PROGRAM REVIEW

FARIBAULT STATE HOSPITAL

FARIBAULT, MINNESOTA

JULY, 1984

Report Prepared by:

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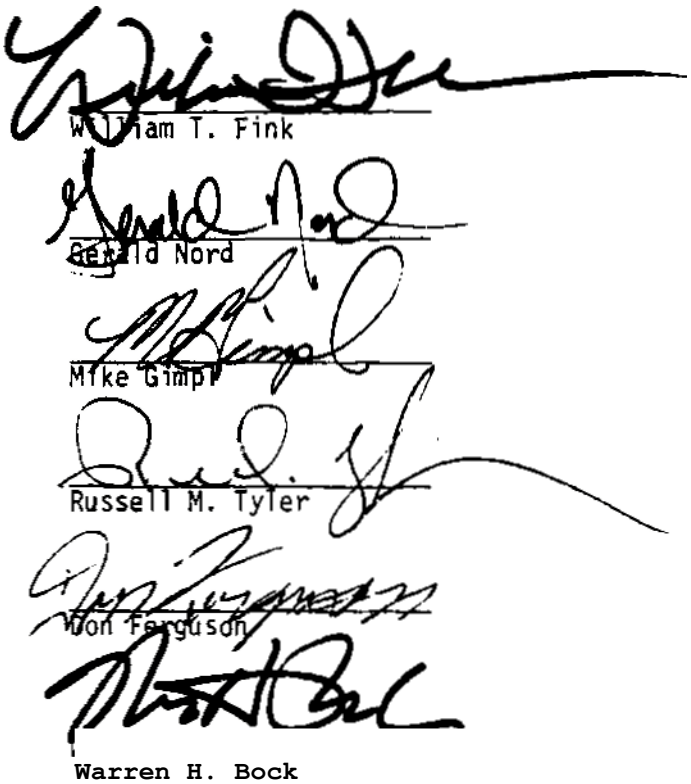
We, the undersigned participated in the Quality Assurance Program Review of Faribault State Hospital and concur with the attached written report as accurately reflecting our individual and collective findings:



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EXECUTIVE SUMMARY

In July 1984, the administration of the Mental Retardation Division of the Mental Health Bureau convened a review team to assess the status of habilitation programming at Faribault State Hospital. The team was composed of seven individuals with a wide range of experiences in human services administration and developmental disabilities programming. The review covered a two day period of intensive sampling and analysis of programs offered at the site.

Major areas targeted for review included assessment/evaluation procedures used in the establishment of programming recommendations, the individual program planning process and program implementation and maintenance. As they were relevant to the program analysis, facility management practices and the level of staffing resources were also analyzed.

Faribault State Hospital has many attributes that contribute toward its potential to match other large, public mental retardation facilities as a habilitation programming site. It has adequate staffing levels and an attractive physical plant. Most senior facility administrators have been with the agency long enough to have developed, implemented and evaluated alternatives for a viable program system. In addition, as the facility is accredited by ACMR/DD, it has met the established minimum standards for quality of services and documentation.

The major questions addressed by the review included:

1. Do the habilitation program plans of the residents of Faribault State Hospital include suitable goals and objectives?
2. If such goals and objectives are present, do written programs exist to guide the efforts of staff in helping residents to learn?
3. Are the written programs implemented at a sufficient frequency to optimize learning?

Review of programs on the residential areas of the facility and at day-programming sites revealed that, for most areas, drastic improvements in programming frequency and quality must occur to establish an adequate level of habilitative activity. Substantial problems with the current program are found at all levels of the program process from resident assessment to program delivery. In large part, skill acquisition programs offered to residents did not appear to address their critical needs. The frequency of program occurrence was also found to be too low to produce optimal conditions for learning. Program technology appeared extremely simplistic and outdated. Similarly, programs to reduce undesirable behaviors suffered from inadequate peer review, simplistic technology and inconsistent application.

Despite the problems found during the review, the attributes of the facility and its staff are such that corrections are possible. Those necessary corrections can only be made if senior managers and clinicians drastically increase their knowledge of and involvement with state-of-the-art programming techniques. Management, from the top down, must also initiate an accountability system that holds staff at all levels responsible for their roles in the programming system. In keeping with those observations, the review team made a series of specific recommendations including a recommendation for a management review of the facility to ascertain whether the present organizational structure is the most conducive to high-quality habilitation programming.

CHARGE TO THE REVIEW TEAM

As an agent of the State of Minnesota, Department of Human Services, the Mental Retardation Division of the Mental Health Bureau is responsible for assuring that persons who are developmentally disabled and reside within facilities operated by the State, are each provided an individualized program of habilitation. Each program must provide an array of services targeted to result in ongoing individual growth and attainment of a mode of daily living which minimizes limitations linked to the person's disability. Services offered may include but are not necessarily limited to educational, psychological, medical, recreational and vocational programs.

In order to evaluate the adequacy, appropriateness and effectiveness of program efforts within state institutions for persons who are mentally retarded, the administration of the Mental Retardation Division recently drafted a Quality Assurance Implementation Plan; The plan requires an annual program review of each state facility providing services to people who are mentally retarded. According to the plan:

> "The agenda for the review will focus on physical safety and protection of residents; placement appropriateness; care, training, and habilitation; the quality of the physical and social environment; planning; staff development; community liaison activities and use by the community as a resource; and future directions of MR programs."

