MANAGEMENT STRATEGIES TO OPTIMIZE CONSISTENCY IN THE I.P.P.

MANAGEMENT STRATEGIES TO OPTIMIZE CONSISTENCY IN INDIVIDUAL PROGRAM PLANNING

By

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Abstract

The individual program plan (I.P.P.), forms the basis of instructional organization for persons with mental handicaps. Although much of the educational literature is based on improving the document itself, little attention is given to the overall process, or to the effects of external factors such as staff attitude and cooperation on the consistent delivery of this procedure. Part A, (The Project), draws on literature from management psychology and organizational behaviour which deals with causes of inconsistency in health-care environments. This section also outlines a method for testing the effectiveness of a management manual (Part B) which proposes to alleviate some of these problems. Part B, written for teachers, I.P.P. managers, social workers and counsellors, presents traditional (behavioural modification) methods used in staff performance training aligned with 6 recommended management strategies, including a Pre-I.P.P. meeting form, a past I.P.P. analysis form and Staff Orientation checklist. The strategies can be used separately from staff performance training projects to determine areas of weakness in the programming process.

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Management Strategies to Optimize Consistency in Individual Program Planning

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PART A

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a) Individual Program Planning

Individuals who have a mental handicap may live with their family while others live in institutions, group homes, or supportive home programs (similar to foster homes). If they are capable, they may live independently in an apartment with support from a community service worker. After age 21 they graduate from a school setting into a sheltered workshop--very few advancing on to competitive employment. These vocational and residential Programs* are operated by community service agencies or government controlled institutions. These agencies are required to prepare an Individual Program Plan (I.P.P.), (Ministry of Community and Social Services Guidelines, 1984) for each person in their care. The I.P.P. is a form drafted at an annual meeting or conference, by a team of counsellors and instructors who share primary responsibility for that client. This group decides what instructional areas are priorities and what areas of instruction they will work on in the upcoming year whether it be academics, behaviour,communication, gross-motor skills, or combinations of these. These decisions are stated in the form of long term goals

* Program-(upper case)- refers to an academic, residential or vocational facility. See Terminology section in Part B for further description.

(1-2 years) and short term objectives (6-12 months). At the I.P.P. meeting it is decided who is responsible for carrying out which programs, and who will provide the follow-up to service goals. (For a sample of an I.P.P. form, see Appendix A.)

In 1985, school boards in Ontario were confronted with the Ministry of Education Bill 82, which stated that all boards had to provide Programs for children with mental and physical handicaps (Exceptional), regardless of severity of disability or potential for cognitive development. Every year of their school lives, each student who has been designated "Exceptional" has his or her case brought to an Individual Placement and Review Committee meeting (I.P.R.C.). This committee is comprised of the school administrators, parents and special education coordinators from the school board (Ministry of Education, Bill 82). This group determines the category of exceptionality and which classroom (or special education Program) the student will attend. If the person lives in a community service agency residential facility or attends a vocational Program, the I.P.P. replaces the I.P.R.C..

After both of these meetings (school board or agency/ institution) it is the responsibility of the teacher or primary counsellor to develop an Individual Education Plan (I.E.P) or Individual Teaching/Treatment Plan (I.T.P.) often referred to as a program* or plan. I use the term I.P.P. manager, to refer to the person who has the ultimate responsibility for the co-ordination of the I.P.P. meeting and the completion of both the I.P.P. and I.T.P./I.E.P. forms. This person is most likely to be the teacher, counsellor, social worker/case manager or the workshop instructor. The plan is supposed to be drafted with input from all the pertinent people in the handicapped person's life. (Unfortunately, not all school boards invite teachers to this meeting.) The parents (if they are available), participate in the I.P.P. and I.P.R.C. meetings and the agency which has primary responsibility for the client (school or service agency) co-ordinates the meeting.

In 1984 the Ministry of Community and Social Services for Ontario developed guidelines to standardize the I.P.P. process in community agencies and institutions

*program- (lower case p)- will always refer to the specifics of the I.E.P. or I.T.P..

which provide non-academic Programs. It should be pointed out that these are not regulations as in Bill 82, but rather guidelines, allowing for individual differences of each agency and the uniqueness of their organization.

For the purposes of this project I have chosen to deal specifically with the I.P.P. process, which overlaps with the I.P.R.C. process only at the level of writing instructional plans (I.E.P.s). Unfortunately the I.P.R.C. is a closed system with little room for recommendations for improvement. The flowchart in Table #1 explains the typical process involved in today's I.P.P. management used in service agencies and institutions.

I.P.P.s have become a science unto themselves over the past eight years because most agencies decided to develop their own I.P.P. format to better fit their particular systems. One agency alone found seven different I.P.P. formats within its various service departments (Love, 1990, p. 2). Program specialists evolved with new improved I.P.P. methods to determine needs and set goals. Methods used by major corporations to plan their market objectives have been applied to planning human objectives on the I.P.P.s (e.g., progress must be measurable). Professional conferences around North America abound with program strategies which promise to lead to better teaching and record keeping. It is apparent that I.P.P.s are intended to help make the caregivers accountable to the parents as well as the client. My question, however, is: just because the procedure exists, is there any guarantee that what was promised or prescribed gets done?

Individual Program Planning Process Flowchart

CLIENT ENTERS A PROGRAM
(vocational, academic, residential)

↓

I.P.P. MANAGER IS ASSIGNED
(teacher, social worker/case manager, primary counsellor)
(prior to admission or within first week)

↓

PRELIMINARY ASSESSMENTS COMPLETED
(observation, teaching trials, basic skills testing etc.)
(after admission and prior to I.P.P. meeting)

↓

KEY TEAM IS CONTACTED BY I.P.P. MANAGER TO ARRANGE AN I.P.P. MEETING/CONFERENCE
(parent, counsellor, teacher, social worker, therapist, psychologist, doctor)

↓

I.P.P. MEETING;
LONG-TERM GOALS AND SHORT-TERM OBJECTIVES DECIDED
(within two-three months of admission)

↓

INDIVIDUAL TEACHING PLAN WRITTEN BY KEY TEAM MEMBERS or I.P.P. MANAGER

↓

SERVICE GOALS CARRIED OUT
(after I.P.P.)

↓

Evaluate, Review and Modify I.T.P.

↓

PROGRAM **REVIEW MEETING**
(3-6 months later)

↓

REPEAT THE WHOLE PROCESS

b) Rationale for Project

In my consulting practise I do not encounter many teachers or counsellors who, when accepting a new client into their program, look at what they need to replicate from the individual's previous program. In some instances where a client has never been outside of the protection of the parent's home, or was living in an institution with very little programming in effect, it is necessary to start from scratch. However, the majority of persons with mental handicaps who enter a new Program have been in either an academic or residential Program somewhere and have a rich history of intervention.

I have seen hundreds of treatment plans or programs which start out in a very promising way, but then for one reason or another are set aside or given up completely. This results in hundreds of thousands of dollars worth of expertise being spent throughout the lifetime of one individual with a handicap, with perhaps a fraction of this making a substantial improvement in their skill level and subsequently their life. One questions how many companies would survive in business if they met twice yearly to decide goals and delegate responsibility and later the goals were unrealized because employees continually found excuses for not working on them.

A large community service agency in Ontario recently completed a research project (Love, 1990) to determine the quality of I.P.P. conferences within it's agency. The results showed a high degree of compliance with the previously mentioned Ministry guidelines, but weaknesses existed in the overall production of program plans. "Most conferences failed to identify priorities from among the goals suggested, and they failed to state goals in measurable terms" (p.1). Love stated that this problem could be due to either "a) a lack of experience of I.P.P. teams in measurement, or b) vague goals that made measurement very difficult without further definition or revision of the goal". The study also found that only 60% of the chosen annual objectives reflected the overall long term goals (2-5 year) determined by the group (p.2).

The study recommended that conferences should to be run more formally by the chairperson to ensure that those in attendance understand the purpose of the meeting. Love

also found confusion in the use of terminology between "major goal" and "long term goal" and suggested that such terms were subject to different interpretation, thus causing semantic confusion (p.31). The most important overall finding was that the I.P.P. conferences (74 in total) used in the research, produced a mean rating of only 6.3 on a scale of 1-10 (10 being high), (standard deviation 1.5) in rating the effectiveness of the conference to produce a "high quality" written plan.

In my view, these results are not unique to this one agency. The current I.P.P. process in many organizations (service agencies or school boards) do not guarantee that the priority needs of the client are addressed thoroughly and consistently. The principal reasons are procedural and management inadequacies at various staffing levels. Staff cannot be consistent in their program output if their interpretation of a goal or a responsibility is different from that of their colleagues, as a result of vague statements on the I.P.P. and/or I.T.P. forms. If supervisors do not thoroughly train staff in job responsibilities and communicate when changes or additions occur, there is role ambiguity for staff and the objectives are once again at risk. When programming objectives are not stated in measurable terms, the result is a haphazard approach to programming. This leads to programs not being carried over from one staff person to another, or from one setting to another, or if they are, they are prone to misinterpretation, therefore creating the waste of service dollars.

I suggest that weaknesses in the I.P.P. process, as partially demonstrated in the research by Love (1990), has led to poor programming or program failure in the past. Later in this section I discuss issues presented by Gardner and Chapman (1985), Cherniss (1988), Robbins (1987) and Meichenbaum and Turk (1987), associated with low job satisfaction and employee burn-out. One such cause of burn-out is repeated non-attainment of personal goals. If staff are repeatedly confronted with a client who is not making any progress, they will surely experience personal feelings of failure. Hence we have a cycle of failure in the I.P.P.process. Staff do not understand their role or the method for achieving instructional objectives, resulting in clients who do not reach the goals selected in

the I.P.P. meeting. The staff personalize this and it is reflected in their continued program failure with the client. Role ambiguity or semantic misunderstandings of the I.P.P. and I.T.P. forms contributes to the non- attainment of goals for both participants. By setting clear, measurable short term objectives for clients, by formally operationalizing staff roles, improving communication and training of staff, consistency and program objectives can be achieved. This project addresses the various components of the I.P.P. process to assist the staff who are involved in I.P.P.s to become more effective in their management of this procedure.

In order to address these weaknesses I have designed several simple-to-use forms and management strategies. I have outlined in detail, some standardized methods for conducting I.P.P. meetings and writing I.P.P.s and I.T.P.s in an effort to improve the semantic understanding and consequently the delivery of these processes. The objective is to optimize consistency between the service providers, and consistency in the goals set and consistency in the techniques used with the clients.

c) Target Audience

This manual is intended for any professional or paraprofessional who works in a social service or educational (special education) system in which I.P.P.s and I.E.P./I.T.P.s are used. This includes principals, special education teachers, social workers, workshop or group home counsellors, therapists, nurses, or related health care professionals. It would also be of benefit to parents of children with mental handicaps who are new to the I.P.P. (or I.P.R.C.) process or those who are familiar with the process and wish to improve goal setting and strategies for their child. The user of the manual need not be a programming specialist. Wherever possible, generic terminology* and examples are used to enable as many service providers as possible to benefit from the information.

* Refer to terminology section (in manual section) to clarify concepts.

d) Consistency Defined

In this context, consistency means standardization (uniform practise) in as many aspects of the management of the I.P.P. as possible. This encompasses areas such as the delivery of treatment programs, training of staff, documentation, communication procedures and transfer of programs from one setting to another. Total consistency is an impossible goal to achieve in all areas because of human variables. This project is intended to provide a framework for optimizing standardization (consistency) and/or to be a screening tool to determine where poor management (inconsistency) has lead to nonattainment of I.P.P. objectives.

Two organizational levels are addressed throughout the project; a) the suprastructure level and; b) the primary level. When referring to the managerial bureaucracies and policies which direct the people and processes dealing with the client, the term suprastructure is used. This level would include principals, department managers, directors or group home supervisors. The primary level, is where the specifics of the instructional program are carried out by "front-line" staff, consisting of teachers, instructors or counsellors. Strategies for optimizing consistency at both levels are outlined in various Chapters.

I have chosen to address consistency in four specific areas: attitude, goals, techniques and maintenance. I also discuss the ways in which they impact on the suprastructure and primary levels. These four areas are dissimilar in concept, yet they overlap a great deal. At the primary level there is a need for consistency of technique which should evolve from the goals which were set at the I.P.P. meeting. This can only be achieved once managers and staff have the appropriate attitude towards organizing and monitoring programming. After we achieve instructional consistency and program success, how do we ultimately maintain it?--Simply by setting the goal of maintaining it (another goal) at the suprastructure level and by making a commitment (adopting an attitude) to guarantee its continued success. Hence, attitude affects both levels, and becomes a very pertinent topic to address, because without the appropriate attitude or

commitment, overall program consistency does not occur, and there is nothing to maintain. Therefore the I.P.P. manager needs to employ a double layer of programming--an umbrella procedure to guarantee the consistent delivery of the many aspects of the I.P.P. .

2) BACKGROUND LITERATURE:

a) Causes of program inconsistency

b) Attitudes: How attitudes are formed

c) Methods to develop consistency

d) Discussion

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a) Causes of program inconsistency

The literature within the fields of psychology, education and mental retardation does not refer to consistency as an aspect of programming or program evaluation. In fact, very little information is available regarding this topic, making it necessary to draw from a variety of research sources such as managerial and industrial psychology, organizational behaviour and health care. In the health care field, consistency is often referred to as adherence*.

Many people say a program is only as good as the staff who deliver it. It is not possible to discuss consistency in program delivery or program adherence and recommend strategies to achieve it, without dealing thoroughly with the issues pertaining to the staff who are responsible for achieving this consistency.

*The topic of program adherence impacts onto the health care field, especially hospitals and medical clinics. The terminology used is treatment adherence (or following doctor's orders) and looks into the ways in which staff play a role in the attainment of health goals for patients. The majority of the literature deals with staff compliance to prescribed teaching methods, to make patients adhere to treatment regimens such as diabetic diets, heart monitoring and catheterization procedures. Because of the nature of the expectations upon health care professionals to perform standardized routines, treatment adherence is definitely applicable to the field of special education and social services. The same types of problems occur across all settings (the hospital, residence or classroom) with very similar results--that is staff compliance in carrying out the prescribed routines. I have used the term program adherence to refer to the same issue as applied to this topic.

Many factors contribute to the dynamics between a person and his or her job, their work associates and their supervisor. As well, such factors as limited resources, union regulations, timetables, contemporary ideology and cultural differences are causes of inconsistency. I have limited my project to seven causes of inconsistency which I adapted from related topics in managerial psychology and organizational behaviour. They are as follows:

Causes of program inconsistency

1. poor attitude of staff
2. job conflict
3. role overload or role ambiguity
4. lack of teamwork between supervisors and subordinates
5. lack of monitoring
6. lack of feedback
7. poor communication

I will now discuss the literature pertaining to these causes.

1. Poor attitude of staff

One reason why staff do not adhere to prescribed instructional programs is that they do not see their role as that of instructor, but rather as a care giver. This perception originates from the more traditional attitude that persons with mental handicaps need to be cared for and made comfortable rather than taught to be independent. Staff expectations are low for the client, hence staff do not see the value in conducting the program in the first place. A program might require that staff spend several hours, over a period of months, to teach the client to perform a skill for themselves, where it might take the staff only two minutes to perform (e.g. . tying shoe laces). Teaching a skill is very time consuming and often the time invested in teaching a skill does not always garner the desired results.

According to Meichenbaum and Turk (1987), some of the attitudes of health care professionals in medical settings which account for their not adhering to treatment programs include:

- pessimism, "my input is not useful"
- "I tried it in the past; it doesn't work with my population" (not applicable)
- "It is too complicated. Who can remember to do all these things?" (Stimulus overload, too many obstacles and barriers)
- "Who has the time to worry about and to do what is suggested? I have to see so many patients per hour or per day and there is no time to do all this adherence stuff." (useful but no time)
- "You don't get reimbursed for education and prevention." (no payoffs)
- "I'm not a 'shrink.' I haven't been trained to do these things." (low self-efficacy) (p.257).

Browder (1987, p.119) agrees that " lack of belief in the possibility of change" affects the level of commitment by family members to adhere to a program. Many of these beliefs can be witnessed in the staff working with persons with mental handicaps in academic, vocational and residential programs as well as with parents and healthcare personnel. Their years of false starts, overwork and poor training can leave them feeling very ineffectual in their jobs, thus reluctant to adhere to an I.P.P. program.

2. Job Conflict and 3. Role overload or role ambiguity

According to Robbins (1987, p. 332-344) and Rahim (1986, p.42) people experience conflict in their job if there is role ambiguity, lack of clear organization, communication break-down, work overload, mutual or one-way dependence, or lack of homogeneity between parties. These problems can lead to inter/intra- personal or inter/intragroup conflict, which might create an employee who is less effective because time is taken up with managing or avoiding conflict. With regard to program consistency, the result of conflict is a staff person who is less likely to be consistent in dealing with a given client, because the staff person is preoccupied with managing conflicts, trying to

understand what their responsibilities are, or planning how to carry them out.

Gardner and Chapman (1985) state that there are different types of work overload. Some of these are: doing too many things on a shift, working too many hours overall, or where ". . . staff are expected to work and make decisions without reasonable planning and preparation. This type of overload causes physical and emotional stress. It leads to burnout." (p.267) This also leads to the reduction in the attainment of overall organizational goals. I suggest that role overload, when linked with several other job factors, is an important variable in overall employee job satisfaction.

4. Lack of teamwork between supervisors and subordinates

Another fundamental element in developing and maintaining program adherence is the role of the teacher or direct care worker. Teachers, according to Harrington and Honda (1986) are expected to be specific generalists. They point out that child care workers must be therapeutic counsellors, managers, teachers and relationship builders. Quite often workers in special education or health-care settings deal with very stressful situations and are expected to perform a variety of roles "which can lead to role conflicts within the organization" (Harrington and Honda, 1980, p. 29). They also state "Staff often work in a professional vacuum-isolated by a lack of emotional and professional support. Oftentimes there is too little intra- agency support and little, if any, inter-agency or peer-to-peer interaction" (Harrington and Honda, 1980, p.26).

Each staff person within an organization plays a fundamental role in promoting the achievement of collective goals. I have observed in some consulting experiences a mutual understanding and appreciation for the roles and tasks of all members of the team, no matter what the nature of those tasks are. This 'honouring' as I like to call it, fosters an attitude of respect between members of the team and as a result of the co-operation, more goals are met.

5. Lack of monitoring and 6. Lack of feedback

Gardner and Chapman (1985) discuss the problems faced by caregivers of the mentally handicapped, who begin their careers with high expectations of being able to help the handicapped, not realizing the stress or the complexities involved with teaching this population. Current state-of-the-art programming requires that the primary worker be trained in behaviour modification techniques, health/medical procedures, orthopaedics, cognitive psychology, social work or case management and other skills such as communication augmentative systems, speech therapy, or technical aids. Once confronted with the reality that persons with mental handicaps a) learn slower than normal individuals and b) require many more teaching trials to acquire a skill, staff become discouraged, overwhelmed and frustrated. The pay is usually low and intrinsic rewards few, leading to burnout and a high turnover of staff (Gardner and Chapman, 1985, p. 268). The repetition and routine soon take their toll on the enthusiasm and energy of a new teacher or counsellor who gets little or no feedback from his or her immediate supervisor.

People in the health care field are usually there because they are reinforced intrinsically. However, if this reinforcement is not substantiated in some form (supervisor feedback or client improvement), they are reluctant to comply to the specifics of their job. Gardner and Chapman (1985) elaborate on this notion:

> The symptoms of burnout are more difficult to analyze. Most people enter the human service field to help others. In burnout, the initial attitude of compassion turns to not caring.The desire to help and to make a contribution and the urge to be creative, turn into a "nobody really cares" mentality. . . . Psychological or emotional burnout is a more complicated problem. Some people become burned out in environments that do not provide emotional support to employees. As a result, many of the initial symptoms and behaviours of burnoutare not sufficiently appreciated because they are present in many staff. A common symptom of burnout is undirected anger. This is anger not justified by special circumstances.

> Instead, it is an anger that boils and ferments near the surface. Unfulfilled expectations fuel the anger. The anger is then directed against supervisors, colleagues, or the people participating in the program (p.264).

Cherniss (1988) conducted a study in which the personal characteristics of two supervisors, in this case school principals, were evaluated in reference to the level of burnout exhibited by their staff. He found that the principal of the school with a low level of staff suffering from job burnout engaged in significantly more support than a school which had higher burnout scores on a job satisfaction test. He concluded that supervisors might help reduce staff burnout by spending more time in planning, organizing, and advocating for staff. Furthermore, a supervisor who listens more and talks less, and who tries to engage in much small talk with staff, will not necessarily be more supportive (p.453). Cherniss suggests it is important that supervisors be task oriented and not simply give the impression that they are supportive; they must follow through with concrete actions.

7. Poor communication

Robbins (1987) noted that semantic misunderstanding can cause misinterpreta- tion amongst staff and inefficiency in an organization:

> Semantic difficulties are a frequent problem in organizations.They impede communication essential for cooperative efforts between units. Semantic difficulties can be attributed to the different training background, and socialization processes that members of units have undergone. . . . As with physicians and professional hospital administrators, their academic training and orientations differ significantly. Differences in training develop disparate vocabularies and jargon, which impede the effective movement of ideas (p. 344).

Many of the staff I talk to about programming say that they could not understand how to carry out an instructional plan, or what was meant by the objectives stated in the I.P.P., because of the way they were written. Given the amount of time it takes to write up an I.P.P. or to prepare an I.T.P., this is very unfortunate. There is either a deficiency in the training of these staff or, as I suspect, the information was not communicated appropriately in the I.P.P. meeting. Before a supervisor lays blame on staff for not adhering to job requirements, he or she must be certain that those requirements were stated and demonstrated clearly in the first place. These problems are addressed in various Chapters of the manual.

Attempts are made to achieve consistency by managers at the suprastructure level in the form of staff training, annual staff evaluation, yearly reports or statistics and staff communications (meetings, memos etc.). But there is rarely regular follow-up to determine specific weaknesses in the system, or determine if the weaknesses originate at the suprastructure level itself. There is a definite need for evaluation of all aspects of program effectiveness in I.P.P.s at both the primary and suprastructure levels. This project attempts to minimize the causes and effects of personal blocks to performance and effectiveness, by providing strategies that take into account the dynamics of the individuals who must carry out the requirements of the I.P.P. process, and pin-pointing where the process needs improvement.

b) Attitudes: What they are and how they are formed

Because of its importance to this topic in all phases of programming, it is necessary to deal with the question of attitude through a review of the current literature on how attitudes are formed.

The use of strategies to optimize consistency implies that teachers and direct care staff standardize their job behaviours in ways which may have been prescribed by someone else, despite the fact that human behaviour is difficult, if not impossible, to standardize. Social psychology has taught us that attitudes and belief systems are learned

by social and cultural experiences. In my view, these experiences form the basis of our personalities and are compounded by education and socioeconomic variables. Although there is more likelihood of success if everyone shares common attitudes, we cannot force staff to alter their attitudes. We can only influence attitude. A consistent attitude is an intangible, abstract characteristic, only measured by subjective tests. In contrast, preset cognitive or skill goals and instructional techniques can be measured by observable and concrete behaviours.

Lawless (1979) states that "effectiveness is defined in terms of the degree of goal achievement observed in the organization" (p. 32). In order to achieve goals, there must be unity among members of an organization and some form of common attitudes or commitment to goals. Lawless goes on to say that attitudes have two elements; one is an affective or feeling component, while the other is a behavioural tendency. We can have an attitude about an issue or an item and simply feel a certain way about it and keep it to ourselves, or we can display in our behaviour our attitudes by such things as the clubs we join, the type of work we perform, or the place we live.

A great deal of research has been done regarding the development of attitudes. It involves the juxtaposition of our feelings, cognition and behaviours and the agreement amongst these elements with ongoing information from our environment. Rosenberg (1960) put forth the theory of affective-cognitive consistency, where our attitudes are affected by the way we value certain things, thus developing our cognitive framework of the world and the way we behave within it. If we believe that an object will lead to attainment of a number of important values then we have a strong positive attitude about it; similarly, strong negative feelings (prejudices) will be associated with beliefs that the object tends to block the attainment of important values.

Festinger (1957), developed a second theory of attitudes, which is slightly more controversial. He suggests that people are not motivated by positive values, but rather by their attempts to avoid cognitive dissonance. Cognitive dissonance is whenever a cognition (an object or idea) is incompatible with our framework of the world and how it should be.

He says that the presence of dissonance is psychologically uncomfortable, thereby motivating people to reduce the dissonance and achieve consonance. One can reduce dissonance by: avoiding issues, gathering with others who share common ideas/beliefs, convincing ourselves that an activity or item is better for us even though it is bad for others, or by forgetting about it. Think about people who continue to smoke, given all the information regarding lung cancer. These people are dealing with a subject which is psychologically uncomfortable for them, but they do not wish to believe the medical reports, the "doctors advice" etc., because it is too difficult to alter their behaviour. As a result, they choose one of the above coping mechanisms to reduce the dissonance they are experiencing.

A third theory regarding attitudes is that of Katz (1960), whose functional theory maintains that holding a particular attitude can maximize rewards and minimize penalties. Individuals therefore form their attitudes according to what motivates them. An attitude can defend the ego against unpleasant truths about the self or the harsh realities of the environment. An attitude can also express a basic value system, or make sense of experiences and the way we understand the world.

The subject of attitude plays an important role in program planning for persons with mental handicaps. The attitude of staff, as discussed above, affects the way they view their role, the client, and program recommendations. In the manual I discuss various methods for the I.P.P. manager to deal with attitudes which come into conflict with the objectives of the I.P.P. team. These strategies can be found in Chapter Three (c).

c) Methods to Develop Consistency

For some staff, consistency in I.P.P. management may be a foregone conclusion. It occurs to them naturally that when they take on a new client they meet with previous primary workers, or when changing an Individual Teaching Plan (I.T.P.) objective, they

discuss it with other pertinent individuals. However, this is not always the case.

Much of the information dealing with employee co-operation comes from the literature on management and industrial psychology. It can easily be applied to social and education services. In particular, behaviour modification has played a strong role in developing strategies which reflect on staff performance training and program adherence. The results of the use of behaviour programming are positive (Reid and Whitman 1983; Bourdon 1982; Burgio et al., 1983; Flanangan et al., 1983; Mayhew et al., 1979; Burg, Reid, & Lattimore, 1979; Iwata et al., 1976; Montegar et al., 1977). The following is a survey of the various aspects of staff performance training as viewed by the behavioural research which was used in developing the strategies.

1. Recognizing a problem exists

The first step towards delivering a consistent program is to recognize there is a problem when clients are not achieving the goals set out in their I.P.P.s. For one reason or another there may be conflict between staff members either intra- personally or interpersonally. These psycho-social issues are a common problem for management when faced with a group of staff, who are often reluctant to try something new or, strategies which are time consuming. This can be a major source of conflict amongst staff and supervisors which can become more complicated if the staff are unionized. It is also a problem for psychologists and behaviour therapists who are asked to remedy these problems.

Jonassen (1989), suggests that it is inaccurate to assume that the reason people do not perform their jobs appropriately is because they do not know how. He recommends that a careful analysis of the problem be conducted to determine the desired consequence of certain behaviours, the source of the problem, the difference between the goal and the actual performance, and the causes of the deficient performance. The source could be a personality conflict, poor communication, competition for limited resources, lack of homogeneity within a group (Robbins 1987) or a variety of sources, unrelated to lack of

skills. Once an analysis is completed, a suitable solution can be selected. Jonassen also points out that use of performance analysis is "widely used in industry, agency and military training operations, however, in more traditional educational settings (e.g., public schools, higher education), the logic is novel" (p. 15).

2. Discussion of problems and plans at all levels (supervisors and subordinates)

Usually it is management (or board members) who request assistance to alleviate problems with staff. This can make staff more reluctant and possibly feel threatened, because they see this move as negative, suspecting management is critical of their skills. If, however, staff ask for help, or voice their own training needs, there is more likelihood of agreement and enthusiasm in regard to performance training (Robbins 1987). A cohesive organization is one in "which all the members like one another, work well together and communicate fully and openly" (Robbins 1987, p. 28). If this does not exist, the overall effectiveness of the organization is threatened.

When people feel powerless while working on a program, because they know they are only a small "cog" in a very large wheel, it results in feelings of low motivation or apathy (Hersey & Blanchard 1972). As a result, we must deal with the attitude of staff not just toward programming or the client but also with being involved in staff performance training. As mentioned earlier, if staff do not see the value in teaching clients to perform skills for themselves, adherence is reduced, which leads to inconsistency and little or no skill acquisition by clients. The team approach in service delivery can help to increase effectiveness (Hersey & Blanchard 1972), but it requires a great deal of effort from the parties involved to sustain the desired objective. Blake (et al., 1970) assert the following:

1. The more groups share common responsibility for problem solving and for decision making, the more likely they are to cooperate.
2. The more groups are able to establish joint memberships, the more likely they are to cooperate.

3. The more groups are willing to share and discuss their perceptions of each other, the more likely they are to cooperate.

(in Cohen et al., 1984, p. 336)

3. Analysis of jobs and 4. Definition of goals and performance objectives

In the field of management psychology, these methods of aligning supervisors and subordinates and setting target behaviours are referred to as participative management and management by objectives, respectively. The use of management by objectives is similar to that of behavioural contracting. Behavioural contracting is an agreement (written or verbal) negotiated between two or more individuals to achieve a particular, mutually agreed upon target behaviour (Kirschenbaum and Flanery, 1985, p. 598). The use of contracts to bring about desired behaviours has been used extensively in therapeutic situations (weight loss, smoking cessation, family-marital relations). Behavioural contracting and management by objectives have both been used successfully by many businesses and direct care staff working with emotionally disturbed individuals, especially adolescents. Hersey and Blanchard (1972) define management by objectives as:

> A process whereby the superior and the subordinate managers of an enterprise jointly identify its common goals, define each individual's major areas of responsibility in terms of the results expected of him and use these measures as guides for operating the unit and assessing the contribution of each of its members.
>
> (p.104)

With regard to "participative management" Burgio (et al., 1983) suggest:

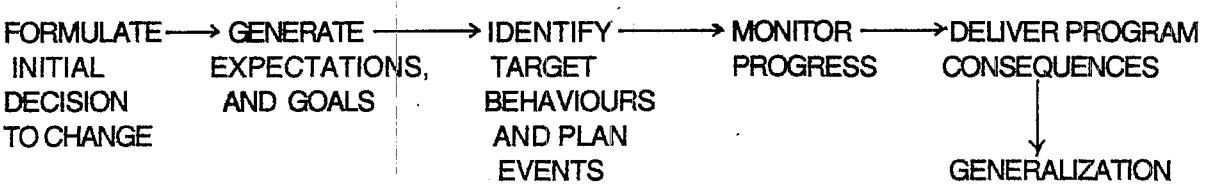
> . . . by allowing staff to participate actively in the design and implementation of a management program, there may be a greater likelihood of acceptance of that program. In this latter regard, Skinner (1953) has suggested that the greater the feeling of personal control within a situation, the lower the probability of a person exerting

counter-control in that situation. (p. 38)

The notion here, which is supported by others (Robbins, 1987; Harrington and Honda, 1986; Kirschenbaum, 1984; Varni and Wallander, 1984; Peck, Killen & Baumgart, 1989), is that individuals are more likely to exhibit certain behaviours if they have been included in the identification of target behaviours, selection of goals and consequences and monitoring of those behaviours. Table #2 represents a model of behavioural contracting and gives an idea of the sequences involved:

Table #2

A SEQUENTIAL MODEL OF BEHAVIOURAL CONTRACTING:



(Kirschenbaum & Flanery,1984, p. 599)

By operationalizing (defining and breaking down into small steps) the role of staff or standardizing the procedures, there is less chance of conflict due to communication difficulties and increased chance for uniform output (Bourdon, 1982). Divack (et al., 1985) states that consistent techniques are required to make behavioural procedures effective and failure of behavioural programs can occur if techniques are not adhered to by all members of a team. Although it is nearly impossible to produce identical responses from a group of people who may be working with a client "it is possible to bring within

acceptable limits everyone's word choice, facial expression, sentence complexity and tone of voice" (Divack et al., 1985, p. 349). Yet this is only possible if the techniques are written and defined as clearly as possible to reduce the likelihood of incorrect interpretation.

5) Training of supervisors and subordinates

How the techniques are taught to staff also affects adherence to prescribed instructional programs. Reid and Whitman (1983) focused on the ability of staff to learn new procedures, and their willingness to adhere to behaviour modification teaching methods. They found that lectures advising staff how to use a technique or modeling it for them, called antecedent approaches, were the least successful in improving staff performance. Contingency management procedures such as immediate performance feedback from supervisors or professional personnel was the most successful in changing staff skills.

The literature strongly suggests that the most positive influence must come from the management level if performance training projects are to be accepted by staff. Resistance to behaviour management techniques continues despite its proven success record. To many, behaviour still implies "negative behaviours" (violent or aggressive) as opposed to learning or performance behaviours. Flanagan (et al., 1983) described a typical situation in which a behaviour training team was asked to "make the best of the situation" by working only with cooperative staff members, without the support of management. This lead to the eventual failure of the project.

The dependence on an outsider to conduct staff training or program techniques is not sufficient to maintain progress. The impetus must come from the management level. Divack (et al., 1985) recommend that the individual(s) involved with staff performance training (such as behaviour management programs) be "viewed as a full member of the treatment team, rather than as an outsider who comes to offer occasional advice" (p. 349). The responsibility for developing consistency and providing feedback should be that of the

primary supervisor or case manager. Meichenbaum and Turk (1987) propose that all aspects of adherence training "cannot merely be delegated to a technician with an accompanying expectation that the improvements will be maintained. Instead, we must modify our own behaviour to maximize the maintenance of patient adherence" (p. 260).

