and new materials is ongoing for effective training. It is hoped that this study will be used as a guide for others to use in the development of their own agency-specific inservice training package. The use of existing staff in creating videos is an excellent way to make staff feel a part of the work and provides them with a refresher of the

material. It also is helpful in that after new staff members have viewed the material, when they see the staff that have been portrayed in the video, they will have instant recall of the material covered in the video.

As a result of this study, this author is in the process of developing a training package similar to this one, for every staff member in the agency. Some of the stages of this plan have already been put into play and the results and feedback are encouraging.

REFERENCES

Adams, G., & Sternberg, L. (1982). Educating severely and profoundly handicapped students. Rockville, MD: Aspen Systems.

Bittel, L.R. (1978). Encyclopedia of professional management. New York: Mc Graw Hill.

Brown, L., Ford, A., Nisbet, J., Van Deventer, P., Sweet, M., York, J., & Loomis, R. (Eds.). (1983). Teaching severely handicapped students to perform meaningful work in non-sheltered vocational environments. In Educational programs for severely handicapped students: Vol. 13 (pp. 1-100). Madison, WI: Madison Metropolitan School District.

Bruninks, R., Kudla, M. J., Wieck, C. A. & Hauber, F. A. (1980). Management problems in community residential facilities. Mental Retardation, 18, (3), 125-130.

Cooper, R. (1974, November). Simulated supermarket. Training, 37-40.

Ebert, R. S. (1979). A training program for community residence staff. Mental Retardation, 17, 257-259.

Federal Regulations with Interpretive Guidelines for Intermediate Care Facilities for the Mentally Retarded (1988). Code of Regulations, Sections 440.150, 442.251, and 483.480, p. J-48.

Feuerstein, R., in collaboration with Rand, Y., Hoffman, M., & Miller, R. (1980). Instrumental enrichment. Baltimore: University Park Press.

Finney, M. & Patton, C. (1991). Director of Human Resources and Director of Residential Services at Coles County Association for the Retarded, Charleston, Illinois.

Florelli, J. S. (1982). Community residential services during the 1980s: Challenges and future trends. Journal of the Association for the Severely Handicapped, 7, 14-18.

Ford, A., Davis, J., Messina, R., Ranieri, L., Nisbet, J. & Sweet, M. (1982). Arranging instruction to ensure the active participation of severely multi-handicapped students. Madison, WI: University of Wisconsin-Madison and Madison Metropolitan School District.

Foxx, R. (1982). Decreasing behaviors of severely retarded and autistic persons. Champaign, IL: Research Press.

George, J. J. & Baumister, A. A. (1981). Employee withdrawal and job satisfaction in community residential facilities for mentally retarded persons. American Journal of Mental Deficiency, 85, 639-647.

Gold, M. (1975). Try another way [film training series]. Indianapolis, IN: Film products of Indianapolis.

Hansen, C. E. (1971). The rehabilitation counselor: Training and Employment. Journal of Rehabilitaion, 37, (3), 39-43.

Hershenson, D. B. (1988). Along for the ride: The evolution of rehabilitation education. Rehabilitation Counseling Bulletin, 31, 204-217.

Illinois Department of Mental Health & Developmental Disabilities (Oct. 1989). Standards and Licensure Requirements for Community Integrated Living Arrangements (Illinois Register). Springfield, IL.

Jacobson, J. W., Janicki, M. P. (1984, August). Trends in staff in a large community residence system 1980-1983. Paper presented at the 92nd annual meeting of the American Psychological Association, Toronto.

Kroll, J. & Racino, J. (1988). Community supports for people labeled by the mental health and mental retardation systems. Syracuse, NY: Center on Human Policy.

Racino, J. (1988, March). Supporting adults in individualized ways in the community. TASH Newsletter.

Repp, A. A., Felce, D., & deKock, U. (1987). Observational studies of staff working with mentally retarded persons: A review. Research in Developmental Disabilities, 8, 331-350.

Singer, G. H. S., Close, D. W., Irwin, L. K., Gersten, R. & Sailor, W. (1984). An alternative to the institution for young people with severely handicapping conditions in a rural community. Journal of the Association for the Severely Handicapped, 9, 251-261.

