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ABSTRACT

Seven articles treat the establishment of operant conditioning programs for the mentally retarded at Pacific State Hospital in California. Emphasis is on the administrative rather than the demonstration of research aspects of operant conditioning programs. Following an introduction and overview, the medical director's point of view on operant conditioning programs is presented and the following aspects of the token economy program are examined in articles by various staff members at the state hospital: demands on the staff, selection of patients, operation of the token economy program, the high school program, and the implementation of new programs in ward care of the retarded. Three additional articles discuss the training program in operant conditioning for institutional staff members, a cross-cultural use of operant conditioning at a mental hospital in Vietnam, and operant conditioning treatment programs at Porterville State Hospital. Additional material details administrative policies and daily procedures at Pacific State Hospital. (KW)

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THE ESTABLISHMENT AND ADMINISTRATION OF OPERANT CONDITIONING PROGRAMS IN A STATE HOSPITAL FOR THE RETARDED

Edited by
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THE ESTABLISHMENT AND ADMINISTRATION OF OPERANT CONDITIONING PROGRAMS

IN A STATE HOSPITAL FOR THE RETARDED

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INTRODUCTION AND OVERVIEW

Thomas S. Ball, PhD, Chief Psychologist

Pacific State Hospital

"Good judgment in our dealings with others consists not in seeing through deceptions and evil intentions but in being able to waken the decency dormant in every person."

Eric Hoffer

This monograph addresses itself to the problems of establishing and administering operant conditioning programs in a state hospital for the mentally retarded. Although one section describes an ongoing token economy program, our emphasis will be on the administrative rather than the demonstration of research aspects of operant programs.

In writing this monograph we neither claim technical superiority for our treatment programs nor unusual or unique administrative knowledge. In fact, much of what we have to say would be familiar to people with experience in any kind of large organization. Thus, whatever the setting, one must effectively gain the cooperation of others to achieve a goal. In our case the goal happens to be the habilitation of mentally retarded people. Our purpose is to provide a point of departure for your thoughts about developing operant programs in your setting. If our experiences serve as a catalyst to your own thinking, then the effort will have been worthwhile.

I value and respect technical competence. However, like the army that won the battle but lost the war, I have known of some brilliant technical demonstrations of behavior modification that produced little or no impact on a total hospital program. From a programmatic perspective I must classify such demonstrations or research projects as administrative failures.

Not that our initial venture into this field represented a masterful stroke of administrative strategy. In point of fact, though scientifically and ethically justifiable, we began with a problem that, administratively, can be the Kiss of Death, i.e., the control of severe

self-destructive behavior through punishment (a mild electric shock). The idea of applying a painful but harmless electric shock to a patient (even though done to prevent severe self-inflicted damage, e.g., blindness from severe head banging) was interpreted as cruel and inhuman and aroused tremendous opposition in some quarters. To my chagrin, I found that operant conditioning was equated with "shock treatment." I was as concerned with those who blandly accepted this concept as with those who summarily rejected our efforts.

Judging from the exchange several of us have had with David Vail, MD. in the pages of Hospital and Community Psychiatry (February and July 1968 issues), my concern over the punishment issue was realistic enough. If anything, it has become an emotionally charged "red herring" for those who would rush to attack the whole field of operant conditioning. This is especially unfortunate, because the really significant overall contribution we have to make is through the judicious use of positive reinforcement (reward). Emotional arguments regarding the use of punishment may obscure this one most crucial point.

Fortunately, my second major step in operant programming involved the introduction, with the aid of Cecil Colwell, of the Breland-Colwell self-help skill training program (Bensberg, 1965). This program, introduced in the context of our federally funded Hospital Improvement Project, met the pressing need for an efficient and effective training approach that could be taught to ward personnel. For profoundly retarded school age patients there was simply nothing to compete with it. Nor were there any professional groups competing for a chance to work with these children, at least initially. Anyone who wanted to deal with the problem had a free hand.

I found myself involved and committed as never before--Colwell saw to that. He trained me and I, in turn, assumed responsibility for a group of ten patients and the direct supervision of psychiatric technicians assigned to this group. As Colwell had trained me I, in turn, trained them. That initial group of 10 was our pilot and demonstration venture. We conclusively demonstrated the efficacy

of the training program. With that as a point of departure it was not difficult to sell the rest of the ward personnel or the hospital administration. It should be noted, however, that a successful demonstration does not, in itself, insure the general adoption of this technique on a ward.*

By assuming control of that initial training group I had unwittingly taken a major step into the world of administrative influence. For a psychologist, even a newly appointed chief psychologist, to be directly giving orders to psychiatric technicians was something almost unheard of. There were raised eyebrows, but de facto control was an absolute necessity at that stage of development. I had ventured into what is traditionally the "closed society" of the hospital ward, a society in which "off-ward" personnel are politely tolerated, but effectively neutralized. Not that most off-ward personnel deserved anything more in the way of respect and gratitude. Realistically, with but a few exceptions, they have had little to offer this patient group, either in the way of effective techniques or even sustained emotional support for personnel. Yet here was an effective technique and I was in the position of introducing it. These people could not be "snowed" with professional jargon. The outcome of my efforts, my success or failure, would be evident to everyone. It was an uncomfortable but uniquely challenging position.

The Breland-Colwell program succeeded extremely well. As part of our effort we were also able to provide our own experimental demonstration of its efficacy (Minge & Ball, 1967). At about this time (1964) the hospital received a Hospital Inservice Training Grant (HIST) for a project that within a year was to represent another significant step in the dissemination of operant programming. This

*For a more complete account of how one establishes this ward program, see Colwell's chapter in the Bensberg manual. For some additional insights into the problems of establishing an operant program on a ward-wide basis see the article by Delmont Morrison in the July 1968 issue of the American Journal of Orthopsychiatry.

project capitalized on what we had learned in the context of HIP and other programs including our sensory-motor training projects (Ball & Edgar, 1967; Edgar, Ball, McIntyre & Shotwell, in press). A HIST nursing team was evolved, the purpose of which was to facilitate the establishment of operant and other programs on one entire ward at a time. Their approach, described later in this monograph, includes an analysis of both successes and failures. It will provide extremely valuable administrative insights.

The acid test of the support and understanding of the hospital administration occurred when I suggested the establishment of a Token Economy Program inspired by a successful demonstration with the mentally ill conducted by Drs. Hal Schaefer and Pat Martin at nearby Patton State Hospital (Schaefer and Martin, 1969). When I approached the hospital's Treatment Program Planning Committee I had the undisputed success of the self-help skill program to my credit. Token economy is but another application of operant technology. But, this time, we proposed to take over an entire ward with a tightly controlled program. Following the Patton model, we insisted that patients would have to earn tokens to pay for all aspects of their daily living accommodations, including food.* We also proposed the control of parental visits. Such features aroused great resistance, primarily from the social work department, but from other departments as well. My proposals "rocked the boat" insofar as the definition and delineation of professional roles were concerned. They also challenged some notions of professional intervention with parents. It was predicted that control of parental visits would break the tenuous bond that existed between many parents and their institutionalized children, that it would encourage parents to rationalize a complete break in the relationship. The proposal also placed me, as the prospective psychologist-director of the program, in a unique position. In our institution, a psychologist had never had major administrative responsibility for an entire ward program.

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*We are planning a research project to evaluate the significance of the food factor in our program. Other successful token programs, such as James Lent's pioneer efforts at Parsons (Lent, 1968) do not require the purchase of meals.

Although emphasizing from the outset the primacy of medical authority in ward problems of a medical nature, I did insist on policy control of the behavioral aspects of the program with, of course, the continuous consultation of the medical staff. I made my position clear in a form of "package deal" that was presented to the reviewing committee (see appendix O). That the "package" was eventually approved was due to the strong support of the hospital administration, especially our superintendent, Dr. Vernon Bugh (see appendix P).

One thing I learned from those meetings was to value informed, intelligent, articulate opposition. Such opposition forces one to evaluate his own assumptions, sharpen his own thinking, and develop a position statement. Largely in response to the perceptive objections raised by our chief social worker, I formulated the position statement (see appendix Q) and eventually, the rebuttal to Dr. Vail's article (Ball, 1968).

That we were able to launch our program in January 1967, an uncertain and difficult time for the California State Department of Mental Hygiene, was due to the vigorous support received from Dr. Bugh and Mrs. Mary Roberts, Superintendent of Nursing Services. We requested our own ward, time to select and train our own staff prior to the arrival of patients, and control over the selection of patients. And we were doing this with no outside funding. The result was a strain on already limited resources. But key administrative people felt that we had something of value and were willing to back us up.

We had to select patients and get them transferred to the ward in a hurry. But due to the special provisions of the program we wanted written parental approval. Once again, we approached the matter as a kind of "contract" that parents could either accept or reject. In group meetings we explained all aspects of the program in detail. We anticipated considerable opposition but much to our surprise there was not only verbal approval but over 90% of the parents attending gave written approval for their daughters or charges to be admitted to the program (see "Consent for Token Economy Project" in Policies and Procedures Section). Many parents have shown unusual cooperation and

have been willing to carry the program, including the use of tokens, into the home (Bourgeois, 1968).

The next development was the involvement of the public health nurses assigned to the out-patient branch of our hospital's pread-mission clinic in nearby Van Nuys. Although a relatively small-scale demonstration project, the nurses experienced many gratifying successes in the application of these techniques with mentally retarded youngsters at home awaiting admission to the hospital. One public health nurse, using the hospital as her base of operation, is carrying out the same kind of program locally, again with considerable success.

Our most recent involvement in the dissemination of operant programming has extended our training efforts outside the confines of the hospital. Thus, at the instigation of the Director of the California State Department of Mental Hygiene, a 9-week training course was established as a collaborative effort between our staff at Pacific State and Dr. Hal Schaefer's group at Patton. This course, described in detail in a later section, provided us with opportunities for gaining new perspectives and insights. We had time to involve a group of intelligent, experienced, and administratively sophisticated people directly in training activities. Equally as important, we developed a stimulating, ongoing dialogue. We were mutually committed and in a position of learning from each other. Lacking such commitment, growth can never take place, either in individuals or in programs.

An interesting byproduct of the training program is the stimulation and sense of renewal it can provide for regular staff. Staff eventually come to take themselves and their activities for granted. Interaction with eager, inquiring trainees can provide much needed stimulation, challenge, and renewal. A further thought about renewal - we find it important to continue thrusting ahead with new ideas and innovations as a means of keeping our programs viable, e.g., in our token economy program, we recently arranged for off-grounds attendance at dances sponsored by a community association for the mentally retarded, installation of closed-circuit TV, our social worker's efforts to evolve improved community released programs and improved follow-up of released

patients, planned expansion to additional wards, etc. Finally, it is clear that staff should be encouraged to participate in professional meetings and write papers (see Bourgeois, 1968, and Sibbach in this monograph). Talent may be unearthed and descriptions of programming produced by people with the most intensive day-to-day exposure to what actually transpires.

