AN ASSESSMENT OF THE THERAPEUTIC ENVIRONMENTS PRESENTED TO RETARDATES BY NURSING HOMES

by

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TABLE OF CONTENTS

LIST OF TABLES

CHAPTER 1

INTRODUCTION

In 1961 when President Kennedy sent his message on mental illness and mental retardation to the Congress he pointed out that there were at that time over 200,000 persons in residential facilities for the mentally retarded. Today there are over six million individuals diagnosed as retarded who live in the United States. Over 126,000 are born annually. (Robinson & Robinson, 1965)

The care of the mentally retarded has historically been associated with large state institutions. Recently the therapeutic quality of such environments has been strongly challenged. With increasing acceptance of such concepts as the "therapeutic community" and "normalization" (Bensburg, 1974; Nirje, 1976) there has been a growing demand to phase out the large hospitals while developing small community-based facilities, close to family and friends, to care for the mentally retarded. Consequently, retardates who would previously have spent their lives in large state institutions are now being placed in group homes, small publicly owned institutions, and privately owned nursing homes. Of these, nursing homes probably represent the major available alternative to the large hospital

and may receive the greatest numbers of transferred patients.

It is assumed that community facilities will provide more humane care and greater potential for the habilitation of retardates than do the traditional institutions. However, to date empirical evidence on this issue is lacking. It is, then, the purpose of the present research to contribute somewhat to the data-base essential for rational policy-making in the future. In this research a number of nursing homes will be studied to assess the extent to which they present therapeutic environments to retardates. In addition, an attempt will be made to determine whether the characteristics of therapeutic environments vary significantly among differing types of nursing homes.

REVIEW OF THE LITERATURE

In this review, literature concerning the following topics will be covered: (1) characteristics and measurement of therapeutic environments; (2) characteristics of effective nursing behaviors; (3) documentation of the trend to shift treatment of the mentally retarded from large state hospitals to community setting; (4) treatment of the mentally retarded in nursing homes; and (5) the nurse's role in nursing homes.

THERAPEUTIC TREATMENT ENVIRONMENTS

The idea that the environment may exert a powerful influence on the health and well-being of individuals and on the extent and speed of their recovery from illness may

be traced back to antiquity. However, deliberate structuring of treatment environments so as to maximize their therapeutic potential is a more recent development, dating roughly from the start of the nineteenth century. About that time, the humanitarian and religious ethos of the times fostered the acceptance of "moral treatment" for the mentally disturbed. "Moral treatment" signified the creation of an environment optimally therapeutic in its physical, social, and psychological aspects. The major advocates of this approach were Pinel of France, Tuke of England, and Woodward of the United States. The successes of moral treatment appeared to have been quite substantial (see Grob, 1966, for a full account of the movement). However, due to profound social, demographic and intellectual changes in the United States during the last quarter of the nineteenth century, the movement lost ground and was supplanted by the policy of relegating those with mental problems to large state institutions. There, treatment was of a custodial nature, punctuated sporadically by the administration of physical or organic therapies.

It was not until the 1950's that widespread familiarity with the writing of Moreno (1934), Sullivan (1947) and Jones (1953) led to a renewed interest in the principles of social treatment. A series of case studies of psychiatric hospitals described the effects of social structural elements and of

interpersonal relations on the treatment process. Some of the studies (Belknap, 1956; Dunham & Weinberg, 1960; Goffman, 1961; Wing & Brown, 1970) portrayed the extremely destructive effects of the traditional state hospital on the personality and humanity of the mental patient, and argued that the deteriorated personalities so characteristic of the "back wards" were the product of institutionalization. Other investigations focusing on private and more progressive treatment centers attempted to clarify the ways in which differing social structures hinder or facilitate treatment goals (Stanton & Schwartz, 1954; Caudill, 1958). Thus Stanton and Schwartz (1954) traced the causes of instances of pathological patient behavior such as excitement, suicide, and incontinence to staff disagreements, conflicts, and disputes regarding authority.

Recognition of the importance of the social-psychological aspects of the environment encouraged numerous attempts to incorporate the principles of "milieu therapy" into existing organizational programs, and to create new models of therapeutic "communities". Among the more famous of such experiments were those by Jones (1953), by Fairweather (1964) and by Sanders, Smith, and Weinman (1967). Although these programs differed in specifics, they were all based on similar conceptions of what is therapeutic. Schwartz's (1957) statements regarding the nature of the therapeutic milieu may

be taken as representative of those generally accepted.

> In a general sense, a therapeutic milieu is trying to achieve enduring changes in the patient's pattern of interpersonal relations (in his emotional life and in his personality) so that it is unnecessary for him to live in a mentally ill way. It does this by providing the necessary corrective experiences and by nourishing and expanding the healthy part of the patient. (p. 131)

And again:

> A milieu to be therapeutic will: (1) provide the patient with experiences that will minimize his distortions of reality; (2) facilitate his realistic and meaningful communicative exchange with others; (3) facilitate his participation with others so that he derives greater satisfaction and security therefrom; (4) reduce his anxiety and increase his comfort; (5) increase his self-esteem; (6) provide him with insight into the causes and manifestations of his mental illness; (7) mobilize his initiative and motivate him to realize more fully his potentialities for creativity and productiveness. (p. 131)

Generally speaking, then, it has been assumed that environments of families, schools, orphanages, nursing homes, as well as of facilities treating the psychiatrically disturbed are therapeutic if they encourage involvement, autonomy, responsibility, self-esteem, insight, and peer support. To test these assumptions, first, tools must be developed to measure the extent to which such goals are achieved in given settings, and second, these measures must be related to outcomes.

Instruments by which treatment milieus may be systematically

assessed and compared have been difficult to devise. Among the more successful instruments developed over the past twenty years are those of Jackson (1964, 1969), of Ellsworth, Foster, Childers, Arthur and Kroeker (1968) and of Moos and Houts (1968).

The Perception of Ward (POW) scales created by Ellsworth et al. (1968) sought to measure specific social psychological dimensions of the treatment setting. Patient perceptions were obtained of the inaccessibility of staff, the involvement of patients in ward management, patient satisfaction with ward life, expected patient autonomy, and the receptivity and involvement of staff. Staff perceptions were obtained of the motivation of professional staff, praise for work, dominant professional staff, and the involvement and participation of nursing team members.

Moos (1974) developed the Ward Atmosphere Scale (WAS) to assess the social climate of hospital-based treatment programs, and the Community Oriented Programs Environment Scale (COPES) to assess the treatment milieu of community based programs. Each of these two scales includes ten subscales which measure three dimensions of the environment, namely, the Relationship dimension, the Personal Development or Treatment Program dimension, and the System Maintenance dimension. The Relationship dimension contains three subscales---Involvement, Support, and Spontaneity; the

Personal Development or Treatment Program dimension contains four subscales---Autonomy, Practical Orientation, Personal Problem Orientation, and Anger and Aggression; and the System Maintenance dimension contains three subscales---Order and Organization, Program Clarity, and Staff Control. From their study of 200 hospital programs in the United States, Canada and the United Kingdom, plus assorted correctional institutions, military companies, educational organizations, and social and task-oriented groups and families, Moos and his associates concluded that their basic types of dimensions---Relationship, Personal Development, and System Maintenance---can discriminate among different subunits within each of these different kinds of environments.

The last of the instruments to be considered here, Characteristics of the Treatment Environment (CTE) was designed by Jackson (1964, 1969) to depict objective phenomena in the treatment milieu, rather than attitudes of individuals. Schwartz's (1957) goals for the therapeutic milieu provided the analytical framework for Jackson's instrument. In its initial form, the CTE consisted of 119 items measuring the extent to which the environment developed patients' initiative and creativity, increased their self-esteem, lessened their anxiety, gave them insight into their illness, reduced their distortions of reality, and increased their ability to participate.

In a revised version of the CTE, Jackson (1969) reduced the number of items to 72, and the underlying dimensions to five. These five factors were identified as active treatment, socio-emotional activity, patient self-management, behavior modification and instrumental activity. The items refer to conditions in the immediate environment of the patient in a mental hospital, such as aspects of the physical environment with psychological import, the resources available to the patient, and the way staff members relate to him.

The CTE has been widely cited and used. Modifications have been suggested by Allen, Graham, Lilly and Friedman (1971) and by King and Smith (1972) on the basis of their factor analyses. Most recently, the use of the CTE has been extended beyond evaluation of settings for the psychiatrically disturbed to evaluation of settings for the mentally retarded. Thus, McLain and his associates have employed this instrument in an on-going research project to determine the effects of differing residential settings on the development of retarded individuals. In their first study, Silverstein, McLain, Hubbell and Brownlee (In press) performed a series of factor and cluster analyses on the CTE and proposed a two-factor solution. The two scales were identified as Autonomy and Activity, and comprised 59 items. The remaining 13 items of the CTE were discarded.

Following this modification of the CTE, the questionnaire was administered to the staff on wards within a hospital for the mentally retarded. McLain, Silverstein, Hubbell and Brownlee (1975a) concluded that the instrument as modified was sensitive to differences in treatment environments of wards within a hospital. Finally, McLain, Silverstein, Brownlee and Hubbell (1975b) further modified the CTE by rewording questions so as to be appropriate for use in community facilities. This form of the CTE was then administered to the staffs of various types of community residential facilities and family homes serving retarded persons. Again it was found that treatment practices employed with retarded persons, as measured by the CTE, do in fact differ in various types of residential settings; and that these differences relate essentially to the amount of activity and the degree of autonomy of the mentally retarded residents.

Of the four types of facilities studied by McLain et al. (1975b)---a state institution for the mentally retarded, Skilled Nursing Facilities, Resident Facilities and Family Homes---the state institution was least therapeutic in terms of the activity of the retarded. The other three types of facilities did not differ significantly in this regard. With respect to autonomy, the state hospital was least therapeutic. The Family Homes were slightly less therapeutic than the Skilled Nursing Facilities, while the Resident Facilities were most therapeutic.