In July, 1984, the first Quality Assurance review was conducted by a team of professionals selected by the Acting Director of the Mental Retardation Division to review Faribault State Hospital. As the first of the reviews, the scope was limited to ensure that adequate time was available for thorough review of the institution's provision of direct habilitation services to its residents. Reviews of medical and support services were conducted only insofar as directly relevant to the review of habilitation programming. Similarly, the management structure and management practices of the institution were evaluated from the perspective of the habilitation program review.

REVIEW TEAM
MEMBERSHIP

Warren H. Bock, Ph.D. - Acting Director, Mental Retardation Division, Mental Health Bureau, Minnesota Department of Human Services. Deputy Director, Mental Retardation Division (1979-1983). Assistant Director, Mental Retardation Division (1973-1979). Director, Minnesota Learning Center, Brainerd (MN) State Hospital (1970-1973). Director, Independent Living Program, Owatonna State School (1966-1970). B.S., Education with minor in Special Education (1964); M.S. Educational Psychology, emphasis in Mental Retardation, Mankato State University (1966); Ph.D., Education Administration, major emphasis in Human Services management, University of Minnesota (1977).

Donald G. Ferguson, Ph.D. - Unit Manager, Brainerd State Hospital, Brainerd, Minnesota. Licensed Consulting Psychologist, Minnesota, Staff psychologist, Coldwater Regional Center, Coldwater, Michigan (1978-1981). Clinical Associate, Northern Indiana State Hospital (1977-1978). B.S., Psychology, Eastern Michigan University. M.A./Ph.D., Psychology, University of Louisville. Contract teacher, St. Cloud State University. Topics of publications and presentations include: interaction of psychotropic drugs and behavioral procedures, evaluation of the effects of psychotropic drugs on vocational and related behaviors, medication reduction monitoring systems, and behavioral programming in institutional settings.

William T. Fink, Ph.D. - Assistant Director, Mental Retardation Division, Mental Health Bureau, Minnesota Department of Human Services. Regional administrator for community-based programs, Louisiana Office of Mental Retardation/Developmental Disabilities, Baton Rouge, Louisiana (1982-1984). Program manager, program evaluation in state-operated residential and community-based services,

Oregon Mental Health Division, Salem, Oregon (1978-1982). Director, national model early childhood intervention program, Center on Human Development, University of Oregon, Eugene, Oregon 1975-1978}. Faculty in the area of habilitation of persons with severe and profound handicaps, University of Oregon, Eugene, Oregon (1975-1979). B.A., social anthropology, University of California, San Diego (1973); M.S., special education, University of Oregon (1974); Ph.D., special education (emphasis in administration and program evaluation), University of Oregon (1977).

Hike P. Gimpl, Ph.D. - Psychology Services Director and staff psychologist, Glacial Ridge Training Center, Willmar State Hospital. Technical consultant for Minnesota Department of Human Services on community Welsch v, Levine clients. NIH researcher, University of Iowa, drug effects and learning (1977-1979). NIH postdoctoral fellowship in behavioral pharmacology, University of Iowa (1975-1977). Ph.D., Psychology, University of Miami, 1975.

Gerry Nord - Mental Retardation Division, Bureau of Mental Health, Minnesota Department of Human Services. Licensed Consulting Psychologist, Minnesota. Rochester State Hospital, Mental Retardation Unit (1973-1982), M.S., Psychology, University of Minnesota, 1975.

Dennis R, Olvera, Ph.D, - Assistant Superintendent, New Castle State Hospital, Indiana Department of Mental Health. Registered Psychologist, Illinois. Director of Evaluation, Region II, Illinois Department of Mental Health and Developmental Disabilities (1982-1983), Director of Evaluation and Training, Region II Office for Developmental Disabilities, Illinois Department of Mental

Health and Developmental Disabilities (1977-1982). Unit administrator and staff psychologist, W.A. Howe Developmental Center, Tinley Park, Illinois {1975-1977}. Chief Psychologist, Waukegan Developmental Center, Waukegan, Illinois (1974-1975). Research Scientist, Behavior Research Laboratory, Anna State Hospital, Anna, Illinois (1972-1974). Unit Administrator and counselor, Illinois Security Hospital, Chester, Illinois (1969-1971). M.A., Behavior Modification, Southern Illinois University. Ph.D. Educational Psychology, Southern Illinois University. Specialty areas in management of aggressive behavior, measurement of habilitation skills and behavior problems of devel-opmentally disabled individuals, rights assurance procedures, and program evaluation,

Russell M. Tyler, Ph.D. - Psychologist, Minnesota Learning Center, Brainerd State Hospital (1980-present, 1975-1977}, Licensed Consulting Psychologist, Minnesota. American Psychological Association, Consultant (Visiting Psychologist), Hastings Regional Center, Hastings, Nebraska (1983). Consultant, Oak Ridge Learning Center, Commonwealth of Virginia, Mental Retardation/corrections (1983). A.B., Psychology, Harvard University. M.S., Experimental Child Psychology, University of Washington. Ph.D., Human Development and Developmental Child Psychology, University of Kansas. Areas of specialization include dual disability (MR/MI) individuals, behavioral assessment, program evaluation and social skills training.

