STAFF KNOWLEDGE OF CLIENT RIGHTS IN WEST VIRGINIA INSTITUTIONS FOR THE DEVELOPMENTALLY DISABLED

by

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(ABSTRACT)

Analysis of staff knowledge of client rights in West Virginia institutions for the developmentally disabled was undertaken in this study. Even with the identification of guaranteed rights for institutionalized individuals through federal and state legislation, standards, policies, and judicial decisions, whose findings have shown that violation of client rights continues to occur in most institutions. A review of the literature indicated that one possible cause for the continuation of rights violations may be the staff limited understanding of client rights . The literature also has revealed few studies have attempted an investigation in this area. This study involved 644 full-time staff who were representative of one of six different job categories. The staff were employed in one of three West Virginia institutions for the developmentally disabled. It was hypothesized that if differences in staff knowledge of client rights were identified, this information could be used to direct staff training and policy-making decisions and perhaps minimize the continuous violations of client rights.

That significant differences in knowledge of client rights did exist

when different job categories of staff were compared within each institution as well as across institutions. It was found that significant relationships in knowledge of client rights exist between staff with different job longevity rates, but the correlation was too low to be considered a reliable predictor of limited value. No significant differences in staff knowledge of client rights were found between the three institutions. The implication of these research findings and the future need for research in this area are discussed.

List of Tables

Table of Contents

CHAPTER 1

Introduction

In the past 20 years, the legal basis of care and treatment of individuals in institutions has changed dramatically. Federal and state legislative and judicial mandates have been enacted to assure the protection of client rights. These resulted, in large part, from the civil rights and consumer protection movements of the 1960's which helped to heighten public awareness of the need to protect the rights of all individuals, including those in institutions (Paschall, Konick and Ostrander, 1982; Williams, 1981).

Due to recent federal and state legislative and judicial mandates, institutions for the developmentally disabled have been required to find alternative placements for clients who possess the ability to function in a less restrictive environment. In some institutions, the reduction in client population through deinstitutionalization has been as much as two-thirds (Harrell and Orem, 1980). With the placement of higher functioning clients into the community, institutions today are serving more individuals who are dangerous, who exhibit unpredictable behaviors, or who are severely handicapped with multiple problems. The individuals left to reside in institutions are those with whom their families or their community as a whole cannot cope and who cannot be adequately served in a less restrictive environment. Nevertheless, the institutional staff is expected not only to cope but to protect the client rights while caring, controlling, and treating those behaviors

that prompted institutionalization (Harrell and Orem, 1980; Lecklitner and Greenbrier, 1983).

Wheeler, Wells, and Bradish (1982) cite Wolfensberger and Kugel's (1969) contention that institutional staff, and society in general, at first sympathize with those who are suffering. If however, the individual does not improve and continues to require additional support, resentment and frustration may develop. Frustration and resentment toward the individuals can lead to inappropriate expressions of these emotions. In an institution, the staff may exhibit these emotions in forms which violate a client rights, such as physical abuse, verbal abuse, and neglect.

In the past several years, there has been an increase in judicial activities in both the federal and state courts involving the issues of rights of institutionalized individuals. The courts have ruled that adequate treatment for institutionalized persons is a federal constitutional right. States, through legislative activities, have enacted statutes on the rights of individuals who are residing in their institutions. Also, state agencies and institutions have developed policies that define and prohibit violations of client rights (Griffith, 1984; Kapp, 1981; Wheeler, Wells, and Bradish, 1982).

In addition, accreditation and certifying agencies have monitoring standards that require institutions to maintain policies and procedures that address the issue of client rights. Two of the most widely accepted accreditation and certifying agencies for institutions that serve developmentally disabled individuals, are the Accreditation

Council for Services for Mentally Retarded and Other Developmentally Disabled Individuals (1983) and the Intermediate Care Facility/Mental Retardation, Certification Standards (1977). If these Standards are not maintained, the institutions may lose their accreditation or certification status with the agency and/or forfeit federal entitlement funds.

The issue of client rights also has received attention on the international level. The International League of Societies for the Mentally Handicapped in 1968 drafted the "Declaration of General and Special Rights of the Mentally Retarded," which was adopted by the United Nations General Assembly in 1971. There were established seven articles on human rights that the United Nations General Assembly felt should be provided to all mentally handicapped individuals, regardless of their residence (Scheerenberger, 1975).

Furthermore, client rights have been indirectly established by groups such as the American Association on Mental Deficiency and the National Association for Retarded Citizens. The above associations provide support in the form of statements of principles. Although statements of principles do not carry the weight of law, they often form the conceptual bases for future federal and state legislation, regulations, standards, and judicial decisions.

Armstrong (1979) and Sundram (1984) have found that there are few matters that have a more profound impact upon the public perceptions of institutions than the abuse of client rights. Wheeler, Wells and Bradish (1982) and Williams (1981), have indicated that there is a lack of research on institutional staff's sensitivity to and perception of

client abuse. A review of the literature revealed a lack of reliable research and data based information on rights issues of institutionalized individuals. Most institutional literature and research have been in the general areas of client care and training. It seems evident that the lack of knowledge and a sound data base on client rights, affects not only the public attitude toward institutions but more importantly affects the provision of quality care and treatment.

The management and control of client rights violations in institutions are complex and controversial. Bourland (1980), Coye and Clifford (1973), and Williams (1981) have reported that client rights are frequently violated in our institutions. The continued reporting of violations to client rights provides evidence that even with laws, regulations, standards, and policies, it still occurs. Why does it still occur? What are the factors that contribute to it's continued occurrence? These and many more questions concerning client rights issues have been left unanswered for far too long. It seems that all too often client rights are being violated in the very institutions that are responsible for their protection, care, and treatment.

Wheeler, Wells, and Bradish (1982) and Williams (1981) attempted to assess what differences in interpretation of video-taped simulations of potentially abusive situations were present between several different categories of staff in residential facilities for the mentally retarded. They found that inconsistencies do exist in the way abusive incidents are viewed. They also indicated that client abuse by staff may not be a result of malicious intent but due to staff's lack of

knowledge and misperception of what constitutes abuse. What may be needed is staff training in order to provide a common understanding of the rights of individuals in institutions. Are staff aware of client rights that are addressed by laws, regulations, standards, and policies? Have federal, state, and local mandates been clearly explained and have rights violations been defined? Are staff adequately trained in client rights and their roles and responsibilities in seeing that those rights are not violated? Information of this nature needs to be disseminated to all levels of institutional staff. Staff who receive adequate training would be in a better position to identify rights versus privileges and obligations versus options. Mandates and policy-making decisions that are not clearly communicated and understood can only lead to staff frustration, resentment, and the possible continuation of client rights violations. All staff members have the right to be fully informed and to be provided a clear understanding of their responsibilities toward the rights of clients (Griffith, 1984; Harrell and Orem, 1980; Paschall, Konick, and Ostrander, 1982).

According to McGarry and Kaplan (1973), rights issues have been interpreted, modified, changed and expanded over a period of time through federal and state legislation and judicial decisions. This makes the staff training issue more critically important. Training will assist in improving staff's knowledge of client rights and hopefully help reduce anxiety among staff.

In addition, establishing a clear understanding on rights afforded to clients in institutions and on what constitutes a violation is

important in limiting staff frustrations. Griffith (1984) and Williams (1981) indicated that client rights in institutions are difficult to define because of their complex nature. They found that statements defining rights issues are often ambiguous and allow for a great deal of latitude in interpretation among staff. If ambiguous terminology is used, staff may be acting abusively without realizing that they are violating a client rights. Using their limited knowledge of client rights, the staff may feel that they have done nothing wrong but have acted in an appropriate and responsible manner. Training can correct these misperceptions. In further support of staff training in institutions, Gardner and Giampa (1971); Wegmann, Lancaster, Bruhn and Fuentes (1981); and Williams (1981) have found that training improves staff sensitivity regarding humanization of client care and treatment.

Begab (1968); Moores and Grant; (1976); and Prothero and Elhers (1974) surveyed attitudes of staff in both psychiatric and mental retardation facilities and identified two other possible causes for the continuation of client rights abuse. They found that there is little difference in staff's attitudes attribute to their background or education, but there are differences reflective of the institutional size in which the staff members work and staff's years of employment with the institution. Baumeister, (1981); Bensberg (1974); and Zigler and Bala (1977) reported that job longevity rates of staff are associated with the quality of care provided to institutionalized persons. Also, Baroff (1980); King and Raynes (1968); and Thormahlin (1965) found that staff in larger institutions are more institutionally

orientated and serve a greater population of clients who are more difficult to manage than smaller institutions. In smaller institutions, Howell and May (1980) found staff to be more responsible and to exhibit a more direct obligation to their clients. Also Bala (1976); Bala, Butterfield and Zigler (1974); Dellinger and Shope (1978); Felesenthall and Scheerenberger (1978); and Zigler and Bala (1977) found staff in smaller institutions are more educated and have more human service experience background than staff in large institutions.

As previously stated, few studies exist on the issues of client rights and even fewer on how institutional staff perceive these rights. Williams (1981) found a high degree of sensitivity regarding humanization of mentally retarded persons among staff in institutions and community residential facilities. Wheeler, Wells, and Bradish (1982) found a high level of agreement concerning attitudes of institutional staff toward abuse and dehumanization of mentally retarded individuals. However, Kopolow (1980) found that institutional staff who spend most of their work day in direct contact with clients are often least positive toward rights issues.

This study provided a research strategy for investigating staff knowledge of client rights in institutions. The study focused on all job levels of staff in three separate developmental disability institutions that serve three different populations of developmentally disabled clients in West Virginia. These institutions include:

1. Colin Anderson Center

Colin Anderson Center, the largest developmental disability institution of the three is located in St. Marys, West Virginia. The center serves 392 clients manifesting developmental disabilities and mental retardation. Colin Anderson Center's client population is predominantly long-term severely and profoundly mentally retarded adolescents and young adults.

2. Greenbrier Center

Greenbrier Center, the smallest developmental disability institution of the three is located in Lewisburg, West Virginia. The center serves 40 clients manifesting developmental disabilities and mental retardation. Greenbrier Center's client population is predominantly short-term higher functioning, trainable and educable mentally retarded adolescents and young adults.

3. Spencer Hospital

Spencer Hospital located in Spencer, West Virginia, serves 125 clients manifesting developmental disabilities and mental retardation. Spencer Hospital's client population is predominantly long-term older adults who are severely developmentally disabled and mentally retarded.

The above client population data were accurate as of January 1, 1985. It is important to remember that this study is to investigate institutional staff knowledge of client rights and not the staff's behavior toward the client.

Statement of Problem

Federal and state legislation, standards, policies, and judicial decisions have decreed that individuals residing in developmental disability institutions have guaranteed rights. Even with the identification of guaranteed rights for institutionalized individuals, findings have shown that violation of client rights continues to occur in most institutions. The literature has indicated that one possible cause for the continuation of rights violations may be the staff's limited knowledge and understanding of client rights. Recent studies have shown that how staff perceive rights issues may have an effect on their sensitivity regarding humanization of care and treatment of clients. The problem is a lack of research investigating staff's knowledge of client rights in institutions for the developmentally disabled.

Purpose of The Study

The purpose of this study was to identify what differences, if any, exist in staff knowledge of client rights. This entailed a survey of all staff by job categories, both within and between institutions.

Research Questions

1. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between persons in different job categories within different institutions for the developmentally disabled?
2. What, if any, differences exist between staff knowledge of client rights, as established by laws

and regulations, between the three institutions for the developmentally disabled without regard to job categories?

3. What, if any, differences exist between staff's knowledge of client rights, as established by laws and regulations, between persons in different job categories in the total sample of three institutions for the developmentally disabled.
4. What, if any, relationships exist between staff knowledge of client rights, as established by laws and regulations, between persons with different job longevity rates?

Significance of Study

Most states have mandated laws that protect the rights of individuals admitted into developmental disability institutions. Also, most institutions have established policies and procedures to assure that violations of client rights do not occur. Assessing staff knowledge of client rights should assist state agencies and institution administrators to identify areas of need for staff training and policy-making decisions. It should also help staff better understand rights issues and, hopefully, benefit the clients by reducing violations of their rights. Additionally, if client rights are clearly understood, staff anxiety regarding those issues is less likely to occur, and the staff may comply more readily with established laws, regulations, standards, and policies. Furthermore, clarity in laws and regulations should improve staff performance and reduce the risk of litigation.

Limitation

For purposes of this study, it was assumed that all staff who directly or indirectly interact with clients would participate in completing the survey. However, the effect of absenses was to prohibit a 100% return rate. (Belknap (1956), Cosen (1963), Kahn (1968), and Stannard (1973) have found that absenteeism is a chronic and common problem in institutions.) Circumstances that may have limited the researcher's data returns include staff's regular days off; off-site working assignments; vacation leave; sick leave; annual leave; and those who, for unknown reasons, are unwilling to complete the survey.

Responding to the survey involves reading twenty-five short vignettes and responding. Levels of staff literacy could have influenced the ability and appropriateness of their responses. Wheeler, Wells and Bradish (1982); and Williams (1981) found in their institutional studies on staff responses, that literacy problems were evident on some of their surveys. Problems were indicated by staff's lack of written comments and the fact that the same choice was always checked.

Each of the institutions and their staff that were studied, provided a diversity of potentially impacting variables. Although the variables are important for future research, this study is limited to identifying, if any, differences in staff knowledge of client rights. The assumption is made that if these differences can be identified, appropriate staff training and policy-making decisions can be provided.

CHAPTER 2

Review of Literature

Since the civil rights movements of the 1960's, there has been an increasing concern relative to individual rights and issues of abuse of those rights. Literature reveals concern about such diverse issues, as child abuse, spouse abuse, abuse of the elderly , abuse of prisoners, and client abuse. This study focuses on only one of these areas, that is, client rights and staff knowledge of those rights.

Individuals in institutions for the developmentally disabled, as well as in any other type of treatment or training facility, should be treated with human dignity, equality, and justice. During the past twenty years, the field of developmental disabilities has seen a dramatic turnabout in public thinking, policy, and programs. There has been a growing recognition of the rights and needs of the developmentally disabled in our society. Also, both the philosophical and legal direction of care, treatment, and training of the developmentally disabled have changed at all institutional administrative and direct care levels. Federal and state governments and the public in general have begun to seriously address these issues (Burgdorf and Spicer, 1983; VanBiervliet and Sheldon-Wildgen, 1981; Wilker and Keenan, 1983; Williams, 1981).

Developmentally disabled persons constitute one of the largest handicapped groups in the United States. There are approximately six million Americans who are considered developmentally disabled

(Bruininks, Meyers, Sigford and Lakin, 1981; Wilker and Keenan, 1983). Between 1967 and 1970, approximately 213,000 persons of this six million were in 108 state-operated institutions and another 65,000 individuals were living in private facilities. By 1975, the institutional population had declined by 168,000 through placements into the community. (Magrab and Elder, 1979; Wilker and Keenan, 1983).

Nevertheless, it has been found that 34 percent of those discharged from institutions are readmitted. A study by Scheerenberger in 1976 found that 70 percent of institutions surveyed failed to show an overall net reduction in client population because of readmissions and new admissions. He further found that clients currently being served in institutions are older and more severely handicapped (Scheerenberger, 1974; Scheerenberger, 1976; Wilker and Keenan, 1983;).

The institutionalized are largely a voiceless group. Often there is no intermediary to represent their rights, interests, and needs. In the past, society has tended to look at developmentally disabled individuals as less than human. The institutionalized person, in particular, has been subjected to oppressions and discrimination. They have been denied their human and civil rights and subjected to dehumanization (Wilker and Keenan, 1983). Only, recently has there been an increasing number of voices raised to demand that action be taken in the maltreatment of the developmentally disabled. Public recognition of the rights and needs of persons who are developmentally disabled is increasing. The public is now scruntinizing all aspects of the service delivery systems within institutions and the full range of activities within the community at

large (VanBiervliet and Sheldon-Wildgen, 1981; Williams, 1981; Wilker and Keenan, 1983).

An emphasis on the rights of developmentally disabled individuals and the provision of services has also been a recent concern of State health agencies, courts, and legislatures. In the past, much legislation and many court decisions were aimed toward protecting society from developmentally handicapped individuals. The trend has changed; there is a growing awareness of client rights for persons residing in state-operated institutions (Gelman, 1971; Grob, 1980; Loadman, Parnicky, and Schober, 1978; McPheeters, 1980; VanBiervliet and Sheldon-Wildgen, 1981; Wilker and Keenan, 1983).

Major actions by legislation, litigation, and administrative changes in the past decade have decreed that individuals with developmental disabilities, no matter where they reside, possess the same rights as other citizens. Those who reside in institutions have the same fundamental rights as other persons. If, for whatever reason, these rights are limited or modified, it can only be to the extent necessitated by the individual's disability and then, only with due process (AD MR/DD, 1983; Burgdorf and Spicer, 1983; Gelman, 1972; Haavik and Menninger, 1981; Harrell and Orem, 19830; Kemp, 1984; Ostrander, 1982; Paschall, Konick, and Ostrander, 1982).

Although, there have been major changes in legislation, litigation, and administrative decisions for the protection of institutionalized individuals rights, growing evidence shows that the rights of these individuals are still being abused and violated. The reasons for this

continued occurrence is unclear (Burgdorf and Spicer, 1983; Clifford and Coye, 1978; Grob, 1980; Wheeler, Wells, and Bradish, 1982; Williams, 1981). In the past few years articles have been written about the rights of institutionalized persons. Many of these articles and investigations have focused on the legal rights of clients in the commitment process and the details of complying with court orders (McPheeters, 1980). Very little attention has been focused on the violation of client rights and the many possible variables that may attribute to its continued occurrence (Clifford and Coye, 1978, Kemp; 1984; Ostrander, 1982; Paschall, Konick, and Ostrander, 1982; Wheeler, Wells, and Bradish, 1982; and Williams, 1982).