6) Measuring/monitoring progress and 7) Feedback

Two of the major problems with strategies which promote staff treatment adherence are the time necessary for their implementation and the psycho-social effects of the procedure on staff. The question of who should monitor and which monitoring system is more effective is still being tested. Staff self-monitoring, supervisor monitoring and public posting of performance continue to be popular, but some research questions if staff can be trusted to give honest information when it comes to self-monitoring (Bourdon, 1982). The important factor to the success of self- monitoring is not only to make the target behaviours measurable and observable, but "attention to the collection system can reduce the extent of errors and the tendency by staff to cheat" in their collection (Bourdon, 1982, p.107).

Sharfstein (1985) thinks that professionals can be trusted to monitor themselves much more effectively than a third party such as the government. He sees third party monitoring of professionals (especially psychiatrists in the U.S.) as intrusive and unwarranted. Kirshchenbaum (1984) suggests that . . . "self-monitoring generally produces more consistent changes in behaviour compared to external monitoring" (p. 611). He supports the notion that self-monitoring is less intrusive and less expensive, since it does not require the time of supervisory staff.

Self-monitoring is highly acceptable to staff, is time efficient with respect to the supervisory time necessary and, in research conducted by Burgio (1983), it is beneficial to clients as well. He designed a procedure for improving direct-care staff performance by using a participative management approach in institutional settings that involved self-monitoring procedures. Staff not only set their own performance standards (for

example, increasing staff to client interactions), but they also monitored and graphed their own behaviour, evaluated their own performance and praised themselves as well. This procedure appears to have overcome the resentment staff have for being monitored (or "watched") by a supervisor.

Although self-monitoring systems have proven to be an effective tool in bringing about changes in staff behaviour, the need for supervisory feedback is just as important to maintaining appropriate staff behaviours. If staff are isolated and their actions go unnoticed, there is less likelihood of improvement or change (Cohen, et al., 1984). Supervisors need to be aware of the manner in which they give feedback. Public posting of staff performance can be confused with a means of "humiliating staff for shortcomings, as opposed to recognizing their efforts" (Green et al., 1978, p. 411). Although punishment or threats of losing one's job is the technique used most often to control staff performance, it is questionable if it will sustain improvement and what the overall effects can do to staff morale (Reid & Whitman, 1983).

Cohen, (et al., 1984) and Lawless (1979) agree that feedback to staff regarding their behaviour, whether it be positive or negative, is fundamental to solidifying skills in a subordinate's behaviour repertoire. The successful secondary outcome, in this case a client or student acquiring a skill, is not enough to bring about a positive behaviour consistently, or to extinguish a negative behaviour respectively. They both recommend that feedback be concise: descriptive rather than evaluative, dealing with specifics and given in small doses--not too much at once. Staff need to feel accountable to superiors on a weekly basis. Bourdon (1982) agrees by stating that "feedback given casually, inconsistently or only when the performance is poor, loses its impact " (p. 108). Supervisors must also set a good example by being willing to subject themselves to feedback as well and making an effort to change their behaviours in response to it.

8) Follow-up and delivery of contingent consequences

Flanagan (et al., 1983) designed a facility-wide consultation and training team

similar to the one I have been referring to. He worked closely with management to promote institutional changes. As in most organizational behaviour management programs there was a strong reliance on middle managers to reinforce staff for attending behaviour training sessions and for delivering specific programs to residents. If contingencies are agreed upon and scheduled evaluation points are determined by all members of the group, success is possible. However, as Flanagan stated:

> If top management fails to track progress and deliver effective consequences, critical events or actions do not occur and failure is guaranteed. Unfortunately, failure is often attributed to behaviour modification procedures being impractical or unworkable when in fact they are merely untried. (p.165)

9) Maintenance

Flanagan (1983) suggested that maintenance be achieved by first, making change and improvements to the institution a priority and second, by continuing, weekly, monthly and yearly, to set performance objectives. He recommends that staff continue to be monitored by management, and management be accountable to predetermined goals reviewed regularly by an external agent (e.g. a consulting team, board of directors or parent group). Bourdon (1982) suggests that "at each level of management managers have a vested interest in examining the progress of the managers two levels below" (p.111). Thus you have a built in maintenance system at both the suprastructure and primary levels. The follow-up process is most important to consistency and although it may be time consuming initially, it saves time in the long run by avoiding the need to start and restart programs or staff performance training sessions.

d) Discussion

Although there are no concrete recommendations for methods to optimize consistency in program management, one can glean from the literature that it is a recognized area of concern and the all-inclusive model for more efficient programming still eludes us.

Until recently, research and management techniques looked at employee skills and used behaviour techniques and monitoring systems to improve the performance of staff. These techniques helped to bring about some degree of short term improvement in some aspects of programming, but little is known about how to maintain successful programming once it has been achieved. Research points out that management should make themselves accountable to annual goals and provide feedback to staff, but more research is needed to determine the optimum system for long term maintenance of performance goals.

It appears that consistency is assumed to be present in the delivery of the I.P.P. process, and in the supervision and training of staff, yet the amount of ongoing research being conducted to improve programming and staff performance leads me to question if supervisors and staff are properly trained in the first place. Perhaps there is a need to improve training programs at the college and university levels, or to examine initial staff orientation methods.

More information regarding methods to change inappropriate attitudes toward persons with mental handicaps would be beneficial. Negative attitudes impact on a variety of program factors such as staff program adherence, public attitudes and community integration.

3) METHOD

The manual is presented in seven chapters, the first two elaborate on the notion of consistency and contain background information for those individuals not familiar with the current literature regarding programming and intervention techniques. Chapters Three to Six elaborate on methods to optimize consistency in attitudes, goals, techniques and in the maintenance of consistency once it is achieved. Chapter Six is a synthesis of many of the notions and could be used by readers who simply want an overview of the strategies. The concluding chapter summarizes the strategies and provides a flowchart for incorporating the strategies into an agency's I.P.P. process.

The strategies to optimize consistency are comprised of several forms to be completed by I.P.P. team members and the I.P.P. manager. The forms are designed to move about with the client and no matter what program the client is attending, the new care-givers are provided with thorough information about the primary intervention needs of that individual so that they can easily adapt their techniques to those which have met with success in the past.

Several sections in the manual outline suggestions for dealing with certain situations such as how to manage an I.P.P. meeting or foster attitude changes. These have been developed from some of the literature on management psychology, as well as my own ideas. The guidelines for the writing of I.P.P.s and I.T.P.s are based on my own experiences after years of preparing and evaluating these documents. The guidelines stress methods to minimize inconsistency due to vague or ambiguous communication.

I find the behavioural research has been helpful in identifying the causes of poor treatment adherence, but recommendations for dealing with problems which result in inconsistency are limited. I have been involved with several staff performance training projects which involved organizational behaviour management principles and consider them useful for teaching staff. However, there are few practical solutions for groups who

cannot access behaviour management teams or performance training specialists. In order to provide the I.P.P. manager with a summary of strategies to obtain consistency, in Chapter Six I juxtaposed the causes of poor treatment adherence with the standard performance training model and designed concrete strategies (detailed in the manual) to facilitate consistency in overall I.P.P. process. The intention is that the strategies can either provide staff with methods to alleviate the problems before they begin, or act as a screening device to identify where the problems exist and alert them to the need for intervention.

The manual in it's complete form is presented in Part B of this project and is followed by the appendices and bibliography.

4) EVALUATION PROCEDURE

To evaluate the anticipated effectiveness of the strategies recommended in the manual the following procedure would be used:

a) To evaluate anticipated effectiveness

Reader survey - The rough draft of the manual would be given out to approximately 18 individuals currently working with persons with mental handicaps. These individual readers would represent a cross-section of professionals and paraprofessionals with variances in the number of years in this field, amount of training, current role or responsibility and age range. They would be asked to evaluate the rough draft using a "Reader Survey Form" (see next section). Their ideas and criticisms regarding style, ease of use, general suggestions for improvement and opinion regarding the topic would be elicited on this form. The information would then be used to rewrite the manual to make it clearer and more useful.

b) To evaluate actual effectiveness

Subjects - Thirty individuals would be selected from a cross-section of vocational, academic and residential Programs. The subjects would hold a variety of positions, but the criteria for selection would be that they manage at least one client I.P.P. as part of their responsibilities. Each subject would select one student/client which they would use throughout the experiment.

Pre-test - Client records would be evaluated by the researcher using the Past-I.P.P. Review Form (Appendix F), recommended in Chapter Three of the manual. Data would be collected regarding the number of times a particular goal has appeared on past I.P.P. s and the number of times short term objectives and subsequent instruction plans had been successful.

Method - The subjects would then be randomly divided into three groups of 10; three or more from each of the Programs listed above. The first group (A) would attend a one-day workshop on programming and consistency, where limited reading material was handed out. The second group (B), would be given copies of the manual, extra copies of the forms, and asked to use these for two years. The third group (C) would be the control group who would be exposed to neither of the above. Contact would be maintained over two years through written correspondence and telephone reminders.

Mid-Experiment Probe - After the first year, a researcher would attend an I.P.P. meeting for subjects in groups A and B, to score how many of the strategies were in use. At this same time client's files from both groups would be examined to determine; if the subjects were using the strategies and; how they were used.

Post-Test - Following the two years a post-test would be conducted with the client records from all groups and the Past I.P.P. Review form, to determine if there had been an increase in the successful attainment of I.P.P. goals and instructional objectives. Staff from group B would also be asked to complete a Survey form detailing their satisfaction with the manual, the forms and recommendations for improvement. Staff from all groups would complete a job satisfaction form.

Evaluation of Results - A successful outcome of this experiment would produce the following results:

- improvement in attainment of I.P.P.s goals in group B, as a result of the management strategies to optimize program consistency
- demonstrate that individuals who had attended a workshop did not make as significant an improvement in their program management skills as those who had used the manual for two years
- secondary data would show that after two years, staff who incorporated strategies to optimize consistency in I.P.P.s had greater job satisfaction

5) RESULTS - READER SURVEY:

a) Description of process

b) Survey form

c) Evaluation of Results

d) Discussion

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a) Description of process

As outlined in section 4, the first stage of evaluation of the manual is to receive feedback from a variety of readers on the format and contents. This was completed in January 1991, and some comments have been incorporated into the final draft of this project. The readers were selected from a cross-section of school boards and service agencies in order to have a broad range of backgrounds and experiences. The survey was designed with input from one of the project supervisors. The readers were given one month to read the manual and asked to complete the survey form below. Other than the covering memo, no other information was given.

Beth Bradshaw
24 Reid Drive,
Mississauga, Ont.
L5M 2A6

Dear Reader

Let me begin by thanking you for helping me to complete this project. Your input is extremely valuable. When reading the manual I am interested in having your comments about the **content, clarity** and **tone.** Please complete the reader survey attached to this letter and, if you like, elaborate on your comments on the back of the form. Even if you don't read the manual, please complete this form anyway.

Once you have finished reading it, please give me a call (858-0779) or return the manual and survey form to me as soon as possible. I need the form back on or before February 5. Thank-you again for your time.

B. Bradshaw

b) READER SURVEY:

What is your position:_____

How many years have you worked with this population?_____

Please answer all of the questions as honestly as possible and elaborate at any time.

Use a check-mark beside the phrase which best describes the way you read the manual:

1. Did you read the manual? yes_____ sort of _____ no _____

2. If "sort of" did you: ___ skim read

___ read only a few sections

___ read selected Chapters

___ other:_____

3. If you didn't read it all, or only skim read it, why? Tick the box beside the phrase which best explains why you did not read the whole manual.

___ I was too busy

___ The manual was too long

___ The manual was too complicated

___ I'm not interested in this topic

___ I started to read it but lost interest

___ other (please explain):_____

4. Place a check-mark beside the word which best describes your opinion of the manual. (Please select one descriptor from each column.)

___ excellent ___very helpful

___ good ___ somewhat helpful

___ fair ___ not helpful

___ poor ____ Other:_____

5 a). What Chapter(s) were the most helpful?

_____

5 b). What Chapter(s) were the least helpful?

_____

6. With regard to the format of the manual, it was: (please select one from each column)

___ excellent ___very clear

___ good ___ somewhat clear

___ fair ___ difficult to follow

___ poor ___ Other:_____

7. What information needs to be elaborated on?_____

_____

_____

8. What information was missing that you feel is pertinent to the topic?

_____

_____

9. What, if anything, was not needed?

_____

_____

10. Which of the strategies do you feel you would likely use?

_____

11. Do you like the title? yes_____ no_____

If not, what other title would you use?_____

12. What are the main criticisms you would make about the manual? Please specify.

_____

_____

13. What other comments would you like to make about the manual or this topic?

_____

14. Would you agree that inconsistency is a major contributor to program failure?

Yes_____ No _____ If not, what is?_____

_____

c) Results of Survey

Of the 18 survey forms given out, 16 were returned. Within the group the average number of years working with this population was 8.9. Respondents were from different organizations; school boards and/or service agencies as indicated with the following codes:

* = community service agency A

+ = community service agency B

@ = school board A

¢ = school board B

† = school board C

The range of occupations of respondents were as follows:

Program managers - 1*

Principal - 1 @

Special Education teachers - 2 ¢ †

College Professor (in this field) - 1

Residential Counsellors - 3 *+

Vocational Instructor - 1 *

Teaching Assistants - 3 ¢ †

Department Director - 3 @ *

Persons not in field - 1

Of the 16 who responded, seven read it completely while the remainder either read only selected Chapters or skim read it. The main reason given by six of the respondents for not reading it completely was that they were too busy. The overall opinion of the manual was: six people felt it was "excellent", while eight felt it was "good". Ten individuals found it very helpful while four found it somewhat helpful. Two people did not respond to this question. Chapters 3, 4d, and 5 were the most helpful. Chapters Four

a,b,c and 6 were considered the least helpful. With regard to the format of the manual, 12 readers found it very clear, with no one stating that it was difficult to follow. Four readers did not answer this question.

Comments regarding the content of the manual were as follows:

- Seven people responded to question #7 which asked what sections of the manual needed to be elaborated on. There was no consensus among their comments. One person felt the manual should elaborate on more case studies and references to practical problems in the field. Another suggested more discussion should be given to the rights of disabled people, and parents' involvement in the process. One person wanted elaboration on the "Progress Postcard" strategy and another felt the theme of consistency should have been referred to more often throughout the manual. Lastly, a residential counsellor felt that more emphasis on consistency of attitudes should be emphasized throughout the manual.
- Four persons made comments for question #8 which asked what information was missing. One felt more attention should be given to the variables which lead to inconsistency, such as "case-load and time restraints". Two others stated that the manual should discuss alternatives to programming, stating that not all clients need a structured program and perhaps my values base or orientation was inappropriate. One person suggested a back-up video be made to go along with the manual as part of a staff training package.
- Question #9 asked what information was unnecessary or not needed. Only five people responded to this question and again, there was no consensus in their comments. One person felt the information on fostering attitude change was unnecessary. Another felt it was not necessary to elaborate on Gentle Teaching. One respondent did not feel it was necessary to elaborate on how to write I.P.P.s and I.T.P.s, stating it was review for persons in this field. One person felt there had been too much definition and repeated analysis of terminology. Another suggested that the manual was overly personal.
- Question # 10 asked which of the strategies would they be most likely to use. Fourteen people responded to this question. Three people said they would use all the strategies.

Four people specified the Pre-I.P.P. form. Two felt they would use the I.T.P. format recommended and three stated they would use the Standard Teaching Procedure outlined in Chapter Five. One person said they would use the communication suggestions made in Chapter Six while another made a supportive (agreement) comment regarding the topic in general.

- Eleven readers liked the title, while four did not. One person suggested: "Consistency; to be or not to be" and another suggested that the main title should focus on implementation of I.P.P.s. One person did not respond to this question.

- Question #12 asked the reader to specify their main criticisms of the manual. Three people commented that the range of the topic was too large, feeling it needed to be consolidated and synthesized. Several people felt there was too much research analysis. Four people gave detailed comments and made remarks on specific sections of the manual (which I have incorporated into the final draft). Another person felt there was too much repetition. One person (who only skim read the draft) repeated their criticism that the manual should give a "more vigorous consideration of values; less presumption that programming is a virtue and an end in itself. This is a dangerous concept in the wrong hands!"

- When asked for general comments, all readers responded. Four stated that the subject matter was very important. The overall consensus was favourable, most stated that they enjoyed it, "liked the chatty style", felt it was "not overly academic and full of jargon", feeling it was very readable and clear. One respondent said that the recommended system was very simple and practical, agreeing that the field is prone to "reinventing the wheel". Once again there was a criticism (from the same individual mentioned in the previous point) that the "value base" of the manual, as stated in the opening text presented a serious problem.

- When asked if they would agree that inconsistency is a major contributor to program failure one person did not complete this question. Fifteen said yes, with no one disagreeing.

d) Discussion

The feedback from the reader survey was generally favourable. Most persons who read it were in agreement that the topic was significant and had a substantial effect on the management of I.P.P.s. The majority of the comments from staff in subordinate positions tended to be positive and reflected their need for concrete input on how to write I.P.P.s and I.T.P.s. Comments from readers in a senior or managerial position were more critical regarding specific philosophical and technical points. I suspect that the positive comments regarding topics such as communication strategies and changing attitudes were a result of the learning interests of the respondent. Readers with strong biases towards Social Role Valorization (S.R.V.) principles tended to repeat their criticisms regarding the lack of consideration for the "valuing" of persons with mental handicaps throughout the manual, making little or no comments on other aspects of the manual such as format or strategies. Several specific comments regarding the set up, amount and placement of background literature was extremely helpful in the preparation of the final draft.

As a result of the feedback from the reader survey changes were made to the chapters on background information and maintenance. Discussions regarding current philosophical attitudes and approaches to programming were grouped into a general information chapter (Chapter Two) thus allowing persons familiar with topics such as history, S.R.V. and Behaviourism to skip over it. The section pertaining to terminology is now placed after the Preface for several reasons. One reason is to immediately acquaint readers (novices and others) with the terms used in the manual, and secondly, in response to the comments on the reader survey, to make the manual clearer-- less bogged down in definitions and terminology. This placement also assists readers who are preoccupied with a different "value base" to determine whether or not the manual supports their philosophical approach, which may lead them to decide to discontinue reading further.

Information regarding methods to foster attitude changes was grouped with information on how to begin the I.P.P. process ("Getting Started"). The chapter on maintenance was simplified and the suggested strategies made easier to find and follow by taking out most of the description of supporting literature. Much of this background theory was placed in section two of Part A. Should the manual be published in the future, Part A would be made available separately, for those readers who want more thorough background research information.

Although the suggestion of presenting the strategies in the form of a video package is a good one, it is questionable if this would be an effective training tool, since, as the research shows, lecture type staff training does not develop staff skills as well as one-to-one teaching sessions with supervisory follow-up. Instead, I would recommend one day workshops for supervisors, in which the manual would be used as the training format. It would review the strategies, demonstrate the correct use of the forms and help participants to identify target areas of need in their individual I.P.P. management process. The expectation would then be for the supervisors to return to their own facility to put the strategies into place with their staff.

6) Conclusions

Upon completion of this project, the need for further attention to the notion of I.P.P. consistency has become strongly apparent. It is evident from the related research and from the results of the reader survey, that the need for consistency in program management exists and is a recognized weakness in many situations. Without following through with the proposed method of evaluation, it is difficult to determine if the strategies put forward in the manual would indeed alleviate some of these problems.

As services for persons with mental handicaps have expanded, the problems in delivery of programs have grown as well. Simultaneously, issues pertaining to philosophical approach appear to interfere with the development of effective intervention techniques such as behaviour management and staff performance training. As a result of writing this manual, it has become apparent that the S.R.V. movement can no longer be looked upon as merely a fringe group, since whole organizations are currently adopting 100% of the S.R.V. principles and choosing not to expose their client's to programming of any sort, as it is considered non-valueing. I can only conclude that this approach will not lead to improved delivery of services, or attainment of skills by the clients, but rather, a further division between service providers. Although efforts were made to detach the information presented in this manual from philosophical arguments, it was not always possible, given topics such as consistency in attitude, (behaviour management) techniques and terminology.

Inconsistency is likely a problem in a variety of professions such as law, politics, manufacturing and commerce. The social service industry is relatively new (basically only 100 years old) and continuing to develop its focus and structure. As organizational processes evolve there are likely to be shifts in management techniques from highly structured to that which is more casual or eclectic. However I doubt it will never become as standardized as the manufacturing sector. As stated in the manual, this is due to the nature of this field, where the social service mandate is that of assisting people to improve their lives. Attempts have been made in this manual to find a balance between the need for improved organizational processes and the sensitive nature of dealing with individual human needs and differences.

PART B - THE MANUAL

Management Strategies to Optimize Consistency in Individual Program Planning

A manual for teachers, I.P.P. managers and counsellors working with persons who have mental handicaps

TABLE OF CONTENTS

CHAPTER FIVE- CONTINUED:

CHAPTER SIX - STRATEGIES FOR CONSISTENCY

CHAPTER SEVEN - SUMMING UP

PREFACE

Many things happened while I was writing this manual. I traveled through Europe for nine months, helped deliver my friend's baby, and a war started in the Persian Gulf. Great events, horrible events. Unfortunately it is the horrible events which have the most impact on us. I cannot help but make a personal connection with this war in my rationale for this project. During the first few days of the war, I noticed feeling disappointment and discouragement. I felt a sense of failure as a member of the human race; the Cold War had finally ended and the Berlin Wall was down. We had come a great distance as a species to be better, to overcome our differences, to be a more civilized race. Two steps forward, one step back. This new war told us all we had not really come that far at all. My sigh of disappointment seemed to be felt collectively, almost around the world; the feeling was evident in interviews I saw on the television, in the peace marches I attended, in the newspaper editorials I read, and in my colleagues and friends.

This disappointment reminds me of my feelings regarding the treatment and management of people with handicaps. How much progress have we made? In the second half of this century the institutions were shut-down. People with handicaps were allowed into the education system, they were given nice homes and recreational programs. But, has society really made a profound difference to the lives of these people, or is it just "window dressing"? The same sigh of disappointment I described above, is there in my professional colleagues and the families I meet. The disappointment is there when I visit a school playground where a child sits alone in a wheelchair, watching others, but no one ever speaks to that child because they don't know how to use the picture board on his or her lap tray. With all our legislation, technology and pedagogy, have we really made any difference in their lives? Two steps forward, one step back.

Since 1976 I have worked in southern Ontario with individuals who have mental handicaps and who range in age from 6 months to 72 years old. In almost all cases they are dually-diagnosed; that is, as having one (or several) other disorders. These include behavioural, communication, visual, motor,

intellectual, and auditory impairments, as well as medical problems such as epileptic seizures. I first worked with this population in a recreation capacity as the co-ordinator of integrated summer programs, then as the training co-ordinator for a communication augmentative service at a "crippled" children's center in Toronto. I later became a special education teacher (behaviour and Total Communication) working with multi-handicapped children. Eight years ago I went on to full-time, free- lance consulting, specializing in non-speech communication and programming with various service agencies. In my role as a consultant it is my responsibility to evaluate my client's programming needs, to make recommendations to the Individual Program Planning (I.P.P.) committees and to design programs to achieve what I have determined to be the appropriate learning goals. I observe and evaluate my clients in their family homes, group homes, institutions, classrooms, workshops, nursing homes, and hospitals. I meet with their teachers, parents, counsellors, doctors, therapists, and anyone who comes in regular contact with them. I work on several mult- disciplinary treatment teams with behaviour, physio, occupational, speech and psycho-therapists and have recommended and designed countless I.P.P.s along the way.

My reason for entering this field in the first place was because I believed (like most of us in the field) that I could make an improvement in the lives of people with handicaps. For the most part, when I was teaching, I did achieve that goal, but it was a temporary triumph. To be truly effective as an educator or practitioner, one must try to ensure that the changes brought about in our clients' (or students') lives are maintained over time and settings. That is the true test of our effectiveness.

This manual deals with a very wide range of information and ideas. Without my practical experiences in the areas described above, I would never have been able to see the system from so many perspectives nor see the need to develop strategies for consistency. It is my intention to share my ideas with people who, like myself, work in this unique profession with it's own unique problems. We are confronted daily with the heroics of medicine and the ignorance of society. How can any of us say we are not changed by the experiences we have while working with a person who has a mental or physical handicap? Out of my experiences, triumphs and disappointments, I have written this manual to try to continue to take steps forward.

TERMINOLOGY:

a) THE PEOPLE

b) THE CONCEPTS

c) GENERAL TERMS

Ineffective communication is one of the main causes of inconsistency in programming (see Chapter Six). The manual is written in a style intended to be "user friendly", free of excessive professional jargon or terminology. In order to ensure that the terms in this manual are understood by all, I will elaborate on their meaning and the way in which I have used them.

Unfortunately, the issue of labels is inescapable in dealing with this subject; as a result, I have spent more time on it than I would have liked. A great deal of linguistic "tap-dancing" has gone on regarding labeling of individuals who have special needs. Terms such as deaf, M.R. (mentally retarded), developmentally delayed and physically challenged, have gone by the wayside. Some people cringe when they hear a term such as retarded, mute or handicapped and are quick to correct those who seem to be less benevolent. Their concern is that stereotypes associated with those terms will distort our perception of the individual; we will see the stereotype, not the true individual. As a result of this thinking, the current trend is to avoid the adjective as the noun---it is now more socially (or politically) correct to say "persons with mental handicaps" or "persons with developmental disabilities" as opposed to "the mentally handicapped" or "the disabled" .

As a realist, I recognize that a label (good, bad, stereotypical or not) is still a label, no matter how polite we try to be. Stereotypes exist in the attitudes of the uninformed, regardless of what terminology is chosen. So rather than beat around the bush for the sake of being polite, I have used the term "mentally handicapped". I certainly hope that readers will be more concerned with the content of what I have said than with the terminology used. My apologies to anyone who may be offended.

a) The People

1. clients

Although the term is rather sterile, I have chosen to refer to the persons discussed in this manual who have mental handicaps, as "clients". This includes students, patients, residents, or children. I think of it as a non-stigmatizing, generic term which does not reveal where the individual lives, their age, status or health condition. (Much like Ms. as opposed to Mrs. or Miss).

I have chosen to deal specifically with persons with mental handicaps (any age) who may also be multihandicapped; from time to time I refer to some individuals who use assistive devices. Many of my clients have dual, or triple-handicaps e.g. mentally handicapped plus hearing impaired with cerebral palsy, or mentally handicapped with vision impairment and autistic tendencies. At times it is difficult to differentiate those with severe behaviour disorders from those with purely psychiatric problems. For the purpose of this manual I will be excluding individuals with "normal" intelligence, who suffer from a confirmed psychiatric disorder. Although much of the information in this manual is geared towards persons with mental handicaps, it may be generalized to persons with only physical or emotional handicaps. However, the reader should keep in mind that because of additional philosophical issues, the manual was written specifically for those individuals with mental handicaps. The various handicaps discussed in this manual as well as the individuals who work with them are as follows:

2. persons with mental handicaps - having a developmental deficit in cognitive abilities, thus affecting their overall social, academic and vocational aptitude.

3. behaviour disorder - includes one of many possible deviant behaviours: self-stimulation, obsessive behaviours, self-injurious behaviours, aggression and autism.

4. persons with physical handicaps - Persons having a motor impairment which affects their movements and possibly their ability to walk, so that they may need assistive devices such as a wheelchair.

5. multihandicapped - Persons who have two or more of the above disorders i.e., they will have a mental handicap and use a wheelchair and are also blind, or they will be mentally handicapped, but also have a behaviour disorder and have a hearing loss.

6. staff - (sometimes referred to in this manual as **subordinates or employees**), the workers who work on the front lines with persons who have mental handicaps: teachers, teaching assistants, counsellors, instructors.

7. manager - (sometimes called **supervisor**), the person who oversees the co-ordination of Programs and the staff who carry out the individual program plans. This can include school principals, group home supervisors or workshop managers.

8. I.P.P. manager - The staff person who has the major responsibility for the actual I.P.P. form and has been assigned to co-ordinate all the pertinent details (and individuals) involved with the I.P.P.. This person may be the social worker, case manager, primary worker, or teacher.

9. primary worker/counsellor - the person who has the most contact with the client at either the vocational, academic or residential Program. They are responsible for designing and carrying out the instructional programs, taken from the I.P.P.. This person could be the teacher, group home counsellor, vocational instructor, day-care teacher or parent.

10. key team members - Since the client usually attends more than one Program, (academic and residential, or vocational and residential) there is usually one primary

worker for each setting. As a result several people are responsible for instructional programming and they need to coordinate their efforts. The key team members are the individuals with the highest level of contact or responsibility in the client's life (this can include the parents, the teacher, the group home supervisor and/or counsellor, workshop instructor, social worker, therapist, or principal).

b) The Concepts

Individual Program Planning

Every year of their life, each student who has been designated "Exceptional" in an Ontario school, has their case brought to a meeting of an Individual Placement and Review Committee (I.P.R.C.) comprised of the school administrators, teachers (in some cases), parents and special education coordinators from the school board (Ministry of Education, Bill 82). This group decides what classroom (or special education program) the student will attend. From this meeting the teacher is to develop an individual education/teaching plan (I.E.P. or I.T.P.). If the person has graduated or is in a residential or vocational program they have an I.P.P., (Ministry of Community and Social Services guidelines, 1983). (For a sample of an I.P.P. form, see Appendix A). In both instances a plan is to be developed with input from all the pertinent people in the handicapped person's life. This group decides what instructional areas are priorities and what they will work on in the upcoming year whether it be academics, behaviour, communication, gross-motor, or combinations of these. The parents (if they are involved), participate in the I.P.P. and I.P.R.C. meetings and the agency which has primary responsibility for the client (school or service agency) co-ordinates the meeting. The flowchart in Appendix J, explains the typical process involved in today's I.P.P. management.

Consistency

By consistent, I mean uniform, standardized, harmonious. With reference to the I.P.P. it means that everyone is performing as many of the program techniques as possible in the same way, having the same information, working towards the same objective and being accountable to the same I.P.P. team for their actions.

It is understandable that total consistency is an almost impossible goal to achieve because each human being is different. That's what makes us all so wonderful...our individuality. But if the workers at the Toyota or Chrysler plants decided to improvise with their own ideas and methods on the job, we might be in serious trouble on our roads. In the social service field, our raw material is a human being, and the desired end product is an independent person; one who has developed to his or her maximum level of potential. I am by no means suggesting that we lose sight of the humanness of what we do by becoming a production-line service provider. Nor am I advocating that primary workers forfeit all their programming creativity. What I am suggesting is that wherever possible, we bring unity to the daily procedures related to the management of the I.P.P. and standardize the techniques used as a result of the objectives selected by the I.P.P. team.

Adherence

This term is used frequently in the health care literature regarding patients or staff compliance with the doctor's prescribed treatment plans. For example, do patients exercise as often, in the manner prescribed by the doctor? Do staff deal with a particular patient in the manner recommended by the doctor?

I have generalized this term to the field of Special Education as it deals with issues common to consistency. For example, do staff carry-out the client's exercise program as prescribed by the physiotherapist? Does the supervisor train their staff on the appropriate method for communicating with non-verbal clients?

Programming

People are often confused by the word "program". We watch programs on T.V., we take our children to Saturday morning programs at the centre and we write programs on the computer. In the field of the mentally handicapped, we have our own areas of confusion. Our clients attend a Program and we then design an Individual Program Plan and then we carry out the individual teaching plan. Or we might say we are meeting with the day-program to discuss the Individual Program Plan and the person who will write up the intervention program. (How's that for professional double-talk?) It needn't be confusing. The main focus of this manual is on the process involved with the I.P.P. and the coordination of the service providers who are responsible to that client. I will also deal with the implementation plan or individual teaching plan and how it should be designed to develop consistency in the I.P.P. process.

For the purposes of this manual, the various types of "programs" can be differentiated as follows:

Individual Program Plan; I.P.P. - (See Appendix A)

The document ,(as determined at an I.P.P. meeting) which outlines the client's needs, long term goals and short term objectives for the next year (or two).

small "p" program - (See Appendix B)

When a lower case "p" is used I am referring to the actual step-by-step outline of how staff are to implement the short term objectives set out at the I.P.P. meeting. It might also be referred to as an individual teaching plan (I.T.P.), implementation plan, action - plan, "How-to" or behaviour program (see Chapter Five). It is expected that all staff who work with the client on that goal/objective are to adhere to this plan and perform the activity in a consistent or uniform manner.

BIG "P" PROGRAM

When a capital "P" is used in the text, it refers to a service (usually government or community funded) provided for a group with specific needs, which utilizes social service staff to work with clients. It can refer to a recreation Program, a home- finding Program or birth-counselling Program and in this field, it refers to vocational, residential or academic Programs.

Long Term Goals (L.T.G.s)

L.T.G.s are the general goals which the I.P.P. team selects for the client for the next 1-2 years. They are broad in nature and encompass a range of domains such as life-skills, vocational activities or communication. Examples include: Gail will live in an apartment in the city by herself. Carl will become more mobile. Glen will play with other children.

Short Term Objectives (S.T.O.s)

S.T.O.s are only 1-8 months in duration, are very specific and encompass only one domain. They are measurable, and work towards the attainment of the L.T.G.s stated in the I.P.P. meeting. Examples which would reflect the L.T.G.s stated above would be: Gail will cook all her meals. Carl will use his electric wheelchair without assistance when going on outings to the mall. Glen will reduce his rocking behaviour from 40 minutes per hour to 15 minutes per hour by playing with a ball.

c) General Terms

Service Agency - the public service organization which co-ordinates the services for the persons with mental handicaps, such as school boards, community associations, and regional service networks

Suprastructure Level- I have used the term suprastructure level throughout this manual to describe the organizational structure which manages the people and processes dealing directly with the client. It is above the primary level and it would differ from agency to agency, situation to situation. It is fundamentally a managerial bureaucracy and it may or may not have a formal definition.