REVIEW PROCEDURES

Prior to starting the review, the Acting Director of the Mental Retardation Division and the external consultant (Olvera) met at length to discuss the recent history of Faribault State Hospital and its interactions with various agencies. On the morning of the first day of the program review, the team members met to discuss the procedural plan. It was stated by the team leader, Dr. Bock that the review was to address three global questions:

1. Do the habilitation program plans of the residents of Faribault State Hospital include suitable goals and objectives?
2. If such goals and objectives are present, do written programs exist to guide the efforts of staff in helping residents to learn?
3. Are the written programs implemented at a sufficient frequency to optimize learning?

The global questions were then reduced to a series of more detailed questions grouped under the three major areas of Program Development, Program Implementation and Maintenance and Ancillary Issues:

I. Program Development

A. Evaluations and Assessments

1. Have current evaluations been performed of each resident's assets and deficits, by appropriate members of the facility professional staff?
2. Do the evaluations result in specific recommendations for programming?

B. Interdisciplinary and/or Transdisciplinary Team Processes

1. Do the residents' records include current monthly, annual, and quarterly reviews?
2. During the reviews, was representation of team members and other interested parties adequate?

3. Are recommendations for programming resulting from the evaluation process treated?
4. Are specific programs identified for implementation?

C. Behavior Management Review Process

1. To what extent are the resident, relatives of the resident, advocates and members of the interdisciplinary team involved in developing a behavior management program for the resident when necessary?
2. Is the program review process, via the facility Behavior Management and Human Rights Committees, adequate?
3. Are the behavior management procedures used, the least aversive or depriving, effective procedures available?
4. Does the written format for behavior management programs ensure an adequate investigation of historical and current variables unique to the resident that bear upon the procedures proposed for use?

II. Program Implementation and Maintenance

A. Skill Acquisition Programs

1. Do programs implemented match those recommended by the annual or quarterly program plans?
2. Are existing programs current? When were they recommended? When were they implemented? How frequently are program sessions held?
3. Is there a standardized format for skill acquisition programs used across the various residential areas of the institution?
4. Have staffs who deliver programming been adequately trained?
5. What are the consequences for staff that do a substantially good or poor job of providing quality programming?
6. Is there a plan for analyzing program data and including such data in program plan reviews?

B. Behavior Management Programs

1. Are staffs that provide behavior management programs pre-trained? How and by whom?
2. With regard to data from behavior management programs, how are they kept, analyzed and reported?
3. What is the prevalence of the use of psychotropic medications? Are existing authorizations and utilization rationales current and appropriate?
4. Are staffs adequately trained in physically managing, in appropriate ways, the resistive and combative behaviors of residents?
5. Does the facility have clearly stated and effectively implemented procedures for handling behavioral emergencies?
6. Judging from documentation relating to behavior management programs, is it apparent that professional, direct-care and management staff share in the development of behavior management procedures?

III. Ancillary Issues

A. Staffing Variables

1. Are there sufficient members of direct-care and professional staff to permit quality programming?
2. What is the extent of contact between professional staff and facility residents?
3. To what extent is medical staff involved in the development of behavior management plans?
4. Are there schisms existent within the staff that adversely affects programming?

5. Do program and support staff interacts cooperatively in the interest of producing good programs for residents?
6. Is management supportive of effective programming?

B. Environmental Variables

1. Do conditions at the facility reflect concerns for safety, cleanliness and normalization?
2. What is the general level of activity within residential areas?
3. Are residents afforded sufficient opportunities for naturally-occurring, positive reinforcement of appropriate behavior?
4. Do professional evaluations of residents and the programs in effect reflect a concern for movement of the resident to the most normal environment possible?
5. Has the facility staff implemented any recent, innovative programs?

Following identification of the specific review questions, the team addressed the review schedule. Review teams of no less than two members were then assigned to visit the residential areas displayed in Table 1.

TABLE 1

Assignment of Review Teams to Residential Units

	Day I	Day 2
Team 1 (Gimpl/Nord)	Elm, Hickory	Cedar, Maple, Pine
Team 2 (Bock/Fink/Olvera)	Willow, SNF	West, Osage, Seneca
Team 3 (Ferguson/Tyler)	Birch, Linden	Holly, Poppy, Laurel, Spruce

The review team then proceeded to the site to meet with members of the senior management staff of Faribault State Hospital. Those staff members included

William Saufferer, Acting Chief Executive Officer; Arnold Madow, Assistant Administrator, Program Services; Dave Campbell, Quality Assurance Officer; and, Grace Crosby, Assistant Administrator, Residential Program Services I. The major purposes of the meeting were for the review team to obtain a general understanding of the organizational structure of the facility and to learn of particular strengths and weaknesses of the overall habilitation program, from the perspective of the management staff.