As previously stated, services and rights issues of the developmentally disabled client have undergone dramatic changes in the past twenty years. State health agencies, institutional adminstrators, and staff must be cognizant of factors that may negatively affect the quality of care and treatment provided to their clients. With this in mind, this review cites literature that suggests some plausible reasons for the continued acts of client rights violations by institutional staff. The review also cites literature that identifies factors which individually and collectively may affect the frequency of the occurrence of client rights violations. These factors include the history of care and treatment of the developmentally disabled; current regulations and laws, and attributes that affect staff performance. There are clearly a variety of factors which contribute to client abuse and violations of client rights. Cultural influences, attitudes and values, working

conditions, lack of supervision, inadequate training, and insufficient resources all have a relationship. For purposes of this study, only one of the many factors have been selected for an indepth review, staff knowledge of client rights. It is assumed that adequate knowledge of client rights will lead to better compliance with those requirements.

The History of Care and Treatment of the Developmentally Disabled

Developmental disability has been a subject of study and controversy since since 500 B.C. In Thebes, Greece, Hippocrates, the father of medicine, mentioned the phenomenon and pointed out that certain deformities of the skull were associated with retarded behavior. About 150 A.D., the Roman physician, Galen, identified differing levels of mental acuity. During the Middle Ages, retarded persons were sometimes labeled as fools and persecuted because of their behavior. In early America, Puritan ideology sometimes resulted in retarded individuals being hanged and burned for suspicion of witchcraft (Ferleger, 1978; Grossman, 1983).

As late as 1820, the retarded and other developmentally disabled individuals were publicly sold to the person who offered to take responsibility for them for the lowest amount of State financial support (Ferleger, 1978). In 1839, Guggenbuhl established the first officially recognized residential facility for the retarded in Switzerland. In the United Stated, Seguin and Howe initiated the concept of residential care during the period of the 1850s. They emphasized small facilities and training programs in order to make the deviant nondeviant (Ferleger, 1978; Scheerenberger, 1975). Another indication of awareness for the

needs of the developmentally disabled was evidenced in 1845 when Dr. Amariah Brigham called for an institution to train idiots. All three men, Seguin, How, and Brigham, were influenced by the work of Itard, whose efforts at training the retarded child described in The Wild Boy of Aveyron (1801) gained international attention (Mesibov, 1976).

In the mid-1800s, Dorothea Dix launched a crusade to convince state legislators that they should establish asylums or institutions in which these handicapped persons could receive humane care and moral treatment. She was successful in that 20 states established asylums. This set the tone for other states to follow suit. By 1875 there were more than 60 public facilities; by 1904 the number had increased to over 104; and by 1940 the total exceeded 250. Also, between 1890 and 1940 the number of clients in these facilities rose from about 32,000 to 394,000. The future of adequate care and treatment looked bright during this period for handicapped individuals (Grob, 1980; McPheeters, 1980).

However, it wasn't long before the facilities that had been started under favorable expectations fell upon dehumanizing times. What at one time was considered protecting the deviant from society, became protecting society from the deviant. The late 1800s and early 1900s saw enactment of laws forbidding marriage among the retarded, statutory sterilization requirements, and the introduction of dehumanizing conditions in the facilities (Crissey, 1977; Ferleger 1978; McPheeters, 1980; Mesibov, 1976; Scheerenberger, 1975; Wolfensberger, 1971).

The sterilization or eugenic movement influenced state legislators, such as those in Pennsylvania (1905) who approved, but not inacted, a state eugenic sterilization bill, "An Act for the Prevention of Idiocy." In 1907 Indiana passed the country's first sterilization law and eventually 28 other states passed similar laws. Between 1907 and 1940, a total of 18,552 persons in state institutions were surgically sterilized (Blatt, 1970; Grob, 1980; Haavik and Menninger, 1981; Hardman, 1978; Mesibov, 1976; Wolfensberger, 1971). Other dehumanizing conditions included lack of personal identity, lack of privacy and communication, lack of individual programs, lack of adequate care and treatment, lack of compensation for labor, and lack of freedom from physical harm (Ferleger, 1978; Grob, 1980; McPheeters, 1980; Scheerenberger, 1975).

From 1918 through 1940, residential facilities had developed throughout the United States consistent with the philosophy and practice of refuge and not treatment for the clients. Then, shortly after World War II, a renewed interest in the developmentally disabled followed and ended the years of the alarmist period (McPheeters, 1980; Mesibov, 1976; Scheerenberger, 1975).

In 1955, the new tranquilizer medications transformed attitudes toward facility clients. States began programs to beautify the ward and to provide some measure of privacy and dignity to clients (McPheeters, 1980). In 1957 Delaware passed the country's first legislation establishing state-supported mental retardation centers (Mesibov, 1976).

During the 1960s and 1970s, increased awareness for the plight of institutionalized persons was shown through advocacy groups, legislation, litigation, and administrative changes. This movement was at least in part an outgrowth of the civil liberties and consumers' rights movements (Paschall, Konick, and Ostrander, 1982; McPheeters, 1980). The era brought the establishment of civil rights for developmentally disabled persons in institutions. It led to the "Declaration of General and Special Rights of the Mentally Retarded" which were adopted by the United Nations General Assembly in 1971. The 1980s have seen, and will see, further changes in state and federal laws, judicial decisions, and administrative policies aimed at institutions and the protection of client rights (Bruininks, Meyers, Sigford, and Lakin, 1975; Burgdorf and Spicer, 1983; Gelman, 1972; Kemp, 1984; McPheeters, 1980; Mesibov, 1976; Paschall, Konick, and Ostrander, 1982; Scheerenberger, 1974; VanBiervliet and Sheldon-Wildgen, 1981).

As evidenced throughout history, handicapped individuals have struggled for their rights of humane care and treatment, and the right to be treated with dignity and respect. Struggles for these rights have been hindered by societies negative attitude toward the handicapped. This prevailing attitude also has effected staff's perception of clients. It is staff's misperception that institutionalized persons, because of their handicapped condition, are not afforded the same basic rights as other citizens. Staff's lack of understanding and misperception of client rights still continues to effect the quality of care and treatment provided to those individuals residing in institutions.

Regulations and Laws

By "client rights" we mean those just, fair or equitable entitlements accruing to individuals either as a result of their special status or simply as basic human rights properly belonging to all persons (Lecklitner and Greenberg, 1983). The rights afforded to persons in institutions are derived from many sources.

One source is through federal and state legislative mandates that are related to developmental disabilities. Most state laws pertaining to the handicapped are passed in response to federal rulings and programs or in response to interest group pressures. Among the most notable federal legislation have been the Developmentally Disabled Assistance and Bill of Rights Act (P.L. 94-103, originally P.L. 91-517), the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963, and the Education for All Handicapped Children Act (P.L. 94-142). State legislation pertaining to West Virginia is Chapter 27 of the State Code which addresses the care and treatment of institutionalized persons (W.V.C. 27) and Chapter 18 of the State Code which addresses the provision of educational services for handicapped children (W.V. C.18). Both federal and state laws set guidelines for the protection of handicapped individuals' rights (Loadman, Parnicky, and Schober, 1978; McPheeters, 1980; VanBiervliet and Sheldon-Wildgen, 1981; Wilker and Keenan, 1983; Williams, 1981).

A second source is through standards developed by certifying agencies and accreditation organizations. Standards used for certifying or accreditation purposes are based on independent judgment of the most

knowledgeable persons in the their fields. In most instances these standards are more stringent than those of state licensing regulations or codes. The two most respected monitoring agencies are the Intermediate Care Facility/Mental Retardation Standards (ICF/MR) (1977) and the Standards for Services for Developmentally Disabled Individuals, Accreditation Council for Services for Developmentally Disabled Persons (ACMR/DD) (1983). In considering this source, it should be recognized that while certification or accreditation is voluntary, it is used often by the courts and advocacy groups to measure the quality of services provided by an institution (Ladimer, 1982; McPheeters, 1980; Scheerenberger, 1975; Wheeler, Wells, and Bradish, 1982).

A third source is guidelines established by advocacy groups. These groups include the National Association of Retarded Citizens, the American Association of Mental Deficiency and the Council for Exceptional Children (McPheeters, 1980; Scheerenberger, 1975; Williams, 1981). Although such groups do not have any mandating authority, they do influence the thinking of those who establish laws and regulations.

The fourth source is through state health agencies and local institutional policies and procedures. The policies and procedures do not have the weight of law but are strictly enforced by administration (Ladimer, 1982; Loadman, Parnicky, Ramo and Schober, 1978; McPheeters, 1980; Wheeler, Wells, and Bradish, 1982).

The fifth and final source is through court imposed conditions. These are specific rulings established under court mandates (Ladimer, 1982; McPheeters, 1980). Judicial decisions has been the single most

influencing factor in changing the relationship between the institutions and the developmentally disabled population. The judicial branch of both federal and state governments has increasingly been called upon to review the activities and performance of institutions. The courts have established major decisions on a variety of fundamental rights issues: the right of clients to refuse treatment; right to due process; right to an individual treatment plan; and the right to services in the least restrictive manner (MDLR, 1981; Wilker and Keenan, 1983).

In the past 10 years courts have ruled that institutionalized individuals have constitutional afforded rights. They have cited the Fifth and Fourteenth Amendments to the Constitution that guarantee that "no person shall be deprived of life, liberty, or property, without due process of law." Due process is perhaps the most important safeguard against arbitrary or abusive governmental action against an individual. Denying developmentally disabled clients such basics as nutritious food, use of personal property, recreation, personal clothing, and an appropriate treatment program, may constitute deprivation of liberty and property and require due process (Friedman, 1976; Haavik and Menninger, 1981). The courts have also held that the Eighth Amendment regarding cruel and unusual punishment, extends to ensuring basic conditions of safety, sanitation, and security (VanBiervliet, 1981; Sheldon-Wildgen, 1981).

A landmark decision that has been confirmed by the federal court was that of Wyatt v. Stickney (1971) which established the right of developmentally disabled person to receive appropriate treatment and

services. This suit, originally a labor dispute, was brought against the Alabama Department of Mental Hygiene for the failure of the state to provide proper staff supervision and treatment for the mentally retarded. The court also emphasized that the mentally retarded also had the right to receive adequate treatment in the least restrictive environment. These cases were followed by still other lawsuits seeking to break new ground by creating additional clients' rights (Friedman, 1976; Lecklitner and Greenberg, 1983; Magrab and Elder, 1979; McPheeters, 1980; Scheerenberger, 1975; Wilker and Keenan, 1983).).

In 1972, Lessard v. Schmidt, the United States District Court for the Eastern District of Wisconsin ruled that Wisconsin's civil commitment procedures were unconstitutional and that individuals do have a right to due process protections in civil commitment proceedings (Lecklitner and Greenberg, 1983; Scheerenberger, 1975). The courts also agreed that clients in institutions do have a constitutional right to be free from cruel and unusual punishment. The Eighth Amendment issue was addressed in the "Willowbrook" case, New York State ACR and Parises v. Rockefeller (1972), now New York State ACR and Parises v. Carey, and in Wheeler v. Glass (1973). In both cases, cruel and inappropriate restraint procedures were being used on clients (Friedman, 1972; Wilker and Keenan, 1983).

The issue of persons' rights to liberty was cited in the case of O'Connor v. Donaldson (1975). The Supreme Court stated that a state cannot constitutionally confine an individual who is capable of surviving safely in freedom by himself (Lecklitner and Greenberg, 1983;

VanBiervliet and Sheldon-Wildgen). In two similar cases, Holderman v. Pennhurst (1977) and Youngberg v. Romeo (1982), ruled that institutionalized individuals have a right to a safe environment, freedom from inappropriate body restraints, and training or habilitation (Gettings, 1982; VanBiervliet and Sheldon-Wildgen, 1981; Wilker and Keenan, 1983).

Most recently, West Virginia has been the subject of litigation involving the rights of individuals in their state-operated institutions. On October 8, 1981, in a class action suit, Macel Medley v. Leon Ginsberg, the federal district court approved settlement of a case involving the rights of mentally retarded children and young adults in seven institutions. The settlement which is known as the "Medley Decree" guarantees class members the right to treatment, education and placement in the least restrictive setting appropriate to their individual needs (MDLR, 1980). In another similar case but addressing a different age population, E.H. v. Matin (1981), also known as the "Hartley Order" was filed in the West Virginia Supreme Court on behalf of four women patients in Huntington State Hospital. The suit alleged that the women lacked a basic treatment plan, therefore proper treatment was not provided. In November of 1981, the West Virginia Supreme Court ruled that State Law gave state hospital patients the right to treatment and that this right could be enforced by the courts. The Court ruled that the lack of treatment for the four petitioners was typical throughout the State mental health system. The Court ordered the Department of Health to develop a comprehensive plan to correct the

deficiencies in the State mental health system, to refurbish the State hospitals, and to assure that all patients would receive appropriate treatment based on nationally recognized standards of care and their individual treatment needs. The West Virginia Department of Health is currently enforcing the actions set forth in the Medley Decree and the Hartley Order (Byrne and Broughton, 1984).

Certainly, the changes in federal and state legislation, judicial decisions, and administrative standards, indicate that the disabled fare far better regarding their rights than they did in the 1960s. Although according to Burgdorf and Spicer (1983), recent studies make it clear that the few landmark cases and headline-making legislation have not brought about anticipated results. The developmentally disabled clients are still having their rights violated in the very institutions that were established for the protection of their rights. In many institutions where litigation has occurred, it is evident that there have been changes in staffing, facilities, and procedures; but there is little evidence that the care and treatment of clients have improved or that their rights are more respected (McPheeters, 1980).

Coye and Clifford's (1978) findings of client rights violations in Michigan's institutions for the developmentally disabled supports Burgdorf and Spicer's (1983) statement that violations of rights are still occurring. Coye and Clifford found that over-all, the most frequently reported violations of client rights were those which abrogated guaranteed protection from physical and verbal abuse, services suited to clients' handicapping condition, freedom of movement, use of

personal property, access to funds, appropriate dietary services, and a safe, sanitary, and humane living environment. They found that in institutions for the developmentally disabled, these rights issues accounted for 85.4 percent of client rights allegations. Also, they found that protection from physical and verbal abuse was the right most frequently reported violated. It accounted for 60 percent of the total allegations. The next most common rights violation was the right to personal property and funds.

Wheeler, Wells, and Bradish's (1982) study of one of North Carolina's mental retardation facilities indicated that even with statutes, policies, and standards, client rights are still being abused by staff. Grob (1980) cites Catherine Lake's study of state hospitals as proving that individual rights are still being systematically violated. In addition McPheeters (1980) indicated that Michael Lottman's review of previous court decrees involving state institutions found that judicial intervention had little impact in providing better treatment for clients and that continued inadequacies still existed. Even in Youngberg v. Romeo (1982), the court concluded that the mentally retarded persons' rights have been and continues to be denied at the Suffolk Developmental Center (MDLR, 1983). The sad reality is that with all the positive reform in legislation, judicial decisions, administrative policies and regulations, the rights afforded to institutionalized persons are still being violated. Why does the phenomenon continue to exist? What are some of the factors that contribute to its ongoing existence? These and many more questions about client rights have been left unanswered far too long.

As indicated, client rights have derived from many soruces. Also, the number of rights issues effecting persons residing in institutions have increased in the past 20 years. Staff are requested to provide adequate care and treatment for clients and at the same time be knowledgeable in the many rights areas. The increasing number of client rights have left some staff ill-informed and lacking in sufficient knowledge of those rights issues. This factor could attribute to the continued violations of client rights in institutions.

Attributes That Affect Staff Performance

There are a variety of factors such as attitudes and values, cultural influences, working conditions, and inadequate training that have a relationship to client rights violations and abuse. This study will only investigate one of the many factors, staff knowledge of client rights.

Why do violations of client right still occur despite all the guidelines provided by federal and state legislation, judicial decisions, and administrative regulations and policies? A growing amount of evidence tends to support one possible cause: the lack of staff knowledge of client rights. The lack of understanding of rights issues may result in staff stress and anxiety, which could eventually effect the quality of care and treatment to clients. Emmener, Stilwell, and Written (1981) have found that work related stress can affect an individual's physiological and behavioral characteristics. If stress is allowed to continue and affect other staff members, it can incapacitate the institutional organization and prevent it from adequately

adequately functioning. Individuals have been found to react differently to stressors. Some staff are thrown into chaos by a change in priorities that is mandated by an external agent, such as a state or federal funding source, administrative advisory boards, or, state or federal legislation while others are caught off guard if they are not looking for, anticipating, or adapting to changes in the attitudes, political, and legal environment in which they work. Festinger (1957), Overbeck (1972), and Wicklund (1976) also support a similar view that individuals compensate by over-reacting to external influences in an attempt to relieve internal stress which is a result of changes that are brought on by the external events.

External events and stressors may be those recent changes in regulations and laws. Wheeler, Wells, and Bradish (1982) have indicated that policies and procedures that dictate a variety of sanctions against abuses of client rights in the absence of a clear understanding of what constitutes an abuse leads to unfairness and bitterness by staff. Loadman, Parnicky, and Schober (1978), have also reviewed several standards developed by external agencies and reported that they lacked a common terminology thus creating confusion among staff in implementation of those standards. Haavik and Menninger (1981) have found that many litigation decisions and statutes relating to institutional functions are overly vague.

In addition, McPheeters (1980), indicates that there is considerable confusion in the terminology of the many standards on client rights. He feels that the rights of clients can be better protected through the use

of clear and unequivocal standards. This view is also shared by Grob, (1980); Loadman, Parnicky, and Schober (1978); Wheeler, Wells, and Bradish (1982). They indicated that most client rights statements are broadly stated, vague in terminology, and allow for considerable interpretation. Wheeler, Wells, and Bradish (1982), have produced evidence that there are inconsistencies in the way abusive incidents of certain rights issues are viewed by institutional staff. Some viewed violations of client rights as more dehumanizing than other incidents of rights abuse. McPheeters (1980) agrees, he feels that a lot of client rights statements are difficult for staff to conceptualize, which might lead to a misunderstanding of what the rights issues are trying to convey.

The importance of staff knowledge of client rights and its effects on staff performance appears to be further supported by Ostrander (1982). He found that the problem with implementing client rights legislation in health care systems is that the staff are unclear on what rights are afforded to clients. This problem also was evident in McPheeters (1980), study of staff in state institutions. He found evidence that staff do vary in their interpretation of client rights. Most staff implied that they were not aware of the many rights issues but would be willing to implement them. In surveying patient advocates throughout the United State's health system, Kemp (1984) found that one of the greatest problems facing advocates and institutional employees was their lack of knowledge in the overall areas of developmental disabilities. Grob (1980); Paschall, Konick, and Ostrander (1982),

after a review of client rights, suggested that all job categories of staff need to know and understand what laws and regulations are mandated. Without this communication link between the system and staff, the quality of client care and treatment may decline (Coye and Clifford, 1978; McPheeters, 1980).