Primary Level- The primary level is the organizational layer where the "front-line" staff operate. This is where the "hands-on" work is done with the client and the actual day to day activities and teaching programs are carried out.

Technique - Refers to the instructional procedure used to teach a skill. It usually involves a list of specific steps to follow according to the learning style of the student. For example, when teaching children how to print, teachers will often begin with teaching the students how to draw circles and sticks (lines), and then they have the students trace the letter in the air. Next they will break-down the letter into a series of lines and circles, while pointing out where the lines connect and where a circle may close or stay open.

CHAPTER ONE - BACKGROUND

a) INTRODUCTION:

(i) Why do we need to be consistent?

(ii) Who would use this Manual?

A few years ago I visited a workshop for the mentally handicapped. I noticed a young man who turned out to be a former student of mine, whom I had taught for four years. I had helped him to progress from a non-verbal behaviour problem to a relatively independent young man with an expressive sign-language vocabulary of over 700 words and a grade 3 reading level. I remember watching him walk down the hall the day he graduated from (secondary) school wondering if anyone would ever talk to, and get to know, this very dynamic young man. I remember questioning myself as to whether I had taught him the right things. When I saw him in the workshop, I experienced what every teacher must feel when, years later, they see one of their prize students suffering from the hardships of the real world. My student no longer spoke full sentences with his hands, instead he used peeps and unintelligible sounds (which I had spent countless hours extinguishing) and only began to sign in one word sentences once I physically prompted him to do so. The staff who now supervised him remarked to me that they didn't know he knew sign language and asked what he had said. People did not talk to him in any manner- sign or speech. To them he was a non-verbal worker on the production line and didn't create too many problems, so he was basically left alone. They didn't know how truly capable he was and what a rich personality he had. Was I a failure? Had I spent five years doing the wrong thing? What went wrong?

This type of encounter is not an isolated experience, for it has happened to me and my colleagues many times. After this meeting I understood why the psychologists, consultants, older teachers and therapists used to look at me in quiet amusement when I bubbled at planning meetings that we could teach Johnny to do thus and so. "That's all very well and good," they'd say apathetically ..."but what about when he graduates? Or when you leave?" In all my youthful exuberance and naivete, I never imagined that the key to working with the handicapped lay not only in the accomplishments we make in programming but in the ability of the system to maintain what we have achieved. If we are to be truly successful in the field of Special Education, we must ensure that the countless hours of instruction are not all wasted each time the client's environment is somehow changed. Therefore consistency in the I.P.P. process becomes a precondition for achieving this maintenance.

In my view, service providers need to give more attention to past I.P.P.s and evaluate the effectiveness of their provision of services on a regular basis. A system does not currently exist which attempts to ensure that the skills and the needs of a person with a mental handicap are carried over from one setting to another, from one staff person to another. I rarely encounter teachers or counsellors who accept a new client into their program and look at what they need to replicate from the individual's previous program. Instead, they try to "reinvent the wheel" and start all over again with what they deem a priority. In some instances where a client has never been outside of the protection of their parents' home, or they were living in an institution where very little programming went on, it is necessary to start from scratch. However the majority of persons with mental handicaps who enter a new Program, have more than likely been in either an academic or residential Program somewhere and normally have a rich history of intervention.

I have written this manual to enable the people who are involved in Individual Program Planning (I.P.P.) to become more effective in their management of this procedure. This is accomplished by formalizing the I.P.P. meeting, improving the way the I.P.P. is written up, following specific criteria for writing I.T.P.'s and defining the role of staff. The overall goal is to optimize program consistency among the service providers, in

their attitude, consistency in the goals set, the techniques they use and in their maintenance procedures. I suggest that inconsistency has led to poor program- ming or program failure in the past and through improved system management and communication, consistency and effective programming will be achieved. The strategies are also designed to move about with the client and no matter where they are, the new caregivers are provided with thorough information about the primary intervention needs of that individual so that they can easily adapt their strategies to that which has met with success in the past.

(i) Why do we need to be consistent?

Everyone in today's busy world would agree that there is already enough paperwork circulating in each office or business. However, the I.P.P. has a valuable function when it comes to record keeping, accountability of staff to their client and organization of service plans. It is no longer acceptable to tell parents that their child is being cared for as in the days of the custodial institutions. The teachers and primary caregivers must document what they want to do with the client and provide a written plan for carrying out these ideas as well as justification for selecting the particular approach chosen. However, this is not to say that simply because we have a document that commits us to what we will be doing, that it will necessarily be done, or done consistently.

According to Maslow, people are motivated to do their jobs for different reasons: safety, physiological, social, ego, self-fulfilling (Connelan, 1987, p. 43). Most people would like to think that they are doing a good job, that they know how to do their job and they are inherently good. For the most part, they hold the same opinion of their colleagues. But being competent and wanting to do a good job does not necessarily mean that a good job gets done. Whatever the reason, they all need some way of confirming that their efforts have somehow made a difference or contributed to a better world. The opportunity to stand back and say "I'm responsible for doing that!" does not always present itself in the field of special education. The road to success is a long, hard one, with many uncontrollable obstacles like: health/medical problems (with our clients), funding

restrictions, staffing shortages and policy interferences which stand in the way.

People who work with the mentally handicapped are often admired by others-- "You must have a lot of patience", "You must find your work very rewarding---I could never do what you do". Once we manage to remove the halo and wings we are left with the reality that our clients are very demanding and, no---we don't have a lot of patience and in fact some days are extremely frustrating. As teachers, administrators, counsellors, case managers and consultants we are expected to: be able to work with the client and bring about changes in their behaviour (whether it be cognitive, motor, life-skills etc.), we are expected to be an organizer of the environment in which we work, a diplomat with parents, other agencies and our colleagues, a team member within the organization for which we work and a constant source of knowledge and skills to do an even better job. Add to this the fact that we also have a non-professional life to live as well. It isn't any wonder that we need to have a lot of patience, just to overcome the expectations placed upon us and the obstacles we encounter.

A consistent system for carrying out our jobs can help to bring organization to the chaos. It helps us to focus on the priorities, to have a clear plan of what needs to be done and how to do it. A consistent system should define what is expected of us and what we can expect from others. We are not superhuman and often the goals set up within a system can help to remove the feelings of doubt, frustration and ambiguity in our roles (Robbins, 1987, p. 343).

Why have consistency in individual program planning? Because it leads to a client who achieves their instructional goals; more quickly, more often. The social service system then works better, the people feel better about their job, they know what is expected of them, there is less time wasted and the amount of progress made with the client increases. This idea is upheld by the research done in the field of institutional staff training, using facility-wide program development. It has shown that positive changes in client behaviour and staff performance can be brought about through highly specified procedures, training, evaluation and feedback (Flanagan, Cray & Meter 1983; Burgio, et al., 1983; Meichenbaum & Turk 1987; Browder 1987; Gardner & Chapman 1985).

(iii) Who would use this manual?

This manual is intended for any professional or paraprofessional who works in a social or educational (special education) system where I.P.P.s are used. This includes: principals, special education teachers, social workers, workshop or group home counsellors, therapists, nurses, (or related health care professionals). It would also be of benefit to parents of children with mental handicaps who are new to the I.P.P. (or I.E.P.) process or those who are familiar with the process and wish to improve goal setting and strategies for their child. The user of the manual need not be a programming specialist.

From time to time the reader will find my use of a term or the explanation of a procedure does not match the one which they are familiar with in the organization for which they work. I have made every effort to make this manual as generic as possible, for use in school boards, associations for community living and institutions. Every effort has been made to refer to situations which are common to most organizations, but this is not always possible given variances in organizational policies and procedures. (For example, some school boards refer to students with physical handicaps as developmentally delayed.) I encourage the reader to refer to the preceding terminology section when such instances occur.

CHAPTER ONE - BACKGROUND

b) CONSISTENCY:

(i) Where should we be consistent?
Major themes:
- **attitude**
- **goals**
- **technique**
- **maintenance**

(ii) Why aren't we consistent?

(iii) Summary of causes of inconsistency

(i) Where should we be consistent?

In my opinion, in order to teach a person with a mental handicap to be as independent as possible, the social service system and it's employees, need to be consistent in as many areas as possible. Specifically in:

- the **attitude** of the staff: towards the client, program, other team members
- the **techniques** of the program
- the communication and information sharing between team members and agencies
- choosing and writing **goals** in I.P.P.s
- follow-up and **maintenance** procedures

There are two different levels in programming which are affected by these factors. The primary level, where the actual front line workers carry out the particulars of the program and the suprastructure level, which oversees the appropriate functioning of the first.

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1) PRIMARY LEVEL: - Adherence to Goals and techniques (called program adherence)

a) - do staff carry out the individual instruction plan?

b) - do staff carry out the instruction plan in the same way as others, according to the prescribed method?

2) SUPRASTRUCTURE LEVEL: - Is there a system to maintain the above program success and the I.P.P. process in general?

Major Themes:

I have chosen to address consistency in four specific areas: attitude, goals, techniques and maintenance and the ways in which they impact on the primary and suprastructure levels.

- attitude:

One of my favorite sayings which I remember hearing on the old "Mary -Tyler Moore Show", from the '70's, was; "You don't have to be a chicken to recognize an egg". How true this is. Everyone views reality from a different perspective based on their own history, needs, interests etc.; but we are all dealing with, and perceive in common ways, one reality. In the field of mental retardation, there are differing philosophies regarding how this population should be educated and provided with residential services. I have encountered a variety of attitudes and methods practised on this population. I have met people who feel they are "on a mission" and if we love the client enough, perhaps the client will stop beating up the other clients. Many parents' attitudes

towards their sons and daughters stem from their intense feelings of guilt, or stress from having a child who requires additional attention. Some older staff I encounter have difficulty being firm with the clients and are reluctant to carry out behaviour programs, preferring to simply make the client's day-to-day routine as non-stressful as possible by doing chores or tasks for them, rather than teaching the client to do these for themselves.

What is important is that everyone on the team be aware of the attitude of the others and efforts be made to transform the attitudes of pity into ones which foster growth on behalf of the client. As Wolf Wolfensberger (the "Guru" of normalization) said, the sooner we start thinking of the person with the mental handicap as a "normal" person, the sooner they will begin to behave that way. This is more productive and furthers the learning process. If we think the client needs to be cared for and made comfortable, they will be forever dependent upon others and not learn to be responsible for themselves (as much as possible). Our attitudes are formed by our expectations and if we don't expect much, then that's exactly what we get! If people cannot agree on the above, at least they should be consistent in their ability to accept differences in attitude--"we agree to disagree". Consistency in attitudes will be discussed further in the next section of this chapter.

- goals:

Just as it is important to have a consistent attitude regarding the client, it is important to have consistent goals. As a team of people working with an individual, it is a waste of time to be going in five different directions, especially with persons who have mental handicaps who require repeated, consistent input and opportunities to practise a skill, in order for it to be learned.

Another aspect of programming which presents itself in my dealings with clients and their caregivers are, improperly prioritized programs. These would be programs which try to teach the client a skill which they will likely never have any need for (like learning how to make tea when they have no hand or arm control), or programs which have been a major source of frustration and failure in past programming. All too often the

primary worker feels they know what is best for this client and they set about changing the routines and programs based on their own biases and experiences with little or no regard for what was accomplished in the past. As a result, clients are subjected to a myriad of individual programming throughout their lifetime where staff attempt to teach them skills based on what they see as important, using a variety of strategies, with only minimal success. The selection and clarification of goals is discussed in detail in Chapter Four.

Case Illustration

Frank is in his mid-50's, has a mental handicap, lives in a group home, exhibits some deviant (but harmless) behaviours and is being trained for competitive employment. He goes home on weekends to see his aging parents. They think nothing of the fact that their son beats his mother regularly during his visits even though he does not exhibit this type of behaviour at the group home. The parents told the staff (via an interpreter) that it was acceptable for their son to behave this way and "he didn't know any better". This is an extreme illustration of a typical generation who felt God punished them for their sins and how we have a different set of rules for the handicapped than for "normal" individuals. The parents were asked what they would do if their younger son, came home and hit his mother. They were appalled at the notion and said he was a "good-boy" and would never do that. Obviously it was easy for the staff to make their point with this couple.

- technique:

One complaint I hear from all levels of staff is that they cannot follow the I.T.P. for a particular person because it was poorly written by the primary worker. We should never try to bring about changes in the behaviours of persons with mental handicaps with more than one technique, rather, we should use one which has been agreed to by all members of the team. It is the responsibility of every team member to ensure that the approach used to teach the client is consistent across settings and staff. This is not possible however, if the terms used in the I.T.P. are vague, the number and type of instructional prompts are not clearly stated and details are left out regarding "trouble-shooting" or consequences.

This is probably the most difficult area in which to attain consistency and the one requiring the most amount of time in training and maintenance for both supervisors and subordinates. But this does not mean that it should not be attempted. The most successful staff training programs I have seen involved several one to two hour sessions in the client's

day program as well as at home, with all the members of the team present. There were follow-up sessions using video and written feedback and regular communication between the staff trainer and the team members. The initial time expenditure paid off in subsequent successful programming, once the consistency amongst the team and their techniques, had been achieved. In Chapter Five, I describe strategies to optimize consistency in the writing of instructional techniques and methods to generate standardized behaviours in staff.

- maintenance:

Maintenance encompasses the overall schema of the procedure for consistency. In order to prevent confusion between follow-up and maintenance, I will use the following example. A new form of virus breaks out in the schools and children are being sent home in large numbers. The department of health decides that all children should be given a particular treatment immediately, to prevent further outbreak. The treatment is the follow-up. If subsequently a screening program were introduced which took place every new school year, to monitor the children and look for signs of the outbreak so treatment could be started before an outbreak occurred, then this would be considered maintenance. Follow-up is the action taken to reach the goal, whereas maintenance is the action taken to continue realizing that goal.

With regard to persons with handicaps, the consistency of the program lies in how staff maintain attitudes, goals and techniques across environments and/or across time periods. Do people follow-up on the service plan decisions made in the I.P.P. meeting? Do they do what they promise and do they communicate changes or new information with the other team members? Methods which lead to maintenance are discussed throughout the manual, but in particular in Chapter Six.

(ii) Why aren't we consistent?

Based on my experiences in the field, I think staff at the primary and suprastructure levels are not consistent in carrying out program goals or techniques for a variety of personal and practical reasons. These could include poor training, interpersonal (personality) conflicts, work overload, unclear expectations by supervisors and/or lack of belief in the ability of the client to learn new skills. Whatever the cause of non-adherence, we must keep in mind that others may have their own reasons for not adhering, and when juxtaposed with external stresses of the job, the result is poor programming. I will examine some of these causes now.

The first is that staff do not see their role as that of instructor, but rather a caregiver. This perception originates from the attitude that the clients need to be cared for and made comfortable rather than taught to be independent. Their expectations are low for the client, hence they do not see the value in conducting the program in the first place. This program might require several hours of their time, over a period of several months, to teach clients to do a skill for themselves, which only takes the staff two minutes to perform for them (e.g. tying shoe laces). When you think about it, they're right; teaching a skill is very time consuming and often the time invested in teaching a skill does not always garner the desired results. Quite often I hear teachers, parents or counsellors say, "Oh, I tried that once or twice and he couldn't do it, so it's easier if I do it". This underexpectation of achievement by staff indicates that they fail to realize that the time and effort spent initially, may pay off in the long term, by increasing the level of independence in the students or clients.

Other reasons for not adhering to a program plan is lack of thorough information, or lack of skills necessary to deliver the required program. In the introduction of this manual, I discussed a situation where I encountered an ex-student of mine who had lost many of the skills I had worked so hard to achieve. If the staff had read information like: past school reports, or talked to his family they would have been aware of his communication augmentative needs and abilities (i.e. - sign language) and learned to interact with the client accordingly. They might also have discovered that he had the ability

to read and write. But, due to a break-down in the transfer of information or program techniques, from one environment to another, the client suffers. Possibly they did read or collect all this information, but didn't know what was meant by a 'Total communication program', or it was too intimidating to acquire the skills necessary for its delivery. Or possibly they did try signing with him and his response was unclear (which is typical of most signers who have a multi- handicap), or he did not respond due to their technique. Thus the staff were discouraged from pursuing the program further. Obviously improved written and verbal communication between primary workers would have prevented this incident. Perhaps the staff just didn't have the time to read the reports, or try the program, or learn the skills. This leads me to a third reason for failure to adhere to program goals or techniques, that being role overload.

Staff get so busy with the day-to-day details of running either a classroom, workshop, or a group home they haven't the time (or the time management skills) to carry out the necessary programs. To say that there is an ignorance of the concept of program consistency would be overstating the fact, but there is a problem for some, so overwhelmed by the diversity of their job and the program, that they miss the overall picture of what exactly is getting accomplished.

According to Meichenbaum and Turk (1987), some of the attitudes of health care professionals which account for their not adhering to treatment programs include:

-" pessimism, my input is not useful"

- "I tried it in the past; it doesn't work with my population"...(not applicable)

- "It is too complicated. Who can remember to do all these things?" (Stimulus overload, too many obstacles and barriers)

- "Who has the time to worry about and to do what is suggested? I have to see so many patients per hour or per day and there is no time to do all this adherence stuff." (useful but no time)

- "You don't get reimbursed for education and prevention." (no payoffs)

- "I'm not a 'shrink.' I haven't been trained to do these things." (low self-efficacy) (p.257).

This information can easily be witnessed in the staff working with persons with mental handicaps. Their years of false starts, overwork and poor training can leave them feeling very ineffectual in their jobs, thus reluctant to adhere to an I.P.P. program. Browder (1987, p. 119) agrees that " lack of belief in the possibility of change" will affect the level of commitment by family members to adhere to a program. I suggest this pessimistic attitude is common amongst some teachers and counsellors working in the field of mental retardation as well.

Individuals who choose a career in working with the mentally handicapped, begin their careers with high expectations of being able to "help" the handicapped, but don't have an appreciation for the complexities involved with teaching and caring for this population. State of the art programming currently requires that the primary worker be trained in behaviour modification techniques, health/medical procedures, orthopaedics, cognitive psychology, social work or case management and other skills such as communication augmentative systems, speech therapy, or technical aids. Once confronted with the reality that persons with mental handicaps a) learn slower than normal individuals and b) require many more teaching trials to acquire a skill, staff become discouraged, overwhelmed and frustrated. The pay is usually low and intrinsic rewards few, leading to burnout and a high turnover of staff. The repetition and routine soon take their toll on the enthusiasm and energy of a new teacher or counsellor.

Based on my observations, staff in this field tend to change their attitude, techniques and ability to adhere to programs on the basis of their developmental level within their job. Initially the new recruits fresh out of school (or those launching a new career) have plenty of enthusiasm, but little concrete training. They begin with high ideals and visions of becoming the next Anne O'Sullivan (Helen Keller's teacher). Then after one or two years, reality sets in and all the goals they set for themselves are unmet and they become frustrated.

At this stage a dichotomy exists; if they are too good, their workload increases, as their supervisors feel they are effective with the clients and can handle more responsibility. The pressure mounts and they usually end up taking their work home with them. They want to do a good job and like the reinforcement from the boss---but with added responsibility comes less personal time, resentment from others who are less effective and a feeling of being owned by their job (Gardner & Chapman 1985). They want desperately to do a good job, but work overload, inadequate support from superiors or program sabotage by other staff, impedes their progress. Good staff don't get financial benefits for being a superior teacher or counsellor and end up asking "Why should I work so hard, I get paid the same as everyone else who does mediocre work?" This leads to apathy, resentment and the feeling that no matter how hard you try, nothing works. After only two or three years they become less idealistic in their outlook and discouraged with never achieving the initial goals they set out for themselves--they become skeptical and develop coping mechanisms just to get them through the shift. This person knows how to dodge responsibility, make the supervisors happy by completing all their paperwork and as Bourdin (1982) puts it "he is able to communicate the appearance of being a performer" (p. 101), without accomplishing anything truly concrete.

It's no wonder that people are reluctant to make the extra effort to be an effective and/or consistent staff person or experience difficulty working as a team, when there is so much intra/interpersonal baggage coming into their daily job. Add to this the constraints of the system which they have little or no control over. To say the personal baggage doesn't belong in the workplace is unrealistic; it exists as part of human nature.

(iii) Summary of causes of inconsistency

As a result of this wide range of issues, I have choosen to categorize the causes of inconsistency as follows:

Causes of inconsistency:

1. **Poor attitude of staff**
2. **Conflict**
3. **Role overload and role ambiguity**
4. **Lack of teamwork between supervisors and subordinates**
5. **Lack of monitoring**
6. **Lack of feedback**
7. **Poor communication**

Strategies to deal with these causes are discussed throughout the manual, particularly, in Chapter Six. The purpose of the manual is to minimize the causes and effects of personal blocks to performance and effectiveness, by providing strategies which take into account the systems and the dynamics of the individuals who must carry out the requirements of the system.

CHAPTER TWO

RELATED ISSUES:

a) HISTORICAL PERSPECTIVE

b) THE CURRENT ATTITUDES

i) - Integration
ii) - Social Role Valorization
iii) - Discussion

c) DIFFERENT APPROACHES TO PROGRAMMING

i) - The Application of Behaviourism to People and Systems
ii) - Gentle Teaching
iii) - Discussion

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a) HISTORICAL PERSPECTIVE

Twenty years ago a manual such as this would not have existed, let alone even be considered a useful tool in the management of people with mental handicaps. Our attitudes regarding the care and treatment of this population have defined the type of services they have received over time. Historically, some of these individuals were locked away in institutions where they were cared for, some stayed at home with their families, while others, due to their parents' embarrassment, became prisoners in their family home. The overriding attitudes toward the mentally handicapped were those of pity, guilt and/or fear. They were thought of as something dangerous, a punishment for past sins, or they were considered to be "Children for a Lifetime"; unable to care for themselves and an embarrassment to their families. Until the latter half of this century the mentally handicapped were viewed as being dangerous or beyond help, and were often locked up with criminals or in the institutions for the insane (Scheerenberger 1987, Greenland 1963). By the late 19th century some were fortunate enough to be housed in large institutions for the "feeble-minded" where their basic needs were provided for: eating, toiletting and cleaning. Education and community integration were rarely if ever considered. Locking

them away was the easiest method for dealing with the social intolerance of the time.

The original institutions for the "retarded" were sequestered away from urban communities. The feeling was that persons with mental handicaps were better off in the country, where the fresh air would help to "heal them". Also, land to build large institutions was cheaper in small towns, far from the big cities. Institutional placement usually came about as a result of the physician advising the parents that their child was a "cripple", or an "imbecile" and would be "better off" living in a facility where he or she wouldn't be a burden on the family. Many parents did "give- up" their children as a result of this advise, but the decision must have been a difficult one. If one went to visit these institutions they saw a way of life unfit for animals, let alone humans (Williams 1984, Tyor & Bell 1984). The conditions were unsanitary, overcrowded, the daily routine and boredom unbearable and respect for human dignity was nonexistent. Eventually it was the efforts of parents, who began to pressure governments to implement social welfare programs for their handicapped sons and daughters, which finally brought about education, housing and vocational programs (Williams 1984, Greenland 1963).

Today the majority of people with mental handicaps live at home or in a group home and most (unfortunately not all) of the institutions have been closed up for good. This movement towards community living has been a long hard road. It has only been during the past 100 years, that their needs for appropriate housing and some form of education were recognized. With the growing awareness by doctors, therapists and teachers that the mentally handicapped could be trained and learn to live with a certain degree of independence, services gradually increased. This awareness, combined with the emergence of the social welfare system in Canada has led to the eventual mandating of educational programs for people with mental handicaps. Once the professionals changed their attitudes, they had to then educate the community as a whole to accept the idea of de-institutionalization as well. Society is gradually changing its way of thinking about the handicapped from one of care and pity to that of respect and tolerance for human rights and individual differences.

In 1888, the first "training school for the feeble-minded" was started in Orillia (Ontario), by Dr. A. H. Beaton (Greenland 1963). Times were difficult and other administrators did not always see the value of educating persons with mental handicaps. Often funds were cut off for supplies, space or personnel. By 1912, 21 classes were opened for the feebleminded in the City of Toronto in an effort to improve services for the mentally handicapped.

Two myths influenced the nature of educational programming at the time. It had been previously thought that only qualified "institutional" staff in a special environment could provide appropriate residential and educational services to persons with mental handicaps because they were "medically fragile". The institution administrators gradually learned that one need not have a medical background to handle this population. Teachers given minimal training in first aid and physical management techniques were able to work with their students without anyone suffering from inappropriate care. The teachers were the perpetrators of the second myth. It was felt that all one had to do was simply set up a classroom and start to teach the "3R's". The view was that teaching methods used with "normal" students could be applied to this population of multi-learning impaired individuals. This is where educators first ran into trouble regarding the issue of special education programming for the mentally handicapped. They ignored the environment and needs of their clientele and transposed the standard educational curriculum of reading, writing and arithmetic to a group who neither understood what was going on, nor had any opportunity to apply what they had learned. If you're going to spend your whole life in an institution, being "cared" for, what reason do you have to learn Canadian History or mathematics? (This will be discussed further in Chapter Four).

b) THE CURRENT ATTITUDES:

i) Integration

ii) Social Role Valorization

iii) Discussion

Introduction

Two terms have been used extensively to describe the philosophy towards services for persons with mental handicaps . One is integration*, which refers to the location of the Program in which the person with the mental handicap lives, works or is educated. Is it segregated from normal society, or is it located within, or as close as possible to, where everyone else lives, works or is educated? Normalization (which grew out of integration), assumes that the person is in an integrated setting and refers to the underlying ideology of the individual treatment given. Are persons with mental handicaps allowed to make choices for themselves, are they dressed the same as "normal" persons that age and are their needs "valued" as much as those of a normal person? One could say; is this individual in an 'integrated' setting with staff who are treating him/her "normally"?

i) Integration

One of the contributing factors which brought about these philosophical changes was the Danish government passing "An Act concerning Care of the Mentally Retarded and other Exceptionally Retarded Persons", in 1959. The purpose of this act was to deinstitutionalize the lives of those who were mentally retarded (Scheerenberger, 1987, p. 116). This meant providing more normal types of living arrangements for persons with mental handicaps, like group homes and allowing persons with mental handicaps to attend regular schools within their home community. Integration quickly spread throughout

*Another term for integration which is often used in school boards is mainstreaming.

Europe and North America. In 1966 the government of Ontario passed the Homes for Retarded Persons Act and theVocational Rehabilitation Act (Simmons 1982). Plans for integrated group homes and vocational facilities in urban centers commenced as a result of this Act, something which had been considered impossible until that time.

As with most changes in social-welfare, the treatment of the people with mental handicaps has been improved, not because we are a more tolerant or caring society, but initially because of simple dollars and cents. The act of moving higher functioning individuals with mental handicaps out of the institutions and placing them in community accommodations came about because it was more economical to house them in group homes or supervised apartments than in an institution. * The success of introducing them into the mainstream was considered a significant change in the quality of life for this population compared to the overcrowding and poor treatment in the institutions (Tyor and Bell 1984, Chapter. 6). Later, governments were pressured to expand this service to the lower functioning mentally handicapped population. However, this move has proven to be more expensive, due to the cost of necessary attendant care and special residential adaptations. Nevertheless, what started off as a financially motivated project for a select group of higher functioning individuals who had been unnecessarily institutionalized, eventually became a morally driven movement for all persons with mental handicaps. Community-based programs and services currently work towards integrating the clients as much as possible and consider anything that smacks of institutionalization or segregation as inappropriate. The attitude now is that wherever possible, the mentally handicapped should be allowed and expected to care for themselves in as many aspects of daily living as possible.

These changes have generally been supported by parents and most institutional staff who realize their retarded son, daughter, student or patient is capable of learning skills and living productive lives (Tyor and Bell, 1984, Chapter 6). They recognize that their child

*Although government documents do not clearly state this to be the fact, they imply that this was the reason in several early policy documents (Ministry of Community and Social Services; Challenges and Opportunities 1987, Williston Report, 1971).

needs "special" intervention but they prefer services which do not segregate or stigmatize them in the process. Attitudes towards people with mental handicaps has changed, thereby changing the overall way society values this population.

ii) Social Role Valorization (S.R.V. or Normalization)

This new way of thinking spread to Sweden where integration was taken one giant step further in 1969 by Wolf Wolfensberger who invented the term "normalization" referring to the underlying attitude of the caregivers towards the clients. Wolfensberger designed his Program Analysis of Service Systems' Implementation of Normalization Goals ("PASSING" or commonly known as "PASS"). In effect, he took the idea of integration and broadened it to bring about changes not only in educational settings but in the underlying philosophy of all aspects of all the services which impacted on a handicapped person's life, including the attitudes of those service providers. His method of evaluating service systems for the retarded became the accepted practise by the 1980's. Wolfensberger defined "normalization", which later became known as social role valorization (S.R.V.) as:

> The use of culturally normative and optimally even culturally valued, means to enable (societally devalued) persons to achieve and maintain valued social roles. Normalization implies both the attainment of certain goals (valued social roles for people), as well as the use of valued means to achieve these goals. In order to establish and/or maintain valued social roles,devalued persons should have life conditions (such as income, housing,work, health and education services) which are at least as good as those of the average citizen's and as much as possible, their competencies, appearances, experiences, status and reputation in the eyes of society should be enhanced and supported. Normalization has a vast number of implications, from the most broad to the most specific and from the highest level of society down to the individual level. (1983, p.18)

In short, Wolfensberger was advocating that people with mental or physical handicaps be treated and given the same (or "at least as good as") opportunities in life as the average/normal person. He argued that they should be valued in every aspect of their daily life from image enhancement to source of income, use of generic services, life-goals and opportunities to make decisions regarding their own future. Whatever was normal for example, for a typical 14 year old, then those values should be assigned to individuals with mental handicaps 14 years of age as well (including clothing, recreation activities, selection of lunch items, the school they attended, the family doctor they went to), in all respects regardless of their mental abilities or physical limitations which are secondary to the achievement of these goals.

In order to appreciate the impact Wolfensberger's philosophy had on the field, one must keep in mind the attitude of the "caregivers" in the seventies. The medical profession, social workers and institutional staff had developed tightly structured bureaucracies and felt they were doing a fine job caring for these "helpless, burdens on society". The mere notion of allowing the people with mental handicaps into the community and allowing them the same freedoms and experiences as the "average" person was totally incomprehensible, as well as a threat to their competency and ultimately their jobs.

Needless to say Wolfensberger was challenging the status quo and, initially, was not a very popular person. He developed a small following as a result of his training program for evaluators of service programs, using his analysis system and sent out teams of people to analyze different programs. These teams set about determining how "normal" the programs were, how much valuing the clients received and how much the environment or program was poorer than the life-style of that of the average person. (See Appendix C for sample). Institutions and service agencies were given a score and told which areas they needed to improve. Not one program has ever passed the evaluation with perfect scores in either Canada and the United States, but some programs continue to make a concerted effort. Wolfensberger developed a bit of a cult following and my experience of the trend at the time was that individuals in this field seemed to be split into two distinct groups. You either agreed with his ideas 100% and became strong advocates of Social

Role Valorization, or you were suspicious of his training methods and what he was suggesting and saw him as a dreamer.

iii) Discussion

I was consulting to several different agencies at that time (early to mid 1980's) and I spoke with quite a few administrators who saw integration as a threat to their programs and normalization as unrealistic. Looking back on that era, it was interesting how anxious they became when the notions of integration and valuing were discussed. Very few would submit to an evaluation such as PASS, for fear that a low score would expose their short-comings, and the government would shut them down for good. But over a period of about 10 years and after a great deal of pressure from parents and professionals in the field, the changes came nevertheless.

The idea of integration is not nearly as threatening to administrators today. When it comes to school placement there still appears to be some question as to; 'how-much?' is the right degree of integration. Some school boards in Ontario (Waterloo Separate School Board; Student Services Handbook, 1987), have implemented a policy where every student is placed in a classroom along with their age-similar peers, regardless of their handicap. Other boards have the students in a separate special education class, within the school, and they are integrated for the non- academic subjects such as physical education, art and music. These students might receive extra tutoring from an itinerant teacher, or a Special Education Resource person. Few school boards continue to have segregated schools of just "mentally handicapped" students. Those that still exist are in the process of amalgamating themselves with local programs and are working toward increasing opportunities for their students to interact with "normal" peers. (e.g., The Metropolitan Toronto School Board).

I became an early supporter of integration but, being the pragmatist that I am, I also became one of the biggest skeptics. In the early eighties, I saw many students placed in classrooms with all normal peers, which causes principals to "gush" when giving tours.

But these children did nothing all day but sit and watch the others in their class because their teacher had no idea what to do with them. Their valuable time was wasted; they could have been learning skills, rather than being a living monument to someone's ideological "Mission in Life". I feel there is no sense to placing a person in a program which reflects the current philosophical trend, but lacks program substance. I would still prefer to place a client in a segregated school program if the teachers, teaching assistants and overall program is strong and forfeit the opportunities for integration in the process. Some would say, well then just get the right people in and "make it work!" and don't settle on second best. That all sounds well and good, but in reality, it is not enough to get in a teacher with special education training and a teaching assistant and to integrate the special student in with a gym or art class. What is needed are individuals who have an attitude which values the client and the principles of integration, the interpersonal skills and confidence to interface with the school community, as well as the administrative support and energy to help the integration process along. These elements are crucial to the success of an integrated program; without them the student is the one who suffers and the individuals exposed to a poorly designed integrated program can have their attitudes permanently, negatively affected. This achieves nothing in the long run. In short, "if you're going to do it, do it right".

The idea of integration has almost become the norm whereas social role valorization has been much slower in its understanding and adoption by different agencies. However, when discussing client behaviours in a meeting it isn't unusual to hear a person report that the client is doing such and such and everyone in the room respond with "well, that's normal" and agree its nothing to worry about. Now staff will evaluate the circumstances and if a behaviour is typical of an average person in the same peer group and life-situation (given the time and place) they will not consider it a problem. (In fact, staff are often considered old fashioned and overprotective if they do not adhere to these principles throughout their interactions with the clients and in carrying out their programs.)

