SERVICE DELIVERY IN ORGANIZATIONS

FOR THE MENTALLY RETARDED

THESIS

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By

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This study analyzes effective service delivery in organizations serving the mentally retarded. Qualitative organizational analyses of three community care facilities were compared to assess effectiveness. Data were gathered by systematic observations, field notes, documents, and employee interviews. Program analysis, the funding system of service delivery, and staff attitudes best indicated effective service. I concluded that effectiveness would improve by focusing on individual consumer needs and further defining service delivery.
ACKNOWLEDGEMENTS

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Finally, I would like to thank my mother. She waded through countless revisions, survived sleepless nights, and traveled bumpy emotional roads to the end. Her love and unconditional acceptance of others showed me what effectiveness really means. Thanks, Mom. I love you.
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CHAPTER I

INTRODUCTION

Introductory Statements

As society advances into the twenty-first century, viewing the past and present state of the mentally deficient is necessary. One of the most challenging tasks facing mental retardation professionals is the development and implementation of services that will meet individual needs. Delivery systems must be effective, accountable, and adaptive to the ever changing demands of federal and state regulations.

This study describes and explains effective service delivery in three community care facilities for the mentally retarded. Certain components, including operation finances and regulations, habilitation services, and direct and supportive care, may influence effective service delivery. To understand why these factors influence effective care, I provide a brief discussion of recent historical developments. Next, I consider the related issues of normalization and deinstitutionalization. Finally, I look at the impact of these issues upon effective service.
Recent History

The history of social reform in mental retardation includes a confusing combination of personal and public litigation, economic restraints, federal regulations for treatment, politics, and increased involvement of consumers (Powers, 1988; Bruininks & Lakin, 1985; Roos, McCann, & Addison, 1980; Landesman & Butterfield, 1987). Public assistance provisions of the Social Security Act were first set in 1935. The beneficiaries did not include persons in public or private mental institutions. In 1965, it became legal for a state to claim federal finances for the cost of care of indigent persons over sixty-five who were patients in "institutions for mental diseases" (Boggs, 1975). Using the narrow definition "institutions for mental diseases," the law failed to include the institutionalized retarded. Residential arrangements became possible without losing public funding. Between 1967 and 1982, the bed capacity of community residential facilities increased from 24,000 to nearly 100,000. This increase cost at least $3.0 billion in public funds in 1985 (Landesman & Butterfield, 1987). Since the mid-1970's, Title XIX Medicaid Reimbursement Program for Intermediate Care Facilities for the Mentally Retarded (ICF/MR), has sustained the service delivery system. The program provides ninety-seven percent of the federal aid to institutions, and seventy percent of federal aid for community programs- $4.6 billion annually (Landesman & Butterfield, 1987; Reid, Parsons, Green, & Schepis, 1991).
Normalization

Justifying the need for residential services defined several concepts. "Normalization" was primary to pioneer service providers. Normalization first emerged from efforts to improve services in Scandinavia (Bank-Mikkelsen, 1969; Nirje, 1969). In 1959, legislation stipulated that any mentally handicapped or person in a similar situation is entitled to claim government assistance (Wedekind, Frank, & Thimm, 1980). The law also provided for equal care for persons in all parts of the country. Amendments to the law in 1965 made it possible for the mentally handicapped to claim an invalidity pension. This enabled many to live outside an institution. In 1970, legislation decentralized social administration. This measure increased the responsibilities of local authorities. They became the primary providers for individuals living at home or in open institutions. The "institutionalized" retarded remained in the care of the central government. The most important aspect of this legislation was that variations in assistance depending on the nature and origin of the handicap were to be avoided. Instead, the handicapped would be provided for according to their needs (Wedekind et al., 1980). Therefore, Danish legislation has placed mentally retarded on the same level as "normal" persons. Their aim is to enable the mentally handicapped to live as normally as possible by concentrating on the problematic aspects of society, rather than the limitations of the individual.

In contrast to the Danish system, German social policy transformed "normalization" into "rehabilitation" (Wedekind et al., 1980). Social services in Germany are made up of a "jointed system." This system divides the mentally
retarded into subgroups based on their association to different supporters of social insurance. Those who do not belong to the subgroups depend on "Sozialhilfe" - public assistance (Wedekind et al., 1980). The Rehabilitation-Assimilation Law of 1974 forced coordination of these different types of assistance. It states that these services must "integrate" handicapped persons "for the longest possible time into work, profession and society" (Wedekind et al., 1980, p. 332). Though the law coordinated the goals of the different providers, it failed to standardize services. Therefore, problems occur in the planning of services. The system adequately distributes payments, but fails to distribute services. Variations in care provided by the different supporters are assumed, but cannot be measured. Rehabilitation, then, may not be provided for those in need of services.

In 1972, Wolfensberger expanded and defined normalization as "utilization of means which are as culturally normative as possible in order to establish and/or maintain personal behaviors or characteristics which are as culturally normative as possible" (p. 28). Based on the Scandinavian and German concepts, his definition emphasizes adjusting the individual's behavior to conform to society expectations. Numerous professional providers in the United States were committed to this concept. Within this framework, life satisfaction, self-esteem, and personal competence are results of involvement with mainstream activities of society (Landesman & Butterfield, 1987). American practice and philosophy reflects this commitment to resocializing the mentally retarded. These individuals must assume behaviors which are defined by the culture as normative. A segregated environment would be detrimental to efforts at
resocializing. Therefore, deinstitutionalization became inevitable.

Deinstitutionalization

Deinstitutionalization is the motivating force behind service delivery systems today. Community care facilities evolved as alternatives to larger institutions. These facilities are filled with consumers taken primarily from institutions. Therefore, deinstitutionalization is an ongoing process that profoundly impacts current service delivery.

Historically, deinstitutionalization was the conceptualized form of normalization for the mentally disabled in the United States. Supporters of the normalization movement perceived large institutions as degrading to the individual. They vehemently opposed efforts to upgrade the quality of institutional care (Ferleger & Boyd, 1979). Opponents correctly noted that simply removing individuals from institutions, or closing all institutions would not guarantee that the principles of normalization would necessarily be achieved. Not opposing deinstitutionalization per se, they rather doubted its universal value to all individuals. They also questioned the quality of care of some community services (Landesman & Butterfield, 1987).

Advocates of selective deinstitutionalization influenced the National Association of Superintendents of Public Residential Facilities for the Mentally Retarded (1974), who offered the following definition of the concept:

Deinstitutionalization encompasses three inter-related processes: (1) prevention of admission by finding and developing alternative community methods of care and training, (2) return to the community of all residents who have been prepared
through programs of habilitation and training to function adequately in appropriate
local settings, and (3) establishment and maintenance of a responsive residential
environment which protects human and civil rights and which contributes to the
expeditious return of the individual to normal community living whenever possible
(Scheerenberger, 1976, p. 124).

A sociological event that altered the entire service delivery system was the broader
vision of deinstitutionalization. It asserted that deinstitutionalization is more than just
a physical event or another treatment setting for perpetual care. Dramatic shifts in
service utilization accompanied the system-wide changes (Bachrach, 1985). Mentally
retarded persons today fall into at least five primary subgroups due to
deinstitutionalization. These groups range from those who have entered the system
and are likely to be released, to those who have entered but are unlikely to be
released. Characterized by permeable boundaries, clients continually "revolve"
through the system. The already obscure lines of proper service delivery are blended
further. Individuals demand specific attention to their unique background, whether or
not such individuals appear similar in functioning level. The deinstitutionalization
movement has therefore been a powerful motivating force in developing highly
diversified programs for the mentally deficient. It continues to intervene between need
assessment and programming concerns (Bachrach, 1985).

Current service delivery reflects the impact of normalization and
deinstitutionalization. For some clients, normalization is somewhat of a contradiction.
Many programs are characterized by super-conformity. Others overwhelm consumers
with over-programming. Officials plan each waking moment for the client. The
normalization process is an exercise in invisibility (Rhoades & Browning, 1982). Deinstitutionalization has been the means to transform the visibly mentally retarded to the invisible. Placing consumers within the community involves selecting out a highly undesirable visible category of people and camouflaging them in a group home. The facility's function is to modify "inappropriate" behaviors so that the condition of retardation goes unnoticed (Rhoades & Browning, 1982).

Baldwin (1985) disagrees with Rhoades and Browning (1977), Robinson and Robinson (1976), and Throne (1975). Their research suggests that normalization is synonymous with deinstitutionalization. However, Baldwin contends that normalization is an evolutionary process that incorporates deinstitutionalizing the mentally handicapped.

The future of service delivery depends on clarifying the principles of normalization. Deinstitutionalization is one interpretation of the principles. It is undeniably superior to warehousing consumers in large institutions. If nothing else, both normalization and deinstitutionalization are instrumental in conveying the value of the mentally retarded. They give many the right to choice, the right to fail, and the right to social value. Therefore, service delivery will continue to be impacted by further defining normalization. It will also be affected by continued efforts at deinstitutionalization. Services that are cost effective, rehabilitating, and progressive are needed immediately. The challenge is integrating effective service within the ideology of normalization.
Chapter Summary

This study determines the effectiveness of service delivery to the mentally retarded. I covered recent historical developments in the area. I next looked at the related factors of normalization and deinstitutionalization. I concluded that these issues require further clarification. They will continue to impact service delivery long into the future.

Chapter II will focus on research in the area of service delivery. I first investigate attempts at defining service delivery. Next, I examine theories that can help us understand the current state of service delivery. Finally, I look at three factors found to influence service delivery.

In Chapter III, I describe the settings of the three organizations used for the analysis in this study. This is followed by a discussion of data collection procedures. I further discuss the limitations of the research.

In Chapter IV, I provide a case study of each of the facilities beginning with general characteristics, then proceed through the components that influence delivery.

In Chapter V, I review the variables found to affect service delivery. Next, I examine the hypotheses that are tested in the study.

Chapter VI will review the factors that affect service delivery. I conclude with suggestions and recommendations for improving the quality of services delivered by these providers.
CHAPTER II

REVIEW OF THE LITERATURE

Introduction

In reviewing the literature, I will focus on three issues. First, I examine theoretical perspectives that aid in defining effective service. I next provide an operational definition of my dependent variable. I conclude with an overview of three variables that may influence effective service delivery.

Theoretical Perspectives

I use an organizational analysis for each facility to view effective service delivery. The theoretical perspective that is most appropriate for assessing effective service delivery is the Contradiction Model. The model assumes organizational effectiveness contains inherent contradictions (Hall, 1987). Campbell (1977), Freeman (1973), and Kahn (1977) determined that "effectiveness" as a scientific concept could not be measured. Therefore, it is incorrect to conceptualize organizations as simply effective or ineffective.
Contradiction Model

Substantial research suggests that effectiveness cannot be approached from simply one aspect of study. Cameron (1978), Campbell (1974), and Rohrbaugh (1980) each demonstrated that effectiveness is multifaceted and involves a variety of measures for analysis. Reviewing the previous findings, Hall (1987) realized the contradictory nature of effectiveness. He developed the Contradiction Model to analyze the contradictions of organizational effectiveness. The model addresses four specific issues.

1. Organizations face multiple and conflicting environmental constraints. An organization must consider the environment, recognize and order the constraints that it confronts, and attempt to predict the consequences of the directions chosen or not chosen, regardless of decision-making approach or style.

2. Organizations have multiple and conflicting goals. An organization must be adept at recognizing the relationships between goals and the acquisition of resources. They learn which goals to stress and which to downplay.

3. Organizations have multiple and conflicting external and internal constituencies. The organization must recognize stability and conflict between and among the customers and clients of an organization, the people who are not clients but are affected by the organization, and members of the organization.

4. All organizations have multiple and conflicting time frames. Decisions are made in terms of the frame of reference for analyzing goal attainment, the nature and phrasing of environmental constraints, and the historical situation of the organization.
These contradictions in environmental constraints, goals, constituents, and time indicate a constructed reality. Hall (1987), Benson (1977), and Pfeffer (1977) view organizations as effective or noneffective in varying degrees based on these constructed realities. Yet, there are compromises that must be made among pressing constraints, goals, constituencies, and time frames. The sequence of the compromises is based on power relationships and coalitions within the organization, coupled with external pressures (Hall, 1987). The organization makes compromises realizing that once an action has been chosen, others are not feasible, especially if resources are limited.

Hall (1987) recognizes that organizations cannot control every constraint. Weather, political and economic shifts, demographic patterns, and local economic developments affect organizations. Therefore, organizations must adjust to these conditions as they deal with other constraints, constituencies, goals, and time frames.

Facilities serving the mentally disabled have many contradictions. The goal of the ICF/MR system is to provide health and rehabilitation services for mentally retarded individuals or persons with related conditions. Technically, the goal of each organization participating in the system should be the same. Yet, in some organizations, the goals will reflect the reality constructed by the organizational decision-makers. For example, these goals may focus on turning a profit instead of "providing health and rehabilitation services for mentally retarded individuals." The reality constructed by the organization with the goal of turning a profit is less effective service. In contrast, the reality constructed by an organization who's primary goal is providing health and rehabilitation services is effective service delivery. Although
both facilities are participating in the same system with the same purpose, only one facility is actually meeting the goal of that system.

Meeting the goals of each organization further involves confronting multiple constraints. These include the environment, mandates of federal and state regulations, multiple constituencies within the organization itself, and conflicting time frames. The organization determines how to address these issues and sets a course of action. This is demonstrated with the previous example. Once the facility has determined profit as the goal, it structures itself to accomplish that goal. It adapts to the environment by purchasing from low-cost suppliers. It attempts to control an external constituency (i.e., state investigators) by maintaining minimum standards of operation. Conflicts between internal constituencies (i.e., administration versus staff) are resolved by providing inferior benefits to staff at a bargain price to the organization. Consequently, service delivery may suffer due to the manner in which the organization adapts to its constraints. Goals identify which constraints the organization will face. The goals determine the course of action that the organization takes to satisfy the set of requirements it creates for itself. Ultimately, service delivery reflects the reality created by the goals of the organization.

Overall, the Contradiction Model rejects the idea that organizational behavior and decisions are rational. It acknowledges the existence of constructed realities. It suggests organizational behavior is not controlled by structured authority. Instead, preferences of the group, values, and beliefs affect organizational behavior (Ott, 1989). Utilizing the Contradiction Model offers a holistic approach to understanding the
processes, behaviors, and realities of service delivery.

**Dependent Variable**

**Defining service delivery.**

The dependent variable, service delivery, has potentially multiple meanings. To hone this definition, I first provide a legal definition of service delivery. I then discuss other definitions used in establishing many organizations. The culmination of the following definitions helps tap the concept of service delivery.

Guidelines delineated by the President’s Committee on Mental Retardation (1969, 1976) and added litigation clarified the expectations of the regulations for many past providers. Wyatt versus Stickney 1972, and Halderman versus Pennhurst State School and Hospital, 1977, were two of numerous cases that furthered the implementation of deinstitutionalization. Such legislation mandated the placement of prepared residents to the least restrictive community setting available (Glahn, Jones, Lichtenstein, & Redlich, 1988). The basis for this litigation was explicit: (a) Clients have a right to receive appropriate treatment in the least restrictive settings in which they could successfully reside, and (b) Institutional programs do not typically provide adequate habilitation programming (Butterfield, 1977; Scheerenberger, 1976). Therefore, in order for deinstitutionalization to be effective, the institutionalized residents must be provided services that prepare them to succeed in community placement.

**Definition by model.**

Service delivery models evolved as one guide used by professional providers to care for the mentally retarded in the community. Baldwin (1985) compared and contrasted five such models applied to the field of mental retardation.
The Medical model relating to diseases and illness was applied to deviations from social norms in mental health. Confusion resulted from the inability to differentiate between the origins and implications of mental retardation and mental illness. Frequent interchanging of the terms "retardation", "disability", and "handicap" was also detrimental to the recipients of the services. The lack of positive terminology in the area inevitably distorted the beliefs and values attributed to persons who were mentally retarded (Heiny, 1978).