So much for a review of how our operant programs have evolved at Pacific State Hospital. Before closing, however, I would like to review certain themes that deserve further detail.

I touched briefly on a kind of resistance, albeit a highly constructive type, encountered in the course of pressing for the establishment of a token economy ward. But resistance comes in many forms. For example, there are those whose oppositions stem from the "gut" level of their own personal needs. Selectively giving food and attention contingent upon appropriate behavior involves a kind of self-discipline that is more than they can tolerate. Conceptualizing patients in terms of a sickness model, they see our controls and our selective responses in the light of a cruel disregard for the patient's disabled state. In many instances it seems as if our approach disrupts the flow of satisfaction that makes work gratifying to such employees. It is usually futile to attempt to convince them otherwise. It is like arguing someone out of a style of life that he finds entirely comfortable. In addition to the employee whose satisfaction is derived from a "babying" relationship to patients, we would also identify those who gain a perverse kind of satisfaction out of encouraging disruptive behavior.

Differences over treatment philosophy can sometimes have serious consequences. The most serious clash of this kind arose between an assistant superintendent and the token economy ward midway through the first year of operation. Clearly, the program's philosophy was irreconcilable with his views. The constructive aspect of this clash was that the issues were clearly drawn. To change program policy to conform to his views would have seriously compromised and gradually undermined the program. Fortunately for the token economy ward the superintendent

backed the program and arranged for its transfer to another hospital division. Even this clash had its constructive aspects in that it strengthened further our sense of self-definition and integrity.

The most salutary objection to the operant approach is the one accompanied by the challenge "I can do it better." Such a challenge occurred when I proposed to treat a mild case of headbanging by means of extinction during headbanging and positive reinforcement for appropriate behavior. A psychoanalytically oriented staff member proposed an alternative and contradictory approach maximizing physical contact and TLC. I suggested a comparative study involving daily time samples of headbanging during non-treatment periods. A willingness to subject your own approach to objective evaluation underscores your commitment to and confidence in what you espouse and can only serve to strengthen your position. In addition, it sets a high standard of objective scientific evaluation of treatment procedures.

The only truly insidious kind of opposition is from those who superficially "go along" with your efforts while only "going through the motions" of cooperation. Such people may be subtly derogatory and even undo your efforts behind the scenes. But in such intensive programming they quite readily emerge as the "bad apples" that they are and can, hopefully, be transferred elsewhere.

Opposition often seems to evolve through a series of stages. This phenomenon was very clearly delineated by our Associate Superintendent, Dr. Alvin Walker, who had been associated with the Patton Token Economy Project prior to his transfer to Pacific. According to Dr. Walker, "At Patton when the Token Economy Program was being developed, it seemed to me that there was considerable resistance to it. This resistance was initially manifested by a total ignoring of the presence, existence, etc. of the program. The second phase was characterized by one staff member joking with another to the effect that he would get tokens if he did his progress notes, etc. The third phase could perhaps be exemplified as a testing out period. For instance, the program would receive obviously inappropriate referrals such as a notoriously aggressive female who had not been helped by any approach, with the

implication that if we could help her, then they would promise to become 'believers'. The fourth phase was a more wholesome acceptance of the program as well as its possibilities, limitations, etc."

As Dr. Walker suggests, even success has its problems. One such problem is the emergence of inter-departmental competition and professional chauvinism. At one point, this arose from an outside nursing consultant who insisted that operant conditioning is an exclusively nursing technique. By defining it in a hostile and competitive fashion she satisfied a need for self-enhancement and status, but at the cost of alienating many others, including myself. In point of fact, for operant programs to be worth their salt they must be utilizable by nursing personnel at the ward level, especially the psychiatric technicians. What was incorrect about the consultant's statement was the claiming of operant conditioning as anyone's exclusive domain.

A second clash occurred with the hospital's rehabilitation department's laundry workshop program. Although not a token economy, the workshop program did include a "token pay" salary of $5.00 per month for patients working productively and consistently in the hospital laundry. Initially, our program was perceived by the rehabilitation supervisor as competitive with her own. Justifiably proud of the success of her own program, she resisted the notion of having patients involved in her program placed on our ward. As the conflict continued, we, in turn, became somewhat hostile to her program. It was only through a continued effort at mutual understanding that the conflict was resolved.

If the principals involved focus on the one paramount consideration, i.e., the welfare of the individual patient, conflicts of the competitive-chauvinistic variety can have highly productive outcomes. Thus, although the HIST nursing consultant temporarily promoted the development of hostile camps, her action ultimately led to an appreciation of each individual's unique contribution. I readily acknowledge that HIST has gained a wealth of information about establishing operant programs on hospital wards. I am happy to listen and learn from their experiences. We, in turn, in the psychology department, can support their efforts. Similarly, we have found that the rehabilitation department's laundry

workshop program was the ideal complement to our own. We could shape behavior to the point at which patients could be absorbed into the workshop for six hours per day. And once there, the work experience, supervision,and reward in real money significantly augmented what we could offer on the ward and greatly enriched the patient's experience.

There is a form of resistance arising simply from the experience of being left out of the picture,e.g., in one hospital a token economy program was established through the active interest and support of the superintendent. In the course of this a pipeline form of communication was established between the ward charge and the superintendent that circumvented the nursing service hierarchy. For the ward charge the advantage of direct support from the top was, in the long run, outweighed by the disadvantages of retaliation from her immediate supervisors,e.g., performance evaluations that damned with faint praise. It is sometimes possible to circumvent middle management in setting up a program,but it is infinitely better to have middle management informed and in a position to provide active support.

As I mentioned at the outset, we can describe our own experience in the hope that it may serve as a catalyst to your own thinking. We cannot provide a blueprint. In a hospital for the mentally retarded, starting out with a small-scale self-help skill program on a single ward may well be a favorable way to begin. On the other hand, a HIST-like operation may be a preferable point of departure. Your decision may well hinge upon the receptivity and administrative climate in your own institution as well as the availability of trained personnel. We still have so very much to learn ourselves. Thus, we have found it relatively easy to train personnel from other hospitals in operant techniques and to provide some administrative indoctrination. The really difficult question is how these trained people are going to relate to the administrative structures of their own institutions when they return to establish operant programs. What roles will they play? How will they relate to the formal and informal power structures? These are questions that send reverberations from the top to the bottom of the administrative hierarchy in that they relate to an institutional

way of life. It is evident at this point that as trainers we have completed the first, and in many ways the easiest, step in the indoctrination of our initial training group. Our hope, ultimately, is that operant programming will, at least in part, sell itself. Thus, as Dr. Cotter reveals on page 73, the efficacy of this approach has been demonstrated in a cultural setting widely different from our own. Even in South Vietnam, there was a need for a radical departure from the traditional "sickness" model of institutional treatment which was shown to be inappropriate and outmoded. Certainly, we should be able to accomplish as much in California state hospitals.

We cannot, however, assume that our programming will "sell itself" at other state hospitals. It is evident that with future groups we must more intensively involve top hospital administration from the outset. We must be sure that they understand the potentialities and also the problems and complexities of such programs. On the basis of this information they must evaluate their own needs and set forth explicit goals. They must carefully select personnel with a high potential for effecting such programs on their return. Also, we must enlarge upon our currently available follow-up procedures to enable us objectively to assess the ultimate impact of our training efforts (See Minge and Ball, 1967, and HIST evaluation procedures, this monograph).

There are, of course, potentially valuable subjective indices of program success. An incident that occurred during a token economy ward staff meeting last May provided just such an insight. During the meeting, over which I was presiding, a noisy altercation took place in the adjacent hallway. Annoyed, I went out, intervened in a conflict, and put an end to it. When I returned to the meeting I was greeted by a note signed by everyone present which read, "You have just been manipulated." And so, indeed, had I been! I was glad to be corrected. But I was happier still that a positive force that I had set in motion was now correcting my own error. I felt the token economy program, had, at last, fully "arrived."

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MEDICAL DIRECTOR'S POINT OF VIEW ON OPERANT CONDITIONING PROGRAM IN A STATE HOSPITAL FOR THE RETARDED

Vernon G. Bugh, MD, Medical Director*
Pacific State Hospital

I have had recent experience in the administration of hospital treatment programs for the mentally retarded of all ages and degrees of disability. One is impressed with the severity of dysfunction in the majority of patients, particularly those whose intellectual endowment is minimal and who have multiple physical handicaps as well. Under such circumstances, the clinicians as well as the administrators of such programs are constantly concerned with ways of approaching the severely disabled with whatever treatment modality may hold out opportunity for improvement.

Traditionally, mental health personnel, especially nursing service personnel, have been inclined to underestimate the capacity for even the severely handicapped to respond to appropriate approaches. There has been a tendency to work with the patient in such a way as not to expect very much change in his total situation. As a matter of fact, it is well known that if a non-ambulatory youngster achieves hospital admission and fails to become ambulatory within three years of the date of his admission, the chances of his ever being ambulatory are minimal. This holds true also with such things as toilet training and the accomplishment of other self-help skills. Thus, there is a residue of older patients in mentally retarded hospitals who have become members of a chronically disabled population in the hospital because insufficient effort was made at an earlier time in their lives.

The above situation obtains partially because of insufficient numbers of treatment personnel. It also obtains because of insufficient techniques for providing an approach to the patient's rehabilitation. Over the past few years conditioning procedures have come into the foreground of many treatment modalities. They have been woven into

*In December, 1968 Dr. Bugh left Pacific State Hospital to accept an appointment as Medical Director at Camarillo State Hospital.

certain psychotherapeutic approaches. In other instances they have become the backbone of a direct approach to the patient's dysfunction. The use of positive conditioning has been known for a long time in connection with behavior of lower animals. Many clinicians have shied away from its use in the "conditioning" of human beings. Somehow, this approach has seemed to be in conflict with our Judeo-Christian heritage and western civilization in which each person is responsible for his own behavior, and superimposed behavior styles have never been considered proper to this kind of individualistic philosophy. In the situation with the mentally retarded, however, it was observed that even though personnel caring for the patients attempted to avoid dictated behavior styles, they were inevitably trapped into so doing. For the most part, this followed the ordinary line of correcting for misbehavior, interrupting self-destructive acts, and in general responding to the patient with "don'ts."

With the inception of operant conditioning programs, a rather significant treatment approach is developing. It is not a panacea for all malfunctioning persons, whether retarded, mentally ill, or organically damaged. However, it can be said that applying the positive reinforcing conditioning to properly selected patients does have the treatment potential for betterment of those patients. It becomes a systematic approach to behavior aspects of human functioning. The more understanding we have regarding how reward and punishment affect the way people behave, the more likely we shall be to use conditioning procedures successfully.

Thus, in the hands of trained nursing personnel (and other mental health specialists) the operant conditioning approach can become a meaningful tool for effecting modifications in the behavior of patients under treatment. In some ways it is similar to the tools of the surgeon or the tools of the psychotherapist in that specific attitudes are learned and specific approaches to assisting the patient in helping himself are adopted. This becomes so systematized that a consistent approach to the patient is maintained and a more socially acceptable person evolves. This is because the person learns what is expected and he finds that he can rise to the level of expectation.