THERAPEUTIC NURSING BEHAVIORS

Health care facilities are complex institutions that include a variety of social subsystems. In a nursing home the nurse is expected and often forced by circumstances to assume a variety of roles, some of which may be non-traditional. Lacking the services or assistance of full-time physicians, psychologists, physical therapists and other health professionals, the nurse is pressed to use various approaches to establish a therapeutic regime. In order to accomplish this goal, the nurse must be aware of how the nursing home's general atmosphere and daily activities promote socialization of the retarded and encourage therapeutic relationships. She must recognize the therapeutic importance of social interaction among patients and nursing personnel and incorporate provisions for interaction into the total care plan.

Several authors have defined the therapeutic nursing process. Among these, Lucille Lewis (1968, p.27) states that to be therapeutic the "...nurse must contribute to the wholeness of man, to the interrelationships of the parts to the whole, to the person's here-and-now as well as to his future, to the health of all the parts so that the person may attain and maintain his highest potential." A more precise definition of the nurse's therapeutic role is stated by Clare Fagin (1970). She suggests that the nurse

moves on three distinct levels in the therapeutic milieu, "...through manipulating the organization of the social system in the patient setting; through her one-to-one relationship with the patient; and through her interactions with groups of patients." (p.298)

John Gorton (1970) has provided an even more detailed list of the elements present in therapeutic nursing. This list includes: (1) the appropriate use of self as a therapeutic agent; (2) understanding what is constructive for a given patient; (3) providing potential to the patient for continuing growth; (4) understanding the patient as a person; (5) examining the patient-nurse relationship; (6) a philosophy of patient care that stresses respect for the patient as a person and recognizes that behaviors have meaning; and (7) appreciation of the potentialities of the patient. According to Gorton (1970, p.5) "...these concepts are fundamental to nursing practice and, when implemented, will ensure therapeutic nursing care." Unfortunately, in many nursing situations they may not be implemented.

In evaluating the level of care delivered to patients in a nursing home the method usually employed is that of "structural evaluation" as defined by Donabedian (1966). This method involves the evaluation of the physical characteristics of the facility and the number and qualifications of the staff, such as their certification,

licensure and credentials. Nursing care is also evaluated in terms of the methods and adequacy of documentation, and in terms of administration of medications. Generally, such evaluation is a review of the policies and procedures of the institution.

The second type of evaluation defined by Donabedian is that of "process evaluation", which is based on the actual delivery of care. The peer review currently in practice in large hospitals is an example of this form of evaluation. Within the past ten years, nursing homes have begun to utilize methods of process evaluation, usually to arrive at estimates of the cost of "quality care".

Both structural and process evaluation may be effective in determining the type of care potentially available to the patient, but neither directly measures its implementation nor the outcome of the actual care patients receive in the institution.

It is usually assumed that if the care is potentially available, it will indeed be delivered and that the patient will benefit from it. And indeed this assumption may be largely correct. Thus, Linn (1974), in a study of 40 nursing homes, reported that structural characteristics such as size of the nursing home, the staff patient ratio, and total costs, were all related to a global assessment of the care received.

The characteristics of the nursing care that should be delivered to the patient have been defined by many agencies. Many similarities are revealed by a comparison of the therapeutic characteristics of the environments as described, first, by Jackson in the CTE (1969); second, by the American Association For Mental Deficiency in its Standards of Residential Facilities for the Mentally Retarded (1972), and third, by Blumberg (1971) in her classic nursing text "Nursing Care of the Long Term Patient". Documentation for this assertion follows.

First, Item #43 of the CTE states as a characteristic of a therapeutic environment that the "...residents are permitted to have their own money and personal possessions". The Standards for Residential Facilities contain reference to personal possessions and handling of money.

> The institution shall permit and encourage personal possessions and the right of ownership (Section 2.1.6)
>
> Laws and regulations shall permit normalized and normalizing possession and use of money by residents. (Section 2.1.7)

Jeanne Blumberg further defines the nurses' role as one that

> may assist him to maintain his (economic) independence and his capacity as a productive member of the community (p.93)

Second, both in the CTE and in the Standards for Residential Facilities there are statements relating to the importance of association with members of the opposite sex.

For example in the CTE, Item #42 refers to a nontherapeutic characteristic:

> The nurse tries to prevent residents from engaging in any behavior that appears to be sexual in nature.

In the Standards for Residential Facilities, Standard #2.1.3.6 pinpoints the same general characteristic:

> Provision shall be made for heterosexual interaction appropriate to the residents' developmental level.

Blumberg (1971, p.22) states that the nurse's role is one of "...looking for the effects of the patient's hospitalization on the interpersonal relationships the patient had before," especially those involving loved ones.

Finally, the CTE states as an example of a therapeutic environment:

> The caretaker encourages residents to take over management of their own affairs whenever possible. (Item #51)

In Standard #2.1.3.1. of the Standards for Residential Facilities it is stated that:

> Residents shall be assigned responsibilities in the living units...in order to enhance feeling of self-respect and to develop skills of independent living.

Blumberg states the same objective in her text (1971, p.29)

> The nurse should aim for maximum independence on the part of the patient in caring for his own personal needs.

Evidence of the considerable agreement concerning what is therapeutic between proponents of the "therapeutic milieu" and nursing leaders suggests the importance of the nurse in the creation of a therapeutic environment.

FROM STATE HOSPITAL TO COMMUNITY FACILITIES

In 1960 there were 108 institutions for the mentally retarded in the United States; in 1974, the total was 235. The number of persons working with the mentally retarded has almost tripled since 1960, reaching a total of 118,909 by 1971 (Statistical Abstract of the U.S., 1974). The growth of new facilities and the expanded training of personnel are directly related to the current policy of placing the mentally retarded patient in smaller, community facilities. This policy is also reflected in the increase in numbers of discharges and transfers of patients from the large state hospitals to the smaller facilities. For example, Fairview, located in Oregon, opened in 1908 with an inmate population of 39. In 1969 the population of the "home for the retarded" was over 3,000. In 1974, the hospital census had decreased to less than 1,500 patients, due to the establishment of group homes and nursing homes providing care for the mentally retarded. (Purdom, G., personal communication, Sept. 1974) Statistics for the state of Washington also show a similar decline in the numbers of patients in the State hospitals for the retarded such as Fircrest and Rainier School. The average daily population of the Washington State hospitals was less than 2,600 retarded in 1974, in contrast to over 4,000 in 1968. The number of discharges today is greater than the total number of admissions to the state institutions, even though the numbers of retarded individuals has not de-

creased. (State of Washington, Statistical Abstract, 1974)

The increase in discharges and the demand for "normalization" programs in the care of the institutionalized mentally retarded patient has initiated many changes and innovations within the institutions themselves. Such programs stress the importance of normal growth and development patterns and encourage the retardate to achieve at his maximum level.

Philip Roos (1971) describes these changes:

> Residential services based on the Developmental Model are structured so as to foster development of culturally desirable behavior, increasingly complex behavior, and maximum control over the environment. For most retarded children and adults this leads to adoption of the normalization principle (Nirje, 1969) according to which the retardate's life is patterned as closely as possible to that of the normal individual. (p.23)

Many of these residential, community facilities are nursing homes.

TREATMENT OF THE MENTALLY RETARDED IN NURSING HOMES

Nursing homes are differentiated according to the level of care the patient requires and receives. An Extended Care Facility (ECF), occasionally called a Skilled Nursing Facility (SNF), is staffed with Registered Nurses twenty-four hours a day. This type of facility is appropriate for incapacitated patients who require skilled nursing care, such as the severely disabled, those who are capable of only a low degree of self help, and those unable to perform the simplest

of activities of daily living. The Intermediate Care Facility (ICF) offers specialized care and is staffed with Registered Nurses and Licensed Practical Nurses in supervisory roles, and with nurses' aides in direct care roles. It is appropriate for the patient who is able to perform some of the activities of daily living but who is unable to administer his own medications or supervise his own medical treatment. The Congregate Care Facility (CCF) is not required to employ licensed staff, and care is planned and delivered by unlicensed staff, nurses' aides, orderlies and other caretakers. It is utilized by those patients who require minimum medical supervision yet at the same time are unable to function without assistance in performing activities of daily living.

The American Association of Mental Deficiency (AAMD) recently published guidelines for the residential facilities or group homes for the mentally retarded. In addition to many recommendations for educational, social and developmental programs the guidelines also furnish recommended staffing patterns. According to the AAMD, a Registered Nurse, preferably with a master's degree in nursing, is required to supervise all care of the retardates placed in such a facility. At this time only 35 facilities in the United States have received accreditation, although over 300 have applied. Therefore, the mentally retarded patients are usually placed in community settings that have not met

criteria specified by the AAMD as therapeutic for their care.

THE NURSE'S ROLE IN NURSING HOMES

In nursing homes the nurse plays the major role in the care of the mentally retarded patient. Charles Stannard, (1973) states:

> The prime responsibility for the day to day provision of patient care and the operation of the (nursing) home rested with the nurses. They held themselves responsible for this, and were held responsible by all the people who interacted within the home. (p.332)

He described the nurses as 'cynical', as evidenced by their modification of the behaviors and goals of nursing service learned in training to accord with the realities of custodial care and social interactions of the nursing homes. The modification of the nursing behaviors provided the potential for patient abuse, usually of a neglectful nature. The behaviors of these nurses were influenced not only by the work setting but also by their own perceptions of the patients and their expectations for them. According to Stannard's study, the nurses regarded the nursing home patients as "...hopeless, their enfeebled mental state necessitated the means of controlling them with drugs and cloth restraints." (p.333). Further studies (Coe, 1970, pp. 283-4, 295-305; Coser, 1963) support this finding of the negative attitudes of the nursing staff toward long-term care patients in institutions. Such patients are thought of as relatively powerless, and since their prognosis for recovery is pessimistic, treatment is defined in custodial rather than in therapeutic terms.

Staff feelings of pessimism are not unusual when dealing with a mentally retarded patient. Several investigators have noted that many staff members perceive the mildly retarded individual negatively (Jones, 1966, 1974; Warren & Turner, 1966). It is also possible that the age of the retardate influences staff attitudes. Although this generalization has never been put to a direct test, at least one investigation (Gottlieb & Siperstein, 1976) has demonstrated more favorable attitudes of professional students toward the mentally retarded child than toward the adult.

In an attitude study conducted by Moores and Grant (1976), 696 murses responded to questionnaires relating to the expectations nurses hold for the adult mentally retarded patient. Significant differences were found in the responses of nurses from different institutions, on all scales representing "optimistic" to "pessimistic" factors.