The review team then proceeded to the facility to initiate site observations on residential areas. The observations included several different review techniques. Typically, team members toured the building to which they were assigned to obtain an overview of the physical plant safety and cleanliness. Usually each household within the building was observed. Often, members of the building staff were interviewed, some briefly and some at length. Records of residents including program notebooks were routinely sampled for examination. Random selection was used in pulling some records for review; others were chosen based on staff reports of severe behavior problems exhibited by particular residents. Review team members also observed ongoing programs occurring within both residential and day program settings. Finally, those written policies and procedures that were thought to be directly relevant to habilitation programming were reviewed.

By training and professional experience, all members of the review team place a major emphasis on the validity and reliability of evaluation findings. Review procedures were set up to offer frequent opportunities for verification of potential findings. First, team members were instructed to and did perform direct observations of programs as a necessary adjunct to records reviews. Second, review team members were always paired in order to ensure that findings were not an artifact of an individual misinterpretation of observations. Third,

following the first day of on-site reviews, the team assembled for a lengthy discussion session directed at assessing the factual bases of findings and the general level of inter-reviewer reliability. Two briefer meetings with the same purpose were held subsequently.

At the end of the second day of the review, team members provided their written notes, summaries and recommendations to the consultant reviewer (Olvera) for use in writing this formal report.

FINDINGS AND RECOMMENDATIONS

General Organization of the Facility

Approximately two years ago, the administration of Faribault State Hospital implemented a unitized organizational structure. Within that structure, each residential building or unit represents an organizational entity. Each residential building is staffed with a professional and para-professional team, direct-care staff and a small management team. The Unit Manager is responsible for the operation of the unit. Each unit contains from two to four households which typically consist of twelve to sixteen residents. According to the facility table of organization, the units are grouped into two administrative areas, Residential Program Services I and II, each of which is headed by an Assistant Administrator, who in turn is supervised by the CEO.

Weekdays, residents receive day program services in non-residential areas of their units or in separate buildings by professional and para-professional staff that function under a distinct organizational structure called Developmental Achievement Programs (DAP). The area is headed by the Assistant Administrator, Program Services, who is supervised by the CEO. According to facility management staff, approximately 670 of the facility's nearly 700 residents attend DAP services regularly.

Physical Plant

With particular, notable exceptions, the residential and program areas of the facility are clean and in good repair. Buildings generally appeared accessible. Staff reported that buildings housing non-ambulatory residents are air conditioned while those housing ambulatory persons are not. For the most part, furniture and equipment in the residential and program areas was attractive and in good repair.

However, two areas, West and Seneca, require attention due to physical plant problems. The general atmosphere in both buildings was not conducive to

the comfort of residents. In Seneca, the major problem was that the building has not been renovated to afford privacy to residents. There were, although the building was clean, several other problems stemming from the poor quality of the interior design, decoration and furniture. The bedrooms in West did provide adequate privacy, but otherwise the building suffered from many of the same problems as Seneca. In addition, the paint in several rooms on West was peeling, the clothing room was in extreme disorder, and several areas of the building were dirty, especially some of the carpets.

In most buildings, it was apparent that staff and residents had made many, and sometimes very attractive, attempts to decorate the living areas. In many instances, those decorations were not in keeping with the chronological ages of the residents whose areas they graced.

Interpretation

The management and staff of Faribault State Hospital have given a substantial amount of attention to providing attractive, clean, safe and homelike environments for residents. Physical plant problems are minimal, thereby reflecting continued efforts and adherence to both ICF/MR regulations and ACMR/DD standards.

Recommendations

1. The physical plant of Seneca Building should be immediately surveyed by senior management staff in order to develop a plan for properly sub-dividing the bedroom areas, replacing worn and unattractive furniture and equipment, and generally increasing the attractiveness of the living areas. The plan should be implemented quickly and therefore, should not be premised upon capital expenditures.

2. Senior management staff should ensure that West is thoroughly cleaned and, kept clean, that rooms are painted and that aged equipment is replaced.

3. The facility should make an effort to better train staff in normalization and in the provision of age-appropriate programs, living environments and expectations of residents.

4. Facility management should re-examine its internal Quality Assurance plan to ensure that it is sufficiently proactive and that the management of the facility is sufficiently responsive to problems found,

Program Staffing

Compared to many other mental retardation facilities, Faribault State Hospital has enviable staffing levels. Staffing analyses were performed on several buildings and revealed similar staffing ratios and patterns across buildings. Two are presented following:

Building A	Resident Population:	48
	Total Staff:	37.5
	Direct-care Staff:	30.5
	Unit Management Team:	7
Building B	Resident Population:	50
	Total Staff:	43
	Direct-care Staff:	34
	Unit Management Team:	9

If a relief factor is used of 1.7 positions for each direct-care staff on duty, Building A would normally have on duty, over three daily shifts, nearly 18 staff. Assuming that three staff would be assigned to night shift to maintain a staff-to-resident ratio of 1:16, 7.5 positions could be assigned to both the day and evening shifts for ratios of 1:6.4 staff to residents. For Building B, with 20 staff working per day, four on the night shift, the ratio of staff-to-residents would be 1:6.25 for both day and evening shifts.