Slater, M. A. & Bunyard, P. D. (1983). Survey of residential staff roles, responsibilities and perceptions of resident needs. Mental Retardation, 21, (2), 52-59.

Symanski, E. M., & Parker, R. M. (1989). Relationship of Rehabilitation Client Outcome to Level of Rehabilitation Counselor Education. The Journal of Rehabilatition, 55, (4), 32-36.

Taylor, S., Racino, J., Knoll, J., & Lutfiyya, Z. (1987). The nonrestrictive environment: On community integration for people with the most severe disabilities. Syracuse NY: Human Policy Press.

Tropman, J. H. (1984). Policy management and human services. New York: University Press.

Van Houton, R. (1980). How to motivate others through feedback. New York: H & H Enterprises.

Walker, M. L. & Myers, R. W. (1988). A counter proposal: Defining the qualified rehabilitation professional. Rehabilitation Education, 2, 49-57.

Wolfensberger, W. (1972). The principle of normalization in human services.

Wolfensberger, W. (1973). Orientation manual on mental retardation. Toronto: National Institute on Mental Retardation. Toronto: National Institute on Mental Retardation.

APPENDICES

COLES COUNTY ASSOCIATION FOR THE RETARDED

Residential Services Exercise #1

Appendix A

Read the following questions carefully and choose the best answer:

1. You are the supervisor. One of your staff reports that a caseworker is neglecting his clients. Do you:

   A. Tell the person who is reporting to you to mind his own business and never report on a fellow caseworker.
   B. Fire the caseworker that is reportedly being negligent.
   C. Talk to the accused caseworker to find out his side of the story.
   D. Give a disciplinary warning to the negligent caseworker.

2. You have ample evidence that a fellow caseworker has been verbally abusing clients and you know that if you report him to your supervisor he will get into trouble. First, you would:

   A. Ignore the problem because you like the caseworker and do not want him to get into trouble.
   B. Ignore the problem because you know the caseworker has been going through some difficult personal times lately.
   C. Talk to other staff.
   D. Talk to some of the clients and find out if anything like this was happening with them.

3. You are at the police station trying to deal with a situation where your clients have been arrested for shoplifting. The shopkeeper is yelling "that retarded people shouldn't be running the streets," etc. Do you:

   A. Agree and say you'll keep tighter reigns on them.
   B. Defend them and begin to confront the shopkeeper.
   C. Explain the philosophy of what our agency is doing and that they have a right to go where they please.
   D. Remove the clients from the room.

4. You, as a caseworker, have a female client that reports she has been sexually assaulted by a male client and after discussion with the male and the male's caseworker, you find that the likelihood of this being factual is pretty great. Do you:

   A. Advise your client to call the police.
   B. Call the police.
   C. Offer options to your client as to how to deal with the situation herself.
   D. Ban the male client from coming over to the female's house.

5. You make a home visit for a fellow caseworker. When you enter, you find the clients in a highly agitated state. They are complaining that the service they are getting from their caseworker is making them very upset. You should:

   A. Tell them that you are not their caseworker and they should not be talking to you about this.
   B. Call their caseworker right away.
   C. Talk to them and try to calm them down.
   D. Call your supervisor.

6. You have a female client who has been raped by a male client. You fear that with sexual activity at some point in time, she may become pregnant. A pregnancy would not be good for her. Should you:

   A. Have her sterilized.
   B. Keep her away from males.
   C. Provide her with sex education.
   D. Put her on the pill.

7. One of your clients has been reported to you as possibly committing a rape to a female client. Should you:

   A. Call the police.
   B. Go talk to the female client.
   C. Talk to your client and get the facts.
   D. Do nothing and just wait for a few days to see what develops.

8. You find that one client is abusing another client. You go to the client being abused to discuss the problem. The client is hesitant to talk about being abused, but after some talking, he does. Now, what do you do?

   A. Encourage the client to call the police.
   B. Give some suggestion for possible solutions for the client to consider.
   C. Call the client's family.
   D. Call your supervisor.