Integration and social role valorization should always be the overall objective, but they require the following elements to be truly successful:

- thoroughly trained staff (in special education, integration and normalization principles)
- staff trained in methods to deal with others who are non-supportive
- frequent involvement of support/resource personnel (daily if possible)
- community support (includes direct community, i.e.: school, classroom, people)
- appropriately adapted environment
- parent co-operation
- a match between the client's primary program needs and the availability of program support to carry these out

The hysteria over integration and normalization has cooled down somewhat; there is no longer an 'all-or-nothing' attitude by the most avid supporters . Professionals and parents seem to have become reconciled to the fact that although we would prefer 100% change, there will always be funding shortages and limitations as to what can be made available for our clients. The best one can ask for is philosophical support from the policy makers and the community, which results in financial and social support.

c) DIFFERENT APPROACHES TO PROGRAMMING

Like any field this one abounds with quick-fix methods and better ways to improve your client. I've heard of parents and professionals trying hypnotism, vitamin therapy, massage therapy and faith healing, to "cure" persons with mental handicaps. We would all like to have the key which unlocks the mysteries of the mind, improves skills and helps us to be better teachers, counsellors or therapists. As a result, the search for effective management techniques to control the behaviours of the students and/or patients continues to be an ongoing quest.

The reason for my elaboration of methods such as behaviour modification and Gentle Teaching is to demonstrate how the field is currently moving in two directions. One camp of educators and practitioners believes in strict adherence to behavioural techniques not only to teach client skills, but to improve staff performance as well. On the other hand, there is a strong shift away from the scientific approach to that which proposes to be more humane, less obtrusive and more casual. Before I justify my reasons for selecting one over the other which I use in my strategies for consistency, I have elaborated on the two ideologies for those readers who may not be familiar with the main points of each approach.* I suggest the reader keep in mind the concept of consistency when reviewing the two ideologies, and evaluating how they might be applied to the following example.

* This section gives the background for major areas where consistency can be achieved and gives an overview of current trends in that area. Much of the information in this section is presented to give the reader a basic understanding of the concepts presented in this manual. It is by no means complete and I recommend that the reader refer to the Bibliography to complement their research.

EXAMPLE

In the past, whether they lived at home or in a large institution, the mentally handicapped were rarely considered educable, worthy of training (Scheerenberger 1987), or employable. In most institutions they spent their days, waiting for their next meal or to be toileted. This was often their only source of stimulation. As a result, they engaged in a variety of behaviours in order to stimulate themselves. Self-stimulation could take on many forms; rocking, moaning, masturbation, hand-mouthing, or sucking on clothing. When this behaviour failed to help pass the time, some residents would engage in more sophisticated behaviours in order to attract staff attention and hence interactions; whether it be positive or negative. Self-injurious behaviours could include head-banging, hand-biting or ear-flicking, while aggressive behaviours (always a sure way to get staff attention) involved hitting other residents, putting fists through windows, or throwing objects at staff. While working in several of these institutions, I saw these problems handled in a variety of ways, but their incidence rarely helped the resident to achieve the ultimate goal of escape from the boredom. The staff attention was usually short-lived and there was always plenty of boredom to go around. Hence we have a vicious cycle; the client, who is trying to communicate his/her boredom (non-verbally), but who's attempts are going unnoticed by staff who are too busy reacting to the extreme behaviours which have come about by the client's many unsuccessful attempts to communicate. This vicious cycle has been a source of major frustration for many institutional caregivers and educators.

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i) The application of Behaviourism to People and Systems

We cannot discuss programming and consistency without discussing B.F.Skinner and his work in the area of behaviour modification. It is felt that mental retardation is an inability to respond appropriately in the environment. According to Burton (1976, p. 142) " the concern is to identify appropriate behaviours and develop the program in such a way as to increase appropriate behaviours ." As most of us know, the work done by Pavlov regarding stimulus - response- reinforcement led B.F. Skinner to his view of a person operating in his environment. The use of operant conditioning* on human behaviour evolved in the first half of this century and led to a great deal of research with the mentally handicapped toward the 60's and continues today (Burton, 1976, p.141).

* "Operant conditioning is the process of changing, maintaining, or eliminating voluntary behaviour through the consequences of the behaviour. Operant conditioning uses many of the techniques of Pavlovian conditioning but differs in that it deals with voluntary rather than reflex (involuntary) behaviours. The frequency with which a behaviour is emitted can be increased if it is rewarded (reinforced) and decreased if it is not reinforced, or punished. Some psychologists believe that all behaviour is learned through conditioning while others believe that intellectual and motivational processes play a crucial role." (Rubinstein, 1975, glossary)

Although it originally was applied in institutions, it was later introduced to the classroom with well documented success (Burton, 1976, p.141). Skinner's experiments showed that even the most severely retarded could learn through a systematic methodology or "precision teaching" (Burton 1976 p. 116), later known as data-based learning. The main principles for behavioural programming are:

1. behaviours are appropriate or inappropriate (undesired)
2. behaviours can be increased or decreased through intervention strategies
3. reinforcing a behaviour will increase its occurrence
4. removing reinforcement for a behaviour (or ignoring it) will decrease its occurrence---behaviours can be extinguished through this process
5. in almost all instances there is a direct link between a behaviour and a prior event (antecedent) which will bring about the behaviour every time *

Just as operant conditioning is a useful technique to practise with our clients, it is equally effective to use as a tool to train and evaluate staff (Browder 1987, p. 222, Reid and Whitman, 1983). The process includes: choosing a measurable goal (or target behaviour), measuring its current rate of occurrence (base-line), looking for antecedents to the behaviour and reinforcers which will bring about the behaviour again and then counting the number of times the behaviour happens again- once the program is implemented. Obviously the target behaviours, antecedents and reinforcers vary greatly, but the principles remain the same.

Over the past 30 years, behaviour modification has become a science unto itself. There has been so much research done in this area with the mentally handicapped, that whole journals have sprung up regarding countless experiments to change behaviours with various populations ("Journal of Behaviour Therapy and Experimental Psychiatry"," Journal of Applied Behaviour Analysis", "Behaviour Research and Therapy", "Behaviour Modification", "Behaviour Therapy"). Unfortunately, the principles have been applied to

*I say in "almost" all cases because in some instances, there is no discernible antecedent.

the extreme, both positively and negatively. In some instances, the use of punishment (in all its worst forms) has been applied to eliminate behaviours which were untreatable using simple positive reinforcement, (See Amnesty International Report, 1984; Baer, 1971; Harris, 1985; Prochaska, 1974; Reilich, 1984). Horror stories abound and at one time "behaviour modification" was a dirty-word. Fortunately, the specialists in behaviour management have become more ethical in their approach and stories about the use of cattle-prods, mace and time-out booths are rare and their application is limited and strictly monitored, usually by behavioural ethics committees.

As previously mentioned there seems to be a split between the educators and practitioners regarding the techniques used with the mentally handicapped. One group is strongly in favour of the precision teaching method and formal, data based behavioural programming; another group is opposed to this strict adherence to data and feels that we have lost the human aspect of what we are doing. An excellent example of this other position is evident in the work of John McGee and Gentle Teaching.

ii) Gentle Teaching

John McGee, from the University of Nebraska Medical Center, suggests that service providers deliver a "value base and methodology" for extinguishing persistent client behaviours such as hitting, kicking, screaming, self-injury and self- stimulation. McGee is frustrated (as many are) with the over-programming of persons with mental handicaps in situations where the behavioural zealots get carried away with their stimulus- response-reinforcement schedules and lose sight of the fact that their client is a human being--not a trained seal. He claims that the mentally handicapped are treated in the same way as prisoners of war and punished in inhumane ways. He encourages people to "love" the client like a brother, despite the possibility that they can be aggressive towards you at any minute. Gentle teaching is...

> . . . a pedagogy that has at its heart an anti-authoritarian posture toward persons with severely aggressive, self-injurious, or avoidant behaviours. It embraces the need to teach bonding, to focus continuously on solidarity with persons with these severe needs, to look upon them as our brothers and sisters in spite of their initial behaviours and to merge a gentle and respectful teaching process with our convictions. This can lead all of us to a deeper solidarity with one another. It is up to care givers to reflect upon these feelings and practises and to clarify and deepen their own posture toward all who are marginalized and oppressed so that all persons learn to share their lives and struggles and learn to live together.
>
> (McGee et al.,1987, p. 28)

I attended one of McGee's 1/2 day workshops in Toronto in 1989 and was rather disturbed by what I witnessed. He had taken clients from a variety of different programs with a wide range of serious behaviour problems and the staff who worked with those clients to a retreat for 4 days of training. He taught the staff to "bond" with their clients, by using repetitive talking (dialoguing) and physical contact no matter what behaviour the client was engaged in. When the client exhibited an inappropriate behaviour, the staff continued talking, provided positive body - language and, if possible, blocked the client from hurting themselves (i.e. if they were repeatedly rubbing their ear on their shoulder, causing the ear to be rubbed raw, the staff person is to gently place their hand on the client's shoulder to block some of the reinforcing sensation). I watched a video of McGee training staff on his methods and heard testimonials from the staff, saying their whole lives had changed because of the workshop, (even though, from what I could see there had been no concrete changes in the behaviour of the clients). The level of interaction with the clients is extremely high, the staff person is expected to almost shadow the client, providing a constant "dialogue" during all activities. When the client is abusive or aggressive, the staff are to continue with the process even if the client is coming after you—as in the video, we were shown where one of McGee's clients literally bit McGee on the head. But the good doctor never missed a beat and kept right on "dialoguing" as he pulled his own hair from the client's mouth.

McGee fails to see that his methods are founded in the basic principles of behaviour management; the continuation of the activity or "dialoguing" as he refers to it, is the same as one of the standard ignoring techniques used in behaviour programming. His procedure is fine if you have only one client to worry about, but most of us do not have that luxury, with classrooms of 6-15 and group homes of 4-8. McGee is not realistic about the lives of our clients. Perhaps we can decrease the behaviours in a client during a four day retreat, with a ratio of three adults to one client, but try to generalize that to a group home or classroom, where you have staff who are not consistent, equally trained or thoroughly convinced that the client should be allowed to spend his day engaged in self-injurious behaviour.

McGee's approach is anti-behavioural and pro-spiritual transformation of individuals with mental handicaps and the people who work with them. He affectionately ends his text book with a poem. He does not substantiate his claims with research or valid data to verify that this approach is effective. I appreciate the fact that he is concerned about the abuse and punishment of the mentally handicapped in institutions and programs throughout the world, but he is a typical example of how a philosophy and an over-exuberant messenger should be carefully examined before being adopted as a program technique. I am not suggesting that Gentle Teaching is not effective, and I like the encouragement to talk (as much as possible) to the clients and to "value" the client as an individual. I have discussed Gentle Teaching in this chapter to point out how we need to find a balance between behaviourism and humanism when determining which techniques we will endorse, without becoming too radical in any one direction.

iii) Discussion

Here we have the issue of equifinality. ("there's more than one way to skin a cat"). Which method do you choose for determining goals and techniques? Wolfensberger and McGee or the behaviorists with their data? This argument is illustrated in two Individual programming books currently popular in the Toronto area.

Galambos and Whetstone (1989) wrote a manual on Individual Program Planning which stresses the importance of client-directed services and promotes family (and friends) involvement in setting goals and delivering services. They encourage the service providers to "combine technologies for helping with a value-base that is aimed at promoting improved quality of life" (Introduction, p.1). They steer away from overly formalized decision making, data based programming and cringe at the idea of management by objectives. In contrast to this, Sigetich (1985), recommends contingency based programming and precision teaching and is a good source of information for the specific procedures to use to carry out these techniques. Like Lou Brown (discussed in Chapter Three), Sigetich appears to be more realistic in how to take a philosophy and turn it into workable techniques, given the realities of the classroom, workshop or the group home, with all persons who have a mental handicap. Sigetich sees programming as a formalized group of techniques whose success is verifiable by data. He states:

> . . .we must use means that are as culturally normative as possible. Again, this does not mean that we are restricted solely to using normal means to effect behaviour change. It means that we must use means that will allow us to create and maintain behaviours effectively; means that are effective but as non-deviant as possible. Note the double use of "as possible" . Using casual, informal behaviour change techniques, using only social reinforcements, refraining from using reinforcements that are powerful enough to create and maintain behaviours are excellent ways to violate the overriding need to be effective in creating and maintaining culturally normative behaviours. Arguing that it is somehow "not normal" (an erroneous interpretation of the principle) to use powerful techniques robs the programmer and the learner of progress. (p.1)

Galambos and Whetstone base success on consumer happiness and satisfaction. I question if the majority of persons who are mentally handicapped are capable of; a) having an opinion about their satisfaction with the type of service they are receiving and; b)

expressing that opinion. Most people experienced in this field would agree that very few clients (especially those with communication disorders) are capable of honestly telling their service providers how they feel about the job they are doing. I think approaches which encourage informal and emotive-based programming are more adaptable to high functioning mentally handicapped individuals. The best we can do with the remainder of the population is second guess what their preferences are and use an educated guess to interpret if they are happy with the result. To base a whole method of programming on a philosophical approach which is feasible with less than half of the population is unrealistic in my opinion.

If it is not already apparent, I support the behaviourists in this ideological argument. However, I want to add one caveat; I do feel it is very important not to lose sight of the rights of our clients. They should never be thought of as merely subjects in an experiment or vehicles to test out another theory. The psychological well being of our clients (and staff) should always be our first priority. I like the compound approach designed by Sigetich, which is based on behavioural methodology. I like his interpretation of Wolfensberger and his pragmatic combination of humanistic principles with scientific accountability. He seems to be able to combine the best aspects of behaviorism while keeping in mind the importance of Social Role Valorization and the reality of the population whom we work with. I would recommend his programming manual for those individuals who are currently looking for one which helps to organize the process, used in combination with the strategies which I have recommended for consistency.

CHAPTER THREE

GETTING STARTED:

a) PRE-PROGRAM CONSIDERATIONS

(i) - Getting to know the client
(ii) - Strengths and Needs

b) ASSESSING THE SITUATION

(i) - Do you have a consistency problem?
(ii) - Pre-I.P.P. Survey and Analysis
(iii) - Analysis of Past I.P.P.s

c) HOW TO FOSTER ATTITUDE CHANGE

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a) PRE-PROGRAM CONSIDERATIONS:

(i) Getting to Know the Client

Before any program can be started it is important that the primary program person sit back and evaluate the total picture, not just the client, but the environment, the long term possibilities for the individual and the reality of the current situation. The primary counsellor may choose to do one of two things during their initial introduction to the client: s/he can go ahead and work with the client for several days without reading any previous information (other than what is vital--medical information etc.) and allow their own first impressions and "gut-instincts" to take over or, they can pore over the reports and documentation from previous teachers/counsellors and let someone else's professional opinions colour their impressions of the client. Either way we learn a great deal about the client and their needs which should be used in designing a plan for the future.

How to Collect information:

- observe (casually or to collect data)
- discuss with others
- interact with the client in natural activities
- review past reports, files

The most important point is not to try programming immediately. If possible, sit back, get a feel for the learning environment, watch others work with the client and make your own observations without trying any of your own strategies. Discuss with other staff why they handled a situation in a specific manner--there may be a very good reason why they ignored the client at a particular moment, but it was not apparent to you why they used such a method. Quite often there are strategies used with clients which from the outside look strange, but the reasoning behind them is founded in years of trial and error programming with that client. Once you are familiar with the client, the environment and the other staff (in action) you will be better equipped to determine the program.

Case Illustration: A group of senior citizens in McDonalds were shocked to see a teacher walk away from her student as the teenaged boy set about banging his head on the table due to a spilt beverage. Unfortunately they thought she was a useless teacher and should have run to comfort him. Little did they know that as a result of ignoring his attention seeking behaviour it had decreased from 136 to 3 head bangs per week.

There are many assessment forms available to use with mentally handicapped individuals ranging from developmental assessments to vocational and behavioural assessments. This manual is not intended to teach people how to evaluate or assess persons with mental handicaps, but rather to know how to make program decisions for them. If you are unsure of how to assess this population, I would direct you to Diane Browder's "Assessment of Individuals with Severe Handicaps" (1987). Personally I am not partial to any one particular assessment battery. It depends on the client, their day Program and area of need. I feel that any assessment which is conducted should help the

evaluator to determine the client's strengths and needs classified as follows:

(ii) Strengths and Needs

1. a) The Individual (biological make-up)

- general health: current problems, recent surgery, overall appearance
- history: previous living placements, family involvement, prior program involvement
- medication: type, reason for medication, possible side-effects
- hearing, vision, allergies
- What's the problem? Is this client learning delayed because of limited experience or impaired capacity---or a little of both?

1. b) The Individual Skills:

Consider the following in terms of weaknesses and strengths:

- communication skills: non-verbal, vocal, gestural, paralinguistic, receptive/expressive skills
- behaviour tendencies: what precipitates behaviour problems
- social skills: desire to communicate, interactions with other clients or staff
- motor skills: what can they move, where, how much, how long can they maintain a motor action
- level of independence: at home, in the community
- appearance: socially acceptable or "stick out like a sore thumb"

1. c) Learning style/capacity

- learning style: preferred sensory modality, visual, auditory, tactile
- rate of learning: number of teaching trials to learn skill, retention within training session
- ability to generalize what they learn to other activities, people, environments
- motivators: social praise, concrete reinforcer, edible

- attend to stimuli: interact with stimuli
- level of learning: spontaneous or physical assistance

In addition the programmer should take into consideration the other aspects of the Program which have direct influence on program adherence and success. These include:

2. The Environment: (home, school, work, recreation, community)
- language: what need is there for the client to communicate? what opportunities do they have for interactions
- how much can others (staff, family, community) support the program?
- what are the staff limitations? time, skills, attitude
- what opportunities are available?
- can the community support the program? school, home, volunteers
- are the expectations of family and caregivers realistic? too high or too low?

3. The Program:
- can you afford the time to conduct a highly structured program?
- are your expectations realistic?
- are you comfortable with your skills--do you need more training?
- what other professional input is necessary? Is it available? What can/should be done in the meantime?
- will the other primary caregivers support the program as well? What needs to happen to bring this support about?

b) ASSESSING THE SITUATION

(i) Do you have a consistency problem?

A wise, old person once told me; "If it ain't broke, don't fix it" and the advise is appropriate when discussing the field of Social Services. How we love to dissect and evaluate and then design processes to fix situations, only to have them redone 6 months later. I think this continual state of examination and planning comes from the feeling that we know something is wrong, but "we can't quite put our finger on it". It is important to look at the results of our efforts: has the client made progress? what is the morale of the team of people working with this client? what type of problems is the team having? Maybe the program is going smoothly and "it ain't broke", so why do we feel we need to fix it? We're so used to assessing and solving problems in the Social Services field its quite possible we don't know when to leave well enough alone. How do we know if we have a consistency problem and we should step in? We have two obvious ways to do this; one by looking at the end results (i.e. the number of client-goals achieved) and the other by surveying opinions of the members of the team. But first, consider your reactions to the following questions:

1. Are you satisfied with the progress that has been made with the client over the past year?

2. How much time has been spent amongst the team (or others) discussing problems? How much time was spent solving them?

3. Do you work with a team of people where more than 2 people are in agreement and are working towards the same client objectives as you?

4. How many of last years I.P.P. goals have not been met? What reasons have been given for not meeting these goals? Is there a consensus for these reasons among staff?

5. How many have been met over the past 5 years?

6. Do you constantly attend meetings regarding your client where you weren't aware of major changes in their life, health, staffing etc.?

7. Do you feel you're "getting no where fast" with this client?

8. If asked, could you write down the main goals which were targeted for your client at their last I.P.P. meeting?

9. Do you have the skills necessary to carry-out the I.P.P. objectives?

10. Do you question what your role is and would you like it clarified?

11. Do you find yourself spending a great deal of time dealing with interpersonal problems with the other members of the team as opposed to working with the client?

12. Are you constantly in a stage of preparing/writing/designing programs which never really get started?

13. How many programs have you written for the client in the last year? How long did each last? How many are currently still running?

If you look over these questions and are honest in answering them, you will probably see patterns developing within your own I.P.P. process. Either there is lack of co-operation (as seen in the answers to questions 3, 9 and 11) or a lack of communication (revealed in answers to questions 6, 9 and 10) amongst the different team players. I suggest that inconsistency in programming could show up in negative responses to questions like 4, 5, 8, 9 and 12. If your answers to questions 1, 4, 5, 7, 9, 12 and 13 always tend to be something like: we had trouble getting the co-operation of the family, school, workshop staff or, it didn't work out or, John began to act up and other things became more important then possibly you need to look at how realistic the goals are in the first place. I will now turn to a strategy which elaborates on the above questions and determines if others involved with the client feel the same.

(ii) The Pre-I.P.P. Survey (Appendix D)

At this point it is important to evaluate the factors which lead to program consistency. Most importantly we must consider the team, their communication skills, attitude and techniques used with the client. Everyone has feelings of frustration on their job, but issues like the ones in the previous 13 questions reflect some of the common problems which can break the links and lead to inconsistency in program delivery. As discussed in Part One (B) some of these issues are brought about by: role ambiguity, lack of organization or direction, interpersonal conflict, lack of communication between team members, work overload and limited skills. It is the responsibility of the team I.P.P. manager to interrupt these non-productive patterns and bring them to the surface for discussion and resolution.

One strategy to help indicate if you do have a consistency problem is to ask each member of the team to complete the Pre-I.P.P. meeting survey (Appendix D) and return it to the I.P.P. manager or another designated person several days before the meeting. The survey is anonymous and the person who sends it out should make every effort to keep it as such. The survey is written in such a way as to elicit open dialogue from the team members, without implying that one suspects problems. It is a simple, easy to complete survey, which people should be able to do in less than 20 minutes. A covering letter/memo should go out with the survey stating that the I.P.P. manager is trying to collect some information before the I.P.P. meeting to determine the direction of the team.

After the survey is returned to the I.P.P. manager, another form (Appendix E) is available to help to analyze the results. However, the I.P.P. manager may choose to just review the results informally to determine if there is a consensus regarding: how many people in the team feel unclear about their role, unsure of the goals for the client, unsure of their skills, or would like to make major changes to the client's program but have possibly been hesitant to discuss them with anyone. This is a very important first step for the next I.P.P. meeting. The information from the Pre-I.P.P. Survey should be presented as the opening topic of discussion. Even if the results are positive, it should be shared anyway to reinforce the group for their cohesiveness.

Analysis of Pre-I.P.P. survey

The Pre-I.P.P. survey (Appendix D) is not intended to be a test of people's memory. It is merely a form to collect information and determine how consistent the team members are regarding the client's program. As in baseball, there is a tremendous preoccupation with statistics regarding each player, their total hits at bat, bases stolen, games played, the ball parks where games are played and the number of fans. This helps managers and coaches to decide which combination of players to use for each game and which ones will be most likely to bring about a successful game. What we want to do in the analysis is see how many team members: think the same thing regarding certain issues, need the same training, want to make the same changes in order to attain as high a level of consistency as possible and also want to also bring about success. Obviously it would be best if people would sit down to discuss and compare their concerns, but this does not always happen. As a result a formal survey, which invites their comments and is later compared with comments from the other team members, is necessary.

Questions one and two should be answered without looking at any documents (i.e. I.P.P. forms, records, reports or charts). They are meant to determine if the team members are aware of the objectives and goals selected for the client at the most recent I.P.P. meeting. Members of the core I.P.P. team should know what the objectives are, but there may be more problems answering #2 (long term goals). This isn't really a problem because the goals are selected at the meeting, written up on the I.P.P. form and then set aside between meetings, since more work goes into defining, writing and putting into practise the short term objectives. One would hope that everyone is working on the same short term objectives. If they are not, this is definitely an area for discussion at the next I.P.P. meeting, especially if the results of the analysis of past I.P.P.s shows that few goals or objectives have been met in the recent past.

Question three should be an easy list to compile. It asks people for their present opinion of priority needs for the client. Simply write down each persons response, check which ones are repeated and determine where the consensus lies. The problem may begin if there is no consensus and everyone has a different opinion of what the priorities should

be for the client. Again this is something to bring up at the beginning of the I.P.P. meeting. Making available the results of this question will save time when choosing priority needs at the I.P.P. meeting and defining long term goals.

Questions four and nine, encourages the respondent sto discuss their concerns and looks at consistency in attitudes. Number four asks in general, what aspects of the whole process they would change. Number nine is a little more specific; asking what they disagree with regarding the management of the client. This is a difficult area to check for consistency, since attitude is abstract and therefore difficult to measure. The person compiling the results should look closely at the essence of people's comments; are they generally positive or negative, counterproductive or typical complaints. If anything, the sharing of some of the comments to number nine might be a way to get the group to open-up and discuss some of their concerns at a Pre-I.P.P. meeting.

Question number five is very important. Role ambiguity or role overload, can be a primary source of intrapersonal conflict for many people and leads to a high rate of staff burnout or interpersonal conflict with other team members (Robbins 1987, Rahim 1986). If the results of this question shows that this is indeed an issue for many people, it could explain the poor consistency in program technique or maintenance. If people are feeling overwhelmed in their role, they will definitely have difficulty delivering the required program. If this is the case, the I.P.P. manager should consider meeting with all the team members individually, to discuss their concerns.

Questions number six, seven and ten looks at the consistency in techniques being used with the client. Number six checks to see if the team members feel positive about working with the client, or if they are frustrated with the progress being made. Number seven will help to determine if everyone: a) is using the same technique and b) agrees with the technique which they are supposed to be using. If everyone is not using the same technique, or is not in agreement with the type of technique, this will likely explain why progress is not being made, or why there are problems with maintaining a program. Number ten asks if anyone needs further training to deal with the client. If someone is unsure of their skills, then once again, program delivery will be inconsistent.

Question number eight is concerned with the level of communication amongst team members, as well as the level of contact with the client. A program can hardly be successful if the members do not interact or communicate regularly regarding ongoing program information. This would reflect on the consistent maintenance of the program. Staff members working with a client in different Programs should communicate at least once a week, (for difficult clients, I suggest once a day), even if it is to report that the client had a "great day!" Communication needn't be lengthy phone calls, or written reports. A simple note or message carried by the client is sufficient.

Obviously number eleven is an open ended question and is there to provide additional opportunity for team members to share their concerns. Again, these can be compiled and commonalities reported to the team.

(iii) Analysis of past I.P.P.s

In addition to the above survey, the I.P.P. manager should review the I.P.P. forms for the past 3-5 years (or longer if desired). They should write down all the long term goals which have been set for a client, keeping track of the number of times certain goals are repeated. They should then do the same for short term objectives and any service plans which were selected. The format from Appendix F might be used. This form shows how many goals, objectives and plans have been met over the past three to five years, which areas/domains the team has the most success in achieving and which target areas are repeated more than twice, but never addressed in any program. It also considers if the I.P.P. manager is aware of which goals, objectives and plans were accomplished, and suggests they learn why they were not successful. This can be done in discussion with the other team members.

These three forms are a means to gather statistics on the effectiveness of the team and the underlying problems with programming for this client. In essence, they are a tool for evaluating the I.P.P. team and their ability to conduct the I.P.P. process. They then help to select objectives for the team to work on, much like the same process used with the

client. Often, it is difficult to pinpoint problems specifically, or their source. The I.P.P. manager may feel initially it is time consuming to co-ordinate and compile all this information. However, in the long term it will prevent people from starting and spending time on a program which is neither necessary or a priority. The following example helps to illustrate this point:

Example

Let's pretend that for the past 3 years, the long term goal for John has been to find him a group home to live in. But, for the past 3 years John's grand-mal seizures have caused him to have frequent and extended periods of hospitalization and rest at home. Each time a possible placement is found, he is unable to initiate the preliminary trial visits because he is unwell. The parents are caught in a vicious cycle of caring for their son, but exhausted most of the time because so much of their time is spent visiting group homes or filling out forms for homes which he never gets to see. It is obvious then that the long term goals the team has been selecting for the past 3 years need to be re-evaluated. They should either be looking at providing more support at home to the parents or they should be spending more time investigating different medical options, which might help to control the seizures. The need here is to rethink and restate the goals; a) John's seizures are affecting the opportunities for him to participate in programming or alternate places to live b) the home needs additional supports (i.e. parent relief, nursing assistance, training). In order to get the above, c) more financial support is needed. It is apparent that less time should be wasted on finding group homes which the client is currently unable to benefit from, and greater emphasis should be placed on ways to deal with the current situation. Thus the long term goal becomes; "John's health needs to be stabilized for a period of at least 6 months, in order for him to move onto another home".

Often we have to put our preferred goals on temporary hold, until the immediate issues which impede their successful attainment are remedied. In the next chapter the selection of goals is discussed more thoroughly. This example has been used to show how the analysis of past I.P.P.s can indicate areas of weakness in the I.P.P. process.

Now that we have determined the areas of difficulty with the I.P.P. you might want to have an organizational meeting with the key team members to discuss the results of the survey and analysis of past I.P.P.s. . This separate meeting will save time at the I.P.P. meeting and help to give it a new focus.

The pre-I.P.P. meeting documentation (Appendices D, E, & F) should be completed at least 2 weeks prior to the meeting in order to give the I.P.P. manager enough time to obtain anything which may be missing. Key team members should also have all their background information on the client compiled and they should be familiar enough with it to present it at the I.P.P. meeting. As a result the I.P.P. manager has an up to date, accurate view of the team and areas which need to be addressed to achieve consistency and the primary teacher or counsellor has complete information regarding the strengths and needs of the client. With all this information prepared at both the primary and suprastructural levels, we can now move on to the actual I.P.P. meeting and the selection of specific goals and objectives.

c) HOW TO FOSTER ATTITUDE CHANGE

Sometimes I wonder which is more difficult: changing client behaviour, or staff behaviour. The most common areas where I find staff having a negative attitude which affects the successful performance of their job is:

1. - attitude (or opinion) towards the client
2. - desire to work as a team
3. - techniques used with the client
4. - communication with others
5. - commitment to I.P.P. goals

In future chapters, I describe strategies to address points 2-5. I will now focus on the first area- "attitude towards the client", review the literature, and give suggestions to bring about consistency in attitude amongst staff.

When discussing organizational behaviour, Lawless (1979) states that attitudes are difficult to change and depend upon three things: the characteristics of the attitude, the personality of the attitude holder, and the group affiliations of the attitude holder. He elaborates:

> From a functional point of view, depending on how many social wants support it (change) and the strength of these wants, the attitude may be more or less changeable. A congruent change of an attitude based on some social want or personality need could be relatively easy, provided the need could be magnified (calling for more need satisfaction).
>
> (p. 259)

> Because attitudes are tied together in systems, we can expect that a change in one attitude will require adjustment in the entire system of which it is a part. Indeed, as the systems are tied together, it may require a change affecting the entire personality. This latter is not easy and in some cases is almost impossible.
>
> (p. 249)

As mentioned in the introduction, the underexpectation of achievement may indeed bring about non-achievement. This is characteristic of one group of individuals who work with the mentally handicapped. It is a more traditional way of thinking, based in feelings of pity for the disabled and the opinion that they need "faith, hope and charity". They have very low expectations of the client and as Burton (1976) describes it:

> Strong underexpectation of achievement: In this instance the parent views the child as completely useless and incapable of even the most elementary skills. In instances, this frequently results in the child fulfilling the prophecy by reducing their motivation or subsequent attempt at achievement.
>
> (p.238)

The people I find most common in this category are (as Burton points out), parents and older staff. Rather than find fault and point an accusatory finger, we need to remember that not everyone has had recent training or opportunities to witness successful programming.

The opposing group is one which began in the early 60's. It was fostered by behaviourism and the notions of social role valorization. Their attitude basically looks at the client as a normal person, in need of support, but not in the form of pity or charity. Its advocates propose education, access to community centers and services and the freedom of clients to make choices regarding their own life (where possible).

Within these two camps there are gradations of attitudes. There are people who take the Social Role Valorization principle to the limit and are unrealistic to the degree of spending more time fighting battles than they do addressing the day to day needs of the client. Then there are those who know it is outdated to feel pity for the client, but resist program ideas, are reluctant to implement programs because it "sounds mean" and feel that making the client comfortable is the best we can hope for. When taken to the extreme, some of these individuals might even sabotage programs as a result of their strong feelings of opposition to programming and pity for the client.

These are just a few examples of the attitudes held by staff which one might encounter in the field, each defending their opinion not only verbally, but in their behaviours. However, with regard to programming it is important that everyone be as unified in their attitude as possible, without anyone feeling "brainwashed" or having their egos threatened. This can only be achieved through intervention from the supervisory level.

Katz (1960), suggests that two conditions are necessary for a change in ego-defensive attitudes. One, the reduction of threatening feelings and the development of a relaxed atmosphere. Second, the opportunity to openly discuss opinions (possibly even "let off steam") reduces the underlying feelings which might build up to strengthen the attitude. However, he cautions that communications intended to reduce feelings of threat or swaying one's opinion, might also strengthen attitudes. Attempts to change attitudes must

be handled carefully by a strong leader, who cannot only recognize the motivation for attitudes, but the values which put them there in the first place.