> ...some hospitals appear to possess more than their fair share of optimists while others contain a disproportionate representation of pessimists. (p.647)

Student nurses obtained much higher "optimist" scores than did the staff, indicating a possible change in attitudes over time. The presumed cause of this change was not indicated by Moores and Grant.

In the light of these findings, it is possible that nursing home staffs may react negatively to mentally retarded adults placed in their care. These reactions may in turn depress the therapeutic quality of the environment.

STATEMENT OF THE PROBLEM

Due to the current trend toward deinstitutionalization, nursing homes are providing long-term care to an increasing number of retarded patients. The prime agent in the delivery of therapeutic care to patients in nursing homes is the nurse, who must not only evaluate the need for care, but plan and deliver the care to the patient on an individual basis. This places the nurse in a strategic position to create either a therapeutic or non-therapeutic environment.

A therapeutic environment has been found to have a significant effect on the progress and general well-being of the patient. It is important, then, that the specific environment created in a facility be analyzed in order to identify the trouble spots, to plan and initiate new and innovative approaches to treatment, to prepare guidelines for helping staff and patients change the environment, as well as to determine its relationships to the structural and organizational framework.

The CTE, as designed by Jackson (1966, 1969), is useful in assessing the therapeutic level of the environment. Although the outcome of such care is not directly tested by the CTE, the basic information received may presumably be used by the facilities studied to improve the level of care they offer to the retarded patient.

The purpose of the present study is to assess the

therapeutic quality of the environment provided by a sample of nursing homes now accepting mentally retarded residents.

CHAPTER II

METHODOLOGY

STUDY UNITS AND SUBJECTS

The goal of the present investigation is to describe the treatment environments of all nursing homes in one county of the State of Washington, which admit mentally retarded patients on a longterm care basis. Four homes in the county accept mentally retarded patients only for brief periods, to treat acute conditions, and were, therefore, excluded from this study. The remaining eleven homes admit retarded residents for indefinite periods of time, and thereby serve as substitutes for the traditional state hospital. Administrators of all these homes initially agreed to permit the investigator to study their facilities.

These eleven homes represent differing levels of care. As is apparent from Table 1, two homes provide minimum supervision, or congregate care only (CCF), and three homes provide only intermediate care, (ICF). One home provides both congregate and intermediate care, and two provide both extended and intermediate care. Finally, three facilities provide all three levels of care---congregate, intermediate and extended. From Table 1, it may also be noted that the homes differ considerably in size, in terms both of number of staff and number of patients. Staff size varies from 6 to 60, with RNs comprising from 0% of the total

TABLE I

SELECTED CHARACTERISTICS OF NURSING HOMES ACCEPTING MENTALLY RETARDED RESIDENTS IN A WASHINGTON STATE COUNTY, JUNE, 1976

NURSING HOME	TYPE OF NURSING CARE*	NURSING STAFF					PATIENTS		
		TOTAL	RN		LPN	NA**	TOTAL	MENTALLY RETARDED	
			No.	%				No.	%
#1	CCF	6	0	0%	0	6	17	4	24%
#2	CCF	13	0	0%	0	13	91	91	100%
#3	ICF	24	8	33%	1	15	88	10	11%
#4	ICF	16	3	19%	2	11	41	10	24%
#5	ICF	21	1	5%	7	13	65	5	8%
#6	ICF, CCF	23	5	22%	3	15	54	17	31%
#7	ECF, ICF	58	6	10%	8	44	119	15	13%
#8	ECF, ICF	35	5	14%	3	27	67	12	18%
#9	ECF, ICF, CCF	51	7	14%	6	38	115	14	12%
#10	ECF, ICF, CCF	60	6	10%	7	47	88	10	11%
#11	ECF, ICF, CCF	24	8	33%	2	14	67	42	63%

* ECF: Extended Care Facility
ICF: Intermediate Care Facility
CCF: Congregate Care Facility

** NA: Nurses' Aides

staff in the two homes classified as "congregate" to 33% in homes #3 and #11. The total number of patients varies from 17 to 119, and the number of retarded patients varies from 4 to 91 persons. The percentage of retarded to total patients in these eleven facilities ranges from 8% to 100%.

The unit of analysis in this study is the nursing home. Information for assessing the therapeutic quality of care in each nursing home was obtained through information provided by staff members. It was hoped that all nursing staff employed in the nursing homes would serve as informants. At the time of the survey, it was estimated that the staff numbered 331 persons, including nurses' aides, orderlies, LPNs and RNs with differing educational backgrounds (diploma, associate degree, baccalaureate programs).

DATA COLLECTING INSTRUMENT

The data for this study were collected through the administration of a questionnaire to all nursing staff in the participating homes. (A copy of the entire questionnaire is presented in Appendix B).

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

The major component of this questionnaire was Jackson's (1969) instrument, the Characteristics of the Treatment Environment (CTE), as modified by McLain et al. (1975) for use in community residential facilities serving retarded persons. In the modified form, the CTE consists of 59 items.

(This instrument, with its directions, is reproduced in Part II, Items 1 through 59 of the questionnaire.)

Scoring is in accordance with the procedures suggested by McLain et al. (1976). The respondent indicates on an 11-point scale how true each statement is of that area of the facility in which he works most of the time. On the scale, "0" represents "completely false" and "100" represents "completely true". Responses are later collapsed into a 9-point scale to facilitate data processing. (See Appendix C for scoring key.)

Two scores are computed for each respondent, one for the dimension of Autonomy and one for the dimension of Activity. To arrive at the first score the subject's responses to the 30 Autonomy Items are averaged; and to arrive at the second score, his responses to the 18 Activity Items are averaged. (The remaining 11 items are not scored, and measure neither Autonomy or Activity.) These scores are then aggregated over all the nurses responding for a given nursing home to arrive at mean Autonomy and mean Activity scores for that home.

These overall scores may in principle vary from "1" (representing the least autonomy or the least activity on the part of the mentally retarded residents of the home) to "9" (representing the maximum autonomy or maximum activity on the part of the retarded). The particular items comprising these

two factors of Autonomy and Activity are listed in Appendix C along with the scoring code.

The instrument appears to be reasonably reliable. McLain et al. (1976) have reported that the mean scores of staff tested on 43 wards in 1972 and again in 1973 correlated significantly; for CTE Factor I (Autonomy), r = .88 and for the CTE Factor II (Activity), r = .69. McLain et al. concluded the CTE mean scores were quite stable over time. The same authors also demonstrated that the CTE differentiated among differing facilities and among programs and wards differing in terms of treatment practices.

To the investigator's knowledge, no evidence is available to date as to the validity of McLain's version of the CTE. However, there is some evidence of the criterion validity of the CTE in its unmodified form. Thus, King and Smith (1972) found that the therapeutic orientation of the treatment milieu, as measured by the CTE, did correlate significantly with patient movement out of the psychiatric setting into the community, and with measures of effectiveness of ex-patients' functioning in the community.

ADDITIONAL DATA

In addition to the data on characteristics of the treatment milieu, the questionnaire provides a few facts regarding selected background and demographic characteristics of the nurse respondents, and some information regarding standard nursing behaviors in the selected nursing homes.

Background information includes age, sex, length of time practicing nursing, length of employment in a nursing home, professional position (RN, LPN, or NA), educational background (diploma school, associate degree program, baccalaureate program or master's degree), job classification (supervisory or non/supervisory) and shift. These questions appear in Part I of the questionnaire.

Three items referring to specific behaviors regarded as therapeutic in nursing are included in Part II of the questionnaire. These items are #61 dealing with the regularity of the collection of data by the nurse, and #60 and #62 dealing with the inclusion of the patient and his family in the planning for nursing care. One item (#65) relates to the nurse's specific attitudes toward the placement of the retarded patient in the nursing home. Finally, two items (#64 and #66) ask the nurse to assess the overall quality of care provided patients in the nursing home. These items have been added to provide some indication of the validity of the CTE.

PROCEDURE

In the winter of 1976 the investigator obtained permission from the administration and the nursing directors of all eleven nursing homes to administer a questionnaire concerning the nursing of the mentally retarded. In July 1976, the research was commenced. At that time, after the

questionnaire was examined, permission was withdrawn in three homes. These three homes were administratively joined, and access to the staff was controlled by the same individual. This individual was Director of Nursing of homes #1 and #6 jointly, and then was transferred to home #7. In defining her reasons for refusal the individual stated that the questionnaire was inappropriate in relation to the staff and the patients in the nursing homes she represented. The questionnaire was, in her opinion, a "psych test", that "should be in a brown wrapper" and that her staff was not "psych oriented". She also stated that the patients cared for in these three nursing homes weren't the "right type" since they had physical handicaps that prevented activities, or were "So retarded they could not participate anyway".

At the other eight homes, inservice meetings were held and the questionnaire was administered to those staff members who were willing to participate. The subjects were repeatedly assured that their responses were confidential. This was essential since the staffs often expressed anxiety that their responses might be construed as dissatisfaction with their jobs. Since all staff did not attend the inservice meeting, repeat visits were necessary. At least two, and in some instances up to four such visits were made in the hope of maximizing return rates. For example in

home #9 the researcher presented four inservice classes dealing with mental retardation after the questionnaire was administered and made two subsequent probe visits to obtain a 69% response rate.

The subjects had no prior knowledge that the study was being conducted, and received the following information immediately before responding to the questionnaire:

1. The information gathered was to serve as baseline data in the nursing care of the mentally retarded patient.

2. The information gathered could serve as a guide in developing course work and continuing education programs for nurses in health care facilities.

3. The results of the study would be freely shared with the facility and the subjects if they desired.

4. Anonymity of each respondent was assured.

5. Each subject was asked to sign a consent form (See Appendix A) and was informed that he was free to withdraw participation at any time.

Following the completion of the questionnaire, the investigator offered to answer questions relating to the subject.