In addition to the direct-care staff, each unit typically has assigned to it, from seven to nine professional and management staff who work something of

a "swing-shift." As a final overlay, DAP staff, present during weekdays; contribute another 161.5 positions as program resources. According to facility management staff, personnel turnover has been fairly low among both professional and direct-care staff.

Observations of staff interactions with residents indicated that staff behaviors toward those in their care were largely well-intentioned. In isolated cases, their attitudes were patronizing e.g. some staff gave adult residents pats on the head or tousled residents' hair. Two questionable interactions were observed. One involved a staff member who playfully tickled and physically pestered a hyperactive resident, thereby increasing the level of hyperactivity. The second occurred when a staff member over zealously used physical guidance to force a resistive, multiply disabled resident to drink a cup of juice. In general however, most staff appeared concerned and positively inclined toward residents.

For an institution that is more than one-hundred years old. Faribault State Hospital has a remarkably young staff. Although no demographic information was collected, most direct-care and professional staff appeared to be twenty to forty years old. As a possible function of their youth, many staff demonstrated a high level of motivation.

Quite a few staff members remarked about the relatively new requirement for professional and management staff to work evening and weekend hours. The rationale for that mode of scheduling is to offer a greater degree of program management, seven days per week, over the residents' normal waking hours. Implementation of the requirement represents a commendable effort to ensure adequate supervision of programming. Particular instances were noted however, where the intent of the schedule was undermined, perhaps unknowingly, by the manner in which time off was scheduled. In at least one instance, both the unit manager, the assistant group supervisor and several of the unit's professional staff were absent simultaneously.

The adequacy of guidance, supervision and training provided to program staff was assessed by the review team as a function of its evaluation of program quality. On some units, notably Poppy and Seneca, systems were in place to monitor the frequency with which staff held program sessions for residents. However, on many other areas, systems to track staff program performance were absent. Most units did not seem to offer differential consequences to staff for performing or not performing as programmers.

The frequency of contact between professional staff and direct-care staff and residents generally appeared adequate. When queried about how they were trained to do programming, most direct-care staff stated that they were taught by professionals assigned to the units. Units that lacked professionals were able to obtain them from other areas on an "on-call" basis.

Three aspects of the manner in which staff are organized appeared questionable to the review team. First, the rationale for management of the DAP structure through a chain of command separate from Residential Program Services was not clear. Facility management staff reported that the arrangement was workable, however several instances were noted where the structure resulted in disjointed recording and storage of program information. Second, the facility table of organization indicates that staff training is under the supervision of the Assistant Administrator, Hospital-Wide Support Services. Third, several staff remarked that the use of a pool of clerical staff for typing program documents has resulted in long delays for return of usable documents.

Interpretation

Given its present number and levels of positions, Faribault State Hospital is adequately staffed to permit provision of high-quality habilitation programs. However, as the subsequent section clarifies, the quality of programs from unit to unit appeared highly variable, although the units were staffed in similar

manners. The unanimous opinion of the review team was that program quality was a function of the competencies and motivation of unit leadership rather than an effect of clinical or management initiatives external to the units. Similarly, the quality of programming within DAP settings ran somewhat parallel to that of units.

Recommendations

1. The management, professional and training staff of the facility should locate or develop an instructional program for staff on attitudes toward residents, the role of staff in providing normalizing circumstances for residents' growth and the varied forms that abuse may take. Staff interactions with residents should periodically be monitored and openly discussed in a non-threatening manner as a method of ensuring that the good intentions of staff become manifest in respectful, nurturing behaviors.

2. Management staff should re-evaluate practices governing scheduled absences of supervisory and professional staff to ensure that adequate guidance is available to program staff.

3. Management staff needs to develop and aggressively implement a plan for assessing program quality, holding staff accountable for performing programming duties and differentially consequating good as opposed to poor staff performance as programmers.

4. The administration of the Mental Health Bureau should review the organizational structure of Faribault State Hospital from a program management perspective, to ensure that the existing entities and system inter-relationships are conducive to high-quality programs,

5. Strong consideration should be given to whether the continued bifurcation of the DAP and Residential Program Services is advisable.

6. The role, functions and supervision of the staff training office within the facility should be evaluated and, if necessary, altered to ensure maximum benefits.

7. Clerical services to program areas need to be evaluated to determine if additional personnel, upgraded equipment or new priorities are necessary to expedite processing of program documents. Given the overall staffing levels at the facility, additional clerical positions could come from within the existing personal services allocation.

Assessment Practices

Professional Assessments of residents were of uneven quality and recency. On one area, the most recent Social History for a resident carried a date of 1960. Other assessments were found to be undated. One aspect of the assessment texts that was all too common was that recommendations were too global to use in preparing program plans. For example, one assessment from a psychologist stated that "_____appears to have optimism," and "_____must learn to trust others." One reviewer noted that the adaptive levels of residents in some areas were characterized as age equivalents rather than as statements about specific skills and deficits. Despite the fact that assessments from staff of some units drew praise from reviewers, the overwhelming criticism was that the recommendations included in assessments were too vague to assist in program planning.