Staff's lack of knowledge and understanding of client rights may also affect morale. Ostrander (1982), found that inadequacies in communication can produce low morale among staff. Paschall and Eichlers' (1982) study suggests that staff's compliance with laws and regulations is positively correlated with good vertical communication in staff hierarchy. Also, the results provided by Paschall, Konick, and Ostrander (1982), suggest that for advocacy to be effective, it is not enough merely to have a list of mandates. These mandates must be communicated to staff, along with their roles and responsibilities. Without adequate communication, staff may not understand where treatment ends and client rights abuse begins. Most staff want to see themselves as allies of their clients. When they are portrayed instead as adversaries of the clients, because of violating rights that they do not clearly understand, low morale results. Staff begin to fear being brought up on charges for straying from the rules. They may feel beaten down and demoralized, and the clients suffer as a result. Low morale has been identified by many experts in the field as one of the major problems of institutions. Providing adequate communication among staff appears to be one means of eliminating morale problems (Baroff, 1980; Bensberg, 1974; McPheeters, 1980; Ostrander, 1982; Paschall and Eichler, 1982; Paschall, Konick, and Ostrander, 1982).

One method that might assist in eliminating factors that may contribute to the continued acts of violating client rights is staff training. Staff training means an organized program to prepare employees to perform their assigned duties competently and to maintain and improve their competencies (AC MR/DD, 1983). A review of institutional staff training programs by McPheeters (1980); Wegman, Lancaster, Bruhn, and Fuentes (1981) have shown that little training in the areas of client rights occurs. If training is provided, it is general in nature and lacks evaluation procedures to measure the employee's knowledge and understanding of the issues. Emmener, Stilwell, and Written (1981); Griffith (1984); Kemp (1984); McPheeters (1980); Paschall and Eichler (1982), stated that staff training should be an ongoing process and that you cannot expect staff to know what to do in the absence of training. They found that staff are more likely to comply with changes when provided adequate orientation. A study by Anderson (1980) on attitudes toward handicapped individuals, discovered that there is a correlation between a person's knowledge of the disabled and a more positive attitude. Williams' (1981) study on staff's sensitivity toward dehumanizing abuse showed that staff sensitivity appeared to be reflective of their previous training on client neglect, verbal, and physical abuse issues. Bella (1976); Gardner (1971); and McPheeters (1980), have indicated that staff training is essential in improving performance and in producing more efficient and effective employees. Without staff training, passing laws or mandating regulations will have little effect toward reforming rights issues in institutions (Gelman, 1972).

Staff training has been found to be a major factor in preventing and correcting institutional abuse (Harrell and Orem, 1980); but for training to be effective systematically, the participation of all levels and categories of personnel (including dietary, maintenance, housekeeping, and clerical staff) is required (McPheeters, 1980; Ostrander, 1982; Williams, 1981). As staff become better informed through client abuse training, incidents of frustration, stress, and anxiety will lessen (Baroff, 1980; Coye and Clifford, 1978; DeKoven, Miller, and O'Connor, 1967; Gelman, 1972; Griffith, 1984; Harrell and Orem, 1980; Kemp, 1984; McPheeters, 1980; VanBiervliet and Sheldon-Wildgen 1981; Zaharia and Baumeister, 1978; Zigler and Balla, 1977). Hopefully, this will be reflected in decreased numbers of client rights violations.

Other factors which may contribute to continued acts of client rights violations are the size of an institution and the employee's years of experience. Research on organizational stress and business structure has indicated that the size of operation directly correlates with the provision of services (Emmener, Stilwell and Written, 1981; Overbeck, 1972; Williams, 1981). Begab (1967); and Moores and Grant (1976) in studying the attitudes of staff serving mentally retarded clients, found little variation in attitudes due to background or education. Staff attitude differences were found, however, to relate to institutional setting and size.

Client rights violations have been reported by Coye and Clifford (1978) to occur twice as often in large institutions as in small ones.

Large institutions appear to be more bureaucratic than their small counterparts. Because they serve larger numbers of clients, they are often relatively depersonalized and lacking in rapport between staff and clients. Baroff (1980) has found that larger institutions have a higher proportion of clients who are more difficult to manage than smaller institutions, who have more capable clients. Also, Howell and May (1980); King, Rynes, and Tyson (1971); McLain (1973); Prior, Mines, Coye, Golding, Hendy, and McGillivary (1979); Schmidmayr and Weld (1971); Veit, Allen, and Chinsky (1976) found staff in larger institutions to be more institutionally oriented; and McPheeters (1980) reported that larger institutions tend to favor staff convenience over services to clients.

In small institutions, staff have been found to be more educated and to have more human service experience (Dellinger and Sharpe, 1978; Felsenthall and Scheerenberger, 1978; Zigler and Balla, 1977). In fact, Bjaanes and Butler (1974) reported that there is a tendancy of staff to be over protective in small institutions. Also, Howell and May (1980); and Tizard (1961) have indicated that staff in small institutions are more responsible, feel a more direct obligation, and interact more frequently with their clients.

The years of experience that a staff member possesses also has been found to be associated with the quality of care and over-all development of persons in institutions (Baumeister, 1981; Zigler and Balla, 1977). Bensberg (1974) reported that staff with more years of experience tend to be more oriented to the clients' needs rather than the system's

needs. Also, a recent study on staff's sensitivity toward dehumanizing incidents by Williams (1981), indicated that the years of experience that a staff member possesses influences the sensitivity of staff toward recognizing dehumanizing incidents.

Summary

As previously reported, despite the importance of client rights issues in institutions, very little research has been conducted. Most of the literature has addressed portions of client rights indirectly through investigations of the legal commitment process and details of court orders (McPheeters, 1980); Also, most of the literature and research focusing on the institutionalized developmentally disabled has been in the area of therapeutic care and training (Wheeler, Wells, and Bradish, 1982). There is a considerable amount of research on individual and environmental factors that affect staff attitudes and morale but few have addressed the possible effects they have on staff's ability to comply with mandated client rights. Factors such as adequate staff training, size of the institution in which staff work, and the number of years the staff members have been employed in their positions may contribute to differences in how they perceive and understand client rights issues.

Wheeler, Wells, and Bradish, (1982) have indicated that there is a lack of research regarding how different levels of staff perceive and understand rights issues. Other studies by Coye and Clifford, (1978); Kemp (1984); Ladimer (1982); (1982); Ostrander (1982); and, Paschall, Konick, and Ostrander (1982), have also stressed the need for future

research in staff knowledge of client rights and its effect on staff performance. It is their belief that without an adequate knowledge base, laws and regulations will create little, if any, impetus for institutional reform.

As stated previously, little research exists on client rights in institutions and the factors that influence staff's ability to conform to client rights mandates. In order for laws and regulations to be effective, it is first necessary for staff to be knowledgeable about them. In determining if there are differences in staff members' knowledge of mandates, it is necessary to identify the rights issues that are relevant to staff as they carry out their roles. The present study provides a research strategy for determining what variation, if any, exists in staff knowledge of client rights as they pertain to laws and regulations in institutions for the developmentally disabled.

The results of this study should assist institutions in various ways. Use of both the findings and the method could lead to development of a more effective training programs, increased staff awareness of client rights, decreased risk of litigation due to violation of client rights, and increased quality of care and treatment. Assessment of staff knowledge of client rights and training based on that knowledge could also result in identification of needed improvements in policies and procedures relating to client rights. Finally, information gained from this study should suggest further research needs.

CHAPTER 3

Methodology

The purpose of this study was to identify what differences, if any, exist between staff knowledge of client rights as established by laws and regulations. This involved a survey of all staff by job categories, both within an institution and between institutions for the developmentally disabled in West Virginia. Few research studies have attempted an investigation of client rights in institutions for the developmentally disabled in order to identify factors that influence staff compliance with those mandates. In order for laws and regulations to be effective, it is necessary to establish initially whether staff understand the mandates they are to follow. In determining whether differences in staff knowledge of these mandates exist, it is necessary to identify the rights issues that influence their decisions regarding clients. This study provides a research strategy for examining the problem. Results of the study should produce information in this limited area of research which can be used to direct staff training and policy-making decisions relative to rights issues and perhaps minimize the continuous violations of client rights.

Through consultation with institutional administrators, program coordinators, staff training officers, and state-level personnel, a survey, in the form of a questionnaire, was determined to be a an appropriate method for completion of this study. Six hundred forty-four full-time employees in West Virginia's three institutions for the

developmentally disabled were surveyed in the course of this investigation. The study was approved by the State Director of Health, State Director of Developmental Disabilities Services, State Director of Employee Services, and Department of Health's Research Committee. Personal interviews by on-site visits and telephone contacts were conducted with administrators and staff training officers of the three institutions in obtaining their support and cooperation. The administrators were especially concerned that the questionnaire be kept to a minimal length to avoid distracting staff from their duties for a prolonged period of time.

To increase clarity of questions and to avoid potential misunderstanding or intimidation of less educated staff, the questionnaire was designed using familiar cultural vocabulary rather than professional terminology. To ensure validity and reliability, a panel of experts in the area of rights issues was selected to review and modify the questionnaire. They also had the responsibility of ensuring that statements within the questionnaire were not ambiguous and clearly related to established laws and regulations affecting developmentally disabled persons in West Virginia institutions. In addition, the questionnaire was pretested by individuals who are employed in a regional residential center for the developmentally disabled. The research coordinator personally distributed and collected all questionnaires within each institution.

Setting and Population

The setting of this study centers around three of six state operated institutions in West Virginia that provide services to mentally and physically impaired individuals. The three selected institutions serve developmentally disabled individuals exclusively. Each institution maintains a different degree of severity. A description of each facility follows.

1. Colin Anderson Center

   Colin Anderson Center is located at St. Marys, Pleasants County, West Virginia. The center serves approximately 392 clients who are predominantly long-term severely and profoundly mentally retarded adolescents and young adults. It functions as a residential center and as a research and training center for developing new and adapting existing methods of treatment and instruction as well as providing learning opportunities for students of the many professions dealing with developmental disabilities. Programs include the Able-Bride, which serves clients who have severe and extensive disabilities; Echo, which serves those who are ready for entry into the classroom setting; and Home-life, which is composed of two-level programming utilizing cottage life environments. Each of the four cottages houses twelve clients and a complement of house staff and support personnel. The two cottages housing the higher functioning clients are also co-educational. Hope, a six month temporary treatment program which serves community,

school crisis, and respite referrals; regular parental training sessions are part of this program.

The center provides a full range of habilitative services including medical housing and food services, psychological, speech and hearing, recreational, and prevocational services. Of the 392 beds, 156 are certified for Title XIX Medicaid as an Intermediate Care Facility/Mental Retardation provider.

2. Greenbrier Center

Greenbrier Center is located in Lewisburg, Greenbrier County, West Virginia. The center serves approximately 40 clients who are predominantly short-term higher functioning (trainable and educable) mentally retarded adolescents and young adults. It functions as an intensive training facility with the expressed goal of providing clients an avenue for a rapid and successful transition back into their community environment utilizing a full range of professional services. The center contains an olympic swimming pool, gymnasium facilities, a stable for therapeutic riding, playground, classrooms, a greenhouse, and three group homes for more independent living experiences. The program offers education, therapy, basic living skills training and recreation on a full-time, part-time, or respite care basis. Specific programs are the following: Functional Life, which promotes self-help, pre-academics, function academics, and independent travel; Independent Living, which teaches kitchen, laundry, and housekeeping skills; and Vocational and

Prevocational, which offers ceramics, aluminum recycling, and community jobs. In addition, horticulture, mini-farms, adaptive physical education, recreation, arts and crafts, music, speech and language, dental care, physical therapy, family living, horseback riding and stables management are areas of programming.

3. Spencer Hospital

Spencer Hospital is located in Spencer, Roane County, West Virginia. The hospital serves approximately 125 clients who are predominantly long-term older severely mentally retarded adults. The program provides therapy, psychological treatment, adult education, recreation, and vocational rehabilitation services.

Prior to September, 1983, this institution addressed the needs of adult psychiatric, developmentally disabled, geriatric clients, and admissions of short-term treatment. As of September, 1983 the staff has been involved in intensive training for this transition phase.

This study surveyed all full-time staff that were present during the three scheduled days of investigation into staff knowledge of client rights. There were 644 subjects that responded and 24 subjects did not complete the questionnaires. For the purpose of this study, all job categories of staff who directly or indirectly interact with clients were surveyed. Subjects were classified into six job categories. These job categories included the following (Wheeler, Wells, and Bradish, 1982):

1. Health Service Workers

Health Service workers are those staff members who provide direct residential care to clients, such as aide attendants or resident aide.

2. Paraprofessional/Trainers

Paraprofessionals, sometimes referred to as trainers are non-degreed professional aides, such as teacher aides, physical therapy aides, recreational aides, floor charge aides, and similar employees.

3. Non-Professional/Non-Direct Care

Non-Professional/Non-Direct Care staff are those whose job responsibilities do not involve direct client interaction such as maintenance, housekeeping, clerical and kitchen staff.

4. Professionals

Professionals are composed of degreed professionals who serve in a service delivery capacity; this category excludes supervisory personnel. Professionals include nurses, physicians, teachers, psychologists, therapists, social workers, and similar personnel.

5. Administrators

Administrators are those whose position is primarily supervisory or administrative in nature, such as directors, program coordinators, business managers, hospital administrators, and staff supervisors.

6. Patient Advocates and/or Human Rights Committee Members

Patient Advocates and/or Human Rights Committee Members are those who provide client protection and advocacy, and may or may not be employed directly by the institutions.

Prior to responding to the questionnaire, staff were requested to provide demographic information pertaining to the following: the name of the institution where they are employed; the job category that best described their current employment or classification; and the number of years employed in their current position. Table 1 presents the sample pattern of the number of subjects per facility and job category.

Instrumentation

As previously indicated, a questionnaire to survey the differences, if any, in staff knowledge of client rights was reported, by institutional administrators, staff training officers, and state-level personnel, to be the most appropriate instrument to use for this study. A survey in the form of a questionnaire requires less staff involvement, reaches a wider population of subjects, and allows greater flexibility in staff participation than do personal interviews. Staff flexibility would allow institutions to maintain consistency in their employees work schedules (Henerson, Morris, and Fitz-Gibbson, 1978). Consistency in staff work performance is vital in the care and treatment of their clients.

A review of sixty different sources of laws and regulations that are applicable to developmentally disabled individuals residing in West Virginia's institutions revealed only twenty-five separate rights cited

TABLE 1
SAMPLE PATTERN OF SUBJECTS
PER FACILITY AND JOB CATEGORY

FACILITY	HEALTH SERVICE	PARAPROFESSIONAL	NON-PROFESSIONAL	PROFESSIONAL	ADMINISTRATIVE	PATIENT ADVOCATES	ROW TOTAL
COLIN ANDERSON CENTER	184	37	111	56	27	3	418
	44.0	8.9	26.6	13.4	6.5	0.7	64.9
	67.9	72.5	61.0	62.2	60.0	60.0	
	28.6	5.7	17.2	8.7	4.2	0.5	
GREENBRIER CENTER	24	3	14	11	9	1	62
	38.7	4.8	22.6	17.7	14.5	1.6	9.6
	8.9	5.9	7.7	12.2	20.0	20.0	
	3.7	0.05	2.2	1.7	1.4	0.2	
SPENCER HOSPITAL	63	11	57	23	9	1	164
	38.4	6.7	34.8	14.0	5.5	0.6	25.5
	23.2	21.6	31.3	25.6	20.0	20.0	
	9.8	1.7	8.9	3.6	1.4	0.2	
COLUMN TOTAL	271	51	182	90	45	5	644
	42.1	7.9	28.3	14.0	7.0	0.8	100.0

in the many documents. These twenty-five rights have been for the purpose of this study designated as standards and identified as such throughout the remainder of this study. The twenty-five most often mentioned rights standards were as follows:

1. Access to Records
2. Appeals Process
3. Civil, Legal, and Human Rights
4. Communication
5. Confidentiality
6. Consent to Treatment
7. Education
8. Freedom from Neglect
9. Freedom from Physical Abuse
10. Freedom from Verbal Abuse
11. Freedom from Chemical Restraints
12. Freedom from Mechanical Restraints
13. Freedom from Seclusion
14. Information/Notice Provided (Fully Informed)
15. Least Restrictive Environment/Alternative Placement
16. Maintain Personal Property and Clothing
17. Manage Personal Finances
18. Nondiscrimination
19. Participate in Program/Treatment Planning
20. Privacy

21. Program Treatment Plan
22. Refuse Treatment
23. Treatment and Care
24. Visiting Privileges
25. Work/Labor Compensation

For each rights standard, a vignette was developed that briefly described a situation which could arise between staff and clients. Participants were requested to read each vignette and decide whether the staff person had acted appropriately or inappropriately with respect to client rights as established by laws and regulations.

To avoid intimidating staff, names were not required on the completed questionnaires. It was assumed that not requiring names would help to establish a risk-free atmosphere which would result in honest and accurate responses. The only demographic data requested were (1) the name of the institution where employed, (2) job category, and (3) number of years employed in his or her present position.

In responding to the questionnaire, participants indicated how they perceived each situation by placing a check mark (☑) beside the alternative interpretations of appropriate or inappropriate. For the purpose of this study, participants were made aware that appropriate is defined as probably not a violation of a client rights and inappropriate is defined as a probable violation of a client rights. This form of response system was selected rather than the conventional number (1,2) or alphabetical letters (a,b) system. A number or letter system appears to establish "mind sets" with some participants. Numbers and letters

have a tendency to imply that there is a rank order to the responses. This may also be a reason some participants indicate responses by marking a consistent number or letter throughout a questionnaire.

It was also emphasized that participants were to consider only the facts given in each situation and not to consider any circumstances not described. Furthermore, they were requested to answer only from the rights point of view and not to consider clinical and management issues.