According to Baldwin (1985), the Developmental model was rigid in its adherence to educational objectives and use of unyielding criteria. He hypothesized this model fostered simplistic conceptualizations of the mentally retarded. It postulated that "abnormal" or "deviant" behavior could be altered using application of systematic reinforcements.

The Psycho-Educational model was more complete (Baldwin, 1985). It was based on an assessment of skills, goals, and target settings followed by a course of programmed instructions. This approach rejected the clinical treatment inherent in the medical model and instead implemented teaching components.

Baldwin (1985) viewed the Social-Ecological models more favorably. Such models considered the consumers habits, models of life, and relations to their surroundings, analyzing the conflicts and disharmony between the consumers and their environment. The concept of normalization was representative of this orientation. This model focused on the most immediate needs of the individual and attached equal importance to the person and to the social ecology.
Professionals chose care models that provide a total delivery system of services along socio-economic and political factors. These factors are based upon society's perceived status of the mentally retarded (Baldwin, 1985). Professional understanding of the right of self-determination and least restrictive environment proves most effective in providing ethical and equal approaches for individualized service delivery.

The Basic Principles adopted by the National Association for Retarded Citizens' (NARC) Position Statements on Residential Services (1976) provides another definition (see Appendix A). NARC hypothesized that people are conditioned by society to adopt basic assumptions that govern how decisions are made. This collection of beliefs and assumptions would then translate into working principles that will affect day-to-day behavior. Therefore, these fundamental assumptions strongly influenced decisions made by about the nature of mental retardation and human services in general (Patterson, 1980). These principles serve as a guide for designing, improving, revising, and expanding service provision to aid the mentally retarded.

Though these principles serve as a basis for virtually all program development in the residential service area, each one is interpreted in policy and procedure of an individual facility. Glahn et al. (1988) directly addressed the specific problem of transition from an institution to community placement for certain residents. For a client to succeed in community placement, she or he is presented with a transitional continuum of service delivery. This goal is achieved by the use of two main strategies: "(a) Each component in the system of service delivery should be distinguishable by the provision that each serves separate functions within the system's
hierarchy, and (b) Each component’s operationally defined exit criteria are the following component’s entrance criteria" (Glahn et al., 1988, p. 48).

In essence, this "continuum for transitional treatment facilities" offers a hierarchy of facilities. They are organized to provide a systematic and behaviorally oriented service. All proceed from institutional living on one end of the continuum to independent living on the other. In this way, individual attention is given to specific training needs, and the person receiving the service is promoted through the system, effectively becoming more independent through each stage.

Table I provides a summary of the stages of service delivery. For this analysis, I draw from the Care Model to help define service delivery. The clinical settings of the organizations in the study adhere most closely to this conceptualization. Moreover, the philosophy of a "least restrictive environment" is the primary focus of contemporary mental retardation professionals.

Overall, service delivery is difficult to define. It evolved through many stages to its current conceptualization. A summary of the stages can be found in Table I. Though the continuum for transitional treatment facilities is ideal, it presently remains an abstraction. As service delivery progresses, the continuum will become less evasive for those who pursue it.

Table 1: Service Delivery Models

<table>
<thead>
<tr>
<th>MODEL</th>
<th>CHARACTERISTICS</th>
<th>RESULTS</th>
</tr>
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<tbody>
<tr>
<td>Medical</td>
<td>Treated mental retardation as an illness</td>
<td>Beliefs and values of mentally retarded were distorted.</td>
</tr>
<tr>
<td>Developmental</td>
<td>Used systematic reinforcements to alter behavior</td>
<td>Rigid programs &amp; criteria fostered simplistic view of mentally retarded.</td>
</tr>
<tr>
<td>Psycho-Educational</td>
<td>Assessed skills, goals, &amp; settings for program instruction</td>
<td>Clinical treatment was rejected in favor of teaching components.</td>
</tr>
<tr>
<td>Social-Ecological</td>
<td>Considered persons' habits &amp; models of life in relation to environment</td>
<td>Importance of individual &amp; social ecology was equal.</td>
</tr>
<tr>
<td>Care</td>
<td>Provides total delivery based on society's perceived status of mentally retarded</td>
<td>Right of self-will &amp; least restrictive environment is ethical &amp; equal.</td>
</tr>
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</table>
Independent Variables

The research literature suggests three main factors affect service delivery in community care facilities. They include (1) operation financing, (2) programming or habilitation services (i.e., teaching of daily living skills), and (3) direct and supportive care (i.e., staff needed to train the clients, staff that provide professional health and mental health services). It must be stated that none of these elements exist alone. Instead, effective service delivery is a process determined, in part, by these variables.

The sections below provide an overview of these three factors. Figure 1 provides a profile of the independent variables. They are discussed further in the following section.

Figure 1: Factors Affecting Service Delivery
Financing care.

Continuing efforts to deinstitutionalize and educate mentally deficient individuals remains a costly endeavor. Even as President Gerald Ford signed Public Law 94-142, a legislative cornerstone of these efforts, he noted that "unfortunately, this bill promises more than the federal government can deliver" (Thornton, 1981, p. 171). The overall growth of Medicaid expenditures has included benefits to Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The ICF/MR system has grown phenomenally since its beginnings in the mid-1970's. It is the largest source of federal funds for individuals with mental retardation, even though there are more than eighty-two related systems (Harrington & Swan, 1990).

The analysis of state policies and their budgetary processes is central to the concerns of ICF/MR spending, because "budgets are political documents which record the struggles of men over 'who gets what' (and) the budget is the single most important policy statement of any government" (Dye, 1977, p. 474-475). One area of current research in budgetary analysis focuses on the extent to, and manner in which state governments fund state-operated institutional systems versus alternative community-based services.

In their analysis of trends during fiscal years (FYs) 1977 through 1986, Braddock, Hemp, and Fujiura (1987) determined that the single most important factor of financing care was the dramatic growth of spending in the states for community services. Organizations providing community services are defined by these researchers as agencies with sixteen or less beds. Community service system expenditures
comprise federal and state spending for the purchase of discrete services from community-based agencies. These agencies provide habilitation, day-training, residential care, respite, case management, vocational or related programs, and Supplemental Security Income (SSI) State Supplement payments. In contrast, organizations providing institutional services are defined as agencies with sixteen or more beds (Braddock et al., 1987). Institutional service system expenditures comprise all operating funds appropriated from federal and state sources for state-operated institutions, developmental centers, training centers, state schools, and state psychiatric hospital units for individuals with mental retardation or developmental disabilities. Comparing the national expenditures, Braddock et al. (1987) found that in FY 1977, the nation expended 2.5 billion as much for institutional care as it did for community services in facilities of all sizes. Yet, in FY 1986, the nation was spending approximately equal sums in both sectors, $4.647 billion versus $4.422 billion, respectively.

Likewise, in an analysis of state Medicaid expenditures between 1980-1984, Harrington and Swan (1990) reported that ICF/MR Medicaid recipients per state population increased somewhat during that period. This increase indicated that greater numbers of recipients were using the available beds. They also determined that as ICF/MR expenditures continue to increase, states will, and in some cases already have begun to adopt policies that constrain costs in the program. One approach is for states to discourage the growth of new ICF/MR beds through their state certificate-of-need policies, as has been the recent practice of the Texas state government. Yet, while
beds are being constrained, the underlying push for deinstitutionalization continues.

How do these concerns affect the present state of service delivery? If the current trends continue, a shortage of funding to ICF/MR operations may occur. When facilities are funded by Medicaid's ICF/MR system, they operate under "Interpretive Guidelines", the federal regulations for participation in the ICF/MR system. The facility must be in compliance with both federal and state guidelines for it to be certified and funded by the ICF/MR system. If certified, funding for each individual in the facility is gained by submittal of "Form 3650." This form is filled out for each person in the facility and serves as an outline of the "Level of Care" required for each individual.

Levels of care are determined by a number of factors including the individual's diagnosis, IQ, health related conditions, need for specialized services and adaptive equipment, and any behavioral concerns that require attention. Once the level of care has been approved by the Texas Department of Mental Health and Mental Retardation (TDMHMR), Medicaid funding for the individual is provided to the facility.

The basic rate provided by Medicaid for an individual participating in an ICF/MR facility is $106 per day. Any other services that the individual requires, as outlined on Form 3650, are funded on the basis of severity and time required for treatment. For example, if an individual is diagnosed as severely mentally retarded with inappropriate behaviors, moderate hearing loss, and cerebral palsy with contractures, $106 would be received for placement in the facility. Then, Medicaid would provide extra funds for
physical therapy treatment for the contractures, speech therapy and audiological services for the hearing loss, and counseling, psychological, and/or psychiatric treatment for behavior problems. Thus, the rate for this individual could total approximately $220 per day based on the diagnosis and related conditions that required attention. Medicaid would be spending close to $80,000 per year on this person alone. It is not unusual for a Level VI facility to house persons with such diagnoses.

Fernald (1986) states that community resources are needed, but funding is limited. He suggests modifications to the ICF/MR system could encourage growth in the area of community services. The most promising solution appears to be implementation of a system of Diagnosis Related Groups (DRGs) (Fernald, 1986). In the past, DRGs have been effective in containing the rapid rise in the cost of medical services. If used in the provision of long-term care for persons with mental retardation, it could be a means of establishing equity. Fernald (1986) perceives the major attraction of DRGs to be universal availability of treatment, regardless of whether the resident were living at home, in a community setting, or in an institution. Treatment mandates would shift resources toward the community where services are in greatest demand. Because Medicaid reimbursement would be based upon compliance, there would be clear incentives for states (Fernald, 1986). Overall, a system of DRGs would tailor services and costs to client needs, regardless of living arrangements.

Critics of this option state that a new, unproven system of DRGs may lack feasibility. Extensive research and demonstration of effectiveness would be required
before the system could be utilized on a large scale. Also, DRGs lack feasibility for states because they require uniform treatment. Subsequently, individuals who are currently inappropriately placed in ICFs/MR would be "dumped" into diagnosis-related groups without arrangement for alternate placements (Fernald, 1986).

The most recent shift in developing services for the mentally retarded has followed this general idea of targeting Medicaid funds to community systems, rather than focusing the majority of the funds to the ICF/MR system exclusively. In 1986, the 144,000 people participating in the ICF/MR system were doing so at an average annual cost of $35,000. In contrast, the 23,000 Medicaid waiver beneficiaries in 1986 had an average annual cost of $9,500 (S.1673, 1988). The cost effectiveness of the HCS (Home and Community-Based Services) system is just one of the many incentives for supporting such a system. The services delivered through the HCS system are provided by waiver services. Such services help the participant avoid institutionalization or placement in a long-term care "training" facility. The purpose of the HCS program is to use the "cluster" approach to deliver individualized services in the least intrusive manner. The system is not designed to change the location of the individual, but provide services that will support the individual in his or her home community (i.e., his own "cluster"). It is a worthy option in that appears to be the most individualized and specialized of the available services at this time (S.1673, 1988). This type of system will be included in the present analysis as a viable alternative to the ICF/MR arena.

In this study I hypothesize that the funding method of the HCS system provides a
higher level of effective service than the funding method of the ICF/MR system. This hypothesis was based on the previous reports that stated directing funds toward non-institutional, community based systems provided cost-effective, individualized services (Braddock et al., 1987; Fernald, 1986; S.1673, 1988).

Accordingly, I hypothesize that targeting funds for the benefit of the consumers provides a high level of effective services. Fernald (1986) substantiated this hypothesis with research that suggested targeting specific client costs and needs in a variety of living situations is presently a priority.

In summary, the exorbitant costs of the ICF/MR system cause a shortage of facilities. Yet, it is currently the most "workable" solution to institutionalization. To address this problem, options have been discussed. These include a system of diagnosis-related groups. DRGs seem a feasible alternative in that they would provide clear incentives for states. They could further serve to target specific client costs and needs, regardless of living arrangements. The HCS system is currently the most cost-effective. It appears to provide the most individualized services available at this time.

Habilitation/programming services.

Possibly the most important aspect of service delivery involves the actual provision of direct treatment. Specifically, I address habilitation services. Active treatment is key to the concept of habilitation. Traditionally, program personnel had responsibility for treatment services. They conducted their services through day treatment programs designed specifically for that purpose, such as schools or sheltered workshops. However, Sparr (1987) noted an increased emphasis on treatment services
provided during non-programmatic times. This service involves professional staff in residential living units (see Burch, Reiss, & Bailey, 1987).

Focus on the treatment activities of direct-care staff has become more common for several reasons. First, therapeutic activities in such situations have historically been lacking for some time (Harmatz, 1973). Second, professional services offered for a specific time period will be of limited benefit if the training is not continued in other, more substantial periods of time (Favall & Phillips, 1986). Third, regulatory agencies recently require more comprehensive treatment in the living units.

State and federal agencies within the ICF/MR system have scrutinized institutions regarding day-long treatment services (Fernald, 1986; Sparr, 1987). If the organizations are unable or unwilling to provide more comprehensive services during non-programmatic periods, they are in danger of losing their allocated funding (Braddock et al., 1987). Common problems in ensuring service provision include lack of preparation of direct-care staff, extreme disabilities or behaviors of low functioning residents, and demands of group training rather than one-to-one supervision (Zlomke & Benjamin, 1983; Eyman & Borthwick, 1980; Scheerenberger, 1982; Reid & Favall, 1984).

Parsons, Cash, and Reid (1989) provided an evaluation of a comprehensive management strategy designed to improve residential treatment services. The investigation consisted of two studies. One was designed to evaluate the extent of treatment services. The other demonstrated the methods used to decrease off-task resident behavior. First, active treatment was categorized into functional and
nonfunctional. The divisions were made according to four skill domains: self-help skill, leisure skill, social communication skill, and community living skill. Engaged behavior, holding and manipulating an object in a manner not intended by the design of the object was also targeted. Results of the first study indicated that when institutionalized residents are in their living unit, they spend two-thirds of their time in non-habilitation activity, or off-task behavior. This suggests that facilities failed to fulfill active treatment requirements. By utilizing practices of time structure, staff assignments, training, monitoring, and supervisor feedback at all levels of management, off-task behaviors decreased from seventy-five percent to forty-one percent.

Evaluations of the program given to the management of each of the facilities provided an objective means of viewing their facility's proficiency in providing constructive living environments for their clients. Therefore, they improved their chances for continued ICF/MR accreditation (Parsons et al., 1989).

An integral part of the ICF/MR certification system is the individual agency survey process. The basic survey process entails at least one on-site review of an agency's compliance with ICF/MR regulations. The survey reports determine an agency's compliance. If the agency is found to comply, they participate in and receive funding from the ICF/MR system. Preliminary evidence suggests that ICF/MR surveys may not be very instrumental in determining proper habilitation services. Repp and Barton (1980) reported that the process had essentially no impact on the amount of habilitation programming extended to the residents. In fact, the
investigators found no difference in the amount of therapeutic services between ICF/MR certified and non-certified units. A more recent study by Reid et al. (1991) suggested similar evidence. They stated that there was considerable disagreement regarding the degree of consistency, accuracy, and objectivity of ICF/MR teams' interpretation of an agency's compliance with the ICF/MR standards.

How can a facility ensure that standards will be upheld? Some professionals in the field suggest program analysis be performed within the organization. Analyses serve many purposes. These include the measurement of program impact, the assessment of the efficacy of different methods of service delivery, the provision of accountability for continuation of funding, and the identification of program elements associated with different outcomes (Guba & Lincoln, 1981; Hawkins, Fremouw, & Reitz, 1981; Krapfl, 1975; Schalock, 1983). Analyses further determine many organizational goals. Community living situations are complex settings. While programs are similar, their specific goals may vary widely. The goals set by each organization address its perspective of which outcomes are most important. Program analysis allows management to see, and possibly change the goals that are addressed. In this way, analysis helps determine the goals of the organization. Guba and Lincoln (1981) went on to suggest that utilization of program analyses demonstrated a willingness of management to critically examine the organization's practices. Management then would exert effort to correct them, further contributing to long-term survival of the facility.