The administrative questions attached to aversive conditioning procedures are more difficult to resolve. Again, this harks back to our heritage and since the severely mentally retarded, for example, are considered to be "not responsible" for what they do, it becomes a problem to invoke aversive conditioning approaches. By and large, it would appear that these approaches will not be necessary if a positive conditioning effort is consistently followed. In any event, the aversive stimuli must be understood as a part of the total approach. Personnel must achieve a non-ambivalent view of their role. Careful supervision is always a requirement. It may have special use in the most self-destructive patient situation.

Overall my experience with operant conditioning techniques within a hospital setting has been gratifying. Progress toward individual patient improvement has been observed. Milieu therapy within a ward program has become more effective. Personnel attitudes and approaches to patients have become more systematically positive. Relationships between personnel and patients are used scientifically so that a new staff member may come to the ward and pick up a treatment contact with a patient or a group of patients by simply following the steps that have been taken in their behalf by the previous staff person. This provides for consistency and quite literal standardization of appropriate behavior patterns for both patients and employees.

Additional study is required with a larger patient population before one can be discriminating in regard to the selection of patients for this approach. However, within the fairly near future it may be possible to spell out more clearly those criteria which will become the basis on which patient selections are accomplished.

T O K E N E C O N O M Y P R O G R A M (TEP)

DEMANDS ON STAFF

INITIAL SELECTION OF PATIENTS

DESCRIPTION OF THE TOKEN ECONOMY PROGRAM

SCHOOL PROGRAM

DEMANDS ON STAFF

Robert Behrens, Staff Psychologist
Pacific State Hospital

Medical Staff

There have been two physicians assigned to the TEP. From its inception in the spring of 1967, through the fall of 1967, the ward physician was Dr. William Morris. In early fall, 1967, Dr. William Sigurdson joined the Pacific State staff as Assistant Superintendent and in addition to his administrative responsibilities assumed the role of ward physician to TEP. In both cases the physicians have been very thoroughly involved in the ward processes. In addition to maintaining medical surveillance they have been actively involved in patient programming. Dr. Sigurdson, for example, has involved himself to the extent of devising individual programs for patients. In both cases, too, the physicians have been regulating patient medication so that [illegible] residents have been frequently withdrawn from psychotropic drugs in order to make them more accessible to behavior modification.

Nursing Staff

In the United States ward or unit facilities are usually headed by one individual who in turn delegates responsibility and authority to other specific individuals. At Pacific, this individual is entitled the ward charge. The senior authority figure, by possessing the power and authority to evaluate her personnel and further by possessing the authority to transfer personnel to other possibly less desirable wards or less desirable shift assignments, has a vast degree of subtle and overt power. The ward charge can and often does require complete allegiance and compliance from the ward personnel. In most wards and units it seems that the differential reinforcement of certain behaviors and the punishment or ignoring of certain other behaviors leads to an almost predictable sequence of emitted behaviors from ward personnel. Thus, personnel are rarely or never allowed to overtly disagree and

challenge the authority of the ward charge. In certain cases the charge may assign the right of questioning and/or disagreeing to specific individuals who have already shown their behavior to be compliant and accepting of the authority. Should a technician or aide choose to disregard the existing system and become critical, he or she will often find herself in the position of doing the hardest or most disagreeable work on the ward. Coffee breaks, for example, can be suddenly and effectively denied a person by making assignments that require his presence with a large group of patients away from the coffee room and providing no relief for him. Technicians might also be required to wash walls or do nothing but change diapers all day. Those individuals who fit well into the system are assigned the more pleasant tasks like doling out medications or serving as relief charge. By judicious use of these ward contingencies then, the ward charge can and often does effectively eradicate from the employee the processes that result in thinking about programming and critically examining the procedures followed. The long term effects of this differential reinforcement cannot be underestimated. Thus, when a new ward program requiring independent judgment and critical evaluation is built into the contingencies of staff behavior, it may often meet with considerable resistance and, as a consequence unrest, and/or frustration. It was foreseen before the program began that the token economy project would require from employees a high level of functioning and demands that they had not met in previous assignments in the hospital. The degree to which these differences would exist was not foreseen. The TEP requires that people now entering the program master in a relatively short time a highly complex ward regime. This ward regime evolved from a relatively simple state in the original days to the current highly sophisticated and carefully thought out procedures that exist. In addition, the employee is required to virtually memorize the programs of those individuals assigned to her, that is, those individuals for which she is a group leader. Unfortunately, the staff is also required to respond to residents not within their specific groups; hence they must know the generalities and specifics of programs for all the

residents. Since the programs have become highly individualized the staff may, for example, be required to ignore sullenness in one girl, to charge tokens from another girl for the same behavior, to seclude a third girl for the same behavior, and to deny the opportunity to work on certain jobs to a fourth girl. The staff further is required to make fine or difficult discriminations about a specific individual's emitted behavior. It becomes very difficult to determine when an individual is sullen, for example, or, even the degree of sullenness. Frowning for one resident may be considered sullen. Withdrawing from group interaction in another resident may be an indication of sullen behavior. Whereas, cursing in a third individual may not be considered sullen behavior. The staff has been assigned the responsibility of trying to assure that the programs are uniformly maintained across their shifts. Thus, one staff member may perceive a resident is sullen whereas another staff member may not perceive her behavior as sullen. When all technicians are required by a program to charge a certain girl a token if they observe her being sullen, this can lead to disagreement and frustration among the staff members. While the staff is generally very supportive of each other and tends to foster the feedback of the why's and wherefore's of differential discriminations between each other, fatigue and stress can often make the staff susceptible to a kind of threat when someone perceives them as not doing the job exactly as they should do it.

The TEP then requires that the highly compliant behavior that is demanded of employees on other wards and that has been previously so highly reinforced, now be extinguished, and that critical behavior, previously punished, now be reinforced. The ward charge is in the highly difficult position of providing differential reinforcement to these individuals. Removed from the ward charge are the usual armada of tools. On the TEP, virtually all ward assignments are rotated among individuals. Thus, no one individual is given a prestigious job such as the administration of medications or the writing of programs. Virtually all the TEP staff knows how to do all ward jobs. This demanding of knowledge of various subfunctioning jobs within a ward

places a great demand on an individual's flexibility and openness to new learning. These behaviors, again, are not required in the typical ward assignment. The TEP staff is virtually required to communicate freely with each other and to express not only their opinions but also their feelings about other individual staff members. These behaviors are also not required in other positions. The result of these multiple demands on staff can easily lead to confusion and frustration. Clearly, some staff members are more capable of tolerating an ambiguous situation and unstructured processes. Unfortunately, we have not yet devised a method of predetermining the degree to which an individual can function in a program such as the TEP. Were there other similar programs and demands made on individuals in this hospital, it would be possible to look at previous experience and to make some realistic prediction of future behaviors. Since there are no programs requiring the kinds of behaviors needed on TEP, there are no similar behaviors in which to predict an employee's future behavior on the TEP. It is entirely possible that an individual considered a highly inadequate, indeed a poor employee on one ward, would be among the best employees on the token economy project. We are aware that it is necessary for a technician to be highly intelligent in order to function adequately on the TEP. Every effort has been made to attempt to secure the brightest staff possible, that is, those who are most capable of things like verbal learning. We are also aware that the TEP requires highly energetic individuals. On a typically poorly staffed ward it is quite possible to justify a relatively high degree of inactivity by saying that we are understaffed and we can't do many things. The TEP can make no such statement. There are almost always enough people around to do things. The staff, therefore, is required to function at a level of activity significantly higher than on virtually any other hospital assignment.

The behavior of the ward charge on the TEP also differs greatly from typical ward charge assignments. As previously suggested the typical ward charge is often a highly autocratic and authoritarian individual. She tells her employees what to do and how to do it.

It is possible she might demand that only two pins be used in a diaper, and if a staff member chooses to use more he or she would receive due criticism. The complexity of the TEP required that the ward charge be anything but authoritarian. The ward charge differentially reinforces independent behavior and ignores or mildly punishes dependent behavior among the staff. Thus, when a staff member came up to the ward charge and required a decision as to whether a situation should be handled one way or another way, the typical response from the ward charge was "you make a decision and then explain to me what you did and why" or "you know the situation and you make the decisions." This often placed the staff in the position of considerable stress. The charge then reinforces by agreeing with or approving what was perceived as correct decisions and disapproving or disagreeing with incorrect decisions in as mild or as pleasant a manner as possible. Thus the staff is not punished or only minimally punished for inappropriate decision making. When the ward charge refuses to make decisions for the staff and reinforces the staff for making independent decisions on its own, she places herself in a relatively new and difficult position. The staff was accustomed to having decisions made for it. While the staff often had verbalized that it wanted to be able to make decisions itself and wanted the right and authority to change things that weren't good, this new-found freedom often became uncomfortable and difficult for the staff to manage. The charge's behavior then placed her in the position of being perceived as a person who was incapable of making decisions. It's so much more comfortable to have a decision made for you and then to criticize the decision if it is not an effective one. When the staff was required to decide for itself which would be the most effective way a patient's behavior should be reinforced and which behaviors should not be reinforced, the staff was thrown into a stressful situation. The ward charge had to learn to tolerate the presence of the stress and to reinforce those individuals who were able to make decisions under stress. Moreover, the ward charge received much of her

differential reinforcement from the ward psychologist and the project director as well as from her own supervisor. This potentially can place the ward charge in a highly stressful and conflicting situation. If supervisors demanded that she make decisions and the ward psychologist demands that she does not make the decisions, she must effectively work out a compromise situation. This token economy project has been fortunate to have supervisors who have been able to allow the ward charge to make a great number of decisions on her own and further to allow her staff to make a great number of decisions. This too requires that the nursing supervisor be placed in a new and stressful situation. The supervisor must support the ward charge in the decision making processes and/or her delegates for these processes or make the decisions herself. Fortunately, in the present case, we have had nursing supervisors who have been willing to grant the ward a functional autonomy that was previously unheard of in this or similar hospitals. Here again the assigned autonomy must again be supported by the ultimate in the nursing hierarchy, that is, the superintendent of nursing services and the hospital superintendent.

