COST-EFFECTIVE STRATEGIES FOR IMPLEMENTING A COMMUNITY GROUP HOME CURRICULUM TRAINING

By

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ABSTRACT

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Public education and the public mental health system, as a part of their mission, have a responsibility to provide services that meet community needs. The costs involved in operating organizational units that deliver these services to the public have been continuing to increase. This researcher investigated how collaboration and planning between higher education and the public mental health system can provide cost-effective training for paraprofessionals who work in community group homes for the developmentally disabled and mentally ill. Costs, staff turnover, and content retention over time were variables analyzed at two instruction sites: a community college and a Michigan Department of Mental Health (MDMH) facility.

Sixty individuals were randomly selected from a waiting list to be trained as group home workers. Thirty received their instruction at an MDMH facility, the other 30 at Schoolcraft Community College. The tool used to assess the trainee's mastery of the course material was the assessment package for the Group Home Curriculum. After four

months, individuals still working in the group homes were asked to return to the facility for retesting on the same materials.

The results were analyzed as a 2 x 2 factorial experiment. There were two factors of interest (instructional site and time of testing) and two levels of each factor (the MDMH facility versus community college for instructional site, original test versus retesting for the time factor). Analysis of variance was used to test hypotheses concerning quality-of-treatment means and to check for interactions between the two factors (instruction site and time).

Test scores at both sites were fairly similar over time. In Module 4B, test scores dropped over time for both instructional sites. For Module 5, scores were lower on the retest at the MDMH, whereas scores actually rose at the community college. Turnover rates differed between instructional sites. Total cost per trainee for the Schoolcraft Community College instructional site was $199. The cost per trainee at the MDMH site, as computed by the retrospective method, was $135, whereas the cost per trainee, as computed by the prospective method, was $122.

DEDICATION

To Mother and Dad: Thanks for being there through all the difficult times, from Shaw Avenue to all the other schools in between, and finally, it happened!!!

To Sandy: Without your support, love, and even temper, this most definitely would never have happened.

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CHAPTER I

INTRODUCTION

Public education and the public mental health system, as a part of their mission, have a responsibility to provide services that meet community needs, yet the costs, both direct and indirect, continue to increase. As the tax base diminishes and state and federal deficits increase, the competition for limited resources escalates among service providers. To complicate matters, the legal constraints concerning rights to an education, freedom of access, and so on, add to the cost of delivering services to an already stressed public system. This study was undertaken to investigate how collaboration and planning between higher education and the public mental health system can provide cost-effective services and enhance both systems.

The Problem

The Michigan Department of Mental Health (MDMH) has an increasing need to develop cost-effective methods for delivering services to its clients. As state and federal dollars diminish, delivered units of service have decreased, and the quality of those services has also been reduced.

The MDMH is continually making a concerted effort to reduce administrative costs as an alternative to program reduction. These

efforts were successful by reducing the MDMH original 1981-82 state-general-fund-supported administrative expenses of $31.6 million to the 1982-83 appropriated level of $25 million--a reduction of 21%. Central administrative staff, located for the most part in Lansing, was reduced from a high of 750 staff to 373 in 1982-83. This reduction in staff greatly decreased the MDMH's ability to manage a complex institutional and community-based system. This reduction most directly affected the Office of Resource Development (ORD), which coordinates the education and training efforts for the MDMH.

The Higher Education System

Higher education has gone through a similar shortfall of operating funds. As of June 7, 1983, the Michigan Senate rejected a $763.5 million spending measure for higher education. The Governor recommended $706.6 million, which seems to be a considerable increase over the 1984 budget of $652.2 million until an inflation factor is considered.

> Over the past decade, state support for higher education in Michigan has declined by 11 percent in real terms, according to a survey by the Chronicle of Higher Education. Only in Illinois have state funds declined as steeply. As a result, Michigan, which was once one of the top four or five states in the country in terms of per capita support for higher education, now ranks 38th. Most of the reductions, moreover, have come in the past few years and they have often been made in the form of emergency recissions with virtually no advance notice. ("Downsizing at the University of Michigan," 1983, p. 283)

Background of the Research

Although resources continue to diminish and the fiscal crisis in Michigan is still present, the MDMH has determined that community

residential placement and deinstitutionalization are, and will continue to be, a top priority as referenced in the department's goal and mission statement contained in the 1981-1986 Program Policy Guidelines. If this public policy is to be successfully implemented, more effective use of existing resources is needed.

The purposes of this field test were to (a) determine whether two public agencies with public service missions can provide quality training in a cost-effective manner and (b) improve the management of resources by the MDMH. This researcher field tested the training of staff working in group homes and identified the strengths and weaknesses of training sites: a state facility and a community college. The results of this research could influence the planning cycle and the distribution of resources managed by the MDMH. More specifically, for the first time, the ORD could formally evaluate different strategies for disseminating training curricula (state facility and community college). Collaborative efforts from all public agencies are necessary if one is to (a) identify the most cost-effective delivery system to carry out the necessary public services, (b) ensure appropriate deployment and use of resources, and (c) ensure competency of service providers. The researcher specifically addressed the first and second items and touched tangentially on the third.

The cost of higher education is also not a new issue. Controlling rapidly rising costs has had an increasing influence on parents, students, unemployed/dislocated workers, and public officials. The evolution of cost issues and cost-containment

strategies in the health care sector serves as an instructive precedent for evaluating cost-containment strategies for higher education. Anthony W. Morgan (1983), Assistant Professor of Educational Administration at the University of Utah, stated:

> Drawing lessons from the health care sector appears to have prima facie validity. Each enterprise is built around a core of semi-autonomous professionals who traditionally have determined the conditions of and evaluated their work. The role of administrator is equally tenuous in educational and health institutions, at least from the perspective of the core professionals. Quality of service is a central, albeit cloudy, issue in both sectors as is duplication of services and the allocation of resources. Incentives prevalent in health care institutions, particularly hospitals, and institutions of higher education are strikingly similar. Each generally strives for a comprehensive array of programs or services, for the latest technology, and for general organizational goals of excellence, quality, and prestige. As Howard Bowen has pointed out, the cost incentives inherent in such organizational goals are not counteracted by incentives leading to parsimony or efficiency; that is, each institutional type tends to spend up to the very limit of its means. While these and other parallels are perhaps more clearly drawn for universities than for community colleges and some types of four-year institutions, the author believes that the possible unfolding of events and policies outlined will develop at sectors of higher education, regardless of real or perceived differences. (pp. 279-83)

One of the factors affecting health and higher educational costs over the past decades has been an increased demand for those services. In 1978, almost 1.5 million students were enrolled in 6,813 private and 812 public vocational schools in the United States, offering programs in such areas as business and commerce, cosmetology, flight training, art and design, and health-related occupations. Between 1976 and 1978, postsecondary occupational school enrollment increased at a rate of 6.9%, compared to a 2.3% growth in college enrollment ("Post Secondary Enrollment Responses,"

1983). Also, community/junior colleges in 1983 enrolled a significant 53% of all freshmen and sophomores in the nation (Montessi, 1983).

Another factor influencing cost of higher education is the enrollment decline projected for the 1980s and 1990s, which also increases unit costs for institutions of higher education. Costs generally cannot be cut, at least in the short run, in direct proportion to enrollment declines. Morgan (1983) proposed three general policy strategies that should be considered by higher education policy makers when dealing with these problems: (a) a central coordination or planning approach, (b) a variety of regulatory strategies, and (c) market strategies.

This researcher addressed the responsibility of higher education to fulfill its mission by meeting the training demands of other markets, namely the public human service agencies serving the community. Traditionally, departments of state government have not been one of the arenas with which public education has been involved to any great extent. It should be the responsibility of leadership in higher education and state government to investigate ways of delivering service units in the most cost-effective manner. Their collaboration and sharing of resources may result in direct benefits to both participating organizations and the communities they serve.

Some experts in higher education have been bold enough to state that "the job of the admission office should be to identify a large number of prospects within the primary market" (Wofford & Timmerman, 1982, p. 49). This market may include state government's staff

development and training needs. A marketing-information system is a continuing and interacting structure of people, equipment, and procedures designed to gather, sort, analyze, evaluate, and distribute pertinent, timely, and accurate information for use by the marketing decision makers to improve their marketing planning, execution, and control (Kotter, 1980). Continuing to provide a high quality of service in a highly competitive, limited-resource environment, marketing strategies must be employed in conjunction with cost-containment approaches. Lolli and Scannell (1983) stated that:

> Commitment, resources, and technical skill represent the necessary components of a meaningful market research endeavor. The extent to which each is present has an impact on both the quantity and quality of the outcome. Those institutions which recognize the need for marketing research and plan accordingly will be in the best position for dealing proactively with the changing environment of the '80s. (p. 150)

Recognizing the need to examine additional markets, i.e., public mental health employees, may increase the support for higher education dollars.

Human Services in Michigan

Since this research involved collaboration and networking with postsecondary and human service agencies, a description of the human service system and its confronting crises/problems is necessary. The recession and resultant nearly 36 months of double-digit unemployment have had a dual effect on Michigan's human service system. At precisely the same time that families and individuals bearing the brunt of the recession turned to public human services, often for the

first time, federal and state revenues necessary to support these services have drastically declined. What resulted was a reduction in the state's ability to respond to legitimate requests for mental health services, income maintenance, and other social services.

> Neither the 300 percent increase in the caseload receiving Aid to Dependent Children in the last three years (1980-83) nor the dramatic change in the proportion of involuntary commitments to state institutions for the mentally ill should be a surprise to anyone. During 1982-83, the unemployment rate increased to 17.2 percent. Perhaps the best study of the relationship of the economy's health to the social and mental health of the population was completed by Dr. Harry Brenner of Johns Hopkins University. Dr. Brenner found that, for every one percent rise in the national unemployment, 39,000 deaths could be expected, including:
> --20,000 from cardiovascular problems
> --900 from suicides
> --500 from cirrhosis of the liver
> --650 from homicides. (Report of the Financial Crisis Council Expenditure Committee, 1982)

While Michigan's Department of Mental Health state facilities have not had the resources to conduct research concerning the social effect of the economic crises during the past three years, evidence has indicated that the loss of employment for thousands of workers has had serious effects. For example:

1. While overall admissions to state psychiatric facilities have decreased slightly since 1979-80 due to restrictive admission policies, the facilities serving high-unemployment areas have had increased admissions (i.e., Northville--5% in 1982).

2. The Michigan Department of Public Health reports that infant mortality has increased from 12.8 deaths per 1,000 in 1980 to 13.2 per 1,000 in 1981, reversing a 30-year trend.

3. The Cabinet Level Hunger Task Force, which was co-chaired by William Long (Director of the Michigan Department of Labor) and C. Patrick Babcock (Director of the MDMH), received reports from numerous public and private agencies regarding increased demand. Probably the most dramatic were from (a) Detroit, where the Mayor estimates as many as 8,000 individuals are homeless, and a growing number of people are turning to soup lines or emergency food supplies; and (b) Lansing, where the emergency food bank has experienced an increase in demand from 2,550 people in 1981 to 9,681 in 1982--a 279% increase. Eighty percent of the monthly participants are requesting assistance for the first time.

Unfortunately, these are not isolated examples. A survey of any sample of public or private human service agency will provide more indicators that unemployed and low-income citizens in Michigan have experienced, and are continuing to experience, serious income, social, and health problems.

Given the increased demand for services coupled with the state's general-fund budget-reduction plan, budget reductions for mental health, education (including higher education and school aid payments), and social services were inevitable. Together, these departments comprise 76% of the general-fund budget. The legislature and executive branch have tried to protect basic services during the years. In spite of these efforts, of the over $770 million in Executive Order reductions in 1981-82, approximately 65% was from mental health, education, and social services.

The experience for the MDMH clearly indicates the effect of reduced state revenues. As outlined in Figure 1, the data indicated that the 1982-83 MDMH budget has increased by $130.9 million (32.7%) since 1978-79. However, had the 1978-79 budget been adjusted purely for inflation, the MDMH's budget in 1982-83 would have totaled $593.3 million. The result is a $57.6 million shortfall from the actual purchasing power four years ago. (See Appendix A for the most recent update.)

On the positive side, this reduction in purchasing power has forced the MDMH to prioritize its service better and to find more cost-effective alternatives to traditional services (e.g., psychiatric, continuing education, training, and so on). However, the quality of these services is influenced significantly by the caliber of employees the MDMH can attract and the continuing staff-development efforts offered through its training programs.

The educational and training programs are coordinated by the ORD. Organizationally, the Director of the MDMH is appointed by the Governor of Michigan. The Director's responsibility is to develop a system of public mental health delivery that is consistent with the legislative mandate as prescribed in the Michigan Mental Health Code. As the organizational chart indicates (Figure 2), the management goals and service-delivery priorities are implemented through the four Deputy Directors, with primary operational responsibility assigned to the Chief Deputy Director.

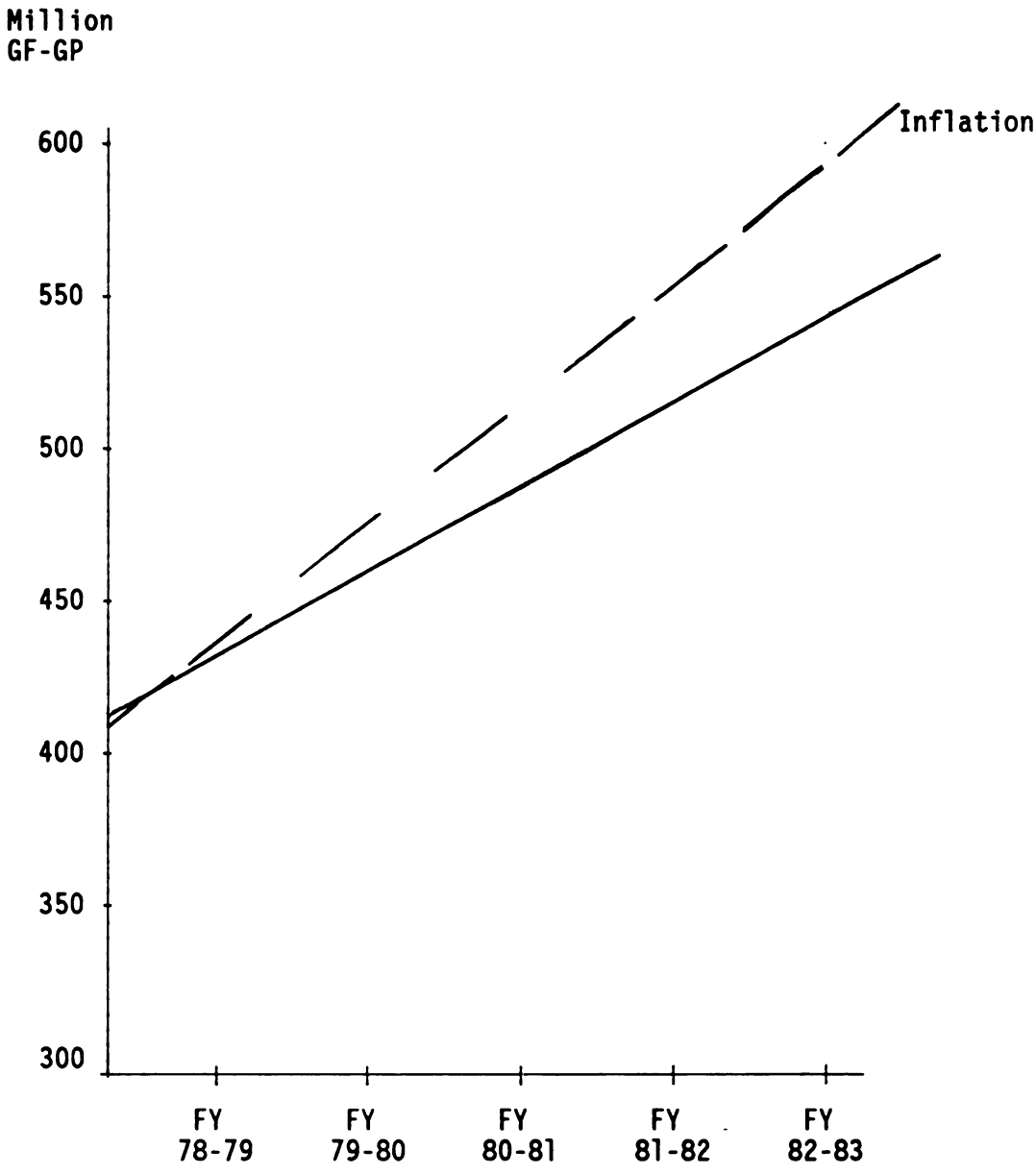

Figure 1.--Effects of inflation on department budget, using Detroit consumer price index inflation rate.

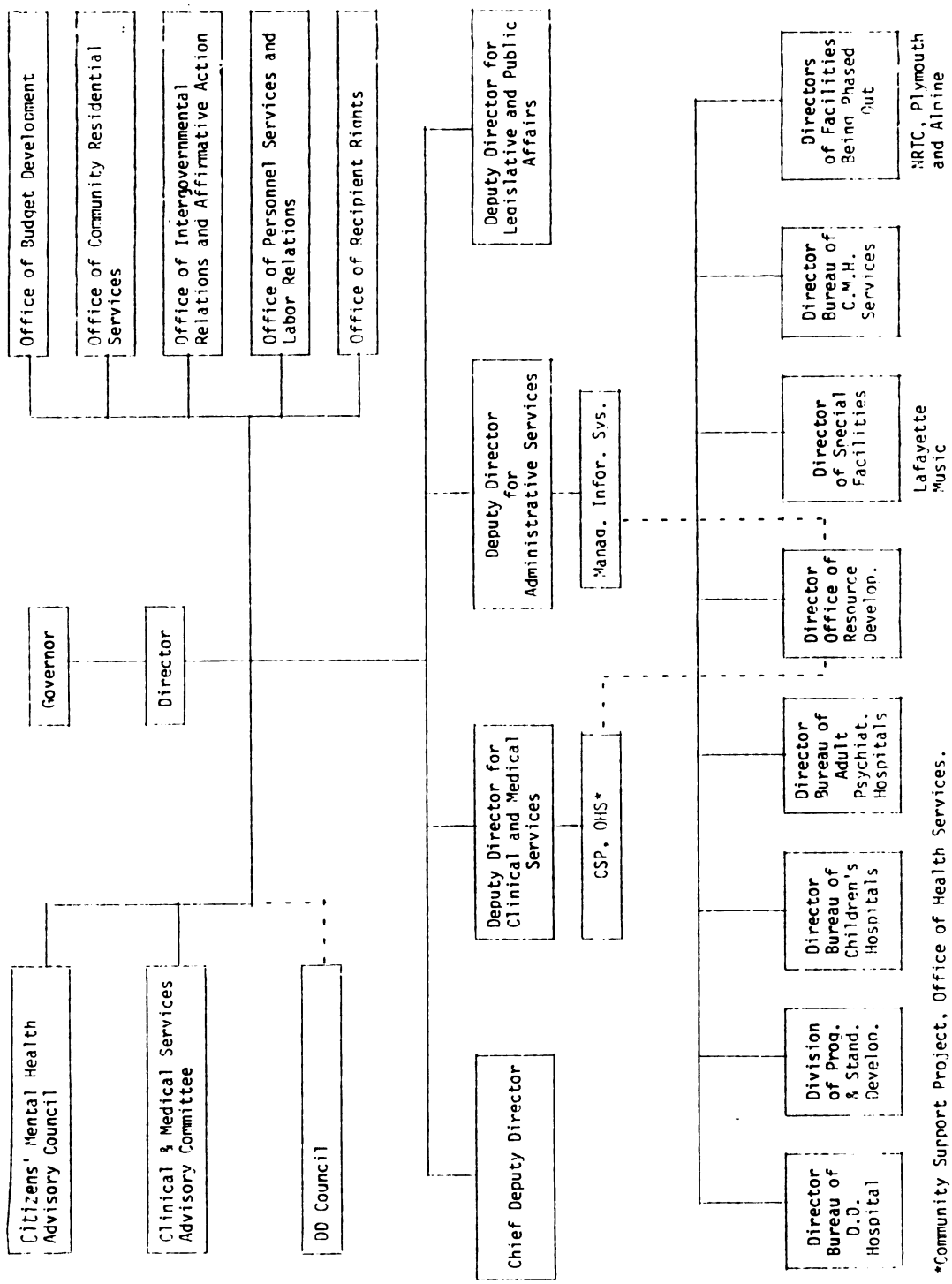

Figure 2.--Organizational chart, Michigan Department of Mental Health.

The MDMH is responsible for planning, program development, management, evaluation, and necessary support functions on a statewide level. Administrative responsibility for state facilities and community mental health service boards (CMHSBs) is managed through this bureau structure.

The ORD, which is also Michigan's State Manpower Development (SMD) Office, reports to the Office of the Chief Deputy Director (Figure 3). As mandated by the National Institute of Mental Health, Health and Human Services (NIMH, HHS), a major emphasis of the SMD Office is to network with higher education agencies for the purpose of developing and disseminating successful manpower strategies to the field. A number of joint planning, program, and curriculum-development projects with the University of Michigan, Western Michigan University, and Michigan State University are in process. The ORD is also responsible for the development, retention, distribution, and use of a competent work force (Appendix B). ORD staff work closely with decision makers at all levels to establish these capacities throughout the system. Primary attention is being given to converting validated information and usable alternatives into the year-to-year budget, decision model, program prioritization, and planning process.