A five member panel of experts who are knowledgeable in the area of rights issues was selected to review each of the twenty-five vignettes. The panel consisted of an attorney from the West Virginia Advocates for the Developmentally Disabled, a court appointed monitor for one of the class action suits in West Virginia, a mental retardation project coordinator, and two consumer rights advocates. Members of this panel represent disciplines that are routinely requested to review allegations of client rights violations in West Virginia's institutions for the developmentally disabled. The panel also assisted in ensuring that the vignettes were clear, unambiguous, and related to laws and regulations affecting institutionalized, developmentally disabled individuals. Furthermore, they identified correct answers for each vignette. The correct answers were relative to the panel's determination of whether each situation depicted an appropriate or inappropriate interaction between staff and client. If members of the panel could not reach a total agreement on what the answer should be, the vignette was rewritten or replaced until total agreement was obtained. Out of the twenty-five vignettes thirteen were modified in

order to obtain a total agreement from the panel. The assumption was made that obtaining unanimous agreement among the expert panel on each of the twenty-five rights issues would provide reasonable assurance of reliability within the instrument.

The questionnaire was pretested at a regional residential center for developmentally disabled individuals. All job categories of staff, fifty-seven employees, at Green Acres Regional Center in Lesage, West Virginia, participated in completing the questionnaires. After any vignette not worded clearly, unambiguous, or operationally defined, staff provided written comments. The use of words and how they are structured establishes the framework of how participants will respond. Many times, in the development of an instrument, a researcher may indirectly elicit desired responses. This may be the result of cultural or local wordings that key participants to certain desired responses. Many times the impression presented is different from what the researcher believes is being provided (Henerson, Morris, and Fitz-Gibbson, 1978). In pretesting the instrument at Green Acres Regional Center, these concerns and others were addressed.

Data Collection

Following approval from the State Director of Health, institutional administrators were notified, by memorandum, of the study. Follow-up telephone contacts were made in an attempt to clarify any concerns and to establish an atmosphere of rapport. Also, telephone contacts and personal interviews were conducted with administrators, staff training officers, State Division of Developmental Disabilities Services

personnel, and State Division of Employee Services personnel regarding an appropriate instrument and the collection of data. In addition, follow-up contacts were maintained with institutional staff and other concerned individuals, e.g., union representatives, patient advocates, and Department of Health personnel, in order to insure that results of the study would benefit both staff and clients.

Upon the request of the institutional administrators and staff training officers, efforts were made not to disrupt the staff working schedules. It was emphasized that medications, feedings, and other care and treatment services are provided accordingly to established routine. Inconsistency in the provision of these services could be detrimental to the clients welfare. With this in mind, staff were given an eight-hour working shift to complete the questionnaire. To avoid taking staff away from their regular duties, the questionnaire was limited to only one item for each of the twenty-five rights areas. The research coordinator was available every hour for collection of the completed questionnaires. In case there were any questions, an on-grounds location and telephone extension number were made available.

All full-time staff that were present during the survey were provided forms which contained general instructions, a sheet requesting background information, and a twenty-five item questionnaire. Responses to the questionnaire were kept confidential, and no one except the research coordinator had access to the staff answers. To avoid threatening staff participation, names were not required on the completed questionnaires. Participants were asked not to discuss

matters relative to the questionnaire or any documents relating to rights issues with other staff during the eight hour period.

To ensure staff participation, the research coordinator personally delivered and collected the questionnaires from all staff members. This involved on-site visits to each of the three institutions for the developmentally disabled and on all working shifts, e.g., 7:00 a.m. - 3:00 p.m., 3:00 p.m. - 11:00 p.m., and 11:00 p.m. - 7:00 a.m. Administrators were requested to notify the staff of the dates and times when on-site visits were to occur.

There were 668 questionnaires distributed and 644 completed forms were returned or a 96% return rate. Five questionnaires were returned with the statement of "no comment" and nineteen were not returned. Following the collection of questionnaires, attempts were made by telephone contacts to staff training officers in an effort to obtain the remaining nineteen. All attempts proved unsuccessful.

Analysis of Data

Responses to the questionnaires were analyzed to measure variations in staff knowledge of client rights issues. The questionnaires were scored by adding the correct responses for each participants total score and were treated as interval data. Staff in six different job categories from three separate institutions for the developmentally disabled completed the questionnaires. Responses were evaluated among the job categories within each institution and compared between the institutions. Also, the overall responses, without regard to job categories were evaluated in each of the participating institutions.

Background information regarding location of employment and years of employment was included on each participant.

The data were analyzed by using the one-way analysis of variance procedure with Fisher's LSD and Scheffe post hoc multiple comparison test, two-way analysis of variance, and by Pearson r correlational method. All data were analyzed on the "Statistical Package for Social Sciences (SPSS)". In addition to the use of inferential statistics, descriptive procedures were applied in the analysis of data. Within the three institutions, individual job category percentage scores of appropriate responses relative to each of the twenty-five rights areas were obtained. In addition, an overall percentage score of appropriate responses for each of the six job categories in all three institutions was obtained and analyzed.

CHAPTER 4

Results

The following section presents the results of the study in both a statistical and verbal format. The present study investigated the following research questions:

1. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between persons in different job categories within different institutions for the developmentally disabled?
2. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between the three institutions for the developmentally disabled without regard to job categories?
3. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between persons in different job categories in the total sample of three institutions for the developmentally disabled?
4. What, if any, relationships exist between staff knowledge of client rights, as established by laws and regulations, between persons with different job longevity rates?

The first three research questions were tested by the use of the SPSS programs to conduct a one-way analysis of variance procedure with Fisher's LSD and Scheffe post hoc multiple comparison test and two-way analysis of variance. The fourth research question was analyzed by means of Pearson r correlational method. It has been found contrary to

expectations based on the literature, the Scheffe did not discriminate as well as the Fisher's LSD, see Tables 2-11 and 13-15. It was important that we identify as many differences as possible, the Fisher's LSD was selected as discussed and is the statistics utilized for the remainder of this study. Also, the two-way analysis of variance procedure was applied to the inter-facility comparison, see Table 12. It did not yield useful information beyond that which was obtained from the one-way analysis of variance. A decision was, therefore, made not to repeat for the other comparisons.

In order to test research question 1, three separate one-way analysis of variance procedures were run for each of three institutions for the developmentally disabled. In Tables 2 to 10, each job category served as a group. Therefore, each of the following tables analyzes whether significant differences occurred within a single institution.

An analysis of variance test on the different job categories with the Colin Anderson Center is presented in Table 2. The F ratio of 19.643 with p at less than .0001 indicates that highly significant differences exist among the six job categories at the Colin Anderson Center. Since significant differences were noted, post hoc multiple comparison tests were needed to determine exactly which job categories were significantly different. The Fisher LSD method was chosen as the appropriate post hoc test. In order to minimize the possibility of a Type I error with this test, the .01 level of significance was used instead of the .05 level. The results of the post hoc multiple comparison procedure is presented in Table 3.

Non-Professional/Non-Direct Care staff knowledge of client rights was significantly different from Health Services Workers, Professionals, and Administrators. Paraprofessionals/Trainers knowledge was significantly different from Professional and Administrators. Patient Advocates/Human Rights Committee Members knowledge of client rights was not significantly different from any of the job categories in the analysis. Professionals and Administrators knowledge were not significantly different from each other. Paraprofessionals/Trainers and Non-Professional/Non-Direct Care staff knowledge were not significantly different. Health Service Workers and Paraprofessionals/Trainers knowledge were not significantly different.

The analysis of variance test of the different job categories within the Greenbrier Center is presented in Table 5. The results show an F ratio of 4.023 with p equal to .0034. Since these results indicate that significant differences do exist between the different job categories at the Greenbrier Center, post hoc multiple comparison tests were performed to indicate where the differences did occur. Fisher's LSD test was again performed with the probability level set at .01. The results of the post hoc test on different job categories within the Greenbrier Center is presented in Table 6.

The results indicate that significant differences in staff knowledge of client rights did occur between Non-Professional/Non-Direct Care and Administrators. Significant differences in knowledge were also found between Health Service Workers and Administrators. No other significant differences in staff knowledge of client rights were found between job categories.

TABLE 2

Analysis of Variance

Test on the Different Job Categories

with the Colin Anderson Center

SOURCE	D.F.	SUM OF SQUARES	MEAN SQUARES	F RATIO	F PROB.
BETWEEN GROUPS	5	1275.5575	254.9114	19.643	0.0001
WITHIN GROUPS	412	5346.6784	12.9774		
TOTAL	417	6621.2344			

TABLE 3

Fishers LSD Post Hoc Multiple Comparison Test on the

Job Categories with the Colin Anderson Center

MEAN	GROUP	Non-Professional/Non-Direct Care 3	Paraprofessional/Trainers 2	Health Service Workers 1	Professionals 4	Patient Advocates and/or Human Rights Committee Members 6	Administrators 5
13.7838	GRP03						
15.0270	GRP02						
16.4293	GRP01	*					
18.5179	GRP04	*	*	*			
18.6667	GRP06						
19.2592	GRP05	*	*	*			

(*) DENOTES PAIRS OF GROUPS SIGNIFICANTLY DIFFERENT AT THE 0.010 LEVEL.

TABLE 4

Scheffe Post Hoc Multiple Comparison

Test on the Job Categories with the Colin Anderson Center

MEAN	GROUP	Non-Professional/Non-Direct Care 3	Paraprofessional/Trainers 2	Health Service Workers 1	Professionals 4	Patient Advocates and/or Human Rights Committee Members 6	Administrators 5
13.7838	GRP03						
15.0270	GRP02						
16.4293	GRP01	*					
18.5179	GRP04	*	*				
18.6667	GRP06						
19.2592	GRP05	*	*				

(*) DENOTES PAIRS OF GROUPS SIGNIFICANTLY DIFFERENT AT THE 0.010 LEVEL.

TABLE 5

Analysis of Variance

Test on the Different Job Categories

with the Greenbrier Center

SOURCE	D.F.	SUM OF SQUARES	MEAN SQUARES	F RATIO	F PROB.
BETWEEN GROUPS	5	144.5778	28.9156	4.023	0.0034
WITHIN GROUPS	56	402.4731	7.1870		
TOTAL	61	547.0508			

TABLE 6

Fishers LSD Post Hoc Multiple

Comparison Test on the Different Job Categories

with the Greenbrier Center

MEAN	GROUP	Non-Professional/Non-Direct Care 3	Paraprofessional/Trainers 2	Health Service Workers 1	Professionals 4	Patient Advocates and/or Human Rights Committee Members 6	Administrators 5
15.2857	GRP03						
16.1167	GRP02						
16.3333	GRP01						
17.5454	GRP04						
19.8889	GRP05	*	*				
20.0000	GRP06						

(*) DENOTES PAIRS OF GROUPS SIGNIFICANTLY DIFFERENT AT THE 0.010 LEVEL.

TABLE 7

Scheffe Post Hoc Multiple Comparison

Test on the Job Categories with the Greenbrier Center

MEAN	GROUP	Non-Professional/Non-Direct Care 3	Paraprofessional/Trainers 2	Health Service Workers 1	Professionals 4	Patient Advocates and/or Human Rights Committee Members 6	Administrators 5
15.2857	GRP03						
15.1667	GRP01						
16.3333	GRP02						
17.5454	GRP04						
19.8889	GRP05						
20.0000	GRP06						

NO TWO GROUPS ARE SIGNIFICANTLY DIFFERENT AT THE 0.10 LEVEL

The results of the one-way analysis of variance of the different job categories within the Spencer Hospital is presented in Table 8. The results show an F ratio of 9.138 with p at less than .0001. These results again indicate that significant differences do occur between the different job categories. Since significant differences were indicated at the Spencer Hospital, the Fisher's LSD test was used with the probability level set at .01. The results of the post hoc test on the Spencer Hospital is presented in Table 9.

The results indicate that Non-Professional/Non-Direct Care staff differed significantly in knowledge of client rights from Professionals and Administrators. Health Service Workers differed significantly in knowledge from Professionals and Administrators. Paraprofessionals differed significantly in knowledge from Administrators. Non-Professional/Non-Direct Care staff, Paraprofessionals/Trainers, and Health Service Workers did not significantly differ in their knowledge of client rights. Patient Advocates/Human Rights Committee Members knowledge was not significantly different from any other job category in this analysis.

Research question 2 was also examined by the one-way analysis of variance procedure. In this analysis, each institution for the developmentally disabled served as a group. Thus, there were three groups whose scores were analyzed to see if the three institutions differed significantly in staff knowledge of client rights. Table 11 presents these results.

TABLE 8

Analysis of Variance

Test on the Different Job Categories with the

Spencer Hospital

SOURCE	D.F.	SUM OF SQUARES	MEAN SQUARES	F RATIO	F PROB.
BETWEEN GROUPS	5	520.4099	104.0820	9.138	0.0001
WITHIN GROUPS	158	1799.6065	11.3899		
TOTAL	163	2320.0164			

TABLE 9

Fisher's LSD Post Hoc Multiple

Comparison Test on the Different Job Categories

with the Spencer Hospital

MEAN	GROUP	Non-Professional/Non-Direct Care 3	Paraprofessional/Trainers 2	Health Service Workers 1	Professionals 4	Patient Advocates and/or Human Rights Committee Members 6	Administrators 5
14.3158	GRP03						
15.6190	GRP01						
16.8182	GRP02						
17.7826	GRP04	*	*				
21.1111	GRP05	*	*	*			
22.0000	GRP06						

(*) DENOTES PAIRS OF GROUPS SIGNIFICANTLY DIFFERENT AT THE 0.010 LEVEL.

TABLE 10

Scheffe Post Hoc Multiple Comparison Test

on the Different Job Categories with the Spencer Hospital

		Non-Professional/Non-Direct Care	Paraprofessional/Trainers	Health Service Workers	Professionals	Patient Advocates and/or Human Rights Committee Members	Administrators
MEAN	GROUP	3	2	1	4	6	5
14.3158	GRP03						
15.6190	GRP01						
16.8182	GRP02						
17.7826	GRP04	*					
21.1111	GRP05	*	*				
22.0000	GRP06						

(*) DENOTES PAIRS OF GROUPS SIGNIFICANTLY DIFFERENT AT THE 0.010 LEVEL.

TABLE 11

Analysis of Variance

on the Scores Between the Colin Anderson Center,

Greenbrier Center, and Spencer Hospital

SOURCE	D.F.	SUM OF SQUARES	MEAN SQUARES	F RATIO	F PROB.
BETWEEN GROUPS	2	39.6708	19.8354	1.340	0.2626
WITHIN GROUPS	641	9488.0986	14.8020		
TOTAL	643	9527.7656			

The F ratio in Table 11 was 1.34 with the probability level exceeding the .05 level. This result indicates that no overall differences exist between the three institutions for the developmentally disabled in terms of staff knowledge of client rights. Since the F ratio in Table 11 was not significant, no post hoc tests were performed.

The analysis of variance procedure associated with research question 3 is presented in Table 12. This table examined the total number of subjects in the study. Each of the six job categories formed a separate group in this particular analysis. Thus, the results of this table indicate whether any overall significant differences occurred between six job categories for the sample as a whole (all three institutions).

As can be ascertained by Table 13, highly significant differences did exist between the six job categories. The F ratio was 30.526, with the probability level of such a difference being less than 1 in 10,000 (p less than .0001).

In order to ascertain where the significant differences occurred, the Fisher's LSD post hoc test was again used with p at less than .01. The results of the post hoc test on the total subjects' sample is presented in Table 14.

Non-Professional/Non-Direct Care staff demonstrated a significant difference in knowledge of client rights when compared to all other job categories. Professionals were significantly different in knowledge from Paraprofessionals/Trainers and Health Services Workers, as well as from Non-Professional/Non-Direct Care staff. Administrators were also

TABLE 12

Two-Way Analysis of Variance on the Scores Between the Colin Anderson Center, Greenbrier Center, and Spencer Hospital

SOURCE OF VARIATION	SUM OF SQUARES	DF	MEAN SQUARE	F	SIGNIF OF F
Main Effects	1842.323	7	263.189	21.827	0.000
Facilities	2.902	2	1.451	0.120	0.887
Job Cat	1802.600	5	360.520	29.899	0.000
2-Way Interactions Facilities Job Cat	136.923	10	13.692	1.136	0.333
Explained	1979.246	17	116.426	9.656	0.000
Residual	7448.160	626	12.058		
Total	9527.406	643	14.817		

TABLE 13

Analysis of Variance on the Different Job Categories in the Total Sample of the Three Institutions

SOURCE	D.F.	SUM OF SQUARES	MEAN SQUARES	F RATIO	F PROB.
BETWEEN GROUPS	5	1839.3697	367.8738	30.526	0.0001
WITHIN GROUPS	638	7688.5620	12.0510		
TOTAL	643	9527.9297			

TABLE 14

Fisher's LSD Post Hoc Multiple

Comparison Test on the Different Job Categories

in the Total Sample of the Three Institutions

MEAN	GROUP	Non-Professional/Non-Direct Care 3	Paraprofessional/Trainers 2	Health Service Workers 1	Professionals 4	Patient Advocates and/or Human Rights Committee Members 6	Administrators 5
14.0659	GRP03						
15.4902	GRP02	*					
16.2177	GRP01	*					
18.2111	GRP04	*	*	*			
19.6000	GRP06	*					
19.7556	GRP05	*	*	*			

(*) DENOTES PAIRS OF GROUPS SIGNIFICANTLY DIFFERENT AT THE 0.010 LEVEL.

TABLE 15

Scheffe Post Hoc Multiple Comparison Test on the Different Job Categories in the Total Sample of the Three Institutions

MEAN	GROUP	3 Non-Professional/Non-Direct Care	2 Paraprofessional/Trainers	1 Health Service Workers	4 Professionals	6 Patient Advocates and/or Human Rights Committee Members	5 Administrators
14.0659	GRP03						
15.4902	GRP02						
16.2177	GRP01	*					
18.2111	GRP04	*	*	*			
19.6000	GRP06	*	*	*			
19.7556	GRP05						

(*) DENOTES PAIRS OF GROUPS SIGNIFICANTLY DIFFERENT AT THE 0.010 LEVEL.

significantly different in knowledge from Paraprofessionals/Trainers and staff. Patient Advocates/Human Rights Committee Members differed significantly in knowledge only when compared to Non-Professional/Non-Direct Care staff. Professionals, Administrators, and Patient Advocates/Human Rights Committee Members were not significantly different from each other in their knowledge of client rights. Also, Health Service Workers and Paraprofessionals/Trainers were not significantly different in their knowledge of client rights.