For the purposes of this study, I hypothesize that utilizing program analysis
improves the quality of services delivered. This hypothesis is supported by the research previously discussed (Guba & Lincoln, 1981; Hawkins et al., 1981; Krapfl, 1975; Schalock, 1983).

Overall, ensuring funds for ICFs/MR hinges mainly on an active treatment program that meets the client's individual needs. Utilizing time structure, specific staff assignments, and supervisor feedback were found to be three measures of improving active treatment. A need for consistency, objectivity, and accuracy was targeted in relation to state surveys. Finally, program analysis was viewed to be one of the most useful means to determine whether or not effective treatment was being provided. Proponents of heavily supervised programs criticized such measures, reporting success of programming hinged on punishment regimes (Repp & Deitz, 1979), written negative feedback to staff (Shoemaker & Reid, 1980; Repp & Deitz, 1979), and public posting of corrections (Green, Willis, Levy, & Bailey, 1978). Yet, the case for focusing upon time structure, credible state surveys, and program analysis is strong (Gladstone & Sherman, 1975; Burg, Reid, & Lattimore, 1979; Thorsen & Mahoney, 1975; Skinner, 1953). Instead of targeting the program specifically, these standards include the overall framework of the ICF/MR system. In doing so, a more comprehensive definition of active treatment is provided.

Direct and supportive care.

Lakin, Hill, & Bruininks, (1988) estimated institutional and community-based residential facilities for the mentally retarded spent over three billion in 1982 to provide residential care personnel to over 244,000 mentally retarded persons in all
types of residential facilities. Persons providing direct care constitute most of the total personnel in such facilities. Nearly 135,000 direct care staff serve in full-time positions (Lakin & Bruininks, 1981). The analyzed salaries of residential care providers show clearly that the industry is labor intensive. Most of the funds allocated to residential services are paid directly to the people who provide it. The goals and purposes for each residential program, the needs and characteristics of the residents, and the qualities of the staff are interrelated. Therefore, the welfare, experiences, and accomplishments of the residents primarily depend upon the individual direct-care staff members.

Many facilities do not focus on meeting the needs of staff members. Lakin, Bruininks, Hill, and Hauber (1982) documented rates of turnover at 55%-75% annually. Detrimental effects include discontinuity of treatment and care, chronic low productivity and staff shortages, the administrative intensity of personnel replacement process, and direct cost of personnel replacement (Baker, Seltzer, & Seltzer, 1977; George & Baumeister, 1981; Lakin & Bruininks, 1981; Levy, Levy, Freeman, Feiman, & Samowitz, 1988; Zaharia & Baumeister, 1978). Lakin (1988) reported that no matter which variables were associated with staff turnover, three were consistent predictors of turnover. They included compensation, advancement, and opportunities for other employment in the area. Lakin (1988) also suggested that human service providers could never dictate resources. Rather, administrators should be aware of six primary causes of turnover: (a) Failing to maximize use of people who promise stability, (b) Failing to maximize new and potential employee knowledge and ability to
perform the job, (c) Failing to communicate that direct-care staff are valuable and valued, (d) Failing to maximize potentially attractive aspects of the direct-care role, (e) Failing to ensure that positions are well-designed and adequately supplemented, and (f) Failing to maximize compensation to employees.

Many programs for managing direct-care personnel exist. Traditionally, heavily supervised programs of contingent feedback, vocal control, posted write-ups, and behavior lotteries have characterized this area of human resource management (see Brown, Willis, & Reid, 1981; Green et al., 1978; Panyan, Boozer, & Morris, 1970; Iwata, Baily, Brown, Foshee, & Alpern, 1976; Patterson, Griffin, & Panyan, 1976). Gladstone and Sherman (1975) suggested focus on participative management was beneficial. Less professional time and financial investments occurred if employees were given the opportunity to manage their own work-related behavior. Burgio, Whitman, and Reid (1983) supported previous findings, asserting that changes in direct care staff, and consequently resident behaviors, were obtained through the use of a participative management system that required little supervisory input. By self-monitoring their use of contingent interaction, or approval of appropriate resident interaction, staff effectively improved their work performance while reducing inappropriate resident behavior (Burgio et al., 1983).

The researchers further suggested one of the most important elements that affected program outcomes concerned staff attitudes regarding consumers. They found that group home staff were the most committed to the program’s implementation. It was staff’s understanding, interpretation, and practice which determines the direction of the
program plans developed for the retarded consumers (Rhodes & Browning, 1982). Their findings supported two earlier reports from Blindert (1975) and Harmatz (1973).

Consistent with providing direct-care personnel, the service delivery system is responsible for providing specialized staff for resident care. Community residences can utilize consultants from diverse fields such as physical therapy, recreation, nutrition, medicine, social work, and psychology. Consultants such as these serve two functions: program development for residents and staff development. Behavioral consulting is among the most important aspects of service delivery. Reid, Wilson, and Faw (1983) clearly indicated that behavioral procedures can be used effectively to teach self-help and community living skills to mentally retarded individuals. Further, staff can be taught to implement behavioral procedures in an effective way. State regulatory agencies often require community residences to maintain records on resident goals, progress, and programs in the form of individualized program plans.

I hypothesize that staff attitudes toward consumers affects service delivery. This hypothesis is upheld by the research of Rhodes and Browning (1982), which is reviewed above.

Overall, direct-care given to the clients plays an integral role in service delivery. Though some have disagreed (see Brown et al., 1981; Shoemaker & Reid, 1980; Green et al., 1978; Panyan et al., 1970; Iwata et al., 1976), three measures to ensure effective care have been targeted: (1) meeting staff needs, (2) self-monitoring, and (3) provision of specialized services. Combining such measures will result in improved quality of life for the clients, which is the aim of effective service delivery.
The Hypotheses

This section reviews the hypotheses that I drew from my review of the literature. The independent variables that appear to affect service delivery are financing care, habilitation services, and direct and supportive care. I based these hypotheses on the components that constitute these independent variables.

Financing care.

Hypothesis 1: The funding method of the HCS system provides a higher level of effective service than the funding method of the ICF/MR system. This hypothesis was based on the previous reports that stated directing funds toward non-institutional, community based systems provided cost-effective, individualized services (Braddock et al., 1987; Fernald, 1986; S.1673, 1988).

Hypothesis 2: Targeting funds for the benefit of the consumers provides a high level of effective services. Fernald (1986) substantiated this hypothesis with research that suggested targeting specific client costs and needs in a variety of living situations is presently a priority.

Habilitation programming.

Hypothesis 3: Utilizing program analysis improves the quality of services delivered. This hypothesis is supported by Guba and Lincoln (1981), Hawkins et al. (1981), Krapfl (1975), and Schalock (1983), who determined analysis benefits the measurement of program impact, the assessment of the efficacy of different methods of service delivery, the provision of accountability for continuation of funding, and the identification of program elements associated with different outcomes.
Direct/supportive care.

Hypothesis 4: Staff attitudes toward consumers affects service delivery. This hypothesis is upheld by Rhodes and Browning (1982). They indicated it was staff's understanding, interpretation, and practice which determines the direction and success of the program plans developed for the retarded consumers.

Table 2: Hypotheses of Service Delivery

<table>
<thead>
<tr>
<th>FACTORS</th>
<th>HYPOTHESES</th>
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<tr>
<td>Financing Care</td>
<td>The funding method of the HCS system provides a higher level of effective service than the funding method of the ICF/MR system. Targeting funds for the benefit of the consumers provides a high level of effective services.</td>
</tr>
<tr>
<td>Habilitation Services</td>
<td>Utilizing program analysis improves the quality of services delivered.</td>
</tr>
<tr>
<td>Direct/Supportive Care</td>
<td>Staff attitudes toward consumers affects service delivery.</td>
</tr>
</tbody>
</table>

Chapter Summary

This chapter provides the theoretical and conceptual foundations for this study. First, I covered the Contradiction Model. The organizational perspective will enhance this study by providing a holistic view of the processes, contradictions, behaviors, and realities of each organization. Next, I investigated the varied definitions of service delivery to the mentally retarded. I selected the Care model that promotes total service delivery. This model promotes effective methods for providing ethical and equal services. Based on this model and review of the studies, I define service delivery as whether or not the goals of the organization are being met, whether or not
the personnel and clientele are satisfied, the organization's ability to acquire and utilize resources, and whether or not the members of the organization agree on what the organization is doing and how it is doing it. Each of these aspects of delivery involves implicit contradictions. Therefore, the Contradiction Model will help explain the variations in these contradictions. Finally, I selected three indicators of effective service delivery. They are financing care, habilitation services, and direct and supportive care. Figure 1 provides an overview of these variables. Table 2 summarizes the hypotheses associated with each independent variable. I will discuss specific measures of these factors in Chapter III.
CHAPTER III

METHODOLOGY

Introduction

This chapter begins with a brief description of the settings of the three organizations used for the analysis in this study. This is followed by a discussion of data collection procedures. I conclude with a review of the limitations of the study.

The Setting

Three programs serve as the basis for this study. Two programs are classified as ICF/MR Level 6 facilities in the state of Texas. To be classified as Level 6, the facilities serve low functioning severe and profound mentally retarded individuals. The third program operates within the HCS (Medicaid Home and Community-Based Services) system and serves all levels of mentally retarded individuals, from profound to mild diagnoses. Because each facility is part of a corporation, an organizational chart is provided to enable a better perspective on the specific position the facility holds within its respective corporation.
I have been previously employed by each program within the past four years. I served in a non-professional capacity in two of the organizations, and in a professional capacity in the third. I maintained personal contacts and acquaintances at each facility. These contacts were utilized to gain entry into the organizations. Because I worked as both a professional and non-professional, rapport was easily established at all levels in each organization.

**Data Gathering**

Each organization had written policies and procedures for granting permission for research. In both ICF/MR programs, I was required to submit a written proposal. I also attended a Human Rights Committee meeting to gain approval for research at each facility. The purpose of the committee is to review any treatment, therapy, and/or programming that concerns the clients in the facility, especially if it concerns possible violation of client's rights. All organizations were assured of confidentiality, told of the benefits of such a study, and assured of respect for client's rights. Each organization granted written approval. The policies of the HCS program did not require Human Rights approval due to the "organizational" nature of the study. Written approval was granted from the HCS program coordinator after verbal approval was obtained from the CEO of the regional offices.

I obtained Informed Consents from staff participating in the study. The consent explained that participation was not mandatory and would not affect employment with the organization. It stated participants would be observed and interviewed with questions relating to job roles and overall program effectiveness. It ensured
confidentiality would be respected at all times and the participants names would not be used. Finally, it informed the participants that they could withdraw from the study at any time and the consent would be void.

The dependent variable is service delivery. Three data gathering techniques measured effective delivery: interviews, observations, and document analysis. They will be discussed in the following sections. The following sampling method describes criteria for participation in the study.

**Sampling.**

Selectivity in participant observation is inevitable (Babbie, 1990). To obtain a true representation of each organization, I attempted to speak with staff from each level of the hierarchy. The administrators, program directors, social workers, qualified mental retardation professionals (QMRPs), and direct care staff participated in the interviews. The number of staff interviewed for each organization varied, based on willingness to participate and size of the organization.

I assessed each organization over a period of eight months. In order to present an overall picture of service delivery, I obtained interviews from both professional and non-professional providers. For the 106 bed program, I interviewed 18 staff members. This program was the largest of the three. Due to the number of employees, many staff were available for interviews. For the 6 bed program, I interviewed 8 staff members. I interviewed 12 staff members from the HCS program. Though this program had the fewest staff members, they were the most willing to interview.

Respondents and informants participating in the study were anonymous. Therefore,
material is presented by case study so that all the important data remain complete. Organizational or materials that may identify the participants are obscured without reducing the caliber of the data. If their identity were revealed, members of the organizations may not have given truthful impressions of their experiences (Babbie 1990).

**Interviews.**

The interviews consist of structured, open-ended questions. Several questions taken from previous studies ensured reliability and validity. (Appendix B provides a list of the concepts measured and the specific questions used to measure each concept. Most questions were modified for the qualitative interview format.) Questions focus on intraorganizational characteristics, intraorganizational relationships, and perception of client care. Other questions focus upon activities, knowledge, and tasks of personnel, activities provided to the clients, planning and preparation for specified roles, intraorganizational relationships and roles concerning outside resources, and overall perception of care. Some questions targeted decision-making, perception of goals, and control over such issues.

Financing care, habilitation services, and direct and supportive care affected service delivery. These variables included certain components. They are discussed in the following section.

First, I discuss service delivery systems (ICF/MR and HCS), state policies, and budgets as components of financing care. To measure service delivery systems, I use two original questions relating to the type of funding utilized by the ICF/MR and HCS
systems. To measure state policies, I use two original questions that concern distributing resources and the practice of restricting beds. Lastly, I measure budgets using two previously tested questions from Alexander (1978). They asked about expenditures in terms of benefits, and responsibility of cost reduction.

Second, I use the concepts of state survey accreditation, active treatment, and program analysis as components of habilitation services. I measure state accreditation by four questions. Two have been tested before by Reid et al. (1991). The questions concerned staff preparation for survey, and the effect of survey on services delivered. I measure active treatment with three original questions pertaining to normalization, client goals, and age appropriateness. Finally, I measure program analysis with six questions. Heller (1988), Hackman and Oldham (1980), and Yeatts, Beyerlein, and Thibodeaux (1991) previously tested four of the questions. They cover staff input, program reviews, and training of staff.

Third, I use the goals and purposes of the programs, staff attitudes regarding consumers, and staff incentives as components of direct and supportive care. I measure purposes of the programs with three questions. Two were tested by Hackman and Oldham (1980), and Yeatts et al., (1991). These questions related to information flow within the program and meeting the goals of the program. I measure staff attitudes regarding the consumers with two questions. One is original. Alexander (1978) tested the other. The questions examine ensuring adequate services and staff perception of services delivered. Lastly, I measure staff incentives with three questions. Two were previously tested by Hackman and Oldham (1980); one is
Observations.

My familiarity allowed for systematic observations of organizational activities and the actors involved. Research efforts included spending time in various organizational settings in each separate case (e.g., central offices, within the various homes and facilities, workshop settings). For each facility, I made observations of each daily shift. This resulted in a more complete perspective of organizational activities. First, observational data allows for a point of comparison with participant perceptions of organizational characteristics and activities with the researcher’s own observations. Second, it enables the researcher to investigate interrelationships between the elements of the whole (i.e., interaction between residents and staff, impact of training experiences, influence of peer culture, implicit messages the organization gives about itself in the training process) (Light, 1983). Finally, observation allows the researcher the flexibility to discover. Categories tend to emerge from what is actually happening, rather than from preconceived ideas. Therefore, observations allow the researcher to develop hypotheses, test them, alter them, and retest them while the study is in progress (Glaser & Strauss, 1967).

Documents.

Documents are the final data gathering source. These documents include organizational policies and procedures, documents dispersed by the organization, memos, federal and state operating regulations, and media reports. I use policies and
procedures set forth by the organizations to compare what I observe with what the organization is hoping to accomplish. I make use of documents dispersed by the organization to look at the image it portrays. I am also interested in the information that is conveyed through these documents and memos. Federal and state regulations aid in evaluating various aspects of the organization (i.e., Does the organization follow regulations? How does it adjust to these types of constraints?). Finally, media reports are useful to assess service delivery as conveyed to the public (i.e., Special Olympic participation, reports of staff that had been jailed, etc.).