It is the responsibility of the I.P.P. manager to recognize when the differences in attitude between the team members is affecting the consistency in the delivery of the program. This can be an extremely delicate issue and one which is best be handled by a person with a certain degree of authority and responsibility. Unfortunately there are many times when a supervisor may be the one with the inconsistent approach making it extremely difficult for their staff to achieve good quality programming. I have recommended a few simple strategies to deal with attitude differences, thus allowing the team to reach a consensus about their attitudes towards the client. The Pre-I.P.P. survey form (Appendix D) should help to bring these differences to the surface thus opening the door to the following strategies:

Strategies to foster attitude change

- Meet with the person and give them an opportunity to explain their opinion and listen carefully.
- Discuss the philosophy of the team without saying that their attitude is "wrong" or "different". Simply state which direction the team is headed as a result of the I.P.P. meeting and how they view the client.
- Point out similarities (even if they are extremely basic) between your opinions and how you both share the common goal of what is best for the client.
- Let them express their feelings of being threatened by a new approach which is carried out by all the other team, except themselves. Discuss this openly.
- Provide them with backup literature which discusses the team philosophy, nothing too involved or difficult to read, something short and light.
- If you have tried these measures and no progress has been made, meet with the person again and let them know that you are aware of their attitude differences and would like a chance to show them another point of view.

- Invite them to visit a program with you or watch a video tape where they can see the advocated approach in practise, (which also shows positive results). Discuss how a certain attitude, technique or team structure can be easily implemented. (Choose your program carefully, otherwise it can backfire on you).
- Arrange for them to meet with a person in a similar situation to theirs (another parent, another staff person from their homeland, or someone similar in age), who has changed their attitude and works effectively with their client as a result. Openly discuss their concerns with the 3rd person and ask them to elaborate on their experiences.

If you meet with resistance on any of the above strategies, you can choose to "agree to disagree", which is likely what you will have to do with parents, or those superior to you. However, if you are dealing with a subordinate staff person who has a fundamental difference of attitude, this can be reason for dismissal in some places. A person working for you, who fails to adopt the philosophy of the team, whose resulting behaviour is having negative effects on the success of the program, is therefore not fulfilling the requirements of their job. It is evident to me that if someone has an inappropriate attitude regarding the persons they are responsible for teaching, or towards conducting prescribed programs, they will likely not be able to carry-out the other aspects of their job in the required manner.

This section has dealt with the complexity of the attitudes of individuals working with persons with mental handicaps. In all other aspects of I.P.P. planning we can articulate concretely our plans to change behaviour. However, the process of making positive changes in attitude involves the interpersonal skills of a strong and dynamic leader and the co-operation of many talented, yet diverse personalities. This is not an easy task and the literature tells us that there are no definite guidelines for changing attitudes, or for being the perfect leader (Hersey & Blanchard 1972). We are not in the business of brainwashing people and it is only as a result of diverse attitudes (in the first place), that positive changes have occurred towards persons with handicaps.

In my view, the best we can do is evaluate the outcome of our attitudes (positive or negative) by evaluating the outcome of our performance. The criteria for success is whether or not we have accomplished what we set out to do.

CHAPTER FOUR

INDIVIDUAL PROGRAM PLANNING:

a) RELATED BACKGROUND THEORY

Functional Programming

b) THE I.P.P.

(i) - Background Information
(ii) - The I.P.P. Manager
(iii) - Teamwork

c) THE I.P.P. MEETING

(i) - Who calls it and the participants
(ii) - Does everyone know what is expected of them?
(iii) - The I.P.P. meeting Agenda
(iv) - Description of Agenda Topics

d) ARRIVING AT CONSISTENT GOALS

e) CONCLUSIONS

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a) RELATED BACKGROUND THEORY

As caregivers and teachers in the field of special education, we are responsible for organizing the various details for another person's life (medical appointments, diets, recreation events, transportation, equipment), which is quite a task, when some of us experience difficulty organizing our own lives. Being self sufficient and a useful member of society is (in general), what most non-handicapped people strive for in their lives. In the past, individuals with mental handicaps were never considered to adopt similar life-goals simply because they were never expected to take care of themselves. As a result of the philosophical changes of the last 15-20 years brought about by the integration and normalization movements, the overriding instructional goal for this population has become

independent living, (with a minimum amount of assistance). When programming for this population, some of the areas which impact on this objective include:

a) Home - when this person reaches 18-20 years old, where can we expect them to be living (independent living or group home)? Normal young people begin to make plans to leave home at about this time.

b) Life-Skills - will this client be able to dress, wash and look after themselves, prepare meals, shop for food and organize their finances enough to manage on their own?

c) Vocational - what kind of work will this client be able to perform? Competitive employment, or sheltered--supervised work?

d) Handicaps - what physical or health limitations do they need to overcome in order to reach maximum independence?

e) Relationships- what sort of relationships does this person have with friends, family, advocates and their immediate community or what opportunities do they have to form relationships?

These are the general areas we must take into consideration when looking at long term planning for clients who are mentally handicapped. Of course, if they are capable of doing this for themselves they should be encouraged to do so, but this manual is not about clients who are functioning at such an independent level. Individual program planning is the process of selecting goals for (and with) clients and organizing what they are taught according to those goals. The tricky part is determining the goals so that they meet the long term needs of the client, given the social service system in place, available funding and community support.

In the past it was all well and good to teach the mentally handicapped basic academic skills and then let their parents or caregiver teach the rest. But what do you do about the client who has not had those learning opportunities and is still struggling with unzipping his/her coat and hasn't any idea what a pencil is for? We still have a responsibility to educate them. The field of special education had to learn a very long time

ago, that teaching can encompass many associated areas including communication, physical-motor development, domestic and life skills, as well as basic academics.

I recall asking a teacher of a "mentally handicapped class", why she was teaching the class to sort out different coloured pegs as part of their academic morning routines. She felt that they should be able to sort things around the house, such as dishes, cutlery and clothing. I asked her why she didn't just teach the class these skills, using those items. She replied that the sorting of pegs was a higher cognitive task, that it taught thinking skills and after all this was a classroom---not a home. (I noticed that the students were not able to generalize this skill to other activities in the school.) At the time, I felt I had missed some point somewhere, but never forgot the futility of the sorting of pegs. Years later my bafflement was met with an empathetic ear in the form of functional programming.

i) Functional Programming

Although Lou Brown is a strong instigator of attitudinal change, I consider him to be more goal or product oriented than Wolfensberger and the principles of social role valorization. He doesn't just suggest that program planning be looked at differently, he recommends concrete methods for bringing about change in special education pedagogy. In the mid 70's, he put forth the view that the goal of educating severely handicapped citizens should be to teach them to function as productively and independently as possible, in integrated, normal, environments. He claimed that the use of artificial instructional materials and settings (like the example described above) do not allow severely handicapped students to solve real life problems or provide them with the skills needed for practical functions, as much as do natural and realistic settings, tasks and materials (Brown et al 1976).

When Lou Brown and his team from Madison, Wisconsin, first began making these suggestions, he, like Wolfensberger, met with a great deal of skepticism and opposition from traditional educators and administrators. Once again, people interpreted his notions as far fetched, unrealistic and impossible to carry out. Mind you, he did put

quite a few people on the defensive. He declared that:

> In special education, the logic of homogeneneity abounds to the point of absurdity. . .By affording credence to the presumed positive properties of the logic of homogeneity within educational systems, educators have systematically,although inadvertently,impeded many handicapped and nonhandicapped students from acquiring the skills, values,and attitudes necessary to function in heterogeneous multifaceted and interpersonally complex adult environments. (Brown et al., 1976)

> Many untrained and undertrained teachers, administrators, physical therapists, speech and language therapists and others are providing direct services. That is knowledge exists that would substantially enhance the quality of educational and related services provided but it is not being utilized because of poorly trained and/or undertrained personnel, inadequate inservice training models, rigid and antiquated belief system. (Brown et al., 1981)

Once the stings from the insults healed, the professionals were able to see that Brown was suggesting a curriculum to help those frustrated with trying to adapt "normal" academic curriculum to students who neither understood what they were learning, nor would be required to use that skill in a future real life situation, (like sorting pegs). He presented the concept of "criterion of ultimate functioning", which refers to the long list of skills that individuals must possess in order to function as independently in social, vocational and domestic environments. His guidelines for the selection of instructional goals are:

1. Why should we engage in this activity?
2. Is this activity necessary to prepare students to ultimately function in complex heterogeneous community settings?

3. Could students function as adults if they did not acquire the skill?

4. Is there a different activity that will allow students to approximate realization of the criterion of ultimate functioning more quickly and more efficiently?

5. Will this activity impede, restrict, or reduce the probability that students will ultimately function in community settings?

6. Are the skills, materials, tasks and criteria of concern similar to those encountered in adult life?

(Brown et al.,1976, p. 9)

With these guidelines, teachers, therapists, counsellors and administrators can effectively select teaching materials, environments and techniques, with a consistent focus and well defined parameters. Confusion in defining program goals therefore is diminished when it comes to programming. We have the parameters to set goals which have the potential to lead to maximum independence for the client in their home, work and recreational life. Of course this must be adapted according to the functioning level of the client, but with the "criterion of ultimate functioning" as a central theme, the chance for a consistent attitude towards programming is increased.

I have never forgotten how Brown summarized his philosophy at a workshop I attended many years ago---"if there is something that needs to be done in that client's life; teach them to do it for themselves". In my view, that is what education is all about.

b) THE I.P.P.

(i) Background Information

The I.P.P. meeting* is normally an annual event and reviewed every 6 months depending upon the agency or school board. The participants include all the people involved with the client's life, including the parents, teacher, counsellor, social worker, doctor/psychologist, nurse, etc. The manager of this meeting can be one of many people. Usually it is the case worker, or the supervisor of the program where the client spends most of their time: workshop, school, group home. This team does not necessarily come together just once or twice a year for I.P.P. meetings. The core members of the group might see one another at different events such as board meetings, training sessions, agency functions (such as Christmas parties or parent's nights), or fundraisers. The most important element of this group of people is their ability to come together as a team and accept the leadership of the person with the most responsibility, the I.P.P. manager.

In order to prevent any misunderstanding, I will review some definitions which were discussed in the Terminology section, at the beginning of the manual. The use of the word "program", in Individual Program Plans (I.P.P.s) refers to the annual plan set out by the primary caregivers and case management team (See Appendix A). At the annual meeting it will be decided which goals the team will work towards for the upcoming year and what skills the client needs to acquire to pursue these goals. The difference between long term goals and short term objectives is quite major. Long term goals are 1-2 years in duration, are broad in nature and encompass a range of domains.

* In the case of school boards, there is an Individual Placement and Review Committee [I.P.R.C.] meeting held every two years and the planning of the Individual Education Plan [I.E.P.] follows the placement meeting. Unfortunately not all school boards involve the team in the planning of the I.E.P. and it is the responsibility of the assigned teacher to write up the plan independently of the team. In some cases the I.E.P. combines the information normally found on the I.P.P. as well as an over- view of the specifics of how the plan will be carried out. As a result there is less documentation, thus less accountability and consistency within educational settings than one would expect. For the purposes of this text, when referring to the I.P.P. it should be understood that the I.P.R.C decides upon only the type of classroom placement of the student and the I.E.P. is comparable to the I.P.P. in that setting.

Short term objectives however are usually 1-6 months in duration, are very specific and encompass only one domain (sometimes two; as in learning to tie a shoe--which involves motor and cognitive skills, but the main focus is usually on only one). After the I.P.P. meeting, the Individual Teaching (or Treatment) Plan (I.T.P.) is written and it gives step by step instructions on how the short term objectives are to be taught. So the key elements to focus on in the I.P.P. meeting are the long term goals and the short term objectives which evolve from the strengths and needs of the client.

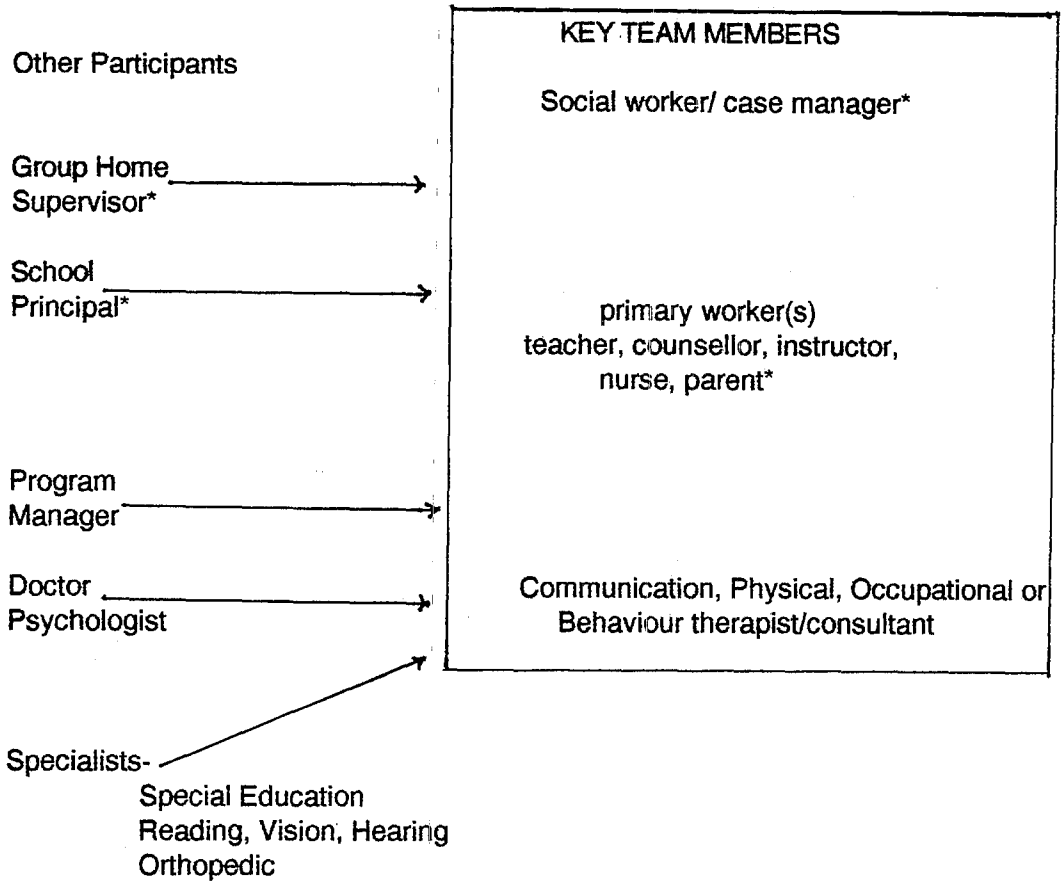
(ii) The I.P.P. Manager

The specifics of the I.P.P. meeting will be discussed further in this chapter but first, it is important to review the role of the I.P.P. manager and their quest for consistency in programming. The I.P.P. manager can be any person (teacher, counsellor, instructor, or social worker/case manager) in the key team who is ultimately responsible for the I.P.P. form. They are the pivotal person, who could work at both the primary and suprastructure levels. They have the most contact with all the key team members and should be aware of the factors which can affect program success. The I.P.P. manager should always keep 4 underlying objectives in mind and work towards the group:

1. agreeing on goals
2. agreeing on technique
3. making a commitment to follow- through on their promises
4. working together harmoniously

If you are the I.P.P. manager in this process, it is easier to try to implement the strategies contained in this manual. If you are not, you might be running the risk of overstepping your role, which may affect your long term career plans. If you are not the I.P.P. manager and you wish to work towards greater consistency, I suggest you share your ideas with the appropriate supervisor and together you can work on bringing about positive changes. There are usually two layers of personnel in I.P.P. teams:

THE I.P.P. TEAM



* Any one of these individuals could be the I.P.P. manager

The I.P.P. manager needs to have a variety of skills. First they must look at the effectiveness of the team (or the output) as demonstrated in the Pre-I.P.P. survey. They should then further their diagnosis of the situation and develop the means to change some or all of the variables which have brought about the problems presented in the I.P.P. survey or from other sources (i.e. personal contact). Next they need to look at the group of people they are working with and adapt their style according to the members strengths and needs, just as they would with the client. According to Hersey & Blanchard (1972), people require different types of leadership depending upon their degree of training, maturity level and need for socioemotional support (development of social relationships

with work associates). Some members will require a high degree of task definition or guidance and high socioemotional support. Others, possibly more professional or mature team members, will require less task guidance and less relationships within the team. The I.P.P. manager will likely be dealing with a whole gamut of problems and will have to provide different support or feedback according to the personalities of individual team members. For example, a first year workshop counsellor may require more task guidance and socio-emotional support because they are unsure of their role or the I.P.P. process, than someone such as a visiting therapist who will not need to have their job defined for them. Although this therapist will need to be made to feel welcome, they don't necessarily need a high degree of socio-emotional support from the manager in order to be productive.

One would hope that all "team" members would see consistency strategies as an attempt to bring about positive changes and not feel threatened by the I.P.P. manager's efforts. But, as Burton, Lawless and others have mentioned, not everyone is able to cope with such a concept and could possibly see it as a means to make them more accountable or a challenge to their competence (ego-defensive). The "turf"-tending which Gardner and Chapman discuss is quite prevalent in this field and some staff are simply not prepared to act as part of a team or appreciate attempts by others to make improvements. This would especially be a problem for a staff person attempting to improve the overall consistency of a team, who is not a supervisor. In this case it is much more difficult since it is normally not the responsibility of a subordinate to point out the performance weaknesses of their supervisor or peers. Hence the need for the I.P.P. manager who is trying to make changes, to become allied with the supervisor, or for performance improvements to be initiated by individuals with supervisory responsibility.

When opposition to change does occur, it is necessary to deal with resistant individuals on a one to one basis, (not over the telephone) and discuss your concerns and specific strategies to foster consistency. If they are more aware of the direction you are headed and feel part of the process they are less likely to suspect you are attacking their effectiveness on the job. A typical organizational behaviour technique when making changes to existing structures is to include those who are to be part of the change process in

the early planning stages, thus making them feel involved and like an ally (Hersey & Blanchard 1972; Robbins 1987; Bourdon 1982). If they still resist, there is nothing much you can do about them. We must accept those things which we cannot change and work around them.

According to Lawless (1979) many teachers are managers in educational and other types of organizations, but few managers consider themselves teachers (p. 469). Since a large part of what managers do is looking at the strengths of their subordinates and motivate them to progress to new skills to achieve a common goal, the effective I.P.P. manager must also be a good teacher. The tone of the team, the commitment, the trust and the communication patterns are set by the I.P.P. manager's example.

Some I.P.P. managers may wish to automatically approach the group to develop a Team - Contract, which is discussed in greater detail in Chapter 6. Others may want to simply state that they would like to set some objectives for the team to address some of the results on the Pre-I.P.P. survey form. For example; "next time we meet, everyone will know who the members of the team are and who is new and what their responsibility is". There are many things which you can do as a leader/manager to foster teamwork. Additional strategies to improve one's team management skills are:

a) **Communicate regularly**--often teams meet every three months to keep the information flowing and the program goals and techniques consistent. This is a good strategy to develop a stronger team. But make sure you have something concrete to discuss, so that people don't feel your meetings are a waste of time. If you can't meet, consider having a client newsletter sent out on a regular basis to keep everyone abreast of the client's status. This is a good project for some parents to do who may feel like an odd link in the team. A newsletter needn't be long, just a few paragraphs on what's new in the program, the client's home-life, information about upcoming events and possibly some current data on program progress. Where possible, the client may want to be responsible for progress updates in the form of a letter to his/her key team members.

This activity addresses a variety of learning areas: social, life-skills, communication and recreation.

b) **Location**-- By having the meeting in a seminar room, or at a kitchen table, rather than an official boardroom, with a large meeting table, the atmosphere can be comfortable and personal. In some cases, the meeting can take place in the client's living room, where team members can be more relaxed . This provides the client (if they are in attendance) an opportunity to do something else if they get restless during the meeting.

c) **Friendliness**-- I am always impressed by case managers who try to lessen the business aspects of the I.P.P. meeting and can develop friendly relationships with the various team members. By providing coffee or tea there is also a chance for people to mingle a little before the meeting, or at a half way point. Suggesting a break for coffee can also help the person chairing the meeting to inject a "time-out" from a discussion, should it get out of hand.

d) **Time management**-- don't waste people's time. Wherever possible, meet separately with specialists and adjunct support people who do not necessarily have that much to contribute to overall program planning. This can save a lot of time in I.P.P. meetings and save your consulting dollars for more time with the hands-on staff. Report their concerns to the team, either at the I.P.P. meeting, or in written form and encourage others to do the same.

e) **Encourage Teamwork**-- Lawless reminds us to use the talents of all members. Some people have talents of which they are not even aware and the manager should recognize and develop these. Explain to people at the beginning of the meeting that this is

an open forum and everyone's input is valuable. One or two people will always dominate the discussion later on, while others will tend to sit back. Try to draw people out and if you have kept your own notes of their earlier comments, you can ask questions based on their input for later program ideas.

f) **Delegate** -- Wherever possible; let others feel involved by the tasks they have to perform and alleviate some of your workload.

g) **Expectations** - - Have high expectations of the team and of the plan's potential to bring about greater consistency in the client's program. According to Hersey & Blanchard (1972), "high expectations result in high performance, which reinforces the high expectations and produces even higher productivity" (p.150).

h) **Resource Person** - - Make certain you are aware of what is going on with the client, the field and the other team members. You should be "up" on the current literature and be willing to freely admit when you are unfamiliar with a subject, or piece of information.

i) **Give Feedback** -- Provide lots of feedback to the team regarding their progress. The research on industrial psychology is very strong about providing feedback to staff, especially in situations where the technique of management by objectives is used. Make feedback as immediate as possible and initially as positive as possible, thus reinforcing early efforts. (See Chapter 6, for further information on this topic.)

j) **Get Feedback** - -Keep in mind you may have other managers on your I.P.P. team; use them as allies and elicit their input at various points of the process. It's often difficult for people who are used to being in the supervisory role to suddenly be placed

in a subordinate position. For example, a principal who is a member of the team, where one of his/her own teachers is the I.P.P. manager, might feel better about being a subordinate if you check with them regularly for feedback or constructive criticism, given their own experience and/or training.

k) **Model** - - Be a good model to the team; your professionalism, enthusiasm and commitment can be contagious. Lawless (1979) puts it best:

> Above all, the manager must be a pacesetter whose enthusiasm for the task, drive to achieve, flexibility in correcting his or her own behaviours, experimental search for greater effectiveness and optimism about future outcomes are things that subordinates are happy to imitate. (p.481)

(iii) Teamwork

Probably one of the most difficult aspects of the whole I.P.P. process is the fact that so many people are coming together from so many professional backgrounds, attitudes and different walks of life. I once attended a planning meeting for a client where there were 14 people in attendance. The meeting was absurd. Nothing was accomplished and everyone was frustrated with the lack of a common direction among the different supposed "team-members". But this is what happens to our clients. The therapists divide the client into parts and look after their designated area (i.e. mouth, limbs, behaviours, etc.). Then the teachers or counsellors lay claim to the training and teaching of cognitive or life-skills and make recommendations which can either help or contribute to the frustration. Add to this the feelings of the parents or clients who might be intimidated by this formidable array of professionals and say very little except how disappointed they are with the service they

are getting. On the other hand you'll get parents who are still carrying around a great deal of grief over having had a handicapped child and are overly emotional in the meeting which distracts from getting on with solving problems. Needless to say the "team" often forgets the client is a whole, in need of a unified approach.

Obviously it is very difficult to co-ordinate all these people and try to get them to co-operate as a group which may only come together once a year. There are reduced ties and accountability to one another, especially if they are from different agencies. Gardner and Chapman (1985) discuss several barriers to the team process:

- professional jargon used in meetings or reports
- "turf-tending" or staff possessive of programs, information or services
- lack of clear role definition (p. 92)

We have managed to make some progress in the field and professionals are learning to be less territorial, more co-operative and productive. But I still walk into meetings where staff or whole agencies (school boards or associations) are obviously not prepared to work as a team and see every suggestion as an insult, or a challenge to their skills. This is where the results of the Pre-I.P.P. survey can come in handy. It can clearly and objectively pin-point problem areas and bring issues to the forefront without letting them smolder under the surface, or result in ineffectual meetings.

Prior to selecting goals for the client, the common goals of the entire I.P.P. process should be clarified and, at this time, any appropriate changes in the structure should be made: duties, relationships, methods for communication, responsibility, and so forth. This discussion should be initiated by the I.P.P. manager at a special meeting of the key team members prior to the formal I.P.P. meeting. This group would decide their structure, how they will include the other members of the multidisciplinary team and what responsibilities they will have to the team. (Use forms in Appendix D, E, & F).

Points as described by McGregor (1960) help to define the well functioning group, which leads to maximum effectiveness:

1. The atmosphere tends to be informal comfortable and relaxed.

2. There is a good deal of discussion in which nearly everyone participates, but the discussion remains relevant to the task.

3. The objectives are well understood and accepted by all members of the group. Initially, there is free discussion of the objective but it eventually is formulated in such a way that they could all commit themselves to it.

4. The members listen to one another. Every idea is given a hearing. No one is afraid of being considered foolish by putting forward even extreme ideas.

5. There is disagreement for disagreements are not overridden. The reasons for disagreement are examined and there is an attempt to resolve them rather than suppress them.

6. Most decisions are reached by some form of consensus in which there is a general agreement and willingness to accept the decision. Formal voting with a simple majority is held suspect as the basis for best action.

7. Criticism is frequent and frank but comfortable and shows little evidence of personal attack.

8. Members feel free to express their feelings as well as their ideas not only on the problem to be solved but on the very operation of the group.

9. Assignments to members are clear and are accepted.

10. The group chairman does not dominate nor is there evidence of a power struggle while the group is involved in achieving its task. The issue is not who controls but how to get the job done.

11. The group is self-conscious about its own operation.

(In Lawless 1979, p. 32).

c) THE I.P.P. MEETING

(i) Who calls it and the participants

Each person who is involved with the client on a daily or ongoing basis is invited to the I.P.P. meeting. The I.P.P. manager or person with primary responsibility for the client should co-ordinate the meeting. Depending upon the unique program needs of the client it may also be necessary to invite representatives from government or funding agencies. If you are in the process of arranging who will be asked to attend and who won't and you're unsure of one or two people, and the list is not too long already, ask them anyway. It's better to ask everyone and then let them decide whether or not they want to attend, instead of taking the chance on not asking them and ruffling some feathers in the process.

Never forget to invite the parents or guardians as well as the client to the meeting. The current opinion by many staff is that the client has a right to be present at the I.P.P. meeting; after all, we are discussing their life. In my view however, if they are not functioning highly enough to understand the purpose of the meeting, it should be left to the discretion of the team to decide if he/she should be present. According to the research by Love (1990, p. 19), only 14% of all clients knew the purpose of the I.P.P. meeting which they had attended. Even though they were encouraged to participate 85% of the time, and asked questions directly 69% of the time, only 8% knew why he or she was invited to the I.P.P. meeting. Although some would argue that we should be teaching the client how to participate in the meeting, I wonder how beneficial it is to spend hours working on a skill which will only be needed once a year, when so many other skills need to be addressed. I suggest that staff be honest; if it will clearly be a waste of time for the client to be sitting there for 2-3 hours, don't bring them along simply for the sake of some "idealistic" philosophy. I find it very frustrating to be sitting in a meeting for a whole morning with John, discussing his obsessive head-bobbing problem, while sitting and watching him do it during the whole meeting.

(ii) Does everyone know what is expected of them?

Many people attend meetings and have no idea what they are doing there. As the I.P.P. manager, if you suspect that some of the people you have invited to the meeting are unsure of their role, because have never been to an I.P.P. before, have a chat with them beforehand, even if it's only a phone call. Explain the purpose of the I.P.P., the meeting and what to expect. Try to help them feel less intimidated by explaining who the other members of the team are and what will be asked of them in the discussions. You may want to give out a list of participants, their title, agency represented and a brief description of their role along with the agenda for the meeting. Also, make it clear what your role is and that you see yourself as the mediator of the team, as well as a team member. In research completed by Love (1990) where the quality of I.P.P. meetings was evaluated, the function of each team member was explained in only 47% of all I.P.P. meetings. This must be very unsettling for many parents or clients who are invited to participate, but do not feel confident about interrupting a meeting to ask for introductions.

At this point the I.P.P. manager has done his/her homework, collected all the documentation, completed the Pre-I.P.P. survey form, reviewed the results of the survey to determine the weaknesses in past programs and all the players should be prepared and know what is expected of them. Now we can move on to the meeting itself.

(iii) The I.P.P. Meeting Agenda:

Basically the I.P.P. meeting should follow the I.P.P. form itself (See Appendix A). The following agenda corresponds with the I.P.P. form (or booklet).

Individual Program Plan, Meeting Agenda

Date:_____ Name:_____

1) Introductions	
2) Pre-I.P.P. survey results	15 - 25 mins.
3) Information Update	5 - 10 mins.
4) Set long term goals (L.T.G.)	20 - 25 mins.
5) Strengths; Who is this person?	15 mins.
6) Needs; to accomplish long term goals	15 - 20 mins.
7) Set short term objectives (S.T.O.)	20 - 25 mins.
8) Service Goals; Responsibilities	10 mins.
- progress review dates	
- Equipment Needs and person responsible	
9) Setting times for further meetings	5 mins.
10) Signing the form	2 mins.

A note about time

The I.P.P. meeting will invariably take up a full morning, afternoon or evening block of time. Count on it being anywhere from 2-3 hours. Tell the team that you will have a break at a agreed upon time. People should not be allowed to talk beyond a certain amount of time (5 minutes ?) and the recommended times on the agenda can help as a guideline for the appointed timekeeper to remind everyone when they are running on too long. A good meeting doesn't get bogged down on certain issues and moves quickly from: presentation of a topic, discussion, problem solving, to decision making. If however, you find one particular topic being repeated or one particular person is presenting a problem, the manager should suggest that a separate meeting be arranged to discuss whatever it is that is becoming a barrier to completing the task at hand. If it is that important, the main protagonist will agree to such an idea. Otherwise it may become evident that for some

strange reason they are just trying to create problems, or heated dialogue.

(iv) Description of Agenda Topics

1)* Introduction

As soon as everyone is comfortably settled and they have a copy of the agenda, other pertinent documents and (preferably) a coffee, the meeting chairperson should begin by introducing everyone and clarifying their roles. In particular the key members of the team should be identified such as the teacher, day-program worker or primary counsellor. This could be done by the I.P.P. manager or by each person individually. As suggested earlier, there could even be a list of participants with the agenda accompanied by the name of the agency they represent. At this time duties could be assigned like: secretary, timekeeper, coffee-maker. It is useful to have a flipchart or a blackboard handy with a designated person writing out the same information which the chairperson is writing on the I.P.P. form so all the meeting participants can follow along with the stating of the objectives and design of the method. Even though this tends to make the I.P.P. more formal (less human oriented) it is better for all involved to read what is considered important and helps their creative thinking skills, allowing them to read along and make suggestions.

2) Pre - I.P.P. Survey

This manual is intended to provide "strategies" to help teams of people working with persons with mental handicaps to work more consistently with each other and the I.P.P. plan. Effective team work cannot be accomplished without ever discussing the functioning of the team (be it positive or negative). Although I consider this process to be just as important to successful intervention as the I.P.P. itself, the cohesion and effectiveness of the team is often considered a secondary matter and a luxury the team cannot afford the time to provide. However, if one considers the amount of time spent in

* The reader is reminded that the numbers used correspond with those on the I.P.P. Form (Appendix A)

meetings, making plans or designing programs which never come to fruition, then the little amount of time spent doing a Pre I.P.P. survey and discussing the results is in fact, a more efficient use of people's time.

At this time it would be useful to address the issues which came up as a result of the Pre-I.P.P. survey and the analysis of past I.P.P.s which were outlined in Chapter 3 . The manager must be cautious not to present the findings too negatively, especially if the majority of the team members are unfamiliar with each other, since this would only destroy attempts to develop team work. If the results tend to be very negative, it would be best, as mentioned, to have a pre-I.P.P. meeting with the key-team members, to work out specific problem areas. The results of that meeting could be presented at this time to inform the whole group that the key-team is aware of certain problems and how they plan to solve them. On the other hand, the manager may have good news to report from the two survey forms and the group could begin the meeting on a positive note. There should be an opportunity for discussion of these results, taking precaution that it does not take up too much time.

3) Information Update

This is the time to review the client's state of health, report on recent assessment results and pending program changes. It needn't take any longer than 5 minutes unless there is some critical issue which has come about as a result of the Pre-I.P.P. survey. If this is the case, mention that it will be discussed in more detail during #4 of the agenda.

d) ARRIVING AT CONSISTENT GOALS

4) Long Term Goals

The topic of choosing and writing goals is more complex than one might think. It is the foundation of the I.P.P. and the follow-up tasks after the meeting. Long term goals are the future activities or skills, which all meeting members agree, are realistic pursuits for the client. For example the group might agree that the client will: 1) learn to wheel their wheelchair independently and 2) begin travelling to their parent's home on the train independently for weekend visits. These are plans which will require a fair degree of teaching and preparation by the service-team over the next two years . The long term goals will indicate to the group what skills the client will require to pursue this course and help them to formulate the short term objectives. Long term goals are often described as "What do we **Wish** this person could do?" (the sky's the limit) and people are asked to brain storm about any possibilities for the client. However, I encourage people to keep in mind the reality of the situation, why set a long term goal if it is not a real possibility for this individual? Why waste valuable time on unrealistic goals which will never come to pass? I like to set open-ended goals, but if the system cannot support it, or the client is definitely unable to ever achieve this skill, let's find a compromise instead. The two long term goals should be the the first thing entered on the flipchart for the group to ponder throughout the meeting.

5) Strengths; "WHO IS" the Client?

A pleasant way to start the meeting and promote open dialogue is to give the team members an opportunity to share with one another the positive things which have happened with the client over the past year and what progress has been made. I have attended many meetings where the staff are often unfamiliar with the client and are surprised when they hear certain information or stories from people who have worked with the client previously. Some examples of such statements could be: " Last weekend Jane took off her coat and hung it up herself", "Jane signed Bobby (her brother) the other

day", "I remember that last year Jane couldn't set her own alarm clock, but she does it now every night". Invariably people slip into stating their major concerns regarding the client or their program. It is best to discuss these briefly, but remind everyone that they will have a chance to "get into things" soon.