The ORD offers consultation and support to training and resource-development staff in the field regarding specialized curriculum preparation and training of trainers, using materials from a variety of resources. The ORD engages in planning, standards development, and continuing education for a variety of persons within

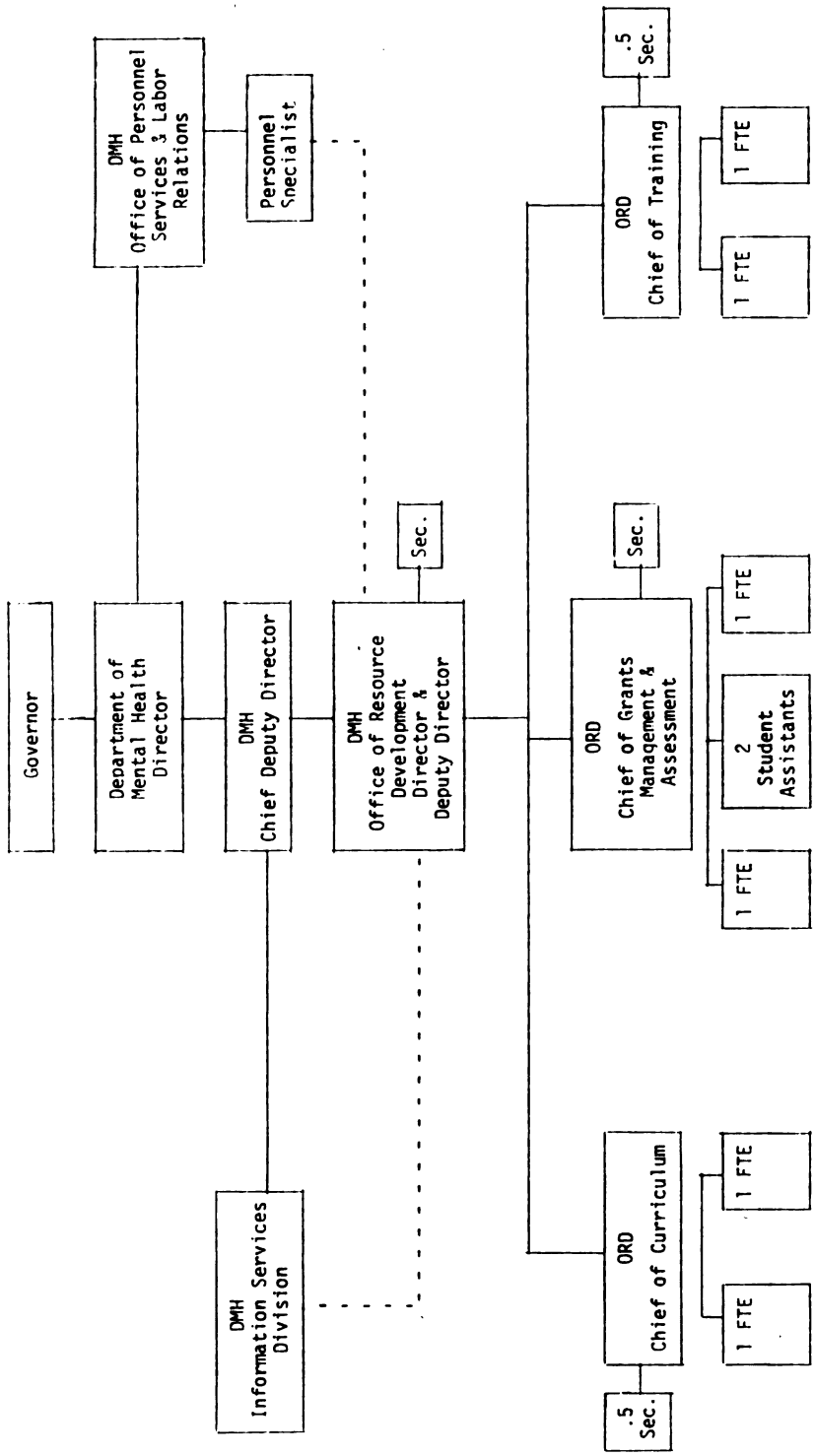

Figure 3.--Organizational chart: Office of Resource Development.

the public mental health system. Assessing the work force has been a function of the ORD since its designation as the SMD Office. For example, the ORD has been given responsibility to implement a program to facilitate re-employment of MDMH employees who have been displaced due to deinstitutionalization and the poor economy.

Recently, the ORD published the Community Group Home Curriculum, Part I (Appendix C), which has been used to train paraprofessionals (residential program aides) providing services to MDMH clients in community group homes. These newly published materials support the MDMH's major program direction and specifically support MDMH goal statements 6, 7, 11, and 12 (Appendix D). These goal statements support quality of service delivery in community residential settings and the downsizing of state psychiatric hospitals and developmental-disabilities centers. The success with which the MDMH meets these goals is contingent on the quality of the training effort put forth by the ORD. With this as the impetus for the study, the researcher proposed to answer the following questions:

1. What is the difference in cost when offering the new Community Group Home Curriculum at a community college versus an MDMH facility?

2. What are the differences in mean assessment scores for each training module for each site (i.e., Schoolcraft Community College and an MDMH facility)?

3. How do the original assessment scores for each paraprofessional compare with a four-month follow-up assessment score for each training site and each training module?

4. What is the turnover rate for trainees at each training site over a four-month period?

CHAPTER II

LITERATURE REVIEW

This chapter initially provides the reader with a summary of general training programs for mental health workers enrolled in community colleges and then identifies specific programs that community colleges have designed to meet identifiable community needs. Finally, there is a discussion concerning research evidence for different instructional methods.

Generalist Training Programs

The training of mental health workers at colleges began at Purdue University in 1966, as a result of a National Institute of Mental Health (NIMH) grant (Simon, 1970). By 1970, there were 45 programs for training mental health workers at community colleges around the nation, and new programs were being added at the rate of one per week (Simon, 1970). These programs, generalized in nature, stressed the use of sensitivity techniques to develop confidence, leadership, and insight for the trainees (Krauss, 1970). Emphasis was placed on the social-cultural aspects of mental health problems and the value of humanistic, caring, remotivating relationships with patients in therapeutic settings (Krauss, 1970). Students in the programs ordinarily took a wide variety of courses, including

English, speech, arts and crafts, philosophy, psychology, anthropology, and first-aid in addition to more specialized training in communication theory, group dynamics, and behavior modification (Atty, 1970). Students also spent up to 1,200 hours in actual contact with clients (Atty, 1970).

The two-year curriculum in mental health developed at the Community College of Philadelphia in the late 1960s was typical of the programs that were created. The objective of the program was to produce mental health "generalists" who could function in almost any mental health setting (Sippel, 1971). In their first year, students took general education courses to develop communication skills and an attitude of "open-minded inquiry into all phases of human behavior" (Sippel, 1971, p. 9). In the second year, more specialized courses in human growth and development and normal and abnormal adjustment were offered. Specialized mental health courses were designed to give trainees a broad background in the field of mental retardation, to show trainees how to apply their knowledge of the social and behavioral sciences to the understanding of people, and to develop skills in communication, observation, group membership and leadership, and the "therapeutic use of self" (Sippel, 1971, p. 9). No fewer than 20 separate organizations cooperated with the Community College of Philadelphia by providing field-work placements for the students.

As a corollary to the development of the new college programs, major conferences were held to determine the role two-year colleges should play in supplying the burgeoning need for paraprofessional

health workers (Gillie, 1972; Penningrowth, 1966). Furthermore, representatives of organizations that might eventually hire the trainees (psychiatric institutes, mental health centers, schools for exceptional children, geriatric centers, hospitals, and halfway houses) frequently formed advisory committees to help the community colleges plan their curricula (Sippel, 1971). The organizations were also willing to allow the trainees to do their clinical training in their facilities.

Despite these efforts, there is currently an inadequate number of trained paraprofessionals to provide adequate care for group home residents (Ashburn, 1982). Community colleges and even large universities have attempted to respond to this void by developing job-relevant curricula for training paraprofessionals in mental health (Ashburn, 1982; McPheeters, 1973). Given the tremendous interest that was focused on the training of mental health workers, why is there still a shortage of competent mental health paraprofessionals?

Basically, the community colleges were establishing two-year mental health technology programs at the associate of arts level. Small numbers of students actually enrolled in the programs, possibly because they were not convinced that a job would be forthcoming after graduation (Krauss, 1970; Sippel, 1971). At the Community College of Philadelphia, which had developed a model program with full institutional cooperation (see above), less than 50% of the trainees actually graduated (Sippel, 1971).

In addition, while the response of community colleges in establishing the programs had been admirable, the process of using a degree program to obtain qualified workers was a lengthy one for state departments of mental health in need of immediate staffing. Also, graduates of the programs were usually not specifically trained to function in a particular setting and had to be retrained by departments of mental health in order for them to function well at their facilities (Ashburn, 1982). Thus community colleges provided general education programs for state departments; however, they did not establish specific, much-needed training programs.

Specialist Training Programs

Community service has long been one of the important missions of community colleges (Frank, 1980). Furthermore, community colleges are currently giving greater attention to community needs and contributing more to community improvement than was true in the past (Mase & Wattenbarger, 1979). Thus, it is reasonable to believe that community colleges could respond positively to the need for better training programs for health paraprofessionals. Several recent reports have pointed to the need for community colleges to work more closely with local governments, businesses, unions, hospitals, and/or community organizations (Frank, 1980) and to determine the best way of meeting the training and educational needs of adults in their service districts, including experimentation with new delivery systems and better coordination with government agencies (Cuyahoga Community College, 1980).

An example of a quick reaction by a two-year college to a pressing community need can be observed in the response by Kellogg Community College to the problem of deinstitutionalizing elderly citizens. A national survey conducted in 1968 pointed out that 39% of the elderly institutionalized residents did not need the specialized care of the institution in which they were living (Andrews, Zinn, & Rae, 1978). Furthermore, a study at the Benjamin Rose Institute in Cleveland, Ohio, found that home-aide services could reduce institutionalization to a great extent and were much cheaper than hospitalization (Beggs, 1970). Shortly thereafter, an analysis completed by the Adult Services Unit of the Calhoun County, Michigan, Department of Social Services found that 33% of the 728 institutionalized senior citizens in that county could have returned to their homes if home-aide and supportive services had been available (Rae, 1975).

Accepting a leadership role in its service area, Kellogg Community College officials compiled a list of agencies that were providing some sort of home health care service and surveyed the agencies to determine whether they would offer employment to trained home health care aides. They were shocked to find that there were no trained aides available, that such aides could find immediate employment in the county once trained, and that several social agencies were in the process of obtaining funds to improve home health care services (Andrews et al., 1978). Kellogg Community College immediately established a home health care aid training program. The program was suited to the immediate needs of the

community, providing intensive training over a short span of time and thus quickly producing a batch of competent home health care aides (Andrews et al., 1978).

Developed by Kellogg Community College in cooperation with the Michigan Department of Social Services and an organization entitled Services to Seniors of Calhoun County, the program comprised 150 clock hours, about equally divided among the topics of home-management skills, basic nutrition, psychology, physical therapy, and field placement. Newspaper advertisements to entice individuals to enroll in the program stressed the excellent job outlook for home aides and the flexibility and satisfaction inherent in the job. Out of 30 original enrollees, 26 graduated from the short program, a high success ratio when compared with two-year programs (Frank, 1980). All 26 found immediate employment, and many senior citizens returned to their homes. Thus, Kellogg Community College made a very effective response to the problem of unnecessary institutionalization of the elderly.

An example of a fine-tuned program that directly attacked a problem at a specific state-operated facility was the one described by Kimball et al. (1980). In this instance, a local university provided an intensive combination of tutorial and direct training for the staff at a residential center for boys with learning disabilities and/or emotional problems. Morale at the center had been a problem. The university trainers instructed the group home staff in specific techniques to be used in the center, and pretests and posttests of

staff perceptions of the group home climate were used to determine the effectiveness of the training.

In Florida, four community colleges serving the geographic areas in which the four largest state mental hospitals were located developed degree programs to train staff members for the group homes that would be used as part of Florida's emphasis on deinstitutionalization. Realizing that the degree process was too lengthy, the colleges instead set up inservice training programs (Ashburn, 1982). These programs involved 290 actual hours of instruction and included training in specific job skills, medication administration, approaches to crisis intervention and control, and psychosocial treatment methods. Also emphasized was the need for trainees to work as part of a multidisciplinary treatment team. Trainees who became actual staff members appeared to do well on the job. First reports indicated that they had positive attitudes toward their jobs and used a team approach more than did staff members who had not undergone the inservice training. Patients also seemed to respond more positively than they had to the traditional staff.

Research Evidence

There is a need not only to develop useful staff-training programs, but also to evaluate empirically the merits of different instructional methods. How does one determine whether a training program has real value or compare the worthiness of different training techniques? Schinke and Wong (1977) described the extreme importance of posttraining testing. In their research, trainers from

the University of Washington provided 12 hours of instruction in techniques of behavior modification to staff members in six group homes for mentally retarded persons. Operant techniques corresponding to specific interactional patterns and the physical structure of small familial settings were taught to staff members. In six other (control) group homes, the trainers provided no direct instruction. Instead, they made themselves available to answer staff questions and provide help with problems as they arose. Pretesting was accomplished in four ways: (a) a knowledge test dealing with concepts, (b) an attitude checklist to determine how staff felt about the group home residents, (c) an evaluation of changes in job satisfaction by the staff, and (d) naturalistic observation done by the trainers to determine whether the quality of interactions between staff and residents had changed as a result of the training.

The results were striking. Trained staff realized significantly more positive gains than untrained staff in knowledge of behavioral techniques and in attitudes toward the residents. While job satisfaction declined in both groups, the decrease was significantly less for the trained staff. Furthermore, trained staff were more efficient in responding positively to positive resident behavior and in responding neutrally or negatively to negative resident behavior. Response latencies also decreased. The frequency and duration of positive interactions between staff and residents increased; the reverse was true for negative encounters. Thus, posttraining testing validated the techniques of instruction used and pointed to the merits of active instruction of staff versus merely providing support

when needed (Schinke & Wong, 1977). As deinstitutionalization continues, there must be some way to evaluate quantitatively the effectiveness of differing group home staff-training programs.

In 1972, Gardner compared role-playing and lecture methods in evaluating the effectiveness of teaching behavior modification to 20 female institutional attendants.

> Pre- and posttest measures were obtained for two major outcome variables--knowledge of behavior modification principles and ratings of ability to apply behavior modification techniques--using the Training Proficiency Scale and the Behavior Modification Test. Results indicate that role playing was more effective in teaching behavior modification skills while the lectures were more effective in teaching principles of behavior modification.

In addition, cost factors associated with different training programs must be considered. Unfortunately, this is seldom done (Mase & Wattenbarger, 1979). With the tightening of funds for extensive and unnecessary programs in allied health education, administrators in community colleges must give careful attention to the employability of graduates and the costs of their programs. State agencies would like to obtain quality training for their staff at the lowest possible price (Mase & Wattenbarger, 1979).

Overall, the paucity of examples in the literature wherein state government and community colleges have actually worked closely together indicates that state government has simply not used public postsecondary education to meet its needs. Community colleges have struggled to anticipate those needs by setting up generalized programs. The successful results produced in those cases in which government agencies and community colleges have worked closely on

specific programs indicate that closer linkages need to be developed and used.

CHAPTER III

DESIGN AND METHODOLOGY

This chapter provides the reader with the details concerning implementation of the training program, a description of the trainees who participated at both sites, and a list of the limitations and delimitations of the research.

Given that the Michigan Department of Mental Health had limited access to historical data related to delivering training at its facilities, the Office of Resource Development (ORD) proposed to evaluate the cost effectiveness of training dissemination, turnover, and trainees' content retention over time. As a part of the National Institute of Mental Health, Health and Human Services 1982-83 grants program, the ORD requested funds to evaluate training dissemination in two types of training sites: (a) an MDMH facility and (b) a higher education facility. More than two sites were recommended for evaluation, but limited resources necessitated that the study be restricted to the two sites. The facilities selected were Wayne Community Living Services (WCLS), one of the MDMH's largest training operations; and Schoolcraft Community College, located less than one mile from that same facility. Both facilities were in close proximity to ORD's satellite office, located in Northville, Michigan.

Method

A meeting was held with the director of the facility selected by the ORD director (the researcher) to complete the training for the MDMH. The research, its purpose, and its benefits to the public mental health system were discussed. The rules for participation were as follows. The facility director's training staff would be requested to train 30 trainees (paraprofessionals) selected by simple random selection, using the MDMH/ORD newly published Group Home Curriculum, Part I. Trainees would be selected from the MDMH's facility trainee waiting list (the same list was used for both sites). The staff conducting the training would be qualified trainers meeting the ORD and Michigan Department of Civil Service standards/qualifications. The training would take approximately three weeks, with approximately 30 hours of classroom training per week. At the end of each training module (Part I included seven modules), an assessment would be administered; scores would be tabulated and recorded. At the end of the three-week period, all tests taken by each trainee would be sent (by mail) to the ORD. Trainees who passed the seven assessments would return to the group home, where they could work independently with clients. At the end of four months, the group home staff originally tested would be asked to return to a testing site to be retested on the same materials used in the initial training. This retesting was to be coordinated by ORD staff. Tests and scores would be submitted to the ORD director.

A meeting was also scheduled at the second training site, the community college. This meeting was held with a program

representative of the community college. Thirty randomly selected trainees were chosen from the MDMH's facility waiting list (the same list was used for both training sites). The researcher explained the study, discussing purpose and responsibility. Both the ORD and the community college signed agreements (Appendix E) reflecting contract obligations. The contract outlined the following:

1. Training would be done by paid community college staff.

2. The ORD would pay a negotiated fee for each class going through the four-week course.

3. Tests would be administered at and by the college. Follow-up testing was supervised by ORD staff.

4. Community college staff had to meet the trainer qualifications or participate in a one-day training of trainers session offered by the ORD.

5. Use of the ORD's trainer manual for the Community Group Home Curriculum was optional.

The reimbursement mechanism used was developed by the MDMH's Accounting Office. The procedure was as follows: (a) a bill would be submitted to the ORD by the community college for the services rendered; (b) a justification memorandum would be sent to the MDMH's Accounting Office with the account number to be billed; and finally (c) a check would be issued within 30 days. The MDMH billed the Federal Manpower Grant, issued by the NIMH, HHS (Appendix F).

Both the community college and MDMH facility representatives agreed to provide the ORD access to information/data relating to cost

variables. The community college agreed to a flat fee for training. Thus, the variables that determined their cost were not necessary.

The facility costs were more involved; the following variables were used:

--Salaries/wages of trainers

--Fringes (vacation, hospitalization, sick leave, etc.)

--Travel

--Meals

--Equipment

--Indirect costs (maintenance, housekeeping, general administration, depreciation, utilities)

--Contract services, supplies, and materials (CSS&M)--telephone, printing, contract with Red Cross

Limitations and Delimitations

The following limitations applied to this research project:

1. The limited state and federal dollars allocated for this research forced the sample size to be small for the community college training site.

2. No comparison to previous costs for training was available due to the lack of historical data.

3. Due to limited funds, only two training sites were used in the design.

4. The research was time limited due to the work-plan restriction for the federal grant.

5. Because of estimated high turnover rates of paraprofessionals, a four-month retest interval was used.

This research compared quality and cost variables at two different instructional sites, using the Group Home Curriculum. This curriculum has been published under the direction of the investigator and is the longest curriculum-development activity undertaken by the MDMH in the past 12 years. It is also the first curriculum that has a complete set of policies and standards for trainer practice. Although this research design may be relevant to a number of MDMH curricula materials, the investigator selected the one that focused on the MDMH's major goal--deinstitutionalization and community placement of its clients.

Subjects

Sixty individuals were randomly selected from the MDMH's facility trainee waiting list to be trained as group home workers. Thirty received their instruction at a MDMH facility, the other 30 at Schoolcraft Community College. All subjects had to be over 18 years of age and agree to sign consent forms.

MDMH Training

At the MDMH facility, the staff conducting the training consisted of qualified trainers meeting MDMH/ORD and Michigan Department of Civil Service standards and qualifications. The MDMH's newly published Group Home Curriculum, Part I, was used as the basis for training. The training took approximately three weeks, with 30 hours of classroom instruction per week. Also, trainees had to attend the training for cardiopulmonary resuscitation (CPR) and first aid, which was subcontracted to the local Red Cross.

Trainees were tested at the end of each training module (there were seven modules in all). At the end of three weeks, trainees passing all seven assessments went to newly developed group homes to work with clients.

After four months, individuals still working in the group homes were asked to return to the facility for retesting on the same training materials. This retesting was coordinated by ORD staff. In an attempt to maximize the number of people taking the retest, the test was offered on three separate dates, all within the span of one week. Each person taking the retest qualified for a $15 expense voucher. This training sequence is summarized in Table 1.

Table 1.--Training sequence.

Module	Number of Questions on Exam
1	50
2	25
3	50
4A	50
4B	50
5	50
6	25
7	20

Community College Training

At the community college, training was done by community college staff. Community college instructors either met qualifications or participated in a one-day training-of-trainers session. Before the instruction, the ORD director met with a representative of

Schoolcraft Community College to discuss the purpose and responsibilities of the research. An agreement signed by the ORD and the community college provided for tests to be administered at and by the college, with results reported directly to the ORD. The ORD was required to pay a negotiated fee for each trainee going through the course. (This course was offered after 5:00 p.m.) The agreement also indicated that use of the ORD trainer manual was optional. Like the facility trainees, individuals tutored at the community college who had passed the seven module assessments began working at newly developed group homes and were called in for retesting after four months.

Materials

The tool used to assess the trainee's mastery of the course material was Form A of the Assessment Package for the Group Home Curriculum. (See Appendix G.)

CHAPTER IV

RESULTS

The purpose of this chapter is to report the results of the data analysis. The researcher will make no attempt at drawing any conclusions, making suggestions, or interpreting data in this chapter. In Chapter V the major conclusions that can be drawn from these analyses are reported. This chapter is organized around the themes of turnover, effectiveness, and costs.

The Turnover section reports the results of data collected on trainees immediately posttested and then retested four months later. This section answers the question, "What is the turnover rate for trainees at each training site over a four-month period?"