Research question 4 investigated what, if any, relationships exist between staff knowledge of client rights and job longevity rates. This research question was tested by the use of the Pearson r correlation coefficient. The two variables, which were correlated was - .08 with p = .015. This correlation would indicate a slight inverse relationship between knowledge and years of employment. Though the probability level is sufficient to state that a difference does exist, correlations which are less than .20 are generally considered to be of limited value. Therefore, very little relationship can be said to exist between knowledge and years of employment. See Tables 16 and 17 for years per facility and job category, respectively.

In addition to the statistical comparison, results were tabulated by job category relative to the percentage of correct responses per rights areas. The results within each of the three institutions is presented in Tables 18, 19, and 20. The results of the overall percentage scores of correct responses by job category in all three institutions is presented in Tables 21.

TABLE 16
Job Longevity
Rates per Facility

ROW PCT COL PCT TOT PCT	COLIN ANDERSON 1.	GREENBRIER CENTER 2.	SPENCER HOSPITAL 3.	GREEN ACRES RES. CENTER 4.	ROW TOTAL
1.	85 52.1 20.3 12.2	22 13.5 35.5 3.2	32 19.6 19.5 4.6	24 14.7 46.2 3.4	163 23.4
2.	137 72.9 32.8 19.7	16 8.5 25.8 2.3	22 11.7 13.4 3.2	13 6.9 25.0 1.9	188 27.0
3.	104 57.5 24.9 14.9	24 13.3 38.7 3.4	44 24.3 26.8 6.3	9 5.0 17.3 1.3	181 26.0
4	92 56.1 22.0 13.2	9 0.0 0.0 0.0	66 40.2 40.2 9.5	6 3.7 11.5 0.9	164 23.6
COLUMN TOTAL	418 60.1	62 8.9	164 23.6	52 7.5	696 100.0

TABLE 17
Job Longevity
Rates per Job Category

COUNT / ROW PCT / COL PCT / TOT PCT	JOB CATEGORY: HEALTH SERVICE 1.	PARAPRO-FESSIONAL 2.	NON-PROF-ESSIONAL 3.	PROFESS-IONAL 4.	ADMINI-STRATIVE 5.	PATIENT ADVOCATES 6.	ROW TOTAL
Colin Anderson	53	16	35	45	14	0	163
	32.5	9.8	21.5	27.6	8.6	0.0	23.4
	19.4	23.9	18.5	42.1	25.5	0.0	
	7.6	2.3	5.0	6.5	2.0	0.0	
Greenbrier Center	73	23	45	14	0	188	
	38.8	12.2	23.9	12.8	10.6	1.6	27.0
	26.7	34.3	23.8	22.4	36.4	60.0	
	10.5	3.3	6.5	3.4	2.9	0.04	
Spencer Hospital	76	14	57	25	9	0	181
	42.0	7.7	31.5	13.8	5.0	0.0	26.0
	27.8	20.9	30.2	23.4	16.4	0.0	
	10.9	2.0	8.2	3.6	1.3	0.0	
Green Acres Res. Center	71	14	52	13	12	2	164
	43.3	8.85	31.7	7.9	7.3	1.2	23.6
	26.0	20.9	27.5	12.1	21.8	40.0	
	10.2	2.0	7.5	1.9	1.7	0.3	
COLUMN TOTAL	273	67	189	107	55	5	696
	39.2	9.6	27.2	15.4	7.9	0.7	100.0

TABLE 18

Percentage of Correct Responses per Rights Areas with the Colin Anderson Center

RIGHTS AREAS		Access to Records	Appeals Process	Civil, Legal, and Human Rights	Communication	Confidentiality	Consent to Treatment	Education	Freedom from Neglect	Freedom from Physical Abuse	Freedom from Verbal Abuse	Freedom From Chemical Restraints	Freedom from Mechanical Restraints	Freedom from Seclusion	Information/Notice Provided (Fully Informed)	Least Restrictive Environment/Alternative Placement	Maintain Personal Property and Clothing	Manage Personal Finances	Nondiscrimination	Participate in Program/ Treatment Planning	Privacy	Program Treatment Plan	Refuse Treatment	Treatment and Care	Visiting Privileges	Work/Labor Compensation
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Health Service Workers	1	67	58	82	72	58	74	89	86	91	91	34	31	84	28	37	81	90	64	84	36	20	88	73	92	45
Professsionals/ Trainers	2	57	73	68	73	68	57	68	92	76	79	28	28	71	33	33	71	84	63	76	46	30	71	55	71	44
Non-Professional/ Non-Direct Care	3	53	39	80	47	60	73	65	86	82	84	15	19	60	13	19	66	91	71	76	30	9	82	37	86	47
Professionals	4	77	88	93	86	65	79	97	88	97	97	68	33	79	24	34	84	88	63	97	50	31	83	77	99	86
Administrators	5	86	82	89	63	60	86	100	82	100	97	63	41	78	41	45	97	97	71	100	45	49	97	89	97	82
Patient Advocates and/or Human Rights Committee Members	6	67	67	100	67	100	100	100	100	67	67	67	34	67	34	34	100	67	100	67	100	67	100	67	67	67

TABLE 19

Percentage of Correct Response per Rights Areas with the Greenbrier Center

RIGHTS AREAS		1 Access to Records	2 Appeals Process	3 Civil, Legal, and Human Rights	4 Communication	5 Confidentiality	6 Consent to Treatment	7 Education	8 Freedom from Neglect	9 Freedom from Physical Abuse	10 Freedom from Verbal Abuse	11 Freedom From Chemical Restraints	12 Freedom from Mechanical Restraints	13 Freedom from Seclusion	14 Information/Notice Provided (Fully Informed)	15 Least Restrictive Environment/Alternative Placement	16 Maintain Personal Property and Clothing	17 Manage Personal Finances	18 Nondiscrimination	19 Participate in Program/ Treatment Planning	20 Privacy	21 Program Treatment Plan	22 Refuse Treatment	23 Treatment and Care	24 Visiting Privileges	25 Work/Labor Compensation
Health Service Workers	1	84	50	92	71	63	67	96	88	84	100	0	30	84	30	30	92	88	55	88	46	9	88	80	92	21
Paraprofessionals/ Trainers	2	67	34	100	34	67	100	100	67	100	67	0	67	100	34	34	100	67	67	67	100	0	100	67	100	0
Non-Professionals/ Non-Direct Care	3	72	50	86	50	79	43	72	79	93	72	22	36	100	29	72	86	79	72	72	36	8	58	43	93	36
Professionals	4	82	91	82	82	28	64	100	46	100	100	10	55	91	28	46	91	82	64	100	46	28	91	73	100	82
Administrators	5	100	100	89	67	45	67	89	67	100	89	56	67	89	34	67	100	89	100	89	56	78	89	67	100	100
Patient Advocates and/or Human Rights Committee Members	6	100	100	100	100	100	100	100	0	100	100	100	0	100	100	100	100	100	0	100	0	100	100	0	100	100

TABLE 20

Percentage of Correct Response per Rights Areas with the Spencer Hospital

	RIGHTS AREAS	Access to Records	Appeals Process	Civil, Legal, and Human Rights	Communication	Confidentiality	Consent to Treatment	Education	Freedom from Neglect	Freedom from Physical Abuse	Freedom from Verbal Abuse	Freedom From Chemical Restraints	Freedom from Mechanical Restraints	Freedom from Seclusion	Information/Notice Provided (Fully Informed)	Least Restrictive Environment/Alternative Placement	Maintain Personal Property and Clothing	Manage Personal Finances	Nondiscrimination	Participate in Program/ Treatment Planning	Privacy	Program Treatment Plan	Refuse Treatment	Treatment and Care	Visiting Privileges	Work/Labor Compensation
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Health Services Workers	1	53	45	86	53	64	75	75	69	89	88	39	51	89	16	24	89	85	64	85	39	12	86	47	99	45
Paraprofessionals/ Trainers	2	64	64	91	73	55	100	91	37	91	91	82	37	82	19	37	91	91	64	82	64	10	82	37	100	55
Non-Professional/ Non-Direct Care	3	53	43	79	62	71	72	76	88	72	78	27	25	53	23	32	71	95	62	79	37	8	74	32	81	50
Professionals	4	69	64	91	78	73	91	82	82	91	69	50	41	73	5	37	96	69	78	96	41	32	96	73	91	73
Administrators	5	89	100	100	89	34	89	78	78	100	100	89	67	89	56	78	100	89	67	100	78	78	89	78	100	100
Patient Advocates and/or Human Rights Committee Members	6	100	100	100	100	0	100	100	100	100	100	100	100	100	100	0	100	100	0	100	100	100	100	100	100	100

TABLE 21

Overall Percentage Scores of Correct Responses per Rights Areas in the Total Sample of the Three Institutions

RIGHTS AREAS		Access to Records	Appeals Process	Civil, Legal, and Human Rights	Communication	Confidentiality	Consent to Treatment	Education	Freedom from Neglect	Freedom from Physical Abuse	Freedom from Verbal Abuse	Freedom From Chemical Restraints	Freedom from Mechanical Restraints	Freedom from Seclusion	Information/Notice Provided (Fully Informed)	Least Restrictive Environment/Alternative Placement	Maintain Personal Property and Clothing	Manage Personal Finances	Nondiscrimination	Participate in Program/ Treatment Planning	Privacy	Program Treatment Plan	Refuse Treatment	Treatment and Care	Visiting Privileges	Work/Labor Compensation
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25
Health Service Workers	1	68	51	86	65	61	72	86	81	88	93	24	37	85	24	30	87	87	61	85	40	13	87	66	94	37
Paraprofessionals/ Trainers	2	62	57	86	60	63	85	86	65	89	79	36	44	84	28	34	87	80	64	75	70	13	84	53	90	33
Non-Professional/ Non-Direct Care	3	59	44	81	53	70	62	71	84	82	78	21	26	71	21	41	74	88	68	75	34	8	71	37	86	44
Professionals	4	76	81	88	82	78	78	93	72	96	88	42	43	81	19	39	90	79	68	97	45	30	90	74	96	80
Administrators	5	91	94	92	73	46	80	89	75	100	95	69	58	85	43	63	99	91	79	96	59	68	91	78	99	94
Patient Advocates and/or Human Rights Committee Members	6	89	89	100	89	66	100	100	66	89	89	89	44	89	78	44	100	89	33	89	66	89	100	55	89	89

As evidence by the distributed results, these charts demonstrate those rights issues in which staff were knowledgeable and those in which there were deficiencies. Scores falling below 80% indicated a lack in knowledge of certain rights areas. For example, in Table 21 all six job categories of staff appear to have an adequate knowledge base on rights issues 3, 9, and 24, but lack knowledge on rights issues 5, 12, 14, 15, 18, 20, and 23. Also, in Table 18 it appears that job category 1 at Colin Anderson Center possesses sufficient knowledge on rights issues 3, 7-10, 13, 16, 17, 19, 22, and 24, but is deficient on rights issues 1, 2, 4-6, 11, 12, 14, 15, 18, 20, 21, 23, and 25. It is clear that there are differences between those rights issues in which staff were knowledgeable and those where there was misunderstanding.

Results of the data analysis can be summarized as follows:

Research question 1 - when different job categories are compared within each of the three institutions, significant differences were found within each of the three institutions.

Research question 2 - no significant differences exist between the three institutions in staff knowledge of client rights.

Research question 3 - significant differences do exist between the job categories in the total sample.

Research question 4 - relationships could exist based on the probability level equaling .015. However, little statistical confidence can be given to a correlation coefficient of -.08.

CHAPTER 5

Discussion

The purpose of this study was to identify differences, if any, exist between staff knowledge of client rights. This entailed a survey of all staff by job categories, both within and between institutions. Four specific research questions were investigated:

1. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between persons in different job categories within different institutions for the developmentally disabled?
2. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between the three institutions for the developmentally disabled without regard to job categories?
3. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between persons in different and similar job categories in the total sample of three institutions for the developmentally disabled?
4. What, if any, relationships exist between staff knowledge of client rights, as established by laws and regulations, between persons with different job longevity rates?

The results of this study indicate that significant differences exist between the different job categories, but not between the different institutions. The effect of years of employment on staff knowledge probably is somewhat spurious or there may be a statistical

effect causing the low correlation, such as the lack of linearity when longevity is used as a factor. Also, Group 6 (Patient Advocates/Human Rights Committee Members) appears to have too small a sample to be useful in the data analysis. This group may have had an abnormal distribution because of the small sample size. Groups 1 (Health Service Workers) and 2 (Paraprofessionals/Trainers) were never significantly different nor were Groups 4 (Professionals) and 5 (Administrators). These four groups appear to form two factors: Factor 1, Group 1 (Health Service Workers) and 2 (Paraprofessionals/Trainers) and Factor 2: Group 4 (Professionals) and 5 (Administrators). Group 3 (Non-Professionals/Non-Direct Care) seemed to often differ from the other groups and so would form a single factor.

Results of this study also indicate that there are differences between job categories of staff regarding their knowledge of specific client rights issues. It was found that several employee groups some staff lacked knowledge on certain rights issues; their scores tended to fall below 80%, which was arbitrarily selected as indicating a need for training in those areas. In addition, it was found that several job categories of staff possibly need more intensive training on certain rights issues. Their scores tended to fall below 60%, which was also arbitrarily selected for this study.

No statistical test of validity and reliability were applied but review of the results suggest that the instrument discriminated adequately between groups and there was sufficient consistency within groups to suggest ample reliability and validity for the purpose of this study.

When different job categories of staff were compared in each of the three institutions, significant differences were found in each of the institutions. Staff knowledge base on certain client rights was also different in the job categories of the three institutions, as shown in Tables 2-10.

In the Colin Anderson Center, Non-Professional/Non-Direct Care staff ($\bar{x}$=13) were significantly different from the Health Service Workers ($\bar{x}$=16), Professionals ($\bar{x}$=18) and Administrators ($\bar{x}$=19). Paraprofessionals/Trainers ($\bar{x}$=15) were significantly different from Professionals ($\bar{x}$=18) and Administrators ($\bar{x}$=19).

In accordance with the criteria established in Chapter three, Health Service Workers appeared to have a sufficient knowledge base on 11 of the 25 client rights, but lacked knowledge in the 14 rights areas. Paraprofessionals/Trainers exhibited an understanding of only 2 of the 25 rights issues and lacked understanding in 23 areas. Non-Professional/Non-Direct Care staff were knowledgeable in only 7 of the 25 rights issues and were not knowledgeable in 18 rights area. Professionals were knowledgeable in 12 of the 25 client rights and were not knowledgeable in 13 rights areas. Administrators understood 15 of the 25 rights issues and lacked knowledge in 10 rights areas. Patient Advocates and/or Human Rights Committee Members were knowledgeable in 9 of the 25 rights issues and lacked knowledge in 16 rights areas. It should be noted that there were three individuals that participated as Patient Advocates and/or Human Rights Committee Members. One of the participants scored 44% on the questionnaire which brought down the

overall score within this job category. Identification of specific rights areas of which the different job categories of staff appeared to lack knowledge can be found in appendix C.

Colin Anderson Center's staff consistently showed a lack of knowledge in the following client rights areas: Freedom from Chemical Restraints; Freedom from Mechanical Restraints; Information/Notice Provided (Fully Informed); Least Restrictive Environment/Alternative Placement; and Program Treatment Plan.

In the Greenbrier Center significant differences were found between Non-Professional/Non-Direct Care staff ($\bar{x}$=15) and Administrators ($\bar{x}$=19). Significant differences were also found between Health Service Workers ($\bar{x}$=16) and Administrators ($\bar{x}$=19).

Health Service Workers knowledge of client rights were adequate in 13 of the 25 rights issues. They appeared to lack knowledge in 12 rights areas. Paraprofessionals/Trainers exhibited an understanding in 9 of the 25 rights issues and had less understanding of 16 rights areas. Non-Professional/Non-Direct Care staff possessed sufficient knowledge only in 5 of the 25 client rights and lacked knowledge in 20 rights areas. Professionals showed they possessed knowledge in 14 of the 25 rights issues and lacked a clear understanding of 11 rights areas. Administrators were also knowledgeable in 14 of the 25 rights issues and were not knowledgeable in 11 rights areas. Patient Advocates and/or Human Rights Committee Members had an adequate knowledge base in 20 of the 25 client rights and inadequate in 5 rights areas. For further clarification of which rights areas the different job categories of staff appeared to lack knowledge, refer to appendix D.

Throughout all job categories at Greenbrier Center, it was found that the only client rights that was consistently misunderstood was the right to Freedom from Mechanical Restraints.

In the Spencer Hospital, Non-Professional/Non-Direct Care staff ($\bar{x}$=14) differed significantly from Professionals ($\bar{x}$=17) and Administrators ($\bar{x}$=21). Health Service Workers ($\bar{x}$=15) differed significantly from Professionals ($\bar{x}$=17) and Administrators ($\bar{x}$=21).

Health Service Workers showed an understanding of 9 of the 25 client rights and lacked an understanding in 16 rights areas. Paraprofessionals/Trainers had knowledge in 12 of the 25 rights and lacked knowledge in 13 rights areas. Non-Professional/Non-Direct Care staff were knowledgeable only in 3 of the 25 rights areas and were not knowledgeable in 22 rights areas. Professionals understood 9 of the 25 client rights issues and did not understand 16 rights areas. Administrators knowledge of client rights was adequate in 15 of the 25 rights areas and deficient in 10 rights areas. Patient Advocates and/or Human Rights Committee Members exhibited an understanding in 22 of the 25 rights issues and did not understand 3 rights areas. Rights areas that the different job categories of staff appeared to lack understanding can be found in appendix E. In all job categories at Spencer Hospital, staff consistently showed that they did not possess a sufficient knowledge base on the following client rights: Confidentiality; Information/Notice Provided (Fully Informed); and Nondiscrimination.

Significant differences existed between the job categories in the total sample. Non-Professional/Non-Direct Care staff ($\bar{x}$=14) demonstrated a significant difference when compared to all other job categories, their mean scores being significantly lower. Professionals ($\bar{x}$=18) were significantly different from Paraprofessionals/Trainers ($\bar{x}$=15) and Health Service Workers ($\bar{x}$=16), as well as from Non-Professional/Non-Direct Care staff ($\bar{x}$=14). Administrators ($\bar{x}$=19) were also significantly different from Paraprofessionals/Trainers($\bar{x}$=15) and Health Service Workers ($\bar{x}$=16), as well as Non-Professional/Non-Direct Care staff ($\bar{x}$=14). Patient Advocate and/or Human Rights Committee Members ($\bar{x}$=19) differed significantly only when compared to Non-Professional/Non-Direct Care staff ($\bar{x}$=14).