The use of interviews, observations, and documents improves the reliability and validity of the data presented by creating what can be labeled "triangulation" (Jick, 1983). The most common use of triangulation is cross validation when two or more distinct methods are found to be comparable and indicate similar data (Denzin, 1978). When researching an organization, this means using multiple methods to look at the same characteristics of a research question (i.e., program effectiveness can be determined by interviewing staff, observing training, and analyzing documentation). The basic assumption of triangulation is that it compensates for the weakness of one method by counter-balancing the strengths of another. Although methods have positive and negative aspects, triangulation is used to exploit the assets and offset the handicaps of each method (Jick, 1983). By using triangulation to integrate multiple data collection methods, a more holistic portrayal of the organization under study can be captured.

Inherent in any discussion of effectiveness is the idea that effectiveness as a
concept contains contradictions (Hall, 1987). This was fully reviewed in Chapter II with the explanation of the Contradiction Model. However, for the purposes of this study, qualitative data constricted the effectiveness of each of the organizations into three categories. These categories were low, moderate, and high levels of effectiveness. A few concepts were considered that aided in this categorization process. I contemplated whether or not the goals of the organizations were met, the organizations ability to acquire and utilize resources, whether or not the personnel and clientele were satisfied, and whether or not there was agreement among the members of the organizations about what the organizations were doing and how they were doing it. I then compared the organizations to determine in which category they belonged. This method provides a comprehensive means of viewing related data.

Limitations

This study had multiple limitations due to a collection of factors. The nature of the qualitative researcher role involves biases and errors. The participants in the research also affect limitations.

Because I have worked in each of the facilities, I brought my own perceptions and attitudes to the research. Though I took every precaution to remain a neutral party, biases emerging from past experiences inadvertently entered into the observations. Errors in recording observations and recalling incidences when writing field notes are also a part of the limitations in qualitative analysis. I continually questioned whether or not I saw or heard an incident accurately. I further had to question the truth of the accounts given me in interviewing sessions. Accuracy was determined, in part, by
consistency between independent reports. However, objective documents (e.g., newspaper articles, company memos) balanced the subjectivity of the observations. On many occasions, these documents supported my own perception of events.

Limitations are also inherent in observations of events. The participants are more likely to act and react in a different manner when there is an observer present (Lofland & Lofland, 1984). Therefore, my presence may have affected the quality of some data taken, especially when staff members were aware there was a supervisor present.

Finally, my use of a structured interview format may have limited the "richness" of the data. Though this format directs the participant's answers, spontaneous thoughts may be suppressed in order to answer the "right way." Further, I had no method by which to screen sources of information. I attempted to interview at all levels of the organization, but some key respondents may have been overlooked. In spite of these limitations, the use of triangulation, as previously discussed, aided in the quality and validity of the study.

Chapter Summary

In Chapter III, I described the settings of the three organizations used for the analysis in this study. I discussed data collection procedures. I concluded with a review of the limitations of the study.

In Chapter IV, I provide a case study of each of the facilities beginning with general characteristics. I will then proceed through the components that affect delivery. Finally, an analysis of each case can be found in Chapter V.
CHAPTER IV

CASE STUDIES

Introduction

The following chapter provides a case study of each of the organizations. I begin with general characteristics of each facility. I then describe how the independent variables affect the services delivered by that facility.

"Facility A" Case Study

General characteristics.

Facility A is a 106 bed, privately owned organization, part of a chain of seven "institutions" in Texas. The administrative staff on-site consists of an administrator (non-licensed), a director of nurses (L.V.N.), a social worker, four department heads, and three qualified mental retardation professionals (QMRP's). The floor staff consists of a nurse, a supervisor, and twelve direct care positions for each shift: 6:00 a.m.-2:00 p.m., 2:00 p.m.-10:00 p.m., and 10:00 p.m.-6:00 a.m. The direct care staff works a four day on- two day off pattern. Four bathers work each day 10:00 a.m.-6:00 p.m., and bathe all the residents in the building. Also, there are five "teachers"
and one supervisor responsible for pre-vocational training of "higher-level" residents. Teachers work 8:00 a.m.-4:00 p.m. Monday through Friday at an off-site facility that belongs to the organization. The residents are not paid for their training at the "workshop." Recreation staff aids in specific training of physical fitness and leisure skills. They work 9:00 a.m.-5:00 p.m. each day of the week. Staff to client ratio is six to seven clients to each staff person, not including the recreation aides.

Because the facility operates under the ICF/MR system, the individuals in the facility have thirty dollars per month out of their Supplemental Security Income (SSI) check as a trust fund for their own "personal" use. This money is used for clothing, televisions, radios, magazines- any "extra" item that is not a primary need. The facility is expected to take care of other necessary items (e.g., food, furnishings, grooming supplies).

This organization most reflects an "institution." Training in areas such as housekeeping, laundry, meal preparation, self-medication, and structure of leisure time is minimal. The facility focuses upon training in basic hygiene and living skills.

Staffed nurses (L.V.N.s) and provider contracts supply health care services. A psychologist visits the facility once per week to track those individuals who are on a formal behavior plan to control "inappropriate" actions, and to "counsel" when required. A psychiatrist visits once per month (on a Saturday morning) to monitor any psychotropic medication used to control resident behavior. One time each month, a dentist, optometrist, and podiatrist assess and provide services for approximately thirty residents at a time. "Trained" staff provide daily occupational, physical, and speech
therapy. The consulting professionals monitor progress once every month.

**Financing.**

As previously explained, determining a Level of Care for each individual provides funds. Where the funds are utilized is not regulated. In the case of Facility A, the parent corporation provides a budget for operating costs. The administrator adjusts resources to suit organizational needs. For example, if the Housekeeping department needed extra mattresses but could not afford them, the Programming department would provide for the expense from their monthly budget.

The company itself provides no benefits or insurance to anyone other than salaried personnel. Salaried personnel consists of the administrator, the accountant, the three QMRPs, and the four department heads. Floor nurses, direct care staff, bathers, kitchen personnel, and secretaries are not offered benefits.

Further, trust funds are an option available to each client. The bookkeeper directs thirty dollars per month of SSI benefits to the trust fund. The facility does not provide clothing unless the trust fund is inadequate in meeting that client's needs. "Need" is determined by lack of shoes, lack of a coat, lack of undergarments, etc. The housekeeping staff purchases garments in bulk. Many clients have similar shoes, clothes, and undergarments.

**Habilitation services.**

Habilitation programming, or training the clients to take care of themselves, is one of the basic functions of an ICF/MR facility. To accomplish this goal, each client must be assessed in every possible area of functioning, from brushing their teeth to
sex education. Once the priority needs of each individual have been established by an interdisciplinary team, the QMRP develops individual program plans that address these areas. Federal regulations also specify that each client must receive a continuous active treatment program. "Continuous active treatment" ensures that the individual is taught skills and interacted with appropriately in all areas of functioning, not just the areas targeted in his IPP (individual program plan).

In Facility A, programming is planned by three QMRPs, a Program Director, and the off-site facility supervisor. Clients in the building get dressed in the mornings, are placed in a classroom until breakfast, and attend class for the rest of the day. The morning class lasts from 9:00 a.m. to 11:00 a.m. Each classroom is assigned fourteen residents. Seven out of the class attend recreation. The seven that remain are trained on oral hygiene, grooming (e.g., wash face, brush hair), shaving, setting a table, folding clothes, and specific IPP goals. There are two trainers in each classroom. While one trainer takes one client at a time to the client's room to train on grooming, oral hygiene, and shaving, the other trainer is responsible for the other six (or more) resident's training. The afternoon class lasts from 2:00 p.m.-4:00 p.m. At that time, the seven clients that trained in the morning class attend recreation, and the seven that attended morning recreation go to class.

The off-site facility provides training for approximately thirty-five residents. The clients place objects into containers, match colors and shapes, place items into envelopes to mail, craft leather items, use a token economy program, and use tools. The supervisor of the off-site facility ensures proper training, and was instrumental in
establishing the program. Trainers interview for their positions, and are paid more than staff at the main facility.

Training in the areas of washing clothes, washing dishes, vacuuming, dusting, making beds, cleaning bathrooms, self-administration of medication, money management, and integration into the community are limited.

Direct/supportive care.

Direct care is a close relative of habilitation in the ICF/MR field. Focus on direct care staff is critical because of the importance of their impact on the day-to-day welfare of the residents in Facility A.

Direct care staff is hired if their application is complete, they have no criminal history, and their references are good. There is no "interviewing" for these positions. The staff attend a training session of approximately seven hours in the conference room for one day. They are put on the schedule, and another direct care worker trains them on their first day. Continued training consists of weekly inservices on specific problems and the same information provided in the initial training session.

Contracting professionals provide supportive care. Emergency rooms, doctors at public hospitals that take Medicaid, and contracted services (i.e., labs for bloodwork, orthodontic needs, etc.) provide services not performed "on-campus." The nursing department staffs a "medical driver" to transport the clients. If the driver is off-duty or is otherwise occupied, the QMRP who has the client on her/his caseload takes the resident where he/she needs to go. After hours, the QMRP on-call provides transportation for all medical "emergencies."
"Facility B" Case Study

General characteristics.

Facility B is a six bed group home in Texas, part of a national organization of services for the mentally retarded. The administrative staff have offices away from the home. The staff consists of a QMRP, an R.N., and two home managers (for each home in the area). Direct care staff is composed of three to four persons who work 6:00 a.m.-9:00 a.m., 3:00 p.m.-9:00 p.m., and 11:00 p.m.-6:00 a.m., and one medication aide who arrives in the morning and evening to give medications. Staff schedules are altered for time conflicts, usually by thirty minute periods. The staff is scheduled on certain days and work no rotating shifts unless they request to do so. Residents attend a pre-vocational and vocational workshop during the day from 9:00 a.m.-3:00 p.m. The workshop contracts with the facility, and the residents are paid bi-monthly for the work they accomplish.

Levels of Care determine client finances. The resident has thirty dollars per month from SSI benefits. The secretary places this money in a trust fund upon consumer request. The individuals work for wages. Their "paycheck" is deposited in the trust fund, or spent as they wish. Furthermore, the facility accepts donations from the community. Donations provide "extras" to those clients who are in need of them. The staff and clients sell candy at Christmas to help support the national organization.

The organization reflects a group home. Clients train on basic meal preparation, housekeeping, laundry, time management, and hygiene skills. Though goals are specific, training in general does not revolve around hygiene and living skills. The
program encompasses a variety of targeted needs. The consumers receive formal training from 5:30 a.m.-9:00 a.m. and 3:00 p.m.-10:00 p.m. Three alternate with meal preparation, while three work on formal IPPs. The consumers who are unable to bathe themselves without supervision are aided from approximately 6:00 p.m.-9:30 p.m.

Aides bathe some residents in the evening, and bathe others in the morning, depending on specific need.

The R.N., medication aide, and contracting professionals supply health care. The psychologist, psychiatrist, and any other needed specialists provide telephone orders. The consumers are taken to the respective office, rather than the service coming to the home. These professionals see the residents once every three months (quarterly). The QMRP counsels with the clients on separate behavioral issues. Direct care staff transport clients in minor medical emergencies. The QMRP and nurse are notified but not required to be present. The QMRP, nurse, and two home managers rotate "on-call" responsibilities.

Financing.

The secretary, who serves as a bookkeeper, records finances. The house stays on a budget to control expenditures. Grocery bills are not to exceed $170 per week. Gas is purchased by direct care staff on a credit card, and the secretary records the receipts. The organization maintains accounts at area grocery, hardware, and general supply stores. These stores have a list of who is authorized to make purchases.

The residents participate in a sheltered workshop that provides pre-vocational training. The facility contracts with the workshop. The contract specifies a certain
amount the facility pays to the workshop for each client that is placed there. Clients are paid for the amount of work they produce. If one client completes 500 bags of screws, and another client completes 20 bags of screws, they will be paid according to the number they bagged (i.e., five cents a bag). Clients use this money for personal purchases.

The facility hires slightly above minimum wage. Full-time employees are offered full benefits. Part-time employees are not offered benefits. If staff works overtime, they receive time-and-a-half for their services.

The facility does not provide clothing unless the trust fund is inadequate in meeting that client’s needs. "Need" is determined by lack of shoes, lack of a coat, lack of undergarments, etc. When an item is needed, the consumer is taken shopping to try on, and, if able, pick out his own clothes.

Habilitation services.

Since Facility B is an ICF/MR organization, training the clients to take care of themselves is one of its basic functions. To accomplish this goal, each client must be assessed in every possible area of functioning, from brushing their teeth to sex education. Once the priority needs of each individual have been established by an interdisciplinary team, the QMRP develops individual program plans that address these areas. Federal regulations also specify that each client must receive a continuous active treatment program. The goal of "continuous active treatment" ensures the individual is taught skills and interacted with appropriately in all areas of functioning, not just the areas targeted in his IPP (individual program plan).
The QMRP establishes habilitation programming for the six clients. She schedules for only six to seven hours of training at the home, because her clients are enrolled in a workshop. Training in the facility includes housekeeping skills (e.g., doing laundry, making beds, taking out the trash), money management, cooking skills, and community integration. Leisure time is in the evenings. Some consumers watch television, some throw balls with staff, others play a piano, and some work on goals.

Three staff provide continuous active treatment in Facility B for the six clients. When formal training is in progress, there are two clients with one aide. When a client begins to engage in an off-task behavior, staff response is quick and to the point. At times, responses were observed to be simultaneous from two staff members. The majority of the time, the observed resident is corrected when he is not performing a task properly or is engaging in inappropriate behavior.

**Direct/supportive care.**

Direct care is closely related to habilitation in the ICF/MR field. Focus on direct care staff is critical because of the importance of their impact on the day-to-day welfare of the residents in Facility B. Staff in Facility B is hired through a process of interviews. All areas of the organization are covered in a two week training period. The staff must also attend First Aid, CPR, and PMAB (Physical Management of Aggressive Behaviors) classes within their first two months of hire. These classes are offered through the state funded Mental Health/Mental Retardation Center in that region. If a staff member is unable to attend day training, First Aid and CPR are offered in the evenings at the community hospital. The training supervisor at the
MHMR center schedules all night PMAB classes if there is enough interest. This serves to supplement the training received at the hospital.

The QMRP has a copy of all regulations, policies, and procedures. The program itself was recently accredited by a national accreditation organization. Document analysis and interviews revealed that informed consents were distributed and received in the correct order.

The R.N., the medication aide, and direct care staff provide health services. The R.N. is the primary provider. She sets up appointments, transports clients, and orders medications. The medication aide comes to the home from approximately 6:00 a.m.-8:00 a.m. and 7:00 p.m.-9:00 p.m. Treatment time dictates her schedule. She also serves as a direct care staff when she wants to earn extra money or is needed. Because the direct care staff is certified in First Aid and CPR, they treat minor injuries (i.e., scrapes, burns, heat rashes, minor cuts, mosquito bites). They also perform emergency life-saving measures (i.e., CPR, rescue breathing, taking pulses).

The facility contracts with supportive care providers. The consumers are taken to the specific doctor's office they are in need of seeing. The consumers see the dentist, podiatrist, and physician as needed. The psychologist and psychiatrist monitor quarterly progress. During the entire study, there was no apparent OT, PT, speech, or sign language training done on the premises.

"Facility C" Case Study

General characteristics.

Facility C is a state operated program, also in Texas. The home itself is part of
the HCS program. Waiver services from Medicaid fund the program. The attractive aspect of this service is that the participant does not have to be taken out of his or her current living conditions to be eligible. Any person with an IQ of 69 or below is eligible for the HCS program. The cluster approach is used to provide individualized services. The components of the cluster include a core residence, in-home support services, and alternative residences. This is to say that the program is designed to cater to the needs of that individual in his unique situation. If the individual wishes to remain at home, services are delivered through the program to the individual in the least intrusive manner possible. If the individual requires a placement, the program provides viable alternatives to the "institutional" setting. The goal of the program is to extend services to the individual where they live. The individual maintains ties with family, friends, and home community. Natural and familiar surroundings aid in the desired outcome for each individual-a useful and productive life.