To return to the function of the ward charge it should be most clearly stated that the effectiveness of this token economy project as all other special hospital projects depends on the effectiveness of the staff's carrying out programs. In the case of the Pacific State TEP, the staff has responded magnificently by tolerating great ambiguity and lack of structure and by assuming new roles that were often extremely uncomfortable for them. The focus of these discomforts had to be directed toward the immediate ward supervisors, that is, the charges and relief charges. Once again, ward supervisors were able to allow individuals a great degree of autonomy and freedom in decision making processes. At times it has become a highly delicate decision as to when you intervene in a situation and attempt to change a procedure or process that occurs while on the ward. The ward charge must tread a highly difficult and narrow line as to when to allow autonomy to continue and to allow an individual to work himself out of a complex disagreeable situation, and when to enter the situation and make direct recommendations or even issue direct orders. For-

tunately, the ward charge has been able to tolerate this stress and ambiguity to a very high degree. It is doubtful that any ward in this hospital or perhaps any hospital anywhere has effectively developed a degree of staff involvement that approaches the current involvement. The staff frequently takes home literature to read at night, cases to write up and to present, or data to be analyzed. The staff has accumulated considerable overtime, some of which they may never be able to take off. Despite the stress and frustrations, the staff's incidence of accident and/or sick time was probably one of the lowest in the hospital.* I feel all this can be attributed to the staff's being involved in the decision making processes and, as a result, developing a feeling of responsibility that the decision be carried out correctly.

In recent months it has become apparent that the highly complex nature of the individual patient programs and the highly complex ward routine may have evolved into a state of complexity that may be becoming unmanageable for the ward staff.** It is possible that the individual programming has resulted in the staff being forced to make discriminations that are so fine and complex that they are being subjected to a degree of stress that is beyond their tolerable level. Should this be the case, the project can and will change the kind of decision making processes required of the staff. There obviously is a limit to the degree to which any ward staff can be expected to make and effectively utilize a discrimination making process. Unfortunately, there is no way to predetermine the degree of stress that will be fostered as a result of making programs increasingly complex and difficult. Perhaps one of the outstanding characteristics of the Pacific State TEP has been the fact that it has continually remained viable despite continuing changes.

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*During 1967 the Token Economy Ward staff averaged 4.2 sick leave hours per month; hospital wide, Nursing Services averaged 7.4 hours. The corresponding data for 1968 were 4.9 versus 6.2 hours.

**Editors Note: The development of three basic treatment programs (see Sibbach's description of TEP) has reduced this complexity.

INITIAL SELECTION OF PATIENTS

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Pacific State Hospital

Given authorization to initiate a token economy program, one is then forced to select the subjects or patients with whom the program will work. The question then becomes, where do the patients come from and what will they be like. There are a limited number of possibilities that exist in a practical setting. The TEP may be forced to utilize a physical plant that is being used for the housing and care of patients. It is quite possible, indeed even probable, that in many cases TEP would be required to take over a ward or housing unit and to work with the residents or patients on that unit. Under unusual circumstances it may be possible to build or reconstruct a new unit. In the latter case, patients would have to be selected from other wards, living units or from new admissions entering the institution. Just as selection of staff is a crucial variable in the effective operation of a TEP, so also is the selection of patients. When one is forced to accept an existing group of patients, this can provide a variety of problems that will have to be contended with. Established social relationships between the patients will have to be contended with in the institution of a token program. Even among the mentally retarded there are existing patterns of power structure and interpersonal relationships that must be considered. In our case it was possible to select a variety of patients from the hospital at large. The selection of patients required that we first establish some sort of criteria. The program director had envisioned that the TEP would prove an ideal way to contend with a group of highly institutionalized individuals with comparatively few physical and emotional limitations. That is, the director suggested that we direct our operations toward those people who were housed at this hospital because they lacked the motivation "to get to work and to get out of the hospital." That there are a number of these patients is unquestionably true. The next problem was to find them. Pacific State is unusual in that it has

a computer-based, up-to-date population movement survey. The staff was able to ask the computer to select and advise us of those patients who were above 50 IQ, without psychosis, without severe physical impairment, and not combative or strongly antisocial. Following the listing of these patients we then deployed members of the psychology department staff to the wards involved to approach their teams for information about the list of patients and/or nominations for the token economy program. It soon became apparent that the so-called poorly motivated patient existed in far fewer numbers than we had expected. The other potential explanation was that these patients were so well institutionalized that the ward staff on the particular wards at which they were then housed were not willing to give them up. It may be that while many of these patients are poorly motivated they still remain a very minor problem to the ward staff. Indeed, they tend to be a major advantage to have on a ward. Many of them can be induced to work and as such are considerable assets to any ward or to any work program. The nominations forthcoming from selected wards resulted in a list of female residents who were often described as "behavior problems." It's traditional in total institutions not to transfer off good patients but rather to get rid of your bad patients. Thus, when asked for nominations for token economy program the wards probably tended to delete from their particular populations those patients who were problems to them. Problems to a ward are not individuals who don't work effectively but rather those individuals whose behavior is such that they cause some sort of trouble. We, therefore, find a potential pool not of poorly motivated people but rather a pool of troublemakers. Patients are transferred only on the recommendations of their ward team,e.g., their ward physician and ward charge, etc. The highly considered and reasoned suggestion that TEP could most effectively deal with the poorly motivated now becomes an absurdity. In practice TEP became a means to deal with those individuals who were problematic.

A list of "suitable patients" was prepared for consideration. The initial notion that the patients be above 50 IQ and that they be poorly motivated was rejected and a new list therefore dealt with individuals

who were primarily behavioral problems. The list contained individuals who ranged in chronological age from 15 to 40 and in measured intelligence from 27 to 80. All of these potential subjects were toilet trained and were free of serious physical impairments that might impair their functioning in a program.

It was established as a result of negotiations in the initial planning that for all patients included in the program a parent or guardian would have to sign a consent slip agreeing that their child could participate in a special training program and that the training program would require their full cooperation. The parents of potential TEP residents were advised that a full description of the program's goals and methods would be forthcoming in group discussions with the hospital's chief psychologist. Subsequently, Dr. Ball gave "seminars" to parents of potential residents at Pacific State Hospital and in Los Angeles. In these seminars the parents were advised that their children would have to earn all aspects of their daily living accomodations, including meals. They were, further, told that physical status would be carefully monitored, medically. An unusually large percentage (90% +) of the parents who attended these seminars were willing then to sign permission slips (see Consent for Token Economy Program, Policies and Procedures Section). The permission slip did not guarantee the inclusion of their child in the program but merely indicated their willingness to be included. The next step was to select a series of twenty-one patients from whose parents we were able to obtain signed permissions. Further, since we purportedly would have a relatively large pool to select from, we would choose those patients with whom we would seemingly make most rapid progress. In practice, the staff was forced to select the first twenty-one patients for which we had parent consents. This rather rapid selection proved necessary because the ward was then functionally available to receive patients and as such we were then contending with the existence of twenty-one hospital beds unoccupied.

It should be noted at this time that again the TEP was bypassing current procedure in establishing new precedents by selecting patients

for a ward program in this manner. To begin with, most previous programs have been required to select patients on the basis of their availability as specified by social service department. In most previous cases social workers had contacted parents and discussed with them different programming for the children and the relative attributes of different sorts of programs. In the present case parent contacts were made by a psychologist. This process in itself was enough to arouse some considerable resistance from key members of the social service department. Although a social worker was assigned to work with the project team at this point, the formulation of the letters and the seminars themselves were conducted by psychologists. Since not all parents did sign consents, it is difficult to determine to what degree the introduction of the concepts of the program influenced the relationship of those non-consenting parents with the hospital program. Fortunately, there were no cases reported of parent resistance or parent hostility. In retrospect, it seems that the idea of inviting parents or guardians to a group discussion about a potential treatment program would seem a highly effective technique. The management of paper work processing of parent consent forms can be best handled, probably, by enlisting the assistance of social workers* and/or other personnel who are well versed in the logistics of paper work processing and also are aware of legal requirements and/or established requirements at the hospital level.

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*Editors.Note: Fortunately, the ward now enjoys the excellent contributions of Mr. Al Ekkens, social worker. Mr. Ekkens is effectively and skillfully handling parent contacts and many other social service functions.

DESCRIPTION OF THE TOKEN ECONOMY PROGRAM

Lois Sibbach, RN

Pacific State Hospital

Staff Orientation

Patients did not arrive on the Token Economy ward until two weeks after the program officially began. The first week prior to their arrival was spent orienting staff to the principles of operant conditioning techniques. Lectures and discussions were conducted by the program director, three psychologists who were to be ward consultants, the ward physician, and the social worker assigned to the program. Reading material* made available for further enhancement of lectures included:

Keller, Fred S. Learning Reinforcement Theory, Random House, 1954.

Bijou, Sidney W. and Baer, Donald M. Child Development I, Appleton-Century-Crofts, Inc., 1961.

"Reinforcement Therapy", a supplement to the film, "Reinforcement Therapy." Smith, Kline and French Laboratories, Philadelphia, Pa., 1966.

Films on behavior shaping were shown.

Because staff chosen for the program had had no exposure to the concepts to be used, a foundation of terminology and definition had to be laid. This was then enlarged in terms of staff-patient interaction as related to the aims and goals of the program.

In retrospect, this intense indoctrination without the opportunity for practical application was not the most efficient way to orient staff to a Token Economy Program. Shorter lectures, extended over a period of two to three weeks, coupled with experiences which could be discussed in terms of theory thus far presented would have led to quicker clarification. So much had been presented so quickly that there was no

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*Editors Note: An updated reading list would include: Ayllon, T., and Azrin N. The Token Economy: A Motivational System for Therapy and Rehabilitation; and Schaefer, H., and Martin, P. Behavioral Therapy (see references on page 12).

time for internalization. During the weeks that followed much time was spent consulting with the ward psychologists and a great deal of effort was expended equating theory with practice. A less intense orientation period might have avoided this situation.

Baseline Observations*

After orientation week, staff went to the wards where patients chosen for the program were residing to make behavior observations. Observations included eating, personal appearance, use of leisure time, peer interaction, work skills, initiative, attention span, and behavioral attitudes. Observations were collected on 3 x 5 index cards and observers were rotated from day to day.

Behavior observations continued for three weeks after patients were admitted to the ward. Groupings of behaviors to be reinforced or ignored/extinguished were made and applied generally to all residents. After tokens were introduced appropriate behaviors such as cooperativeness, politeness, grooming improvement, mature behavior, speaking clearly, and good eye contact were reinforced with one or two tokens

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*Editors Note: A summary of transfers and community placements from the Token Economy ward was prepared on 3/18/69. At that time, five patients had been transferred to other wards. Of this group, two had been transferred because of prolonged psychotic episodes during which time it was necessary to maintain a locked ward. One was transferred because of persistent run-away behavior, also, necessitating a locked ward policy. Another patient was transferred after only three days on the ward because of run-away behavior. After returning to the hospital from an AWOL she was transferred to a locked ward. Another patient was transferred to another ward after having received moderate but significant benefit from the program. Eight patients are presently being processed for Foster Care homes. Three patients have been returned to their own homes. Thirteen patients have already been placed in various kinds of Foster Care placements (Family Care, ATD, APS).

and verbal praise. Maladaptive behaviors were ignored and, whenever possible, their absence reinforced.

In addition to these general observations, a Rating Scale of dependent and independent performance was used (see Appendix N). This scale determined each patient's level of functioning and, subsequently, what areas needed improvement. Grooming, manners, and personal hygiene were handled in group sessions with individual follow-up. Verbal praise and tokens were given for any attempt at improvement. Much teaching was on an impromptu basis. Attention span variances and differences in frustration tolerance accounted for some individualized instructing.