ANALYSIS OF DATA

In the analysis to follow, the therapeutic climate of a sample of nursing homes will be assessed by measuring the degree of autonomy and activity these homes permit retarded patients. In order to identify factors which may influence the therapeutic quality of the environment, Activity and Autonomy Scores of the nursing homes will be correlated

with certain of their structural characteristics such as size, nature of clientele, staff attitudes to clientele, and to certain nursing procedures, such as documentation of patient care and inclusion of patient and family in health care plans. In order to determine whether the quality of the environment is perceived similarly or differently by differing staff categories, the staff member's characteristics such as age, work shift, education attained, and position will be related to his/her responses on the CTE. Finally, the validity of the Activity and Autonomy Scores of the CTE will be checked by noting their correlations with an overall measure of quality of care.

CHAPTER III

FINDINGS AND INTERPRETATIONS

RESPONSE RATES

As was stated previously, one administrator controlling access to three homes withdrew permission from the investigator to conduct the proposed study. With regard to the remaining eight homes, staff response rates ranged from 29% to 85%, and averaged 55%. (See Table 2) The response rate of RNs was 39%, somewhat lower, although not significantly so, than the response rates of LPNs (57%) and of Nurse's Aides (56%).

In view of these facts, how much confidence may be placed in the findings of this study? What conclusions may be drawn regarding the therapeutic quality of the care provided retarded patients in the nursing homes of the community as a whole? Would substantially different CTE scores have resulted, leading to substantially different conclusions, if the three nursing homes had not refused to participate, if responses had not come disproportionately from the lower echelons of the nursing hierarchy, and if a higher proportion of total staff had responded?

The lack of scores from the three nursing homes probably resulted in an overestimation of the activity and autonomy permitted retarded patients in the county's nursing homes.

TABLE 2

NUMBER OF STAFF MEMBERS AND NUMBERS OF RESPONDENTS IN NURSING HOMES ADMITTING MENTALLY RETARDED PATIENTS IN COUNTY STUDIED

NURSING HOME	NURSING STAFF TOTAL	RNs	LPNs	NAs	RESPONDENTS TOTAL	RNs	LPNs	NAs	RESPONSE RATE
#1	6	0	0	6	REFUSED TO PARTICIPATE				
#2	13	0	0	13	11	0	0	11	85%
#3	24	8	1	15	11	1	1	9	46%
#4	16	3	2	11	7	1	1	5	44%
#5	21	1	7	13	6	0	3	3	29%
#6	23	5	3	15	REFUSED TO PARTICIPATE				
#7	58	6	8	44	REFUSED TO PARTICIPATE				
#8	35	5	3	27	21	1	2	18	60%
#9	51	7	6	38	35	3	4	28	69%
#10	60	6	7	47	23	4	4	15	38%
#11	24	8	2	14	16	5	1	10	67%
TOTAL: ALL HOMES	331	49	39	243					
PARTICIPATING HOMES	244	38	28	178	130	15	16	99	

This conclusion is based on the inference that the director of nursing of the nonparticipating homes adhered to a "medical", rather than "developmental model" in dealing with the retarded. (This inference was drawn from her statement that the patients were "too retarded anyway" to warrant freedom or responsibility.) According to Roos (1971, p.231), the Developmental Model is based on the assumption that "all retardates have potential for growth, learning and development". Those who reject this model generally advocate a "medical model", assuming "(1) mental retardation is a medical problem; (2) only physicians can handle medical problems; (3) therefore only physicians can administer mental retardation programs". In facilities stressing the medical model, patients' activity and autonomy are restricted. On this reasoning, if data had been available from the three nonparticipating homes, the overall CTE scores would probably have been lower than those presently obtained.

The lower response rate of RNs than of other nursing categories probably did not appreciably raise or lower CTE scores for the homes. This conclusion is based on the finding of McLain et al. (1975) that responses to the CTE are not significantly influenced by the job status of the respondent. Additional evidence to this point will be introduced later in this chapter.

Finally, the low overall response rate (130 of the 244 staff members responded) may have contributed to an exaggerated estimate of the therapeutic quality of nursing home care for the retarded in the county. There is some suggestion that participants, in comparison with nonparticipants, were more satisfied with their place of employment and more optimistic in their attitudes to the retarded. Thus, a number of nurses expressed reluctance to complete the questionnaire for fear their jobs might be jeopardized. While the investigator repeatedly assured respondents of confidentiality, it is possible that many nurses decided the safer course would be not to participate at all. Unfortunately, no data exist here by which to estimate the number of staff members who failed to respond due to job insecurity, and the number who failed to respond due to other reasons, as "lack of time". On the assumption that those who feared their responses might be taken amiss tended to hold more unfavorable opinions of the homes than other staff members, it might be concluded that the study results probably present too favorable an appraisal of the therapeutic quality of care received by the retarded in the community's nursing homes.

THERAPEUTIC CHARACTER OF THE NURSING HOME ENVIRONMENTS

AUTONOMY OF MENTALLY RETARDED PATIENTS. As indicated earlier, an Autonomy Score was obtained for each nursing home by

averaging the ratings of all staff from that home on all 30 items comprising Factor I of the CTE. This Autonomy Score reflects the extent to which patients were delegated responsibility, and were granted freedom in their interpersonal interactions, their movement in space, and their use of resources.

As can be seen in Table 3, scores on the Autonomy Factor could in principle vary from 1 to 9. For the eight homes, the range was from 4.98 to 7.33, and the mean score was 6.10. This mean score signifies that autonomy was granted patients more frequently than it was withheld, and that autonomous patient behaviors tended to occur more frequently than non-autonomous behaviors.

In Table 4, the eight nursing units are ordered with respect to the amount of physical care considered necessary for residents. Patients judged to need the most physical care are placed in Skilled Nursing Facilities (ECFs, ICFs), whereas patients judged to need the least physical care are placed in Congregate Care Units. This assignment reflects a common tendency to equate "skilled nursing care" with physical care involving the performance of specialized procedures on the patient, with the aid of specialized equipment. Such a definition of skilled nursing underlies the official view, embodied in state and federal guidelines for Medicare

TABLE 3

SCORES ON AUTONOMY FACTOR OF CTE:

BY NURSING HOME

NURSING HOME	CTE FACTOR I (AUTONOMY)
#2	6.70
#3	4.98
#4	6.78
#5	6.07
#8	5.34
#9	5.94
#10	5.71
#11	7.33
MEAN SCORE	6.10
RANGE	4.98-7.33

participation, that skilled care can be delivered only where specific types of physical equipment are available; and that patients in need of "skilled nursing" must therefore be physically moved into those designated areas.

This emphasis on technical proficiency brings into sharp relief the nurse's activity in contrast to the patient's passivity, and the nurse's competence in contrast to the patient's incompetence, an incompetence which may then be generalized to include all aspects of his care. As a consequence, personnel in Skilled Nursing Facilities do not usually expect patients to exercise autonomy or assume responsibility. In Willem's words (1970), "the more a location or activity is defined as being essential to care and treatment, the less patients are permitted to initiate their own behavior and the more they are required to be passive, docile and dependent". (p.240)

Results of the present investigation accord with this observation of Willems . From Table 4 it may be seen that the amount of autonomy characteristic of patients in nursing homes increased progressively as the level of nursing skill in those units decreased. Home #3 provided the highest level of skilled care, and received an Autonomy Score of 5.34. Homes #3, 4, and 5 provided the next highest level of nursing care, and their mean Autonomy Score was 5.94.

Homes #9, 10, and 11 offered skilled nursing care to some inmates, and custodial or congregate care to others. The mean Autonomy Score for those homes was 6.44. Finally, Home #2 provided only congregate care, and received the highest autonomy score of 6.70.

McLain et al. (1975) reported similar findings. They ranked differing types of facilities in terms of the extent of autonomy permitted retarded persons. The order was, from least to most autonomous, the State Hospital, Skilled Nursing Facilities, Family Homes, and Resident Facilities. The Skilled Nursing Facilities in the McLain et al. study correspond closely to the Extended Care and Intermediate Care Facilities (ECFs and ICFs) of this study; and their Resident Facilities appear to be the functional equivalents of the Congregate Care Facility (CCF) of this study. From Table 4 it may be noted that the Autonomy Scores of these corresponding facilities are very similar. Thus, when the five Skilled Nursing Facilities of McLain et al. are compared with ECFs and ICFs (Homes #3, 4, 5, 8) of the present study, the mean Autonomy Scores are, respectively, 5.91 and 5.79. The latter value (5.79) is well within one standard deviation (.41) of the former (5.91). Likewise, comparing the Resident Facilities of McLain et al. with the Congregate Care Unit of this study, the Autonomy Scores are 7.39 and 6.70, respectively. Again, the latter value lies within one standard deviation (.98) of the former.

TABLE 4

MEAN AUTONOMY SCORES BY TYPE OF FACILITY STUDIED: COMPARED TO MEAN SCORES FOR SIMILAR NURSING FACILITIES STUDIED BY MCLAIN ET AL

NURSING HOME	TYPE OF FACILITY	CTE FACTOR I (AUTONOMY)	CTE FACTOR I (AUTONOMY: MCLAIN ET AL)
#8	Extended Care Intermediate care	5.34 ┐ 5.79	5.91*
#3,4,5	Intermediate care	5.94 ┘	
#9,10,11	Extended care Intermediate care Congregate care	6.33	
#2	Congregate care	6.70	7.39**

* Mean score for Skilled Nursing Facilities tested on CTE Factor I (Autonomy) by McLain et al. (1975).

** Mean score for Resident Facilities tested on CTE Factor I (Autonomy) by McLain et al. (1975).

It may be concluded, then, that retarded patients are accorded less autonomy in skilled nursing facilities than are patients in residential facilities professing to offer less skilled care. This conclusion is supported both by the results of the present investigation and by those of McLain et al.

To this point, only the overall Autonomy Scores have been discussed. When responses to the 30 specific items constituting the Factor are individually analyzed, it became clear that some items consistently received high scores, and other items low scores. In Table 5, there are listed 8 items for which the mean scores fell more than one standard deviation from the grand mean for all 30 items of the Autonomy Factor. The highest scoring items were #18, 56, 46, 40 and 17. Items #18 and #40 deal with personal hygiene and with the housekeeping responsibilities of the patient. Item #17 and #46 stress the control of inappropriate behavior.

Items #13, 45 and 9 scored lowest on the autonomy scale. They pertain to participation in social or community activities, and to association with members of the opposite sex.