The Effectiveness section reports the results of the data collected and analyzed to answer the questions, (a) "What are the differences in mean assessment scores for each training module for each site?" and (b) "How do original assessment scores for each paraprofessional compare with a four-month follow-up assessment score for each training module and each training site?"

The Costs section reports the data analysis designed to answer the question, "What is the difference in cost when offering the new Community Group Home Curriculum at a community college versus an MDMH facility?"

Turnover

Turnover rates differed between dissemination strategies (Table 2). At the community college, of the original 30 trainees, 20 individuals (67%) completed the instructional program and took the original tests. At the MDMH facility, 29 persons (97%) completed the course and were tested. Only five individuals (17%) from the community college were retested, whereas ten (33%) MDMH trainees took the retest.

Table 2.--Number of individuals who completed testing.

	Number Beginning Instruction	Number Completing Original Test	Number Retested
Community college	30	20	5
Department of Mental Health	30	29[a]	10

[a]Eight of the 29 were not originally tested on Modules 4A and 4B.

Thus, out of 20 individuals completing the original test at the community college, 15 were not retested (Table 3). Ten of these quit working at the group homes (a 50% dropout rate), whereas the other five were still employed but did not show up for retesting.

Out of 29 individuals completing the original test at the MDMH facility, 19 were not retested (Table 3). Only six of these had terminated employment (6/29 = 21% dropout rate). The other 13 simply failed to appear for retesting.

Table 3.--Fate of individuals not retested.

	No. Completing Original Test	No. Not Retested	No. Dropouts	No. Still Employed But Not Retested
Community college	20	15	10	5
Department of Mental Health	29	19	6	13

Effectiveness

Statistically, the results (number of correct answers for each person for each module) were analyzed as a 2 x 2 factorial experiment. There were two factors of interest (instructional site and time of testing) and two levels of each factor (the MDMH facility versus community college for instructional sites, original test versus retesting for the time factor).

Analysis of variance was used to test research questions concerning quality-of-treatment means and to check for interactions between the two factors (instruction site and time).

The actual number of correct answers by each person for each module was used as the variable of interest rather than the percentage score to avoid problems associated with the use of ratios (i.e., non-normality). Scores obtained for each treatment combination for each module were analyzed for normality using a test developed by Shapiro and Wilks (cited in Gill, 1978). No departures from normality were found. Use of Hartley's fmax test (cited in

Gill, 1978) ruled out heterogeneity of variance between treatment groups.

Since replication was unbalanced (as mentioned, at Schoolcraft 20 people took the first test and 5 took the retest; at the MDMH facility from 21 to 29 people were tested on various modules on the first date and 10 people were retested), a technique developed by Federer and Zelen (cited in Gill, 1978) to deal with unbalanced data was used. Sums of squares (and thus mean squares) were calculated for main effects (instructional method and time), interaction, and experimental error, and F-tests were carried out to determine statistical significance.

Test scores obtained by trainees at the MDMH facility and the community college were very similar (see Table 4). No significant difference was found between test scores at the two instructional sites for Modules 1, 2, 3, 4B, 5, 6, and 7. For Module 4A, scores were significantly higher at the community college (42.45) than at the MDMH (39.45). This was the only case in which instruction site had a significant effect on test results.

Test scores were fairly similar over time (see Table 5). For Modules 1, 2, 3, 5, 6, and 7, time of testing had no significant effect on test scores. For Module 4A, test scores dropped from 47.9 on the first test date to 34.0 on the retest. For Module 4B, test scores declined from 47.28 to 41.70.

Table 4.--Comparison of test scores between Schoolcraft Community College and the Department of Mental Health.

Module	No. of Questions on Exam	Mean No. Correct Answers: Community College (± 1 SE)	Mean No. Correct Answers: MDMH (± 1 SE)
1	50	44.68 ± 1.02	42.85 ± .81
2	25	22.51 ± .52	21.65 ± .41
3	50	42.73 ± .88	43.15 ± .70
4A	50	42.45 ± .71[a]	39.45 ± .63
4B	50	45.20 ± .64	43.78 ± .57
5	50	44.43 ± .69	44.15 ± .55
6	25	21.80 ± .35	22.02 ± .28
7	20	19.90 ± .08	19.80 ± .07

[a]Indicates mean score for Schoolcraft was significantly higher than MDMH mean score.

Table 5.--Comparison of test scores between original test date and retest dates for each module.

Module	No. of Questions on Exam	Mean No. Correct Answers: Original Test (± 1 SE)	Mean No. Correct Answers: Retest (± 1 SE)
1	50	42.83 ± .73	44.70 ± 1.31
2	25	21.71 ± .37	22.45 ± .67
3	50	42.73 ± .81	43.15 ± 1.13
4A	50	47.90 ± .55[a]	34.00 ± .92
4B	50	47.28 ± .50[a]	41.70 ± .83
5	50	45.32 ± .49	43.25 ± .89
6	25	21.67 ± .25	22.15 ± .45
7	20	19.85 ± .06	19.85 ± .11

[a]Indicates score was significantly higher on original test date.

Two significant interactions were found between test site and time--on Modules 4B and 5 (see Table 6). In Module 4B, test scores dropped over time for both instructional sites, but the decline was more precipitous (from 47.76 to 39.8) at the MDMH than at Schoolcraft (46.8 to 43.6) (Figure 4). For Module 5, scores were lower on the retest at the MDMH (the decline was 46.79 to 41.5), while scores actually rose at the community college (from 43.85 to 45.0) (Figure 5).

Table 6.--Mean test scores (± 1 SE) for each treatment combination and module)

Module	No. of Questions on Exam	Community College		MDMH	
		Original Test	Retest	Original Test	Retest
1	50	43.35±.92	46.00±1.70	42.30±1.20	43.40± .79
2	25	21.83±.49	23.20± .37	21.59± .55	21.70± .82
3	50	41.45±.92	44.00±1.41	44.00± .89	42.30±1.25
4A	50	49.50±.28	35.40±1.94	46.30± .70	32.60±1.93
4B	50	46.80±.71	43.60±1.21	47.76± .64	39.80±1.25
5	50	43.85±.90	45.00±1.38	46.79± .53	41.50±1.25
6	25	21.20±.41	22.40± .40	22.14± .35	21.90± .43
7	20	19.80±.12	20.00±0.00	19.90± .06	19.70± .15

Sums of squares, mean squares, and F-ratios are shown for each module in Appendix H. To summarize, in the seven modules, only five significant effects were found, all in Modules 4A, 4B, and 5. One significant effect (Module 4A) was found for instruction site, two effects were obtained for time of testing, and there were two interactions.

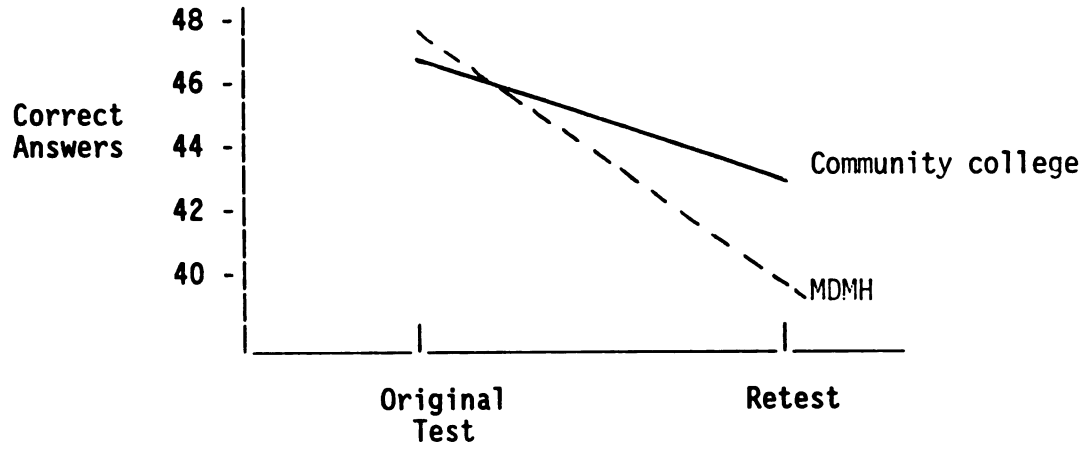

Figure 4.--Module 4B test scores.

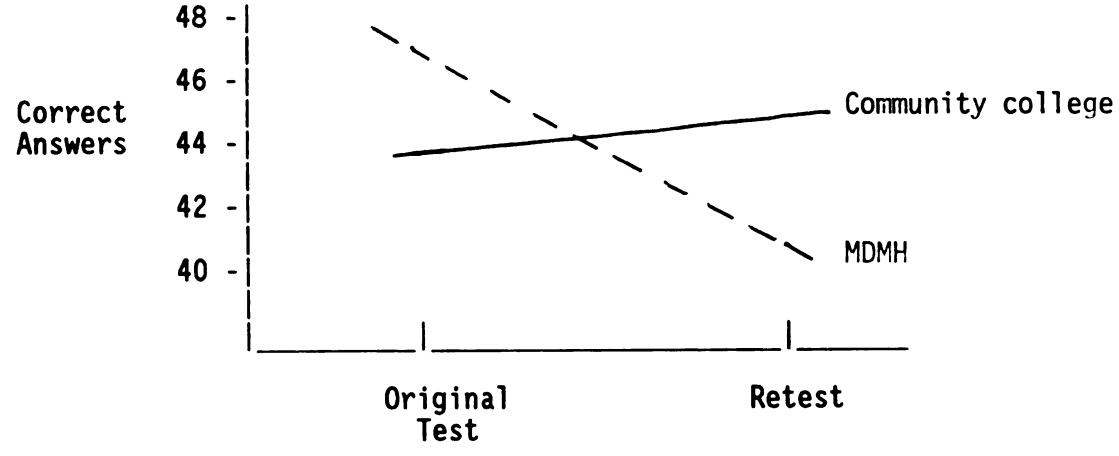

Figure 5.--Module 5 test scores.

Costs

Community college: Contracts signed by the ORD and Schoolcraft Community College reflected flat fees for delivering the training. The cost for the total training package was $5,970, including $1,550 for administrative and duplication costs and $4,420 for the actual training. Administrative costs for the college included equipment, telephone, printing/duplicating/mailing, travel, meals, meeting time with instructors and school personnel, administrative support (clerical, accounting, and so on), utilities, and training-site rental. The faculty costs included training 30 students in the Group Home Curriculum; holding sessions four nights a week, four hours per session, for four weeks; assessing the content knowledge; and making copies of test results.

MDMH facility: The process of cost accounting for the MDMH facility involved two methods for computing the costs of delivering training. The first method entailed a retrospective costing-out system. Calculations for trainer planning and classroom time were computed; supplies, meals, telephone, and travel were totaled; indirect costs applied to the training unit were estimated (Table 7); and contract costs for delivering CPR and first-aid with the Red Cross were included. A total figure was then computed and divided by the original number of trainees (30) entering the training program.

The second method entailed a prospective costing-out formula for the training resources used to deliver the Group Home Curriculum. Standards were developed (such as class size, number of hours in a training day, and so on); a formula was developed reflecting the

number of classroom hours needed to deliver Part I of the Group Home Curriculum; and supplies, telephone, and indirect costs were estimated, using figures collected by the retrospective method. The detailed formula and calculations for both these methods may be found in Appendix I.

Table 7.--Total cost report, by program, Macomb/Oakland Regional Center (Wayne Community Living Services).

	Total Cost
Charges	
Direct	$351,311
Indirect + overhead	$134,285
Total	$485,596
Performance units	26,832[a]
Total cost per unit	$ 18.09
Direct costs/unit:	
Personnel	$ 12.79
Full-time equivalent (employees)	12.9
Other direct	$ .29
Indirect costs/unit	
General administration	$ .38[b]
Fringes	$ 4.33[b]
Physical plant	$ .10[b]
Maintenance	$ .07[b]
Housekeeping	$ .06[b]
Depreciation	$ .04[b]

[a]Training hours.

[b]Cost per training hour.

The results for delivering training at both instructional sites were tabulated by both the retrospective and prospective methods.

Total cost per trainee for the Schoolcraft Community College instructional site was $199. This figure includes all direct and indirect costs. The cost per trainee for the MDMH as computed by the retrospective method was $135, whereas the cost as computed by the prospective method was $122 per trainee.

CHAPTER V

SUMMARY, CONCLUSIONS, RECOMMENDATIONS, AND REFLECTIONS

Summary

The major objective of the MDMH is to place their inpatient recipients of service back into a more normalized environment, namely a community residential setting. To increase the probability of success of that placement, the department needed a well-trained work force and a formalized training program. The ORD was assigned the responsibility to develop the Community Group Home Curriculum training package. Part I of this training must be completed by all paraprofessionals working directly with residents within 30 days of hire. Up to 12,000 persons are trained each year in the Detroit Metro area, which includes Wayne, Oakland, and Macomb Counties. Given the continued problem of competing for state general fund dollars, the department was interested in evaluating the cost of delivering this curriculum and hopefully establishing additional strategies for implementation of the training package. The ORD was interested in comparing the cost effectiveness of their training with other training sites.

The ORD is the training arm for the MDMH and also the designated state manpower-development office as designated by the NIMH-HHS. Given the goals of a newly acquired NIMH grant, the ORD proposed to

review cost-effective strategies that would improve the delivery of training as mandated by the MDMH. A proposal to evaluate the delivery of training at a number of training sites outside of the MDMH control was developed. Sites were selected that had similar public service missions and a commitment to continuing education beyond the postsecondary level. Public higher education, namely the community college system, seemed most appropriate, given (a) their previous involvement with training mental health workers and (b) the federal support and mandate for grantees to develop linkages with higher education. A number of community colleges were considered as alternative delivery systems, but cost was a factor that limited the study to two training sites--an MDMH facility and one community college.

The researcher investigated whether collaboration and planning between higher education and the public mental health system can provide cost-effective training for paraprofessionals who work in community group homes for the developmentally disabled and mentally ill. Costs, staff turnover, and content retention over time were variables analyzed. Sixty individuals were randomly selected from a waiting list to be trained as group home workers. Thirty received their instruction at an MDMH facility; the other 30 received instruction at Schoolcraft Community College. The tool used to assess the trainees' mastery of the course material was the assessment package for the Group Home Curriculum. Although there are seven modules, eight comparisons were made due to two different assessments for Module 4 (1, 2, 3, 4-A, 4-B, 5, 6, and 7). After

four months, individuals still working in the group homes were asked to return to the facility for retesting on the same materials.

Findings and Conclusions

Turnover

Reduction in turnover of trainees (paraprofessionals) was of utmost importance to the MDMH. A majority of the continuing training needed was due to group home staff leaving employment within one year of hire (50 to 60% turnover rate) in this three-county area. The data analysis indicated that turnover rates were consistently higher at Schoolcraft Community College. The college had a turnover rate of 33% (10 of 30) during the initial training as compared to the departmental facility's rate of 3% (1 of 30). Dropout rates of persons completing the original test increased to 21% (6 of 29) for the facility and 50% (10 of 20) for the college. The increase in dropout rate over the four-month period is even more dramatic if one were to use the original number of trainees enrolled (i.e., 30 per training site). In this case the overall four-month dropout rate for the community college is 67% (20 of 30), with 24% (7 of 30) for the MDMH facility. These staggering dropout rates are a major cost factor for the department. One major conclusion that seems reasonable to make is that turnover is extremely high no matter which site is used. Factors that may have exacerbated the yearly state turnover rates (50 to 60%) are the possible location of the individual instructional sites and the different times training modules were offered (evenings versus days) at these sites.

The researcher was also concerned about the low response rate for retesting. Subjects were notified before completing the course that they would be requested to return for retesting. Even though the retest was offered three times within the same week, only ten were retested from the facility and five from the community college. To encourage participation, a $15 fee was paid to all persons agreeing to be retested. Obviously, the $15 fee was not enough incentive to encourage them to return. Fifty percent (5 of 10) of the direct care workers trained at the community college and still working did not show up for the retest, compared to 57% (13 of 23) of the employees trained at the facility. The low response rate for both groups indicates a need to develop different strategies that provide incentive to participate in follow-up testing (e.g., increase fees, make retesting a part of the employment obligation).

Given these supportive data and analysis concerning turnover, the investigator concluded that turnover, although higher at the community college, was high at both training sites. This variable is one of the most important issues to be considered.

Effectiveness

Comparing the effectiveness of the training at the different instructional sites also was a major interest of the study. Content retention over time was equally important to evaluate. Since the dropout rate of more than 50% to 60% was documented from historical data and this research documented a dropout rate of up to 67% within

four months, one would hope that content retention for those who remained would be higher.

No significant difference was found in test scores between instructional sites except for Module 4-A. One may assume, from a cursory review, that one significant effect out of eight comparisons may not be enough for a large state department to consider supporting one instructional site over another. But the content of this module (i.e., life-threatening situations/CPR) is considered the most important for trainees to comprehend. In a community residential setting where physicians and other adjunctive therapists are not normally a part of the on-grounds full-time staff complement (as on inpatient wards), group home staff are the only immediate recourse for patient safety. When one further investigates the training procedures for Module 4-A, it is found that the facility training department contracts this module out to another vendor--the Red Cross--which means that the significantly higher scores at the community college were not compared to facility trainers, but to Red Cross trainers. One final point concerning test scores: Although no significant effects were found on the seven other comparisons, those trained at the community college did have a higher mean number of correct answers in six out of eight comparisons.

When looking at test scores over time, six of eight comparisons indicated no significant differences were found. However, scores dropped significantly in the most crucial modules of 4-A and 4-B (life-threatening situations/CPR and first-aid). This finding

continues to raise concerns given the fact that medical staff is not readily available in the community residential setting.

Two interactions were found between test site and time. One related to Module 4-B (First Aid) and the other to Module 5 (Medications). Module 4-B dropped over time at both the facility and the community college. The decrease in test scores was less severe at the community college for Module 4-B. Module 5 actually showed an increase in test scores over time by those trained at the community college.

Generally speaking, although only five significant effects were found, they occurred in the content areas of CPR, first-aid, and medications, where comprehension is of top priority to the department. In most cases, the decline in content retention was more precipitous at the MDMH facility, whereas those trained at the community college had an increase in test scores in one of the eight modules (i.e., Medications).

In light of the supportive data and analysis concerning effectiveness (content retention), the researcher concluded that content retention/effectiveness scores were higher at the community college in six out of eight modules, and test scores were improved in the most crucial life-threatening areas (CPR, First Aid, and Medication).

Cost

Cost is a major consideration for program delivery in any public service system. Although many propose that quality of service should

not be compromised for a lack of resources, the reality facing the department is limited training dollars. One must make a determination as to whether the department supports its own self-contained training delivery system, contracts these services out to other vendors (e.g., community colleges, private training corporations, and so on), or develops some combination of the two previous strategies.

When one looks at the cost of delivering training at the community college, the figure of $199 per trainee is compared to a high of $135 for the MDMH facility (retrospective method). This $64 difference must be considered in the context of a first attempt by the community college to deliver a new curriculum versus the long-standing delivery at the MDMH facility.

Another consideration is that the MDMH may have other hidden administrative savings not reflected in this research if replication at the community college occurred on a larger scale. Economy of scale is another variable that implies a higher cost factor for the community college. Given the obligation to deliver one training for 30 direct care workers/paraprofessionals as compared to a DMH facility training up to 5,000 trainees per year, it is assumed that cost at the facility may be cheaper. The bottom line, given the present data, is if the MDMH had to train 15,000 people next year and place them in these three counties, it would cost an additional $960,000 ($64 x 15,000 employees) if they use the community college. This assumes no other cost benefits to the department, given that they contract for service.

Based on these supportive data and analysis concerning cost, the researcher concluded that cost is definitely higher at the community college, but this higher cost may be due to the "newness" of the endeavor and the duration of the contract.

Recommendations

Recommendations for Further Research

As the researcher was also the Director of the Office of Resource Development responsible for overall delivery of the training system, this study had a dual significance. Limited resources, a lack of historical data, and a small sample size and return rate make replication a necessity. Replication must occur before major changes are made in the training delivery model used by the department. This study uncovered only the "tip of the iceberg," and a larger sample size, a varied number of instructional sites, and interval testing over a one-year period should be included in future designs.

Given the results of this research, it is recommended that training monies be identified not only to replicate the study but to pilot a training strategy that incorporates the higher education arena as a part of the department's total training delivery system.

With an MDMH budget in excess of $1 billion, the $960,000 additional cost seems a minimum price to pay for improved efficiency even if effects are limited to two or three of the eight comparisons. Because the content areas cover life-threatening situations, they are a top priority. The costs involved in one unfortunate death in a community group home would justify this expense--if not from a

quality-of-care standpoint, then because of legal and compensation costs alone.

The only reservation to the above position is consideration of the high turnover rates. No one variable is more disconcerting than the 24% to 67% turnover that occurred during this study. Because of the high turnover rates, the researcher thinks it is worth supporting a dual system (i.e., MDMH and pilot contract with agencies, colleges, and so on) for some given length of time (e.g., 12 months, 18 months).

Recommendations for Change and Future Direction

Although the results of this study have been reviewed by the department for some time, the direction to support solely an MDMH training system occurred. Until just recently, the department has reconsidered and is about to contract with other community colleges to deliver Community Group Home Curriculum training and other training packages developed by the ORD and the Department's Personnel Office.

Consideration is being given to larger sample sizes, interval testing and follow-up over longer periods, varied training sites, trainees receiving college credit for department curriculum, and having community college human service graduates participate in the testing and assessment of their content knowledge of the department's Community Group Home Curriculum.

These changes have occurred two years after the results of this initial study. The researcher believes that factors such as the Governor's office and the Michigan Human Services Cabinet supporting higher education and state government collaboration as a part of its public policy influenced this direction. As stated in the opening paragraph of Chapter I, "Public education and the public mental health system, as a part of their mission, have a responsibility to provide services that meet community needs." This direction seems more a reality today than ever before. Michigan's Executive Office is now more actively supporting this policy direction, which this research supported three years ago.