Patient Orientation

At the beginning of the third week patients arrived on the ward, were assigned rooms and given minimum explanations of expectations, such as making beds and keeping rooms neat and clean. Rooms were bare in appearance--containing a bed, nightstand, and metal wardrobe locker. No curtains, bedspreads, throw rugs,or pictures adorned the rooms.

This week was devoted to orienting patients to the ward. (The label of "patient," which gives an impression of illness, was replaced with the title of "resident.") Residents were allowed to carry on their current work assignments and structure was minimal to help facilitate adjustment to the ward. This also allowed staff greater freedom to become acquainted with the residents and familiarize themselves with the ward. Staff was asked to continue noting behaviors which might be significant in terms of incorporation into subsequent programs. Typical notations during this period include:

"Cooperative, interested in ward routine."

"Concerned over possessions."

"Anxious to return to work job."

"Depressed, fear, anxiety."

"Suspicious, but cooperative."

"Quiet and concerned."

"Restless, disorganized. Needs much supervision."

"Needs direction and supervision to dress and make bed."

Introduction of Tokens

Ten days after residents arrived on the ward tokens were distributed for the first time. Residents had been prepared with explanations of what tokens were, how they could be exchanged for meals and other privileges such as dances, treats, etc.

A concurrent introduction of a new vocabulary began at this time. Words such as "privilege," "appropriate," "behavior," and "peer" were introduced and defined for the residents. As the program expanded, additional words were included--"personal hygiene," "grooming," "socialize," "inappropriate," "well-groomed," etc. These and many more have become a part of residents' vocabularies. At no time have staff resorted to "talking down" nor have they put conversation on a level too complex for residents' comprehension.

As residents demonstrated initiative (but not necessarily ability) they were rewarded with the plastic tokens which resembled real money in denomination, color, and size. One cent and five cent coins were first introduced, producing one of the first learning situations of the program. Many residents had no concept of money value, nor were some capable of counting beyond two or three numbers.

Preliminary requirements for each resident included personal grooming (hair combed, lipstick, clothes neat and clean), and a neat room (bed made, floor swept, room dusted). "Room checks" were conducted three times daily, one-half hour before each meal. Tokens were given for each requirement attempted or done satisfactorily. In addition, verbal praise and explanations of how skills could be improved were given and time was spent teaching those who had little knowledge or skill.

The economy was structured so that a balance existed between the cost of necessities (meals) and the number of tokens which could be earned at room check time. Successful completion of minimum daily living requirements (passing room checks) would provide only the tokens necessary to purchase the next meal. Since appropriate grooming included the use of toothpaste, deodorant, and cosmetics, residents were motivated to perform additional tasks which would give them the

tokens necessary to purchase these items.

The scope of token-earning tasks was gradually enlarged to include a ward housekeeping task, daily ironing, showers, shampoos, an off-the-ward job and individualized requirements, i.e., socializing with peers, reading, speech, crafts, games, etc.

Ward Store

An on-the-ward store, named "The Pink Elephant" by the residents, offered various items which could be purchased with tokens: jewelry, nail polish, cologne, lipstick, hand lotion, hair spray, deodorant, tooth paste, candy, fruit, and cookies. Food items could not be purchased if a resident had not eaten the previous meal.

Activities

The increase in earning power made it possible to acquire minimum daily necessities and participate in an increasing number of activities. The following privileges were made available for a token charge commensurate with the economy:

Dance)
Go-Go) Once weekly activities
Movie)
Recreation Hall)
Swimming
Picnics - on grounds
Picnics - off grounds
Trips off grounds
Visits
Leaves
Parties
Canteen trip - 1/2 hour
Use of record player - 1/2 hour
Watching television
Naps
Phone calls home
Overnight at residence
Walk - 1 hour

On the ward task completion, appropriate behavior and personal appearance were prerequisites for participation. Any outstanding fines also had to be paid.

(At this time the program functioned with a locked ward policy and residents were escorted to and from activities by staff.)

Individual Programs*

A Kardex was set up containing 5 x 8 cards for each resident. Each card had two headings, "Behavior to be Reinforced" and "Behavior to be Extinguished." As behaviors were observed they were entered on the cards in the appropriate columns. This was the beginning of individualizing approaches. The cards were the first "programs" written (see Appendix A).

Off-Ward Work Assignments

The Token Economy program was expanded to include off-the-ward work assignments. Residents with more extensive capabilities were given assignments requiring minimal supervision from staff. One girl worked in the employee's dining room, one with a psychiatric technician who was also a trained beautician. Two girls worked together on an infirm ward making beds, doing errands, sorting and folding linen,and doing general housekeeping. Another resident did similar tasks on another ward.

The remaining residents either were not skillful enough or their behavior did not warrant working without supervision from staff. An arrangement was made with a nearby ward to do dormitory housekeeping for two to three hours each day. Tasks included making beds, sweeping and mopping, and bagging laundry. Residents were divided into two groups, each with a staff member supervising, demonstrating,and teaching. Emphasis was put on development of helping relationships, sharing responsibility, neatness, cleanliness, teamwork, and initiative. Staff attempted to relate each learning experience to home situations,e.g., responsibility for one's own bedroom, sharing tasks, care of possessions, and doing chores which are not necessarily enjoyable, but must be done.

Each resident was given a card to carry and present for a staff member to sign when her off-ward job was done. Every evening at pay call cards were presented to the paymaster, marked "paid" and tokens given providing there was a signature. Staff prompting, either to do a task, or to obtain a signature was minimal, except for emphasizing generally that assumption of responsibility is rewarded.

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*Editors Note: Dr. Richard Nies, our first full-time TEP ward psychologist, established the initial model for program writing.

Use of Vacant Doctor's Residence

A vacant doctor's residence on the hospital grounds was made available to the program. The residence, a furnished two-bedroom house, was used to enhance general learning gained on the ward. Exposure to a simulated home setting proved exceptionally valuable. On hospital wards, planning is directed toward the care of large groups. The residence made it possible to expose residents to the kinds of situations they would encounter at home or in a foster-home placement. Some residents could run a commercial ward dishwasher but knew nothing about washing dishes in a kitchen sink. On a typical ward, showers are turned on and off by staff and water temperature is automatically controlled. Food is prepared and delivered to wards from a main kitchen.

The availability of the residence made it possible to provide domestic situations which would make the transition from an institutional setting to community living much easier. A group of six residents spend the evening and overnight, three times a week. Girls share bedrooms and are responsible for their appearance. The group as a whole participates in keeping house,i.e., vacuuming, dusting, furniture polishing, doing dishes, cooking, baking,and meal planning. Nutrition, preparing food from recipes, table setting and etiquette, and the care of foods are also stressed. Each resident prepares her own breakfast, choosing from a variety of hot or cold foods. Evening activities range from group discussions to just popping corn and viewing TV.

The residence is also used for special social activities. Parties to which residents may invite "dates" are held. Residents plan the refreshments, decorate the home, bake,and do all necessary party preparations. Groups have planned, prepared, and served dinner to their parents. Upon one occasion, the residents baked a "graduation" cake as a surprise for a resident leaving to live in the community.

Stabilization of Structure

Approximately five weeks after residents first arrived on the ward the basic structure of the program had been established.

Money matters were discussed in terms of "cents" not tokens, and as comprehension and ability to equate tokens to money occurred, the

cost of living increased. The price of meals increased from 2¢ to 5¢ and "seconds" and desserts cost an additional 5¢. To bring attention to food items which should be eaten sparingly (potatoes, breads, desserts, rich foods) extra charges were made for them and explanations given,e.g., "This is very starchy"-"Lots of calories in this," etc.

Cigarettes were first sold by the pack at prices comparable to those in the community. This was soon changed to one cigarette at a time. Some residents without permission to smoke were found to be offering pack-owners exorbitant amounts of tokens for one cigarette. Those who spent tokens for cigarettes in preference to meals were not allowed to smoke unless they had eaten the previous meal. Cigarettes were such powerful reinforcers for some that their purchase was made contingent upon the demonstration of certain behaviors or the completion of a certain number of tasks.

Some residents went to great lengths to circumvent smoking controls, and thus program enforcement. Cigarettes were solicited from friends at the canteen, staff on wards where the residents worked,and parents who were not aware of the program's smoking policy. When these methods failed, butts were scavenged from ashtrays and wastebaskets.

It was of note that while residents were extremely skillful in procuring cigarettes,their subsequent attempts to smoke secretly were quickly spotted. Two residents, usually quite social, took to periods of sitting by themselves in the yard--to smoke. Another spent an unusual amount of time in the bathroom--an area not frequented by staff. Cigarettes were found hidden in underwear, shoes, under mattresses, in pockets, purses, even in utility closets and outside the ward.

Action taken to bring this problem under control included suspension of campus privileges, fining when caught smoking illegally or in the possession of cigarettes, loss of legally earned cigarettes. Staff on work wards were advised and parents informed of the program's smoking policies. Staff developed an anticipatory awareness of these resident's behavior patterns in regard to smoking. They became such skillful sleuths that their confrontations and consistent application

of programmed controls made this a problem of short duration except in one or two instances.

Room Rent

Room rent, 20¢ a week, was due each Monday evening. Until rent was paid, all other spending privileges, including meals, were suspended. Padlocks and keys for wardrobe lockers could be rented for 7¢ per week.

Responsibility Levels

An "open ward" policy was initiated toward the end of the second month. Prior to this residents had not been allowed to attend activities unless escorted by staff, nor had visits or weekend leaves been permitted. Each resident was assigned a "responsibility level" which could be raised or lowered according to the dependability displayed. "Campus Alone," "Campus with two others," and "Campus with staff" were the levels set forth depending upon responsibility for complying with program policies, promptness, etc.

A staff member was designated as monitor, and responsibility for reporting to the monitor upon leaving and returning to the ward was placed on the residents. Lateness in returning resulted in a drop in level or suspension of campus privileges for varying durations depending upon the severity of the situation. Each girl was issued a Campus Card and required to carry it whenever off the ward. Suspension of Campus Cards resulted in staff escort to and from required activities such as school, off-ward job, clinic appointments, the dentist, etc. Canteen trips, dances, and all off-ward social activities were not permitted during loss of Campus privileges.

Phone Calls

Administrative approval was granted to allow phone calls to parents. One call per month, for a charge of 20¢ in tokens, was permitted with conversations limited to five minutes. The ward social worker contacted parents to be certain calls would be welcomed and to ascertain the most convenient evenings to place the calls. This was a precedent. No other ward does this.

After the introduction of Special Reinforcement Tokens phone

calls were paid for with these "behavior tokens" instead of regular tokens.