Interpretation

Many professional staff seems to be performing assessments of residents simply because they are required to do so by regulations and standards. Full use of assessments as tools for program planning has not occurred either because appropriate measures have not been located or because the value of assessment is not appreciated.

Recommendations

1. The various professional groups represented on the facility staff should review existing, applicable standards for evaluation of residents. Those groups should identify acceptable instruments and formats for reporting results.

2. Senior clinicians and managers should develop and participate in a plan of random review of professionals' assessments of residents.

3. The quality of assessments produced by each professional should function as a major determinant of his/her performance rating.

4. As necessary, professional staff should identify and administrators should arrange to offer appropriate workshops in assessment of residents.

Interdisciplinary Team Process

At best, the opinion of the review team was that the interdisciplinary process was perfunctory on most units. Although representation at program reviews was usually adequate, the process did not yield a valuable product. It was not uncommon to find that the goals and objectives in recent program plans matched those of the prior and even earlier years. Criteria for meeting program objectives seem to have been set haphazardly and without reference to reasonable performance expectations. When those criteria were not met, the goals and objectives were simply carried forward. One case was documented where the resident failed to meet an objective one year only to have the success criterion raised for the next year.

Few units seemed to rely upon program data analyses to drive recommendations for future programs. One resident who is placed in a locked timeout room for misbehavior had an annual review which contained a Direct Assessment of Maladap-tive Behavior consisting of three typewritten lines. Data presented in most plans usually dealt more with frequencies of maladaptive behaviors than with progress in skill acquisition.

Interpretation

One reviewer summarized the interdisciplinary team process at the facility by remarking:

> "Most of the paperwork is in place. However, a close reading reveals significant inconsistencies, failure to recognize priorities and a need for state-of-the-art methods and content."

No consistent methodology was in place to require Unit Managers, senior management or clinicians to routinely review program plans. As a result, the team process has been permitted to drift as long as paper requirements are met.

Recommendations

1. As a corrective action, facility managers from all levels need to become expeditiously and heavily involved in reviewing the content of program plans. Responsibility for development of adequate plans should be fixed in such a way that each plan can be tracked to a singular team leader.

2. Management staff and clinicians need to re-evaluate standards for program plan development and ensure that they are sufficiently operational.

3. Competency testing should be developed as a method of identifying interdisciplinary team members who require re-training in setting goals and objectives, in using data to drive program change and in linking assessments to planning.

4. Most areas of the facility could benefit from using the "criterion of ultimate functioning" as a metric useful in developing a holistic program plan for residents.

Behavior Management Program Review

According to facility policy, behavior management programs may require review beyond the interdisciplinary team by the Behavior Management Committee and by the Human Rights Committee. The necessity of review is determined by the type of behavior modification technique used in the program. The facility policy classifies particular techniques as "aversive" and stipulates that programs

containing such procedures must be reviewed by the Behavior Management Committee for technical soundness. The program must then be sent to the Human Rights Committee for review "regarding human rights, ethics and compliance with FSH regulations."

Minutes of the meetings of both committees were requested for perusal during the review. From the meeting minutes on file, it appeared that the Human Rights Committee has met twice in the past six months and has reviewed eight cases. Eleven programs were reviewed by the Behavior Management Committee over a recent ten week period. The minutes of the meetings were very brief and often did not identify what types of programs were under review.

Interpretation

The review of programs using aversive techniques is pro forma at Faribault State Hospital. It appears that the committees do not meet frequently enough to even cursorily review all applications of aversive procedures. In addition, doubt exists as to whether the class of reviewable procedures is sufficiently inclusive. For example, the policy on Aversive Behavior Modification Programs places over-correction techniques in a "gray area" of programs that may be aversive. Such procedures are routinely reviewed in many other facilities.

Recommendations

1. Facility management staff should design and implement a chart-by-chart study of the prevalence of programs classed as aversive or falling in the "gray area." Each such program in use should be reviewed to determine the necessity of program continuation.

2. Programs continued should be periodically reviewed at a frequency appropriate to the severity of the behavior to be treated and the aversiveness of the procedure used. Reviews of new programs should generally occur prior

to implementation and thereafter according to severity of the target behavior and aversiveness of the procedure.

3. The facility regulation for the topic area (#3109) should be reviewed and possibly revised.

4. Until there is a definite improvement in the review process, meetings of the Behavior Management and Human Rights Committees should frequently be attended by the Acting CEO.

Skill Acquisition Programs

Developmental disabilities professionals have long recognized that sequenced skill training using massed training sessions produces demonstrable progress of time. In addition, it is widely accepted that maladaptive behavior can be reduced indirectly by increasing the time residents spend in structured, skill acquisition programs. Philosophically, many staff at Faribault State Hospital has accepted the concept of active programming. However, many have not. In practice, most units and day program sites appear to fall well short of their potential.

As mentioned in prior sections, the linkage between assessments, program plans and programs is very weak. Consequently, the relationship of many ongoing programs to the needs of clients was not clear. Programs may be traceable to goals and objectives but may not relate to client needs. One reviewer commented in summary that there was:

> "molecular programming with no evidence of (a) molar concept of (the) individual and long term needs/objectives."