Reflections

Part of the difficulty in implementing this study was the perception that the Director of the Office of Resource Development of the MDMH was interested in phasing out the existing training faculty. Their apprehension to cooperate, participate in the study, and collect accurate data and cost figures was therefore problematic. Also, given the fact that the researcher was also the ORD Director added to the apprehension. An overall uneasiness occurs when cutbacks are being considered, no less having the effectiveness of one's training office being compared to a community college. Supplying the data that might possibly support their extinction was, to some, a bit much to ask for one who was part of the existing training community (i.e., ORD and facility training offices).

On the other hand, most training offices have more than enough to do, and extinction was not the real direction at all, but an opportunity to evaluate other training delivery strategies that might complement the limited training resources within the MDMH. A possible spin-off was to create new markets where MDMH faculty could market their skills (e.g., community colleges may hire MDMH trainers as part-time faculty).

The community college, on the other hand, was quite receptive to the proposal. They obviously had nothing to lose and, although small, the contract reflected additional markets they could access. The major problem with the community college would be in adjusting or incorporating this curriculum in their overall degree programs. This effort would encourage state departments, such as Mental Health, to channel their training responsibility to the higher education sector. Another benefit for the participating state department is the delivery of a content-specific curriculum pertinent to on-site jobs instead of the generic training acquired from two-year degrees.

One of the general complaints of state administrators, managers, and supervisors is that persons graduating from school have no real job-related experience and most often need to be retrained when entering the workforce. Whether this is actually true or not may be debated, but having employers influence the development of a curriculum or endorse a community college curriculum is invaluable. Having employers such as the MDMH influencing training materials seems wise, if not reasonable.

Other problems impeding the implementation process include a commitment from persons to be retested. This may be handled by administrative policies and/or directives as a part of the employment agreement or by increasing the amount one receives for a retest.

One must conclude that without funding from NIMH in 1984 this study would never have been possible. Both the MDMH and public higher education have a public service mission, yet both were somewhat cautious about committing resources to this project if not subsidized. Given the daily crises affecting the MDMH, resources for research seem to take a secondary priority, even when planning can potentially save dollars.

These issues should be considered and will probably recur within a replicating situation. Finally, the reader must keep in mind the time frames for this research:

1. NIMH grant: July 1, 1983, to June 30, 1984
2. Training occurred: April/May 1984
3. Follow-up test: September 1984
4. Recommendation to MDMH: March 1985
5. Recommendations implemented starting April 1987
6. Dissertation: September 1987

APPENDICES

APPENDIX A

GONGWER NEWS SERVICE EXCERPT REGARDING HUMAN SERVICE AND FINAL 1983-84 GENERAL FUND BUDGET

State, $136.8 million; Wayne State, $111.9 million; Central, $33.3 million; Eastern, $38.6 million; Ferris State, $24.6 million; Grand Valley State, $14.7 million; Lake Superior State, $6.5 million; Northern, $23.8 million; Oakland, $22.1 million; Michigan Technological, $23.9 million; Saginaw Valley State, $7.7 million; Western, $51.3 million; UM-Dearborn, $10.5 million; and UM-Flint, $9.4 million. MSU's Agricultural Experiment Station and Cooperative Extension Service would each get 9 percent increases to $14.2 million and $12.6 million, respectively.

Financial aid would increase 10.2 percent to $53.9 million, including $12.8 million for scholarships, $17.5 million for tuition grants, $16.5 million for tuition differential grants, and $6.5 million for grants to private institutions.

COMMUNITY COLLEGES: A uniform 6.5 percent increase was recommended for each of the 29 institutions, bringing total spending to $143.2 million.

HUMAN SERVICE

MENTAL HEALTH: A total budget of just under $740 million, $596.3 million from general funds, is recommended by the governor. If enacted, the budget would be an overall 8.3 percent increase over the current year's expenditures, and a general fund increase of 14.2 percent.

The budget presumes that on October 1 there will be a total patient population in the state's adult and children's psychiatric hospitals, and developmentally disabled centers, of 6,325. Through the year that population will decrease by 700 patients. Because of the patient decrease the staffing needs assessment ratio will be improved, a department spokesperson said, from just over 80 percent at the beginning of the fiscal year to approximately 90 percent.

The budget calls for overall employment of 11,091.5, a decrease of 277. The budget also includes the closure of the troubled Plymouth Center, which must close under a federal court order, and the Northville Residential Training Center. Residents of those centers will be transferred to community group homes. The two closures are part of an overall long term plan, Tom DeLoach of the department said, and not specifically ordered for this budget.

The budget specifically calls for $85.9 million in general fund programmatic increases which is offset by reductions of $51.2 million. The largest programmatic increase is $37 million for community mental health—a total general fund appropriation for community mental health of $447.3 million is recommended—along with another $33.9 million for community placement program development. Another $10.3 million is recommended to replace losses of federal funds associated with population reductions in facilities, and $4.9 million is allocated for staffing improvements in adult and children's psychiatric facilities. Programmatic cuts include $15.6 million for reductions in the developmentally disabled centers; $12.1 million due to increased reimbursements for mentally ill programs; $16.4 million in continued 1983 Executive order reductions; $7.1 million in director's discretionary reductions.

The budget also includes a general fund expenditure of $112.1 million for residential services, $138 million overall. Funding for the department's executive office would be a general fund figure of $27.9 million, an overall expenditure of $33.8 million.

PUBLIC HEALTH: Mr. Blanchard is calling for an overall budget for the department of $226.5 million, with a general fund total of $100.2 million. The overall budget is an increase of 5.6 percent over 1982-83, the general fund total is a 13.9 percent increase. The budget recommends a drop in employment of 70.1 persons to a total of 1,838.1 workers.

Programmatic increases of $1 million each for the crippled children's program and state-local cost sharing are recommended, as $180,800 for equipment and $150,000 for public accounting

FINAL 1983-84 GENERAL FUND BUDGET

Department	1982-83 Spending	1983-84 Appropriations	$ Change	% Change
Social Services	$1,874,239,700	$2,071,507,201	$197,267,501	10.2
Mental Health	521,974,300	596,317,000	74,342,700	14.2
Public Health	87,974,700	100,214,600	12,239,900	13.9
Corrections	225,899,200	260,975,600	35,076,400	15.5
Education	24,728,624	26,603,000	1,874,376	7.6
School Aid	357,362,000	503,627,000	146,265,000	40.9
(School Aid Fund)	(811,768,000)	(890,499,000)	(78,731,000)	(9.7)
Community Colleges	135,000,000	144,708,800	9,708,800	7.2
Higher Education	700,497,239	761,166,400	60,669,161	8.7
School retirement	0	1,500,000	1,500,000	0.0
Executive	2,601,357	2,922,700	321,343	12.4
Legislative	51,539,900	54,039,800	2,499,900	4.9
Library	15,041,600	17,761,000	2,719,400	18.1
Judicial	56,998,900	64,895,100	7,896,200	13.9
Attorney General	14,067,600	16,162,300	2,094,700	14.9
State	8,170,400	9,529,400	1,359,000	16.6
Mgt. & Budget	106,792,636	87,104,100	-19,688,536	-18.4
Treasury				
Operations	47,762,900	52,553,700	4,790,800	10.0
Debt Service	112,472,000	117,482,800	5,010,800	4.5
Civil Service	6,528,400	8,504,300	1,975,900	30.3
Civil Rights	7,821,800	8,496,300	674,500	8.6
Commerce	49,331,800	64,576,500	15,244,700	30.9
Labor	56,724,300	56,034,200	-690,100	-1.2
Lic. & Regulation	12,994,700	13,258,500	263,800	2.0
State Police	120,352,400	128,782,900	8,430,500	7.0
Military Affairs	8,891,100	9,897,200	1,006,100	11.3
Agriculture	17,839,100	19,957,300	2,118,200	11.9
Natural Resources	42,823,500	52,045,300	9,221,800	21.5
Transportation	9,200,000	9,200,000	0	0.0
Capital Outlay	50,425,000	50,679,000	254,000	.5
Total	4,726,055,156	5,310,502,001	584,446,845	12.3
Estimated revenues	4,753,600,000	5,354,000,000	600,400,000	12.6

APPENDIX B

PORTION OF POSITION DESCRIPTION FOR ORD DIRECTOR

16. GENERAL SUMMARY: Briefly summarize the general function and purpose of your job. Directly responsible for the development, organization, and maintenance of a training system that is responsive to the management and policy direction of the public mental health system. This includes the setting and implementing of policy and standards for training programs and trainer practice in the public mental health system; developing and implementing a monitoring and assessment system; managing the development of training resources (curricula and training development for 85+ trainers in the system); directing training for medical, clinical, and administrative professionals in the public mental health system; managing/coordinating central office (16 staff) and field training CONTINUED - SEE ATTACHMENT

Percentage of Time	17.a. DESCRIPTION OF WORK: Describe each duty you perform. Use a separate paragraph for each duty and show by percentage how much time you spend on each. Include the kinds of equipment or material, if any, used in each duty. Use additional paper if necessary. FOR EMPLOYEES WHOSE POSITIONS ARE CLASSIFIED IN THE CLERICAL SUPPORT SERVICE: Following each duty, list the tasks you perform in order to complete the duty. Use the CS-214A numbered list of representative tasks which is available in all Personnel Offices. You need only indicate the task numbers. Describe any other tasks which are not listed. Duty: One of the various responsibilities that makes up your total job. Task: An action or activity performed in order to accomplish a duty.
____%	DUTY 1: Responsible for directing and managing comprehensive statewide training system for the DMH that is responsive to current priorities and anticipates future changes. Coordinate, evaluate, determine the location and utilization of 85+ trainers developed and maintained by the Office, including position allocation, curricula development, performance evaluation, and trainer selection and assignment to staff special projects; work with all bureau chiefs, facility directors, and CMH directors to identify and develop TASK NO.: CONTINUED - SEE ATTACHMENT
____%	DUTY 2: As Director of the Office, oversee the development and implementation of departmental policy and standards regarding training programs, the development of curricula and standardized assessments, uniform implementation of curricula, and trainer development for 85+ DMH trainers and training managers, and 39 CMH training offices TASK NO.:
____%	DUTY 3: Maintain a system and capacity for providing needed training and continuing education to physicians, other clinical staff, and administrators in the public mental health system. Supervise the Continuing Medical Education Committee and its program budget. Function as a senior faculty for trainer development and selected training programs for Clinical and administrative staff in the system. TASK NO.:
____%	DUTY 4: Responsible for establishing and maintaining a system of ongoing monitoring and assessment of the training programs throughout the public mental health system to determine the effectiveness and impact on DMH goals and priorities. This includes facility and CMH training programs and all continuing education programs. Coordinate evaluation research for the Group Home Curriculum - macro and micro assessments. TASK NO.:

17.b. Which of the duties cited above do you consider to be most responsible? (Respond with the duty number(s) from above.)

1 through 8, 13, 14

17.c. FOR CLERICAL POSITIONS ONLY

WHAT PERCENTAGE OF YOUR TOTAL TIME DO YOU SPEND TYPING? ____ %

WHAT PERCENTAGE OF YOUR TOTAL TIME DO YOU SPEND TAKING SHORTHAND? ____%

CONTINUATION PAGE

#16 - General Summary

budgets and federal grants awarded to the Office. Responsible for the development of the statewide human resource component of all DMH priority plans and assist in the evaluation and monitoring of DMH/CMH staff capacity relating to the projections of human resource needs.

#17 - Description of Work

#1. corrective action for deficiencies and monitor the implementation; work with the chief deputy director to determine departmental priorities for training; provide consultation and technical assistance for facility directors and program managers as needed to improve the operation of field training programs; develop and field test cost effective curriculum dissemination mechanisms for published curricula.

APPENDIX C

GROUP HOME CURRICULUM, PART I

Cover

Preface

Tables of Contents--Chapters 1 Through 7

GROUP HOME CURRICULUM

PART I

participant manual

Edited by:

Franklyn L. Giampa

Gaynell Walker-Burt, Ph.D.

Dorothy Lamb

PREFACE

The Michigan Department of Mental Health is committed to the return of institutionalized mental health clients in the least restrictive environment possible. As part of this commitment, the Office of Resource Development was given the task of developing a statewide, standardized curriculum to be used for the training of direct care staff in community residential homes. This curricula is the result of three years' work, and involved many persons.

Originally initiated under the direction of Harvey Day, Ph.D., William Fullmer, Lindsay Roth and Janet MacCormack, the project was completed under the direction of Franklyn Giampa, Gaynell Walker-Burt, Ph.D., and Dorothy Lamb. The utilization of this manual is intended to provide you with the information, knowledge and skills necessary to promote an atmosphere for the group home clients' growth, safety and participation in community life.

Franklyn L. Giampa, Director
Office of Resource Development

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APPENDIX D

MDMH PRIORITY SERVICE GOAL STATEMENT

MICHIGAN DEPARTMENT OF MENTAL HEALTH PRIORITY SERVICE GOALS [1]

1. To unify the Public Mental Health System by transferring the responsibility for management of service delivery from the state to community mental health boards.

2. To improve the management capability of all community mental health boards.

3. To provide services at reasonable cost and to offset this cost as much as possible through first and third-party sources in order to permit the sustained redirection of state and local funds to community-based services.

4. To provide high quality treatment and care for the mentally ill and developmentally disabled requiring service from state facilities. This treatment and care should be appropriate to condition and provided within a system which promotes continuity of care.

5. To develop a continuum of community-managed mental health services for children and adolescents.

6. To reduce the utilization of state-operated psychiatric facilities for adults through the develpment of appropriate community alternatives.

7. To provide services appropriate to condition for persons in the least restrictive and least costly settings required to enhance attainment of client-centered objectives.

8. To provide services appropriate to condition for DD persons in communities who are currently unserved or underserved.

9. To provide services to the at-risk populations.

10. To improve the quality of community mental health programs and services through the attainment of accepted standards of operation and through the efficient application of quality assurance mechanisms.

11. To assure that human resources are appropriately utilized.

12. To assure that services that are appropriate to condition and are delivered according to equivalent standards of quality, effectiveness and efficiency are made equally available to all residents of the state.

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[1] Program Policy Guidelines of the Michigan Department of Mental Health, Seventh Edition, Fiscal Year 1983-84, April, 1982

APPENDIX E

LETTERS OF AGREEMENT WITH COMMUNITY COLLEGE

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48926
C. PATRICK HABCOCK
Director

LETTER OF AGREEMENT

This contract is between the SCHOOLCRAFT COLLEGE, hereinafter referred to as the PROVIDER, and the MICHIGAN DEPARTMENT OF MENTAL HEALTH - OFFICE OF RESOURCE DEVELOPMENT, hereinafter referred to as the AGENCY. The duration of this contract is from APRIL 15, 1984 THROUGH APRIL 27, 1984, and is subject to the availability of funds.

1. During the terms of this contract, the PROVIDER agrees to perform to the best of his/her ability services as the AGENCY or its designee may from time to time request, in conjunction with the tasks outlined in #2 below. The PROVIDER shall perform services during normal business hours at the Schoolcraft College, 18600 Haggerty Road, Livonia, Michigan 48152, or at such other places and at such other times as the PROVIDER and the AGENCY shall from time to time agree upon.

2. In consideration of such services, the AGENCY agrees to pay to the PROVIDER during the term of this contract the sum of $1,550.00 within 20 days of receiving a billing from the PROVIDER. The PROVIDER agrees to:

   a. Prepare, develop, and coordinate implementation strategy for conducting 64 hours of instruction for 30 trainees in the content of Part I of the Group Home Curriculum.

   b. Prepare and duplicate necessary materials for conducting said training.

3. The PROVIDER agrees that he/she will not at any time either during or after the term of this contract reveal, divulge, or make known to any person, firm, or corporation any confidential information whatsoever in connection with the AGENCY or its clients.

4. The interest of the PROVIDER under this contract is not assignable.

5. The PROVIDER affirms that he/she is not currently an employee of the Michigan Department of Mental Health, nor is he/she privy to insider information which would tend to give, or give the appearance of tending to give, an unfair advantage to said PROVIDER. Breach of this covenant may be regarded as a material breach of the contract and a cause for termination thereof.

6. The PROVIDER agrees not to discriminate against an employee or an applicant for employment with respect to hiring, tenure, terms, conditions, or privileges of employment or with respect to a matter directly or indirectly related to employment solely on the basis of race, color, religion, national origin, age, sex, height, weight, marital status, arrest record, or mental or physical handicap. Breach of this covenant may be regarded as a material breach of the contract and a cause for termination thereof.

7. The PROVIDER agrees not to discriminate against a recipient of its services or an applicant for receipt of services or members of the public generally solely on the basis of race, color, religion, national origin, sex, age, height, weight, marital status, arrest record, or mental or physical handicap. Breach of this covenant may be regarded as a material breach of this contract and a cause for termination thereof.

8. The PROVIDER agrees to comply with the appropriate sections of the Standards and Procedures issued by the DEPARTMENT OF CIVIL SERVICE under the title "Executive Directive 1979-4, Civil Rights Compliance in State and Federal Contracts," as reissued September, 1979.

9. The PROVIDER agrees to save harmless and indemnify the AGENCY from and against all loss, liability, or expense that may be incurred by reason of any claim arising out of or in connection with PROVIDER'S work and that PROVIDER shall, for the term of this contract, maintain professional liability insurance in such amounts as may be required by the AGENCY ($150,000.00 for physicians and others similarly situated).

10. The parties intend that, should any section, clause, or part of this contract be found to be invalid, invalidity shall not affect the presumed validity of any other section, clause, or part of this contract, nor shall it serve to relieve either party of duties imposed by the remainder of the contract.

11. The parties intend that this contract is a Michigan contract and that it is to be governed by the laws of Michigan.

12. The parties agree that any amendment or modification of this contract is to be effective only if in writing, signed by authorized representatives of each party, and incorporated by specific reference to this document.

13. Any correspondence, reports, or other communications necessary to the implementation or performance of this contract are to be directed as follows:

TO THE AGENCY: Michigan Department of Mental Health
Office of Resource Development
Lewis Cass Building, Sixth Floor
Lansing, Michigan 48926

ATTENTION: Franklyn L. Giampa

TO THE PROVIDER: Schoolcraft College
18600 Haggerty Road
Livonia, Michigan 48152

ATTENTION: Betty Andrews

14. This contract may be terminated by either party with or without cause upon 30 days notice in writing to the other party. Such notice is effective upon mailing.

15. The parties agree that this contract represents the entire, complete, and integrated understanding between them, as regards the specific subject matter herein.

SIGNED:

TITLE

DATE

SIGNED:

Vice President Business

TITLE

3/28/84

DATE

Director
Michigan Dept. of Mental Health

TITLE

4/2/84

DATE

Director, Office of Resource Development
Michigan Department of Mental Health

TITLE

April 5, 1984

DATE

STATE OF MICHIGAN

JAMES J. BLANCHARD, Governor

DEPARTMENT OF MENTAL HEALTH

LEWIS CASS BUILDING
LANSING, MICHIGAN 48926
C. PATRICK BABCOCK
Director

LETTER OF AGREEMENT

This contract is between the SCHOOLCRAFT COLLEGE, hereinafter referred to as the PROVIDER, and the MICHIGAN DEPARTMENT OF MENTAL HEALTH - OFFICE OF RESOURCE DEVELOPMENT, hereinafter referred to as the AGENCY. The duration of this contract is from APRIL 30, 1984 THROUGH MAY 25, 1984, and is subject to the availability of funds.

1. During the term of this contract, the PROVIDER agrees to perform to the best of his/her ability services as the AGENCY or its designee may from time to time request, in conjunction with the tasks outlined in #2 below. The PROVIDER shall perform services during normal business hours at the Schoolcraft College, 18600 Haggerty Road, Livonia, Michigan 48152, or at such other places and at such other times as the PROVIDER and the AGENCY shall from time to time agree upon.

2. In consideration of such services, the AGENCY agrees to pay to the PROVIDER during the term of this contract the sum of $4,420.00 within 20 days of receiving a billing from the PROVIDER. The PROVIDER agrees to:

   a. Train 30 students in content of the Group Home Curriculum, Part I.

   b. Hold classes four nights a week, for four hours per session, for four weeks, for a total of 64 instructional hours per student.

   c. Assess content knowledge of students upon completion of the training and share results with AGENCY staff.

   d. At a minimum, utilize Part I of the Group Home Curriculum to train and assess content knowledge.

   e. Ensure that instructors utilized by the PROVIDER meet basic trainer qualifications of the AGENCY.

   f. Make copies of test results and mail them to the AGENCY.

3. The PROVIDER agrees that he/she will not at any time either during or after the term of this contract reveal, divulge, or make known to any person, firm, or corporation any confidential information whatsoever in connection with the AGENCY or its clients.

4. The interest of the PROVIDER under this contract is not assignable.

5. The PROVIDER affirms that he/she is not currently an employee of the Micnigan Department of Mental Health, nor is he/she privy to insider information which would tend to give, or give the appearance of tending to give, an unfair advantage to said PROVIDER. Breach of this covenant may be regarded as a material breach of the contract and a cause for termination thereof.

6. The PROVIDER agrees not to discriminate against an employee or an applicant for employment with respect to hiring, tenure, terms, conditions, or privileges of employment or with respect to a matter directly or indirectly related to employment solely on the basis of race, color, religion, national origin, age, sex, height, weight, marital status, arrest record, or mental or physical handicap. Breach of this covenant may be regarded as a material breach of the contract and a cause for termination thereof.

7. The PROVIDER agrees not to discriminate against a recipient of its services or an applicant for receipt of services or members of the public generally solely on the basis of race, color, religion, national origin, age, sex, height, weight, marital status, arrest record, or mental or physical handicap. Breach of this covenant may be regarded as a material breach of this contract and a cause for termination thereof.