Bank, Contract Buying

A bank was established and incentives for saving money were made available in the Pink Elephant. Transistor radios, room adornments, records, and magazines were among the items obtainable for token prices commensurate with the program's economy. Curtain, bedspreads, throw pillows, scatter rugs, and all other items costing 50¢ or more, could be purchased on the installment plan for 50¢ down. Three payments, one each week, completed the contract. If a payment were missed, the item was repossessed. Bank books were issued and banking hours held three times a day. Residents were encouraged to "save for a rainy day", i.e., deposit small amounts frequently for room rent, trips, beauty shop appointments, visits and parties.

CONTRACT

NAME:_____

ARTICLE:_____

DATE OF PURCHASE:_____

PAYMENT:

#1_____ #4_____

#2_____ #5_____

#3_____ #6_____

FINAL DUE DATE:_____

TOTAL PRICE:_____

STAFF INITIALS:_____

RESIDENT'S SIGNATURE:

_____

LS:rrg
6-11-68

Program Complexities

The Token Economy Program functioned with the previously described format for about two months. During this period it became evident that the bases upon which programs had been structured were not specific enough to deal with the variety of behaviors being exhibited. Programs became more complex as residents adjusted to their new home, settled down, and shed their "party manners."

One resident, institutionalized for seventeen years before admission to the program, had spent a major portion of that time sitting, smoking, and remaining on the periphery of the world about her. She protested having to assume the responsibility for earning cigarettes, food, and lodging.

Another, a product of the Watts area of Los Angeles, knew no way to survive except by her wits, intimidation, and extortion.

Others, habitual liars, delinquents, low-motivated or lazy individuals, expected to blend into the environment and be given comfortable, cozy situations similar to the ones where they had previously resided. Adverse behaviors began to emerge as residents challenged demands made upon them.

As maladaptive attitudes were displayed they were noted and modification techniques instituted to deal with them. Each program was unique in some respect. One resident might participate in the school program and be required to spend some time each day socializing with staff or peers. Another program emphasized sensory-motor training and speech, and yet another would include none of these. In theory, this ultra-refinement and individualized approach was ideal. In practice, staff were overwhelmed in their efforts to remember and implement the increasingly complex programs. Each staff member supervised a group of four residents. Because of staff days off, illness, or vacations, an additional girl or two might temporarily become a member of another group. With at least a dozen assigned tasks per resident, and these individualized for each, it was almost impossible to keep up with tasks completed, what behaviors to reinforce, ignore, extinguish and "fine." (see Appendix B) Much staff time was spent checking and reviewing

programs to be sure each resident met all of her daily assignments. Residents were becoming as overwhelmed as staff.

Job Cards

For staff as well as resident's clarification, a small card was designed which listed each girl's daily tasks. Each staff member carried her group's cards and made appropriate notations as tasks were done. The cards covered a one-week period and included all requirements from arising to bedtime. Daytime personnel gave their cards to a corresponding group leader on the afternoon shift with a brief report on the day's activities.

Eventually, the responsibility of carrying the "job card" was given to the residents. This reduced the anxiety of not knowing what to do and having to seek a staff member to find out what tasks were not completed. Residents were encouraged to do tasks on their own and have their group leader check the product of their efforts when finished.

Until this time, pay-call for all jobs completed during the day was held each evening. With the introduction of job cards, payment was made at the time of task completion. If jobs were done unsatisfactorily or not at all, an "x" was placed in the appropriate square. Tokens were charged for non-completion. A sliding scale payment was used for those who had made some attempt to complete a task, and individual abilities were taken into consideration. Some might receive partial payment because of obvious laziness or "goofing." On the spot payment made it possible to give immediate reinforcement upon task completion. Previously, with the paycall method, a delay of as much as six to eight hours occurred between task completion and reinforcement other than general feedback.

JOB CARD

9-15-68 Joan P.

		M	T	W	Th	F	S	S
Person	5/5		pd					
Clothes	5/5							
Shoes	5/5			X				
Rm & Locker	5/5							
Exercise	5/5							
Ward Job	5/5							
Off Wd Job	4.50			pd			-	-
Wash Clothes	5/5							
Shower	5/5							
Social w/ peers	5/5							
Iron	5/5							
Homework	5/5						-	-
4:30 Rm Check	10/0							
Crafts	5/5							
Game	5/5							
Shampoo	5/5	-	-		-	-	-	-

Squares are marked "pd" if a task is satisfactorily completed and 5¢ in tokens paid.

An "x" is marked for non-completion of a task.

"Ex" is marked to excuse a task. (when resident on leave, ill, visit, etc.)

5/5 - the first number indicates the amount to be paid, the second the amount charged for non-completion.

A "-" indicates the task is not required on that day.

Intershift Communication

With the relinquishing of job cards to residents' care, a drop in intershift group leader communication was noted. Time wise, it was not practical for staff to report about each group member to the ward charge and she, in turn, to the afternoon shift. Reporting diminished to highlights of the day's activities with more emphasis on the negative behaviors. Unpaid fines were sometimes the only evidence of a resident's efforts for the day.

An attempt to deal with this intershift communication problem was made through the introduction of notebooks for each of the five resident groups. Each notebook contains copies of group member's programs and

group leaders are encouraged to enter notes in these books in lieu of a verbal intershift report. Notes may cover program change suggestions, successful techniques used, behavior observations--any special aspects of the day. At the beginning of each shift group leaders check their notebooks for pertinent information which can be used in approaching their group and dealing with behavior. At such time as programs are reviewed much guideline information for revisions will come from these notebooks.

Group leaders give a general report to the shift charge if something has occurred which should be made known to all of the oncoming shift.

Grouping

For some time thought was given to the practicality of incorporating "grouping" into the Token Economy Program. (This is not to be confused with the number of residents in groups assigned to each staff member.) Performance was such that grouping in three general categories was possible. Groups were designated by color, Red, Blue, and Green.

Residents were primarily assigned to groups according to capabilities and/or level of responsibilty. Those with the greatest need to improve in grooming and skills of daily living were placed in the Red group, as were those who needed the most focus on behavior. Those who were meeting program expectations with the least amount of difficulty were placed in the Green group. The balance of the residents were performing somewhere between the two groups and became Blue group members.

As residents progressed, appropriate promotions from Red to Blue to Green groups were made. Promotions were dependent upon consistent task completion, lessening of problem behaviors, and increased assumtion of responsibility. Concomitant with promotions were increasing privileges such as dances, wearing private clothing, unsupervised Canteen trips, higher earning power (see Appendix C).

Demotions could result from AWOL, continued tantrum and destructive behavior, repeated lateness, lack of responsibility in completing tasks, poor grooming and personal hygiene, bullying, and other inappropriate

social behavior.

Promotions or demotions were also made on a probationary basis in instances where only one or two factors were involved, i.e., personal hygiene, tardiness, or poor grooming. During the probationary period much emphasis was put on elimination of the specific behavior.

Promotions and demotions were discussed at the weekly intershift meeting and put into effect following the meeting. Soon, residents began campaigning for promotions two or three days before the intershift meetings, and noticeable improvement in behavior and task completion could be seen in this time. Promotion time was changed so that residents could not predict when a promotion might occur. The possibility that promotions and demotions might not necessarily be discussed at each weekly meeting was stressed, and when promotions did occur they were put into effect at random times of the day and week. Demotions were usually made after each meeting, but occasionally were made at the time of gross program deviation, i.e., AWOL, extreme persistent aggressiveness, or stealing on an off ward work assignment.

Token earning power was adjusted for each group so that residents could earn enough to support themselves and afford whatever privileges were available to their group, provided most daily tasks were acceptably and consistently done, and a minimum of fines incurred. Red and Blue groups received on-the-spot payment. Pay scales for the Red and Blue groups were identical (5¢ paid for each task completed and 5¢ charged for non-completion) with the exception that the Blue group could earn up to 50¢ more per day on an off-ward work assignment. Payment for the off-ward job was not made immediately, but awarded after return to the ward--an introduction to delayed reinforcement.

The Green group received a weekly salary of $25.00 which provided the opportunity to learn budgeting and experience an extended period of delay of reinforcement except for verbal reward. The cost of living was proportionately higher for this group. (Room rent, $5.00 per week; meals, 50¢; pay for completed tasks, 25¢). Green groupers continued to carry job cards although payment for task completion was

made weekly. They were still held responsible for obtaining signatures for each job done. Non-completion resulted in an "x" being placed on the job card. On payday, "x"'s were tallied and 25¢ deducted from salaries for each "x."

As residents progressed from group to group more activities became available. See Appendix D for a list of costs according to the group membership.

Eating arrangements were set up according to group membership. As one progressed from group to group, dining became more pleasurable and less structured (see Appendix E).

On-the-ward work experiences were provided for the Red group with much staff teaching and supervision. Residents in the Blue group were given an off-ward work assignment on a nearby ward. A staff member accompanied this group. Initiative was encouraged and routines were structured to foster helping relationships and autonomy. Pay was on a sliding scale according to attitude, behavior, initiative, and productivity (see Appendix F).

It was necessary to lessen the amount which could be earned by Blue groupers when it was noted that they could earn enough on the off-ward work assignment to afford the charges incurred when on-the-ward tasks were not done. Residents were paid 5¢ for completion, charged 5¢ for non-completion of tasks. An increasing number of girls began ignoring some of their responsibilities. Some were offering to pay not to participate in morning exercises. Others neglected some of their housekeeping tasks or offered to pay for non-participation in crafts, games, speech, or socializing. Some paid others to do their jobs. Upon investigation, it was found that approximately 35% of the Blue Groupers' daily earnings came from the payment received for their off ward job. This gave them enough money to afford to pay for not doing at least 1/3 of their other assignments. Deflation of off-ward pay corrected this problem. (Raising the cost of living would have also corrected this situation, but it was doubtful if residents were ready to work with higher denominations of money at that time.)

The ingenuity displayed by those residents who were circumventing their responsibilities is not to be discounted. Changing the economy forced residents to resume activities which had been individually structured to improve skills which, if lacking, would be a deterrent to community placement.

Green group members were given individualized work assignments based on their capabilities. The patients' library, laundry workshop, employees' dining room, and jobs on other wards were made available.

The Green group went to and from work unescorted. The work day was approximately six hours long with 1½ hours break for lunch. Girls were docked for lateness and for refusal to go to work. Periodic checks were made with "employers" and staff was available to work out any problems with places of employment. Each girl was required to have her employer initial her job card for each block of hours worked. If performance had been unsatisfactory, an "x" was marked and the resident was docked on payday.

The laundry workshop, a funded position, made it possible to earn a small amount of real money in addition to a weekly token salary. This money was kept on the ward and made available to residents to spend on outings or at the Canteen.

The laundry workshop is operated under the auspices of the Rehabilitation Department. This Industrial Therapy job provides an excellent opportunity for residents to learn skills which can be utilized in the community. The workshop is operated on a basis similar to employment anywhere. Lateness is not tolerated and employees are docked for tardiness and quitting early. Coffee breaks are provided. Quality of work is emphasized and good supervision and on-the-spot teaching insures a high quality of work.