As shown in appendix F, Health Service Workers demonstrated knowledge in 11 of the 25 client rights and lacked knowledge in 14 rights areas. Paraprofessionals/Trainers understood 9 of the 25 right issues and did not understand 16 rights areas. Non-Professional/Non-Direct Care staff were knowledgeable only in 5 of the 25 rights issues and were not knowledgeable in 20 rights areas. Professionals exhibited knowledge in 12 of the 25 client rights and lacked knowledge in 13 rights areas. Administrators showed an understanding in 14 of the 25 rights issues and lacked understanding in 11 rights areas. Patient Advocates and/or Human Rights Committee Members exhibited an adequate understanding in 17 of the 25 client rights and lacked a clear understanding in 8 rights areas.

In all job categories in the three institutions, staff consistently appeared to be deficient in the following client rights areas: Confidentiality; Freedom from Mechanical Restraints; Information/Notice Provided (Fully Informed); Least Restrictive Environment/Alternative Placement; Nondiscrimination; Privacy; and Treatment and Care. Reasons for these apparent consistencies are discussed below.

As previously mentioned, the Patient Advocates and/or Human Rights Committee Members appeared to have been too small a sample to be useful in the data analysis. Within the institutions, this job category proved not to be significantly different than any other group. In looking at the total job categories in all three institutions, the Patient Advocates and/or Human Rights Committee Members showed to be significantly different only from Non-Professional/Non-Direct Care staff.

West Virginia's institutions for the developmentally disabled may be unique when it comes to the issues of client rights. Since 1981, state-operated institutions in West Virginia have been ordered through litigation of the Medley Decree and the Hartley Order, to develop and implement policies on client rights. The responsibility of implementing client rights policies has been given to the Administrators and Professional staff. Monitoring of client rights in conformity with these policies has been the responsibility of Patient Advocates and/or Human Rights Committee Members. The results of this study indicate that these three job categories of staff scored on the average, higher than the rest of the participants. Also, staff training on major client

rights has been provided within the last year to all new employees and Health Service Workers.

Results indicated that certain rights issues were most often missed by all staff, for example: Access to Records; Appeals Process; Communication; Confidentiality; Consent to Treatment; Freedom from Neglect; Freedom from Chemical Restraints; Freedom from Mechanical Restraints; Information/Notice Provided (Fully Informed); Least Restrictive Environment/Alternative Placement; Nondiscrimination; Privacy; Program Treatment Plan; Treatment and Care; and Work/Labor Compensation. In addition, one week prior to the distribution of the questionnaires, all employees at the three institutions were counseled in the areas of physical and verbal abuse toward clients. This was mandated by the West Virginia Civil Service Commission, because of the increased incidents of reported client abuse. Results from the study showed that overall knowledge base in these two rights areas were high among all staff. These factors may have influenced the results of this study.

Furthermore, it can be speculated that job assignments and responsibilities may have affected staff knowledge of client rights. Staff did appear to exhibit a more adequate understanding of rights issues that were directly related to their job assignments. This was evident with Health Service Workers and Paraprofessionals/ Trainers. These two job categories of staff showed sufficient knowledge on rights areas that addressed direct care services; maintenance of personal property and clothing, right to refuse treatment, and visiting

privileges. Staff did, however, exhibit a lack of understanding in rights areas that were related to non-direct care services: confidentiality, right to information/notice provided (fully informed), and right to least restrictive environment/alternative placement. This trend appeared to be consistent throughout most of the job categories. The only job category that deferred was Non-Professional/Non-Direct Care staff. Historically, Non-Professional/Non-Direct Care staff in West Virginia's institutions have received little or no training on client rights issues. The lack of training could have accounted for the persistent low scores exhibited within each institution, when compared overall with other job categories.

In addition, current Department of Health policies regarding the use of chemical restraints, mechanical restraints, and seclusion may have affected staff responses toward these rights areas. Department policies prohibit the use of aversive conditioning procedures for individuals residing in West Virginia institutions for the developmentally disabled. For this reason, staff that showed a limited understanding in these rights areas may have been influenced by the lack of applicability toward their institutional setting and client population.

It can also be speculated that the prevailing negative attitude of some staff could have affected their understanding of client rights. There may have been some staff who viewed the clients as incapable of functioning as normal human beings. They may have felt that certain rights areas were not applicable to developmentally disabled persons, because of their handicapped condition. There appeared to be a

misconception by staff that handicapped persons residing in institutions have the same basic rights that are afforded to all citizens.

The following are recommendations that may assist in alleviating deficiencies in staff knowledge of client rights:

1. Develop and implement a comprehensive training program that addresses all areas of client rights.
2. Train all job levels of employees.
3. Provide more than one training session, i.e., every three months, six months, or yearly.
4. Involve in training session at least one respresentative from each of the six different job categories of staff.
5. Implement procedures to evaluate staff knowledge of client rights by means of a pre and post survey instrument.
6. Develop policies that address all areas of client rights.
7. Develop policies and procedures that are clearly stated and unambigious.
8. Develop a State-level office on advocacy for patient/client rights.

These recommendations, and their effect toward alleviating deficiencies in staff knowledge of client rights, may also provide implications for further research. Recommendations and implications for future research will be further discussed within this chapter.

No overall differences existed between the three institutions for the developmentally disabled in terms of staff knowledge of client rights issues. There appeared to be no relationship between the size of

the institution and the staff knowledge of rights issues, which contradicts the findings cited by Begab (1967); Moores and Grants (1976); and Williams (1981) in the literature.

Although staff training has been consistently provided in all three institutions, there appears to have been some selective factor operating in that individuals in different job categories have learned client rights in a differential manner. Either the training, the manner in which the staff perceived the training, or other selective factors seem to be related to job categories rather than the location of the institution, who provided the training, or where the training took place. The basic difference does not appear to be between institutions but between job categories in terms of which rights issues they understand and how well they understand them. It can be determined that the difference between one job category and another is related to clusters of rights issues; by identifying those rights issues, institutions can better focus their training efforts.

Very little relationship was found to exist between staff knowledge of client rights and years of employment. The significance the correlation coefficient, Pearson r of - .08, indicated that it cannot be considered to be relevant. Contrary to what the literature suggests, there was not a major difference based on years of employment. In fact, there was a slight inverse relationship, notwithstanding to the findings cited by Bensberg (1974) and Williams (1981) in the literature. It cannot be inferred from the results that the longer individuals have been employed in a job, the less likely they are to be aware of client

rights. An important factor to considered is that within the last year, all staff have had some form of client rights training, which may have brought the newest employee up to the level of longer tenured employees. This factor might have influenced the results in a way that contradicts what would otherwise be predicted. However, this does not explain why the slight relationship that does exist is in a negative direction.

This study attempted to answer the following research questions:

1. Q. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between persons in different job categories within different institutions for the developmentally disabled?

   A. When different job categories are compared within each of the three institutions, significant differences are found.

2. Q. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between the three institutions for the developmentally disabled without regard to job categories?

   A. No significant differences exist between the three institutions in staff knowledge of client rights.

3. Q. What, if any, differences exist between staff knowledge of client rights, as established by laws and regulations, between persons in different and similar job categories in the total sample of three institutions for the developmentally disabled?

A. Significant differences exist between between the job categories in the total sample.

4. Q. What, if any, relationships exist between staff knowledge of client rights, as established by laws and regulations, between persons with different job longevity rates?

A. Significant relationships could exist based on the probability level equaling .015. However, little practical confidence can be given to a correlation coefficient of only -.08.

It is evident from the results that differences do exist between job categories of staff regarding their knowledge of client rights. It is also evident from the results that the difference in staff knowledge is related to their lack of understanding of certain rights issues. The results indicate implications for further training with those job categories of staff who lack knowledge in the more subtle areas of client rights. In addition to staff training, results of this study have implications for further policy development in the more subtle areas of client rights issues as well as for further clarification of those rights issues.

Although this study provided a research strategy for investigating staff knowledge of client rights in institutions, it suggests a need for further research. The West Virginia Department of Health plans to use the results of this study in developing and implementing future staff training programs, as well as improving current policies and procedures. In order to investigate the impact of those changes, a

post-test should be provided to see if staff in the different job categories have a better understanding of client rights.

As indicated in the review of the literature, 25 major client rights affect developmentally disabled persons in West Virginia's institutions. As we have seen, there is variation in how different job categories of staff perceive the many rights issues. Another implication for future research is that one could investigate the reasons why certain job categories of staff consistently exhibit a lack of knowledge in certain rights areas. Also, why do certain job categories of staff have a clearer understanding of certain client rights. It is apparent that each of the 25 client rights are subject to future research.

In addition, this study needs to be replicated in another state to see whether the findings are unique to institutions for the developmentally disabled in West Virginia or whether they apply in other state institutions as well. Also, a similar study needs to be implemented in institutions that serve a different population of clients, for example, psychiatric facilities, to see if the findings in institutions for the developmentally disabled hold true for other types of institutions. Research of this kind should help all interested parties to better understand the nature of staff knowledge of client rights.

BIBLIOGRAPHY

BIBLIOGRAPHY

Anderson, R. J. The effects of verbal and visual cues on attitudes toward disabled persons. Unpublished doctoral dissertation, University of North Carolina at Chapel Hill, 1980.

Armstrong, B. A question of abuse: where staff and patient rights collide. Hospital and Community Psychiatry, 1979, 30 (5), 348-351.

Balla, D. A., Butterfield, E. C. and Zigler, E. Effects of institutionalization on retarded children. American Journal of Mental Deficiency, 1974, 78 (5), 531-549.

Balla, D. A. Relationship of institution size to quality of care. American Journal of Mental Deficiency, 1976, 81 (2), 117-124.

Baroff, G. On "size" and the quality of residential care. Mental Retardation, 1980, 113-117.

Baumeister, A. A. Mental retardation policy and research: the unfulfilled promise. American Journal of Mental Deficiency, 1981, 85 (5), 449-456.

Begab, M. J. The effects of difference in the curricula and experience on social work students attitudes and knowledge about mental retardation. Unpublished doctoral dissertation. The Catholic University of American, 1967.

Belkap, I. Human problems of a state mental hospital New York: McGraw-Hill, 1956.

Bensberg, G. J. Administration and staff development in residential facilities. Mental Retardation, 1974, 29-32.

Bjaanes, A. T., and Butler, E. W. Environmental variation in community care facilities for mentally retarded persons. American Journal of Mental Deficiency, 1974, 78 (4), 429-439.

Blatt, B. Exodus from pandemonium. Boston: Allyn and Bacon, 1970.

Bourland, G. Analysis of 1980 residents advocate study. Unpublished manuscript, 1980. (Available from Colin Anderson Center, St. Marys, West Virginia).

Bruininks, R. H., Myers, C.C., Sigford, B. B., and Lakin, K. C. Deinstitutionalization and community adjustment of mentally retarded people, Monograph of the American Association of Mental Deficiency, 1981.

Burgdorf, R. L., and Spicer, P. P. The legal rights of handicapped persons, Baltimore/London: Brookes, 1983.

Byrne, D.H., and Broughton, L.C. Annual report of compliance with the West Virginia behavioral health care delivery system plan. West Virginia Department of Health, 1984.

Coser, R. L. The hospital in modern society. New York: The Free Press, 1963.

Coye, J. L., and Clifford, D. A one-year report on rights violations under Michigan's new protection system. Hospital and Community Psychiatry, 1978, 29 (8), 528-533.

Crissey, M. S. Mental retardation: past, present, and future. American Psychologist, 1975, 800-820.

Decisions. Mental Disability Law Reporter, 1983 7 (5), 382-383.

DeKoven, T., Miller, C.R., and O'Conner, G. Selected variable of institutional employees by patient contact and length of employment. American Journal of Mental Deficiency, 1967, 71 (1), 101-108.

Dellinger, J. K., and Shope, L. J. Selected characteristics and working conditions of direct service staff in Pennsylvania CLA's. Mental Retardation, 1978, 19-21.

Emener, W. G. Stilwell, W. E., and Witten, B. J. Delivering human services for abused clients: a system and individual approach. Family and Community Health, 1981, 4 (2), 71-83.

Felsenthal, D., and Scheerenberger, R. C. Stability and attitudes of primary caregivers in the community. Mental Retardation, 1978, 16-18.

Ferleger, D. The future of institutions for retarded citizens. Mental Retardation and the Law, 1978, 28-42.

Festinger, L. A theory of cognitive dissonance. New York: Harper and Row, 1957.

Friedman, P. R. The rights of mentally retarded persons, American Civil Liberties Union: Avon, 1976.

Gander, J. M., and Giampa, F. L. The attendant behavior checklist: measuring on-the-ward behavior of institutional attendants. American Journal of Mental Deficiency, 1971, 75 (5), 617-622.

Gelman, S. R. Legislation as an impediment to change: impact on the

rights of mentally retardated. Sexual Rights and Responsibilities of the Mentally Retarded, Proceedings of the Conference of the American Association on Mental Deficiency, Region IX, October 1972, 49-57.

Gettings, R. B. Appeals court uphold grounds for Pennhurst suit; content proceedings against Pennsylvania officials sustained. Intelligence Report, April 1982, Bulletin No. 88-21, 1-5.

Gettings, R. B. Supreme court rules retarded residents have limited constitutional rights. Intelligence Report, June, 1982, Bulletin No. 82-39, 1-5

Griffith, R. Client abuse: broadening the perspective. Superintendents Digest, 1984, 3 (2), 46-52.

Grob, G. N. Abuse in American mental hospitals in historical perspective myth and reality. International Journal of Law and Psychiatry, 1980, 3, 295-310.

Grossman, H. J. Classification in mental retardation, Published by American Association on Mental Deficiency, 1983.

Haavik, S. F., and Menninger, K. A. Sexuality, law, and the developmentally disabled person, Baltimore/London: Brookes, 1981.

Hardman, M. L., and Drew, C. J. Life management practices with the profoundly retarded: issues of euthanasia and withholding treatment. Mental Retardation, 1978, 390396.

Harrell, S. A., and Orem, R. C. Preventing child abuse and neglect: a guide for staff in residential institutions. U.S. Department of Health and Human Services, DHHS Publication No. (OHDS) 80-30255, April 1980.

Henerson, M. E., Morris, L. L, and Fitz-Gibbon, C. T. How to measure attitudes, Beverly Hills/London: Sage, 1983.

Howell, H. H. and May, A. e. Resident-care practices in the county of Somerset, England. American Journal of Mental Deficiency, 1980, 84 (4), 393-396.

Kahne, M. J. Suicide in mental hospitals: a study of the effects of personnel and patient turnover. Journal of Health and Social Behavior, 1968, 9, 255-266.

Kapp, M. B. Patient rights and mental health. Urban Health, November 1981, 41-44.

Kemp, D. R. Resident advocates: a mechanism for protecting the rights

of institutionalized mentally retarded. Journal of Mental Health Administration, 1984, 11 (2), 48-51.

King, R. D., and Raynes, N. V. Patterns of institutional care for the severely subnormal. American Journal of Mental Deficiency, 1968, 72, 700-709.

Kopolow, L. Attitudes towards patients' rights, advocacy program examined. Au Contraire, 1981, 1 (8), 7.

Ladimer, L. The role of the arbitration process in changing mental illness and mental retardation systems. Psychiatric Quarterly, 1982, 54 (2), 123-137.

Lecklitner, G. L. and Greenberg, P.D. Promoting the rights of the chronically mentally ill in the community: a report on the patient rights policy research project. Mental Disability Law Reporter, 1983, 7 (5), 422-429.

Loadman, W. E., Parnicky, J. J., and Schober, E. J. Manual on standards for services affecting the developmentally disabled, The Nisonger Center for Mental Retardation and Developmental Disabilities, Ohio State University, Columbus, Ohio, July 1978.

Magrab, P. R. and Elder, J. O. Planing for services to handicapped person, Baltimore/London: Brookes, 1979.

McGarry, A. L and Kaplan, H. Overview: current trends in mental health law. American Journal of Psychiatry, 1973, 130 (6), 621-630.

McLain, R. E., Silverstein, A. B., Hubbell, M., and Brownlee, L. The characterization of residential environments within a hospital for the mentally retarded. Mental Retardation, 1973, 24-27.

McPheeters, H. L. Implementing standards to assure the rights of mental patients, U.S. Department of Health and Human Services, DHHS Publication No. (ADM) 80-860, 1980.

Mesibov, G. B. Mentally retarded people: 200 years in American. Journal of Clinical Child Psychology, 1976, 5, 17-21.

Moores, B. and Grant, G.W. Nurses' expectation for accomplishment of mentally retarded patients. American Journal of Mental Deficiency, 1976, 80 (6), 644-649.

Ostrander, S. A. The impact of clients' rights Legislation on hospital staff. Administration in Mental Health, 1982, 9 (4), 25-271.

Overbeck, D. B. Perception of change attendant task priorities by two classes of institutional administrators. Training School

Bulletin. 1972, 23 (1), 155-159.

Paschall, N. C. and Eichler A. Rights promotion in the 1980s. Mental Disability Law Reporter, 1982, 6 (2), 116-121.

Paschall, N. C., Konick, A. J., and Ostrander, S. A. Institutional advocacy: impact one year after legislative change. Administration in Mental Health, 1982, 10 (2), 136-144.

Prior, M., Minnes, P., Coye, T., Golding, B., Hendy, J., and McGillivary, J. Verbal interaction between staff and residents in an institution for the young mentally retarded. Mental Retardatrion, 1979, 65-69.

Prothero, J. C., and Ehlers, W. H. Social work students' attitude and knowledge changes following study of programed materials. American Journal of Mental Deficiency, 1974, 79 (1), 83-86.

Schreenberger, R. C. A model for deinstitutionalization. Mental Retardation, 1974, 3.

Schreenberger, R. C. A study of public residential facilities. Mental Retardation, 1976, 32-35.

Schreenberger, R. C. Managing residential facilities for the developmentally disabled. Springfield: Thomas, 1975.

Schmidmayr, B. and Weld, R. G. Attitudes of institution employees toward resident-oriented activities of aides. American Journal of Mental Deficiency, 1971, 76 (1), 1-4.