8. The PROVIDER agrees to comply with the appropriate sections of the Standards and Procedures issued by the DEPARTMENT OF CIVIL RIGHTS under the title "Executive Directive 1979-4, Civil Rights Compliance in State and Federal Contracts," as reissued September, 1979.

9. The PROVIDER agrees to save harmless and indemnify the AGENCY from and against all loss, liability, or expense that may be incurred by reason of any claim arising out of or in connection with PROVIDER'S work and that PROVIDER shall, for the terms of this contract, maintain professional liability insurance in such amounts as may be required by the AGENCY ($150,000.00 for physicians and other similarly situated).

10. The parties intend that, should any section, clause, or part of this contract be found to be invalid, invalidity shall not affect the presumed validity of any other section, clause, or part of this contract, nor shall it serve to relieve either party of duties imposed by the remainder of the contract.

11. The parties intend that this contract is a Michigan contract and that it is to be governed by the laws of Michigan.

12. The parties agree that any amendment or modification of this contract is to be effective only if in writing, signed by authorized representatives of each party, and incorporated by specific reference to this document.

13. Any correspondence, reports, or other communications necessary to the implementation or performance of this contract are to be directed as follows:

TO THE AGENCY: Michigan Department of Mental Health
Office of Resource Development
Lewis Cass Building, Sixth Floor
Lansing, Michigan 48926
ATTENTION: Franklyn L. Giampa

TO THE PROVIDER: Schoolcraft College
18600 Haggerty Road
Livonia, Michigan 48152
ATTENTION: Betty Andrews

14. This contract may be terminated by either party with or without cause upon 30 days notice in writing to the other party. Such notice is effective upon mailing.

15. The parties agree that this contract represents the entire, complete, and integrated understanding between them, as regards the specific subject matter herein.

SIGNED:	SIGNED:
Elizabeth C. Andrews	W Kenneth Lindner
Vice President for Education	Vice President - Business
TITLE	TITLE
March 28, 1984	3/22/84
DATE	DATE
C Robert Bell	Franklyn L. Giampa
Director Michigan Department of Mental Health	Director, Office of Resource Development Michigan Department of Mental Health
TITLE	TITLE
4/2/84	April 5, 1984
DATE	DATE

EDUCATIONAL SERVICES CONTRACT

Schoolcraft College
18600 Haggerty Road
Livonia, MI 48152
591-6400, Ext. 404

This contract, made this 28th day of March, 1984, by and between SCHOOLCRAFT COLLEGE, a quasi-corporation organized and existing under the Community College Act of the State of Michigan (the "College") and The State of Michigan Department of Mental Health - Office of Resource Development (the "Company")

Address Lewis Cass Building Lansing, MI 48926
Number Street City State Zip

Franklyn L. Ciampa (517) 373-2180
Responsible Individual Business Telephone

WITNESSETH:

In consideration of the fees and covenants hereinafter contained, the College agrees to provide the educational program or service (as hereinafter defined) upon the following terms and conditions:

Conduct a four credit hour Basic Certification course for Group Home Para-Professionals for 30 employees according to the following schedule: Monday through Thursday from 5 to 9 pm for 16 sessions beginning April 30 through May 24, 1984, in Room F130 of the Schoolcraft College Forum Building. Instructor: Sally Harrison. Textbooks will be purchased from the Department of Mental Health. Registration conducted at first class session.

(2) The Company agrees to pay:
$199 per employee enrolled in the above course. College will invoice $1,550 on 5-1-84 for administration and coordination, and $4,420 on 6-4-84 for tuition and fees.

At the signing of the contract, the Company agrees to pay the contract amount in full within (5) days upon receipt of an invoice from the College.

(3) The General Conditions attached hereto are hereby made a part hereof as if fully set forth herein See attached.

IN WITNESS WHEREOF, the parties hereto have caused these presents to be executed by their duly authorized officers as of the day and year first above written.

Witness:

By: _____

SCHOOLCRAFT COLLEGE

By: W Kenneth Lindner
Vice President for Business Affairs

COMPANY

By: C Patrick Hall 4/2/84
Authorized Company Official

Director, Michigan Dept. of Mental Health
Title

Distribution:

Company	- white
CE/CS	- green
Accounting A/R	- yellow
Registrar	- pink
Bursar	- gold

B&I-01-83

APPENDIX F

APPLICATION OF GRANT SUBMITTED TO NIMH

APPLICATION FOR FEDERAL ASSISTANCE (NON-CONSTRUCTION PROGRAMS) — OMB Approval No. 29-R0218

PART I

1. TYPE OF ACTION (Mark appropriate box): [ ] PREAPPLICATION; [X] APPLICATION; [ ] NOTIFICATION OF INTENT (OPT.); [ ] REPORT OF FEDERAL ACTION

2. APPLICANT'S APPLICATION — a. NUMBER: 5T23MH15379-06; b. DATE: Year month day 1983 3 18

3. STATE APPLICATION IDENTIFIER — a. NUMBER; b. DATE ASSIGNED: Year month day 19

Leave Blank

4. LEGAL APPLICANT/RECIPIENT
- a. Applicant Name: Michigan Department of Mental Health
- b. Organization Unit: Office of Resource Development
- c. Street/P.O. Box: Lewis Cass Building
- d. City: Lansing — e. County: Ingham
- f. State: Michigan — g. ZIP Code: 48926
- h. Contact Person (Name & telephone No.): (517) 373-2180

5. FEDERAL EMPLOYER IDENTIFICATION NO.: 1386000134A7

6. PROGRAM (From Federal Catalog) — a. NUMBER: 13.244; b. TITLE: Mental Health Training Programs

7. TITLE AND DESCRIPTION OF APPLICANT'S PROJECT: Mental Health Services Manpower Systems Development Program

8. TYPE OF APPLICANT/RECIPIENT: A-State; B-Interstate; C-Substate District; D-County; E-City; F-School District; G-Special Purpose District; H-Community Action Agency; I-Higher Educational Institution; J-Indian Tribe; K-Other (Specify). Enter appropriate letter: A

9. TYPE OF ASSISTANCE: A-Basic Grant; B-Supplemental Grant; C-Loan; D-Insurance; E-Other. Enter appropriate letter(s): A

10. AREA OF PROJECT IMPACT (Names of cities, counties, States, etc.): State of Michigan

11. ESTIMATED NUMBER OF PERSONS BENEFITING: N/A

12. TYPE OF APPLICATION: A-New; B-Renewal; C-Revision; D-Continuation; E-Augmentation. Enter appropriate letter: B

13. PROPOSED FUNDING

a. FEDERAL	$ 168,000 .00
b. APPLICANT	.00
c. STATE	.00
d. LOCAL	.00
e. OTHER	.00
f. TOTAL	$ 168,000 .00

14. CONGRESSIONAL DISTRICTS OF: a. APPLICANT: Statewide; b. PROJECT: Statewide

15. TYPE OF CHANGE (For 12c or 12e): A-Increase Dollars; B-Decrease Dollars; C-Increase Duration; D-Decrease Duration; E-Cancellation; F-Other (Specify): N/A. Enter appropriate letter(s):

16. PROJECT START DATE: Year month day 1983 7 1

17. PROJECT DURATION: 36 Months

18. ESTIMATED DATE TO BE SUBMITTED TO FEDERAL AGENCY: Year month day 1983 3 18

19. EXISTING FEDERAL IDENTIFICATION NUMBER: 5T23MH15379-06

20. FEDERAL AGENCY TO RECEIVE REQUEST (Name, City, State, ZIP code)

21. REMARKS ADDED: [ ] Yes [X] No

SECTION II — CERTIFICATION

22. THE APPLICANT CERTIFIES THAT: N/A

a. To the best of my knowledge and belief, data in this preapplication/application are true and correct, the document has been duly authorized by the governing body of the applicant and the applicant will comply with the attached assurances if the assistance is approved.

b. If required by OMB Circular A-95 this application was submitted, pursuant to instructions therein, to appropriate clearinghouses and all responses are attached: (1) (2) (3) — No response / Response attached

23. CERTIFYING REPRESENTATIVE — a. TYPED NAME AND TITLE: C. Patrick Babcock; b. SIGNATURE: [signature]; c. DATE SIGNED: Year month day 1983 3 18

SECTION III — FEDERAL AGENCY ACTION

24. AGENCY NAME

25. APPLICATION RECEIVED: Year month day 19

26. ORGANIZATIONAL UNIT

27. ADMINISTRATIVE OFFICE

28. FEDERAL APPLICATION IDENTIFICATION

29. ADDRESS

30. FEDERAL GRANT IDENTIFICATION

31. ACTION TAKEN: [ ] a. AWARDED; [ ] b. REJECTED; [ ] c. RETURNED FOR AMENDMENT; [ ] d. DEFERRED; [ ] e. WITHDRAWN

32. FUNDING

a. FEDERAL	$ .00
b. APPLICANT	.00
c. STATE	.00
d. LOCAL	.00
e. OTHER	.00
f. TOTAL	$ .00

33. ACTION DATE: Year month day 19

34. STARTING DATE: Year month day 19

35. CONTACT FOR ADDITIONAL INFORMATION (Name and telephone number)

36. ENDING DATE: Year month day 19

37. REMARKS ADDED: [ ] Yes [ ] No

38. FEDERAL AGENCY A-95 ACTION — a. In taking above action, any comments received from clearinghouses were considered. If agency response is due under provisions of Part 1, OMB Circular A-95, it has been or is being made. b. FEDERAL AGENCY A-95 OFFICIAL (Name and telephone no.)

PHS 5161-1 (PAGE 1) Form Approved (Rev. 3/79) OMB No. 68-R1379

STANDARD FORM 424 PAGE 1 (10-75) Prescribed by OMB Circular No. A-102

APPENDIX G

ASSESSMENT PACKAGE OF THE GROUP HOME CURRICULUM

INTRODUCTION TO COMMUNITY RESIDENTIAL SERVICES AND YOUR ROLE AS DIRECT CARE STAFF

Module 1 Test Form A

Instructions: Choose the one best answer and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. Which of the following is characteristic of a normalized community home environment?

   a) Outings into the community are conducted in a highly-supervised, rigid fashion.
   b) Life is largely routine and emphasizes conformity.
   c) Meals are served, beds are changed, and clothes are washed for the recipients without expecting them to help.
   d) The immediate environment facilitates the learning of independent living skills that most people take for granted.

2. Which is not one of the three goals of residential programming?

   a) Programs are designed to increase the clients' control of their environment.
   b) To foster a lifestyle of passivity and dependence.
   c) Programs increase the complexity of the recipients' behavior.
   d) The human qualities of the clients are emphasized.

3. What must staff consider when planning activities which would help foster social integration of recipients into the larger community?

   a) Plenty of opportunities to make choices and decisions.
   b) Plenty of support and encouragement for recipients to progress toward more productive and independent activities.
   c) The expectation that recipients will always take increasing responsibility for themselves.
   d) All of the above.

4. Describe a characteristic of institutions where mentally ill persons were thought of as subhuman.

   a) Recipient management/treatment programs were called therapy.
   b) There were generous allocations for parties, picnics, and religious worship.
   c) Attempts were made to facilitate social interaction between staff and recipients.
   d) Food was served without forks and knives, only spoons to eat it with.

5. When mentally handicapped persons are perceived as developing individuals, they are seen as more _____, than unlike others.

   a) Like
   b) Opposite
   c) Strange
   d) Undeveloped

6. Describe a characteristic of care of mentally handicapped persons when they are perceived as developing individuals.

   a) Residential placements tend to be of a special kind, for example, as a menial worker in a religious community.
   b) Mentally handicapped persons are sheltered against injury or risk from sharp edges, electrical outlets, hot water, etc.
   c) Institutions lack privacy, individuality, and opportunity to have personal possessions.
   d) Mentally handicapped persons are perceived as capable of growth and learning.

7. Describe a characteristic of care when mentally handicapped persons were perceived as "Holy Innocents."

   a) Living units were called nursing units or wards.
   b) Mentally handicapped were apt to be labeled as animal-like or even vegetables.
   c) Mentally handicapped were indulged in, much like children.
   d) Little access to "risk," such as stairs, electrical outlets, hot water, etc.

8. Values, attitudes, and beliefs have little to do with how we provide services.

   a) True b) False

9. The levels of mental retardation are:

   a) Low, medium, high.
   b) Autistic, psychotic, learning disabled, emotionally disturbed.
   c) Mild, moderate, severe, profound.
   d) Dysplastic, rejuvenative, dyslexic, borderline.
   e) All of the above.

10. Which of the following are causes of mental retardation?

    a) Socio-environmental
    b) Unknown
    c) Medical
    d) All of the above

11. Where would you find <u>statewide</u> definitions for "Mental Illness," "Mental Retardation," and "Developmental Disabilities?"

    a) Dictionary
    b) Medical Book
    c) Michigan Compiled Laws
    d) Michigan Mental Health Code

12. Mental retardation is a:

    a) Disease
    b) Sickness
    c) Condition
    d) Psychosis

13. A person diagnosed as mentally ill requires inpatient treatment when:

    a) He/she is expected to do serious physical harm to him/herself or others.
    b) He/she cannot take care of his/her basic physical needs.
    c) He/she is unable to understand his/her need for treatment.
    d) All of the above.

14. Which choice best identifies things you can do to create a climate that will help recipients grow and develop?

    a) Take care of all the recipients' needs; criticize each new activity they attempt. Focus on the recipients' faults.
    b) Find out why recipients performed a specific behavior, keep recipients informed of how you want them to perform. Punish all other behavior.
    c) Focus on the whole person, value and respect others, be consistent, provide a "low risk" atmosphere, be a helpful role model, use small steps.
    d) Focus on maladaptive behavior and eliminate it as quickly as possible. Then push recipients to be independent by not providing assistance for any daily living activity.

15. Mental illnesses may be due to:

    a) Organic malfunctioning
    b) Severe or prolonged stress and strain
    c) a and b
    d) None of the above

16. Ted, a staff person on the afternoon shift, has decided that the procedure being used to get Linda to be more cooperative is not working. He believes he knows of a better procedure to use.

    Ted should:

    a) Stop using the procedure he does not think is working and try the new procedure.
    b) Keep using the procedure he does not think is working.
    c) Tell his supervisor that the procedure is not working and suggest a change.
    d) Complain to other staff that the procedure is not working.

17. Whether you plan it or not, your behavior may be imitated by recipients and staff.

    a) True b) False

18. If a new behavior works and is supported by others, it becomes a part of us. If it doesn't work or leaves us feeling worse in some ways, we will stop doing it.

a) True b) False

19. Joe is told a new way to hold his bowling ball and that it will improve his bowling score. While bowling with friends, he tries to hold the ball in the new way. The first couple of times Joe barely hits any pins; his friends laugh. The next time Joe bowls, he is most likely to:

a) Go back to the way he used to hold the ball.
b) Ignore the poor score he gets and his friends laughing and keep using the new hold.
c) Give up bowling.
d) Try the new way of holding the bowling ball again.

20. Recipients will learn and you can help them by:

a) Providing opportunities for practice in a low risk setting.
b) Being tolerant and patient - communicating that it's okay for mistakes.
c) Giving feedback and encouragement often.
d) Giving them room to achieve the change in their own way and at their own pace.
e) All of the above.

21. If the feedback someone receives about a new behavior is negative, it usually makes the person more determined than ever to master the new behavior.

a) True b) False

22. Which of the following is something you can do which will <u>not</u> help recipients learn?

a) Forcing them to perform the new behavior in the real world.
b) Being tolerant and patient--communicating that it's okay for mistakes.
c) Giving feedback and encouragement often.
d) Giving them room to achieve the change their own way at their own pace.

23. It is important that, as a direct care staff, you maintain a certain amount of flexibility in terms of work roles you assume.

a) True b) False

Find the example that best describes each direct care role:

24.	Behavioral Advisor	a) Provides new knowledge, skill-practice, feedback, repractice and support.
25.	Trainer	b) Identifies strengths and weaknesses and suggests alternatives.
26.	Nurturing Supporter	c) Creates climate to support recipients trying new behaviors.
27.	Limit Setter	d) Ensures individual's rights, safety, well-being and maximum access to treatment resources.
28.	Protector/Advocate	e) Establishes boundaries to control behavior, protect property and rights of others.

29. Some of the resistance to community living alternatives is based on misconceptions about recipients.

a) True b) False

30. Community alternatives for the recipient are often hard for the public to accept because:

a) It is a change from the way recipients were treated in the past.
b) People may have basic misconceptions about recipients.
c) People may have prejudices about people who are different.
d) People may have had bad experiences with poorly run group homes.
e) All of the above.

31. It is important to make the group home look as much like other houses on the block as possible.

a) True b) False

32. Avoid inviting the neighbors over for visits or social activities.

a) True b) False

33. Which of the following staff behaviors are likely to <u>offend</u> the neighbors.

a) Acting like family rather than staff.
b) Going out of your way to be friendly.
c) Parking on the grass.
d) Attending school events.
e) All of the above.

34. It is best to <u>discourage</u> the recipients from:

a) Getting out to vote.
b) Attending religious activities.
c) Leaving home improperly dressed.
d) Attending school events.
e) Going outside where the neighbors will see them.

35. Staff responsibilities differ from recipients' responsibilities because:

a) Recipients' responsibilities depend to some extent upon their capability and legal competence; whereas staff are presumed to be capable and competent.
b) Staff have more rights than recipients.
c) Staff have fewer rights than recipients.
d) Recipients must be assumed to be irresponsible; otherwise, they wouldn't be recipients.

36. All but which of the following are rights shared by recipients and staff.

a) The right to be employed for wages.
b) The right to a public education.
c) The right to freedom from discrimination.
d) Rights under Chapter 7 of the Michigan Mental Health Code.

37. A recipient is restrained from hitting other recipients. This is a denial of his/her right to freedom of movement.

a) True b) False

38. Referring to recipients by name when discussing work with friends or family violates the recipients' right to confidentiality.

a) True b) False

39. The purpose of the Michigan Mental Health Code is to:

a) Bring together all laws concerning mental illness and mental retardation.
b) Update laws passed in 1923.
c) Protect the rights of recipients living in institutions.
d) Protect the rights of recipients living in the community.
e) All of the above.

40. Listening in on a client's telephone conversation violates rights to confidentiality.

a) True b) False

41. Taking photographs with permission violates rights to confidentiality.

a) True b) False

42. The Plan of Service:

a) Specifies goals and objectives for the recipient.
b) Identifies progressive steps of development for the recipient.
c) Identifies the consequences of service for the recipient.
d) Includes an implementation plan.
e) All of the above.

43. The functions of the interdisciplinary team include:

    a) Identifying the needs of the individual recipient.
    b) Identifying short term objectives.
    c) Identifying long term objectives.
    d) Building on strengths of the recipient.
    e) All of the above.

44. The interdisciplinary team includes which of the following:

    a) Physician
    b) Psychologist
    c) Social Worker
    d) Direct Care Staff
    e) All of the above

45. The purposes of the recipient record are to document all <u>except</u> which of the following:

    a) Any changes in recipient status.
    b) Why recipient is in the home.
    c) Services needed and provided.
    d) Who the recipient receives mail from.
    e) Progress or lack of progress.

46. It is all right to write in the recipient's record in pencil as long as you get the important information down.

    a) True b) False

47. When you make an error in the recipient's record, you should:

    a) Scribble through the mistake and write the word "error" over it.
    b) Tear the sheet out and throw it away.
    c) Always draw <u>one</u> line through errors, above it write "error," your initials, and the complete date.
    d) Any of the above.
    e) None of the above.

48. Your ability to describe, and not evaluate, behavior is important because:

    a) Other interdisciplinary team members make decisions about services for the recipient based on your written observations.
    b) Your observations will reflect changes in the recipient's behavior.
    c) Your observations will show progress or lack of progress.
    d) Your observations will reflect when goals are reached.
    e) All of the above.

49. How would you best rewrite this evaluative statement so that it is descriptive? "Fred is lazy."

    a) Fred sleeps too much.
    b) Fred stays in bed until 11:00 a.m. every day.
    c) You can't depend on Fred in the morning.
    d) Fred is a loafer.
    e) All the above are descriptive statements.

50. How would you best rewrite this evaluative statement so that it is descriptive? "Polly is aggressive."

    a) Polly hit five other recipients this morning.
    b) Polly is violent.
    c) Polly is dangerous.
    d) Polly is unpredictable.
    e) None of the above are descriptive statements.

INTRODUCTION TO INTERVENTION WITH PEOPLE WHO HAVE DEVELOPMENTAL DISABILITIES

Module 2 Test Form A

Instructions: Choose the one best answer, and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. Heredity is the most important factor in influencing which of the following items:

   a) The language a person speaks.
   b) The type of clothes a person chooses to wear.
   c) How appropriately a person eats his/her meals.
   d) A person's eye color.

2. Can you do anything about a person's genetic makeup?

   a) Yes b) No

3. Which of the following statements best describe the position a group home staff person should adopt:

   a) Recipients will be provided an environment which is designed for maximum behavioral growth if staff concentrate on the environment rather than heredity.
   b) Recipients will be provided the best living arrangement if staff concentrate on the hereditary characteristics of each individual.

4. If a recipient is having a tantrum, and you give him a piece of candy so that he stops, he will probably be:

   a) Less likely to have a tantrum in the future.
   b) More likely to have a tantrum in the future.

On the blank before each statement, place the letter of the intervention strategy described by the statement.

5. ____Necessary in order to monitor and be aware of changes in recipient's behavior; is critical when a change in the recipient's behavior has occurred.

6. ____To gather information, to communicate support, acceptance, and empathy, useful when a recipient is attempting to communicate

7. ____To decrease a recipient's agitation; when a problem cannot be eliminated or changed.

8. ____To help a recipient approach a problem logically and systematically; when a recipient is confronted by a problem which appears unsolvable by the recipient alone.