Community Activities

During the first year of operation an attempt was made to give residents as many community experiences as possible. Activities included:

Griffith Park Zoo

Beach trips

Dairy tour

Shopping trips	Disneyland
Dinner out	Knott's Berry Farm
Bus trips	Santa Ana Botannical Gardens
Indio Date Festival	Drive-in Theater
Arboretum trip	Carousel Theater

Enthusiasm was very high at first, but as residents became more sophisticated more selectivity developed. Girls refuse to join in, showing a preference for remaining on the ward. Some, whose programs called for a token payment for non-participation in social activities, paid willingly not to go. The previously high anticipation and motivation to save money for trips dropped considerably.

Upon examining the situation, staff concluded that residents had been over-exposed to special activities. Off-grounds activities had been planned on a once weekly basis. Combined with the three evenings of weekly hospital activities (dance, Hollywood A-go-go, and movie), four out of seven days and/or evenings had been filled! All off-grounds activities were stopped for two months, and during this period an additional type of token was introduced into the program.

Introduction of Supplemental Tokens

As a supplement to regular tokens, Special Reinforcement Tokens were integrated into the program. These were to be awarded for highly acceptable behavior, and their acquisition would be symbolic to other residents that one had performed exceptionally well. It was hoped that this additional token would give staff the tool needed to turn focus from the control of behavior through fining to control by positive reinforcement. This is not to say that staff were not rewarding appropriate behaviors, but that tokens had lost a certain amount of meaning when used as a "reward."

Parties, special dinners for parents or friends, residence stays for the Red group, all off-grounds activities such as trips and shopping were made dependent upon SRTs rather than the regular token money. SRTs (numbered poker chips) could be earned by the demonstration of various behaviors which the program was attempting to strengthen (see Appendix C). In addition to these appropriate behaviors, SRTs

could be earned for spontaneous efforts involving initiative e.g., handling stressful situations well, helping others, marked independent efforts to improve grooming, manners, speech, control of temper, etc. A graph was posted so that residents could keep note of SRTs earned. A record was also kept by staff, describing the specific behavior for which an SRT was given (see Appendix H). SRTs were numbered to discourage stealing from one another.

Occasionally, residents were not allowed to use earned SRTs. AWOL, destructive or tantrum behavior, extremely poor appearance, or the loss of Campus privileges could exclude one temporarily from an activity. Credit for earned SRTs was not lost, but participation was postponed until a later time. Outstanding fines had to be paid before using SRTs.

By the time community activities resumed, residents had had ample time to learn the function of SRTs. The time lapse and/or the use of Special Reinforcement Tokens did much to raise the interest in social activities. Trips have since been planned less frequently so that a drop in enthusiasm will not occur again.

Variables in Program Application

The Token Economy program has concurrently applied various methods of behavior modification in attempting to alter behavior. Fining, on a general and individual basis, has been utilized since the early months of the program.

Charges or "fines" of 1 or 2 tokens were made for physical aggression, bullying, negativism to the extent of misusing equipment, bumming cigarettes, and intentionally ignoring instructions. It was necessary to impose fines for particular behaviors rather than attempt to ignore them. This control aided staff in "settling down" those who had been leaders by force rather than by group choice on their previous wards. Fining forced a degree of conformity. Money spent to pay fines made task completion a necessity if these residents wanted to partake of ward privileges and activities. (Leadership qualities were not stifled but attempts were made to channel them into positive directions.)

In reviewing the program's first year of operation it was noticed that "waves" of fining periods had occurred. Periodically, the greatest emphasis had been on the "don'ts," with the number of fines greatly outnumbering the reinforcement slips written.

It was previously mentioned that at the change of shift, "unpaid fines were sometimes the only evidence of a resident's efforts for the day." This was, indeed, a communication problem, but it also reflected staff application of the program. In reviewing the upsurges of fining, many variables were discovered that contributed to these episodes.

The physical structure of the ward lent itself well to the program in respect to each resident having her own private room. The limited space elsewhere made it difficult to effectively carry out some aspects of the program. Residents and staff functioned in such close proximity to one another that many times this claustrophobic environment fostered actions and reactions which might not have otherwise occurred.

The dayhall was used for ironing, hair setting, games, crafts, playing records, TV watching, sensory-motor training, dancing, and impromptu gatherings. This was a focal point of ward activity. It was also the only room available for these activities. The hall by the ward bank and store was another favorite congregating area. It was the crossroads of all ward traffic.

If one were to monitor the activities going on in one of these areas at a time when most residents were on the ward, the scene would be self explanatory. One resident might walk past another seated in the dayhall and stumble over outstretched feet. The seated girl might retaliate by kicking out or swearing, and the other return the kick or shout back. This could lead to fines for one or both or asking either or both to retire to their rooms if they became aggressive toward one another.

Staff attempting to ignore behaviors might be enveloped by several residents talking at once and, while responding, might find themselves reinforcing the ones they were trying to ignore.

Some residents, in their impatience for attention from staff,

might interrupt loudly, elbow through the group, shout, or whine until attention was received. Residents as well as staff responded with admonitions regarding interrupting, loud voices, etc. Those residents with low frustration tolerances responded with tantrums. Most of these behaviors have resulted from the limited confines of the ward. Staff have responded accordingly by fining. While fining was appropriate in such instances, it is recognized that many of these behaviors have been precipitated by inability to "spread out and relax." The recognition and reinforcement of appropriate behaviors was extremely difficult under these circumstances. In spite of these most challenging and taxing situations, the staff's frustration tolerance was commendable. In a different physical environment many of these actions might never have occurred.*

Increased fining has occurred during periods of staff shortage due to illness and vacations. While the program has what is considered to be a rich staff-to-resident ratio, the prolonged absence of personnel has resulted in doubling of assignments and absorbing of absent staff's groups into other groups. The fatigue factor was aptly demonstrated when two day-shift staff were gone, one for a month and the other for a two week overlapping period. This occurred at a time when influenza was prevalent and other staff were occasionally absent. While staff willingly assumed extra duties, the stepped-up pace, coupled with efforts to fulfill program expectations, produced a fatigue factor which resulted in a change in staff response.

During this time, and other periods of increased staff stress, an increase in fining was not demonstrated during that particular shift, but during the one immediately following it. It has been agreed that in instances of staff shortage the assumption of extra duties lends to

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*Conversely, the selection of a ward for token economy which is too spacious might lend itself to a diminuation of resident interaction with the environment by too much spreading out and a lessening of opportunities to develop appropriate peer and staff relationships.

more concentration on routine and less attention to resident functioning. Residents have less individual attention, and staff tend to be less critical or overlook fine points of individual programs. By the end of the shift a certain amount of "highness" amongst residents has developed. The staff coming on duty have the task of settling down the residents. Because of adequate ward coverage (not short of staff because of vacations and/or illness), they are better able to define inappropriate behaviors. This results in an increase in fines.

Similar situations have also occurred when an individual staff member has performed in such a way as to "blow up" her (his) group. The corresponding group leader on the following shift is then faced with the task of quieting the group before constructive program approaches can be initiated.

Staff have developed much insight into their own feelings and attitudes in relation to program approaches. Being able to identify bases which influence staff and, in turn, resident functioning has played an important part in the consistency needed for this type of program to be successful.

Staff have also developed increasing perception in recognizing repercussions resulting from day to day interactions: staff to staff, staff to residents, residents to staff, and even residents to one another. Personal problems, insufficient sleep, "vacationitis," and not feeling well are all contributors to upsurges of fining.

The importance of discussing the various situations which may precipitate waves of fining cannot be underestimated. To recognize, understand, and anticipate the variables which may lead to alterations in program application may be considered the primary behavior problem of a token program--shaping staff as a prerequisite to resident behavioral change.

Recently, all fining was stopped. Except in rare instances, i.e, AWOL or destruction of property, no charge is made for non-completion of tasks, napping, coming into the office or other staff areas uninvited, or general inappropriate behaviors.

At the time fining was stopped, three additional changes occurred

simultaneously. (1) Each resident's behavior status was reviewed and one or two target behaviors were selected for focus. (2) Costs for meals and purchases in the Pink Elephant were increased. (3) Staff began "flooding" the ward with Special Reinforcement Tokens.

Selected target behaviors were added to each resident's job card. Behavior was reviewed at room check time and initialed by staff if appropriate. If performance had not been appropriate, an "x" was entered, resulting in denial of all privileges including meals until an acceptable "block" of behavior occurred. (Blocks are designated as the periods between meals and the period after dinner until bedtime.) An attempt was made to relate appropriate behavior with privileges. An "x" could be marked on job cards at any time during a block by any staff member who witnessed a target behavior.

Except for explaining new or revised programs to residents, this was the first time staff discussed specific behaviors with residents in terms of making them aware of what staff were looking for and attempting to change in relation to behavior acceptable to the community.

Concerted efforts to improve have been seen in many residents. Some have become comfortable enough with their "faults" to be able to discuss them, ask for advice, or point out to staff when a stressful situation has not caused them to "blow up." The insight developed by some residents has also made them more aware of peer behavior. Upon occasion a resident might be heard to say to her peer, "You'll be k'd' forthat," or "You can't eat. You got an 'x' for behavior." Residents are adept at learning each other's behaviors and warn, help, threaten, or tattle about them, depending upon their relationships with those to whom attention is directed.

The cost of living was raised when fining ceased. Because of no token expenditures to pay fines, a surplus of tokens could have accumulated rapidly. Increasing the costs of meals and items in the Pink Elephant was aimed toward more realistic prices and also offered additional learning experiences in counting higher denominations of money.

Special Reinforcement Tokens replaced regular tokens for buying all off ward privileges.

Staff began a "total push" of awarding SRTs for even the smallest effort: getting something for someone, wiping up a spill, offering to help carry something, politeness, efforts to control tempers, comments such as, "Your slip is showing," "You look nice," picking up, straightening up, decorating the ward, volunteering--any effort, many times seemingly unimportant. Explanations of why SRTs were received were concomitant with awarding, as was verbal reinforcement, i.e., "Very good," "You did a very good job," "That was generous of you," etc. Staff also made it a point to openly discuss SRT rewarding within earshot of residents, giving specific descriptions of how well the resident (or residents) had performed.

Residents responded enthusiastically to the abundance of SRTs, and/or the good things they were hearing about themselves. Each resident soon accumulated an ample supply of SRTs and soon all residents were able to afford off ward activities, providing target behaviors were acceptable (see Appendix M). A chart was posted so that residents could contrast and compare how many SRTs had been accumulated. As SRTs were used they were crossed off on the chart.

Residents soon learned two simple equations from these program changes: SRTs = privileges, and X's = no privileges--or, specifically, a differentiation between appropriate behavior and its rewards and inappropriate behavior and its consequences--the basis of behavior modification. (It is of note that new program members respond with as much enthusiasm to the acquisition of SRTs and in like manner to the marking of an "x," as do residents who have been in the program for several months.)