Standards for institutions for mentally retarded persons with related conditions. Department of Health, Education and Welfare, Social Security Administration, 1977.

Standards for services for developmentally disabled individuals. Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Person, 1983.

Stannard, C. I. Old folks and dirty work: the social conditions for patient abuse in a nursing home. Social Problems, 1973, 20 (3), 329-342.

Summary and analysis. Mental Disability Law Reporter, 1981, 5 (1), 306.

Summary and analysis. Mental Disability Law Reporter, 1980, 4 (4), 219-245.

Sundran, C. J. Obstacles to reducing patient abuse in public institutions. Hospital and Community Psychiatry, 35 (3), 1984, 238-243.

Thormahlen, P. W. A study of on-the-ward training of trainbalbe mentally retarded children in a state institution. California Mental Health Research Monograph, 1965, 5.

Tizard, J. Community services for the mentally handicapped. London: Oxford University Press, 1961.

VanBiervliet, A., and Sheldon-Wildgen, J. Liability issues in community-based prgorams, Baltimore/London: Brookes, 1981.

Veit, S. W., Allen G. J., and Chinsky, J. M. Interpersonal interactions between institutionalized retarded children and their attendants. American Journal f Mental Deficiency, 1976, 80 (5), 535-542.

Wegman, M., Lancaster, J., Bruhn, J. G., and Fuentes, R. G. Child neglect and abuse. Family and Community Health, 1981, 4 (2), 11-17.

Wheeler, A. J., Wells, M. E., and Bradish, V. The Identification of variance in assessing resident abuse. Unpublished manuscript, 1982. (Available from Murdoch Center, Butner, N.C.).

Wicklund, R. Perspective on conginitive dissonance. Hillsdale, N.J.: Eralbaum, 1976.

Wikler, L, and Keenan, M.P. Developmental disabilities no longer a private tragedy, Silver Spring: National Association of Social Workers, 1983.

Williams, R. R. Staff sensitivty to dehumanization of the mentally retarded. Unpublished doctorial dissertation. The University of North Carolina at Chapel Hill, 1981.

Wolfensberger, W. Will there always be an institution? Mental Retardation, 1971, 1-7.

Wolfensberger, W. and Kugel, R. (eds.) Changing patterns in residential services for mentally retarded. (President's Committee on Mental Retardation, Publication No. SNRR1289040-000-00365-7), Washington ,D.C.: U.S. Government Printing Office, 1969.

Zoharia, E. S. and Baumeister, A. A. Technician turnover and absenteeism in public residential facilities. American Journal of Mental Deficiency, 1978, 82 (6), 580-593.

Zigler, E. and Balla, D.A. Impact of institutional experience on the behavior and development of retarded persons. American Journal on Mental Deficiency, 1977, 82 (1), 1-11.

APPENDIX A

APPLICABLE RIGHTS STANDARDS ACCORDING TO ACCREDITATION AGENCY, STATE, AND FEDERAL SOURCES AFFECTING DEVELOPMENTALLY DISABLED CLIENTS RESIDING IN WEST VIRGINIA STATE-OPERATED BEHAVIORAL HEALTH FACILITIES

APPLICABLE RIGHTS STANDARDS
ACCORDING TO ACCREDITATION AGENCY, STATE, AND FEDERAL SOURCES
AFFECTING DEVELOPMENTALLY DISABLED CLIENTS RESIDING
IN WEST VIRGINIA STATE-OPERATED
BEHAVIORAL HEALTH FACILITIES

In the past, most state and federal legislation was aimed at the protection of society from developmentally disabled individuals. For those who were institutionalized, little or no "rights" were provided for their protection and care. Most recently, this trend was changed with the advent of case law, state laws, federal laws, and the establishment of accreditation agencies which require assurance of the rights of persons who are developmentally disabled. In West Virginia, there have been many changes for the protection of clients' rights. Protection has occurred as the result of two major state litigation cases, changes within the State Code, impact of federal public laws, and the influence of accreditation agencies.

Through these sources, standards regarding clients' rights have been established. The National Institute of Mental Health, 1977, defines standards as "the criteria and measures by which one can judge whether orders are being carried out." Although helpful, these standards have converged on the state-operated institutions so quickly and in such vast numbers, that staff have expressed concerns regarding their knowledge of existing standards and their related sources.

This document represents an effort to integrate the many rights standards from accreditation agencies, state, and federal sources that affect developmentally disabled clients in West Virginia's state-operated institutions. Hopefully, it will assist administrators and staff in assessing compliance with mandated standards and the development of future policies and procedures.

It is important to note that this material is limited to clients'

rights standards which were derived from documents (accreditation agencies, state and federal sources) that made reference to rights of individuals residing in institutional or residential facilities. Please keep in mind that this investigator did not review every section of each document, only those sections that referred to institutional and residential rights issues. For this reason, rights standards that were not shown as applicable could possibly be addressed in another section of this document.

Some may ask why this investigator reviewed all areas of clients' rights issues that affect developmentally disabled individuals who are residing in West Virginia's state-operated institutions. The system of facility in which the client resides can violate his/her rights by not specifying procedures for carrying out those rights. In most instances, the facility develops and attempts to implement policies and procedures; provide appropriate services; and, establish an environment that is conducive to the protection of those rights. It is the individual staff member in those facilities who has the real task and responsibility in protecting each client's rights. This study proposes to investigate staff's knowledge of clients' rights issues as it pertains to abuse and neglect. It is the opinion of this investigator that clients' rights, for the most part, can only be violated by a staff member by means of abuse or neglect.

This opinion is reflected in most state statutory provisions governing the protection of developmentally disabled individuals. In 1982, Barry University of Miami Shores, Florida, did a survey of 44

states regarding their state statutes. It was found that 38 states indicated that "abuse is to injure or damage someone, as well as the intentional failure to do or provide something to or for a disabled person," and that "neglect is the failure to do something or leave something undone.' Although the terminology is broad, it does imply that for individual member of of the staff to directly violate a clients right, involves an abusive or neglectful act. Also, this was the theory under which New York State Association for Retarded Children, Inc., v. Carey, the "Willowbrook" case, was decided. In May of 1974, the Federal District Court indicated that institutionalized mentally impaired individuals' rights cannot only be violated through neglect, but also from any form of abusive act which might limit those rights and cause regression or prevent development of an individual's physical, intellectual, emotional, or social growth. Other previous research finding such as Bourland (1980), Coye and Clifford (1973), and Williams (1981), have found that most alleged violations of clients' rights by staff are the result of some form of neglectful or abusive act.

DEFINITIONS
OF
Accreditation Agency, State, and Federal Sources

1. Accreditation Council for Services for Mentally Retarded and Other Developmentally Disabled Persons (AC/MRDD):

   The Council is a consortium of professional, service provider, and consumer advocate organizations working to improve services for developmentally disabled individuals by:

   - developing valid standards for service of high quality;
   - providing instruction in the meaning and implementation of the standards and encouraging their use;
   - developing reliable means of assessing compliance with the standards;
   - assessing on request, the compliance of agencies with the standards; and
   - awarding accreditation to agencies found to be in substantial compliance with the standards.

2. West Virginia Department of Health, Policy 3050 (D.O.H. Policy 3050):

   Policies governing visiting privileges.

3. West Virginia Department of Health, Policy 3052 (D.O.H. Policy 3052):

   Guidelines for Personal Spending by Patients from Patient Trustee Accounts.

4. West Virginia Department of Health, Policy 3152 (D.O.H. Policy 3152):

   Department regulations regarding patient records in state mental health facilities.

5. West Virginia Department of Health, Policy 3311 (D.O.H. Policy 3311):

   Department policies regarding physical and verbal abuse of patients.

6. West Virginia Department of Health, Policy 3325 (D.O.H. Policy 3325):

   Policies in the Department of Health regarding treatment of patients in behavioral health facilities.

7. West Virginia Department of Health, Policy 3450 (D.O.H. Policy 3450):

   Department policy regarding Research in State Mental Health/Mental Retardation Facilities.

8. West Virginia Department of Health, Policy 3542 (D.O.H. Policy 3452):

   Department policy regarding Patient Labor in state-operated mental health facilities.

9. West Virginia Department of Health, Policy 3543 (D.O.H. Policy 3543):

   Policies regarding Recreational and Social Activities for Patients.

10. West Virginia Department of Health, Policy 8000 (D.O.H. Policy 8000):

    Patient Grievance Procedure.

11. West Virginia Department of Health, Policy 8000.02 (D.O.H. Policy 8000.02):

Department guidelines regarding Patient's Rights to Communicate

12. Hartley Decree (Hartley order/Hartley):

E.H. v. Matin case, commonly called the "Hartley Decree" and now being referred to as the West Virginia Behavioral Health Care Delivery System Plan," was filed in the West Virginia Supreme Court in 1981 on behalf of four women patients in Huntington State Hospital. The suit alleged the women lacked a basic treatment plan, therefore, proper treatment was not provided.

In November of 1981, the West Virginia Supplement Court ruled that State Law gave mental hospital patients the right to treatment and that this right could be enforced by the courts. The Court ruled that the lack of treatment of the four petitioners was typical throughout the State mental health system. Accordingly, the Court ordered the Department of Health to develop a comprehensive plan to correct the deficiencies in the State mental health system, to refurbish the State hospitals and to assure that all patients would receive appropriate treatment based on nationally recognized standards of care and their individual treatment needs.

The parties involved, through lengthy planning and negotiating sessions agreed upon the master plan now called the "Hartley Plan" for the reform of the State's behavioral health system. The plan was filed with and approved by the Kanawha County Circuit Court in November of 1983.

13. Hartley Order(s) (Hartley Order 3050 - 8000.02):

Hartley order 3050 to 800.02 are in reality Department of Health policies which were included in the "Hartley Court Order - West Virginia Behavioral Health Care Delivery System Plan." These documents can be found under Department of Health Policies 3050 - 8000.32, respectively.

14. Immediate Care Facility/Mental Retardation (ICF/MR):

A state-operated facility for the mentally retarded or persons with related conditions that provides health and rehabilitative services. Clients of th facility require care above the level of room and board, however, they do not require the degree of care necessary for placement in a hospital of nursing facility. In order to continue their eligibility for federal Title XIX funds, they must have met standards specified by federal regulations.

15. Joint Commission on Accreditation of Hospitals (JCAH):

The Joint Commission on Accreditation of Hospitals (JCAH) is composed of the American College of Physicians, American College of Surgeons, American Hospital Association, and American Medical Association. Its primary role is to coordinate efforts of its Accreditation Councils.

JCAH awards accreditation for psychiatric and substance abuse hospitals, facilities, and programs that consistently demonstrate excellence in areas that most directly affect patient care.

16. Office of Behavioral Health Services, Licensing Review Documents (License Regulations - D.O.H.):

The West Virginia Department of Health uses several resources to review behavioral health centers for licensing. The Division of Health Facilities Evaluation provides a coordinating role in which they provide information to the public, take applications from centers, review health and physical safety issues, collect reports from other division and the Fire Marshall, prepare a collective recommendation to the Director, and keep track of licenses issues. The Office of Behavioral Health Services reviews treatment and client rights issues and prepares a report for Health Facilities Evaluation's use.

In order to prepare licensing reports, all offices or divisions use the Behavioral Health Licensing Regulations Survey Report Form.

The Office of Behavioral Health Services reviewers check each treatment and human rights regulation. Additionally, reviewers who note potential problems on other regulations notify Health Facilities Evaluation in order to assure a thorough review of the problem.

17. Macel Medley v. Leon Ginsberg (Medley Decree):

On October 8, 1981, the federal district court approved a settlement of a case involving the rights of mentally retarded children and young adults at Colin Anderson Center, Greenbrier

Center, Weston, Spencer, Lakin, Huntington and Hopemont Hospitals. The case is a class action suit brought on behalf of mentally retarded persons who are institutionalized because of lack of community services and residential facilities to meet their needs. The settlement guarantees class members the right to treatment, education, and placement in the least restrictive setting appropriated to them as individuals.

18. West Virginia Department of Health Orientation Manual (Orientation Training):

The manual is to provide a resource for the development of orientation programs in the facilities. The material meets all mandates of Hartley standards and Department of Health orientation policies. This resource manual attempts to assure that attitudes consistent with the Hartley Plan philosophies are conveyed in the orientation programs.

The orientation program is not to build skills or to give any indepth understanding, but rather provide employees with:

- an introduction to the facility; what it is about; who the key staff are.
- an awareness of the role in a system of health care and how that system fits together.
- some awareness of their rights and responsibilities as employees and to direct them to resources for answers to specific questions.

- a certain attitude about mental illness, developmental disabilities, and elderly patients; an attitude that such clients can be helped through treatment or training programs; and that they have the right to be treated with the same dignity and respect as any one of us.

19. Public Law 94-103

Developmental Disabilities Assistance and Bill of Rights Act (P.L. 94-103, D.D. Act);

All programs for persons with developmental disabilities should meet standards which are designed to assure the most favorable possible outcome for those served.

Congress established this law to identify the rights of persons with developmental disabilities who may reside in such programs.

20. Public Law 94-142

Education for All Handicapped Children Act (P.L. 94-142, Education Act):

Regulations guaranteeing educational rights for elementary and secondary level handicapped students.

21. Advocates Handbook on the Legal Rights of Handicapped People (WVADD);

This Manual was prepared pursuant to advocacy training of the West Virginia Advocates for the Developmentally Disabled.

22. West Virginia Code, Chapter 18, Article 20, Section 1 (W.V. Code 18-20-1):

    Education of Exceptional Children.

    Chapter 18, Article 20, charges the State Board of Education with the responsibility for establishing regulations governing programs and services for the education of exceptional students.

23. West Virginia Code, Chapter 27, Article 2, Section 3 (W.V. Code 27-2-3):

    Rules as to patients. Rules and regulations as promulgated by the board of health in regard to the admission of patients to mental health facilities, the care, maintenance and treatment of inpatients, residents and outpatients of such facilities and the release, trial visit and discharge of patients therefrom.

24. West Virginia Code, Chapter 27, Article 4, Section 1 (W.V. Code 27-4-1):

    Authority to receive voluntary patients.

25. West Virginia Code, Chapter 27, Article 4, Section 2 (W.V. Code 27-4-2):

    Right to release on application.

26. West Virginia Code, Chapter 27, Article 4, Section 4 (W.V. Code 27-4-3):

    Admission and treatment of voluntary patient; statement of rights; consent for treatment.

27. West Virginia Code, Chapter 27, Article 5, Section 4 (W.V. Code 27-5-4):

    Institution of final commitment proceedings; hearing requirements; release.

28. West Virginia Code, Chapter 27, Article 5, Section 9 (W.V. Code 27-5-9):

    Rights of patients.

29. West Virginia Code, Chapter 27, Article 11, Section 1 (W.V. Code 27-11-1):

    Committees; appointment.

30. West Virginia Code, Chapter 27, Article 11, Section 4 (W.V. Code 27-4-1):

    Powers and duties of committee generally.

31. West Virginia Code, Chapter 27, Article 16, Section 1 (W.V. Code 27-16-1):

32. West Virginia Code, Chapter 29B, Article 4, Section 1 (W.V. Code 29B-1-1):

    West Virginia Freedmon of Information Act.

33. West Virginia Code, Chapter 44, Article 10A, Section 1 (W.V. Code 44-10A-1):

    Guardianship of mentally retarded and mentally handicapped persons generally.

34. West Virginia Code, Chapter 44, Article 10A, Section 1 (W.V. Code 44-10A-3):

    Duration of guardianship.

APPLICABLE RIGHTS STANDARDS ACCORDING TO STATE, FEDERAL, AND ACCREDITATION AGENCY SOURCES AFFECTING DEVELOPMENTALLY DISABLED CLIENTS RESIDING IN WEST VIRGINIA STATE-OPERATED BEHAVIORAL HEALTH FACILITIES

Types of State, Federal, and Accreditation Agency Sources / Applicable Rights Standards	Access to Records	Appeal Process	Civil, Legal, and Human Rights	Communication	Confidentiality	Consent to Treatment	Education	Freedom from Neglect, Physical Abuse, and Verbal Abuse	Freedom from Chemical and Mechanical Restraints	Freedom from Seclusion	Information/Notice Provided (Fully Informed)	Least Restrictive Environment/Alternative Placement	Maintain Personal Property and Clothing	Manage Personal Finances	Nondiscrimination	Participate in Program/Treatment Planning	Privacy	Program Treatment Plan	Refuse Treatment	Treatment and Care	Visiting Privileges	Work/Labor Compensation
A.C.M.R./DD		X	X			X		X			X		X	X		X	X	X			X	X
D.O.H. Policy 3098																	X	X			X	
D.O.H. Policy 3052					X								X	X								
D.O.H. Policy 3152	X				X	X					X											
D.O.H. Policy 3311			X					X	X													
D.O.H. Policy 3325						X			X	X	X	X				X		X	X	X		
D.O.H. Policy 3490																		X				
D.O.H. Policy 3500						X					X											
D.O.H. Policy 3542								X			X							X				X
D.O.H. Policy 3543																X		X				
D.O.H. Policy 8000		X			X						X				X							
D.O.H. Policy 8000.02				X													X					
Hartley Order 3098																	X	X			X	
Hartley Order 3052					X								X	X								
Hartley Order 3152	X				X	X					X											
Hartley Order 3311			X					X	X													
Hartley Order 3325						X			X	X	X	X				X		X	X	X		
Hartley Order 3490																		X				
Hartley Order 3500						X					X											
Hartley Order 3542								X			X							X				X
Hartley Order 3543																X		X				
Hartley Order 8000		X			X						X				X							
Hartley Order 8000.02				X													X					
Hartley - Clothing													X			X		X				
Hartley - U.S. Physically Handicapped																				X		

APPLICABLE RIGHTS STANDARDS ACCORDING TO STATE, FEDERAL, AND ACCREDITATION AGENCY SOURCES AFFECTING DEVELOPMENTALLY DISABLED CLIENTS RESIDING IN WEST VIRGINIA STATE-OPERATED BEHAVIORAL/HEALTH FACILITIES