The priorities of the nursing homes, as inferred from these staff responses, would appear similar to those expressed by administrators of facilities for the retarded, as reported by Ostram, Rosenblood and Hubbard (1971). They

asked 79 administrators to rank-order the importance of 520 items from the AAMD Standards for Residential Facilities (1971). They found that most importance was attached to "hygiene and health measures", "safety and sanitation", "medical services and records", and much less importance attributed to "training services", "psychological and recreational services", and "occupational therapy services". Quoting these authors,

> the foremost concern for these superintendents was with the physical well-being (and perhaps maintenance) of their residents...the psychological well-being and improvement of the patients appear to be subordinant concerns. (p.31)

STRUCTURAL CHARACTERISTICS IN RELATION TO AUTONOMY

This study is concerned with the effect of selected structural characteristics on the therapeutic quality of care. As may be seen from Table 6, the structural characteristics of the eight nursing homes vary widely. Numbers of staff ranged from 13 to 60, and the staff-patient ratio ranged from .143 to .682. Retarded patients comprised from 8% to 100% of the inmate populations. Less variation was apparent in the mean age of employees, which varied from 26.7 to 43.6 years. There was no variability with respect to the sex ratio of employees (only 8 of the 130 respondents were male) so the relationship of sex ratio to therapeutic quality of the environment could not be assessed in this research.

TABLE 5

INDIVIDUAL ITEMS FROM THE CTE SCORING

HIGHEST AND LOWEST IN FACTOR I (AUTONOMY)

ITEM	MEAN SCORE	STANDARD DEVIATION
#18 Responsibility for own grooming	7.15	1.05
#56 Doors open to permit visiting	7.14	.91
#46 Nurse explains inappropriate behaviors	6.91	.81
#40 Responsibility for maintaining own rooms	6.88	1.42
#17 Nurse gives rationale for inappropriate behavior	6.88	.99
#13 Nurse encourages association between sexes	5.35	1.00
#45 Allows participation in evening community activity	5.12	1.12
#9 Patients escorted when outside facility grounds	4.70	2.16

In Table 7, Pearsonian coefficients are presented to represent the relationships of the selected structural variables with the Autonomy Factor. The negative correlations between the Autonomy Score and size of institution (measured either by number of staff, by number of patients, or by the staff-patient ratio) were not statistically significant, indicating that size of nursing home has little effect on the autonomy level. Other investigators (for example, Barker & Gump, 1964) have claimed that there is an optimal staff-patient ratio. It is necessary both to avoid "overmanning" and "undermanning". An excess of staff tends to result in specialization and nonresponsiveness to the needs of the person as a whole. Too few staff prevents adequate services and care. Such a view suggests that the relation between the staff-patient ratio and the therapeutic quality of the environment is a curvilinear one. To test this hypothesis would require a larger number of institutions than studied here.

The correlation coefficient between the per cent of retarded patients and autonomy was .663. A positive, but slightly lower, correlation was obtained between autonomy and the number of retarded patients. Both coefficients approached statistical significance (2-tailed test) suggesting a trend to greater autonomy in facilities with larger numbers or proportions of retardates. Perhaps a selection process is

TABLE 6

SELECTED STRUCTURAL CHARACTERISTICS OF EIGHT NURSING HOMES

NURSING HOME	NUMBER STAFF	NUMBER PATIENTS	STAFF/ PATIENT RATIO	RETARDED PT'S NUMBER	RETARDED PT'S % OF ALL PATIENTS	STAFF MEAN AGE	PERCENT STAFF IN SUPERVISORY POSITIONS*	MEAN APPROVAL (ITEM #64)**
# 2	13	91	.143	91	100%	39.3	.55	7.82
3	24	88	.273	10	11	33.6	.18	4.73
4	16	41	.390	10	24	43.6	.29	6.71
5	21	65	.323	5	8	35.5	.50	8.00
8	35	67	.522	12	18	26.7	.14	7.05
9	51	115	.443	14	12	30.9	.11	6.00
10	60	88	.682	10	11	34.0	.22	7.83
11	24	67	.418	42	63	30.0	.38	8.75
MEANS	30.3	77.75	.399	24.25	30.87	34.2	.30	7.11

* Head nurses, charge nurses, team leaders

** Mean score of staff respondents to question #65, "How much do you approve of the policy of admitting the retarded to this nursing home now?"

TABLE 7

CORRELATIONS OF SELECTED STRUCTURAL VARIABLES AND CTE FACTOR I (AUTONOMY) IN EIGHT NURSING HOMES

STRUCTURAL VARIABLE	PEARSONAIN CORRELATION OF VARIABLE WITH CTE FACTOR I (AUTONOMY)
SIZE:	
Number of staff	-.370
Number of patients	-.350
Staff/patient ratio	-.228
TYPE OF PATIENT:	
Number of retarded patients	+.528
Percent of all patients retarded	+.663
STAFF CHARACTERISTICS:	
Mean age	+.383
Percent in supervisory positions*	+.607
STAFF ATTITUDES:	
Approval of admitting retarded patients to nursing home (Item #65)	+.670**

* Charge nurses, head nurses, team leaders

** Significant at .05 level, 1-tailed test

operating whereby only those nursing homes whose administrators and staff entertain relatively optimistic opinions of the retarded accept larger numbers for care. Or perhaps the work-load for staff becomes too onerous when large numbers of the retarded are present, unless some responsibilities are delegated to them.

There was no theoretical reason to expect autonomy to be either more or less extensive with younger or older staff. Hence, it was not surprising to find the correlation small in magnitude and not significant statistically. However, it should be pointed out that possibly the hypothesis of the existence of a relation between the two variables was not properly tested, given the restricted range of mean ages in the institutions studied.

It had been expected that autonomy would be greater in homes with larger proportions of supervisory personnel, on the reasoning that such personnel tend to be better educated than other staff, and hence should be more familiar with current thinking regarding retardation and its treatment. However, inasmuch as the association between the two variables only approached statistical significance, the conclusion cannot be drawn that the autonomy level of a facility increases as the proportion of staff in supervisory positions increases.

The structural variable manifesting the strongest association with autonomy was the staff's attitude toward admitting retardates as patients to the nursing home. The expected

positive relation was obtained, and achieved statistical significance at the .05 level, (1-tailed test). Presumably staff members who approve admitting the retarded to an institution hold more favorable views of such individuals, and possibly believe them more capable of "improving" with treatment.

ACTIVITY OF MENTALLY RETARDED PATIENTS IN NURSING HOMES

The importance of activity, both social and instrumental, for the psychological well-being of the individual is well recognized. The individual's continued growth and development, his self-esteem, his orientation and grasp of reality all depend on activity. Inactivity and passivity of inmates in institutions lead to alienation and apathy on their part, to formal structuring of staff-inmate relationships along the authoritarian-submission dimension, and to dehumanization of inmates (Goffman, 1961; Roth & Eddy, 1967; Roos, 1971). The personality deterioration so characteristic of "back wards" has frequently been attributed to the institutionalization itself (Wing & Brown, 1970, among others). Rehabilitation facilities, along with traditional state hospitals, share the tendency to discourage inmate activity, and to enforce idleness. Thus, Willems (1970) calculated that 65% of the patient's time in one rehabilitation facility was spent on the ward in "idleness, receiving nursing care and eating".

TABLE 8

SCORES ON ACTIVITY FACTOR OF CTE: BY NURSING HOME

NURSING HOME	CTE FACTOR II (ACTIVITY)
#2	7.60
#3	5.76
#4	7.67
#5	7.12
#8	5.33
#9	6.28
#10	6.33
#11	7.80
MEAN SCORE	6.74
RANGE	5.33-7.80

TABLE 9

MEAN ACTIVITY SCORES BY TYPE OF FACILITY STUDIED: COMPARED TO MEAN SCORES FOR SIMILAR NURSING FACILITIES STUDIED BY MCLAIN ET AL

NURSING HOME	TYPE OF FACILITY	CTE FACTOR II (ACTIVITY)		CTE FACTOR II (ACTIVITY: MCLAIN ET AL)
#8	Extended care Intermediate care	5.33	6.47	7.61*
#3,4,5	Intermediate care	6.85		
#9,10,11	Extended care Intermediate care Congregate care	6.80		
#2	Congregate care	7.60		7.29**

* Mean score for Skilled Nursing Facilities tested on CTE Factor II (Activity) by McLain et al. (1975)

** Mean score for Resident Facilities tested on CTE Factor II (Activity) by McLain et al. (1975)

The CTE offers an objective measure of the level of activity in a particular treatment environment. Activity Scores (CTE Factor II) obtained in this research are presented in Table 8. They range from 5.33 to 7.89 on a 9-point scale, and average 6.74. This mean signifies that retarded patients in the eight homes are somewhat more active than inactive, but still considerably less than maximally active.

In Table 9, the findings of this research may be compared to those of McLain et al. (1975). First, McLain et al. found that Skilled Nursing Facilities, and Resident Facilities did not differ significantly from one another in activity level. In this study, also, the difference is not significant between the Activity Score of the Congregate Care Unit and the ECFs and ICFs providing skilled nursing. Second, there appeared to be no difference in activity level between the CCU studied here and McLain's Resident Facilities. The score of the former (7.60) fell within one standard deviation of the score of the latter (7.29, S.D.=.59). However, there is a difference between the Activity Scores of the Skilled Nursing Facilities in the two studies. The mean score for this study was 6.47, which fell two standard deviations away from the value of 7.61 (S.D.=.53) obtained by McLain et al. This finding may indicate that the nursing facilities studied here encourage activity for the retarded

to a somewhat lesser extent than do similar institutions in other areas of the nation. (McLain et al. conducted their study in the Los Angeles area.)

In Table 10, the individual items from CTE Factor II are presented which received the highest and lowest scores. These scores all fell one standard deviation or more from the grand mean score for all 18 activity items. Two of the items scoring highest (#12 and #30) involved planned group activities which could be carried out within the facility within certain bounded areas and time periods. Two of the items receiving the lowest scores (#7 and #20) represented individual, spontaneous, unplanned activities such as play, intellectual efforts, and social interactions.