It is also a good idea at this point for the client (if present) to talk about themselves and what their objectives are for the meeting. This is not always possible, since, as Love (1990) discovered, most clients are unaware of what the meeting is about, but if they are high enough functioning to appreciate what is going on, then I strongly recommend that they be given a chance to speak their mind at this preliminary stage.

Next, a list of the client's strengths should be written down, possibly according to "domains" such as: domestic, social, academic, communication etc. These can be placed on the I.P.P. form (page 2) for future reference. From the above example regarding the client learning to set her own alarm clock, we could come up with the following strengths: Jane; likes to operate her alarm clock--"likes electric appliances"; has learned one more skill to lead towards independent living--"likes to do things for herself"; learns sequences slowly but once she gets the idea, she never forgets it --"good memory for sequenced tasks". These skill-strength statements will be helpful later when we are trying to decide how to approach other program areas. For example, if Jane learns sequences well and likes to operate small appliances, then when discussing future vocational options, she might be considered to operate a small piece of equipment at work, or work in a kitchen operating a dishwasher.

6) NEEDS - Writing "Needs-Statements" Effectively

Now that we know what the long term goals and client strengths are, it is important to line the two up to determine the needs. The needs should be taken directly from the previous discussion as well as from the Pre-I.P.P. survey form which the manager has already brought to everyone's attention. The needs should be written out in clear simple terms, for example: "John needs to be more independent", is a poorly worded need statement. First of all, how do we measure more and what exactly does independent

mean? Independent where? Independent how? A better way of wording it is: "John needs to learn how to prepare himself small meals". This wording gives us a clearer idea of what level John is at, clearly what his needs are and which area he needs to become more independent in, that being life-skills. A few more examples are:

EXAMPLES OF APPROPRIATE NEEDS STATEMENTS

- to be more compliant to requests: "John **needs** to require fewer physical prompts when engaged in an activity with staff"
- to decrease self-stimulatory behaviour: "John **needs** to learn new activities when he is bored and begins to self-stim."
- to become more social with others: "John **needs** to be involved in more situations where he can make friends and learn appropriate social skills"

Keep in mind these statements are still somewhat general, which is acceptable since they will lead later to the very important task of choosing short term objectives.

Once all the identified **needs** are listed on the flipchart, the group should then have a chance to discuss what are the priority needs. What skills does the client require to meet the long term goals discussed earlier? What is the primary current issue standing in the way of meeting these goals which might have come up on the Pre-I.P.P. survey? What is realistic to the situation...given health/medical, academic, or staffing limitations? In the research by Love (1990 p. 16) regarding the quality of I.P.P. planning, he found that in only 39% of the I.P.P. meetings in his study, set priorities for short term objectives (referred to as long term goals in his study) based on what had been identified as major goals. It is very important that the long term goals reflect the short term objectives and vice-versa.

Michael Owen (1987) points out that staff are forced to decide between limited resources and increasing service needs. "To make maximum use of agency resources it is important that energy be directed towards those goals that are the most important for each

client" (p.108). He suggests use of Maslow's hierarchy of human needs as a basis for priorizing goals:

1. Basic needs (food, clothing, shelter, safety)
2. Relationship and belongingness needs
3. Needs other than 1 or 2
4. Developing strengths

Three or four priority needs should be selected for the I.P.P. task but the others should be entered in the minutes for future reference. The three which have been selected should then be circled on the flipchart and entered on the I.P.P. form.

Brainstorming:

Now that the I.P.P. team knows what the client needs to learn to do, they can sit back and think of creative ideas to help bring about this learning. This is a good time for the group to reflect on past successes and/or failures and consider alternate program environments or activities. From this will evolve the specific short term objectives.

7) SHORT TERM OBJECTIVES:

Short term objectives (S.T.O.) are the instructional activities which the primary caregivers will be working on with the client over the next 6 months. They are never carved in stone and the group should feel free to make alterations as they proceed through the meeting. They should be agreed upon by all the individuals attending the I.P.P. and flow directly out of the Needs Statements.

One of the causes of inconsistency discussed in Chapter one is poor communication. When referring to S.T.O.s it is important that anyone who reads the I.P.P. understand what is intended and what will be done with the client. This can only be done if S.T.O.s are stated clearly, in measurable terms with minimal opportunity for misinterpretation. In the research conducted by Love (1990), only two out of five I.P.P.

conferences stated objectives in measurable terms (p.15). I suggest that this leads to semantic misunderstanding and consequently affects consistency in programming. As a result, the following criteria for writing S.T.O.s should be employed in all I.P.P.s to reduce inconsistency:

Wording:

It is always best to take a need and turn it into a positive skill. Consider the consequences of the issue and state (very concretely) what the flip-side of that problem might be. For example; If I eat too much, I gain weight. The consequences are that I can't fit into my wardrobe from last summer. The opposite of a negative consequence, stated positively and concretely are; if I lose 10 pounds I will be able to wear my favorite summer dress which is currently one size smaller that my figure. So my S.T.O. becomes; in one month I will wear my pink summer dress to Bea's party. (Notice how I added a positive reinforcer).

S.T.O. statements should be worded positively, excluding terms such as: decrease, stop, refrain from, not, no-longer etc. In addition to being written in a positive way, using clear, concrete terminology, they should be measurable with the criteria for successful completion included. These S.T.O. statements always begin with the word **WILL.** For example:

EXAMPLES OF APPROPRIATE WORDING FOR SHORT TERM OBJECTIVES

- Need Statement: "John needs to learn to prepare himself small meals"

S.T.O. : "John will learn to make a sandwich and a bowl of cereal".

- Need Statement: "John needs to stop biting his nails when he is bored and has nothing else to do with his hands".

S.T.O.: "John will be taught 2 activities (doodling and puzzles) to occupy his hands during free-time".

These two are measurable and easy to understand. The criteria for successful completion are apparent in both instances--John will have achieved his objective once he is sitting at a table doodling--not engaged in nail-biting (the percentage of the time can be determined later in the Method section). In the second example, the staff will have accomplished their task, the day John independently goes to the cupboard and makes himself a bowl of cereal and fixes a sandwich. Statements which interpret the intent or meaning of the behaviour should also be avoided; we simply want to state what behaviour the client is exhibiting, as objectively as possible.

Here are a few more examples (the underlined words are ones to stay away from):

INCORRECT WAY:

Needs statement: "John needs to stop hitting his head whenever he becomes frustrated ".

S.T.O.: "John will have opportunities to practise waiting at the table and stop hitting his head".

CORRECT WAY:

Needs Statement: "John needs to stop hitting his head on the table when waiting for dinner to be served".

S.T.O.: "John will learn to wait at the table (sitting without hitting his head) for one minute before his meal is served" (the time to be gradually increased to a maximum of 5 minutes).

INCORRECT WAY:

Needs Statement: "John needs to have more contact with his family".

S.T.O.: " John will learn to behave appropriately around his parents".

CORRECT WAY:

Needs Statement: "John needs to have more positive encounters at home with his family, but they are frustrated with his behaviours during meals ".

S.T.O.: "A full-time staff person will go to John's parent's home on 4 occasions with

John to demonstrate the program to deal with head banging during meals".

It is this concreteness and simplicity that we should always strive for when writing S.T.O.s. A common result of not simplifying the objectives is teachers and counsellors making commitments to objectives which they are not sure about, or ones which are unrealistic given the skill level of the client. I have dealt with teachers and counsellors who commit themselves to a task which the client/student may not be able to do, not as a resultof poor teaching, but due to the client's behaviour, health problems or other uncontrollable variables. Possibly they have committed themselves to something as a result of peer pressure in the meeting. That's where the manager needs to be skilled at reading body language and step in to double check on a team member who agreed to do something, which perhaps s/he may not honestly want to do.

Primary counsellors who are familiar with the client's skills and have done adequate background research have a fairly good idea as to what they can teach and commit themselves to. I always suggest that teachers and counsellors should initially work towards very small objectives, while they get to know the client. Once these have been achieved...move on to slightly harder tasks but ones which are definitely attainable. Isn't it better to report at the next I.P.P. meeting that John achieved his goal 3 months ago and moved on to two others which were also achieved? If primary counsellors are unsure if the client can read a whole book, learn the whole alphabet, tie their shoes, or make a whole sandwich, then it needs to be broken down into manageable tasks: John will, learn to read one chapter, learn the first half of the alphabet, buckle shoes with velcro-closures, or simply learn to butter bread.

Many school boards (Metropolitan Toronto School Board; directive) are encouraging teachers to write S.T.O.s which are open-ended and vague to prevent the possibility of parents suing the schools for not reaching educational objectives. By using statements like: "increased independence", "have better awareness of...", "learn to appreciate", no one could ever hold them to these objectives since they are wide open in interpretation, as well as unmeasurable. I feel that this type of vagueness is unfair to the

students and misleading to parents who usually have unrealistic expectations of their child. When they hear objectives such as "John will have a better understanding of grammar"--- they might feel John is ready to write short stories, while the teacher could easily be planning to teach John how to write a sentence. This vagueness also leads to misinterpretation of objectives and can create problems for members of the team regarding issues such as technique or method.

Double Check the S.T.O.s:

Once the objectives have been written up and agreed upon, they should be reviewed to make sure of the following:

- they reflect the priorities as determined by the group
- are agreed upon by all the meeting members
- are realistic given the environment and client's life-style
- are measurable
- are stated as positively and optimistically as possible

Adding to the S.T.O.s:

In addition to getting the wording accurate the specifics also need to be decided. The I.P.P. form (see Appendix A) which I recommend has spaces for this information. The I.P.P. manager should ask the group the following:

-when is this objective to be started/completed?

- who is responsible for writing the "How-To" or implementation plan?
- is the criterion for success clearly stated?
- is follow-up staff training required?
- who is to be contacted for further follow-up and who will contact them?

8 a) Service Goals

Once again we are trying to develop consistency in programming and make people accountable. On the second inside page of the I.P.P. form there is a column titled "Person to Write Program" and "Review Date". These should be filled in with the name of the person/s responsible for writing the program and the expected time to commence the program, as well as a time when the program will be reviewed and a decision made regarding its effectiveness and appropriateness to continue.

On the back of the form is a section called Service Goals. This is more administrative in nature and is geared towards the social worker, therapists, or program supervisors. Typical service goals might be : "Mr. Thompson will complete the grant for funding for a summer program for Jane". "The director of nursing will enquire about a 'drug holiday' for Jane during Dr. Anderson's next visit". This also applies to equipment needs and enquiries about alternate placement. If it appears that one or two people are doing most of the follow-up work, see if you can delegate some jobs to others, or invite volunteers.

8 b) Client or Staff Goal?

There should also be a section on the I.P.P. to state what goals have been set for staff, or what skills they need to learn. To explain this, imagine you are in a meeting where it is decided that John will learn to use the sign "cookie". Now he can't be expected to go to a manual and look it up for himself. Therefore, the staff have to know the sign in order to teach the client. The result is a staff goal "staff will attend a 10 week sign language course offered at the college".

Many goals are staff dependent if we think about it. All teaching involves the modification of the behaviour of the teacher or the requirement that they know a certain skill in order to have the student perform a specific activity. Very few of our clients can learn on their own devices and as a result we must alter our behaviour to bring about changes in theirs. I recommend that on the I.T.P. the performance responsibilities of the

staff be clearly outlined, as well as the response of the staff person to the client's reactions during teaching. This will be discussed in further detail in the next chapter.

9) Setting further meeting times

There is often a tendency, because the meetings run so very long, for people to jump up from the meeting and leave immediately. If people have made a commitment to do something regarding the I.P.P. then the I.P.P. manager should set the time and date right then and there for that activity. Thus they can confirm that what was discussed, decided and promised--will occur. This can include future meetings, appointments, training sessions, assessments and review dates. People are often so busy in this field, they postpone activities or forget what they have committed themselves to. By having it in writing, and a prearranged date agreeable to everyone, there is more of a chance for it to happen.

10) Signing the form

As a closing activity, everyone should have an opportunity to look over the I.P.P. form and sign the back of the "rough-draft". That way they are more accountable and can see in writing what they are to do for follow-up. The I.P.P. manager can ask who would like to have a copy of the final form and if they feel any changes are necessary. The completed form could then go in for typing, leaving the back page as is and copies of the final draft sent out as quickly as possible to keep people reminded of their responsibilities.

At this time if the team would also like to sign a contract, as discussed in Chapter Six this is the time to do so. Copies of the contract could then be sent out with copies of the final draft of the I.P.P. form.

Here we have the completed I.P.P. form. Although the whole process may seem very long and tedious, once again, it is more time efficient in the long run to have the program specifics thoroughly discussed and defined rather than going through the process year after year, repeating the same concerns, dealing with the same problems or arguing about program failures. Once this plan has been made up, subsequent review meetings can be shorter and if the same team is still involved a year or two later and plans followed, then future I.P.P. meetings will also take less time.

e) CONCLUSIONS

As with any organization, there must be organization of the I.P.P. team. I find the I.P.P. teams which have formed out of the groups of people working with my clients lack structure and the manner in which they carry out their business is ad hoc. Certain teams are very good, but for the most part, school boards, workshops and associations, do not have clearly outlined procedures for I.P.P. teams or meetings. Yet the seriousness of the topic being discussed is critical to another person's life. I would like to think that if a group of people were meeting to discuss plans for my future, that they would mutually understand: who is in charge, who is the primary worker, and the role of the other pertinent players in the team. I would also hope that those people agree on most things like, what will be done for me, their philosophical approach and their long term goals for me. I think we owe that to persons with mental handicaps whom we have on our caseload. In my view, if we are getting paid to evaluate their life and impose on them certain life choices and ways and means for how these choices will be fulfilled, then we should agree to work as a productive member of a team with consistent attitudes towards the client, with consistent goals and techniques and consistent methods for maintenance of our plan.

CHAPTER FIVE

CONSISTENT TECHNIQUES:

a) WRITING INDIVIDUAL TEACHING PLANS FOR MAXIMUM CONSISTENCY
   (i) - Description of I.T.P. Design

b) TEACHING NEW SKILLS TO CLIENTS
   (i) - Standard teaching procedure
   (ii) - Task analysis

c) STRATEGIES FOR TRAINING STAFF OR PARENTS

d) CONCLUSIONS

Now that the I.P.P. meeting is over and the target behaviours or objectives have been selected, the staff must sit down and decide **HOW**, that behaviour will be taught. The prescribed procedure, technique or "recipe" needs to be designed and this is called the individual teaching plan (I.T.P.). The two most important aspects to guarantee consistency in technique are to: a) make sure the technique (I.T.P.) is written up precisely and sequentially and b) make sure that the people carrying out the individual teaching plan are doing so using the same techniques.

This chapter attempts to deal with the familiar old saying, "you can't teach an old dog new tricks!" We are looking at two different instructional groups requiring different types of intervention. However, the same principles of learning and teaching of new behaviours applies to both, albeit on a somewhat different scale. The first group of course is the clients, whom we want to teach new skills or more appropriate behaviours. Then there is the front-line staff and parents who may also need to learn new behaviours, but in addition, they need to unlearn inappropriate teaching habits. This is necessary to standardize the techniques practised with the clients which, in some cases, have been prescribed by someone else.

a) WRITING INDIVIDUAL TEACHING PLANS (I.T.P.S) FOR MAXIMUM CONSISTENCY

Writing step by step instructions for how a program is to be conducted, is the "meat and potatoes" of programming. We wouldn't hand an aircraft mechanic a wrench and tell him to go rebuild a faulty engine. He/she would have the benefit of a manual, specification sheets and diagrams. The same should apply to the teaching of this population. As has been proven with precision teaching (Burton 1976), breaking down a skill or task into small steps and using repetitive teaching trials, leads to a higher rate of success than teaching a skill one way, one day and then another way another day, by another person. The individuals with mental handicaps have difficulty generalizing skills across environments and as Lou Brown pointed out (in the previous chapter) they need to be taught each skill in the setting where it is to occur. The criterion for a well written program should be: if the staff person who wrote it, were to be off sick and a new person came in to relieve him or her, could the program be carried out exactly the same way? (Or a very close facsimile).

The I.T.P. should be written soon after the I.P.P. meeting either by the primary counsellor or by a team of people who are responsible for that domain. For example, I have helped to write many communication programs with teachers and counsellors and the supervisor attended in some instances to ensure that the program design was feasible and to better acquaint themselves with the program technique. Or, it can be prepared by the primary teacher and the rough draft shared with other key team members for input or alterations. The completed I.T.P. form (from Appendix B) on the following page, is one which I prefer to use. You may choose to use another model, but the basic elements should be included. An additional sample I.T.P. can be found in Appendix G.

COMPLETED EXAMPLE OF I.T.P. :

Individual Teaching Plan

(i)
NAME: John Doe
DATE: February 12, 1990
AGE: 9

WRITTEN BY: Jane Staff - counsellor
OTHER STAFF RESPONSIBLE: A. Supervisor Pat Time, Jeff Alternate, June Volunteer, Mr.& Mrs. Doe (parents)

(ii)
SHORT TERM OBJECTIVE: John will engage in playing with a toy for 10 minutes and not engage in self-stimulation fiddling with his clothes)

(iii)
STAFF RESPONSIBILITY: to verbally reinforce John every 2 minutes when John engages in appropriate play (i.e. playing (i.e. with toys)

(iv)
CURRENT BEHAVIOUR/SKILL: baseline data shows that during a 1 hour period, John fiddles with his clothes 60% of the time and plays with toys and/or manipulates objects 10% of the time

MEASUREMENT OF SUCCESS (as follows) :

INCREASE POSITIVE TO: John will manipulate toys or objects for 10 consecutive minutes

DECREASE NEGATIVE TO: John will decrease fiddling with his clothes to 25% during a 1 hour period

(v)
WHEN: staff will conduct a teaching session every day after school. **HOW LONG:** 1 hour

MATERIALS: stop watch or timer, preferred toys or objects (toy truck, toy piano & cup/spoon

(vi)
METHOD OF DATA COLLECTION: Cumulative time measure of self-stimulation during a one hour time sample. Start the stop watch when John engages in fiddling with his clothes. When John stops engaging in fiddling, stop the watch. (Do not return the watch to zero). Data is collected 4 out of 7 times per week, on randomly selected days. Enter the totals on attached data sheet.

(vii)
METHOD:

After John gets home from school, staff will give him a few minutes to unwind, get a snack and go to the washroom. They will then seat him at the kitchen table, or the living room floor and present him with 4-6 toys.

1. If John independently engages in playing or manipulating an object for 10 seconds or more, they will verbally praise him saying "good John, you are playing with the _____".
2. after the initial 10 seconds, staff will repeat their praise for every 30 seconds of ongoing toy play.

Interfering behaviour:

- If John engages in self-stimulation, staff will ignore (set the time on the stop watch), model playing with the toys and wait him to independently bring his hands down. They will then go to step 1 above.
- If he does not bring his hands down himself, after 2 minutes, they will give him a light touch cue and reinforce him after 5 seconds on task and return to step 2.

Expanding the criteria:

- once John is engaging in toy play for 2 minutes, staff will extend their schedules of reinforcement to:
Initial 30 seconds of play, staff give praise
Next 60 seconds of play, staff give praise
Praise every 2 minutes thereafter.

- the criteria will then be increased by 2 minutes every time the objective is met, to a total of 10 minutes

Trouble shooting:

- If staff are interrupted for some reason and cannot deliver praise on time (i.e. another client has a seizure, or the telephone rings), they should make every effort to follow through with the program. If more than two reinforcements are missed, stop for 5 minutes, then resume again and make up the time.

Generalization of program to other places:

- During an outing or activities around the house, if staff notice that John is not engaged in self-stimulation for 60 seconds they are to verbally praise him for the alternate activity he is engaged in. Eg. "John, good for you! You're watching T.V. with your hands down."
- Staff should give John something to do with his hands, like carrying a grocery bag while walking, or wiping the table after dinner.

(i) Description of I.T.P. Design

Section (i)

NAME: John Doe **WRITTEN BY:** Jane Staff - counsellor

DATE: February 12, 1990 **OTHER STAFF RESPONSIBLE:** A. Supervisor Pat Time, Jeff Alternate, June Volunteer, Mr.& Mrs. Doe (parents)

This information is the general introduction regarding the I.T.P.. It is there to help anyone reading it to know when it was written, by whom and who the other person are who could help to explain it and/or to carry it out. I have read many I.T.P.s and never knew who wrote them, who else was aware of it and how old it was.

Section (ii)

SHORT TERM OBJECTIVE: John will engage in playing with a toy for 10 minutes and not exhibit self-stimulation (i.e. fiddling with his clothes) during that time.

The short term objective should be taken directly from the I.P.P. form (see Chapter Three). It should repeat exactly what was decided upon at the meeting and any changes should be agreed upon by the members of the key team. If there are major changes, it should be brought to the attention of the whole I.P.P. team. For further elaboration of the wording of short term objectives, return to Chapter Three).

Section (iii)

STAFF RESPONSIBILITY: to verbally reinforce John every 2 minutes when John engages in playing with the toys

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The exact requirements of the staff should be stated, to remove any doubt in anyone's mind as to what is expected of them. This makes it much easier for supervisors to be able

to evaluate staff; it gives them something concrete to point out and ask staff to do. The persons responsible for carrying out the program should also be clearly stated on the I.T.P. so there is no confusion amongst staff as to who is to do the program. In some instances only the teacher or primary counsellor is to conduct the program, possibly because it is still in the preliminary stages, but most often all staff are responsible for the program.

Section (iv)

CURRENT BEHAVIOUR/SKILL: baseline data shows that during a 1 hour period, John fiddles with his clothes 60% of the time and plays with toys and/or manipulates objects 10% of the time

MEASUREMENT OF SUCCESS (as follows) :

INCREASE POSITIVE TO: John will manipulate toys or objects for 10 consecutive minutes

DECREASE NEGATIVE TO: John will decrease fiddling with his clothes to 25% during a 1 hour period

---

This section defines exactly what the client's skill level is, preprogram. This is one of the main reasons why we must do further assessments after the I.P.P. meeting to establish what is called "base-line data". In some cases this information will already be available to us because of the assessments of physical therapists or behaviour consultants who can say; "John's range of movement is 20%", or "John hits his head 3 times every hour". If you do not have an exact measure of the behaviour or skill you wish to program for, don't begin until you do. You'd be surprised how many people rush in to begin a program without the slightest idea what the client could do beforehand. From this information we can decide exactly what our criteria of success will be. In this particular case the client is to learn to play with an object for 2 minutes and decrease the amount of time spent engaged in self-stimulation to 25% during one hour. This is a measurable objective and one which staff can look at on a graph and say, yes the program is working or no, it has not been successful after four weeks of teaching. I will discuss the importance of data further in this chapter.

Section (v)

WHEN: staff will conduct a teaching session every day after school. **HOW LONG**: 1 hour

WHERE: In the kitchen at the table, or in the living room on the floor

MATERIALS: stop watch or timer, preferred toys or objects (toy truck & cup and spoon)

The when, where and what are very important. Some staff are unsure when a program is to be done, what equipment is to be used and for how long. This information on the I.T.P. clarifies the procedure and will help other people new to the program to remember important details. Once again it should be written so anyone reading the program could figure out exactly how it should be done.

Section (vi)

METHOD OF DATA COLLECTION: Cumulative time measure of self-stimulation during a one hour time sample. Start the stop watch when John engages in fiddling with his clothes. When John stops engaging in fiddling, stop the watch. (Do not return the watch to zero). Data is collected 4 out of 7 times per week, on randomly selected days. Enter the totals on attached data sheet.

The importance of data collection cannot be stressed enough. People who conduct programs for persons with mental handicappeds unfortunately do not record enough data in their one-to-one dealings with their clients and I often meet staff who have no idea if they are making progress with their client or not. Much of their information on the success of a program is based on observation and opinion. If a major company never kept monthly records of their sales in a particular area and their sales staff, how would they know where to open a branch office or who was producing sales and who was ready for a promotion? From my experiences in the field, staff tend to see data collection as redundant or too time consuming. However, it is important that they be shown (possibly by the supervisor or through personal experience) the time it takes to record data is always recouped later, when the data shows what skills the client masters using certain teaching techniques. It will also

help to cut the time wasted in program plans which are not successful. Staff will no longer have to continue to do a poor program day after day, if the data shows that there is a problem with the procedure after only 4-5 trials.

There are many methods which can be used to collect and record data while conducting an I.T.P. (Sulzer & Mayer, 1972) and staff can learn to be very creative in their data collection methods. One teacher I worked with was an extremely busy person with eight pupils to teach, all on programs which required the collection of data and only one assistant. She managed to keep track of all eight programs by wearing counters on her wrists, carried a small note pad in her pocket and tape recorded small group sessions and called out the figures into the tape recorder then jotted down what she had said into the tape at a later time. This way she was able to keep data on skill acquisition for several students at one time, while keeping track of other behaviours which were occurring simultaneously. Needless to say, this technique required a great deal of planning and co-ordination, but the results paid off for any confusion she may have experienced. (I don't recommend this method for a new teacher--- it's a skill you work your way into with many years of teaching; much like juggling while atop a unicycle).

Section (vii)

METHOD

(ADDITIONS TO METHOD)

INTERFERING BEHAVIOURS:

TROUBLE-SHOOTING:

METHOD TO FADE PROMPTING:

SPECIAL SUGGESTIONS:

The method section would begin on the second page of the I.T.P. form and provide the step by step procedure for the teaching of the target behaviour. As mentioned it must be stated as clearly as possible and anyone picking it up should be able to follow along and carry out the plan. Individuals experienced in reading and following I.T.P.s might not think of all the possible interpretations of what they have written, since it is so clear and obvious to them. Hence, they should be especially careful to include all the details of the procedure so that an inexperienced reader could follow along easily. For example, they may say, "Tell Helen to telephone her mother" - but perhaps Helen uses sign language, so even though it is clear to the experienced staff person that it is necessary to sign and speak at the same time, or to use limited vocabulary, it is not evident to the novice what is to be said. Therefore, the wording of the instruction should be "tell Helen to telephone her mother-- while signing; Mother; telephone; now". Or, a special section could be attached to the I.T.P. explaining the details of sentence structure with the client.

The sub-sections of the method section are flexible and should include all the additional aspects of the methodology not previously discussed. They can include any number of exceptions or alterations, but most important they should inform staff what they are to do in "what if" situations and how the program will be altered as the client begins to learn the skill.

In general, I.T.P.s are like recipes, but we can't always expect staff to know or understand how to execute certain aspects of the process. Like cooking, where one needs to know what certain procedures mean (e.g. puree, fold, sift), staff need to know what certain techniques mean. Therefore, it is very important that the supervisor (either principal, workshop coordinator, or group home supervisor), makes sure the staff are trained in the techniques of behaviour training. Terms such as: verbally prompt, graduated guidance, ignore, token reinforcer, touch cue, should be well understood by all staff reading an I.T.P. , otherwise they should be explained in detail and attached to the I.T.P. and a follow-up training session should take place.

It isn't enough to write an I.T.P. without conducting a staff training session as well. Merely asking people to read the program and carry it out daily will not

guarantee the consistency needed to make it successful. If there is a problem bringing all the team members together for one or two training sessions, then a video tape is an excellent way to demonstrate the exact expected procedure. Once again it is the responsibility of the supervisor to make sure everyone involved has had time with the primary worker to review the program and any unique details. If they cannot do the training themselves, they should make certain that a qualified person does so instead. The method for carrying out these training sessions is discussed in the final section of this chapter.

b) TEACHING NEW SKILLS TO CLIENTS

As discussed in Chapters Three and Four the overall goal for each client is independence in as many of their daily routines as possible. This includes all domains or activities: meals, dressing, free-time, mobility, vocational activities and social skills. Persons with mental handicaps are slower at learning these skills by observation and modelling alone. They must be taught most skills activity by activity, step-by-step. It is well known that this population:

- learns more slowly
- has poor retention skills
- needs activities broken down into sequences
- requires more teaching trials to assimilate a skill.

There are many methods which have been tried and tested with persons with mental handicaps over the years. The strategies which I have had the most success with and repeatedly prove to be effective in the research, are based on the principles of operant learning as discussed earlier in this chapter. They are:

- ignore negative behaviours and reinforce positive behaviours
- shape appropriate behaviours through repetitive teaching trials and by breaking the task down into small steps
- provide reinforcement according to predetermined schedules and based on the preferences (motivators) of the client *

The following standard teaching procedure (i) is one I recommend to most staff engaged in teaching a skill to a client. It can be adapted according to the needs of the client and generalized to any activity or domain: communication, academics, motor skills, domestic or hygiene programs.

*This manual is not intended to teach behaviour modification skills. I suggest the reader turn to the many texts available on this subject. I have simply reviewed some of the basic principles to assist in the understanding of designing I.T.P.s..

(i)

STANDARD TEACHING PROCEDURE

- give instruction (John, put on your coat)
- wait 5- 8 - 10 seconds for the client to self initiate the activity
- verbally prompt them again
- wait
- give them a light touch cue (physical prompt) (lightly move their hand in the direction of their coat)
- wait
- give them a bit of physical guidance as to what they are to do (hand them their coat, or prompt them to push one arm into a sleeve)
- label the activity being conducted ("you're putting on your coat")
- wait for an approximation (doing part of the task independently)
- reinforce (verbal praise, smile, head nod, pat on the back) for any approximation
- repeat process if necessary

This standard teaching procedure would be combined with the use of task analysis which is simply taking a task and breaking it down into individual steps as in the sample below. In this manner the teacher can target one step at a time, several steps, or the whole task and collect data on each step along the way. They might measure how many of the steps the client needs verbal or physical prompting with, how many steps they self-initiate and their degree of accuracy. The collection of this data will help staff to determine their rate of success and if they should alter their technique in some way to improve performance. For example, in the tooth-brushing activity a counsellor may notice that when they carry out the program with the client they use physical guidance for 40% of the steps , whereas the data collected from another staff person shows they use physical guidance 75% of the time. This would show that there is possibly a discrepancy in the consistency of the techniques being used because the one counsellor has the client working more independently than the other. However the reason for the discrepancy could be that the client prefers one counsellor over the other. This could be verified by looking at the data of staff performance when conducting other programs with this and other clients.

(ii) EXAMPLE OF; TASK ANALYSIS

Recording Form for Toothbrushing (33 steps)

1. Pick up toothpaste with left hand.
2. Unscrew cap with right hand.
3. Put cap down.
4. Pick up toothbrush with left hand.
5. Squeeze toothpaste (in right hand) onto toothbrush (in left hand).
6. Put toothpaste down.
7. Turn on cold water with right hand.
8. Wet toothbrush (in left hand).
9. Turn cold water off.
10. Put toothbrush in right hand.
11. Brush front teeth back and forth five times.
12. Turn bristles downward.
13. Brush bottom right mollars back and forth five times.
14. Brush bottom left mollars back and forth five times.
15. Turn bristles upward.
16. Brush top right mollars back and forth five times.
17. Brush top left mollars back and forth five times.
18. Turn bristles downward.
19. Brush insides of bottom front teeth five times.
20. Turn bristles upward.
21. Brush insides of top front teeth five times.
22. Put toothbrush in left hand.
23. See #8.
24. Rinse toothbrush
25. See #10.
26. Put toothbrush down.
27. See #1.
28. Pick up cap with right hand.
29. Screw cap (in right hand) on toothpaste tube (in left hand.)
30. See #7.
31. Pick up towel with right hand.
32. Wipe mouth.
33. Put towel down.

c) STRATEGIES FOR TRAINING STAFF AND PARENTS:

I find the most important part of training staff or parents is your relationship with them. They need to be able to trust their trainer and feel comfortable about being critiqued by that person. I believe in being "up front" and having a lengthy discussion before the training actually starts about: your role, their feelings about being retrained, the client, the teaching objectives and about different teaching methods. Quite often they already know where their weaknesses are and will tell you what they want to work on. On the other hand, it is not uncommon to meet staff who feel their style is fine and they have no intention of changing. They may have a mental block about certain things like: having to use "behaviour modification", about having a younger person teaching them, or about having a specialist coming into their work environment who might create more work or report negative things to their superior. This line of thinking brings us back to the issue of attitude and the necessity to have common attitudes which bring about consistent techniques. If this negative attitude does exist, I suggest further discussions regarding the goals of the team, are in order.

The techniques used in behaviour management prove to be very difficult for us to learn as adults. It is the reverse of the way most of us were raised. Ask yourself, how many times did your mother ignore you when you threw your peas on the floor from your high-chair? How many times did she say; "Good washing behind your ears!" Our knee-jerk reaction to teaching people is to tell them what they are doing wrong, or how to do it better, rather than praise them for the little things they do right. In programs where behaviour modification is used the trainer/teacher does not respond to negative behaviours, these are ignored, either by looking away, dropping eye-contact, pausing in the activity or by walking away from the person exhibiting the behaviours. Now imagine asking a woman who has reentered the work force after having raised three children to "ignore" the inappropriate behaviours of their new client! It not only goes against learned (motor) behaviours, some people even feel silly doing this.

The next important element is to reinforce (praise, smile, give a token or edible to) the client after they have behaved in a desired way. For example if we are teaching the

client to feed themselves and the client picks up the spoon without being prompted (told or shown), we would smile or say "Great! You picked up the spoon!". This is not difficult to teach staff since they see immediate results in their clients as soon as they start using praise and this, in turn, reinforces their own "reinforcing behaviours". Ignoring takes much more time to perfect. But if you think about it, if we were ignored every time we made a joke at a meeting we would quickly stop doing it. Right? If everyone laughed uproariously we would try to think of more jokes to make. It's as simple as that. Unfortunately, individuals are used to being punished for doing things wrong and some even thrive on the negative attention because that's the only attention they've ever received.