In view of the numbers of staff resources available, it would seem that the amount of time residents spend in skill acquisition programs could be higher than was observed. An analysis of one program plan for a non-ambulatory resident revealed that three programs were ongoing. One was scheduled six times per

week for 30 minutes, the second five times per week for 30 minutes and the third nine times per week for about five minutes. In total, the maximum programming time per week for the resident would be six hours and fifteen minutes. It is quite possible that the time intended for programming was 40% less than the reviewer's analysis suggested since the first two programs could easily be run concurrently. Both were muscle relaxation programs that used the same technique but focused on different muscle groups. On another unit, a review of a resident's hygiene program data indicated that over the first nineteen days of July, 53% of the data had actually been recorded.

Observations of programming areas tended to confirm the records analyses. A reviewer noted that:

> "People spent a great deal of time unattended or not engaged even though there were adequate staff present."

Observations in DAP areas did not confirm that either structured or unstructured activity levels were higher than on units. Vocationally-oriented programs were not observed to occur in DAP settings, unless they involved residents on the facility work programs. Two reviewers observed a class in telling time and, due to the teacher's hurried, on-the-spot construction of teaching aids and trial-and-error teaching techniques, left with the distinct impression that the class had been "put on" for their benefit. The best DAP program observed involved two staff and six residents working on a gardening project.

Review of several of the skill acquisition programs demonstrated that the technology in use was quite simplistic. For example, one resident who was to learn to tolerate lying in a particular position was on a program where he was placed in the position and left. He was to be removed from the position if he cried out or if a set time interval elapsed. The time interval was not gradually increased. Another resident was to receive a small plant or some other rein-forcer for meeting a personal hygiene criterion for three of five work days.

His room was barren of visible personal belongings. Many residents of ore unit were on what were referred to as individualized token economy programs. Comparison of two revealed that the adaptive behaviors required were the same; they were individualized on the basis of maladaptive behaviors. The back-up reinforcer for top performance was one can of pop per day.

Similarly, the training techniques in use tended to be outdated. Many areas used either backward or forward chaining techniques as the sole method of instruction. Although those techniques are optimal for teaching some skills, more recent behavioral technology has produced a virtual explosion of methods to supplement and replace chaining. Data were typically kept to indicate only that a trial was completed correctly or not. Many data analyses summarized for periodic reviews were anecdotal, incomplete or non-understandable. None of the program records reviewed included a data-keeping procedure where progress could be observed as a function of the degree of staff assistance (prompting) required for trial or step completion.

Finally, the locus of the program descriptions, all too frequently, was the staff. Many programs were stated in terms of frequency of staff implementation rather than resident behavior. Nonetheless, staff behavior as programmers was obviously tracked by management in only a few locations including Seneca, Poppy and Pine.

Interpretation

Faribault State Hospital management and senior clinicians have not placed a great deal of emphasis on developing or importing a system for skill acquisition programming. It also appears that many unit managers and professionals would require re-training or increased motivation to develop adequate programs within their own areas. The largest problem with the programs is that most unit managers did not seem to demand a great deal of program involvement from their staff, and did not seem compelled to do so by senior managers.

Many staff did mention that the facility does intend to use the "West Virginia System" as a facility-wide, skill acquisition program curriculum. Those reviewers familiar with the system did not recommend its use at Faribault State Hospital. From cursorily reviewing the materials, the system appears exceedingly comprehensive yet intricately complex. In view of the simplicity of the programs now used at the facility, it is doubtful that the "West Virginia System" could be implemented correctly on most units. Successively upgrading programs would seem to offer a surer road to adequacy.

Recommendations

1. Rather than generally identifying staff responsible for holding program sessions (e.g. RPS/DAP staff), particular individuals should be identified as trainers and held responsible for running programs as scheduled.

2. Managers should develop differential consequences for staff who actively perform as programmers and staff who do not.

3. Professional staff who "prescribe" programs for residents should ensure that those chosen for implementation actually address the priority needs of residents. If necessary, peer review mechanisms should be utilized for critiques of professionals' program judgments.

4. Senior managers and clinicians should quickly devote a great deal of time to studying programming systems and methods at other facilities in order to design a system for Faribault State Hospital. The ability to introduce the system gradually should be a major requirement of the design.

5. Those units which are beginning to develop adequate programming systems should be recognized by management for their efforts. The management and professional teams on such areas should remain intact even if the residents they currently serve are placed, moved or otherwise dispersed.

6. The facility professional and training staff, with massive support from management, should design and implement a major bootstrapping effort to upgrade programs at the facility.

7. Any system designed for implementation should include as elements, accountability of direct-care staff for functioning as trainers, accountability of professional staff for designing adequate programs and teaching staff to run them, and accountability of managers for ensuring that staff behaviors are differentially consequated.

Behavior Management Programs

Nationally, state-operated facilities for people who are mentally retarded are often viewed as options of last resort. New admissions tend to represent a population that for either behavioral or medical reasons cannot easily be served in alternate settings. Similarly, as a movement, deinstitutionalization has bypassed those individuals whose extreme behavior problems would be unacceptable in most community settings. Several articles published in leading journals on mental retardation indicate that the most frequent reason for return of residents from community settings to institutions is problem behaviors.