Need for services is indicated in the Individual Service Plan developed by the individual and the Interdisciplinary team upon the individual's enrollment into the program. Specific services are provided for each individual. The following list of services is reimbursable through the program: Case management services, Respite services (allows the consumers an alternate place to go when they are tired of their current situation and need to get away for a few days), Homemaker services (allows funds for modifying a home- i.e., widening doors for wheelchairs), Dietary services, Adaptive aids, Nursing services, Habilitation services (training), Occupational Therapy services, Physical Therapy services, Speech and Audiology services, Psychology
services, and Social services.

Two participants resided in the specific facility that I observed. Both were classified as Level VI (severe range of mental retardation). The off-site staff consisted of the HCS program coordinator, the case manager for the two residents, service providers, and office staff. A total of five direct care workers worked with the clients. The on-site staff worked shifts of 6:00 a.m.-9:00 a.m., 3:00 p.m.-11:00 p.m., and 11:00 p.m.-7:00 a.m. Weekend shifts varied to suit the needs of the residents.

**Financing.**

As previously mentioned, waivers finance most services. Medicaid funding provides for consumers required services. These residents are required to be enrolled in a day program of some sort; whatever is best suited for that individual. The two observed individuals attended a sheltered workshop that meets their needs. They receive wages for the work they perform.

Part of the HCS program includes training in managing finances. These consumers manage their own money to the best of their abilities. Part of the responsibility of the case manager is to aid the clients in establishing a working budget. If they are unable to manage funds, a designated person may aid them. Money from federal aid (SSI) is deposited into a checking account. Room and board is paid by the client from the checking account. The secretary provides quarterly reports of finances to each client. The consumers are responsible for balancing their checkbooks each month. They also keep a running record of petty cash and expenditures.
The staff, both full and part-time, work on a salary basis. The staff is compensated at a lower rate than other areas of the state due to the location of the program. However, the cost of living in the area is considerably lower than competing sectors of the state. Both full and part-time staff are offered benefits. They include medical, dental, and retirement plans. Alternate plans are also offered to those who are interested (i.e., IRAs, money market accounts).

As previously stated, the consumers are responsible for their own room and board, as long as they reside in a living unit outside their original "home." This means that they are required to attend day programming (have a job) to help pay for their bills. Federal aid covers those individuals who still attend school. The HCS program ensures that each consumer is not in need of items essential to survival (e.g., food, clothes, etc.). If a client’s funds are short, he will not "do without." The program will ensure she/he is provided for. HCS also takes care of transportation expenses. Each house has a company car. Credit cards purchase gas, and direct care staff is required to fill out mileage, service, and gas purchasing reports.

Respite services are provided free of charge to all persons participating in the program, regardless of their living arrangement. Respite is the only waiver service in the program that includes room and board. This service provides a place where residents can get away from their situation for a few days. Respite is limited to thirty days per year for each individual. The clients are still provided the other services outlined in their Individual Service Plans during their stay at a respite house.
Habilitation services.

"Evidencery Standards" regulated by state agencies (i.e., HICFA, TDHS) govern habilitation programming. These standards are unique in that they allow the individuals a great deal of freedom determining their program goals and objectives. After an Interdisciplinary team and the individual determine priority needs, the case manager develops Individual Service Plans. The plans address what waiver services the consumer will receive, as well as program objectives for the following year.

The case manager ensures all programs are complete and updated. Case managers assess the individual. They develop the Individual Service Plan and coordinate the person's Individual Care Plan. They are the primary monitors of service delivery in the program. Because they understand the needs of their individual case loads, they are able to coordinate resources that will provide for those needs. They also maintain records on each individual's progress and evaluate whether service delivery is in compliance with state standards.

Specific employees are hired to provide habilitation training to the clients. They are called "habilitative service providers." They are compensated at a higher wage than direct care staff. Their responsibilities include scheduling newly hired staff for training, testing competency of staff, scheduling staff for ongoing training, and recording documentation on training they provide the individuals.

A sheltered workshop provides day programming. Pre-vocational and vocational training is given. The consumers are compensated for the work they perform. For example, if a client folds fifty boxes per week, he will be compensated for the boxes
he folds. Therefore, the more work he performs, the more money he receives. Also, individuals determine their own leisure activities. They are provided with information on activities, but are not required to attend.

**Direct/supportive care.**

Facility C hires direct care staff through an interview process. Interviewees meet with the program director, case manager, and habilitative provider to discuss the job responsibilities and needs of the individuals. If hired, they must attend two weeks of training before they work with anyone in the program. Facility C is state funded, and a great deal is invested in staff training. Employees attend initial training in PMAB, First Aid, CPR, AIDS prevention, and a series of related sessions that teach them how to work with the individuals in the program. If there is a need, they perform emergency life-saving measures (i.e., CPR, rescue breathing). They treat minor injuries that may occur in the homes.

The Individual Care Plan prescribes supportive care. As previously mentioned, the Medicaid HCS program funds these services through waivers. Nurses were observed coming to the facility once per week, but were also available to the clients by telephone. The case manager ensured that appointments were set for required procedures, and that proper services were delivered.

**Chapter Summary**

In the previous chapter, I provided a case study of each of the facilities beginning with general characteristics. I proceeded through the independent variables that affect delivery.

In Chapter V I will analyze the case studies by looking at each independent
variable involved. I will also review the hypotheses and discuss the effectiveness of each organization.
CHAPTER V

ANALYSIS

Introduction

In Chapter V, I discuss the variables hypothesized to affect service delivery. Next, I review specific hypotheses used in the study. To conclude, I discuss the variables that affect service delivery. They are program analysis, staff attitudes, service delivery systems, and budgets.

Before I discuss specific variables, I will review the criteria by which I defined effective service delivery. Chapter III stated that I classified effectiveness of each organization as high, moderate, and low. I placed the organizations in the categories by the following standards: whether or not the goals of the organizations were being met, whether or not the personnel and clientele were satisfied, the organizations ability to acquire and utilize resources, and whether or not the members of the organizations agreed on what the organizations were doing and how they were doing it. Service delivery is epitomized by these standards. How an organization addressed these issues defined effectiveness for that organization.
Table 3 provides an overview of the variables that substantiate effective services are being delivered. I will focus on the indicator of program analysis. The characteristics of program analysis are methods of service delivery, funding, and program elements and outcomes.

Table 3: Indicators of Effective Service Delivery

<table>
<thead>
<tr>
<th>INDICATOR</th>
<th>CHARACTERISTICS</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active Treatment</td>
<td>Independence training in self-help, leisure, social communication, &amp;</td>
<td>Evaluate staff knowledge of client goals, normalization, least</td>
</tr>
<tr>
<td></td>
<td>community living skills in the least restrictive environment.</td>
<td>restrictive environment, &amp; age appropriateness.</td>
</tr>
<tr>
<td>Program Analysis</td>
<td>Methods of service delivery, funding, program elements &amp; outcomes.</td>
<td>Assess methods of staff input, periodic reviews, adequacy of staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>training, &amp; effect of program on consumers.</td>
</tr>
<tr>
<td>Staff Incentives</td>
<td>Provision for compensation, advancement, &amp; job satisfaction.</td>
<td>Evaluate company benefits, advancement opportunities, job preparation.</td>
</tr>
</tbody>
</table>

Table 4 provides an overview of the variables that cause service delivery. I will focus on service delivery systems, budgets, and staff attitudes. The characteristics of service delivery systems are provisions of health and rehabilitative services for mentally retarded individuals. The characteristics of budgets are allocations of funds for service delivery. The characteristics of staff attitudes regarding consumers are provision for the welfare, experiences, and accomplishments of the consumers.
Table 4: Causes of Effective Service Delivery

<table>
<thead>
<tr>
<th>CAUSES</th>
<th>CHARACTERISTICS</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Service Delivery Systems</td>
<td>Provision of health or rehabilitative services for mentally retarded individuals.</td>
<td>Evaluate funding methods &amp; variations of services delivered.</td>
</tr>
<tr>
<td>State Policies</td>
<td>Methods of controlling service delivery systems.</td>
<td>Assess equal distribution of resources &amp; growth restrictions.</td>
</tr>
<tr>
<td>Budgets</td>
<td>Allocation of funds for service delivery.</td>
<td>Appraise expenditures in terms of consumer benefits &amp; responsibility of cost reduction.</td>
</tr>
<tr>
<td>Goals/Purposes of Program</td>
<td>Objectives to facilitate treatment outcomes.</td>
<td>Assess staff understanding of individual program plans &amp; strategies of implementation.</td>
</tr>
</tbody>
</table>

For each of the independent variables, I will first discuss the measures I used to determine their existence. I will then examine the effectiveness of the organizations based on each indicator. Overall effectiveness will be viewed as low, moderate, or high (see Chapter III for discussion of standards categorizing low, moderate, or high levels of effectiveness).

Independent Variables

Service delivery systems.

I hypothesized that the funding method of the HCS system provides a higher level of effective service than the funding method of the ICF/MR system. Braddock et al. (1987) distinguished between ICF/MR community service providers and ICF/MR institutional service providers. Organizations providing community services are defined as agencies with sixteen or less beds. In contrast, organizations providing institutional services are defined as agencies with sixteen or more beds. The two
ICFs/MR involved in my study will be evaluated according to this definition. Therefore, Facility A will be considered an institutional service provider. Facility B will be considered a community service provider.

Organization A

As an ICF/MR facility, Organization A receives retroactive Medicaid and SSI benefits for each consumer. Medicaid funds provide for services (i.e., health, psychological, physical therapy, etc.). Once the consumer has entered the facility, SSI benefits reduce to thirty dollars a month for personal use. The individuals can place this money in a trust fund. The trust fund furnishes the consumer with "spending money." Receipts are kept in order to track these expenditures.

The facility enjoys great freedom in deciding where to channel existing funds. The services provided by Facility A are unique to the organization. They provide no compensated day programming for any of their residents. Consequently, they save approximately $200 a day on each consumer by deferring contracts with sheltered employment organizations.

Only salaried personnel receive company benefits. Floor nurses, direct care staff, bathers, kitchen personnel, and secretaries are not offered benefits. This might not be such a concern to the staff if the company compensated in other ways, i.e. higher salaries. Yet, direct care is paid minimum wage for their work. Nurses are compensated at a lower rate than two similar organizations in the area. The administrator stated that she was in the process of attempting to get "at least a dental plan" for the non-salaried employees. She later stated that numerous former
administrators had submitted adequate plans for benefits, but the owners determined benefits for employees too expensive. Failing to target funds to this area affects the quality of employee the facility is able to hire. Low quality is directly reflected in the care provided the residents in the facility, which appears to be insufficient.

The facility also cuts costs by retaining unqualified personnel. The speech therapy assistant has no formal training in speech. She utilizes basic sign language- only simple words and phrases learned from a book. The "physical/occupational therapy assistant" has no training other than was given her by the former assistant, who also had no previous training other than from the consulting physical therapist. This does not present problems until client performance deteriorates, as is evident from document analysis. Client performance had decreased in each area when assistants recently changed. Likewise, lack of space, low quality supplies, and a meager programming budget suggest ineffectual concern for services delivered.

Organization B

As an ICF/MR facility, Organization B also receives retroactive Medicaid and SSI benefits for each consumer. Medicaid funds are responsible for providing services (i.e., health, psychological, physical therapy, etc.). Once the consumer has entered the facility, SSI benefits are cut to thirty dollars per month for personal use. The facility provides a trust fund for those individuals who wish to use it. The trust fund furnishes the consumer with "spending money." The secretary keeps receipts in order to track these expenditures.

Facility B elects to distribute their resources differently than Facility A. The
house is well cared for and appears to be in better condition. There are no torn
curtains or broken furniture, and it is decorated attractively (i.e., different styles of
bedspreads, wallpaper, paint, furnishings, shower curtains). Consumers receive extra
benefits. These include a basketball goal, picnic area, covered patio, private baths for
each room, and birthday parties.

Facility B provides benefits to full-time staff members. Staff is paid higher-than-
minimum wage. When questioned about satisfaction with pay and benefits, the staff
responded that they were not being paid enough, but the benefits were of some help.
Staff development also retained some of the facility’s funds. Hiring procedures and
concentration on staff development resulted in a better quality of staff. The facility
was further effective in using outside resources to save money (i.e., free training at the
community hospital).

Organization C

Because Facility C participated in the HCS system, their funding procedures were
dissimilar from Facility A or B. HCS provides for services based on a waiver
program. This means a service will be provided at a certain rate if the consumer
requires it. SSI is based on the individual financial status of the consumer. These
funds are directly applied to room and board costs. The consumers who participate in
the program have a job, which further contributes to boarding costs. The consumer
receives any existing funds after room and board payments. They may apply this
money to personal needs (i.e., haircuts, extra clothing, radios, televisions) or extra-
curricular activities. They can increase these funds by escalating job production.
Because the workshop compensates by "piece" of work completed, increased output results in increased pay. This waiver program appears to deliver the most individualized and effective services. Case management services ensure that residents receive treatment in each area of need. They further coordinate plans to address these areas, and follow up on any recommendations made by the IDT. Service providers record detailed accounts of contact with consumers. These accounts also exist as a tracking measure to ensure proper service delivery.

Hiring procedure, initial training, and continued training is exceptional. Quality benefits and higher salaries encourage staff stability. Therefore, consumers benefit from experienced, dedicated trainers who respect their roles as service providers.

Discussion

I hypothesized that the funding method of the HCS system provides a higher level of effective service than the funding method of the ICF/MR system. The definition provided by Braddock et al. (1987) distinguished between the two ICFs/MR that I reviewed.

I found Facility A, defined as an ICF/MR providing institutional care, to be low to moderately effective within the ICF/MR system. The lack of benefits, lack of day programming, and lower wages contributed to unqualified personnel.

I found Facility B, defined as a ICF/MR providing community based care, to be moderately to highly effective within the ICF/MR system. The facility and clients were well-cared for, benefits and training existed for staff, and the consumers were provided with certain "extras" lacking in Facility A.
Facility C was highly effective, existing within the HCS system. The waiver program provides for its participants well, as services are tailored to meet specific client needs. Facility training was exceptional, benefits were available to all staff, and trainers valued their roles as providers.

Summary

The hypothesis that the funding method of the HCS system provides a higher level of effective service than the funding method of the ICF/MR system is substantiated by my study. Facility A was found to be low to moderately effective. Facility B was found to be moderately to highly effective. Consumers in both programs received services ranging from inferior to adequate. Yet, the services in Facility C revealed a marked improvement, partly due to the HCS waiver system of service provision (see Table 5 for a summary of findings).

The first hypothesis is strongly supported by the three facilities. This finding suggests that the funding method of the system each facility participates in significantly affects the financial aspect of service delivery. Therefore, this independent variable, service delivery system financing, seriously impacts the financial services the consumers receive.

This finding indicates that the HCS system is accomplishing their goal of providing effective, economical services. The use of waivers enhanced the ability of the organization to acquire quality resources (i.e., workshop training, individual doctor visits, respite care). The personnel were satisfied with their wages, benefits, training, and overall working conditions. The clientele appeared satisfied and well-cared for.
Finally, the members of the organization agreed upon what the organization was doing. The general response indicated that the system was there to provide for these consumers, and was successfully meeting its objectives.

**Budgets.**

In Chapter II I hypothesized that targeting funds for the benefit of the consumers provides a high level of effective services.

**Organization A**

In Facility A, the administrator juggles finances. Problems arise when the departments disagree on who is responsible for what. On one observed occasion, the direct care staff used too many gloves for inappropriate purposes, such as getting a pair to push a dirty wheelchair down the hallway. Buying the "good" rubber gloves would push one department over budget. Therefore, the Food Service department bought extra plastic gloves (used in handling food products) from their budget. These gloves were inappropriate for handling human waste, but the direct care staff was expected to perform their daily tasks at a danger to themselves. Ultimately, the clients were not attended the care they required. Staff was frightened they would acquire disease or infection due to the poor quality of the gloves.