9. As a supervisor, you have sufficient evidence to believe one of your caseworkers is neglecting his clients. You have the caseworker in conference right now and are discussing a situation reported to you of neglect. Do you:

   A. Ask the caseworker to fix the problem.
   B. Offer to help the caseworker fix the problem.
   C. Give him a verbal warning.
   D. Go with the caseworker and follow-up on some of these reports of neglect.

10. You make a home visit and find the two roommates are not getting along

at all. One is verbally and physically abusing the other and it is obvious to you that the situation at hand is not going to improve any time soon. Should you:

A. Try talking to them.
B. Take them both for an outing.
C. Separate them within the apartment.
D. Take one on an outing to get him away from the other and then investigate the situation.

11. You go over to a client's house as scheduled, to go grocery shopping. Upon arrival, you find the client's apartment to be a mess. Do you:

A. Make her clean it up right then.
B. Verbally intimidate her to the point as she will respond to your direction to clean the apartment.
C. Ignore the mess because it is late and you do not have the time right then to deal with another issue.
D. Abort your plans to go grocery shopping and work on helping her learn how to clean by working with her.

12. You go to the home of one of your clients for a regularly scheduled visit. Upon arrival, you find your client upset about something. Do you:

A. Ignore the client's apparent behavior and go ahead with why you had come over in the first place.
B. Tell her that you are not there to discuss her personal problems and she will have to talk to someone else about her problem.
C. Listen to her and give moral support.
D. Investigate the situation but ask questions and follow-up on her report.

13. You are walking down the hallway to your office and you pass by the office door of a fellow caseworker. The door is open and you see and hear the caseworker verbally and physically abusing a client. Would you:

A. Keep on walking because this is not your problem.
B. Stop in and try to intervene.
C. Report this incident to your supervisor.
D. Attack the caseworker.

14. A female client reports that a male client made her do something that she did not like and she does not want to see him anymore. The two have been friends for a long time and you see this report as being unusual. You suspect the male client may have forced himself on her sexually. Do you:

A. Call the police and make a report.

B. Encourage the female client to call the police and file a complaint.
C. Go to the male client's caseworker and discuss the issue.
D. Call the male client in and confront him.

15. The police department call you down to the station because they are holding two of your clients for shoplifting. You go down to the station and both clients deny the charges. Do you:

A. Call your supervisor.
B. Call the shopkeeper a liar.
C. Talk to the clients privately to get their side of the story and their view of what happened.
D. Reprimand the clients publicly.

16. Your client calls you and reports that he is not feeling well. He wants you to come over to see him. Since you do not know this client very well, you call on a fellow caseworker who knows the client to validate the client's call. The co-worker feels both of you should go to check on him. After getting to the client's house, you question him and determine that he has a possible serious injury. Do you:

A. Give him a heating pad, some aspirin and send him off to bed.
B. Take him to the hospital.
C. Call an ambulance.
D. Call your supervisor.

17. You make a home visit and find the client to be unconscious. Do you:

A. Take his pulse.
B. Try to wake him up.
C. Call your supervisor.
D. Call an ambulance.

18. You go over to a client's house and discover he had died. Would you:

A. Call the police.
B. Call the ambulance.
C. Call your supervisor.
C. Run next door to get a neighbor.

19. You make a home visit and discover one of the two roommates has been missing for a few days. Do you:

A. Call the police first.
B. Call the family first.
C. Check around with neighbors, other clients and places where he hangs out first.
D. Call your supervisor.

20. The police call your office and ask for you to come down to the station because two of your clients have been taken in for shoplifting. You immediately go and find that the evidence is there and one of the clients has confessed to stealing. Should you:

A. Offer to pay for the items and get the shop owner to drop the charges.
B. Say that the two are retarded and do not know what they are doing.
C. Say that they are responsible for their actions and must suffer the consequences as would anyone else in this situation.
D. Say that they have learned a valuable lesson and it will not happen again.

21. You are supervising three clients in an apartment situation. It is night time and you have been sleeping. You wake up, make a bed check and find one of the clients is missing. Would you:

A. Go out looking for him.
B. Call your supervisor.
C. Call the police.
D. Awaken the other clients to see if they know where he is.