9. ____To inform recipient about how his/her behavior is affecting others; when a recipient's behavior is inappropriate.

a) Helps recipient solve problems
b) Observe recipient
c) Provide information/ give feedback
d) Active listening
e) Remove recipient from problem

10. The stereo is very loud and noises are known to agitate a recipient. The staff turn the volume down. This is an example of which of the following intervention strategies?

    a) Removing the recipient from the problem.
    b) Removing the problem from the recipient.
    c) Observing the recipient.
    d) Providing support.

11. Laura has suddenly started to spend most of her free time by herself and no longer socializes with staff or other recipients. A staff person points this out to her and asks if she would like to talk. The staff person listens closely to her and helps her identify feelings of loneliness and rejection. This is an example of which of the following intervention strategies?

    a) Active listening.
    b) Giving recipient alternatives.
    c) Physical control of recipient.
    d) Removing recipient from problem.

12. Which of the following are methods of intervening with agitated recipients without resorting to a physical confrontation?

    a) Know each recipient well, so that you will be able to recognize early signs indicating potential agitation.
    b) Get the recipient involved in activities away from the agitating situation.
    c) Inform the recipient that his agitation is totally inappropriate and that there is no place in this group home for that kind of behavior. Physically remove recipient from the situation.
    d) a and b
    e) a, b, and c

13. What is the difference between intervening with a recipient who is just becoming agitated and intervening with a recipient who is agitated to the point of attacking?

    a) When a recipient is just becoming agitated, show no emotion.
    b) When a recipient is about to attack, show care and concern.
    c) When a recipient is about to attack, use "active listening."
    d) When a recipient is about to attack, show no emotion.
    e) All of the above.

14. What is the cause of agitated behavior?

    a) Fear
    b) Frustration
    c) Anger
    d) Organic causes
    e) All of the above

15. The key to staying relaxed is to forget about the situation you are involved in. Forgetting eliminates the causes of the tension.

    a) True b) False

16. As a direct care staff person, you are confronted with making decisions regarding which of the following?

    a) The goals set for/with the recipient.
    b) The amount of involvement recipients will have with their parents and friends.
    c) The techniques used to help the recipient reach the goals.
    d) a and b above
    e) a and c above

17. Family should not be involved in setting goals for a recipient because generally they are too close to the recipient to be objective.

    a) True b) False

18. A direct care staff does not make value decisions regarding intervening in a recipient's behavior.

a) True b) False

19. Which of the following are guidelines for selecting intervention techniques?

a) Select an intervention which maximizes a recipient's learning.
b) Select an intervention which will eliminate the unacceptable behavior the quickest, regardless of what the technique is.
c) Select an intervention which allows staff to control recipient's behavior.
d) a and b above
e) b and c above

20. What activity must be done after you physically intervene with recipients:

a) Talk about what happened.
b) Document the incident.
c) Reward the recipient
d) a and b
e) b and c

21. It is important that you take some time out after a physical confrontation to calm down.

a) True b) False

22. When is it appropriate to use physical intervention:

a) When the recipient won't do what you tell him/her to do.
b) When your supervisor tells you to use it.
c) When the recipient behavior is such that he/she is very likely to injure himself or others, or when the recipient's plan of service indicates to use it.
d) When the recipient repeatedly insults you.
e) All of the above.

23. Jeff is silently pacing back and forth. You have seen him cause injuries to staff and other recipients soon after he starts pacing. What should you do:

a) Immediately intervene physically to stay one step ahead.
b) Immediately approach Jeff, speak firmly and calmly, show no emotion, continue until his pacing subsides.
c) Stay clear of him so that he will calm down.
d) Lock the doors, attempt to confine him to a small area.
e) Demand that he go to bed immediately.

24. In what situations may you apply physical intervention techniques which involve gradual application of pressure/pain to the recipient:

    a) When the recipient grabs your hair or bites you and won't let go.
    b) When the recipient grabs your neck.
    c) When the recipient starts kicking another recipient.
    d) When the recipient repeatedly hits his/her head on the floor.
    e) All the above.

25. Which of the following principles allow you to use "releases" successfully?

    a) Communicate with recipient in calm voice which shows no emotion.
    b) Sudden bursts of speed.
    c) Focus recipient's attention away from your next move.
    d) Stay one step ahead of recipient.
    e) All of the above.

Module 3 Test Form A

Instructions: Choose the one best answer, and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. The following are all considered by Maslow to be basic human needs except:

   a) Consolatory needs
   b) Esteem needs
   c) Physiological needs
   d) Safety needs
   e) Self-actualization needs

2. Even if safety needs are not met, an individual normally remains motivated to meet his esteem needs.

   a) True b) False

Match the following "components, parts, or organs" with the body systems they are a part of:

3. Stomach
4. Thyroid
5. Cartilage
6. Uterus

   a) Reproductive system
   b) Skeletal system
   c) Endocrine system
   d) Skin (Integumentary system)
   e) Digestive system

Match the body system with its major function.

7. Circulatory system
8. Endocrine system
9. Nervous system
10. Respiratory system

   a) Supplies oxygen to blood and expels waste through lungs
   b) Secretes hormones into blood
   c) Removes wastes from blood, produces urine
   d) Carries food, oxygen, water to body cells, and expels waste from cells
   e) Controls and coordinates bodily activities

11. The following general factors contribute to health maintenance except:

   a) Nutrition
   b) Caffeine
   c) Clean environment
   d) Elimination
   e) Posture

12. Showering is sufficient to maintain good personal hygiene.

   a) True b) False

13. Which areas of the body <u>especially</u> need to be thoroughly cleaned and dried?

    a) Hands
    b) Face
    c) Neck
    d) Any area where the body surfaces touch
    e) All of the above

14. Female recipients should wipe from front to back after toileting.

    a) True b) False

Match the following items to its major function:

15. Nutrition
16. Posture
17. Elimination
18. Clean environment

    a) Restores body's energy level
    b) Promotes circulation
    c) Rids body of waste products
    d) Maintains alignment of body parts
    e) Prevents illness, spread of disease

19. The basic food groups which need to be included in a person's diet in order to maintain good health are:

    a) Fat-starch group, milk-bread group, fish-cheese group.
    b) Protein-vegetable group, egg-fish group, fat-amino acid group.
    c) Fruit group, vegetable group, bread group, dairy group.
    d) Fruit-vegetable group, bread-cereal group, milk-cheese group, meat-poultry-fish-bean group.
    e) None of the above.

20. Good nutrition is important because it helps the body in:

    a) Proper growth and repair of body tissues.
    b) Prevention of "deficiency diseases."
    c) Resistance to disease and infections.
    d) Maintaining energy.
    e) All of the above.

21. Which of the following are major classes of <u>nutrients</u> necessary for balanced nutrition:

    a) Protein, vitamins, minerals.
    b) Carotene, protozoa, mitochondria.
    c) Carbohydrate, fat, water.
    d) a and b.
    e) a and c.

22. Menu planning is important because:

a) It saves money.
b) The menu must include the 4 basic groups in proper portions.
c) None of the recipients know how to eat right.
d) It is difficult to serve a well balanced diet.
e) None of the above.

23. What is meant by a "special diet?"

a) A more flavorful diet than for other recipients.
b) A diet requested by the recipient's parent or guardian.
c) A diet meant to satisfy the recipient's preferences.
d) A diet prescribed by a physician because of a recipient's specific medical condition.
e) All of the above.

24. Three examples of special diets are:

a) High protein diet, low carbohydrate diet, spinach-grapefruit diet.
b) Bran diet, liquid protein diet, high carbohyrate diet.
c) Diabetic diet, bland diet, weight reduction diet.
d) Macrobiotic diet, Hillsdale Diet, Sodium-restricted diet.
e) None of the above.

25. Medication may have undesirable interactions with certain foods.

a) True b) False

26. All of the following are bacteria which may cause food poisoning <u>except</u>:

a) Salmonella
b) Mitochondria
c) Staphylococcus
d) Streptococcus
e) Botulism

27. To avoid contamination when shopping for foods requiring refrigeration, you should:

a) Shop for refrigerated food first.
b) Shop for refrigerated food last.
c) Avoid buying canned food.
d) After buying groceries, make several stops on your way home.
e) None of the above.

28. When shopping for canned foods you should:

a) Buy home canned products only.
b) Buy cans that bulge as they are the freshest.
c) Buy cans that are dented as they are often cheaper.
d) b and c.
e) None of the above.

29. Keeping hands and nails clean before preparing food will help prevent food poisoning.

a) True b) False

30. Cleaning utensils and food preparation surfaces will help prevent food poisoning.

a) True b) False

31. Cold water should be used for cleaning dishes, pots, pans, and worktable surfaces.

a) True b) False

32. It is harmful to thaw frozen foods in the refrigerator.

a) True b) False

33. Incubation period is the time:

a) Before acquiring an infection.
b) Between developing symptoms and acquiring an infection.
c) Between developing an infection and acquiring symptoms.
d) Between acquiring an infection and developing symptoms.
e) All of the above.

34. Choose the best answer.

To prevent a communicable disease from occurring, one must:

a) Break 6 of the 6 links in the infectious process chain.
b) Break 2 of the 6 links in the infectious process chain.
c) Break 3 of the 6 links in the infectious process chain.
d) Break 1 of the 6 links in the infectious process chain.
e) None of the above.

35. Your hands are the means by which <u>most</u> germs are spread from one person to another.

a) True b) False

36. A person may be more likely to "catch" a communicable disease when:

a) She/he is vaccinated.
b) She/he is under stress.
c) She/he is eating a balanced diet.
d) She/he is immune.
e) All of the above.

37. Choose the correct sequence of the steps of good handwashing technique:

1. Use a rotating frictional motion.
2. Apply soap thoroughly, especially under nails and between fingers.
3. Dry thoroughly.
4. Rinse well with running water.
5. Turn off water with a paper towel.
6. Wet hands.
7. Interlace fingers and rub up and down.

a)	b)	c)	d)	e)
3	1	7	6	None of the above
2	3	6	1	
6	2	4	4	
5	4	5	2	
7	5	1	3	
1	6	3	5	
4	7	2	7	

38. Signs/Symptoms which suggest a communicable disease include:

a) red, runny eyes
b) cough
c) swelling of glands
d) black eye
e) a, b, and c

39. All of the following may indicate an emergency condition <u>except</u>:

a) Failure or obstruction of breathing.
b) Failure of heartbeat.
c) Loss of consciousness.
d) Excessive bleeding.
e) Nausea.

40. All of the following are health-threatening, <u>non</u>emergency conditions <u>except</u>:

a) A persistent sore throat.
b) Repeated episodes of agressive behavior (not typical for the person).
c) Diarrhea not affected by approved nonprescription medication.
d) Loss of consciousness (not a normal seizure).
e) A fever not reduced by normal procedures.

41. Which of the following must you do <u>first</u> in an emergency situation?

a) Record what happened.
b) Collect the recipient's Medicaid Card.
c) Transport the recipient.
d) Call appropriate agency for emergency help.
e) None of the above.

42. If an ambulance or emergency vehicle is <u>not</u> available, you should immediately:

a) Notify hospital of impending arrival.
b) Transport recipient to hospital/emergency.
c) Diagnose the condition.
d) a and b.
e) a and c.

43. Any physical or behavioral change could be important and should be recorded.

a) True b) False

44. Put the following in their proper observation/reporting sequence:

1. Make a written report.
2. Changes detected in recipient's condition.
3. Call emergency number, give first aid.
4. Frequent observation.
5. Is change an emergency? Yes
6. Call your supervisor.

a) 5, 6, 4, 3, 2, 1
b) 4, 2, 5, 3, 6, 1
c) 1, 6, 5, 3, 4, 2
d) 5, 1, 3, 4, 2, 6
e) None of the above sequences are correct

45. What is the average adult <u>oral</u> temperature?

a) 99.6°F
b) 100°F
c) 97.6°F
d) 98.6°F
e) None of the above

46. What is the average pulse rate for an adult?

a) 52-60 times per minute
b) 60-72 times per minute
c) 72-80 times per minute
d) 80-92 times per minute
e) None of the above

47. What is the average adult respiration rate?

a) 5-12 times per minute
b) 12-20 times per minute
c) 20-32 times per minute
d) "a" for males; "b" for females
e) None of the above

48. The strength of the pulse is not important.

a) True b) False

49. The following are all possible causes of epilepsy <u>except</u>:

a) Tumors
b) Poor self esteem
c) Poisons
d) Head injuries
e) Poor nutrition

50. The aim of treatment of epilepsy is partial or complete control. Treatment includes all <u>except</u>:

a) Diet
b) Anti-convulsant drugs
c) Antibiotic drugs
d) Surgery

Module 4 Test Form A

Instructions: Choose the one best answer, and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. Can you tell how serious a gunshot wound is by looking at the surface of the wound?

   a) Yes
   b) No

2. If you suspect a fracture of the lower leg, what parts do you keep from moving?

   a) Hip, ankle, broken bone ends.
   b) Broken bone ends, ankle, knee.
   c) Hip, ankle, knee.

3. If something seems to be embedded or stuck into an eye:

   a) Bandage both eyes and get medical help.
   b) Lift the object out with the corner of a clean cloth.

4. How do you check for breathing?

   a) Look at the pupils of the eyes.
   b) Check to see if the person's heart is beating.
   c) Listen for breathing and feel for air at the mouth. See if the chest is moving.

5. To give abdominal thrusts to an unconscious person, place the heel of one hand:

   a) Below the navel.
   b) Over the rib cage.
   c) Between the rib cage and the navel.

6. Give abdominal thrusts:

   a) Downward, toward the ground.
   b) Upward, toward the lungs.

7. Describe the first steps for mouth-to-mouth breathing:

   A = Airway: _____ and _____.
   Quick = _____.
   Check = _____ and _____.

8. A woman who has just been in an auto accident feels pain and tenderness in her back. You do not see any signs of injury. What do you do?

   a) Keep her from moving.
   b) Have her walk around to see if that makes her feel better.

9. A woman is bleeding heavily from a cut on the leg. She is unconscious. What do you do first?

   a) Apply direct pressure and elevate the injured leg.
   b) Check for breathing and heartbeat. Stop the bleeding as soon as you can.

10. What do you do first after rescuing a victim of electric shock?

   a) Call an ambulance.
   b) Give care to prevent shock.
   c) Check breathing and heartbeat.

11. How do you help an <u>unconscious</u> victim of poisoning who is breathing?

   a) Call the poison center.
   b) Give water or milk to drink.
   c) Cause vomiting.

12. If a person receives an electric shock:

   a) Give mouth-to-mouth breathing right away. Then stop the electric current.
   b) Do <u>not</u> touch the person before you stop the electric current.

13. An older woman seems to be unable to move one side of her body. Her speech is hard to understand. You think she may have had:

   a) A stroke.
   b) A heart attack.
   c) Heat exhaustion.

14. What kinds of wounds should a first aider wash?

   a) Only large, dirty wounds.
   b) Only small wounds.
   c) All wounds.

15. A blunt injury of the eye:

   a) Needs medical care only if the eye is very bruised and swollen.
   b) Must have immediate medical care.

16. The first time you checked an injured man, he was conscious. Do you need to check again later for consciousness?

   a) Yes.
   b) No.

17. If you cannot inflate the victim's lungs the first time you try to give four quick breaths:

    a) Give 4 abdominal thrusts.
    b) Retip the head and try again.

18. What method of controlling bleeding should you use only if nothing else works?

    a) Direct pressure.
    b) Tourniquet.
    c) Pressure point.

19. Will an arm pressure point control bleeding from the head?

    a) Yes.
    b) No.

20. Bleeding from most wounds is controlled best and most easily by:

    a) Pressure points.
    b) A tourniquet.
    c) Direct pressure.

21. Is there anything you can do to reduce the chance of heart attack or stroke?

    a) No, the tendency to those conditions is inherited.
    b) Yes, keep in good physical condition and don't smoke.

22. If a victim of choking is still conscious, and 4 back blows and 4 thrusts fail on the first try, you should:

    a) Try to give four quick breaths.
    b) Keep giving back blows and thrusts.
    c) Go for help.

23. If a person can cough forcefully, the airway is:

    a) Completely blocked.
    b) Not completely blocked.

24. Which position is best for someone who is awake, but may be in shock?

    a) Lying face down.
    b) Sitting up with the head forward.
    c) On the back with the feet raised.

25. If you cannot tell for sure how deep a burn is, you should assume that it is a:

    a) Deep burn.
    b) Thin burn.

26. What is the first aid treatment for a sprain?

    a) Same as for a fracture.
    b) Rest. Frequent, mild exercise.

27. Is a small, second-degree burn on a critical area serious?

    a) Yes.
    b) No.

28. If you think there may be an object in an unconscious person's airway, what is the correct order of first aid steps?

    a) Probe in the mouth, give 4 back blows, try to give breaths, give 4 thrusts.
    b) Try to give breaths, give 4 back blows, give 4 thrusts, probe in the mouth.

29. Remove all clothing from the area of a burn that was caused by:

    a) A chemical.
    b) Fire.

30. What is the first step for a <u>conscious</u> victim of poisoning?

    a) Call the poison center.
    b) Give water or milk to drink.
    c) Cause vomiting.

31. If there is immediate danger from the surroundings, what precautions should be taken before moving a person with a broken leg?

    a) Hold the broken bones and adjacent joints as still as possible, then move the person.
    b) Help the person to walk with the support of two other persons at the shoulders.

32. Wash a chemical off the skin for at least:

    a) 1 minute.
    b) 5 minutes.
    c) 15 minutes.

33. Wash a chemical out of an eye for at least:

    a) 1 minute.
    b) 5 minutes.
    c) 15 minutes.

34. A member of a highway work crew becomes nauseated while working in the sun on a hot day. The person has hot, dry skin and a high body temperature. What care is necessary immediately?

    a) Have the person sit down for a while and have a warm drink.
    b) Cool quickly by putting water all over the person and the person's clothing.

35. You are bandaging an open burn that has fire-charred clothing in it. You should:

    a) Bandage over the clothing.
    b) Remove the clothing before you bandage it.

36. What is the first thing to do for any unconscious victim?

    a) Check for breathing, and if not breathing, try to give breaths.
    b) Give 4 back blows and probe in the mouth.

37. A baseball player has a bruise on his head and was unconscious for a few seconds. He is awake now. You should:

    a) Assume that he is probably all rights now, because he is awake.
    b) Suspect that he may have a serious head injury and get medical advice.

38. You cannot tell whether a victim's ankle is broken or sprained. Do you give first aid for a broken ankle?

    a) Yes.
    b) No.

39. What do you do first for a chemical burn of the skin?

    a) Wash the chemical off.
    b) Try to find out how to neutralize the chemical.

40. Which burns may be cooled directly in water?

    a) Small, thin burns with no open tissue.
    b) Large, deep burns with open tissue.

41. If you are giving breaths to a baby, how big is a puff?

    a) A breath of moderate size.
    b) The amount of air you can hold in your cheeks.

42. After giving A Quick Check, give one puff to a baby every:

    a) 3 seconds.
    b) 5 seconds.

43. What is the most important thing to do for any victim of convulsions?

    a) Give fluids to drink.
    b) Give mouth-to-mouth or mouth-to-nose breathing if necessary.
    c) Recommend mild exercise.

44. What are the four critical areas of the body for burns?

    a) Hands, feet, arms, and legs.
    b) Hands, feet, face, and genitals.
    c) Feet, legs, genitals, and torso.
    d) Feet, face, arms, and legs.

45. An important point of care for frostbite is to:

    a) Rub vigorously to stimulate circulation.
    b) Provide immediate gentle warming.
    c) Put ice on the frozen parts.
    d) Break the blisters.

46. An unconscious victim of head injuries should be checked frequently to see if:

    a) Bandages need to be changed.
    b) Mouth-to-mouth breathing is needed.

47. After you have given 4 quick breaths, how often do you give breaths to an adult?

    a) Once every 3 seconds.
    b) Once every 5 seconds.

48. A victim of a radiation accident should be taken to a radiation medical facility:

    a) Always.
    b) Only if care is needed for injuries.

49. A person who has been in the sun feels ill, is <u>sweating</u>, and has a <u>normal</u> body temperature. What is the first aid?

    a) Rest in the shade. Give salt water to drink.
    b) Pour cool water all over the body.

50. Which cut has a higher risk of infection?

    a) A shallow cut that bleeds freely.
    b) A small, deep cut that bleeds very little.

Module 4 Test Form A

Instructions: Choose the one best answer, and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. Before starting CPR:

   a) Find out the cause of the victim's collapse.
   b) Obtain permission from the victim's family.
   c) Check for medical information in victim's wallet or on special bracelet or necklace.
   d) Be sure victim is breathless and pulseless.

2. If slight gastric distension occurs in a victim as a result of artificial ventilation the rescuer should:

   a) Apply manual pressure over the victim's upper abdomen to relieve the pressure.
   b) Keep the victim's head and shoulders higher than the chest.
   c) Reposition the airway and continue rescue breathing without attempting to expel stomach contents.
   d) Keep the victim's head and shoulders lower than the chest.

3. The most common cause of airway obstruction in an unconscious victim is:

   a) Food
   b) Mucous
   c) Dentures
   d) Tongue

4. In order to initiate CPR on a drowning victim:

   a) Start chest compressions before the victim is removed from the water.
   b) Drain water from the lungs before ventilating.
   c) Do not tilt the head back since it may cause vomiting.
   d) Begin mouth-to-mouth ventilations in the water if possible.

5. Which of the following can cause failure to ventilate the victim's lungs adequately?

   a) Excessive air in the stomach.
   b) Inadequate head tilt.
   c) Lack of an airtight seal.
   d) All of the above.

6. In the victim of Cardiac Arrest, the most reliable indicator of effective rescue breathing is:

   a) The patient color changes.
   b) The victim's chest rises and falls.
   c) When the rescuer ventilates, air enters easily.
   d) The victim's pupils constrict.