This organization is plagued with rumors of adequate finances. Reports indicated that the owners arrived on one occasion in two separate Rolls Royces to lunch with a previous administrator. The facility was said to have produced a profit of three million the past year. One observed document reflected a profit of approximately $400,000 from three months into the current fiscal year.
Whether or not the reports are accurate, I found the facility lacked in providing some aspects of budgeting care. In order to place a resident in a day training program, the facility must pay a daily fee. Available resources for job training and job skills exist in the area. Yet, Facility A has no one participating in a compensated training program or job. The training provided at the off-site facility, though similar to a workshop setting, is also non-compensatory. Therefore, even those residents capable of producing their own income are not allowed the opportunity to do so.

Some residents have few garments. If their trust fund is not adequate to buy clothes, they are purchased in bulk. Money is taken out of one of the budgets to purchase the clothing (i.e., programming, housekeeping). Therefore, if the company buys clothes, it will be enough to provide for a need (very few clothes for each client). The facility also fails to allow the residents to choose their own clothing. They are expected to utilize what is given to them without their input or consent. A few staff purchase items themselves or bring garments from home for the residents, because they feel the clients are not receiving what they "deserve." Some staff simply cannot find enough clothes for a resident to get through one day of changes.

Related to finances is the issue of stealing. Both administrative and direct care staff report many people steal from the company. Consumer's clothing, shampoo, soap, training supplies, cleaning supplies, and food are just a few of the reported items found missing weekly. Also, the administrative staff purchase items with company money to take home (i.e., cases of cokes, air freshener, candles, lotion, decorative items).
Adequate facilities are becoming a priority to the facility. The administrator stated the roof would have to be fixed as soon as possible. She reported, "Every time it rains, there are about seven new leaks. The roof is falling in on some places. To redo this roof will cost over $10,000. I suggested they buy (stated name of recently closed mental health center). At least the $10,000 would make a good down payment."

Space is also a concern. During the day, the residents that are not "high-level" enough to attend the off-site day program go to four "classes" for training. The "classrooms" are actually empty bedrooms. Seven residents are in the classes attempting to train, while the other seven are taken out for recreation. If a resident refuses to go to recreation, that person is left in the classroom. The classrooms are cramped, especially if there are more than the "ideal" seven persons in the room at one time. Each classroom is not equipped with a sink and bathtub. They each have toilets. To ensure privacy, the residents must be taken to their own rooms to train on brushing their teeth, washing a sink, shaving, bed making, etc. One trainer must go with that one client, while the other trainer is left to handle the other six residents. The staff is expected to "make do" with the existing conditions.

Organization B

Facility B appears to be kept in good condition. The house is decorated attractively, with personal possessions of each client in their respective rooms. The house manager states that it is relatively easy to "keep up" the house, except for having to buy new furniture for one client, as he continually breaks his in "fits of anger." Training space is adequate in the kitchen, living, bedroom, and bathroom.
areas. The rooms are large enough for the consumers to fit comfortably when in group training.

Facility B also accepts donations. If one of the trust funds is short, donations of clothing provide for this type of need. The clients are also taken shopping so that they may pick out, try on, and purchase their own clothing, a practice not found in Facility A. The clients appear clean, comfortable, and appropriately clothed. Staff finds it easy to identify the client’s clothes, therefore reducing the problems of interchanged clothing, as was found in the first organization.

The consumers appeared to eat well most days. Since the home is directed as "family style," the food appeared less "institutionalized." If a client did not like what was on the dinner menu, he was offered an equally nourishing meal. Staff was better able to keep track of adaptive equipment required by the consumers than in Facility A. Allergies to certain foods were known. Overall, the $170 weekly grocery budget adequately targeted nourishment needs.

The staff questioned the practice of allowing thirty dollars a month to be placed in a trust fund for the clients. After I explained that this was an option provided by the facility, they seemed to agree it would work. Yet, many questioned why they never saw the clients with their own money. Observations indicated that many of the clients were taken out shopping, and the staff bought small trinkets with five dollars at a time. The home manager was responsible for taking the residents to purchase clothes. When questioned, he stated that this was generally where most of the trust fund went. He reported, "Their clothes wear out fast from washing them so much." (Client’s
name) eats his, (name) tears his into threads, and (name) has toileting accidents. They are children when it comes to clothes."

Stealing from the company is not a significant problem for the facility. However, the facility receives peanut butter, cheese, flour, cornmeal, and sugar from "welfare" services. They have an over-abundance of these items. Several employes reported taking some of the food because "they couldn't use it all and it was spoiling anyway."

Other reports from staff revealed they suspected the client's families of stealing clothes from the clients when they went on home visits. Yet, this was not a consistent problem for the company.

Organization C

Facility C appears to provide a cost-effective program that is meeting consumer needs. Waivers appear to focus an individual's funds to her/his needs, rather than operating costs or contracts for the program. Supportive Care funds were spent on services that the clients actually used. The service providers in the area submitted required documents that reflected adequate care. Case management services were extremely effective in following up on the Individual Care Plans to ensure the consumers received exceptional care.

One of the most interesting aspects of this HCS facility was that the clients I observed were buying their own home. Through federally funded programs including Housing and Urban Development, the Federal Housing Authority, and Farmer's Housing Authority, they were able to finance the home in which they were living. The program director reported that he had attended a seminar on buying homes for
people with low incomes. He stated that the individuals paid a maximum of forty percent of their gross income. The houses were financed at a one percent interest rate. The incomes were reviewed annually, and payments were revised if needed, but the principle remained the same. These individuals were provided with a rare opportunity that escapes most other consumers altogether.

Discussion

I hypothesized that targeting funds for the benefit of the consumers provides a high level of effective services. I found Facility A maintained a low level of effectiveness in targeting funds for the benefit of its consumers. The administrator adjusted the funds, yet departments argued over financial responsibilities. Resources for paid training programs in the area existed, yet none of the consumers were provided the opportunity to attend. Adequate clothing was a concern for staff and residents. Stealing from the company by all employees was a major concern. Finally, inadequate facilities over-extended staff tempers and budget.

I found Facility B provided a moderate level of effectiveness in targeting funds for consumer benefits. Facilities were sufficient. Consumers maintained personal possessions and had plenty of room in which to train. Donations provided for clothing shortages. Though most of their SSI fund went toward clothing, consumers were allowed to shop for and choose their own items. Meals were not restricted to "institutional" foods. Rather, clients were provided a choice. Staff restricted stealing to excess food stuffs. Though not commendable, they were not placing consumer welfare in jeopardy.
I found Facility C highly effective in targeting funds for consumer benefit. Waiver fees were easily targeted toward priority needs. Supportive care was similar to private care, in that appointments were made and attended at the doctor’s office, rather than collectively. Exceptional documentation was recorded by these providers to ensure adequate care. Case management effectively followed adequacy of care. Finally, these consumers purchased their own home. This was a marked difference over the other facilities observed.

Summary

The hypothesis that targeting funds for the benefit of the consumers provides a high level of effective services was upheld by each of the organizations. Overall, Facility A rated low in effectiveness of targeting funds due to lack of adequate facilities and a non-compensated consumer training program. Facility B was found to be moderately effective based on attractive facilities and the provision of consumer choices regarding meals and clothing. Facility C was highly effective in channeling waiver funds to address priority needs. They also provided their consumers with the highest degree of independence by enabling them to purchase their housing (see Table 5 for a summary of findings).

The second hypothesis, targeting funds for consumer benefit, was not as strong an indicator of the aspect of financial care in service delivery. Though the hypothesis was upheld by the facilities, the service delivery system in which the facility participated had a much greater impact on financing service delivery. Therefore, this independent variable, budgets, did not notably affect financing care.
This finding indicates that consumer-targeted budgets are minimally important to service delivery. The ability of each organization to utilize the resources with which it was provided reflected the services it delivered to its consumers. Again, the personnel and clientele of Facility C indicated higher satisfaction with the budget. The staff (at all levels) agreed that the funds were targeted in the manner that best addressed the needs of the consumers. In contrast, Facility A and B did not appear as effective in this area. Funds were distributed elsewhere, and the staff members’ perceptions contradicted one another.

Staff Attitudes.

As reviewed in Chapter II, I hypothesized that staff attitudes toward consumers affects service delivery.

Organization A

Overall, Facility A is plagued with a disconcerting staff attitude of indifference. On occasions too numerous to count, residents are verbally, and sometimes physically abused or neglected (e.g., dragged from a chair, forced to sit down, called derogatory names, slapped on arms or legs). The abuse stems, in part, from poor quality and general apathy of staff members. I observed daily incidents where staff members drag a resident from a chair, off the floor, or from one place to another. Many residents are left in wet or dirty clothes for hours. Direct care personnel states, "That client isn’t on my card today. He’s not mine." On one occasion, staff members observed a weekend supervisor striking an aggressive resident in the mouth as he pushed the client up against the wall. No disciplinary action was taken until the incident was
anonymously reported to a state office by a witness. The supervisor was suspended two days after the incident happened because of separate criminal charges reported in the local paper, not related to the incident itself.

While the state survey was present, a consumer was left at the off-site facility from 4:45 p.m. to 9:15 p.m. An off-duty staff member drove by the locked enclosure and saw the client. She brought him back to the facility. No one reported him missing until that time. On yet another occasion, a wheelchair client fell four times in one month due to lack of proper supervision. Inservices were conducted each week on proper handling of that specific resident, but she continued to sustain black eyes, stitches, and bruises each week of that month.

Though officials conducted inservices that directly addressed each of these incidents, and staff members were disciplined or fired, no change occurred in overall attitude. Continued apathy and indifference remained. The welfare of the clients remained in jeopardy throughout the course of the study.

Organization B

The prevailing attitude of the staff in Facility B is boredom. First, I must state that the clients were well cared for, and there were no observations of abuse or neglect, (physical or verbal) during the course of the study. The staff successfully used their training to cope with behaviors and training difficulties. They conveyed feelings of concern, affection, and consideration for their consumers.

However, the staff was not greatly concerned with the accomplishments of the consumers. Trainers did not demand a great deal from the clients. Most of the
training was performed "halfway." One staff reported, "They aren't learning this stuff anyway. It's easier just to do it for them. These goals are stupid. (Client name) has been on this one for at least nine months. He'll never get it." The staff appeared to feel that if they were bored with the goals, the consumers were too. It did not matter that the client required further training in that area.

Leisure time was not structured. That is, there was a schedule, but the staff did not follow it. Generally, clients were bathed and IPPs completed by 8:00 p.m. They would then go out and take a van ride until time for the 9:00 p.m. staff to go home. This was their method of fighting boredom. Otherwise, the evening consisted of throwing a ball back and forth and watching television.

One client who was blind and functionally deaf responded to whistles when the staff requested something of him. When asked where his hearing aids were, the staff responded that they had been broken for "about two weeks" and were "probably being fixed." It did not appear the staff member was very concerned about this need. As long as the client functioned with whistles, the staff was satisfied.

Organization C

Facility C has the predominate attitude of valuing staff and consumers. Hiring procedures in the HCS program provide a high quality staff. Having to "pass" three people in the program, the staff appeared to hold their role as a service provider in high regard. One member stated, "These guys (consumers) depend on us a lot. Not really to take care of things, but just to be there. We went through a lot of training to just know how to 'be there' for them." When questioned about salary and benefits,
the staff members responded that they felt their salaries were competitive with other programs in the area. Many had worked for other companies that had not compensated as well: "Well, here you aren’t paid minimum wage... they pay pretty good... I think they want you to stay ('you' is staff)."

The organization also appears to have stability among staff. When asked why, the program director responded, "We have the best services around the area. Our staff is happy because they see the clients happy. They have worked (stated name of competing service) and know they won’t get paid nearly as well. (Competing service) doesn’t do anything for their poor guys ('guys' in reference to clients)." The program director appears to feel that his staff serves the consumers better because they are "cared for." This was the only spontaneous statement recorded in any of the facilities of the confidence of client care.

Discussion

I hypothesized that the staff attitudes toward consumers affects service delivery. For each of the facilities, there was a different attitude resulting in a different outcome of care (see Table 5 for a summary of findings).

Facility A was found to have a dangerously low level of effectiveness in the area of staff attitudes. Staff members were found to be indifferent, neglectful, and sometimes abusive. Their apathy was apparent in the inferior conditions of the residents. Many were pulled upon, cursed at, and allowed to injure themselves. Attempts by the management staff were ineffective, as inservice after inservice accomplished no change in overall attitude.
Facility B was found to be moderately effective in the domain of staff attitudes. Their overall attitude was one of boredom. The staff in Facility B were well-prepared to perform their training tasks, but were not interested in executing them. They tended to "baby-sit" their consumers (i.e., do required tasks for the clients, "play" with them, take them for rides). The effect of these actions conveyed the message that they were bored with the entire program.

Facility C was found to rate high in effectiveness of staff attitudes. The staff valued their roles as trainers, as they worked hard to attain these positions. They felt valued in terms of wages. Also, the staff members were made aware through training and observation, of the integral part they played in determining the experiences of the consumers. Therefore, they valued the consumers they served.

Summary

The hypothesis that staff attitudes toward consumers leads to the success of services delivered was upheld in each of the facilities. I rated the staff at Facility A low in effectiveness with the attitude of indifference. Consequently, their consumers were neglected and sometimes abused. The staff at Facility B attained a moderate rating with the attitude of boredom. Consequently, their clients were "taken care of." However, their consumers were not allowed a great variety of experiences or successes. I rated the staff at Facility C high in effectiveness due to the value they placed on their consumers. Consequently, they were available to the consumers, but successfully fulfilled their role as trainers. Previous research by Rhoades and Browning (1982) was upheld. It appears that the attitudes of the staff in each facility
affects the welfare, accomplishments, and continued success of the consumers (refer to Table 5 for a summary of findings).

I found the third hypothesis, staff attitudes affect service delivery, strongly supported in each of the facilities. This finding indicates staff attitudes critically impact the direct care aspect of effective service. Therefore, management focusing on the attitudes of staff would improve the quality of services provided by direct care roles. If staff attitudes were improved, better training, physical care, and rehabilitation could result. In this way, the goals of effective service delivery from the aspect of direct care could be achieved.

As for the overall impact on service delivery, this finding indicates that attitudes have a great influence. The goals of each organization were difficult to meet without a proper outlook on what was supposed to be happening. It appeared that ability to utilize resources modified staff attitudes (i.e., training provided to staff, benefits, materials to train clients). Further, the satisfaction of the personnel showed in the attitudes they manifested toward the consumers (i.e., bored, neglectful, abusive, interested). Finally, the attitudes altered staff members' outlook on what the organization was doing.

Program Analysis.

As reviewed in Chapter II, I hypothesized that utilizing program analysis improves the quality of services delivered.

Organization A

Facility A had no formal program analysis. The facility provides a one day
training session that lasts approximately seven hours. New staff are placed in a class with seven individuals who have a variety of behaviors with which to deal, and are expected to know how to properly train a resident after their initial training period. Moreover, the only additional training provided is weekly inservices that cover the same information as the initial training session.

Training attempts overwhelm many staff members. The in-house training schedule has structured class from 9:00 a.m.-11:00 a.m. and 2:00 p.m.-4:00 p.m. This type of training schedule is rather "hit and miss." On multiple occasions, I observed "off-task" actions in at least five of the seven clients "training." Two clients performed their tasks to the best of their ability, but were not shown the correct way to perform the task because they were not presenting any behavior problems to the trainer. For example, the client's assigned task might be matching and folding a pair of socks. This client would match the wrong socks, then tie them in a knot, but the trainer would not correct the mistakes. He stated, "At least he's doing something. Everyone else just sits there and wets their pants." Another staff member stated, "It takes all of my time just trying to keep them from leaving the class. I can't train them when there are three that need to be changed, two that are always leaving class, and one that hits everyone else all the time." The program's effect on the consumers is "learned helplessness." Instead of training the residents, the staff performs the tasks for them without giving them the chance to do the task independently. Residents learn to be helpless and lose many skills they formerly possessed.