22. Two clients, who are roommates are not getting along. One is domineering and the other is passive. This situation has gone on for some time without improvements. Should you:

A. Place a third roommate in the apartment with the hopes that it will help to improve the situation.
B. Make the two shake hands and make up.
C. Move one to another apartment.
D. Place 24 hour supervision in the apartment until the situation improves itself.

23. You walk into an office and see and hear a caseworker verbally attacking and name calling a client. Do you:

A. Go in, sit down and join in the discussion.
B. Leave the office and call the supervisor.
C. Ask the client to leave the room and go with you.
D. Reprimand the counselor right there and then.

24. You stop in for a home visit on a couple of clients who are not your clients but you are in the neighborhood and just stopped by as a courtesy to your fellow caseworker. You find the couple to be out of food, no utilities, no money, etc. You ask them about the situation and they inform you that they have told their caseworker about the problems and he said he would take care of their needs. It is obvious to you that the caseworker is neglecting his duties and his clients. Should you:

A. Move the clients out of this apartment until the problem is corrected.
B. Talk to your supervisor.
C. Give the clients all the money you have on hand and tell them to go to the store.

D. Confront the client's caseworker when you get back to the office.

25. You have a client that you have not heard from in several days. You know he had been sick and you begin to worry. You cannot reach him by telephone. You decide to talk with your supervisor about this for guidance as to what to do. Should you:

A. Keep trying the phone.
B. Call the police.
C. Call family or friends.
D. Go over to his house.

Adopted: 05/01/91

COLES COUNTY ASSOCIATION FOR THE RETARDED

Residential Services Exercise #2

Appendix B

Now that you have studied the material given you, read the following questions carefully and choose the best answer:

1. You go over to a client's house and discover he had died. Would you:

   A. Call the police.
   B. Call the ambulance.
   C. Call your supervisor.
   D. Run next door to get a neighbor.

2. Two clients, who are roommates, are not getting along. One is domineering and the other is passive. This situation has gone on for some time without improvements. Should you:

   A. Place a third roommate in the apartment with the hopes that it will help to improve the situation.
   B. Make the two shake hands and make up.
   C. Move one to another apartment.
   D. Place 24 hour supervision in the apartment until the situation improves itself.

3. You stop in for a home visit on a couple of clients who are not your clients but you are in the neighborhood and just stopped by as a courtesy to your fellow caseworker. You find the couple to be out of food, no utilities, no money, etc. You ask them about the situation and they inform you that they have told their caseworker about the problems and he said he would take care of their needs. It is obvious to you that the caseworker is neglecting his duties and his clients. Should you:

   A. Move the clients out of this apartment until the problem is corrected.
   B. Talk to your supervisor.
   C. Give the clients all the money you have on hand and tell them to go to the store.
   D. Confront the client's caseworker when you get back to the office.

4. The police department call you down to the station because they are holding two of your clients for shoplifting. You go down to the station and both clients deny the charges. Do you:

   A. Call your supervisor.
   B. Call the shopkeeper a liar.
   C. Talk to the clients privately to get their side of the story and their view of what happened.

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5. You go to your client's house as scheduled, to go grocery shopping. Upon your arrival, you find the client's apartment to be a mess. Do you:

A. Make her clean it up right then.
B. Verbally intimidate her to the point as she will respond to your direction to clean the apartment.
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D. Go over to his house.

7. One of your clients has been reported to you as possibly commiting a rape to a female client. Should you:

A. Call the police.
B. Go talk to the female client.
C. Talk to your client and get the facts.
D. Do nothing and just wait for a few days to see what develops.

8. As a supervisor, you have sufficient evidence to believe one of your caseworkers is neglecting his clients. You have the caseworker in conference right now and are discussing a situation reported to you of neglect. Do you:

A. Ask the caseworker to fix the problem.
B. Offer to help the caseworker fix the problem.
C. Give him a verbal warning.
D. Go with the caseworker and follow-up on some of these reports of neglect.