7. Complications which may result from chest compressions even when properly performed include:

   a) Punctured lungs.
   b) Laceration of the liver.
   c) Fractured ribs and sternum.
   d) All of the above.

8. Excessive artifical ventilation pressures:

   a) Cause no harm to the cardiac arrest victim.
   b) Affect only adult victims.
   c) May cause stomach distension.
   d) Affect only infant and children victims.

9. The heart lies between:

   a) The clavicle and the scapula.
   b) The sternum and the spine.
   c) The clavicle and the spine.
   d) The sternum and the xiphoid process.

10. One circumstance under which a non-physician may discontinue CPR is:

   a) When the rescuer thinks the victim will not survive.
   b) When the rescuer suspects the victim will suffer permanent brain damage.
   c) When the rescuer is exhausted and unable to continue.
   d) When the rescuer sees no reaction of the pupils or other sign of life.

11. What condition should exist before the rescuer attempts to revive a victim by performing CPR?

   a) Permanent brain damage has occurred.
   b) Evidence that breathing and the pulse are absent or questionably present.
   c) The victim's pupils are dilated.
   d) The victim has shallow respirations.

12. When the rescuer is alone with a cardiac arrest victim and there is no possibility of someone else arriving at the scene the rescuer should:

   a) Telephone for help before starting CPR.
   b) Do nothing and wait for help to arrive.
   c) Open the victim's airway then telephone for help.
   d) Perform CPR for one minute than telephone for help.

13. Since successful resuscitation of drowning victims has been reported after prolonged periods of submersion in cold water:

   a) Leave drowning victims in the water for as long as possible.
   b) Initiate CPR even if the victim has been submerged for 20 - 30 minutes or more.
   c) Delay CPR because of the hypothermia effect.
   d) Use the back pressure-arm lift method of resuscitation.

14. Keeping the heel of the hand lightly in contact with the chest during the relaxation phase of chest compression is important because:

    a) Over-expansion of the chest is avoided.
    b) Correct hand position can be maintained.
    c) Stomach distention can be prevented.
    d) The heartbeat can be felt.

15. If breathing does not seem to be present after you have opened the airway:

    a) Begin chest compressions.
    b) Give blow to back.
    c) Check pupils.
    d) Attempt mouth-to-mouth ventilation.

16. CPR may be discontinued when:

    a) The rescuer suspects that ribs are fractured.
    b) The victim has a neck fracture.
    c) Another non-physician rescuer agrees that the patient is dead.
    d) When the victim's pulse and respiration are restored.

17. CPR may not be indicated:

    a) In case of known terminal irreversible illness.
    b) On victims who may incur permanent brain damage.
    c) Unless a physician is present.
    d) If after 15 minutes the CPR effort appears to be unsuccessful.

18. During one-rescuer CPR, how often should a rescuer palpate the carotid pulse to check for return of a spontaneous effective heartbeat?

    a) After the first minute of CPR and every few minutes thereafter.
    b) After the first five minutes of CPR and every five minutes thereafter.
    c) Every ten minutes.
    d) Every five minutes.

19. When a cardiac arrest occurs CPR should be initiated by:

    a) Any trained individual present.
    b) Physicians only.
    c) Paramedics and physicians only.
    d) Paramedics, nurses and physicians only.

20. The rescuer can best provide an airtight seal during mouth-to-mouth ventilation by pinching the victim's nostrils and:

    a) Cupping a hand around the patient's mouth.
    b) Using an airway.
    c) Applying his/her mouth tightly over the victim's mouth.
    d) Holding the jaw down firmly.

21. To perform chest compressions on an adult, one hand is placed on the top of the other with the heel of the lower hand pressing:

    a) Over the lower one-half of the sternum.
    b) On the upper third of the sternum.
    c) On the middle of the sternum.
    d) On the xiphoid process.

22. The principal method used for opening the airway in most cases is:

    a) Head tilt, with either neck lift of chin lift.
    b) Turning the head to one side.
    c) Striking the victim on the back.
    d) Wiping out the mouth and throat.

23. After ventilations by the rescuer, the victim will exhale by:

    a) Normal relaxation of the chest.
    b) Gentle pressure of the rescuer's hand on the upper chest.
    c) Compressions on the chest.
    d) Turning the victim's head to the side.

24. The major emphasis of emergency cardiac care is:

    a) Transportation of the victim of a life-threatening emergency to the hospital.
    b) Stabilization of the victim of a life-threatening emergency.
    c) Getting a doctor to the scene.
    d) Seeking professional life support services.

25. What should you do first for an apparently unconscious victim of illness or accident?

    a) Open the airway.
    b) Establish unresponsiveness.
    c) Administer the abdominal thrust.
    d) Examine the victim's mouth for foreign bodies.

26. The symptoms of a heart attack:

    a) May be mild and ignored, or attributed to some other cause.
    b) May occur suddenly without warning.
    c) May subside and return.
    d) May include all of the above.

27. A person experiencing a heart attack may say that it felt like:

    a) "Someone was standing on my chest."
    b) "A belt was being pulled around my chest."
    c) "Bad indigestion."
    d) Any of the above.

28. The proper rate of rescue breathing in the adult is:

a) 4 times per minute.
b) 12 times per minute.
c) 20 times per minute.
d) 28 times per minute.

29. A rescuer's first effort to assure that the patient's airway is open should be:

a) To listen to the chest for breathing sounds.
b) To properly position the head.
c) To clear foreign matter from the throat.
d) To shake shoulder and shout "Are you okay?"

30. The A-B-C's of CPR stand for:

a) Airway-Breathing-Cardiac Compresssion.
b) Adjuncts-Breathing-Carotid Pulse.
c) Airway-Breathing-Circulation.
d) Airway-Back Blows-Chest Thrust.

31. CPR should not be interrupted for more than:

a) 1 second to check responsiveness.
b) 20 seconds for any reason.
c) 5 seconds with no exceptions.
d) 5 seconds except in certain circumstances.

32. When performing external chest compression on an adult, the sternum should be depressed:

a) 1/2 to 1 inch.
b) 1 inch to 1 1/2 inches.
c) 1 1/2 inches to 2 inches.
d) 2 to 2 1/2 inches.

33. The pulse of a victim suspected to be in cardiac arrest should be checked:

a) Immediately after opening the airway.
b) After the first four ventilations.
c) After the first two ventilations.
d) Before ventilations are given.

34. One can determine if an unconscious victim is breathing by:

a) Checking the blood pressure.
b) Checking for cyanosis.
c) Checking the pulse.
d) Looking, listening, feeling for signs of air and chest movement.

35. If a lone rescuer finds a non-breathing and pulseless victim lying face down at the scene of an auto accident, and the rescuer suspects that the victim has a back injury, what should the rescuer do?

a) Turn the victim as a unit and begin CPR.
b) Turn the victim's head to one side and begin CPR.
c) Do nothing and wait until help arrives.
d) Attempt to apply CPR with the victim in the face-down position.

36. In mouth-to-mouth resuscitation the victim's dentures routinely should be:

a) Removed because they contain bacteria.
b) Left in (unless unusually loose) because they help to make an airtight mouth-to-mouth seal.
c) Removed because they frequently obstruct the airway.
d) Left in because it is illegal to remove them without the victim's consent.

37. The greatest risk of death from a heart attack occurs:

a) Within the first two hours after onset of symptoms.
b) Two to eight hours after onset of symptoms.
c) Eight to twelve hours after onset or symptoms.
d) Twelve to twenty-four hours after onset of symptoms.

38. If vomiting occurs during a resuscitation effort, the best immediate procedure to follow is:

a) Insert a naso-gastric tube.
b) Pause for a moment until the victim appears quiet again, then resume mouth-to-mouth ventilation.
c) Switch to mouth-to-nose ventilation.
d) Turn the victim's body to the side, sweep out the mouth and resume CPR.

39. When performing the head tilt-neck lift, the hand lifting the neck should be placed:

a) Under the shoulders between the shoulder blades.
b) Under the neck close to the back of the head.
c) Under the neck close to the shoulders.
d) On the forehead.

40. To perform effective CPR the victim should be positioned on his/her back.

a) With head elevated.
b) With head turned to side
c) With a pillow under the head.
d) With head tilted back.

41. All of the following are risk factors of a heart attack except:

    a) Cigarette smoking.
    b) High blood fat-cholesterol level.
    c) High blood pressure.
    d) Nausea and vomiting.

42. When one rescuer performs CPR, the ratio of chest compressions to lung inflations for any adult victim is:

    a) 12 compressions to 2 ventilations.
    b) 5 compressions to 1 ventilation.
    c) 7 compressions to 1 ventilation.
    d) 15 compressions to 2 ventilations.

43. The heart attack victim's most common reaction to symptoms of heart attack is to:

    a) Panic and faint.
    b) Call for a doctor.
    c) Deny that he might be having a heart attack.
    d) Drive to a hospital.

44. Respiratory arrest is characterized by minimal or absent respiratory effort, failure of the chest or upper abdomen to move, and:

    a) Dilation of pupils.
    b) Cardiac arrest.
    c) Swelling of the tongue.
    d) No air movement through nose or mouth.

45. Using 4 - 10 seconds to establish unresponsiveness in collapsed victims is important because:

    a) The victim may have only fainted.
    b) It may prevent unnecessary resuscitation efforts.
    c) It may prevent possible damage to a sleeping person.
    d) All of the above are important reasons.

46. Chest compressions must always be accompanied by:

    a) Manual thrusts.
    b) Artificial ventilations.
    c) Relief of gastric distension.
    d) Administration of drugs.

47. In order to determine correct location for chest compressions:

    a) Feel for the lower end of the sternal notch and measure with one to two fingers above that point.
    b) Find the navel and measure 2 hands above it.
    c) Estimate the appropriate place and put hands into position.
    d) Find the upper margin of the sternum and put hands directly below it.

48. The purpose of "Good Samaritan" legislation is:

    a) To require all medical professions be trained in CPR.
    b) Protect training institutions.
    c) To eliminate lawsuits.
    d) To minimize possible fear of legal consequences to the lay person for providing CPR.

49. The number one cause of death in the United States is:

    a) Cancer.
    b) Accidents.
    c) Heart and blood vessel disease.
    d) Stress.

50. When the rescuer palpates the pulse of the adult victim with one hand, the other hand of the rescuer should:

    a) Maintain the head tilt.
    b) Sweep out victim's mouth.
    c) Feel chest for movement.
    d) Find landmark for compressions.

MEDICATIONS

Module 5 Test Form A

Instructions: Choose the one best answer, and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. "Any substance that, when taken into the living organism, may modify one or more of its functions" is the definition of a:

   a) Medication
   b) Type of prevention
   c) Mineral
   d) Drug
   e) None of the above

2. The following are all major drug sources except:

   a) Synthetics
   b) Molecules
   c) Minerals
   d) Animals
   e) Plants

3. Which of the following is not a modern use of medication?

   a) Improvement of intelligence
   b) Maintenance of function
   c) Diagnosis of disease
   d) Relief of pain
   e) Prevention of disease

4. Drug misuse refers to:

   a) Indiscriminate use of drugs
   b) Addiction to drugs
   c) Narcaotics
   d) Mind altering drugs
   e) Depressants

5. Both state and federal legislation guide the administration of medication.

   a) True b) False

6. All medication the recipient receives must be ordered by:

   a) Nurses
   b) Interdisciplinary team
   c) Home Administrator
   d) Person licensed to do so by Department of Licensing and Regulation
   e) Any of the above

7. A recipient who refuses medication should be forced to take the medication as soon as possible, so that he/she doesn't refuse the next time.

a) True b) False

8. A direct care staff person is legally responsible for the administration of medication within the limits of the skills acquired in training.

a) True b) False

9. A drug administered directly to a tissue or organ when only a limited area is affected is considered to have _____ effects.

a) Systemic
b) Body
c) Psuedo
d) Local
e) All of the above

10. Which of the following are factors that influence drug effectiveness and dosage?

a) Sex of recipient
b) Time administered
c) Overall condition of recipient
d) Age of recipient
e) All of the above

11. The route in which a drug is administered affects the dosage and effectiveness of the drug.

a) True b) False

12. All of the following are major routes of medication administration except:

a) Oral
b) Vaginal
c) Intracranial
d) Topical
e) Injectible

13. At the conclusion of this training program, you will be qualified to administer medication by injection.

a) True b) False

14. All of the following are terms related to the actions of drugs except:

a) Contraindications
b) Doppler's effect
c) Desired effect
d) Adverse effect
e) Side effect

15. What document(s) must be obtained from the physician for each written medication prescription for recipients?

    a) A written order from the interdisciplinary team.
    b) A written physician's order.
    c) A written prescription.
    d) a and c.
    e) b and c.

16. The following are all necessary components of a properly labeled pharmacy label except:

    a) The diagnosis.
    b) Directions for use.
    c) The date the prescription was most recently dispensed.
    d) Recipient's name.
    e) Prescriber's name.

17. Special instructions on a pharmacy label might include which of the following?

    a) Shake well.
    b) Keep out of direct sunlight.
    c) Take with food or milk.
    d) Might cause discoloration of urine or feces.
    e) All of the above.

18. A new medication has been prescribed for one of the recipients. You are not familiar with the specifics about the medication. You...

    a) Look in a textbook to find out.
    b) Ask a licensed health provider such as a doctor or nurse consultant.
    c) Use your own knowledge or judgment.
    d) Consult the Doctor's column in the newspaper.

19. In what kind of containers must medications be stored?

    a) In containers provided at your group home.
    b) All medication of the same type should be combined and stored in the same container.
    c) It should be stored in the original container in which it was dispensed by the pharmacist.
    d) All medication should be combined in one container for each recipient.
    e) Any of the above is okay.

20. Temperature is not important to consider when storing medications at your group home.

    a) True b) False

21. Medications must be stored:

a) In the compartment above the stove.
b) In open canisters to allow air to reach them.
c) In locked compartments.
d) In the medicine cabinets in the bathroom.
e) None of the above.

22. All medications must be stored:

a) In refrigerated compartment.
b) Under proper temperature control.
c) In heated compartment.
d) At room temperature.
e) c and d.

23. Keys to the medication storage cabinet must be:

a) Kept by all staff.
b) Hung where convenient to reach.
c) Kept on the person assigned to medication administration for that shift.
d) Only a nurse may have keys to the medication cabinet.
e) None of the above.

24. Creams and ointments should always be stored in the medication cabinet with the rest of the internal medication.

a) True b) False

25. Direct care staff may receive non-medication telephone orders from a physician.

a) True b) False

26. If you receive a non-medication telephone order from a physician, you should:

1. Carefully repeat the order back to the physician;
2. Make clarifications as necessary;
3. Immediately write it on the health record;
4. Notify the supervisor/nurse consultant;
5. Refer the physician to the pharmacist.

a) 1 and 2
b) 2 and 3
c) 3 and 4
d) 1, 2, 3 and 4
e) 5

27. All of the following are common dosages forms except:

    a) Suppositories
    b) Tablets
    c) Platelets
    d) Ointments/Creams
    e) Capsules

28. Over the counter drugs do not have to be transcribed to the medication record.

    a) True b) False

29. If the recipient refuses his/her medication:

    a) Give the recipient a double dose that night;
    b) Do nothing. It won't hurt to miss just one dose;
    c) Notify physician or nurse consultant, your supervisor, and document it properly;
    d) Force the recipient to take it;
    e) None of the above.

30. The definition of "adverse effect of medication" is obtaining the specific effect of the drug for which it was administered.

    a) True b) False

31. Choose the correct sequence for the disposal of medication.

    1. Destroy the medication beyond possible reclamation, with a witness present.
    2. Document the disposal of the medication on the recipient's record and write discontinue or D/C on the medication record where the next dose would have been recorded.
    3. Make sure there is a physician's order on file in the recipient's record authorizing discontinuation.
    4. Make other staff aware of the discontinuation of the order.
    5. With a witness, compare the pharmacy label with the physician's order to make sure the right medication is being discarded.

    a) 1, 2, 3, 4, 5
    b) 2, 5, 3, 1, 4
    c) 3, 5, 1, 2, 4
    d) 4, 2, 3, 1, 5
    e) 5, 4, 3, 2, 1

32. The parent's/guardian's permission must be obtained before medication can be administered to a recipient.

    a) True b) False

33. What information about a medication must you obtain before administering it to a recipient?

1. Desired effect
2. Deprivation
3. Time it takes to work
4. How it is excreted
5. Side effects

a) 1, 2, 3
b) 1 only
c) 2, 4
d) 1, 3, 5
e) 1, 2, 5

34. If a change in behavior or health of the recipient occurs just following receipt of medication, you should ignore it as it is to be expected.

a) True b) False

35. Information from the pharmacy label must be accurately transcribed to:

a) The Plan of Service.
b) An incident report form.
c) A chronological log.
d) The medication record.
e) c and d.

36. Each time you administer a medication, you need to be sure to have the <u>right</u>:

a) Record, way, hour, person.
b) Amount, area, action, response.
c) Recipient, medication, dosage, time, route.
d) Routine, reason, effects, action, consequences.
e) None of the above.

37. What is the first thing you should do to ensure that you administer the correct medication?

a) Have another staff member watch to catch errors.
b) Compare the medication record sheet and the pharmacy label.
c) Contact your medical supervisor.
d) Compare the pharmacy label to the Plan of Service.
e) None of the above.

38. In order to be sure that you give the right dosage, you need to do all <u>except</u> which of the following:

a) Ask the recipient what his/her usual dosage should be.
b) Compare medication record sheet and the pharmacy label.
c) Carefully measure or count correct dosage.
d) Compare amount measure with the pharmacy label.
e) All the above are necessary.

39. The procedures for handling of medications for administration outside the group home should include all except which of the following:

    a) Hand deliver the medication containers to the appropriate facilities.
    b) Transfer the medication to the appropriate container at the other facility.
    c) Explain the situation to the pharmacist so that he/she can prepare a correctly labeled container for each facility and he/she can dispense the medication to each of those containers.
    d) Share any information regarding the medication given by the physician, pharmacist, or nurse, with the other facility.
    e) Ask the pharmacist to type "school" on the school vial.

Match the abbreviations and symbols to the words they represent.

40. q.i.d.
41. h.s.
42. q.
43. tsp.

    a) hour of sleep (bedtime)
    b) four times per day
    c) every
    d) tablespoon
    e) teaspoon

44. When a medication is discontinued, why should the direct care staff compare the pharmacy label with the physician's order?

    a) So that the leftover medication can be used for other recipients.
    b) To make sure the right medication is being disposed of.
    c) To make sure that the right records are taken out of the recipient's records.
    d) All of the above.
    e) a and c only.

45. Two direct care staff, when a medication is discontinued, should destroy the medication beyond possible reclamation.

    a) True b) False

46. What other types of medications may have to be disposed of?

    a) Medication that has deteriorated in appearance or smell.
    b) Contaminated medication (spilled or dropped).
    c) Medication whose shelf life has expired.
    d) All of the above.
    e) None of the above.

47. Which of the following will help to prevent medication errors?

    a) Have the recipients store and take their own medication.
    b) Only dispense medications that another staff member prepared.
    c) Observe the five rights of medication administration.
    d) Have the pharmacist administer all medication.
    e) None of the above.

48. What is the first thing you should do if a medication error occurs?

a) Complete an Unusual Incident Report.
b) Record in the recipient's chart exactly what happened.
c) Take the recipient to an emergency room.
d) Contact a physician and follow his/her instructions.
e) Notify supervisor/nurse consultant/case manager.

49. Once a medication error does occur and the emergency is over, be sure to:

a) Record exactly what happened in the recipient's record.
b) Inform all other recipients that a medication error occurred.
c) Flush the medication down the toilet.
d) All of the above.
e) None of the above.

50. When a physician must give a medication order over the telephone, you should:

a) Repeat the order back to the physician to confirm it.
b) Treat the recipient by administering the medication.
c) Ask the physician to call your pharmacist to take the orders.
d) None of the above.
e) b and c.

ENVIRONMENTAL EMERGENCIES: PREVENTING, PREPARING AND RESPONDING

Module 6 Test Form A

Instructions: Choose the one best answer, and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. Which of the following are environmental hazards for which you must be prepared?

   a) Water shortage, heat failure, power outages.
   b) Fire, poison, tornadoes.
   c) Floods, winter storms, lightning.
   d) All of the above.

2. Your best source of information in most emergencies is:

   a) The next-door neighbor.
   b) Battery-powered radio.
   c) Television.
   d) Police department.

3. Charcoal fires, burners or grills are safe indoor cooking equipment.

   a) True b) False

4. Recipients should be included in learning and taking part in the emergency preparedness plan.

   a) True b) False

5. The primary rule of safety when there is a fire is:

   a) Call the fire department immediately.
   b) Get out quickly.
   c) Put out the fire.
   d) Close off the burning area.

6. When reporting an emergency by telephone, you should:

   1) Describe the situation.
   2) Talk quickly to save time.
   3) Give the address.
   4) Hang up after you've asked for help.

   Circle the correct response:

   a) 1, 2
   b) 1, 3
   c) 1, 4
   d) 2, 3
   e) 3, 4

7. Water is the best way to put out a(n):

   a) Electric fire.
   b) Wood fire.
   c) Grease fire.
   d) Gasoline fire.
   e) None of the above.

8. If your clothes catch fire, you should:

   a) Run to get away from the flames.
   b) Drop and roll on the floor.
   c) Stand and wrap up in a blanket.
   d) Get under the shower.

9. If the door to a room is closed and you smell smoke, you should <u>first</u>:

   a) Open the door and check for fire.
   b) Leave the room by a window.
   c) Feel the door for heat.
   d) Check under the door for smoke.

10. Syrup of Ipecac is a:

   a) Solution to dilute a poison.
   b) Solution to wash a poison from skin.
   c) Solution to cause vomiting.
   d) Solution to top an ice cream sundae.