However, the participants receive some positive experiences from the off-site
program. They progress at a faster rate and have fewer behavior problems. The staff to client ratio is the same as the main facility, yet continuous active treatment is demanded by the supervisor. These consumers are corrected when they incorrectly perform a task. Staff members react quickly and more frequently than in the main facility, and the residents attentively respond to interactions.

Training in washing clothes, washing dishes, vacuuming, dusting, making beds, cleaning bathrooms, self-administration of medication, money management, and integration into the community is limited or non-existent at Facility A. For example, training in money management consists of identifying different coins. Actual use of the money is not targeted, other than an occasional trip to the vending machine in the break room for a privileged few. Community integration consists of a trip to the park, a van ride, or a rare outing to a sporting event. In such cases, the residents with the fewest behaviors are picked by the recreation staff to go. Some residents were not observed to leave the facility for the eight months I was employed. Detrimental effects stem from this practice. It appears some consumers become more restless, self-abusive, and even aggressive.

Integrating training is another complex issue. For many residents in the facility, an action is tolerated by one staff and forbidden by another. Further, staff members use different words and phrases to instruct a resident on the same task. The staff expects a resident to perform a certain task one time, but then performs the task for the resident the next time. The consumers become confused and frustrated when they receive contradictory messages, and can not or will not understand what is supposed to
occur. Integration is important to reinforce the formal training that occurs, but is rare in Facility A.

Staff input in Facility A is informal and ineffective. Input is restricted to inservice meetings once per week. At that time, whether appropriate or not, many staff members complain about work conditions, training, compensation, and lack of benefits. The management staff perceives this type of input as "griping." Therefore, any useful suggestions are ignored.

Laxity in job performance is another ineffective means of input. When supervisors direct staff to perform a task, the staff responds, "That client isn't on my card today. He's not mine." The staff uses the structure of the program in this way to avoid performing a necessary task. This is a negative attempt on the part of the staff to be heard. They are left with no other means of input.

Organization B

I found Facility B did not perform a formal program analysis. The staff members in Organization B trained over a two week period (see Chapter III, case study for Facility B). This initial training period serves them well. They handle minor emergencies, behavior problems, and general resident training in a more effective manner.

Interaction and training of the residents seems less formidable in Facility B. This is due in part to better staff to client ratio. Usually, one staff member trains two consumers. This allows for individualized attention. The staff seemed aware of the behaviors and limitations of their clients. One observation included a staff member
placing a bag of trash by one non-compliant client's chair. The staff member stated, "O.K. You know that your job is to take the trash to the outside dumpster. Please get up from your chair so that you can take the trash to the outside dumpster." The phrasing was accurate. The staff member expected the client to perform his task, and he did. Document analysis revealed that another client whose attention was hard to keep learned to vacuum while in the program, and his favorite job was vacuuming.

Strengths in the training were found in staff expectations. Each member expected the same response from a particular client. Requests were consistently phrased by staff members. These skillful training techniques reduced confusion and frustration for the client.

The consumers are enrolled in a day training program. Yet, the staff speculated about its effectiveness. The house manager stated, "They just sit there most of the day doing nothing. They're bored." My observations revealed the workshop did not provide a variety of tasks to these consumers. Consumers learned to place various screws in bags, and eventually learned to staple them. The workers in the program mainly "baby-sat" the clients. One staff stated, "I've known (client name) for years. He will never be any different. He hasn't learned a thing here." Yet, this same consumer learned to vacuum at the home. The work program affected no significant change in the functioning level of the residents.

I observed integration of active treatment between the workshop and home. Training on specific behaviors and how to deal with them was relatively uniform. Copies of the behaviors and formal behavior programs were available to staff of both
programs the clients attended. Therefore, accurate training phrases and terms further reduced client confusion. Program IPP goals required reassessment. Some clients had been working on the same objective for many months with little or no progress. Others were working on objectives they had already mastered. This is known as "over-training" on a goal and does not allow the resident to progress at an adequate pace. State regulations require program reviews by the IDT at least quarterly to assess the need for retargeting goals. This was not the case in Facility B.

Staff input in Facility B is almost non-existent. The staff reported that inservice training had not occurred for over two months. This is unusual for a program that generally provides weekly inservices for the employees. One employee stated that she had made the QMRP mad at the last inservice. The staff member reported, "She (the QMRP) wants everything done her way and she yells at you if you try to suggest something. At the last inservice we had, she griped at me because I suggested that it would be easier for the staff if we came to inservices on the days we picked up our paychecks. We haven’t had one since. She really doesn’t care about us or the clients. She never comes out here to even see them." From the staff member’s perception, input was not appreciated and was hardly tolerated. The staff also complained about the nurse. Three employees stated that the nurse was mean to them and "left toenail clippings on the floor by the kitchen table" for them to clean. When asked about specific care given the clients, one staff member finally responded positively. The member reported, "She pays attention when you tell her something is wrong with one of the guys. She just hates us." Observation of medical documents revealed that the
residents were receiving adequate care. Yet, input relating to the direct care role was ignored by management staff.

Organization C

I found Facility C utilized no formal program analysis. Staff training was exceptional. Staff members were well prepared for emergencies and everyday concerns after two weeks of intensive development. New staff members saw quality training methods and procedures by observing the habilitative service providers. The staff was also encouraged to attend seminars out of town on new methods of training and managing programs. Many of the administrative staff members attend regular seminars of this nature. Also, all employees are required to attend continuous staff training. Speakers are brought from various types of programs in other areas to lecture (i.e., AIDS prevention, Special Olympics). Consumer responses reflected the exceptional training procedures. The organization trained staff members for their specific jobs and considered them responsible enough to perform their tasks. Through observation, I noted that the consumers tended to respond favorably to their service providers.

Facility C required the case managers to monitor program outcomes. I found this a worthy practice. The program was set up to follow the needs of each specific client. Part of the job description of the case managers included spending a specified amount of time with each person on their case load. This was unique to the HCS program. Other QMRPs were usually programming for people they had not adequately assessed, observed, or even spoken to.
The clients in Facility C paid for room and board. This increased many specific independent living skills. They learned to plan meals that are healthy, live within a budget, and provide for extra necessities (i.e., personal hygiene items, clothes). Training in managing finances to the best of their ability is a great leap in teaching independence. Clients participation in a day program integrated the concepts of having a job in order to provide for oneself. This concept is basic to independent living, and is left out of numerous other programs.

Respite care was another positive aspect of the HCS facility. Respite provided a place consumers could go to escape their house mates, pressures, and even responsibilities for a few days. Many professionals forget clients need to have time to themselves. In group home living, structured programming occupies the majority of the day. Time to themselves is a need of many individuals, and the Respite program is effective in meeting that need. There is not a similar service in other group homes.

Utilizing Evidencery Standards appears to improve the quality of client programming. With the Evidencery Standards, the case managers can tailor the program to the needs of the individual, rather than having the individual "fit into" the existing program. The person is given the opportunity to choose what he/she feels is a priority need for them at that time. This is not to say that recommendations of the Interdisciplinary Team are ignored. Rather, the individual helps the team determine what plans he is interested in pursuing. State investigators do not reprimand the facility for allowing self-determination in this manner.

Staff input in Facility C exists formally. The program director's office serves as
the back door to the off-site offices. When company cars are brought to the fenced area behind the office, the only exit is through the same back door. There is a blackboard with each staff member’s name that serves as a means of communication. They leave notes for the respective personnel. Each staff member is also provided a "box" in the office to receive information. If the director does not speak personally with members when they arrive, he can contact them through the blackboard or boxes.

Direct care staff members attend IDT meetings. This is one of the most effective means of staff input, as they are the persons responsible for the elements of program care. Their input aids in a holistic assessment of required consumer services. Therefore, a more effective service program is developed.

Discussion

I hypothesized that utilizing program analysis would increase the quality of services delivered to the consumers. The study revealed that none of the organizations utilized a formal program analysis (refer to Table 5).

I found Facility A provided a low level of effectiveness in delivering services in relation to program analysis. The absence of a program analysis was reflected in many areas of the services delivered. Staff training left members unprepared to adequately perform their role as client trainers. The focus of the program was rather narrow. Integration of training was not apparent. Therefore, consumers were frustrated and confused during training sessions. Although the off-site program provided adequate training, there were not enough consumers affected by its program
to indicate notable improvements on overall service delivery. Staff input was limited to "gripe" sessions or indirect negative techniques (i.e., laxity in job performance).

Facility A upholds the case for program analysis. If the preceding areas of concern were targeted, a program analysis could be used to improve service delivery.

Facility B provided a moderate level of effectiveness in delivering services, even without a program analysis. The initial two week training period better prepared the staff. Skillful training techniques (i.e., consistent phrasing, expectations, integrated training) reduced consumer frustration levels. However, the day training workshop was not challenging. Consumer goals required IDT reassessment to promote adequate progress. Also, staff input was not important to management personnel. Most suggestions were ignored. Facility B also strengthens the case for using program analysis to improve service delivery.

Facility C provided a high level of effectiveness in delivering services. Initial staff training lasted two weeks and was the most intensive of the three facilities observed. The staff was required to attend development seminars. Members from other organizations held training seminars. In this way, the program adeptly utilized outside resources for improving services. The case managers spent adequate time with their case load to provide individualized programs. Staff input was "formalized." They were allowed means of conveying suggestions and concerns by using the blackboards, boxes, and, most significantly, IDT meetings. The program director was easily accessible through the "back door" (office) and by his genuine interest in his staff. Facility C does not support the hypothesis that using program analysis improves
service delivery. It appears that there are alternate factors involved in delivering services in Facility C.

Summary

None of the facilities practiced program analysis. When the overall program was measured, Facility A had a low level of effectiveness. Facility B had a moderate level of effectiveness. Both Facility A and B could benefit from some method of program analysis, as Guba and Lincoln (1981), Hawkins et al., (1981), Krapfl (1975), and Schalock (1983) have suggested. Facility C had a high level of effectiveness. This organization contradicts previous research that suggests program analysis improves service delivery (see Table 5 for summary of findings).

This finding indicates that service delivery varies by the existence of program analysis. None of the organizations utilized formal analysis. Yet, addressing key elements of a program analysis would improve the effectiveness of services delivered. Factors such as staff input worked to nourish the satisfaction of the personnel. Competent training methods contributed to agreement among the members of what the organization was doing and how it was doing it. Utilizing outside resources altered the services that the consumers received. These findings suggest that hypothesis four, utilizing program analysis improves services, significantly impacts effectiveness. The independent variable, program analysis, is the primary factor in providing effective services. I found it to have the greatest impact on service delivery.
Table 5: Levels of Effectiveness

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<th>Program Analysis</th>
<th>Staff Attitudes</th>
<th>Service Delivery Systems</th>
<th>Budgets</th>
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<td>Organization A</td>
<td>L</td>
<td>L</td>
<td>M</td>
<td>L</td>
</tr>
<tr>
<td>Organization B</td>
<td>M</td>
<td>M</td>
<td>M+</td>
<td>M</td>
</tr>
<tr>
<td>Organization C</td>
<td>H+</td>
<td>H</td>
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<td>H</td>
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H= high; M= moderate; L= low
+/- = degree of effectiveness

Overall Impact On Effectiveness

I focused on four variables affecting these organizations. They are service delivery systems, budgets, staff attitudes regarding consumers, and program analysis. The first hypothesis predicted that the funding method of the HCS system provides a higher level of effective service than the funding method of the ICF/MR system. Service delivery systems (ICF/MR, HCS) were operationally defined as methods of funding and variations in services delivered. The data suggest that service delivery systems have a significant effect on actual services delivered. Facility C was rated highly effective in this area. It was the only organization of the three that was part of the HCS program. Most beneficial is the systems use of waivers to provide services. The consumers are evaluated for the services they require, and are given funds for that particular purpose. By design, this system regulates where funds go and to whom they go. Therefore, it is easier to observe whether or not the consumers are receiving the services they need.
The second hypothesis predicted targeting funds for the benefit of the consumers provided a high level of effective services. Budgets were operationally defined as appraisal of responsibility of cost reduction and expenditures in terms of consumer benefits (refer to Table 4). Data reveal that budgets have a lesser impact than other variables in the study. Each of the organizations upheld this hypothesis. Yet, contradictions in controlling the budgets were apparent. Outside resources, participation in a system, and national company policies all served as environmental constraints (i.e., state funding, HCS versus ICF/MR funds, and what national "chain" the organization was beneath). Therefore, though different choices could have been made in channeling funds, it was not a intricate factor in the puzzle of service delivery.

The third hypothesis predicted that staff attitudes toward consumers affected service delivery. I operationally defined staff attitudes as opinions and perceptions of adequate service delivery (refer to Table 3). The data reveal that staff attitudes have serious implications in effective service delivery. Facility A had the worst staff attitudes, and staff members were, at best, indifferent to client welfare. In contrast, staff members valued consumers at Facility C, and consumers were given the most adequate care. Further, the staff in Facility A harbored contradictory perceptions of adequate delivery. As Hall (1987) states, organizations have multiple and conflicting constituencies. In each facility, there were cases where direct care staff perceptions of service delivery did not coincide with those of the administrative staff. This was a common occurrence in Facility A and B. Many staff members indicated the residents
were not receiving adequate services. When observed, this occasionally was a true statement. Yet, when I asked an administrator, the response contradicted with those of the staff. Generally, the management felt services were adequate. This rarely occurred in Facility C, where staff responses were overall positive and directed to organization goals. They seemed to be aware of their purpose and function in the outcome of organizational goals.

The fourth hypothesis predicted that utilizing program analysis would improve the quality of services delivered. I operationally defined program analysis as the methods of staff input, periodic reviews, adequacy of staff training, and the effect of the program on the consumers (refer to Table 3). None of the programs utilized formal analysis. Facility A and B delivered low and moderate services, respectively. They could improve their services if they intently focused on this independent variable, as it affects service delivery the most. Yet, the services in Facility C were found to be highly effective. This was due, in part, to the existence of elements that would be included in a program analysis. These elements were formal means of staff input, monitoring by case management of proper service delivery, exceptional staff training, and skillful use of outside resources. Therefore, the factor of program analysis had the greatest affect on services delivered.

As Table 5 indicates, I found Facility C provides the most effective services including financial care, habilitation, and direct and supportive care. The facility had elements of program analysis that are vital to proper service delivery. The organizations participation in the HCS program enabled it to effectively target and
address consumer needs. Staff attitudes were generally positive. They valued the consumers and integrated their exceptional training into the goal of the organization: individualized, effective service delivery. Finally, the staff agreed to what the organization was doing and how it was doing it.

Chapter Summary

In Chapter V, I reviewed the variables found to affect service delivery. Next, I examined the hypotheses that were tested in the study. I found that program analysis had the greatest effect on services delivered. Data indicated that staff attitudes and participation in a specific service delivery system were also significant variables affecting service delivery. Finally, budgets of the respective organizations were found to have only modest implications in services delivered.

Chapter VI will review the factors that affect service delivery. I will conclude with suggestions and recommendations for improving the quality of services delivered by these providers.
CHAPTER VI

CONCLUSIONS

Introduction

This study examines service delivery in organizations serving the mentally retarded. There are three areas that affect service delivery. They are financing care, habilitation programming, and direct and supportive care. To define these areas, I focused on the components of active treatment, program analysis, staff attitudes regarding consumers, staff incentives, service delivery systems, state policies, budgets, survey accreditation, and the goals and purposes of each program. I focused on four variables that affected these organizations. They are service delivery systems, budgets, staff attitudes, and program analysis. The four hypotheses are:

1. The funding method of the HCS system provides a higher level of effective service than the funding method of the ICF/MR system.