STRUCTURAL CHARACTERISTICS IN RELATION TO ACTIVITY

The magnitudes of the associations between activity level and selected structural characteristics of the homes are presented in Table 11. As was the case with the Autonomy Factor, these relations may occasionally approach, but rarely achieve, statistical significance. Only two variables proved significantly related to activity. One was the percent of staff in supervisory positions (r=.751). A possible explanation for this finding may be that a modern developmental approach to retardation may be more readily adopted in institutions where more supervisors are employed, inasmuch as these supervisors are more likely to be well educated than

TABLE 10

INDIVIDUAL ITEMS FROM THE CTE SCORING HIGHEST AND LOWEST IN FACTOR II (ACTIVITY)

ITEM	MEAN SCORE	STANDARD DEVIATION
#12 Participate in creative activities	7.80	1.08
#30 Parties in the facility	7.52	.87
#57 Nurse calms excited patient	7.37	.86
#7 Little play activity	6.10	1.10
#20 Social, intellectual and play activities	6.03	1.25
#35 Behavior controlled through privileges	5.76	.79

TABLE 11

CORRELATIONS OF SELECTED STRUCTURAL VARIABLE AND CTE FACTOR II (ACTIVITY) IN EIGHT NURSING HOMES

STRUCTURAL VARIABLE	PEARSONIAN CORRELATION OF VARIABLE WITH CTE FACTOR II (ACTIVITY)
SIZE:	
Number of staff	-.475
Number of patients	-.410
Staff/patient ratio	-.325
TYPE OF PATIENT:	
Number of retarded patients	+.510
Percent of all patients retarded	+.614
STAFF CHARACTERISTICS:	
Mean age	+.593
Percent in supervisory position*	+.751**
STAFF ATTITUDES:	
Approval of admittance of retarded patients to nursing home (Item #65)	+.655**

* Charge nurses, head nurses, team leaders

** .655 significant at .05 level, 1-tailed test
.751 significant at .05 level, 2-tailed test

other staff.

Finally, the correlation between level of activity and staff attitudes to admitting retardates to the homes was positive as expected, and was significant (r=.655,significant at .05 level, 1-tailed test).

It may be concluded, then, that the selected structural characteristics account only to a slight extent for differences among homes in level of patient activity.

RESPONDENT CHARACTERISTICS IN RELATION TO CTE SCORES

The Autonomy and Activity Scores of the entire pool of 130 respondents were correlated with selected background characteristics of these staff members, i.e., age, shift, education, and position (supervisory vs. nonsupervisory). Sex was omitted as a variable in that only 8 of the respondents were male.

These correlations are presented in Table 12. Shift and education did not influence responses in any systematic way. However, the respondent's age and position proved to be significantly associated with his/her responses to the questionnaire. Older persons, and those in supervisory positions viewed the environment more favorably. The former findings are consistent, but the latter findings inconsistent, with the findings of McLain et al. (1975) and of Jackson (1969) that demographic characteristics affected responses to the CTE only minimally.

TABLE 12

CHARACTERISTICS OF RESPONDENTS RELATED TO CTE SCORES ON AUTONOMY AND ACTIVITY (N = 130)

CHARACTERISTIC	PEARSONIAN CORRELATIONS AUTONOMY	ACTIVITY
AGE	+.214**	+.224**
SHIFT	-.058	-.098
EDUCATION	+.137	+.010
POSITION (SUPERVISORY/NONSUPERVISORY)*	-.226**	-.233**

* Head nurses, charge nurses, team leaders

** Significant at the .05 level or better

TABLE 13

NURSING CARE PROCEDURES IN RELATION

TO CTE SCORES (N = 130)

NURSING CARE PROCEDURES	PEARSONIAN CORRELATIONS AUTONOMY	ACTIVITY
Including client in planning care (Item #60)	.312*	.276*
Including client and family in setting goals (Item #62)	.384*	.507*
Daily documentation of client status (Item #61)	.168	.316*

* Statistically significant at .05 level or better

OTHER FINDINGS

The questionnaire included three items concerning nursing procedures (#60, 61, and 62). The highest correlations were found between the responses to Item #62 and Activity and Autonomy Scores (See Table 13). In short, including the retardate and his family in the setting of goals was most closely related to respondents judgments of the autonomy and activity levels of the homes. Including the retarded patient in planning care (Item #60) also had an impact on patient autonomy and activity. Daily recording of the patient's condition (Item #61), a highly prized procedure in the eyes of administrators (Hubbard, 1971), was not significantly related to autonomy of patients, but was to their activity.

Respondents were also requested to judge the therapeutic quality of care provided by the home in which they worked -- the overall quality of care for patients (Item #66) and the overall quality of care given specifically to the mentally retarded (Item #64). There was a highly significant correlation between the two judgments (r=.682). These items were introduced into the questionnaire to provide a validity check on the "therapeutic" nature of the CTE Factors of Activity and Autonomy. The Pearsonian correlation of responses to Item #64 (overall quality of care given to mentally retarded patients in the home) with level of autonomy was

TABLE 14

JUDGMENTS OF QUALITY OF CARE (ITEM #64) IN RELATION TO SELECTED CHARACTERISTICS OF STAFF, TO OTHER MEASURES OF QUALITY OF CARE, AND TO ITEMS ABOUT NURSING CARE PROCEDURES (N = 130)

VARIABLES	PEARSONIAN CORRELATIONS: BETWEEN ITEM #64 (QUALITY OF CARE FOR THE MENTALLY RETARDED) AND SPECIFIED VARIABLE
SELECTED CHARACTERISTICS OF STAFF:	
Age	.080
Shift	-.016
Education	-.035
Position (supervisory/nonsupervisory)	-.186*
QUALITY OF CARE:	
Autonomy (CTE Factor I)	.598*
Activity (CTE Factor II)	.499*
Quality of Care: All patients (Item #66)	.682*
NURSING PROCEDURES:	
Including client in planning (Item #60)	.226*
Including client and family in setting goals (Item #62)	.435*
Daily documentation on client (Item #61)	.136

* Significant at .05 level or better

.598, and with level of activity, was .499. These findings support the view that levels of Autonomy and Activity do indeed measure the therapeutic climate of the environment.

Finally, again taking Item #64 (quality of care accorded mental retardates) as a criterion, correlations were computed between that score and selected background characteristics of the caretaker. Neither age, shift nor education were significantly correlated with this response, (See Table 14). Again, as in the case of the CTE Factors, the nurse's position appeared to affect his/her judgment of quality of care given retardates.

Finally, responses to Item #64 proved significantly related to the items regarding nursing procedures of including the patient in planning his care, and including the patient and his family in setting goals, but not to the practice of daily documentation of patient condition. These results are similar, then, to those obtained when Activity and Autonomy Scores were correlated to those responses, and provide one check on their validity.

RELATION OF AUTONOMY TO ACTIVITY IN THE THERAPEUTIC ENVIRONMENT

The two components of a therapeutic climate are closely related, and a home which is characterized by a high level of activity is also characterized by a high level of the

autonomy (r=.956). Moreover, respondents who report high levels of autonomy also report high levels of activity (r=.778).

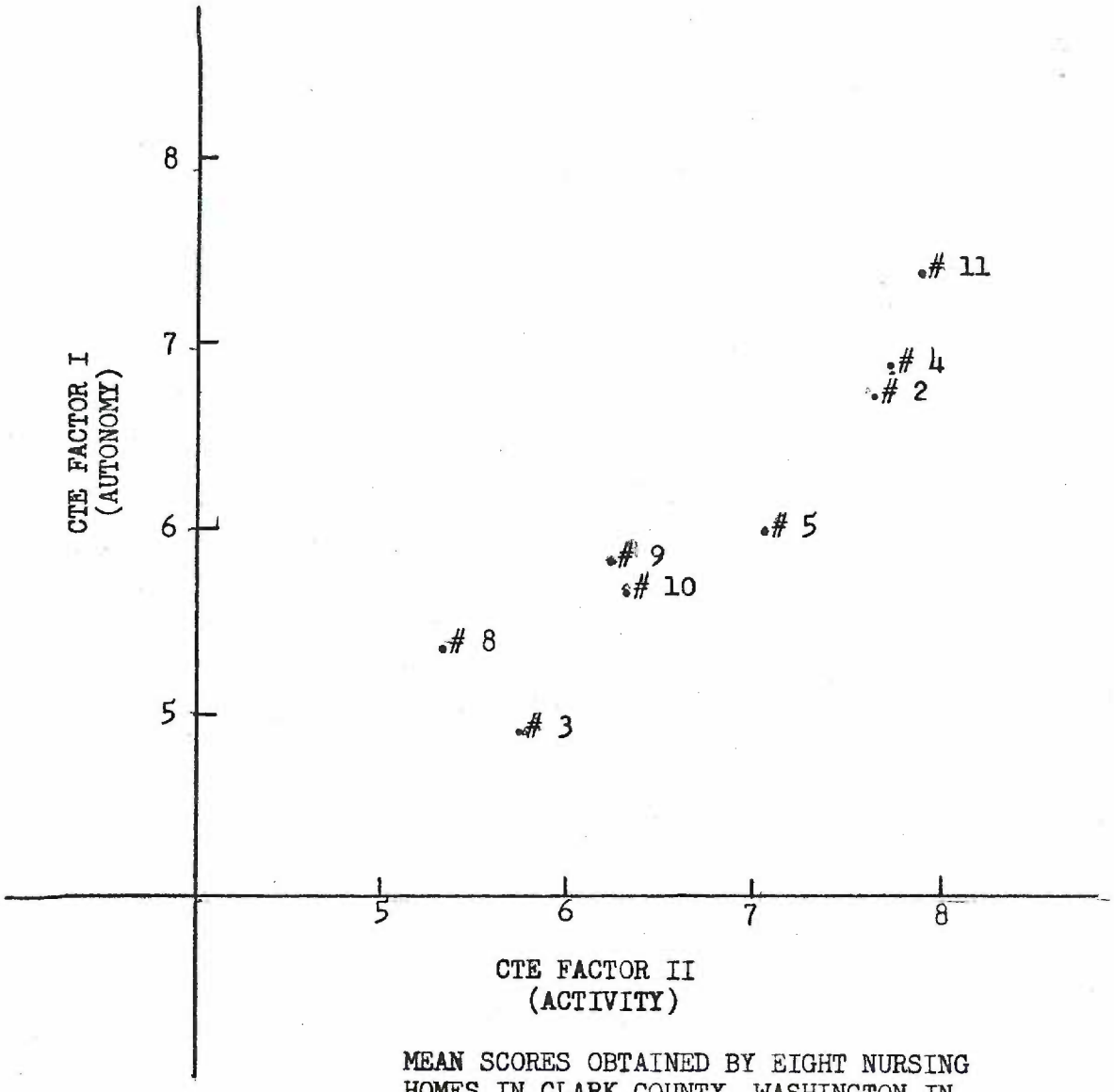
The relationship between the two environmental indices may be shown more clearly in a graphic comparison of the homes' mean scores on CTE Factors I and II (See Figure 1). Along the horizontal axis, Activity Scores are plotted, and along the vertical axis, Autonomy Scores. In examining this figure, it is apparent that the eight homes may be separated into groups of four each, at the coordinates of 7 (X-axis) and 6 (Y-axis). Homes manifesting higher levels of autonomy and activity were #5, 2, 4 and 11. All of these homes were privately owned, served smaller patient populations, and all delivered congregate care level nursing. (Only one facility included an extended care area.)