As stated above, the trainer of the staff and parents should make every effort to open the door to learning a new skill or changing old habits. Most people don't like to be shown how to do something especially if they are a "seasoned pro", or they have just completed their training and know "everything". McGregor (1960) points out: "criticism can be frequent and frank but comfortable and shows little evidence of personal attack" (in Lawless, 1979, p. 32). One method which has been an effective (non- threatening) tool in teaching staff new techniques is the use of video cameras. Although cameras can be intimidating (because no one likes to see themselves on television), it is an objective and fair observer. The use of videos* has become very popular in the last ten years and it is not uncommon to see video equipment as standard equipment in some classrooms or programs. Behaviour management specialists make videos of people working with their clients and show it to them as they discuss the principles of behaviour training and let the staff make their own observations of their errors and inappropriate techniques.

The methods used to teach staff and parents are somewhat similar to those used with the client. Reinforce positive behaviour and shape skills in small steps. In cases where it isn't easy to ignore negative behaviour, so it is usually best to point out to people

* I use video taping as a method to record client's communication skills. A staff person will narrate as the client demonstrates certain signs, showing how a client signs particular words using their own unique style. Over time it is added to as the client makes progress and then becomes a visual glossary of the client's skills. It can move about with the client from program to program, hence the effect on skills is minimized by staff or environmental changes.

what they are doing wrong (as quickly, fairly and diplomatically as possible) or show them a video tape several times and discuss their mistakes. The following procedure is useful when teaching staff and parents intervention techniques:

- to begin, discuss what behaviours the method is intended to bring about and then:

a)- demonstrate

b)- let staff try it - - while you observe

c)- point out how the client reacted and what staff did well

d)- try it again (possibly together) and watch again

e)- make positive suggestions for changes using statements like: "Try it this way, it usually works better if you_____, Keep in mind that _____"

f)- be as positive as possible without sounding patronizing--state what they do well and then what they need to work on. Most performance training specialists recommend a ratio of 5 reinforcing/positive statements to each negative statement (or even 7-1 depending on the staff person).

g)- watch them one more time or video tape them and have them analyze themselves. If they continue to make mistakes go back to a) above

Another technique which I have used successfully to train staff and parents is an Interaction Skills Inventory (Appendix K). This form helps to point out poor communication or teaching skills when a video camera is not available. I developed this form several years ago for supervisors to use with staff to clarify their communication techniques or for peers to evaluate each other, (which is often less threatening than having a supervisor observe you). The form breaks down the types of interactions between communication partners and looks at annoying habits which block communication. For example, are staff responding to the client's attempts to communicate and are they using an appropriate tone of voice with a 25 year old man. It also evaluates the staff's use of prompting procedures and aversive techniques, which often are a source of inconsistency amongst staff.

Everyone need not be trained in a one-to-one method, and some individuals can learn by simply reading over an I.T.P. (if it has been written clearly enough) or by watching a quick demonstration. Over time you will get to know the staff who are familiar with various techniques. Use your discretion and if the staff seem to follow the prescribed technique fairly closely suggest a few minor corrections and save the training session for another person. If however, you have gone through this process and staff performance is still not what you expect, you can take the stance that these techniques are a requirement of the job and this is how things are to be done. In some cases the supervisor or trainer may have to take disciplinary action if staff continually fail to perform according to the job description. The "tough" approach is useful as long as there isn't a staffing shortage and good staff are plentiful. Otherwise your "hands are tied" and you may just have to face the fact that that staff person cannot be trained and unfortunately you must then lower your programming standards.

Noncompliance to the prescribed technique is especially an issue when dealing with parents (or volunteers) of children with mental handicaps. Such behaviour is common among older parents whose attitudes are based on that of pity, or among those parents who are less involved and perhaps only see their child on weekends or holidays. Either because of lack of training, or feelings of guilt, they essentially sabotage programs by not adhering to prescribed techniques and undo a great deal of work done by staff. Once again we are confronted with the issue of consistent attitudes, which in this instance are affecting technique. In addition to the suggestions made in Chapter Three c), regarding developing consistent attitudes, I suggest the I.P.P. manager, Program supervisor or primary worker confront the problem only if it is having an obvious effect on the client's behaviour in their Program.

In this case you cannot use the "tough" approach and tell the parent or volunteer it is a requirement of their job to adhere to a particular technique. In these instances I advise staff to include the person in question in all training sessions for the staff as well as all I.T.P. planning meetings. The point here is to demonstrate to them the amount of hard work which is going into their child's program and how important it is to have cooperation

from all parties. In addition, they should be shown (perhaps on video) how their inappropriate techniques affect the client and are in opposition to the program goals. If their behaviour is having a critical effect on the overall program success, their actions can be presented at the next I.P.P. meeting (as a last resort). The only reassurance I can give to staff who are dealing with this sort of problem is to remind them that many of our clients have difficulty generalizing skills from one environment to another. Hence they usually learn two sets of behaviour; one at home with the family and one in the Program (school, workshop, group home).

d) CONCLUSIONS

Staff training is fundamental to any I.T.P.. Without standardization of techniques, we are left with a variety of haphazard methods employed with the clients. Most important, other attempts at consistency are negated if it does not exist at this level. In my experience, consistency in techniques is one of the major causes for program failure in our schools, group homes and workshops. Ultimately it is the responsibility of the program manager to guarantee that everyone coming into contact with the client use similar, standardized techniques. Once again, we cannot control the behaviours of everyone who comes into contact with the client, but every effort should be made to train the primary persons to adhere to program techniques. This is especially true once programs are in operation and target behaviours objectives are being met. This brings us to the final aspect of consistency which is maintenance.

CHAPTER SIX

STRATEGIES FOR MAINTAINING CONSISTENCY:

a) CAUSES, METHODS & STRATEGIES

b) COMMUNICATION STRATEGIES

(i) - Ontario Student Records

(ii) - Client Intervention History

(iii) - Progress Postcards

c) CONCLUSIONS

I loved the scene in the Hollywood movie "Rainman", where Tom Cruise (the normal brother) grabs his autistic-savant brother (played by Dustin Hoffman) and says; "Quit-it!! Stop acting like such a retard!". I'm sure there have been many long, hot, afternoons, spent in a cloistered classroom (or a family kitchen), when the humming and rocking, or constant chattering, teeth-grinding or head-banging became unbearable and we, the care-givers with paper work piling up and meetings demanding more of our time, simply can't take anymore. We know we should not show the student or resident that their behaviour is driving us crazy, but we want to shake them as Tom Cruise did, and say, "O.K., you can stop now! Act normal!"

Even the very altruistic, committed and consistent among us have our moments. How do we make sure that we don't slip and react to something we shouldn't? How do we guarantee that our (already) heavy work load will not interfere with what we have agreed to in an I.P.P. meeting? What are our priorities? The client or the paperwork? We have good intentions, but has anyone ever taken the time to evaluate their productivity and

how often they set objectives, follow a plan, stay within thetime allotment, work through the system and reach their goals?

Maintenance links and controls the effectiveness of the various procedures at the the primary and suprastructure levels. Just as we cannot talk about attitude at only one level, we cannot look at maintenance as an isolated concept. It encompasses our routines; not only how we do them, but how much value we give those routines. Maintenance can take two forms, one being concrete, standardized procedures to follow (i.e. paperwork) and the other being a predisposition or attitude to maintain consistency. Without both being present, consistency cannot survive at any level in any part of the process. Hence, we look at maintenance as a personal (emotive) strategy as well as concrete strategies which affect consistency. I have already examined philosophies and methods to foster and develop attitude, and methods to standardize I.P.P.s and I.T.P.s, I will now discuss strategies which attempt to maintain the efforts to achieve consistency in other areas of the program. For those individuals who are familiar with much of the information presented in Chapters One - Five, this chapter outlines how all the recommended strategies fit into the overall I.P.P. process.

a) CAUSES, METHODS AND **STRATEGIES** TO IMPROVE PROGRAM CONSISTENCY

Causes of program inconsistency	Staff training model (Method)	Strategies to improve program consistency
1. poor attitude of staff 2. job conflictt	1) Recognizing a problem exists 2) Discussion of problems & plans by all levels: upper management, supervisors & subordinates	- pre-I.P.P. survey - Analysis of past I.P.P.s form
3. role overload or role ambiguity 4. lack of team work between supervisor and subordinates	3) Analysis of jobs to determine measurable, controllable work outputs -Baseline data 4) Definition of goals and performance objectives (target behaviours)	- Staff Orientation and Evaluation form - Team Contract
5. lack of monitoring - primary level - suprastructure	5) Training of supervisors and subordinates 6) Measuring progress; data collection is ongoing in program	- I.P.P. Manager and primary worker reminder checklist
6. lack of feedback from management	7) Feedback to subordinates 8) Follow-up and/or delivery of contingent consequences	- Staff Orientation and Evaluation form
7. poor communication	9) Maintenance	- D.S.R. - Client Intervention History - Progress Postcards

1) Poor Attitude	1) Recognizing the Problem and seeking help
2. Job Conflict	2) Discussion of problems

Methodology: A training team of behaviour therapists or a psychologist goes into the setting (residence, institution, classroom etc.). They have either been invited by the upper management, who recognize there is a staff conflict or a problem with client programming and have sought out help, or are directly responsible to the setting (school board or service agency) and have been assigned to deal with a particular student or client. (In other instances they are university staff conducting research.) Usually a prior problem has already been identified by management and/or staff or an hypothesis has been formulated which is being tested out.

The first step towards delivering a consistent program is to recognize there is a problem. For one reason or another there may be conflict between staff members at any or all levels. The term apathy has been used to describe a major cause of lack of staff adherence to prescribed programs (Meichenbaum & Turk). They see the reluctance on the part of staff to teaching treatment adherence to patients, as a problem with the beliefs and attitudes of the health care professionals. They identify the following reasons:

> - pessimism--perception of low outcome efficacy and low self-efficacy
> - faulty memory, inadequate skills and resources
> - previous failures
> - the complexity of implementing a treatment adherence program
> - stimulus overload, no time to carry out a program
> - no additional reinforcement for carrying out the program--they get paid no matter what quality of treatment delivery they provide. (1987, p. 257)

A specialist in organizational behaviour, Basadur (1990) reminds us of the importance of defining problems and looking at them in new ways. By doing so we come

to creative solutions and this leads to improved organizational effectiveness and improved mental health for everyone. In the field of social services there is a tendency to do things the way they have always been done, so as to "not rock the boat". The combined input of the team, and open lines of communication are necessary to overcome obstacles to progress both in the staff and clients. If there is conflict between staff members, or resistance to programming due to a poor attitude, the managers must encourage dialogue and look for creative solutions for dealing with this problem. Methods to foster attitude change were dealt with in Chapter Three c).

3. Role Overload & Role Ambiguity 3) Job Analysis

Methodology - The training team observe or assess the environment and operationalize the tasks performed by the staff as well as the expected behaviours of the students or clients (i.e. greeting residents, feeding and talking to residents, giving therapy to residents, students lining-up, students sitting at their desks and paying attention, etc.).

By improving communication and by clearly defining the tasks and techniques to be carried out by staff, ambiguity can be reduced. By operationalizing (defining and breaking down into small steps) the role of staff or standardizing the procedures there is less chance of conflict due to communication difficulties and increased chance for uniform output (Bourdon 1982). Although it is nearly impossible to produce identical responses from a group of people who may be working with a client "it is possible to bring within acceptable limits everyone's word choice, facial expression, sentence complexity and tone of voice" (Divack et al., 1985, p. 349). I contend that this is only possible if the techniques are clearly written out and defined as specifically as possible to reduce incorrect interpretation as outlined in Chapter Five.

Strategy

Staff Orientation and Evaluation Checklist

I have developed (and used) a form called the Staff Orientation and Evaluation Checklist (Appendix H) in group homes to overcome the problems of role ambiguity. In essence, what I did was a task analysis of staff responsibilities and performance expectations. It is intended for use by group home supervisors as part of their orientation for new staff and then it is reviewed after one, three and twelve months to evaluate performance and give feedback on skill development. This form is specific enough so supervisors can address weaknesses and strengths in staff interaction skills used with the clients as well as responsibilities regarding operation of the group home. It also makes supervisors accountable for their responsibilities related to staff training. Staff cannot be expected to perform a task which they have never been shown. This form is easily adaptable to the classroom or workshop and would be helpful to principals and workshop managers who must evaluate their staff on a regular basis.

4) Lack of team work between members 4) Definition of goals & objectives

Methodology -The training team meets with staff (supervisory and subordinates) to discuss problems. It is very important to combine both levels of employees in the training project, to develop team work. Over one or two meetings everyone agrees to a set of performance goals (or target behaviours), a system of monitoring, feedback and subsequent consequences (called contingencies). The training team then collects base line data to determine the current status of the selected target behaviours. This can be anything from choosing to increase the number of interactions between staff and clients/students or the number of times staff reinforce clients.

In the field of management psychology, these methods of aligning supervisors and subordinates and setting target behaviours are referred to as participative management and management by objectives respectively. The use of management by objectives is similar to that of behavioural contracting. Behavioural contracting is an agreement (written or verbal) negotiated between two or more individuals to achieve a particular, mutually agreed upon target behaviour (Kirschenbaum and Flanery, 1985, p. 598). Behavioural contracting and management by objectives have both been used successfully by many businesses and direct care staff working with emotionally disturbed individuals, especially adolescents.

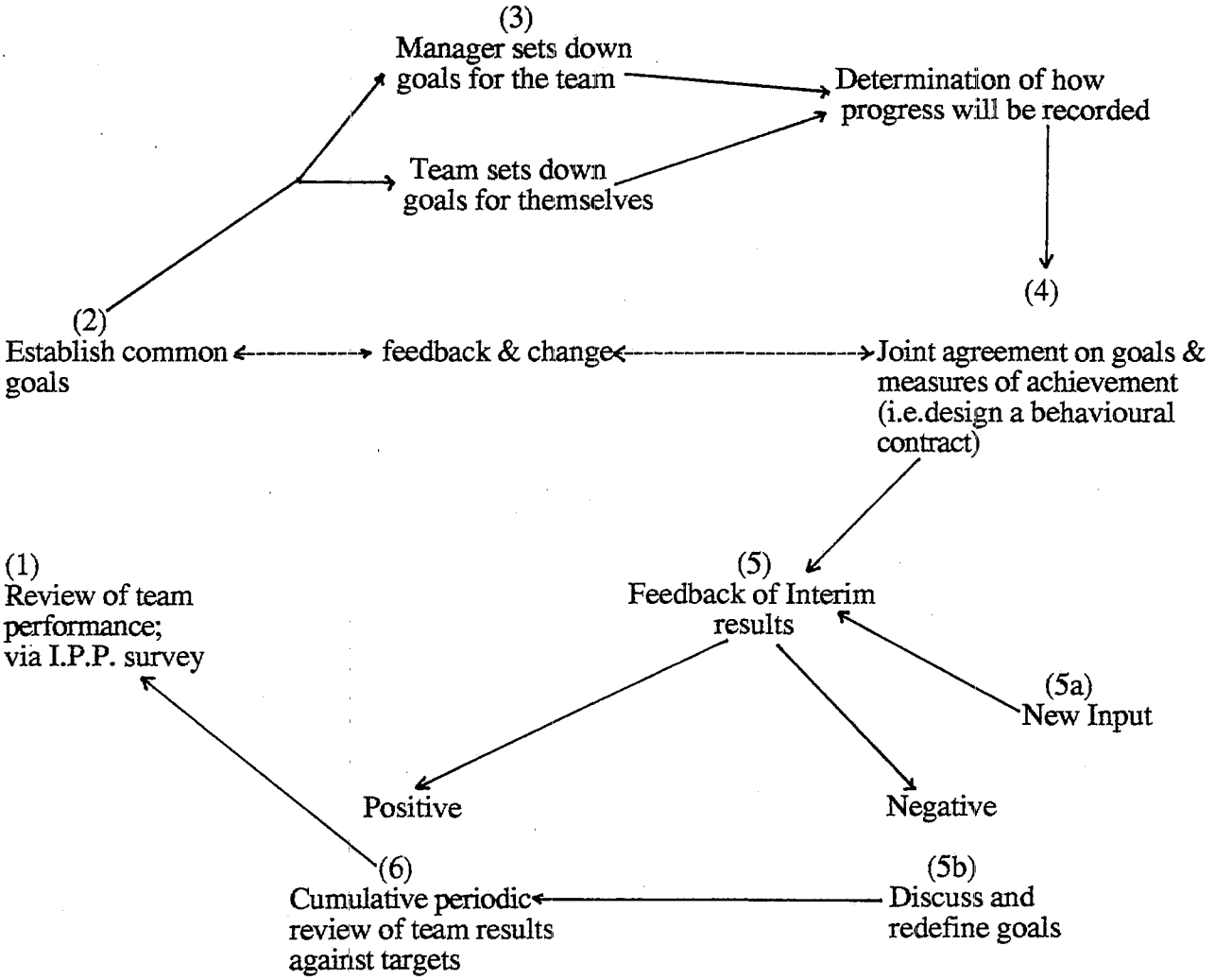
Strategy

Behaviour Contracting with the Team

The literature emphasizes the importance of setting objectives to improve the performance of staff on an individual or small group basis. I also see this as a useful technique for the manager to implement with the whole I.P.P. team. Quite often this team is an ad hoc group. The majority of the members are not necessarily directly accountable to the team manager and come from a variety of environments. Therefore, it is often a good idea to develop a contract to work as a team. The mere request by the team manager, to make up a contract may help the team members to become more aware that there is a problem within the current functioning of the team, or it may initiate a certain degree of compliance from the team,thus leading to greater co-operation amongst the members (Kirschenbaum and Flanery 1984, p. 599).

I hesitate to recommend any one particular format for making up a behavioural contract, thinking it best to leave that up to the discretion of the team. They may want to keep it informal, or possibly have some creative suggestions of their own. The design of a team contract should clearly articulate the expectations and goals for the group and the plans to follow through on these. It may be a very simple contract, done verbally, but recorded within the minutes. Or, it might be more specific and formal, similar to the I.P.P. written up for the client. I have completed I.P.P. forms

with two executive committees I sat on, and it was effective in defining what the expectations and goals were of the group and determining responsibilities. Once there is agreement to work out a contract, the process for carrying out the objectives would take the following format:



(adapted from Hersey & Blanchard 1972, p.106, cycle of management by objectives)

Let's continue with the other causes of inconsistency and methods of staff performance training.

5. Inappropriate Monitoring - **primary level** 6) Measuring progress

Methodology - The team teaches staff how to collect and analyze data to monitor the progress of the behaviour plan.

- They continue to collect and compare the data on the specific skills being taught (to staff or clients or both) to demonstrate how the goals are being met. Daily, weekly or monthly results are reviewed by the supervisors along with the trainers.

6. Lack of Appropriate Feedback - 7) Feedback & 8) Follow-up

Methodology - The supervisory staff is included in all phases of the training. Their responsibility is to provide reinforcement to staff and/or to give feedback on the progress. Once the (initial) goals are met there is a gradual fading out of the trainers, leaving managers and staff to monitor themselves. The training team may or may not stay involved, in some cases they return regularly to provide further training, deal with problems or to monitor progress.

Feedback goes hand in hand with monitoring of staff performance. Although punishment or threats of losing one's job is the technique used most often to control staff performance, it is questionable if it will sustain improvement and what the overall effects can do to staff morale (Reid & Whitman 1983). Supervisors need to be aware of the manner in which they give feedback. Most specialists recommend that it be concise and descriptive rather than evaluative, dealing with specifics and given in small doses--not too much at once. Supervisors must also set a good example and be willing to subject themselves to feedback as well and make an effort to change their behaviours in response to it.

5. Lack of monitoring - **suprastructure** 10) Maintenance

Method: The long term monitoring of progress (of staff performance or program adherence), is limited. Once the behavioural team does its initial intervention, it will possibly collect some follow-up data, or return in 3-6 months to see if its procedures are still in place. If progress has dropped off, it might return to reinstate the procedures and continue to monitor, again for only a short period of time unless funding is available to secure this team full time. Currently, there is no method available to maintain follow-up over a longer period of time outside of making managers responsible for maintenance.

The dependence on an outsider to conduct staff training or program techniques is not sufficient to maintain progress. The impetus must come from the management level. Divack (et al., in Ylvisaker 1985) recommend that the individual(s) involved with staff performance training (such as behaviour management programs), be "viewed as a full member of the treatment team, rather than as an outsider who comes to offer occasional advice" (p. 349). The responsibility for developing consistency and providing feedback should be that of the primary supervisor or case manager.

Staff and supervisors should meet weekly, monthly and yearly to set and review performance objectives, according to Bourdon (1982). Staff should be monitored by management and management accountable to predetermined goals reviewed regularly by an external agent (e.g. a consulting team, board of directors or parent group). Bourdon (1982) suggests that "at each level of management managers have a vested interest in examining the progress of the managers two levels below" (p.111). Thus you have a built in maintenance system at both the suprastructure and primary levels. The follow up process is most important to consistency and although it may take up time initially, it saves time in the long run, avoiding the need to start and restart programs, or staff performance training sessions.

Strategy

I.P.P. Reminder Checklists

In order to monitor and maintain progress at both levels, I have designed the 2 checklists (Appendix M & N) to remind I.P.P. managers and staff of the many I.P.P. details they are responsible for. (In some cases one person would complete both forms.) If some of these recommendations sound rather obvious or matter of fact to you, then you likely don't have a problem with consistency. In some Programs (or agencies) I have come into contact with, they do.

7. Poor communication

In my experience there has been very little attention given to one of the most critical areas of I.P.P. maintenance, that being communication. The standard performance training model rarely, if ever addresses "communication technique" as an area for training. There are several aspects to communication which influence consistency: communication breakdown, ambiguous (or vague) communication, or semantic misunderstanding (confusion over what has been said or implied).

A strong emphasis has been placed on the support of staff at the supervisory level as well as having a cohesive team who share common goals. It has been my experience that none of this can be accomplished unless there is clear, frequent and supportive communication between all members of the team. We want to develop a relationship with the client, a rapport with the primary counsellors and an ongoing discourse amongst the team members. I discussed in previous chapters that the method of obtaining consistency in attitude, is through discussing values and feelings with resistant team members. The vehicle to attain consistent goals is through dialogue in the I.P.P. meeting. Consistent techniques and maintenance are achieved through written instruction plans, follow-up reports and performance reviews. Hence, one of the key factors to maintaining overall consistency is communication.

Case Illustration

Sean had very few verbal skills and a serious facial tick, which his teacher noticed, increased when he used his picture board. The teacher finally had an opportunity to meet Sean's mother at a parents night and was surprised to watch the student communicate whole sentences to his mother using a series of facial ticks, including rolling his eyes, tilting his head and wrinkling his cheeks and not once using the Picture board. She was able to understand that he wanted to go home, have dessert and watch the "HULK" on television, all of this from what the teacher had thought was a psycho-motor self-stimulatory behaviour. The long term benefits of this system can only be determined once Sean is no longer in his mother's care.

The ability to verbally express ones needs, is one of the features that makes us human. We can call for attention, ask "Mama--what's that?", or tell our side of the story. This skill is seriously impaired if you are mentally handicapped. You are at the mercy of your caregivers, to interpret what you may or may not want, until (if you are lucky) you learn some verbal language skills. Many individuals with mental handicaps often never acquire the ability to fully express their thoughts, or even verbalize. They must rely on their body language, gestures, grunts or moans, or some form of augmentative communication system to make their needs known to others. Most of my clients are not fortunate enough to have a built in interpreter at home. Some clients don't even have a "Mom" or "Dad" to develop a non-verbal code system with. This role is shared by residential or institutional staff who have better things to do than figure out what Johnny wants every time he is banging his spoon on the table or tugging on his pants.

This then is one of the major problems with the provision of service for persons with mental handicaps. Their inability to speak on their own behalf makes them dependent on the educated guesses of the care givers to decide what they want. I think most service providers do fairly well at interpreting the needs of their clients, but where the weaknesses occur is in passing along this information to other involved individuals or their replacements. This leads me to another important objective, that being, staff (current or past) imparting information regarding the client to people currently involved and to people who may come into contact with the client in the future. All agencies should share vital programming information with one another. It's not only professional, but the client is entitled to informed primary workers. Unfortunately this is not always the case.

b) COMMUNICATION STRATEGIES

(i) The O.S.R.

One such area where staff from different agencies can improve their communication skills is in the very valuable document called the Ontario Student Record (O.S.R.), which is a file that a school must open the day a child is admitted to school for the first time. This file follows the student from class to class, school to school, year after year. When a student graduates these files are saved for 70 years (who knows where?) and then destroyed. These files contain a wealth of information on the student, with copies of report cards, assessment results, memo's, decisions from I.P.R.C. meetings and letters to and from parents. These files, however, are considered legal, confidential documents and are not to be shared with anyone outside of the school board. Parents and students must get special permission from the principal in order to look through these (Bill 82). Why these documents are stored away for 70 years eludes me. These should be passed along to the student or their next Program (receiving agency) when they graduate so that others can benefit from the past 18 (or so) years of programming experience.

I can already hear some militant parents growling, saying that they would prefer to burn the O.S.R.s , as they are "a testimony to the incompetence of many a school board" who failed to provide their idea of adequate services to their child. I disagree. I think the O.S.R.s tell a wonderful tale of the programming struggle which went on between the school and the parents, and reviews the intervention history of the student, including successes and failures. If school boards do not want to share all their information (or reveal their "dirty laundry"), I suggest that certain documents be designated "Vital programming information" and be put in a separate section of the O.S.R. with the full knowledge that it will be passed along some day. These documents could be a different colour, or stored in a separate section of the O.S.R. and the day the student graduates, it is automatically given to the next service provider. Admission procedures into a Program (workshop or group home) should include the passing along of this document. Staff in these Programs could benefit a great deal from having information such as: Johnny has already worked on tying his shoes for 14 years with 14 different teachers, with no success,

therefore they needn't bother wasting any more time (especially his) on this skill. In some instances the workshop staff do go to the school to meet with the incoming clients, but information is usually shared only verbally and informally. I discourage this method, since it is likely to lead to inconsistency.

(ii) Client Intervention History (Appendix L)

Now that we have shared the information, what are we going to do with it? So far in this manual, I have been able to detach myself as a communication specialist and just deal with the I.P.P. process. At this point however, I cannot help but point out that communication is 50% expression and 50% reception. I do not find staff take the time to go over I.P.P.s or files, read reports or talk to past caregivers often enough. Program managers and principals constantly complain to me that staff do not read what is given to them, nor do they abide by it. Therefore, we must make whatever information we have on the client as complete and relevant as possible. We don't want to make staff feel like robots when dealing with their clients, however the weakest area in programming seems to be in the intake of information and consequently, the performance of staff as a result of what they read or were told. Written communication is needed which explains client preferences to unfamiliar caregivers and details past intervention or instructional programs used with the client.

Although many agencies have a client information form in the main file (or program binder), I suggest that in place of this they use the Client Intervention History (Appendix L), which details more than just health-medical information. This form is essentially a written representation of the client. It would be completed by the previous primary worker and the new primary worker when a client is changing from one Program to another (one classroom to another). It is necessary that all staff become familiar with it's contents because the client can rarely communicate this information for him or herself.

(iii) Progress Postcards:

Meichenbaum and Turk (1987, p. 264) suggest methods such as checklists that can be strategically placed in one's office or postcard reminders, and telephone prompts to follow up service or program plans. I like their idea of postcard reminders to develop treatment consistency in staff and "patients". I think they can be used in service agencies to act as reminders to team members, or to report program progress. I suggest that staff use either a standardized format, which they send out to all key team members, or add a little fun to the process by buying some of the commercially available postcards which have humorous, artistic or old pictures on the front. This will make the event of reporting progress more interesting and the funnier the card, the more likelihood of staff passing it around. A third idea is to have the client draw a picture on the postcard so they become part of the process as well. It should be noted however, that the cards are not just meant to be chatty greetings, they should have very clear information on them, reporting status of the program, current data levels or any changes which need to be made. As mentioned previously, this information could also be shared in a "client newsletter", which either the parents prepare, or if the client is literate s/he can do for themselves.

When it comes to communication, nothing should ever be taken for granted. Supervisors and subordinates should feel comfortable about stating when they do not understand something or asking one another to clarify when there is a communication breakdown. In situations where there are staff are dealing with clients who have multihandicaps requiring a high degree of nursing care, this is especially important.

In general, just because things seem to be going smoothly, doesn't mean we can relax. When things are going well it is an important time to reinforce and generalize the progress. Here are some general communication pointers for I.P.P. managers and staff alike:

- never assume anything, always follow-up and always reinforce positive behaviours
- never assume someone understands an intervention or instruction program, watch staff do it, make notes and discuss it later.

- never assume people don't need feedback, as the research shows, everyone needs to know how they are doing, they need positive reinforcement and a sense of accomplishment, which is not always forthcoming from this population
- staff also need to know that their behaviour is recognized by another person and that they do make a difference however small it may be
- never assume that just because you haven't heard from someone, that everything is fine - -"no news is good news". This is usually not the case. Follow-up with a phone call if someone was supposed to get something to you or report back to you.
- have staff initial memos and all documents to ensure that they have read it or at least seen it.

c) CONCLUSIONS

Clear and frequent communication between staff is fundamental to successful program maintenance. We can devise and implement many concrete strategies to meet this objective and evaluate the success of our efforts. Unfortunately, clear and frequent communication from clients to staff about their needs or satisfaction is more difficult to achieve and is often a low priority of staff. Many individuals with mental handicaps are at our mercy to identify, interpret and articulate what they are trying to communicate; whether it be pleasure, frustration, grief or illness. This form of interaction is dependent upon the attitude, interpretation and communication skills of each and every staff person.

With regards to the overall maintenance of programs for persons with mental handicaps, stress has been placed on the staff and methods of training and monitoring rather than on a system or procedure to oversee the process. Issues such as: psycho-social needs of staff, environments, client skills, potential attitude differences and diversity of backgrounds or roles, present an formidable list of variables which affect program success and consistency. The related strategies which have proven to be effective are: management recognition of staff needs, clear definition of roles and the expectations placed on staff, involvement with the selection of (and agreement by) all levels of personnel with the program techniques or objectives, clear communication, self-monitoring of progress and

frequent feedback to staff from management. In order to maintain adherence, the person responsible for monitoring must be an active member of the team, such as the casemanager or supervisor, not an external individual such as a behaviour or management consultant. I have supplemented this behavioural staff training model with concrete strategies to develop consistency in attitude, goal setting, technique and maintenance of the I.P.P. process.

CHAPTER SEVEN

SUMMING UP:

a) DEALING WITH CHANGES

b) SUMMARY OF STRAGIES FOR CONSISTENCY

c) CONCLUSIONS

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a) DEALING WITH CHANGES

In my view the true testimony to an effective system, is it's ability to deal with change. According to Robbins (1987) most people are resistant to change on a large scale because:

> Any change can be an actual threat to employees' economic well-being, security, social affiliations, or status. Change can result in the loss of money, friends, or work group associates. Since employees have a highinvestment in specific skills, change also threatens employee self-interest. (p. 325)

On a small scale, Robbins says that people don't like changes because they quickly learn what behaviours are expected in a particular job and become contented with the routines. If something is introduced which may be good for us, but threatens the status-quo, this causes insecurity and conflict. Just look at what happened when computer technology was introduced into offices. Even when something is supposed to improve our life, often our immediate response is to mistrust and reject it.

Once you have convinced staff that the procedures for consistency are not going to cause them the loss of their jobs, then you must also show them how you can be flexible and accommodate the many changes which occur in the environment. The best way to do this is, again, through communication techniques.

If it is a change to the I.P.P. by one of the members of the I.P.P. team or as a result in the status of the client, the person wanting to make changes should arrange a short meeting with the key-team members. They should explain what they want to change in the program and why. Once it is discussed and agreed upon by all the members, formal changes should be made to the respective documents.

If the change is an external event, such as the approval for a move to a new Program, or funds for a one-to-one worker, then the team should meet and decide if changes can wait until the next I.P.P. meeting. If the external event causes extensive changes, perhaps a new I.P.P. needs to be conducted. Members of the team should feel that their input is valuable and nothing is "written in stone". If they feel that an error occurred when an objective was selected or a time line was set, they should be encouraged to present their ideas. This will make them (possibly) more realistic when it comes to selecting objectives at the next I.P.P. meeting and more accountable in the long run.

b) SUMMARY OF STRATEGIES FOR CONSISTENCY

At this point I have already presented and explained all my recommended strategies to develop and maintain consistency. The following Procedure for Consistency flowchart indicates where they would appear in the typical I.P.P. process presented in Appendix J.

The strategies which have been incorporated into the following consistency procedure include:

- **Pre- I.P.P. survey and review form*** (see Chapter Three b, ii)
- I.P.P. form (see appendix A)
- Client Intervention History (see Chapter Six c,ii) (Appendix L)
- **Staff Orientation and Evaluation form** (Appendix H)
- **Progress Postcards** (see Chapter Six c, iii)
- I.T.P. (see Chapter Five)
- **Team contract** (see Chapter Six a, iii)
- **I.P.P. Manager's Reminder checklist** (see Chapter Six a, vi)

* Highlighting indicates any strategy which is an addition to current procedures. The remaining forms/strategies (or ones similar) are already in use by agencies where I.P.P.s are in use.

I.P.P. CONSISTENCY PROCEDURE

STANDARD PROCESS	PROCEDURE FOR CONSISTENCY
CLIENT ENTERS A PROGRAM	- Vital information is collected, all past documentation (especially program and medical information) and O.S.R. if possible - have previous staff complete client Client Intervention History form - begin I.P.P. reminder checklist for yourself and give one to primary worker - meet with direct care staff as soon as possible to review important information, such as health/medical needs, previous objectives and programs and unique characteristics. Invite past primary worker if possible to review this information and demonstrate any essential techniques -set date for I.P.P.meeting in 6/8 weeks
CASE MANAGER IS ASSIGNED (prior to admission or within the first day or two)	- Match client's previous and current needs to specialties of staff (e.g. match client who is diabetic with staff who has nursing background, if available). Once the program is well established, then other staff can be trained in these particular methods. The client should not be made a teaching subject for untrained staff. - use Staff orientation and evaluation checklist to train staff on the appropriate management of client and performance of their responsibilities
KEY TEAM IS CONTACTED BY CASE MANAGER TO ARRANGE AN I.P.P. MEETING	- for new clients, this will have been done within the first week - for clients already in a program the date should be one year after the last I.P.P. or six months following the review meeting

one month prior to meeting

PRE-I.P.P. SURVEY FORM IS SENT OUT
- with covering letter, if staff are unfamiliar with the process

Adjunct to this
- visit the programs, observe and discuss client progress with staff

one to two weeks prior to meeting

PRELIMINARY ASSESSMENTS DONE
- Review client's file to see if testing has been done in the last year and if the information is reliable and/or complete. If necessary arrange for further testing or conduct your own.