9. You are at the police station trying to deal with a situation where your clients have been arrested for shoplifting. The shopkeeper is yelling "that retarded people shouldn't be running the streets," etc. Do you:

A. Agree and say you'll keep tighter reigns on them.
B. Defend them and begin to confront the shopkeeper.

C. *Explain the philosophy of what our agency is doing and that they have a right to go where they please.*
D. *Remove the clients from the room.*

10. You make a home visit for a fellow caseworker. When you enter, you find the clients in a highly agitated state. They are complaining that the service they are getting from their caseworker is making them very upset. You should:

A. *Tell them that you are not their caseworker and they should not be talking to you about this.*
B. *Call their caseworker right away.*
C. *Talk to them and try to calm them down.*
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11. You find that one client is abusing another client. You go to the client being abused to discuss the problem. The client is hesitant to talk about being abused, but after some talking, he does. Now, what do you do?

A. *Encourage the client to call the police.*
B. *Give some suggestion for possible solutions for the client to consider.*
C. *Call the client's family.*
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C. *Say that they are responsible for their actions and must suffer the consequences as would anyone else in this situation.*
D. *Say that they have learned a valuable lesson and it will not happen again.*

13. You have a female client who has been raped by a male client. You fear that with sexual activity at some point in time, she may become pregnant. A pregnancy would not be good for her. Should you:

A. *Have her sterilized.*
B. *Keep her away from males.*
C. *Provide her with sex education.*
D. *Put her on the pill.*

14. You walk into an office and see and hear a caseworker verbally attacking and name calling a client. Do you:

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16. You make a home visit and find the two roommates are not getting along at all. One is verbally and physically abusing the other and it is obvious to you that the situation at hand is not going to improve any time soon. Should you:

A. *Try talking to them.*
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B. *Encourage the female client to call the police and file a complaint.*
C. *Go to the male client's caseworker and discuss the issue.*
D. *Call the male client in and confront him.*

18. You make a home visit and discover one of the two roommates has been missing for a few days. Do you:

A. *Call the police first.*
B. *Call the family first.*
C. *Check around with neighbors, other clients and places where he hangs out first.*
D. *Call your supervisor.*

19. Your client calls you and reports that he is not feeling well. He wants you to come over to see him. Since you do not know this client very well, you call a fellow caseworker who knows the client to validate the client's call. The co-worker feels both of you should go to check on him. After getting to the client's house, you question him and determine that he has a

possible serious injury. Do you:

A. *Give him a heating pad, some aspirin and send him off to bed.*
B. *Take him to the hospital.*
C. *Call an ambulance.*
D. *Call your supervisor.*

20. You have ample evidence that a fellow caseworker has been verbally abusing clients and you know that if you report him to your supervisor he will get into trouble. First, you would:

A. *Ignore the problem because you like the caseworker and do not want him to get into trouble.*
B. *Ignore the problem because you know the caseworker has been going through some difficult personal times lately.*
C. *Talk to other staff.*
D. *Talk to some of the clients and find out if anything like this was happening with them.*

21. You make a home visit and find the client to be unconscious. Do you:

A. *Take his pulse.*
B. *Try to wake him up.*
C. *Call your supervisor.*
D. *Call an ambulance.*

22. You are supervising three clients in an apartment situation. It is night time and you have been sleeping. You wake up, make a bed check and find one of the clients is missing. Would you:

A. *Go out looking for him.*
B. *Call your supervisor.*
C. *Call the police.*
D. *Awaken the other clients to see if they know where he is.*

23. You are the supervisor. One of you staff reports that a caseworker is neglecting his clients. Do you:

A. *Tell the staff person who is reporting to you to mind his own business and never report on a fellow caseworker.*
B. *Fire the caseworker that is reportedly being negligent.*
C. *Talk to the accused caseworker to find out his side of the story.*
D. *Give a disciplinary warning to the negligent caseworker.*

24. You are walking down the hallway to your office and you pass by the office door of a fellow caseworker. The door is open and you see and hear the caseworker verbally and physically abusing a client. Would you:

A. Keep on walking because this is not your problem.
B. Stop in and try to intervene.
C. Report this incident to your supervisor.
D. Attack the caseworker.

25. You, as a caseworker, have a female client that reports she has been sexually assaulted by a male client and after discussion with the male and the male's caseworker, you find that the likelihood of this being factual is pretty great. Do you:

A. Advise your client to call the police.
B. Call the police.
C. Offer options to your client as to how to deal with the situation herself.
D. Ban the male client from coming over to the female's house.