2. Targeting funds for the benefit of the consumers provides a high level of effective services.

3. Staff attitudes toward consumers affects service delivery.
4. Utilizing program analysis improves the quality of services delivered.

Evaluation

Each of these hypotheses were reviewed and discussed in Chapter II. Chapter V analyzed these hypotheses. I found that program analysis had the greatest effect on services delivered. Data indicated that staff attitudes and participation in a specific service delivery system were also significant variables affecting service delivery. Budgets of the respective organizations were found to have only modest implications in services delivered. Facility C provides the most effective financial, habilitation, and direct care services out of the three organizations studied. Its structure and processes adhere closely to the areas found to significantly enhance service delivery. The facility had elements of program analysis that are vital to proper service delivery. The organizations participation in the HCS program enabled it to effectively target and address consumer needs. Staff attitudes were generally positive. They valued the consumers and integrated their exceptional training into the goal of the organization: individualized, effective service delivery. Finally, there was little contradiction in staff responses to what the organization was doing and how it was doing it.

However, as I tested these hypotheses, I found active treatment and survey accreditation served as constants for the organizations to meet minimum standards required by the state. Therefore, these factors did not vary the degree of effectiveness in any of the organizations. This contradicts previous findings that indicate focus on active treatment improves services (Sparr, 1987; Harmatz, 1973; Favall & Phillips, 1986; Braddock et al., 1987). Further, staff incentives and purposes of the programs
were considered closely related to the discussion concerning staff attitudes and program analysis. Consequently, I included these variables in the discussions of staff attitudes and analyses. They were contributors to the overall program.

Problems/Possible Corrections

An examination of the research approach has revealed areas that could have been modified or changed in the study. First, questions in the structured interviews could have been strengthened. The questions may have focused on areas that staff were not knowledgeable of, and responses may have been given to hide this fact. Some questions were not as clear as they could have been. Other questions may not have targeted the areas that they were designed to target. This was most likely the case with the questions that have not been previously tested. Yet, this problem may have also contributed to the study by allowing for greater elaboration by the respondents. Many were not hesitant to respond to any question, whether they appeared to have knowledge of the concept or not.

Second, many of the variables chosen as factors influencing service delivery overlapped to the point of uselessness. For example, "program analysis" and "goals/purposes of the programs," though appearing as different factors, were integral components of the same concept. Therefore, the analysis considered them as one contributing factor under the label of "program analysis."

Third, the focus of this study did not include consumer, family, or community perception. The inclusion of these variables could have expanded the scope of the study. Consumers could benefit from further research including these variables.
Finally, the study focused on the culture within each facility. Future studies including the culture of the complete corporation would further expand these findings. Assessing the structure of the corporation would allow for comparison of the various facilities involved in each. Service delivery may vary between these facilities depending on the composition of each facility's culture. The independent variables affecting service delivery could change, and would therefore indicate alternate causes of effectiveness.

Conclusions

The practical benefits and contributions of this study cover a number of areas. First, the research suggested that effective service delivery still evades an operational definition. There are many contradictions and aspects from which to view the problems of active treatment, normalization, budgeting, and program set-up. Simply encouraging deinstitutionalization does nothing to provide adequate alternatives. The existence of abuse and neglect remains to haunt those in community care facilities as well. Second, the study revealed a critical need of program analysis. This would aid in continual reassessment of service provision in the field. Training methods would improve, budgets could be monitored, and programs would be forced to evaluate where their services failed. Third, the study substantiated there are effective alternatives to the most popular form of service delivery. As predicted, the HCS program is competently providing individualized, cost-effective services that are meeting priority needs. It should be considered as an addition to the immense field of ICF/MR providers.
Some of this research can be applied directly to managing a program. First, professionals must identify the individual needs of the consumer. For example, is it necessary for a Level VI individual to continue training to learn how to tie a shoe? If he can successfully put his shoes on by sticking Velcro together, what is the purpose of learning to tie a shoe? He may be more interested in learning to call his parents. The point is that many individuals are trained in areas of which they have no interest. Their progress appears minimal, at best. The HCS program (Facility C) suggests targeting the individual’s interests in the program increases his success rate. The consumer is interested in what he is doing, and will naturally perform well. Determining with the individual what is important to him/her is the key to developing individualized program plans.

Second, though I did not include it as a separate independent variable, the findings indicated that effective staff training was essential to the success of service delivery. The staff members ability to understand their importance to the program is primary. The consumer’s quality of life depends on the people with whom they "live." If the staff members are not trained to understand, empathize, and work with the consumer’s limitations, the reality experienced by the consumer is intolerable.

Third, management must learn to listen to the needs and concerns of their staff. If a program is not working, direct care staff opinions will help clarify problems. In order to create a total delivery system, each member involved in that system is instrumental to its effectiveness. Facility C integrated all levels of staff into their IDT meetings and structured means of input. The organization was also the most effective
of the three. Yet, many members of professional management continue to bypass this principle. This was apparent in Facility A and B, where staff input was generally ignored.

Normalization.

Normalization remains an intangible ideal. The service delivery system is designed around Wolfensberger's (1972) definition that focuses on adjusting the behavior of the mentally retarded to society's cultural norms. Throughout this study, professionals promoted the Care model of a complete delivery system. Yet, many aspects of the system remain behaviorally oriented. As Rhodes and Browning (1982) state, normalizing the mentally retarded requires a process of re-socialization. The consumers enter a program to hide their deviant behaviors by becoming "normal." They are taught to assume the behaviors of normal people. For many, this system will never allow them to succeed.

The findings of this study suggest that professionals need to critically assess the impact of the current system. The consumers deserve a realistic assessment of their abilities. Many will never have the cognitive abilities to decipher the perplexing norms in which they exist. Normalization training should continue, undoubtedly. Yet, it must focus on more than an individual's limitations. Professionals should take another look at "normal" behavior of the collective society. Possibly, a re-socialization of participants on both ends of the spectrum is needed.

The pursuit of the most effective service delivery system continues to be an elusive task. The problem is exacerbated by the presence of contradictory factions,
confusion of terms, lack of funding, and environmental constraints. The evidence points toward multiple causes of effective services; however, further research needs to be done to identify these causes and layers of influences.

This thesis has contributed a small piece in the puzzle of effective service delivery. The research hides the realities of the daily existence of each individual. The data gathered depict a living person who struggles within the existing systems. Some have very desperate needs. Hopefully, researchers will continue to strive to meet these needs in the future of exceptional service delivery.
APPENDIX A

NARC STATEMENTS
Constitutional Rights

Principle 1: Retarded children and adults are guaranteed the same constitutional rights as other children and adults and may not be deprived of life, liberty, or property, without due process of law; nor shall they be denied equal protection granted by the law.

Residential Facilities

Principle 2: Residential facilities of all varieties are particularly vulnerable to conditions or situations that can impair the quality of life for the residents whom they serve. Facilities become dehumanizing when they become developmentally counterproductive by violating the dignity of the resident and limiting his or her opportunity to gain "useful knowledge." Dehumanization is a denial of the individual's basic rights to liberty and the pursuit of happiness guaranteed by the United States Constitution.

Educational Opportunities

Principle 3: Individuals with retarded mental development have a right to the general social priority of participation in appropriate educational opportunities. Retarded individuals should have those opportunities which will promote their
personal development. For example, if they are treated as children throughout their lifetimes, retarded persons are deprived of the opportunity to learn adult behaviors.

Developmental Experiences

Principle 4: The purpose of a residential service implies that clients of the service are in need of ongoing developmental experiences which they are unable to receive at home. While the learning needs of both retarded and non-retarded persons are continuous throughout their lifetimes, the retarded individual usually has a more intense need for structured learning situations. By the very nature of their handicap, mentally retarded persons require increased or specialized opportunities to learn new skills of independence.

Personal Goals

Principle 5: Programs for retarded persons must give attention to the individual’s personal goals. Most retarded men and women are capable of setting personal goals and communicating their desires and aspirations. Even nonverbal retarded children and profoundly retarded adults can often participate in decision making and goal setting if given a legitimate opportunity. The retarded individual and the family or guardian should participate in planning for residential placement and/or program participation.

Life-Style

Principle 6: Retarded children and adults should be helped to live as normal a life as possible. The structure of daily routines, the life-style, and the nature of
the physical environment should approximate the normal cultural pattern to the
greatest extent possible.

The Developmental Model

Principle 7: Retarded children and adults are capable of learning and
development. Each individual has potential for progress, no matter how
severely handicapped he or she might be.

Principle 8: The basic goal of programming for retarded persons consists of
maximizing the individual’s personal, social, and vocational development, and
as such is identical with the goal of educating and socializing all other
citizens. The adequacy of programs, as well as of physical and psychological
environments, can be evaluated in terms of the degree to which they fulfill this
goal.

Principle 9: Specific program objectives must be tailored to meet the needs of
each individual, and will vary for different degrees of impairment.

Principle 10: All programs for retarded persons must meet the three basic
criteria of the developmental model:

1. Contribute to increasing the complexity of the individual’s behavior.
2. Contribute to increasing the individual’s ability to control his or her
environment.
3. Contribute to maximizing those qualities that have been designated as
"normal" or human.
Utilization of Community Services

Principle 11: Programs for the mentally retarded should utilize the community’s existing services to the fullest extent.

A Comprehensive System of Services

Principle 12: A comprehensive system of community services must be developed to provide for:

1. Early identification of handicaps that are developmentally disabling.
2. Early assistance to correct or alleviate those disabilities and a continuity of services to thereby reduce the need for residential services.
3. Ongoing services to the individuals and family to ensure the greatest possible gains in development.

Social Integration

Principle 13: Community services should be strategically located throughout the state, region, or county to promote maximum social integration of disabled citizens into the community (see Patterson, 1980, for further explanation and discussion).
APPENDIX B

STRUCTURED INTERVIEW INSTRUMENT
APPENDIX B

DEPENDENT VARIABLE: SERVICE DELIVERY

Financing Care

Service Delivery Systems (ICF/MR, HCS)

1. Do you think there is a difference between waiver and per diem in providing services? (Evans, 1993).


State policies

1. What do you think could be done to ensure equality in distributing resources so that individuals will have equal access to services they need? (Fernald, 1986). (modified)

2. Do you think there is a relationship between restricting beds and the quality of services delivered? (Evans, 1993).

Budgets

1. Do you evaluate expenditures in terms of the benefits they will provide for the clients? (Alexander, 1978). (modified)

2. Do you look upon yourself as being responsible for reducing costs? (Alexander, 1978).
Habilitation Services

Survey Accreditation

1. How well do you think the existing method of conducting an ICF/MR survey results in an accurate differentiation between high quality treatment services versus low quality treatment services? (Reid et al., 1991).

2. Overall, how helpful or detrimental is the ICF/MR survey process to your agency in regard to improving resident services? (Reid et al., 1991).

Active Treatment

1. What does "normalization" or "least restrictive environment" mean to you? (Evans, 1993).

2. What do you think about age appropriateness? (Evans, 1993).

3. Are you aware of what your client's goals are? (Evans, 1993).

Program Analysis

1. In what ways can you give input into the effectiveness of your program? (Heller, 1988). (modified)

2. Does your job allow for periodic evaluation by staff members? (Heller, 1988).

3. Is adequate training provided so staff members can successfully implement the program? (Yeatts et al., 1991). (modified)

4. Does the program significantly affect the lives of the consumers? (Hackman, 1980).

Direct/Supportive Care

Goals/Purposes of the Program

1. How is the staff made aware of the goals of the program? (Yeatts et al., 1991). (modified)

2. Are you given the freedom to decide how to accomplish the program?
Staff Attitudes Regarding Consumers

1. What can you do to ensure the consumers receive adequate services? (Alexander, 1978). (modified)

2. Do you think the clients receive the services they need? (Evans, 1993).

Staff Incentives

1. What further benefits could be added to ensure staff stability? (Hackman, 1980). (modified)

2. Are opportunities for advancement provided the staff? (Hackman, 1980).

3. What is the most effective part of job preparation? (Evans, 1993).
July 1, 1993

Jennifer Evans
1005 Belvedere
Arlington, TX 76010

Dear Ms. Evans:

Your proposal entitled "Issues of Effective Service Delivery in Organizations Serving the Mentally Retarded," has been approved by the IRB and is exempt from further review under 45 CFR 46.101.

The following modification must be met before you can go forward with your study:
- Informed consent statements must be signed by each of the staff members interviewed for the study.

If you have any questions, please contact me at (817) 565-3946.

Good luck on your project.

Sincerely,

Sandra Terrell, Chair
Institutional Review Board

ST/tl
INFORMED CONSENT

I, ____________________________, am willing to participate in an organizational study (participant name) of the facility of which I am an employee, ____________________________. The purpose of this (facility name) study is to evaluate the effectiveness of service delivery in this facility. The researcher hopes to use the information gained from this study to provide the facility with an overall perspective of service delivery that may encourage modifications in the program.

As a participant, I understand that I will be interviewed one to two times. I understand I will be asked to answer questions relating to my perception of job roles, goals of the organization, and overall effectiveness of service delivery. I also understand that I will be observed performing daily work activities. Confidential notes will be recorded by the researcher during these times. I have been informed my name will not appear in any notes taken by the researcher. I will be referred to as "staff." Under this provision, I agree that any information obtained may be used for publication and education purposes as the researcher requires.

I have been informed that my participation is not mandatory. I understand that there is no risk or discomfort if I participate in the study. I have also been informed that I am free to withdraw from and discontinue my involvement with the research at any time. If I choose to withdraw, my employment within this organization will not be affected in any way.

If I have any questions or problems concerning my participation in the study, I should contact Dr. David Neal, the project director, at (817) 565-4267 (work). I can reach Jennifer Evans, the researcher, at (817) 382-3362 (home) or (817) 383-3576 (work).

__________________________  ____________________________
(Date)                    (Participant)

__________________________  ____________________________
(Date)                    (Researcher)
March 17, 1993

To Whom It May Concern:

We authorize Jennifer Evans to survey our program for her masters thesis at University of North Texas, and we will be looking forward to working with her.

Sincerely,

[Signature]

Program Manager

HH:ts(JE)
April 9, 1992

To Whom It May Concern;

Upon approval by the Human Rights Committee in Texas for , permission has been granted for Jennifer Evans to include as a factor in her graduate research.

Respectfully

[Signature]

Texas Assistant Director
Meeting Minutes
for
Specially Constituted Committee

On November 6, 1992 at 1:00 pm a meeting of the Specially Constituted Committee of was held in the conference room. The meeting was attended by the individuals listed on the attached enrollment form.

The following agenda was presented to the committee and each item presented and discussed individually before any formal action was taken.

I. Review purpose of the committee. No new additions or deletions were noted at this time. (See attachment)

II. Review of Residents Rights. No new additions or deletions were noted at this time. Copies were made available to all committee members. (See attachment)

III. Current Behavior Management Programs. The Committee reviewed behavior plans for 20 of our residents and the Committee approved them. (See Attachment)

IV. Reviewed Psychotropic Medication Use. All clients on psychotropic medications were presented for discussion and approved. (See Attachment)

V. Review of Incidents reported to the Texas Department Health or Entries due to Complaints. (See Attachment)

VI. The following proposals for research studies were presented and approved by the committee. Jennifer Evans, student at UNT seeking a MS in Sociology, proposed a research study for comparison of service
delivery among different level VI MR facilities.
(See attached)

VII. Other: There was a discussion of the off-site facility (Annex) being turned into a pre-vocational center for the clients. Skills of focus are measuring, sorting, matching, coordinating and stuffing envelopes. This was approved by the committee.

Each item on the agenda was presented, discussed, and approved without any additions or corrections by committee members. Upon completion of all business it was unanimously voted to adjourn the meeting.

Respectfully submitted.

[Signature]

Social Worker

Recording Secretary
WORKS CITED