I.P.P. REVIEW FORM
- COMPLETED BY CASE MANAGER
- compile findings needed for I.P.P. discussion

I.P.P. MEETING
- complete I.P.P. form (draft) have it signed by those in attendance
- send out a typed copy to all members
- record attendance, take additional anecdotal minutes and send out copies to those not in attendance

- write up behavioural contract with team members

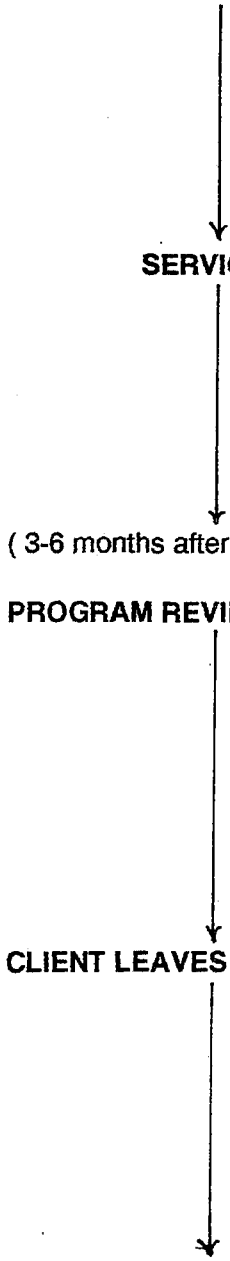
INDIVIDUAL TEACHING PLAN

ROUGH DRAFT WRITTEN:
- copy sent to other members of the key team as well as the manager for approval or input

IMPLEMENTED:
- initiate program,trial run for 2 (or more) weeks to work out any flaws

FINAL COPY WRITTEN:
- train other staff on techniques to be used and data collection methods

FOLLOW-UP:
- memo/postcard sent from primary counsellor to key team to report the results of the first month of program (i.e. data they have collected)
- visit program and give feedback to staff



EVALUATE

- review and make modifications as necessary

SERVICE GOALS CARRIED OUT

- use memo/postcard form or newsletter to announce to other key team what has been done and the outcome (e.g. John went for a hearing check-up and the results were.....)

(3-6 months after I.P.P. meeting)

PROGRAM REVIEW MEETING

- discuss areas where the system broke-down, make plans to eradicate that in future
- review & evaluate program
- modify as necessary
- check objectives and progress to date

CLIENT LEAVES THE PROGRAM

- If and when the client is moved to a new program, invite the new I.P.P. manager and/or primary worker for one day to observe and discuss the client's program.
- share all documents and ensure these forwarded when the client leaves

REPEAT THE WHOLE PROCESS

If these strategies (or ones similar) are currently being followed, but problems persist, I suggest you go back over the chapters on attitude, choosing and writing goals and consistent techniques; the three main areas where inconsistency in programming occurs. The overall feeling one might have at this point is that a tremendous amount of additional responsibility and paperwork was just created. If you are currently in a system which utilizes I.P.P.s, you should already have the I.P.P. form, the I.T.P., an annual report, a staff evaluation form and a client information sheet. In essence all I have added to the overall process is 3 new pieces of paperwork. They are the Pre-I.P.P. Survey, the Survey Review form and the reminder checklists. (As mentioned earlier if you are the primary worker as well as the case manager, you will have 2 checklists, hence 4 additional documents). You can choose to use the Staff Orientation and Evaluation form and the behaviour contract depending on your needs. The information from the 3 additional documents will assist you in completing the already existing forms. The time required to complete these is minimal, compared to the amount of time required if you don't. The time you take to discuss problems, modify programs and look for solutions can be reduced with these procedures and more positive time can be spent reinforcing the suprastructure, or with the client.

c) CONCLUSIONS

My criteria for success of this manual on consistency is to look back on my former student (now in the workshop, who no one speaks to) and ask, would these strategies make any difference? Would he have a richer life, more interactions, a better job? The determining factor is the staff. If members of an I.P.P. team are already demonstrating a reluctance to be consistent in their management of the client's program, there is no guarantee that the strategies I have recommended will bring about the desired behaviour. Other methods may bring about the desired results of a consistent I.P.P. process. Once again I must state that the strategies can only help to pin-point where problems exist, and offer concrete solutions if staff are willing to follow the strategies. Their ultimate

co-operation depends on their attitude, their responsibility to their job and the authority of the manager. We cannot force individuals to perform their jobs in a specific, standardized fashion. We can only demonstrate to them the positive consequences when this occurs, be specific with our expectations and hope that their pessimism or non-co-operation is altered as a result. A program is only as good as the individuals who carry it out.

Naturally it is easier for a supervisor to develop appropriate programming behaviours in their subordintes, than it is for a subordinate to point out their supervisor's shortcomings. For those of you working in a situation where the problem lies with the supervisory level--take heart. Your efforts are not going unnoticed. If not by your supervisor, they are most appreciated by your clients. I know they'd say "thanks for all you're doing", if they could.

APPENDICES

A - Individual Program Plan: I.P.P. sample form

B - Individual Teaching Plan: I.T.P. sample form

C - Sample of "Passing" form - Wolfensberger

D - Pre-I.P.P. Survey: sample form

E - Analysis of Pre-I.P.P. Survey: sample form

F - Analysis of Past I.P.P.s: sample form

G - Additional sample of completed I.T.P.

H - Staff Orientation and Evaluation Checklist

J - Standard I.P.P. Flowchart

K - Intervention Skills Inventory: sample form

L - Client Intervention History: sample form

M - I.P.P. Manager's Reminder Checklist

N - Primary Worker's Reminder Checklist

Appendix A

INDIVIDUAL PROGRAM PLAN _____, 19_____

1) Name: _____ D.O.B. _____
(see back page for persons in attendance)

2) REVIEW OF LAST YEAR'S IPP OBJECTIVES :
(or I.P.P. Survey form)

3) UPDATED INFORMATION, ASSESSMENTS, ETC.

Date: Completed by:

General Health/Medical : _____
Hearing : _____

Vision : _____
Dental : _____
Seating : _____

Therapy : _____

Communication : _____

Other : _____

RECOMMENDATIONS FOR
FURTHER ASSESSMENTS : _____

4) LONG TERM OBJECTIVES:

7) SHORT TERM OBJECTIVES	STAFF PERSON TO WRITE I.T.P.	REVIEW (date)

** Additional strengths and accomplishments since last IPP may be found on attached page(s).

Appendix B

Individual Teaching Plan

NAME:_____ **WRITTEN BY:**_____

DATE: _____ **OTHER STAFF RESPONSIBLE:**_____

_____

SHORT TERM OBJECTIVE:_____

_____

_____

CURRENT SKILL LEVEL (or BEHAVIOR):_____

_____

MEASUREMENT OF SUCCESS (as follows):

INCREASE POSITIVE TO:_____

_____

DECREASE NEGATIVE TO:_____

_____

WHEN:_____ **HOW LONG:**_____

WHERE:_____

MATERIALS:_____

METHOD OF DATA COLLECTION:_____

_____

METHOD

(ADDITIONS TO METHOD)

INTERFERING BEHAVIORS:

TROUBLE SHOOTING:

METHOD TO FADE PROMPTING:

SPECIAL SUGGESTIONS:

PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals)
CHECKLIST

1. Agency Being Assessed: _____ Date(s): ____ ____ ____
(Month) (Day(s)) (Year)

2. This form shows the level assignments of:

☐ Pre-conciliation team poll.

☐ Pre-conciliation rating levels assigned by individual evaluators;

Evaluator's name: _____

Evaluator's team role: ☐ Team leader
☐ Team member
☐ Other: _____

☐ Post-conciliation team decision (if this Checklist shows ratings both of an individual team member prior to conciliation, as well as of a team's conciliation, then check both this box and the one above).

3. The levels shown on this form are based on the following type of assessment:

☐ The service of a single-component agency _____
(enter service name if different from agency)

☐ One component, namely _____
of a multi-component agency, where this component was:

☐ The only component assessed at this time.

☐ One of a number of components of the agency assessed at this time, with the results of the assessments of the other components recorded on a separate Checklist each.

☐ Consolidated assessment of several components of a multi-component agency, as if these were one unit. The following components are represented on this Checklist:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Instructions to Evaluators for Filling Out PASSING Checklist

1. In order to reduce the likelihood that awareness of the rating level weights would bias assignment of levels, the PASSING Scoresheet/Overall Service Performance Form, and any other materials which show the weights of each of the ratings, should be put away while individual rating level assignments on are recorded on this Checklist or the PASS/PASSING Individual Rating Evidence Organization Sheet.

2. Evaluators should make their *individual level assignments in pencil* by placing *a circle* (○) in the box that corresponds to the level that they decide best characterizes the service's performance on each rating.

3. Evaluators should mark their individual ratings in pencil so that if they change their minds on a level assignment *prior to team conciliation*, they can easily change the level they have assigned.

4. However, evaluators are *not* to make any changes in their individual level assignments either during or after conciliation by the full assessment team.

5. Evaluators should mark the *final conciliated team level assignments* on the Checklist *in pen* by placing *an X* in the box that corresponds to the level that the team agrees upon for each rating.

6. If the final conciliated team level assignment is the same as a team member's individual level assignment, then the X should be placed inside the circle (⊗)in the same box.

7. Evaluators should turn in their completed Checklists at the end of conciliation to the team leader or other relevant person. Evaluators will have a record of the service's performance on the assessment on their own copy of the Scoresheet/Overall Service Performance Form, which they are supposed to fill out at the end of conciliation under the team leader's direction.

PASSING (Program Analysis of Service Systems' Implementation of Normalization Goals), 2nd Edition
CHECKLIST

1 RATINGS PRIMARILY RELATED TO SOCIAL IMAGE ENHANCEMENT

11 IMAGE-RELATED PHYSICAL SETTING OF SERVICE

		LEVELS
R1111	Setting-Neighborhood Harmony	1 2 3 4 5
R1112	Program-Neighborhood Harmony	1 2 3 4 5
R1121	External Setting Aesthetics	1 2 3 4 5
R1122	Internal Setting Aesthetics	1 2 3 4 5
R1131	External Setting Appearance Congruity With Culturally Valued Analogue	1 2 3 4 5
R1132	Internal Setting Appearance Congruity With Culturally Valued Analogue	1 2 3 4 5
R1141	External Setting Age Image	1 2 3 4 5
R1142	Internal Setting Age Image	1 2 3 4 5
R1151	Image Projection of Setting—Physical Proximity	1 2 3 4 5
R1152	Image Projection of Setting—History	1 2 3 4 5
R1153	Image Projection of Setting—Other Internal Physical Features	1 2 3 4 5

12 IMAGE-RELATED SERVICE-STRUCTURED GROUPINGS & RELATIONSHIPS AMONG PEOPLE

R121	Image Projection of Program-to-Program Juxtaposition	1 2 3 4 5
R122	Service-Neighborhood Assimilation Potential	1 2 3 4 5
R1231	Image Projection of Intra-Service Client Grouping—Social Value	1 2 3 4 5
R1232	Image Projection of Intra-Service Client Grouping—Age Image	1 2 3 4 5
R124	Image-Related Other Integrative Client Contacts & Personal Relationships	1 2 3 4 5
R1251	Service Worker-Client Image Transfer	1 2 3 4 5
R1252	Service Worker-Client Image Match	1 2 3 4 5

13 IMAGE-RELATED SERVICE-STRUCTURED ACTIVITIES & OTHER USES OF TIME

R131	Culture-Appropriate Separation of Program Functions	1 2 3 4 5
R132	Image Projection of Program Activities & Activity Timing	1 2 3 4 5
R133	Promotion of Client Autonomy & Rights	1 2 3 4 5

14 IMAGE-RELATED MISCELLANEOUS SERVICE LANGUAGE, SYMBOLS, & IMAGES

R141	Program Address of Client Personal Impression Impact	1 2 3 4 5
R142	Image-Related Personal Possessions	1 2 3 4 5
R1431	Image Projection of Personal Labeling Practices	1 2 3 4 5
R1432	Agency, Program, Setting, & Location Names	1 2 3 4 5
R144	Image Projection of Service Funding	1 2 3 4 5
R145	Image Projection of Miscellaneous Aspects of a Service	1 2 3 4 5

2 RATINGS PRIMARILY RELATED TO PERSONAL COMPETENCY ENHANCEMENT

21 COMPETENCY-RELATED PHYSICAL SETTING OF SERVICE

		LEVELS
R2111	Setting Accessibility—Clients & Families	1 2 3 4 5
R2112	Setting Accessibility—Public	1 2 3 4 5
R212	Availability of Relevant Community Resources	1 2 3 4 5
R213	Physical Comfort of Setting	1 2 3 4 5
R214	Challenge/Safety Features of Setting	1 2 3 4 5
R215	Individualizing Features of Setting	1 2 3 4 5

22 COMPETENCY-RELATED SERVICE-STRUCTURED GROUPINGS & RELATIONSHIPS AMONG PEOPLE

R2211	Competency-Related Intra-Service Client Grouping—Size	1 2 3 4 5
R2212	Competency-Related Intra-Service Client Grouping—Composition	1 2 3 4 5
R222	Competency-Related Other Integrative Client Contacts & Personal Relationships	1 2 3 4 5
R223	Life-Enriching Interactions Among Clients, Service Personnel, & Others	1 2 3 4 5
R224	Program Support for Client Individualization	1 2 3 4 5
R225	Promotion of Client Socio-Sexual Identity	1 2 3 4 5

23 COMPETENCY-RELATED SERVICE-STRUCTURED ACTIVITIES & OTHER USES OF TIME

R231	Program Address of Clients' Service Needs	1 2 3 4 5
R232	Intensity of Activities & Efficiency of Time Use	1 2 3 4 5
R233	Competency-Related Personal Possessions	1 2 3 4 5

Appendix D

PRE- I.P.P. MEETING SURVEY

please note this is a no name survey (anonymous) but we would like the name of the client_____

date:_____

1. Without looking at any documents, list the short term objectives which you have been working on with the client since the last I.P.P. meeting:

_____
_____
_____
_____

2. Describe the long-term goals which were chosen at the last I.P.P. meeting for the client:_____
_____

3. What do you feel are the client's priority needs at this time?

Academic:_____

Vocational:_____

Domestic:_____

Social or Interpersonal:_____

Communication:_____

Physical/Motor:_____

Other:_____

_____

4. What do you see as the most important areas for change in: the team, the I.P.P., the client's program, or anything else?

_____
_____
_____

5. Do you feel comfortable with your role and with what is expected of you by the other team members? _____
If not please elaborate :_____
_____
_____

6. When was the last time you had a sense of accomplishment with this client? What was achieved?_____
_____
_____

7. What one to one technique do you feel works best with this client when teaching them a new skill? _____
_____
_____

8. Other than receiving this survey form, when was the last time you had contact with another member of this team regarding this client?
_____
Contact with the client?_____
_____

9. What if anything, do you strongly disagree with regarding the program for this client?
_____
_____

10. What skills do you feel you need to develop for this job or for working with this client:
_____
_____
_____

11. Please elaborate on any of the above points._____
_____
_____

Appendix E

Analysis of Pre-I.P.P. Survey

1. List all the short-term objectives stated by the respondents:

_____
_____
_____
_____
_____
_____

2. List all the long-term goals which were stated by the respondents:

_____
_____
_____
_____
_____
_____

* Highlight the ones which are the same as the previous I.P.P.. Calculate the percentage correct.

3. List the priority needs for the client, as chosen by the team members:

Academic:_____

Vocational:_____

Domestic:_____

Social or Interpersonal:_____

Communication:_____

Physical/Motor:_____

Other:_____

_____

* High-light the priorities selected two or more times.

4. List the points which people chose to change about the program.

_____
_____
_____
_____
_____
_____

*High-light the points chosen more than twice.

5. Do people (in general) feel comfortable with their role? What percentage

do,_____ what percentage don't? _____

What were some of the elaborations on problems with roles (if any)?

_____
_____
_____
_____

6. When was the last time people had a sense of accomplishment with the client?
(state the percentage)

past month_____ within past two months_____
past 6 months_____ past year _____
past two years_____ not recently (if ever)_____

7. What one technique do people feel works best with this client?

_____
_____
_____
_____
_____
_____

8. Amount of contact with other team members:

daily_____ weekly_____
biweekly_____ monthly_____
bimonthly_____ every six months_____
not since the last meeting_____

With the client:

daily_____ weekly_____
biweekly_____ monthly_____
bimonthly_____ every six months_____
not since the last meeting_____

9. What do people strongly disagree with regarding the program for this client?

_____
_____
_____
_____
_____
_____

*Highlight the issues repeated more than once.

10. What skills do people feel they lack most with the client?

*Highlight the skills repeated more than once.

11. What statements did team members make which could lead to inconsistency in carrying out the program?

12. What main issues do you feel should be shared with the team?

13. What changes in I.P.P. goals, objectives or techniques are needed to be effective for the next _____months?_____

14. What staff or system changes need to be made to bring about consistency or improvements in #13 above?

Appendix F

Analysis of past I.P.P.s

date: _____

Number of years reviewed: from:_____ to:_____

Long-term goals chosen:

1)_____# of times repeated:____

2)_____# of times repeated:____

3)_____# of times repeated:____

4)_____# of times repeated:____

5)_____# of times repeated:____

6)_____# of times repeated:____

7)_____# of times repeated:____

8)_____# of times repeated:____

9)_____# of times repeated:____

10)_____# of times repeated:____

11)_____# of times repeated:____

12)_____# of times repeated:____

Short-term objectives:

1)_____# of times repeated:____

2)_____# of times repeated:____

3)_____# of times repeated:____

4)_____# of times repeated:____

5)_____# of times repeated:____

6)_____# of times repeated:____

7)_____# of times repeated:____

8)_____# of times repeated:____

Short-term objectives Cont.

9)_____# of times repeated:____

10)_____# of times repeated:____

11)_____# of times repeated:____

12)_____# of times repeated:____

Service Goals:

1)_____# of times repeated:____

2)_____# of times repeated:____

3)_____# of times repeated:____

4)_____# of times repeated:____

5)_____# of times repeated:____

6)_____# of times repeated:____

7)_____# of times repeated:____

8)_____# of times repeated:____

Take a highlighting marker or a different coloured pen and high-light the goals, objectives and plans listed above which were achieved. If you are unsure whether or not they were achieved make note of this and ask the I.P.P. team members later.

Which areas/domains have the highest rate of success? (e.g. service plans, behaviour, hygiene)

_____
_____
_____
_____
_____
_____

Now circle the goals, objectives and plans which were chosen more than twice, but never accomplished. Write these below:

_____
_____
_____
_____
_____
_____

Appendix G; Additional example of an Individual teaching plan

---

Communication Program: June 16,1989
Ken Klient; Koroni School

Needs: Ken currently does not indicate his needs to his caregivers; he is very passive in his daily routines and waits for staff prompting; before he will participate in the shared activity or; when asked to make a choice.

Long-term Goal: for Ken to indicate his needs by actively choosing activities or concrete items

Short-term Objective: for Ken to make deliberate (intentional) choices between concrete items

Target Behaviour: Ken will touch a preferred item using the tips of his fingers, with his palm extended--or by reaching for and grasping the item

Person/s Responsible: all group home staff

When: this program will be carried out in one to one teaching sessions during snack time (15-20 minutes) which will take place twice a day (minimum once); 1) after school
2) before bed-time (prior to brushing teeth)

- it should also take place throughout daily routine activities

Where: At the kitchen table or at a table in the play-room

Method:

1) present Ken with two preferred items (drink and fruit or dessert) and ask him "what do you want Ken?"

a)- wait 8-10 seconds; if he does not respond;

- show Ken the items, label each clearly and ask again

- wait 10-12 seconds

- if he clearly looks like he wants a particular item, but is not responding, use a light touch-cue to help him to tap that item and say "do you want the _____?" Then wait again for him to make the choice independently.

?›?No Response:

2)- if he continues not to indicate his choice, tell him "you're telling me you don't want anything". Remove the items and initiate another (different and less motivating) activity for 3-5 minutes

- During this time Ken should not be given anything else to eat, however, staff should try to engage him in as much interaction as possible

- After this time-out period, Ken should then be given another opportunity to make a selection and staff should repeat #1 above

!! Response !!:

3) If Ken does choose an item, by either touching it or grabbing for it, staff should immediately **praise** him verbally and **give** him the item. They should also label the item which he has chosen (e.g. "good Ken, you told me you want the _____").

- Staff should enter on the data sheet (attached) the # of prompts and what Ken selected

-Staff should repeat the choice procedure until the edibles are finished or until 20 minutes have passed

Trouble Shooting:

Noises; - if Ken makes a noise or behaves inappropriately during the choice-making, staff should look away, discontinue the activity for 8-10 seconds (until he finishes) and say **NOTHING.** Then resume as if nothing had happened. They should never laugh or comment on what he has done.

Object Manipulation; - if Ken grabs another item (or piece of clothing) during the choice- making, staff should gently redirect his hand to the table or to his lap and hold it there for 5 seconds before releasing. If this continues for more than 8 redirections, staff should say (in a firm voice) "No fiddling Ken" while prompting his hand down again.

Lack of Interest; - Ken seems to have his good days and bad days. On the bad days he is generally lethargic and uninterested in activities which occur around him. When this occurs staff might try a warm-up session with Ken, where they spend 10-15 minutes joking or "rough-housing" with him, encouraging him to play with staff. Ken enjoys loud noises and songs with physical actions. (Staff should use their judgment to determine the appropriate level of physical contact and volume, so as not to get Ken too excited). This warm-up session should be conducted away from other loud noises (T.V., other clients) to ensure that Ken is attending as much as possible.

General Suggestions:

- Ken should be given regular opportunities to make choices such as this throughout his daily routines. For example, during walks he can be asked which direction he would like to take (left or right), when doing his grooming routine he should be given a choice of hygiene activities (wash-face first or brush-teeth?).

Staff should follow through consistently with whatever choices Ken makes first, praise him for indicating a choice and always label what he has chosen.

- Staff should never assume what Ken wants. They should wait for him to actively indicate a need, rather than anticipating all his needs for him.

APPENDIX H

STAFF ORIENTATION AND EVALUATION CHECKLIST

Staff Name:_____
Supervisors Name:_____

Second Supervisor's Name:_____

Dates:

Orientation:_____

First Month Review_____

3rd Month Review_____

One Year:_____

Performance Codes:

√ Achieved

\+ = Needs Work

N/A = Not Applicable

Method: Each item is written so that it is initially taught to the staff during their orientation with their supervisor and then, it is evaluated at the three different time periods. Comments should be made with the appropriate corresponding number. For example, if the skill was not reviewed during the 3rd. month review, the comment would read: "3. skill not reviewed at this time." If there is no date entered in a square, that implies it has not yet been taught, or reviewed, therefore the staff person is not responsible for that skill area.

AREA	Orientation 1.	1st Mon. 2.	3rd. Mon. 3.	1 Year 4.	Comments
Client Related					
1. practical Needs (enter client's initial as it is reviewed)					
2. health/medical needs					
3. eating, dishes, place at table, seating					
4. hygiene					
5. sleeping habits bedtime routine					
6. clothing selection & coordination					
7. equipment					
8. routines:daily weekly, monthly					

AREA	Orientation 1.	1st Mon. 2.	3rd. Mon. 3.	1 Year 4.	Comments
Pertinent to client's with Physical Needs					
9. lifting/carrying procedure					
10. back care					
11. positioning & handling					
12. safety & wheel-chair use					
Pertaining to all clients, Individual Program Plans (I.P.P.s)					
13. I.P.P., what, when where (flowchart)					
14. I.T.P. responsibilities - service goals follow-up - writing - training - data - evaluate & change					
15. inform others when changes are made to I.P.P./I.T.P.					
16. initiating new ideas for new programs					
17. client's binder kept up to date					
18. client reports completed					
19. familiar with behaviour programs of all the clients - carries these out (cooperation) - asks questions if you do not understand					
General					
20. contact with family members, workshop, teachers,					
21. outings/ special activities					

AREA	Orientation 1.	1st Mon. 2.	3rd. Mon. 3.	1 Year 4.	Comments
Intervention (or Teaching) Skills					
22. Prompting - wait for selfinitiation - waits for client attention before starting - verbal prompts - touch cue - hand-over-hand					
23. Praise - contingent on behaviour - appropriate verbal input - tactile and/or eye contact - set a motivator (e.g. "if you do __, then we will do X") - ignore when necessary or, continue with task, or, redirect as needed					
24. Correction - remove your contact - hands down prompt - remove client from activity - set an ultimatum and follow-through					
25. Teaching a skill - task break-down is according to client's skill level - wait for them to self-initiate before prompting - wait time (allows client enough time to respond) - keeps voice calm when frustrated, (or does not make a facial expression) or removes themselves as necessary - calms client down when necessary					

AREA	Orientation 1.	1st Mon. 2.	3rd. Mon. 3.	1 Year 4.	Comments
26. Communication skills					
(See Interaction Skills Inventory) - insert results here					
27. General issues pertaining to teaching a client					
- selects age appropriate activities					
- provide a balance between teaching and recreation activities					
- shares their insights with other staff					
"Task Specific" Staff Responsibilites					
28. Medical matters - contacts Doctor as needed					
- relays Medical information to other staff					
- dispensing, recording of medication					
- medical supplies: surplus & restocking					
- health directives and information is placed in proper file					
- seizure procedures followed appropriately					
- minor medical treatments (enemas, compresses, etc.)					
- medical/hygiene (staff, clients,equipment)					

AREA	Orientation 1.	1st Mon. 2.	3rd. Mon. 3.	1 Year 4.	Comments
30. Emergency procedures					
- medical emergencies, records etc. what to take with you - location of local hospital - numbers ready for emergency: taxi, ambulance. doctor, supervisor - accidents and unusual occurrences, incident reports - Fire - hoses & extinguishers location & use -smoke detectors - fire drill procedure and emergency routine					
31. Housekeeping					
- trash disposal - cleaning: daily, weekly, monthly, annually, standards - house supplies (i.e. food, hardware, office supplies) - meal planning and preparation - involve the clients as much as possible - returning items when finished with use					

32. Other Pertinent Details related to this Position

CLIENT ENTERS A PROGRAM
(vocational, academic, residential)

↓

I.P.P. (OR CASE) MANAGER IS ASSIGNED
(teacher, social worker, primary counsellor)
(prior to admission or within first week)

↓

PRELIMINARY ASSESSMENTS DONE
(observation, teaching trials, basic skills testing etc.)
(after admission and prior to I.P.P. meeting)

↓

KEY TEAM IS CONTACTED BY I.P.P. MANAGER
TO ARRANGE AN I.P.P. MEETING/CONFERENCE
(parents, counsellors, teachers, social worker,
therapists, psychologist, doctor)

↓

I.P.P. MEETING;
LONG-TERM GOALS AND SHORT-TERM OBJECTIVES DECIDED
(within two-three months of admission)

↓

INDIVIDUAL TEACHING PLAN WRITTEN BY KEY
TEAM MEMBERS or PRIMARY WORKER

↓

SERVICE GOALS CARRIED OUT
(anytime after I.P.P.)

↓

Evaluate, Review and Modify I.T.P.

↓

PROGRAM **REVIEW MEETING**
(3-6 months later)

↓

REPEAT THE WHOLE PROCESS

Appendix K

INTERACTION SKILLS INVENTORY

NAME OF STAFF:_____

NAME OF OBSERVER: 1) _____

2) _____

DATE AND ACTIVITY BEING OBSERVED:

1) _____

2) _____

3) _____

4) _____

Enter the appropriate code letter beside the points below: observation code: S = a strength, /= not a problem
N/W = needs work

SKILL	COMMENTS
1) Voice: volume - too high - too soft	
2) Modulation: - is your voice tone irritating? - are you mumbling - is you voice tone age appropriate	
3) Labeling: (depending upon the client's level) do you: - label the item in use (shared referent) - label the action - label the sound - identify other persons - describe an item further - expand on their responses - is your vocabulary selection approp.	
4) Do you give the client opportunities to make choices?	
5) Are your initial instructions clear?	
6) Do you break down the task according to skill level?	
7) Do you give the client a chance to respond to your instructions before repeating the prompt	

SKILL	COMMENTS
8) Do you talk to other staff about problems with the client in front of the client?	
9) Ability to deal with frustration: - you keep calm - remove yourself - it shows in your facial expressions - it shows in your physical contact	
10) Are you spontaneous to events and use them as a topic of discussion with the client?	
11) Positioning for activity: - when teaching the client are you in close proximity, where eye-contact can easily be made? - are they close enough for you to physically prompt them if necessary? - are you too close?	
12) Do you give the client a chance to repair conversation break-downs? - ask them to repeat - ask them to use another word - ask them to use another strategy (sign, gesture, point, picture) - do you ask other staff for help?	
13) Do you use topics (items) which are motivating to the client (favourites)?	
14) Do you anticipate what the client wants thus, denying them the opportunity to express their needs appropriately?	

OVERALL COMMENTS

Appendix L

CLIENT INTERVENTION HISTORY

NAME:_____

DATE OF BIRTH:_____

RESIDENTIAL BACKGROUND:

_____

_____

ACADEMIC BACKGROUND: _____

_____

VOCATIONAL BACKGROUND:

_____

BRIEF HISTORY, FAMILY BACKGROUND:

_____

_____

_____

GENERAL MEDICAL INFORMATION:

_____

_____

recent surgery _____

hearing _____do they wear hearing aids?_____

vision _____do they wear glasses?_____

motor _____

allergies _____

current medication _____

METHOD OF COMMUNICATION:_____

_____

EQUIPMENT USED: _____

a) who is responsible for it? (maintenance, storage & repairs)_____

b) where can it be found?_____

OTHER AGENCIES CURRENTLY INVOLVED: (behaviour, therapy, etc.):

_____

_____

FAVORITES:

people _____

activities _____

food _____

other _____

HABITS: _____

_____

ROUTINES: _____

_____

PET PEEVES: _____

_____

STRENGTHS: _____

_____

WEAKNESSES: _____

_____

HOW DOES THIS PERSON LEARN BEST? (describe in detail):

_____

_____

WHAT TECHNIQUES ARE DEFINITELY NOT EFFECTIVE WITH THIS INDIVIDUAL? (please describe in detail)_____

_____

_____

LIST THE INSTRUCTIONAL PROGRAMS WHICH THIS PERSON HAS BEEN INVOLVED WITH IN THE PAST 5 YEARS, AND THE OUTCOME (POSITIVE OF NEGATIVE) OF EACH. PLEASE GIVE THE NAMES OF THE INDIVIDUALS RESPONSIBLE AND THE LOCATION THE PROGRAM WAS CARRIED OUT:

ACADEMIC:_____

_____

_____

PHYSICAL/MOTOR:_____

_____

_____

COMMUNICATION: _____

_____

_____

BEHAVIOR:_____

_____

_____

OTHER: _____

_____

OTHER IMPORTANT INFORMATION:

_____

_____

_____

WOULD YOU KINDLY LIST SOME NAMES OF PREVIOUS PRIMARY WORKERS, CASE WORKERS (etc.) WHO WOULD CONSENT TO GIVE FURTHER INFORMATION IF NEEDED, ON THE BACK OF THIS PAGE, THANK-YOU (please include numbers where they can be contacted):

Appendix M

I.P.P. MANAGER'S REMINDER CHECKLIST:

name:_____
Name of Client:_____ date:_____

Things to do:

a) Prior to I.P.P. Meeting

- Set I.P.P. date & contact all those who are to attend
- or set Review Date:
- Send out Survey Form to key team .
- Review and compile results of survey (15 days later)
- Set a date to visit Program
- Visit program and talk to key team

b) For Meeting

- arrange room & refreshments
- arrange for person to take minutes (if needed)
- make sure all documents are ready
- remind anyone who might be prone to forget date
- arrange for client to be there
- arrange for interpreter to be there if necessary

c) After I.P.P. Meeting

- Key team has seen I.P.P. final copy
- Key team has written I.T.P.
- Staff trained on I.T.P.
- Service objectives completed (Follow-up contacts made i.e. letters sent, registrations done)
- Assessments completed
- Equipment purchased
- One month evaluation of I.T.P. completed, any modifications necessary?
- visit Program to provide feedback and reinforcement
- Progress postcard sent out

Appendix N

PRIMARY STAFF I.P.P. REMINDER CHECKLIST

name:_____

Name of Client:_____ date:_____

Things to do:

a) Prior to I.P.P. Meeting

- note date of I.P.P. meeting
- complete all assessments
- list strengths and needs and goals I feel are important
- collect pertinent data, make sure it is up to date
- complete I.P.P. survey form and return to manager
- arrange for client to be at meeting

b) At I.P.P. meeting

- be prepared to present report (s)
- record all my responsibilities

c) After I.P.P. Meeting

- have looked over I.P.P. final copy and returned it to Manager
- written I.T.P. with key team or shared it with them
- tried out I.T.P. for two weeks to iron out "kinks"
- have trained other staff responsible on I.T.P.
- Service objectives completed
- Assessments completed
- Equipment purchased
- Follow-up contacts made (i.e. letters sent, registrations done, phone calls made)
- Progress postcard sent out

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