The lower scoring homes differed from the higher scoring homes in two respects - extent of staff turnover, and in organizational form. First, Homes #3 and #8 had experienced widespread administrative and staff changes, including the appointment of new Directors of Nursing, during the six months prior to the administration of the questionnaire. In Home #9, a new Director of Nursing was being sought at the time of the study, and in both Homes #9 and #10, applications for new administrators were being accepted. The greater turnover noted for these homes may have reflected poorer staff morale, and this morale in turn may either have

resulted from or resulted in a less therapeutic climate.

Second, the lower scoring homes, #3, 8, 9 and 10 were all members of large corporations. One of these homes belonged to a corporation including 200 nursing homes on the West Coast. The higher scoring homes were all privately owned, and all provided congregate care, at least to some patients. Mean Autonomy Scores were 5.49 for the large incorporated facilities, in contrast to 6.72 for the privately owned homes. Mean Activity Scores were 5.93 for the incorporated, versus 7.55 for the private facilities.

Currently, there is a trend to the incorporation of nursing homes into large networks, with the same management consultants, same policies and procedures. This development has occurred, at least in part, to facilitate compliance by nursing homes with the increasingly complex and strict state and federal rulings regarding their operation. While incorporation has apparently aided the administrators and staff of the incorporated facilities to meet this objective, it evidently has not resulted in improving the therapeutic quality of the care received by patients.



MEAN SCORES OBTAINED BY EIGHT NURSING HOMES IN CLARK COUNTY, WASHINGTON IN THE AREAS OF AUTONOMY AND ACTIVITY OF THE RETARDED PATIENT

FIGURE 1

CHAPTER IV

SUMMARY AND CONCLUSIONS

In recent years, a movement has developed shifting the locus of treatment for the mentally retarded from large state hospitals to community-based facilities. It has been assumed that these latter facilities will provide more humane care, and a greater potential for habilitation. Empirical evidence to support this claim is lacking to date. The present research represents an attempt to assess the quality of care given retardates today in eight nursing homes located in one county of the State of Washington. Additionally, this research attempts to determine the extent of systematic variations in the therapeutic climates of these homes according to variations in selected structural characteristics.

The staff members in each home provided ratings on an instrument (Jackson's CTE, as modified by McLain et al.) designed to measure aspects of the environment presumably salient for therapeutic care, namely, the autonomy and activity of patients. The importance of these two dimensions has been independently recognized by the American Association for Mental Deficiency, by authorities in nursing, and by authorities in environmental psychology.

Analysis of these data led to the following conclusions.

First, in the homes studied, while autonomy and activity were permitted to retardates more frequently than they were withheld, they still were far from maximally encouraged. Autonomy and activity levels also were somewhat lower than those reported for a number of similar facilities in the State of California.

Second, patients were accorded less autonomy in skilled nursing facilities than in residential facilities offering less skilled care. "Skilled nursing" was apparently defined almost entirely in terms of competency in technical procedures involved in the delivery of physical nursing care.

Third, autonomy was more evident in specific areas which tended to ease the burden of the caretakers and promote smooth functioning of the organization. Thus, the patients were more likely to be delegated responsibility for their personal grooming, for cleaning their rooms, and for acting in an acceptable manner than they were likely to be granted autonomy with respect to their interactions with members of the opposite sex, freedom to leave the grounds unescorted, and participation in community activities. These results suggest that "normalization" programs advocated by the American Association for Mental Deficiency have not been implemented widely.

Fourth, activities most likely to occur were of the planned variety, contained and carried out within the boundaries of the facility under the direction of staff, while

activities least likely to occur were of the unplanned, spontaneous, social and informal variety. The picture which emerges is one of regimentation and control.

Fifth, the selected structural characteristics appeared to account for only a small portion of the differences in autonomy and activity among nursing homes. Neither size of the organization, nor mean age of the staff proved related to the autonomy or activity of patients. However, staff attitudes of approval to the policy of admitting retarded patients to the homes were significantly related to higher levels both of autonomy and activity. It is possible that homes with larger numbers or proportions of retardates among their patients granted greater autonomy than homes with smaller numbers or proportions of such patients. Finally, personnel foster greater activity among patients than homes with smaller proportions of supervisory personnel. Such homes report more activity, but the reports may be inaccurate in that supervisory personnel may respond on the basis of expectations rather than on the basis of knowledge derived from direct and continuous contact with patients.

Sixth, certain characteristics of the respondent appeared to affect his/her perceptions of the environment. Respondent ratings were not related to workshift or education, but were related to age and position in the organization. Older persons and those in supervisory positions tended to see the retarded

as enjoying more autonomy and activity than did younger staff members and those in nonsupervisory roles. Supervisors also tended to respond to a single question regarding overall quality of care given the retarded, in a more positive fashion than did nurses in other positions.

Seventh, staff members, to the extent that they believed the patient and his family were included in setting goals and in planning care also tended to rate the overall quality of care higher. However, the extent to which staff members reported daily documentation of the patient's status proved unrelated to their judgments of the quality of care delivered.

Eighth, autonomy and activity were higher correlated. Homes scoring high on one factor tended to score high on the second.

While this study has provided some insight into the quality of care provided mentally retarded patients in nursing homes, the limited sample size of eight precludes broad generalizability of the present findings. However, these findings do indicate a need for nursing home administrators and directors periodically to evaluate treatment modalities, and to increase levels of autonomy and activity of patients in their institutions.

Recently, Helen Armour Pym (1975), head of the Washington Group Home Association, stated that a current study conducted by the State of Washington showed "... Washington's nursing homes are housing more than 500 developmentally disabled

persons who do not belong in them." If there is no viable alternative to the nursing home in delivering care to this population, then the facilities which accept retarded persons must develop specific programs based on developmental and normalization concepts in order to meet more fully their needs.

Since nurses assume prime responsibility for the level of care rendered patients in nursing homes, the increasing placement of the retarded in such facilities will necessitate the evaluation by nursing leaders of the particular education and skills essential for nurses to function effectively with such patients in such settings. This study suggests skilled nurses (Registered Nurses) currently permit even less autonomy and activity to their charges than do nurses in the lower echelons, as Licensed Practical Nurses or Nurse's Aides. It is apparent that nursing cannot continue to use a narrow medical model in dealing with the retarded, but must adopt developmental models that will build a therapeutic environment stressing maximum independence and habilitation.

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APPENDICES

APPENDIX A

INFORMED CONSENT FORM

CONSENT FORM

I_____ herewith agree to serve as a subject in the study titled AN ASSESSMENT OF THE THERAPEUTIC ENVIRONMENT PRESENTED TO RETARDATES BY NURSING HOMES being conducted by Karine Guard R.N.(under the direction of J. Brown PhD). The purpose of the study is to explore the nursing care being given to the mentally retarded patient in a nursing home.

It is my understanding that I will be asked to respond to questions relating to the activities and treatment of the mentally retarded patient. The time required for this questionnaire is approximately one-half(½) hour.

I understand that all information collected is confidential and anonymous in nature, and will not be used in a manner that will affect my position or employment at _____. I may not receive any direct benefit from my participation but I understand that Mrs. Guard will answer any question I may have regarding the study. I understand I am free to refuse or withdraw from participation in this study at any time. I have read the foregoing.

_____
Name-Signature

_____
Date Time

_____
Witness

APPENDIX B

QUESTIONNAIRE

PART I

A. Year of graduation from school of nursing_____

B. Nursing School located in_____
city state

C. Length of time practicing nursing_____

D. Length of time working in a nursing home_____

E. Please list any degree you may hold, including a nursing home administrators license_____

F. If you have completed any courses dealing with mental retardation please list them.

_____
course where offered date

G. If you have attended any lecture, seminar or workshop dealing with mental retardation, please list them.

_____
date

H. Level of nurse

RN-MS_____ RN-Diploma_____

RN-BS_____ LPN _____

RN-ADN_____ Nurses Aide_____

Other_____

I. Job Classification

_____

J. Shift_____

K. Age_____ Sex_____

PART II

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

1. There are a large number of statements in this questionnaire. Please think of each statement and ask yourself how true it is, or how false, about the Nursing Home where you work.

2. It does not matter what other people think or say. We know that most people see things a little differently.

3. Just read each statement quickly, but carefully. CIRCLE ANY NUMBER ON THE SCALE. The number you circle should tell us how true or false the statement is.

4. To summarize: Read each statement quickly. Then circle the number on the scale which represents how true or how false the statement is. Then go on to the next statement. Circle a number on every statement. Do not look back over your work.

5. The term "nurse" refers to any person involved in the nursing care of the patient in the nursing home, aides, orderlies, housemothers, caretakers etc.