Adopted: 05/01/91

KEY
APPENDIX C

	#1	#2
1	C	B
2	D	C
3	C	B
4	C	C
5	C	D
6	C	D
7	C	C
8	B	D
9	D	C
10	D	C
11	D	B
12	D	C
13	B	C
14	C	C
15	C	D
16	C	D
17	A	C
18	B	C
19	C	C
20	C	D
21	B	A
22	C	B
23	C	C
24	B	B
25	D	C

APPENDIX D

Titles of the vignettes used in the training video as mandated by the state as required topics for training.

#1. A Female Client Who Has Been Sexually Assaulted

#2. Abuse

#3. Neglect

#4. Death

#5. Serious Injury

#6. Assault

#7. Missing Person

#8. Theft

The video tape is available for viewing at the Coles County Association for the Retarded, 825 18th, Charleston, Illinois 61920 (217) 348-0127.

APPENDIX E

Residential Services Training Material

Outline

I. Definitions
   A. Developmental Disability
   B. Respite Care

II. Role of the Provider

III. Concepts in Development
   A. Definitions
      1. Growth
      2. Maturation
      3. Learning
      4. Development

   B. Factors Affecting Development
      1. Environmental Factors
      2. Physical Factors
      3. Social Factors
      4. Cognitive Factors

IV. The Stages of Normal Development
   A. Infancy/Early Childhood, 0-6 Years
   B. School Age, 6-12 Years
   C. The Adolescent
   D. The Adult

V. Factors Impeding the Developmental Process
   A. Motor Skills
   B. Adaptive Skills
   C. Communicative Skills
   D. Social Skills

VI. Developmentally Disabling Conditions
   A. Genetic Defects
      1. Down's Syndrome
      2. Phenylketonuria (PKU)
      3. Tay-Sachs Disease

   B. Infections

1. Encephalitis
2. Meningitis
3. Rubella

C. Lead Poisoning

D. Mental Retardation
   1. Causes, Prevention and Cures

E. Seizure Disorders/Epilepsy
   1. Grand Mal
   2. Petit Mal

F. Cerebral Palsy

G. Autism

H. Prevention of Developmental Disability Conditions

VII. Introduction to Systems Theory
   A. Initial Client/Family Contact
   B. Impact on the Family
   C. Stages of Adaptation
      1. The Regressive Reaction
      2. The Helpless Reaction
      3. The Perseveration Reaction
      4. Impulsivity and Anger
      5. Low Self-Esteem

VIII. Ways to Encourage Self-Esteem

IX. Behavior Modification

X. Speech, Language, and Communication

XI. Learning to Understand Others

XII. Non-Verbal Communication

XIII. Tips on Working with Visually Impaired People

XIV. Medical Concerns and Responsibilities

XV. Leisure and Recreational Activities

The Residential Services Training Material is available for viewing at the Coles County Association for the Retarded, 825 18th, Charleston, Illinois 61920 (217) 348-0127.

BIOGRAPHY

Michael R. Finney was born in Newton, Illinois on February 1, 1954. He attended schools in Newton, and graduated from Newton Community High School in 1972.

He entered Olney Central College in Olney, Illinois in 1972 where he majored in Psychology, and transferred to Eastern Illinois University, Charleston, Illinois in 1976. He received his Bachelor of Arts degree in December, 1979. At that time, he began work as a vocational evaluator at the Effingham County Association for Retarded Citizens in Teutopolis, Illinois.

In January, 1980, he was enrolled for graduate study at Eastern Illinois University where he majored in School Psychology. In January, 1981 he transferred to Southern Illinois University -Carbondale where he majored in Rehabilitation Administration and Services. He received a Master of Science degree in June, 1982.

From 1982 to 1988 he worked as a Rehabilitation Counselor for the Texas Rehabilitation Commission in Houston, Texas, and is currently working as Director of Human Resources at the Coles County Association for the Retarded in Charleston, Illinois.

In January, 1990, he was enrolled for graduate study at Eastern Illinois University. He is a candidate for the Specialist in Education Guidance and Counseling degree from Eastern Illinois University in May, 1992.