11. The wrong treatment for a poison victim is often more dangerous than none.

   a) True b) False

12. When taking a recipient for treatment of poison, what should you take with you?

   a) Any vomit from recipient.
   b) The poisonous substance, if any is left.
   c) The poison container.
   d) The recipient.
   e) All of the above.

13. The first step when someone is poisoned is:

   a) Make them vomit.
   b) Call poison control or doctor.
   c) Give them milk or water.
   d) Call the police.

14. If caught outside during a lightning storm, you should find a high place to stand on.

a) True b) False

15. The difference between a tornado watch and a tornado warning is:

1) In a tornado watch, you can actually see the tornado.
2) In a tornado warning, a tornado has been sighted or detected--take cover immediately.
3) In a tornado watch, tornadoes or severe thunderstorms are possible.
4) In a tornado warning, conditions are right for a tornado.

Choose the best response.

a) 1, 2
b) 3, 4
c) 1, 4
d) 2, 3

16. The safest place during a tornado is:

a) The basement.
b) Southwest corner on the first floor.
c) Closet on the first floor.
d) Interior hall on the first floor.

17. When you hear about a tornado warning, you would take all of the following precautions except:

a) Take cover immediately, preferably in a basement.
b) Crawl to the wall with the largest window.
c) Protect your head.
d) Avoid windows, doors, outside walls.
e) If outside without shelter nearby, lie flat in a ditch or ravine.

18. If caught outdoors in a thunderstorm, you should avoid metal equipment.

a) True b) False

19. Your first precaution in preparing for possible winter storms is:

a) Avoid going outside.
b) Keep posted on weather conditions through T.V., radio, newspaper.
c) If you must drive, drive slowly.
d) Turn up the heat to 80°F.
e) None of the above.

20. All of the following are ways to prepare for possible isolation in winter storms except:

    a) Have first aid supplies available.
    b) Stock emergency supply of food and water.
    c) Park cars on the north side of the street.
    d) Stock battery-powered radio, flashlights.
    e) Have emergency fire-fighting equipment available.

21. If you must drive during a winter storm, drive alone to avoid risking anyone else's life.

    a) True b) False

22. During a power outage, you should do all the following except:

    a) Bring a barbecue indoors and light it for heat.
    b) Keep refrigerator and freezer doors shut to avoid thawing.
    c) Use a flashlight.
    d) Transfer foods that will be used quickly to a cooler to avoid opening refrigerator doors.

23. In case of a heating failure during cold weather, you should do all the following except:

    a) Use a portable heater.
    b) Dress in layers adding sweaters and outer clothing as needed.
    c) Keep everyone moving, if possible, to keep warm.
    d) Keep sleeping bags available.
    e) Avoid overexertion.

24. Staff must be prepared to prevent and/or treat which of the following cold weather conditions?

    a) Hypothermia
    b) Frostbite
    c) Risk of heart attach or stroke
    d) All of the above
    e) None of the above

25. When a flash flood is the result of a severe thunderstorm, you should:

    a) Avoid high places.
    b) Avoid low places.
    c) Stay outdoors if possible.
    d) All of the above.
    e) None of the above.

YOUR RESPONSIBILITIES FOR PROTECTNG RECIPIENTS' RIGHTS

Module 7 Test Form A

Instructions: Choose the one best answer and mark it on your answer sheet only. PLEASE DO NOT WRITE ON THE TEST.

1. After arriving at work in the morning, you notice that one of the recipients in your home has bruises on her arms and body. In response to your questions, she fails to provide an explanation of how this occurred.

   a) You check the previous day's record to see if there is any appropriate entry regarding this recipient. If there is none, you bring the matter to the attention of your supervisor.
   b) You do nothing since the recipient probably fell.
   c) You ask the person who worked the previous evening. If his answer appears reasonable, you do nothing further.

2. While working at night you notice that one of the recipients is sleeping in someone else's bed. You attempt to wake him by talking to him and shaking his shoulder but fail to get him to move.

   a) If this deprives another recipient of sleeping space, you get help (if possible) to take the recipient to his own bed. Otherwise, you do nothing then but subsequently make sure that the recipient goes to sleep in his own bed.
   b) Using your hand you hit him several times across the buttocks in order to get his attention.

3. While outside, you notice several recipients attacking and beating another recipient.

   a) You do nothing, it is just some of the recipients having a little fun.
   b) You separate the participants, getting assistance from other staff if necessary. After checking to see that the recipient is not injured, you find out what happened and make every effort to see that it does not reoccur.

4. While at work, you hear a fellow staff member use derogatory racial/ethnic slurs in speaking to recipients.

   a) You do nothing since the recipients do not object and use of such words is a common occurrence.
   b) You take her aside and tell her that use of such terms is not wise since it may lead to disciplinary actions if reported.
   c) You report the incident to your supervisor.

5. Despite a variety of training and remedial efforts, a recipient in your home has again defecated in his clothing.

   a) You change the clothing and continue your efforts to teach the recipient proper toilet habits. In so doing, you check with appropriate staff for other innovative training approaches.
   b) You inform the recipient that since he refuses to use the available toilets and continues to defecate on himself, he will have to keep wearing the soiled clothing.

6. You have observed a fellow staff member hurting a recipient. The staff member tells you that if you report this incident, he will see that you get in trouble.

   a) You report the entire occurrence to your supervisor, including details of the threat that was made to you.
   b) You do nothing, nobody else has noticed this and you want to get along with your fellow staff members.

7. A recipient in your home continually uses dirty words in talking to other recipients and to staff members. Despite your repeated efforts to correct her and change this habit, she continues to do so.

   a) You do nothing further since it is impossible to change the recipient's language.
   b) You wash the recipient's mouth out with soap and water and state that you will do so again if she continues to use dirty language.
   c) You continue your efforts to encourage the recipient to use acceptable language using different approaches that may be more effective. You work with your supervisor to ask for consultation from the case manager.

8. You hear a staff member soliciting a recipient for sexual relations.

   a) You do nothing, since the recipient does not appear to object to the comments made.
   b) You tell the other staff member to be more discrete since she will get in trouble if caught.
   c) You immediately bring the matter to the attention of your supervisor.

9. Despite a variety of efforts by you during breakfast, a recipient continues to throw his food around the dining room and interferes with other recipients eating.

   a) You remove the recipient from the dining room and follow through according to the individualized plan of service.
   b) You inform the recipient that if this behavior continues he will be taken out of the dining room and will not receive any food for the rest of the day.

10. A recipient is playing with feces and smearing it on herself and surroundings.

    a) You clean the recipient, remove the feces and make every effort to see that this does not reoccur. You check with other staff for the most appropriate approaches.
    b) You are busy with other matters and will get to it as soon as you can. There is no rush, the recipient will dirty herself again anyway.

11. While on duty you notice another staff member pulling a recipient's hair and hitting her in the face.

    a) You do nothing, since the recipient has been difficult, has caused trouble and this is the only way to handle her.
    b) You directly attempt to stop the other staff member telling him that this is not permissible and report the incident to your supervisor.

12. One of the recipients in your home does not participate in group sports despite your urging. He is listless and lethargic.

    a) You make the recipient run around the yard several times as you know this is good exercise that will snap him into line.
    b) You do nothing, if the recipient does not want to participate he doesn't have to.
    c) You refer the recipient for an evaluation by the nurse or doctor. If there are no problems you encourage the recipient to participate but do not force him if he does not want to.

13. A recipient in your home does not pay attention and appears to ignore you when you speak to her.

    a) You leave the recipient alone since it is impossible to get her attention.
    b) You put your hands on the recipient's shoulders and shake her vigorously in order to get her attention.
    c) You stand in front of the recipient, establish and maintain eye contact, and by words and gestures attempt to develop communication.

14. A recipient in your home is becoming increasingly agitated and you are concerned that he will do injury to himself, to other recipients and/or staff.

    a) You try to get the recipient involved in some activities in another setting in order to distract him and minimize the agitation.
    b) You tell the recipient that if he doesn't stop, you will tie him up and leave him alone in a room.
    c) You do nothing but watch the recipient so that you can respond if he does anything improper.

15. Despite your efforts, one of the recipients in your home has been noisy most of the night and is keeping other recipients from sleeping.

    a) You tell the recipient that since she will not behave properly, she will have to sit on a chair the entire night.
    b) You take the individual out of the room, try to determine why she is noisy and continue your efforts to calm her.

16. While at work you notice that a staff member has a recipient's arm twisted behind his back and is pushing him out of the room. The recipient appears to be in pain. You are informed that the recipient attempted to attack the staff member and this is the only way to control the situation.

    a) You do nothing since the other staff member is acting appropriately.
    b) You offer to assist the other staff member, pointing out that this is not an appropriate action and report the incident to your supervisor.

17. While at work you notice a staff member giving one of the recipients a bottle of whiskey.

    a) You do nothing since drinking is normal and consumption of liquor makes the recipients more manageable.
    b) You tell the other staff member to be careful as he will get in trouble if caught.
    c) You attempt to retrieve the bottle of whiskey and report the incident to your supervisor.

18. You are trying to teach a recipient how to perform a household task. Despite your repeated efforts, the recipient does not appear to comprehend and continues to do the work incorrectly.

    a) You keep trying, and attempt different approaches that may be understood more easily.
    b) In disgust, you tell the recipient that she is stupid and will never learn anything.

19. You have asked one of the recipients to go to the dining room. She ignores you and continues walking in an opposite direction.

    a) In order that the recipient will be sure to hear you, you shout at her to get in the dining room or she will be punished.
    b) You take the recipient by the arm, repeat the statement, and attempt to guide her to the dining room.

20. Two recipients in your home are fighting. A staff member is standing nearby watching the fight and shouting encouragement to the participants.

    a) You do nothing, this is a situation that requires no action on your part.
    b) You stop the fight and tell the staff member that she should not have allowed this. After checking to see that no one was injured, you then report the incident to your supervisor.

APPENDIX H

CALCULATION OF RETROSPECTIVE AND PROSPECTIVE METHODS

Calculation of Retrospective and Prospective Methods

1. The Retrospective Method

An account of direct costs used in the training was the responsibility of the training manager at the MDMH facility (Wayne Community Living Services [WCLS]). Each day was recorded for classroom sessions; hours were documented, and the number of trainers used to deliver the instruction was recorded. Hourly rates for these respective trainers were computed. Daily lunches were recorded for trainers. Clerical support was also documented in hours of service, and hourly rates were computed. Planning hours were also included in the overall cost. As well as the documented planning, a 25% planning factor was included to incorporate the entire planning effort of trainer resource persons, etc., used in the training. Cost figures were also developed for CPR and first-aid training delivered by the Red Cross; WCLS has a contract with the Red Cross to train these content areas (Modules 4A and 4B) on a per person basis. Duplicating costs, supplies, and so on, were recorded, and the rental cost for the state car was included.

The Total Cost Report (Table 7) for WCLS was used to compute the indirect costs. General administration, physical plant, maintenance, housekeeping, and depreciation were the variables used. Fringe benefits were not used as an indirect cost but were tabulated as a direct cost and included in the personnel/trainer cost at a 29% level. This figure is used by the MDMH Personnel Office.

A total cost figure was computed and then divided by 30--the number of trainees starting the training.

2. The Prospective Method

The following standards/assumptions were developed by the ORD with respect to implementing the Group Home Curriculum:

a. The training day is six hours.

b. The remaining two hours of the work day are spent in documentation, designing, planning, debriefing, and breaks.

c. The ratio of trainer to trainees is 1:16.

d. There are 215 days available for conducting training sessions per year. The number of days available for training is figured in the following manner:

2080 hours/year divided by 8 hours/day = 260 work days/year

260 Work Days - 13 Sick Days - 15 Annual Leave Days - 12 Holidays - 5 Staff Development Days (training-of-trainers sessions, dissemination conferences, etc.) = 215 WORK DAYS AVAILABLE FOR TRAINING

This formula was developed as follows:

STEP ONE:

CURRICULUM	CREDITS	SUPERVISED INSTRUCTIONAL HOURS[1]	SUPERVISED INSTRUCTIONAL DAYS[2]	ADDITIONAL HOURS 1:8 TRAINER/ TRAINEE SESSIONS[3]	ADDITIONAL DAYS 1:8 TRAINER/ TRAINEE SESSIONS[2]	TOTAL NUMBER OF DAYS NEEDED TO TRAIN GROUP HOME CURRICULUM[4]
Part 1	80.0	60.0	10.0	22.0	4.0	14.0

1. Hours not in supervised instructional sessions are spent in practicum sessions, in home assignments, readings.

2. Number of hours divided by 6 hours/training/day.

3. Modules in Physical Intervention (Module 2), Health (Module 3), and Recognizing and Responding to Life Threatening Situations (Module 4) require class sizes of 1 trainer to 8 trainees or 1 trainer to 10 trainees. Additional training hours are needed to allow for required additional staff time.

4. Total of Supervised Instructional Days and Additional Days 1:8 Trainer/Trainee Sessions.

STEP TWO:

Given that there are 215 training days per year, and it takes 14 days to train Part I, then:

215 divided by 14 = 15

The facility can offer training in the Group Home Curriculum 15 times per year, with 1 trainer on staff.

STEP THREE:

15 sessions per year times the number of trainees attending each session is:

15 x 16 = 240

240 trainees may receive instruction in the Group Home Curriculum per year, if the facility is given the trainer resources equivalent to 1 FTE.

STEP FOUR:

The dollar amount to support 1 FTE is $35,000. This includes salary and wages as well as fringe benefits.

$35,000 divided by 240 = $146

The formula is as follows:

$146 + indirect costs + telephone, supplies, travel, meals + contract with Red Cross = cost per trainee

Indirect ($144), telephone ($25), supplies ($460), travel ($80), meals ($132), and Red Cross ($471) are estimated at $1,312. This is then divided by 30. Other expenses per trainee are $44.

The formula is as follows:

$146 + $44 = $190 salaries, other cost per trainee and wages/expenses direct

The step-by-step process that a facility would use to compute costs with the prospective method is as follows:

Agency X has projected that 500 trainees need training in Part I of the Group Home Curriculum. The turnover rate for Agency X is approximately 10% per year. The class size averages 12 trainees. Since Agency X is rural, they need additional travel time to training sites. How many dollar should Agency X request?

STEP ONE: ADJUSTMENT FOR TURNOVER RATE

500 trainees x 10% turnover rate = 50 additional trainees. 500 initial trainees + 50 additional trainees (due to turnover) = 550 total trainees.

STEP TWO: ADJUSTMENT FOR CLASS SIZE

Up to 15 sessions are held each year. 16 trainees were figured per session in the state formula, but Agency X only averages 12 trainees per session. 15 sessions x 12 trainees/session = 180 trainees per FTE per year (not 240 trainees).

STEP THREE: ADJUSTMENT FOR TRAVEL TIME

The number of maximum useful hours in one training day is 6 hours. Agency X is located in a rural area; therefore, additional travel time (2 hours) is needed. The training day is diminished by 2 hours per week (on the assumption that trainees will not drive back and forth each day but will drive one additional hour each on Monday and on Friday). A total of 14 training days is used in the state

formula, with an adjustment needed for travel time. 14 days/session divided by 5 work days/week = 3 weeks. 3 weeks x 2 hours/week for travel time = 6 hours travel time, or one more day of training per session. 14 days/session + 1 day travel time = 15 days needed for training Part I of the Curriculum.

STEP FOUR: FINAL COMPUTATION WITH ABOVE VARIABLES

215 work days/year divided by 15 days/session = 14 sessions/year (instead of 15 devised in the state formula). 14 sessions x 12 trainees = 168 trainees/year with the dollar support of 1 FTE. 1 FTE = $35,000 (salary and fringes). Cost per trainee is $208 ($35,000 divided by 168).

Other costs = $208 + $44 = $252/trainee salaries and other costs wages.

This method has the flexibility to modify the standardized formula for projecting training costs of a facility, given deviation from the norm variable (travel, class size, etc.).

1. The Retrospective Method--Calculations

The total cost for salaries, wages, and fringes to deliver the training was $2,740. In addition, the Red Cross contract was $471 for 30 participants. Supplies ($460), meals ($132), telephone (under $25), and the state car ($80) totaled $697. Indirect costs, including general administration, physical plant, maintenance, housekeeping, and depreciation, totaled $.65 per training unit. A total of 360 training units was used, bringing indirect costs to $144.

$2,740 + $471 + $697 + $144 divided by 30 equals per trainee cost of $135.

2. The Prospective Method--Calculations

Using the step-by-step technique devised, the following totals were developed:

STEP ONE:

15 sessions per year x 30 trainees = 450 trainees per year, for $35,000 per trainer.

STEP TWO:

$35,000 divided by 450 trainees = $78 per trainee--salaries, wages, and fringes (direct costs).

STEP THREE:

Using data from the retrospective method:

Red Cross contract = $471, Supplies $460, Meals $132, Telephone $25, State car $80, Indirect $144.

TOTAL: $1,312

The total other costs are $1,312. This amount is divided by 30 trainees, equaling $44 per trainee for other costs.

STEP FOUR:

$78 (direct costs) + $44 (other costs) = $122 per trainee.

In the example used in Chapter IV, the total per trainee was $190. The discrepancy is caused by the fact that Wayne Community Living Services (Site I: the MDMH facility) has taken the liberty of "increasing" the class size to 30 trainees instead of 16 as programmed in the formula and standards. In addition, an example of Agency X was developed which also deviated from the class size by decreasing it to 12 trainees. This increased the cost to $252 per trainee.

APPENDIX I

ANOVA TABLES: MODULES 1, 2, 3, 4A, 4B, 5, 6, 7

Table I.1.--ANOVA for Module 1.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	34.65	34.65	1.34
Time	1	.93	18.29	.71
Interaction	1	6.87	6.87	.27
Error	60	1551.60	25.86	

Table I.2.--ANOVA for Module 2.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	7.87	7.87	1.17
Time	1	5.70	5.70	.85
Interaction	1	4.56	4.56	.68
Error	60	402.60	6.71	

Table I.3.--ANOVA for Module 3.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	1.88	1.88	.10
Time	1	1.88	1.88	.10
Interaction	1	51.60	51.60	2.70
Error	60	1149.10	19.15	

Table I.4.--ANOVA for Module 4A.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	91.03	91.03	7.16*
Time	1	1955.0	1955.0	153.9**
Interaction	1	.44	.44	.03
Error	53	673.37	12.71	

*p < .01.

**p < .001.

Table I.5.--ANOVA for Module 4B.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	20.29	20.29	1.98
Time	1	156.68	156.68	15.32**
Interaction	1	61.03	61.03	5.97*
Error	52	531.81	10.23	

*p < .025.

**p < .001.

Table I.6.--ANOVA for Module 5.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	.82	.82	.07
Time	1	44.59	44.59	3.79
Interaction	1	118.57	118.57	10.08*
Error	60	705.81	11.76	

*p < .005.

Table I.7.--ANOVA for Module 6.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	.50	.50	.16
Time	1	2.40	2.40	.78
Interaction	1	5.93	5.93	1.93
Error	60	184.75	3.08	

Table I.8.--ANOVA for Module 7.

Source of Variation	df	SS	MS	F-Ratio
Instruction site	1	.10	.10	.60
Time	1	0	0	0
Interaction	1	.46	.46	2.76
Error	60	9.99	.17	

APPENDIX J

DEFINITION OF TERMS

Definition of Terms

Community Mental Health Services Board. Each county has a locally elected board to coordinate mental health services in their area. These services are supported by local and state tax dollars. This service delivery is part of the public mental health system.

Developmental Disability. An impairment of general intellectual functioning or adaptive behavior that meets the following criteria. The developmental disability (a) originated before the person became 18 years of age; (b) has continued since its origination or can be expected to continue indefinitely; (c) constitutes a substantial burden to the impaired person's ability to perform normally in society; and (d) is attributable to one or more of the following: mental retardation, cerebral palsy, epilepsy, or autism; any other condition of a person found to be closely related to mental retardation because it produced a similar impairment or requires treatment and services similar to those required for a person who is mentally retarded; or dyslexia resulting from a condition described above.

Group Home Curriculum. Part I of the Group Home Curriculum includes seven modules designed to be used for paraprofessionals employed in community residential homes serving the developmentally disabled and mentally retarded.

Mental Illness. A substantial disorder of thought or mood that significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life.

Michigan Department of Mental Health. One of 16 state departments reporting to the Governor.

Michigan State Manpower Development (SMD) Office. The ORD has been awarded a federal grant from the National Institute of Mental Health, Clinical Training Unit, Department of Health and Human Services.

Office of Resource Development (ORD). One of several organizational units reporting to the Chief Deputy Director of the Michigan Department of Mental Health; responsible for education, training, and human resource development.

Public Act 258 of 1974, as amended (Mental Health Code). An act to modernize, add to, revise, consolidate, and codify the statutes relating to mental health; to delineate the powers and duties of the Department of Mental Health; to establish county community mental health programs; to delineate state and county financial responsibility for public mental health services; to create certain funds; to establish procedures for the civil admission and discharge of mentally ill persons to and from mental health facilities; to establish procedures for the civil admission and discharge of mentally retarded and other developmentally disabled persons to and from facilities; to establish guardianship arrangements for mentally retarded persons; to establish certain rights of persons who receive mental health services; to establish financial liability for the receipt of public mental health services; to establish certain procedures pertaining to mentally ill and mentally retarded persons who are under criminal sentence, to persons who are mentally

incompetent to stand trial, and to persons who have been found not guilty by reason of insanity; and to repeal certain acts or parts of acts.

Public Mental Health System. A state/county/locally supported mental health program delivery system.

State Regional Center for the Developmentally Disabled (DD Center). A facility operated by the Michigan Department of Mental Health for care, treatment, and training of persons with developmental disabilities admitted subject to Sections 508 and 509 of the Mental Health Code.

State Psychiatric Hospital (MI Hospital). A facility operated by the Michigan Department of Mental Health for 24-hour care and treatment of mentally ill persons meeting criteria for admission as defined by Sections 401, 411, and 415 of the Mental Health Code.

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