6. Withhold your name.

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

1. Mentally retarded residents who are physically able frequently go on trips (picnics, walks, visits, ets.) outside of the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

2. All of the mentally retarded residents who are physically able participate regularly in some recreational activity.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

3. Mentally retarded residents are not given the responsibility for handling and spending their own money.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

4. Up-to-date newspapers and magazines are available to all mentally retarded residents.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

5. Nurses often take those mentally retarded residents who are physically able on trips outside of the facility, either individually or in groups.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

6. The nurse permits mentally retarded residents to "try out" new situations before they really get involved in them.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

7. There is very little play activity for mentally retarded residents in the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

8. Mentally retarded residents are hardly ever asked about what activities they would like to engage in or how they want to spend their time each day.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

9. All mentally retarded residents are escorted by a caretaker whenever they leave the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

10. Mentally retarded residents are told that if they do not behave properly they will be punished, either by restriction or other loss of privileges.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

11. Mentally retarded residents seldom have the opportunity to start activities themselves.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

12. All mentally retarded residents are encouraged to participate in music, painting, handicrafts, or other creative or self-expressive activities.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

13. The nurse does not encourage association between retardates of the opposite sex.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

14. Mentally retarded residents often engage in activities together without the nurses participation.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

15. The nurse takes thorough precautions that doors are kept locked, screens secure, and other security procedures are carefully followed.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

16. The nurse never discusses mentally retarded residents' personal problems with them.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

17. The nurse frequently explains to a mentally retarded resident why he should or should not engage in particular kinds of behavior.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

18. Mentally retarded residents are not encouraged to take very much responsibility for maintaining their own personal cleanliness and grooming.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

19. Mentally retarded residents who are disturbing other residents are often told by the nurse to cease behaving that way.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

20. Mentally retarded residents are kept busy in the facility by frequent social, intellectual or recreational activities conducted by the nurse.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

21. Mentally retarded residents are not encouraged to make changes in the facility which they think will increase its attractiveness or convenience.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

22. The nurse avoids entering into discussions with mentally retarded patients about the policies and regulations of the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

23. The nurse spends a large proportion of her day sitting with residents.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

24. Mentally retarded residents are not permitted to make decisions about turning radios and TV sets on or off, selecting stations, etc.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

25. The number and variety of activities in which the mentally retarded residents can participate in the facility has been increasing steadily during the last year.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

26. Whenever a mentally retarded resident is transferred from one facility to another, the reasons for making the change are always explained to him.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

27. Physical restraints are frequently employed with mentally retarded residents.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

28. The feelings and wishes of mentally retarded residents are taken into consideration in making decisions about transferring them, by discussing the proposed changes with them beforehand.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

29. The nurse participates regularly with mentally retarded residents in positive activities.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

30. Parties or other social activities are hardly ever held in the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

31. The nurse trusts most of the mentally retarded residents to work out their relationships with one another without interference.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

32. The nurse has gradually given up attempting to get withdrawn or "difficult" mentally retarded residents to participate in activities in the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

33. Mentally retarded residents movements are, on the whole, highly restricted.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

34. Suggestions made by mentally retarded residents regarding activities and living arrangements are seldom adopted.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE.	

35. Mentally retarded residents behavior is controlled by the nurse by letting residents have certain privileges or taking them away from them.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

36. The nurse works with individual mentally retarded residents to help them correct their behavior a little bit at a time (by easy stages).

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

37. Mentally retarded residents are free to select their own activities during the day.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

38. The nurse is constantly seeking ways of expanding mentally retarded residents freedom of movement (about the facility, yard and community).

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

39. The nurse always attempts to keep mentally retarded residents from behaving in a hostile manner.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

40. Mentally retarded residents are not encouraged to take very much responsibility for maintaining their own rooms.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

41. Mentally retarded residents opinions about the physical environment, arrangements, and the nurse are considered seriously.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

42. The nurse tries to prevent mentally retarded residents from engaging in any behavior that appears to be sexual in nature.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

43. Nearly all the mentally retarded residents are permitted to have their own money and personal possessions.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

44. Mentally retarded residents are encouraged to start projects with other mentally retarded residents to improve the physical environment of the nursing home.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

45. Mentally retarded residents are not allowed out of the nursing home in the evening very often to participate in community activities.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

46. The nurse hardly ever explains to the mentally retarded resident why particular behaviors are appropriate or inappropriate (good or bad).

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

47. When mentally retarded residents are asked to work, the relationship between the work and their own well-being is always made clear to them.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

48. In general most of the mentally retarded residents participate in activities in the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

49. On the whole, the nurse demands strict obedience from mentally retarded residents.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

50. Mentally retarded residents have many opportunities to express themselves in music, painting, hobby-work or other creative activities.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

51. The nurse encourages mentally retarded residents to take over management of their own affairs whenever possible.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

52. Mentally retarded residents are encouraged to help one another in taking care of themselves.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

53. The nurse freely selects individual mentally retarded residents with whom she wishes to work intensively.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

54. The nurse is always trying to get mentally retarded residents to want to take more responsibility in the facility.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

55. The nurse does not become too interested in mentally retarded residents as individuals.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

56. The doors between rooms are often left open to permit visiting among mentally retarded residents.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

57. Whenever a mentally retarded resident is excited or disturbed, the nurse spends as much time as required to calm him down.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

58. The nurse does not encourage the families of mentally retarded residents to take them for rides or outings.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

59. Mentally retarded residents are encouraged to make their own decisions in spending their personal money.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

60. The nurse includes the mentally retarded resident in nursing care conferences and planning.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE				COMPLETELY FALSE	

CHARACTERISTICS OF THE TREATMENT ENVIRONMENT

61. Documentation on the nurses notes is a daily responsibility of the nurse in the care of the mentally retarded patient.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE					COMPLETELY FALSE

62. The mentally retarded resident and his family are frequently consulted about setting goals and the level of nursing care.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE					COMPLETELY FALSE

63. Recording of the condition and status of the mentally retarded patient is done on a less than daily basis according to the nurses discretion.

100	90	80	70	60	50	40	30	20	10	0
COMPLETELY TRUE					HALF TRUE HALF FALSE					COMPLETELY FALSE

64. Thinking of the overall quality of care given to mentally retarded patients in this facility, how therapeutic do you consider it to be?

100	90	80	70	60	50	40	30	20	10	0
HIGH										LOW

65. There is a current trend to treat the mentally retarded in community facilities or nursing homes rather than state institutions. How much do you approve of the policy of admitting the retarded to this nursing home now?

100	90	80	70	60	50	40	30	20	10	0
HIGH										LOW

66. Thinking of the overall quality of nursing care given to all patients (not just retarded) in this nursing home, how therapeutic do you consider it to be?

100	90	80	70	60	50	40	30	20	10	0
HIGH										LOW

APPENDIX C

CTE SCORING CODE

INFORMATION FOR SCORING THE COMMUNITY VERSION OF THE "CHARACTERISTICS OF THE TREATMENT ENVIRONMENT"

CTE SCORING CODE

Response	Code
100 (Completely True)	9
90	8
80	7
70	6
60 or 50 or 40	5
30	4
20	3
10	2
0 (Completely False)	1

Response	Code
100 (Completely True)	1
90	2
80	3
70	4
60 or 50 or 40	5
30	6
20	7
10	8
0 (Completely False)	9

The community version of the CTE was devised by project personnel in the NICHD supported research program "Patterns of Care and the Development of the Retarded" centered at The Neuropsychiatric Institute-Pacific State Hospital Research Group, Pomona, California.

ITEMS IN TWO NEW CTE SCALES

COMMUNITY VERSION

I. Autonomy: 4, 8R, 9R, 11R, 13R, 14, 16R, 17, 18R, 21R, 22R, 24R, 26, 28RR, 31, 33R, 34R, 37, 40R, 41, 43, 44, 45R, 46R, 47, 51, 52, 54, 56RR, 59.

II. Activity: 1, 2, 5, 6, 7R, 12, 20, 25, 29, 30R, 32R, 35, 36, 38, 48, 50, 55R, 57.

Note -- R designates items for which the scoring is reversed in both Jackson's scales and the new ones; RR designates those for which the scoring is reversed in Jackson's scales only.

AN ABSTRACT OF THE CLINICAL INVESTIGATION

OF KARINE A. GUARD

For the MASTER OF NURSING

Date receiving this degree: June 11, 1977

Title: AN ASSESSMENT OF THE THERAPEUTIC ENVIRONMENTS PRESENTED TO RETARDATES BY NURSING HOMES

Approved: [redacted]

Julia Brown, Ph.D Clinical Investigation Advisor

The purpose of this study was to assess the therapeutic quality of the environment encountered by mentally retarded residents in eight nursing homes in a Washington State county. In addition, an attempt was made to determine the extent to which the therapeutic climates of these homes were affected by such structural factors as size of the organization, staff-patient ratio, mean age of staff, mean educational level of staff, and proportion of supervisory to nonsupervisory staff.

The therapeutic climate of each home was measured by means of an instrument, Jackson's Characteristics of the Treatment Environment, as modified by McLain. Use of this instrument (the CTE) provided estimates of the patients' autonomy and activity, two factors commonly identified as of prime therapeutic importance.

Every staff member in the eight selected homes was requested to complete a questionnaire which included both the CTE, and items regarding the respondent's background characteristics and opinions.

One hundred and thirty persons, representing from 29% to 85% of the total staff members of the homes, participated in this study.

Analysis of the data resulted in the following findings. First, autonomy and activity were highly correlated. Second, in the homes studied, autonomy and activity levels were neither very high nor very low. Autonomy was more frequently permitted than withheld, and activity occurred more frequently than it was absent, but neither were maximally or universally encouraged. Third, autonomy was more evident in specific areas which promoted smooth functioning of the organization and eased the workload of the staff, such as personal grooming, than in areas which promoted the personality and social development of the patient, such as interacting with members of the opposite sex, or participating in community activities. Fourth, activities tended to be planned and controlled by staff, rather than informal and spontaneous. Fifth, only certain of the selected structural characteristics of the homes appeared to exert systematic effects on autonomy and activity levels. These were type of facility (whether "skilled nursing" or not), proportion of mentally retarded patients, proportion of supervisory staff, staff approval of admitting retardates as patients, and staff policy of including patients and families in planning nursing care. Greater autonomy was reported in homes with large numbers or proportions of retarded patients; greater activity was reported in homes with larger proportions of supervisory personnel; and both greater autonomy and greater activity were reported in homes classified as other than "skilled nursing" facilities, in

homes in which staff expressed greater approval of admitting retarded patients, and in homes in which patient and family were included in setting goals and in planning nursing care.