In view of the trends affecting institutional populations, it is especially compelling for public mental retardation facilities to have excellent programs for behavior management. Failure to provide adequate skill acquisition programs or a normalizing environment may prevent an individual's reaching maximum potential However, failure to adequately manage problem behaviors minimally restricts community placement and may lead to severe injury or death.

During past years, institutions frequently dealt with behavior problems by administering large doses of major tranquillizers to residents. More recently however, physicians have become conservative in their approach to using psycho-tropic drugs because the medications produce irreversible, undesirable side-effects. As a result, reliance upon behavioral procedures has increased.

Faribault State Hospital appears to have adopted some progressive practices with respect to use of psychotropic drugs. Of the residents whose records were reviewed, few received psychotropic major tranquillizers. Facility staff estimated that roughly 20% of the residents received major tranquillizers and that their use continues to decrease. Poly-pharmacy of major tranquillizers, usually an undesirable practice, was found in only one case reviewed.

Because of their substantial physical and medical problems, many residents at Faribault State Hospital do not pose significant behavior problems. Simply, they do not have the range of motion, strength or endurance to be severely mal-adaptive. Some residents, however, have sufficient stamina and guile to cause tremendous problems. It was on these latter residents that reviewers focused to evaluate behavioral technology at the facility.

Only one unit, Poppy, seemed to be treating behavior problems in a systematic, data-based manner. Other units with severe behavior problems did not seem to have an analytical approach to behavioral interventions. On Poppy, behavioral chain-breaking and proactive interventions were used to prevent maladaptations from growing into crises. Data were collected systematically and evaluated over the long term to detect trends in treatment. The Unit Manager reviewed restriction reports daily to remain abreast of the use of aversive techniques.

In contrast, Cedar, stands out at the far end of the spectrum as an environment that seems to have great difficulty in effectively managing behavior problems. A reviewer who spent considerable time on Cedar commented that he was surprised by the "lack of serious analysis of extremely maladaptive behavior in this unit." The problem was noted as pervasive in that it appeared that "even minimal crisis control procedures are not or cannot be carried out." The reviewer closed by stating that "I do not believe this unit is capable of even managing severe behavior let alone programming for its elimination."

Other units such as West, Hickory, Maple and Osage seemed to fall between Poppy and Cedar with respect to behavior management competency. Case summaries from some of these environments illustrate the problems.

Hickory - A case of extreme self-injury was reviewed. The reviewer remarked that he could not find evidence that staff had requested consultation to assist in program design. Medical and behavior staff needed to work more closely. The progression from less aversive to more aversive procedures seemed "mechanical".

Maple - The reviewer was on one household for ten minutes and observed one resident throwing a clothes hamper, one resident slapping staff and the reviewer himself, and two residents slapping each other . . . resulting in one being cut badly and requiring medical attention.

West - A dually diagnosed resident with a history of running away, suicide tendencies and self-injurious behavior reported to staff that he had been beaten by a man while off grounds. The progress notes read that on one day staff were afraid he might harm himself but four days later a note stated "we really feel he is enjoying all this attention and decided to ignore him for the time being . . ."No programmatic interventions followed the incidents,

Osage - A deaf resident placed in a locked room for aggressive/destructive behavior is programmed with an illogical contingency. If he exhibits a low level of destructive behavior which can be corrected, he must sit until calm and work to restore the environment. If he is aggressive or breaks something that cannot be repaired, he does not have to work but goes to the timeout room for fifteen minutes. The record read, "This program will be continued if the monthly evaluation shows at least a 5% reduction in the frequency of target behaviors. If a monthly evaluation shows no decrease or an increase

in frequency of target behaviors, the IDT will have a special meeting to determine revisions needed or other alternatives to this program." The trend demonstrates a significant increase in target behaviors since the program was started last October.

Interpretation

Faribault State Hospital appears to have very few professional staff that are adequately trained or motivated to work effectively with residents who present severe behavioral problems. Consequently, the technology in place at the facility tends to be simplistic and haphazard. Functional analyses of behavior were not observed to occur except possibly on Poppy. Management staff may not recognize the hallmarks of high-quality behavior management programs.

Recommendations

1. Within the constraints of its existing allocation for personal services, management should initiate a search for highly trained and experienced behavior analysts. If necessary, interviews should be co-conducted with someone from outside the facility experienced in behavior management.

2. The format for behavior management programs should be standardized for all units and structured in such a manner as to force reviews of relevant research.

3. Each person at the facility who is currently authorized to write behavior management programs should be identified. Those persons should be required to pass a competency test constructed by the Mental Retardation Division.

4. Consideration should be given by the administration of the Mental Retardation Division to designing an in-state network of consultants who may be available to assist at Faribault and other state hospitals. As necessary, AABT should be contacted for assistance with extreme cases.

5. Faribault State Hospital, in conjunction with the Mental Retardation Division should aggressively recruit behavior analysts to ensure that one such individual is assigned to each group of fifty or fewer residents.

6. Management and clinical staff should review unit populations to determine whether current housing patterns exacerbate behavior problems. If so, rational changes should be implemented.