Types of State, Federal, and Accreditation Agency Sources / Applicable Rights Standards	Access to Records	Appeal Process	Civil, Legal, and Human Rights	Communication	Confidentiality	Consent to Treatment	Education	Freedom from Neglect, Physical Abuse, and Verbal Abuse	Freedom from Chemical and Mechanical Restraints	Freedom from Seclusion	Information/Notice Provided (Fully Informed)	Least Restrictive Environment/Alternative Placement	Maintain Personal Property and Clothing	Manage Personal Finances	Nondiscrimination	Participate in Program/Treatment Planning	Privacy	Program Treatment Plan	Refuse Treatment	Treatment and Care	Visiting Privileges	Work/Labor Compensation
Hartley - Food/Nutrition																X		X				
Hartley - Hygiene																						
Hartley - Maintenance, Safety, Emergency																						
Hartley - Medical Nurse																		X				
Hartley - Physical Environment				X														X				
Hartley - Physical Therapy																		X				
Hartley - Placement/Movement		X									X										X	
Hartley - Psychological Service																		X				
Hartley - Records					X																	
Hartley - Self Government																X						
Hartley - Speech, Audiology, Language																		X				
Hartley - Vocational/Adjunctive Therapy																		X				
Hartley - Within Community/ Intervention																		X				
I.C.F./M.R.				X		X		X			X		X	X			X		X			X
J.C.A.H.			X	X	X	X					X	X			X		X		X	X	X	
License Regulations - D.O.H.	X	X	X	X	X	X		X		X	X				X	X		X		X		
Madley Decree		X					X	X	X	X	X	X				X		X		X		
Orientation Training		X	X	X	X	X		X			X		X	X			X		X	X	X	X
P.L. 94-103 D.D. Act									X									X		X	X	
P.L. 94-142 Education Act	X	X					X				X	X				X		X				
W.V.A.D.D.		X	X	X	X	X	X	X	X	X	X		X	X			X		X	X	X	X
W.V. Code 18-20-1											X							X				
W.V. Code 27-2-3																						
W.V. Code 27-4-1																						
W.V. Code 27-4-2											X											

APPLICABLE RIGHTS STANDARDS ACCORDING TO STATE, FEDERAL, AND ACCREDITATION AGENCY SOURCES AFFECTING DEVELOPMENTALLY DISABLED CLIENTS RESIDING IN WEST VIRGINIA STATE-OPERATED BEHAVIORAL HEALTH FACILITIES

Types of State, Federal, and Accreditation Agency Sources	Applicable Rights Standards																								
	Access to Records	Appeal Process	Civil, Legal, and Human Rights	Communication	Confidentiality	Consent to Treatment	Education	Freedom from Neglect, Physical Abuse, and Verbal Abuse	Freedom from Chemical and Mechanical Restraints	Freedom from Seclusion	Information/Notice Provided (Fully Informed)	Least Restrictive Environment/Alternative Placement	Maintain Personal Property and Clothing	Manage Personal Finances	Nondiscrimination	Participate in Program/Treatment Planning	Privacy	Program Treatment Plan	Refuse Treatment	Treatment and Care	Visiting Privileges	Work/Labor Compensation
W.V. Code 27-4-3											X														
W.V. Code 27-4-4						X					X								X						
W.V. Code 27-5-4		X									X														
W.V. Code 27-5-9			X			X					X							X	X						
W.V. Code 27-11-1		X			X						X														
W.V. Code 27-11-4																									
W.V. Code 27-16-1		X									X														
W.V. Code 29B-1-1	X	X																							
W.V. Code 44-10A-1																									
W.V. Code 44-10A-3		X									X														

APPENDIX B

QUESTIONNAIRE

CLIENT RIGHTS PROJECT

The Division of Developmental Disabilities Services is attempting to survey staff knowledge of client rights issues. This is to involve all levels of staff who work at Colin Anderson Center, Greenbrier Center, and Spencer Hospital. This survey provides 25 brief descriptions of situations which may sometimes arise involving staff and clients. You are to read each situation and decided whether the staff person acted appropriately or inappropriately with respect to the client rights in the situation described. As you decide on a correct response please do not obtain assistance from any other materials of staff. We want your responses about the instance of possible violations according to client rights. Your answers will be kept confidential and you will not be expected to identify yourself. The only identifiable information will be your current job category and the number of years you have been employed in this position.

Before you start, identify on the survey sheet your job category of employment. To find what category you fall under, refer to the attached sheet labeled, "Job Categories." Next, identify how many years you have been employed in the current position you now hold. If you have been employed for less than a year, indicated your years of experience as 0. For each situation, three alternative interpretations are listed, place a check mark (☑) beside appropriate or inappropriate, the selection that you think is correct for what you have read. For purposes of this survey, appropriate means probably not a violation of a client rights. Inappropriate means a probable violation of client

rights. Please provide only one choice. It is important to consider only the facts given in each situation. Do not consider any circumstances not described within each situation. Also, answer only from the rights point of view, do not consider clinical or management issues. If you would like to make any comments about your selection or about what you have read, feel free to include them on the given lines.

When finished, return the completed survey sheet to your immediate supervisor. Thank you for your cooperation.

JOB CATEGORIES

1. Health Service Workers

   Health care workers are those staff members who provide direct residential care to clients, such as aid attendants or resident aides.

2. Paraprofessionals/Trainers

   Paraprofessionals, non-degreed professional aides, such as teacher aides, physical therapy aides, recreational aides, floor charge aide, and similar employees.

3. Non-Professional/Non-Direct Care

   Non-professional and or non-direct care staff are those persons whose job responsibilities do not involve direct client interaction such as maintenance, housekeeping, clerical and kitchen staff.

4. Professionals

   Professionals are composed of degreed professionals who serve in a service delivery capacity; this category excludes supervisory personnel. Professionals include nurses, physicians, teachers, psychologists, therapists, social workers, and similar personnel.

5. Administrators

   Administrators are those persons whose positions are primarily supervisory or administrative in nature, such as directors, program coordinators, business managers, hospital administrators, and staff supervisors.

6. Patient Advocates and/or Human Rights Committee Members

   Patient Advocates and/or Human Rights Committee Members are those

persons who provide client protection and advocacy. They may or may not be employed directly by the institutions.

A SURVEY OF STAFF KNOWLEDGE OF CLIENT RIGHTS

Name of facility _____

Job Category _____

Years of Employment _____

INSTRUCTIONS:

This survey provides 25 brief descriptions of situations which may sometimes arise involving staff and clients. You are to read each situation and to decide whether the staff person has acted appropriately or inappropriately with respect to the client rights in the situation described. Check the box marked appropriate or inappropriate according to what you have decided. Space has been provided if you wish to make any comment or to clarify your response. You do not have to comment unless you wish.

1. Bill, a retarded eighteen-year-old, with a sixth grade reading level, is requesting to look at his records. The staff tells Bill that it would be of little use for him to see them because of his limited reading ability. Instead, a staff member read his records and met with him later in the day to explain what was reviewed.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

2. Sandy, a severely retarded sixteen-year-old, often accuses male staff of sexually abusing her. In the last month, she registered six false complaints to the patient advocate. To protect the male employees from possibly being falsely accused, the staff restrict Sandy to an all female living unit and limit her contact with the advocate.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

3. Every Sunday, clients attend religious services in the activity room. Frank, an eighteen-year-old retarded male, says he does not believe in God and dares anyone to make him go! Some staff remain on the unit with Frank and allow him to sleep in until the other clients return from church.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

4. Betty, a twenty-year-old retarded female, gets moody and cries following a first time visit from her friend. The staff tells her friend not to visit Betty for a couple of weeks.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

5. It is seven days until Christmas and a local church is requesting information so that appropriate gifts can be given to all clients. The staff reviews the records and provides them with each clients last name initial, sex, and age.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

6. Ruth, a severely retarded adult, is a newly admitted client who has yet to have a commitment hearing. The staff requests that she participate in vocational and independent living skill classes. Ruth refuses to participate. Later the staff return and strongly suggest that she attend some form of skill development classes. Ruth, again, refuses to participate and dares anyone to make her attend. Some of the staff turn and walk away, leaving her on the unit with two female attendants.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

7. Kent, a severely retarded, physically handicapped, twenty-one-year-old, is requesting to attend a local public school. The staff refuse to make a referral. They feel that due to his severe handicap and age he could not qualify for admission.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

8. A staff member takes Dick and seven other severely retarded, behaviorally disordered adult clients to the ballfield. While the staff member attends to another client, Dick climbs to the top of a block wall, falls off, and breaks his arm.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

9. Pat, a retarded child, often bites others for no apparent reason. To "fight fire with fire" the staff directs those who are bitten to bite her back! This continued for about a month and Pat eventually stopped biting others.

   Is this: ☐ Appropriate ☐ Inappropriate

   Comment:

   _____

   _____

   _____

10. Staff on a living unit for severely retarded adults have nicknames for the clients: Pimple, Drool, Dumbo, etc. Clients respond to their nicknames and appear not to mind. Overall, the staff and clients interact without any problems.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

11. Robert, a 250 pound, severely retarded adult, often has physical outbursts. In the past month, he has physically hurt six other clients and three staff attendants. The physician wrote a standing order to administer a sedative drug when Robert exhibits aggressive behavior.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

12. Mike is a profoundly retarded adult who has some walking skills, but he is usually confined to a wheelchair because he often falls and hurts himself. During busy times, the staff secure a strap around his waist so that he will not get out of the wheelchair unassisted and hurt himself.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

13. Sam, a profoundly retarded adult, is taken to his room and the door is locked, after the staff failed to control his aggressive behavior. The staff returned in fifteen minutes, after he has calmed down, and unlock the door. Sam leaves his room without any more incidents and joins in group activities.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

14. A local university has been given a research grant to study the behaviors of institutionalized mentally retarded adults. The Clinical Director allows the educators to interview and observe the clients, but with the understanding that names be kept confidential. Results of the study are published in a leading professional journal on mental retardation.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

15. Jack, a moderately retarded, behaviorally disordered, sixteen-year-old, verbally threatens to kill his teacher. He is referred for the first time to the local Mental Health Center. The Center obtains a Probable Cause Order and Jack is admitted to a state facility within twenty-four hours of the incident. The facility was once a detention center for juvenile delinquent boys, but now provides treatment for behaviorally disordered adolescents.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

16. Bill, a moderately retarded twenty-four-year-old, is looking at pictures in a Playboy Magazine he has received from a friend. A female staff member takes it away from him, because she does not think it is morally productive to look at things like that.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

17. Vicky, a retarded seventeen-year-old, receives monthly allotments of monies, which are put into the patient's trustee account. Vicky is requesting that all of the monies be given directly to her and not put into a trustee account. The staff denies her request on the grounds that the parents had signed a written authorization for them to manage her funds.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

18. Steve, a retarded, behaviorally disordered, fifteen-year-old, is a newly admitted client. Prior to admission, the staff obtain information that he often picks on other individuals who are younger in age and smaller in stature. The staff decides to put Steve on a living unit where clients are older (sixteen and seventeen-year-old males) and, for the most part, larger.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

19. Terri, a profoundly retarded, fifty-three-year-old, is scheduled for a meeting to update her treatment plan. She requests to attend, but the treatment team decides to deny her participation because of hostility exhibited in previous planning meetings.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

20. Mary, a thirty-year-old retarded female, is taking a shower with five of her friends and notices there is no soap. The staff brings each a bar of soap and requests that the girls return the soap when finished.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

21. Jerry, a moderately retarded fourteen-year-old, has been in the program for six months and is progressing extremely well. Jerry has already met all the established treatment goals and the staff is looking forward to his annual review plan meeting, which is six months away The staff are confident that after his annual review, Jerry he will be placed in a foster home because of his progress.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

22. Peggy, a retarded adult, often has moods of depression throughout the day. A physician decides that, in the best interest of the patient, she is to receive a specified medication. Peggy is told that the medication will help her depression, but it could also cause body spasms. Upon hearing this, she refuses to take the medicine and the order is discontinued.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

23. Lisa, a severely retarded child, at times bites and sucks on her fists. The staff decides to wrap and tie strips of cloth around her hands until she stops the biting and sucking behavior.

    Is this: ☐ Appropriate ☐ Inappropriate

    Comment:

    _____

    _____

    _____

24. Chuck, a severely retarded adult, often becomes hyperactive and at times disturbs other clients and their visitors. To respect the rights of other clients, the staff lock Chuck in his room during daily visiting hours.

Is this: ☐ Appropriate ☐ Inappropriate

Comment:

_____

_____

_____

25. Randy, a retarded adult, is hired as an employee of the facility to help keep the grounds clean. He assumed all responsibilities of a former employee who had recently retired. Randy is paid $1.25 per hour and $.05 for every pop bottle he turns into the canteen. He earns enough money to maintain a daily supply of tobacco and coffee which he uses a lot.

Is this: ☐ Appropriate ☐ Inappropriate

Comment:

_____

_____

_____

APPENDIX C

COLIN ANDERSON CENTER
TRAINING NEEDS

COLIN ANDERSON CENTER
TRAINING NEEDS

JOB CATEGORIES / RIGHTS AREAS	Health Services Workers	Paraprofessionals/Trainers	Non-Professional/Non-Direct Care	Professionals	Administrators	Patient Advocates and/or Human Rights Committee Members
Access to Records	x	x	x	x		x
Appeals Process	x	x	x	x		x
Civil, Legal, and Human Rights		x				
Communication	x	x	x		x	x
Confidentiality	x	x	x	x	x	
Consent to Treatment	x	x	x	x		
Education		x	x			
Freedom from Neglect						
Freedom from Physical Abuse		x				x
Freedom from Verbal Abuse		x				x
Freedom from Chemical Restraints	x	x	x	x	x	x
Freedom from Mechanical Restraints	x	x	x	x	x	x
Freedom from Seclusion		x	x	x	x	x
Information/Notice Provided (Fully Informed)	x	x	x	x	x	x
Least Restrictive Environment/Alternative Placement	x	x	x	x	x	x
Maintain Personal Property and Clothing		x	x			
Manage Personal Finances						x
Nondiscrimination	x	x	x	x	x	
Participate in Program/Treatment Planning		x	x			x
Privacy	x	x	x	x	x	
Program Treatment Plan	x	x	x	x	x	x
Refuse Treatment		x				
Treatment and Care	x	x	x	x		x
Visiting Privileges		x				x
Work/Labor Compensation	x	x	x			x

APPENDIX D

GREENBRIER CENTER
TRAINING NEEDS

GREENBRIER CENTER
TRAINING NEEDS

JOB CATEGORIES / RIGHTS AREAS	Health Services Workers	Paraprofessionals/Trainers	Non-Professional/Non-Direct Care	Professionals	Administrators	Patient Advocates and/or Human Rights Committee Members
Access to Records		x	x			
Appeals Process	x	x	x			
Civil, Legal, and Human Rights						
Communication	x	x	x		x	
Confidentiality	x	x	x	x	x	
Consent to Treatment	x		x	x	x	
Education	x		x			
Freedom from Neglect		x	x	x	x	x
Freedom from Physical Abuse		x				
Freedom from Verbal Abuse			x			
Freedom from Chemical Restraints	x	x	x	x	x	
Freedom from Mechanical Restraints	x	x	x	x	x	x
Freedom from Seclusion						
Information/Notice Provided (Fully Informed)	x	x	x	x	x	
Least Restrictive Environment/Alternative Placement	x	x	x	x	x	
Maintain Personal Property and Clothing						
Manage Personal Finances		x	x			
Nondiscrimination	x	x	x	x		x
Participate in Program/Treatment Planning		x	x			
Privacy	x		x	x	x	x
Program Treatment Plan	x	x	x	x	x	
Refuse Treatment			x			
Treatment and Care		x	x	x	x	x
Visiting Privileges						
Work/Labor Compensation	x	x	x			

APPENDIX E

SPENCER HOSPITAL
TRAINING NEEDS

SPENCER HOSPITAL
TRAINING NEEDS

JOB CATEGORIES / RIGHTS AREAS	Health Services Workers	Paraprofessionals/Trainers	Non-Professional/Non-Direct Care	Professionals	Administrators	Patient Advocates and/or Human Rights Committee Members
Access to Records	x	x	x	x		
Appeals Process	x	x	x	x		
Civil, Legal, and Human Rights			x			
Communication	x	x	x	x		
Confidentiality	x	x	x	x	x	x
Consent to Treatment	x		x			
Education	x		x		x	
Freedom From Neglect	x	x			x	
Freedom From Physical Abuse			x			
Freedom From Verbal Abuse			x	x		
Freedom From Chemical Restraints	x		x	x		
Freedom From Mechanical Restraints	x	x	x	x	x	
Freedom From Seclusion			x	x		
Information/Notice Provided (Fully Informed)	x	x	x	x	x	x
Least Restrictive Environment/Alternative Placement	x	x	x	x	x	
Maintain Personal Property and Clothing			x			
Manage Personal Finances				x		
Nondiscrimination	x	x	x	x		x
Participate in Program/Treatment Planning			x			
Privacy	x	x	x	x	x	
Program Treatment Plan	x	x	x	x	x	
Refuse Treatment			x			
Treatment and Care	x	x	x	x	x	
Visiting Privileges						
Work/Labor Compensation	x	x	x	x		

APPENDIX F

TOTAL SAMPLE
TRAINING NEEDS

TOTAL SAMPLE
TRAINING NEEDS

JOB CATEGORIES / RIGHTS AREAS	Access to Records	Appeals Process	Civil, Legal, and Human Rights	Communication	Confidentiality	Consent to Treatment	Education	Freedom from Neglect	Freedom from Physical Abuse	Freedom from Verbal Abuse	Freedom from Chemical Restraints	Freedom from Mechanical Restraints	Freedom from Seclusion	Information/Notice Provided (Fully Informed)	Least Restrictive Environment/Alternative Placement	Maintain Personal Property and Clothing	Manage Personal Finances	Nondiscrimination	Participate in Program/Treatment Planning	Privacy	Program Treatment Plan	Refuse Treatment	Treatment and Care	Visiting Privileges	Work/Labor Compensation
Health Services Workers	x	x		x	x	x						x	x		x	x		x		x	x		x		x
Paraprofessionals/Trainers	x	x		x	x				x		x	x	x		x	x		x	x	x	x	x			x
Non-Professional/Non-Direct Care	x	x		x	x	x	x	x			x	x	x	x	x	x		x	x	x	x				x
Professionals	x				x	x		x			x	x		x	x		x	x		x	x	x			
Administrators				x	x			x			x	x		x	x		x	x		x	x	x			
Patient Advocates and/or Human Rights Committee Members					x			x						x	x					x		x			

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