This approach has been in effect for six months and shows no indication of losing its effectiveness. This is not to say that an immediate change was noted when fining ceased. On the contrary, maladaptive behaviors seemed to increase. Negating the control of behavior through fines undoubtedly amplified these behaviors at least in the minds of staff if not in reality. Staff had no alternatives but to ignore, ignore, ignore. In the days immediately following, residents made only one or two references to not receiving a fine "for a long time." (Residents were not told that fining had stopped.) If any

thoughts about fooling staff or staff becoming lenient occurred they were not stated. This was a trying transitional period for staff, who diligently gave SRTs, resisted impulses to reprimand, and ignored behaviors which had previously merited fines.

Residents were given ample opportunity to spend SRTs. Coincidentally, two social activities which are most looked forward to each year occurred during this period, providing strong motivators for earning SRTs. (These were the annual beach trip and weiner roast, and the Los Angeles County Fair in Pomona.) Shopping trips, off-grounds Sunday excursions, and swimming were additional incentives as well as regularly scheduled weekly dances, movies, and previously mentioned activities.

One might speculate that if this approach continues to be significantly effective it would be the method of choice in instituting a Token Economy Program. This is not necessarily true. The innovations recently introduced in the program could not have been as effectively carried out if staff had not acquired the background they now have in implementing various behavior modification techniques.

School Program

Staff had attempted to structure lessons in arithmetic, reading, writing, and telling time, but found it difficult to plan lessons without a resource person to establish guidelines. An appeal was made to the school principal, and a credentialed MR teacher was made available to conduct one class per week and assign homework (see Appendix I). Each resident's needs were evaluated and instruction planned. Residents completed homework assignments in the evening with staff assistance. To maintain continuity of instruction each girl was assisted only by her group leader, with homework assigned on evenings coinciding with the staff member's scheduled days on duty.

Program Refinements

As the Token Economy program progressed into its second year, it had reached its present operable state through constant updating, revising, and refinement.

When behaviors changed, programs were reviewed and rewritten. It became a policy to immediately review a resident's program if she

were demoted. Those aspects of behavior which led to demotion were reviewed and subsequent program alterations made The total program was constantly scrutinized with a view toward providing those experiences which would be most meaningful in terms of future community placement.

"Graduates" left the program to return home or to live elsewhere in the community. Those residents who were found unsuitable for token economy were transferred to other wards. As vacancies occurred new candidates were selected and integrated into the program milieu.

Program refinement took on a dual aspect. In addition to resident program revisions, constant updating of ward policies and procedures necessitated the establishment of some permanent guidelines for staff to follow. A Ward Manual was developed and included information for review as well as for orientation of new staff. Contents covered ward routines as well as policies relating to program application (see Policies and Procedures section).

Staff were given a more comprehensive view of the bases upon which programs were formulated by involving them in program writing. Each staff member selected a resident and, following a model outline (see Appendices J, K, and L), made observations, categorized them, and suggested modification techniques appropriate to the resident's needs. Subsequent meetings with the ward psychologist were held to formulate workable programs. A great deal of effort and enthusiasm was displayed by staff. Most important, the insight gained by this experience has led to many excellent suggestions when programs are updated and revised, and staff continue to write a majority of the programs.

The program has continued to explore areas which would provide meaningful training for productive work as well as home living. In too many instances community placement can result in just a change of living quarters, from the hospital to a home, without any sort of productive activity ensuing. The Token Economy program does not intend to place residents just for placement sake. Program goals include exposure to an enriched way of living in hope that these residents will learn that community placement does not mean leaving the hospital

to sit out the remainder of one's life in a home. Whether residents are capable of holding jobs or not, they can at least contribute to some degree in maintaining themselves as productive members of a household.

Sheltered Workshops

The recently opened sheltered workshop at Pacific provided the program with an opportunity to evaluate residents' adaptability to a work situation. The workshop, established and operated under the auspices of the School Department, offered the Token Economy program six job positions. All residents were assigned a work schedule, rotating groups of six every month. Jobs are identical to those found in community workshops and residents earn real money--a highly motivating factor for good attendance. As a whole, girls have demonstrated high productivity, fulfilling contract commitments on schedule with a minimum of rejected work.

Residents are encouraged to save their wages until the end of the month, and, after each group finishes a turn in the workshop, arrangements are made for a shopping trip to town. The day is spent shopping, "just looking," and having lunch. Girls do their own ordering and each pays her own check.

This work experience proved successful enough to warrant investigating the placement of residents in a community workshop. The Pomona Valley Sheltered Workshop was contacted and arrangements made for two residents to begin a trial work period. Integration into the Workshop occurred without incident and the girls have continued to participate with no problems. The residents travel to and from work on city busses, transferring once at the bus depot (see page 96). They purchase bus tickets weekly, and carry lunches and change for soft drinks. They work six hours a day, five days a week.

One of these girls is now being processed for family care placement near the workshop, where she will continue to work after she leaves the hospital.

It is hoped that the other resident may return home in the future if arrangements can be made for her to work in a workshop near her

home. Both of her parents must work and one of the problems hindering her return home is that supervision is not available during the day.

Part Time Residents - Day Care

When residents can function successfully in community employment, i.e., a sheltered workshop, the Token Economy Program may find it difficult to justify retaining them in the program if their participation has diminished to eating and sleeping on the ward with minimal interaction. While this minimal interaction may be just enough control to maintain the level of functioning attained, it has been proposed that a type of behavior modification approach with day-care residents could supplement those hours when the full-time residents are not at the hospital. These candidates would be selected from the hospital admissions waiting list. Through careful investigation and selection, those chosen would have a modified program which, if successfully carried out, might make it possible for the candidate to remain at home permanently with hospital admission not ever becoming a reality. Parents would need careful screening, for it would be important for them to carry through with the program at home.

This proposal is in the investigative stage at the present time, and seems to have merits which will make pursuing the idea worthwhile.

SCHOOL PROGRAM

Susan Hasazi
Special Education Consultant

It has been the policy of the TEP from its inception to consider formal academic training as an integral part of each resident's behavioral programming. However, the creation of a viable school program for all TEP residents was found to be quite difficult for a variety of reasons. School facilities within an institution are frequently limited and only a small percentage of the institutional population may participate. Many TEP residents lack the social skills and behavioral control to function in a classroom situation. (In fact, many TEP residents have been institutionalized because of problems in the school setting). When school facilities are available, school personnel may be unwilling or unable to carry out extensive individual programming in a large classroom. Residents may be reinforced for inappropriate behavior while off the ward or, simply, reinforced non-contingently. At the very least, residents usually return to the ward satiated on a variety of reinforcers used to "back-up" the tokens. In short, the major difficulty with off-ward school programs is the loss of control over the resident's environment. Hence, efforts were focused on establishing an on-ward school program.

The on-ward school program began with staff attempts at structuring lessons in arithmetic, reading, writing, telling time, etc. The staff found it difficult to plan lessons without a resource person to establish guidelines. An appeal was made for assistance to the school principal and a credentialed MR teacher was made available to the ward. She held class one afternoon a week and assigned homework for the remainder of the week (see Appendix I). Each resident's needs were evaluated and instruction planned accordingly. Residents followed up "class" work by completing homework assignments in the evening with staff assistance. This program, while it created less problems than the off-ward program, failed to meet the needs of all residents for several reasons. The teacher had limited time available to spend

on the ward, and so had to teach all TEP residents at once. Since the residents functioned academically at widely different levels, the class material unavoidably was too complex for some and too simple for others. Additionally, the staff felt their ignorance of appropriate teaching techniques handicapped their effectiveness in assisting residents with their homework. Finally, and perhaps, most importantly, the teacher found it cumbersome to incorporate token reinforcement techniques into her normal teaching routine.

The present school program circumvents the problems inherent in the previous programs but is founded on the unproven assumption that the residents' academic needs can be met by psychiatric technicians without prior teaching experience. The technicians are given training in teaching techniques and are provided with appropriate teaching aids by a credentialed MR teacher available to the ward on a consulting basis. The technicians then assume a group of four or five residents, functioning academically at roughly the same level, and conduct classes five days a week. Classes are held for approximately an hour a day, and are incorporated into the residents' daily routines. Residents may earn from zero to thirty cents (in tokens) per day depending on their responsiveness, etc. They are also reinforced with the traditional "gold stars," candy, and, of course, much verbal praise. The technicians have the advantage over previous teachers in that they know each resident intimately. They know, for example, what will be most reinforcing to each resident, what control procedures will be most effective, and what each resident's particular academic needs are. Hence, there are no conflicts between academic training and other aspects of behavioral programming.

The present school program has not been in effect long enough to evaluate its merits adequately. The technicians are enthusiastic about the progress the residents are making and have developed confidence in their own teaching abilities. The residents are likewise highly enthusiastic about the program and in several cases school is being used as a reinforcer, itself, by making access to it contingent on the emission of other behaviors. Plans for systematically evaluating the

the school program are underway. The evaluation will be relatively gross, such as administering some achievement test to each resident upon entering the TEP and at two or three month intervals until the resident graduates from the program. Such an evaluation would not establish the comparative value of the program; all it would establish is, if and how much academic material the residents had learned while in the TEP. Since academic training is not the prime goal of the TEP, it is not felt that a more extensive evaluation of the school program is necessary.

IMPLEMENTATION OF NEW PROGRAMS IN WARD CARE OF THE MENTALLY RETARDED

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Pacific State Hospital

The Hospital In-Service Training (HIST) program has been involved in the present phase of teaching and establishing programs for approximately 18 months. The over-all goal of HIST is to establish improved patient care programs by instructing ward personnel in new techniques of caring for the mentally retarded. The curriculum includes behavior shaping, sensory-motor training, recreation, and work therapy as well as ward administration. The primary focus of the program has been on teaching behavior shaping and ward management techniques necessary for improved patient care.

The methods of instruction include meetings to discuss ward problems, classroom instruction, on the spot counseling, and numerous hours of clinical instruction. The HIST personnel spend from 4-8 hours on the ward 7 days a week instructing personnel, helping with difficult patient problems, and establishing group and individual patient care programs. Perhaps the best description of the method is that HIST is a task force for improving patient care.

The HIST program has evolved formal and informal evaluation techniques. The formal evaluation consists of observations for 5 minute periods, at random intervals throughout the day and evening shift before training begins and after training is completed. The observations are done by a trained observer and the focus of the observations are employee-patient interactions. Each observation is categorized into interaction or supervision using the following criteria:

Interaction - the employee is teaching, talking with or to a patient, touching a patient, using rehabilitation nursing techniques.

Supervision - the employee is doing routine ward work watching patients but not interacting with patients.

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Each observation is then further categorized into sub-groups. Interaction observations are categorized into "reinforcing adaptive behavior" or "reinforcing maladaptive behavior."

Criteria for "reinforcing adaptive behavior:" In general carrying out behavior shaping techniques such as praising, exercising, touching, giving food reward for adaptive behavior, ignoring (or handling impersonally) maladaptive behavior.

Criteria for "reinforcing maladaptive behavior:" "Yelling at," handling a patient roughly, not reinforcing adaptive behavior, doing things "for" instead of allowing patient to do things, labeling or talking about maladaptive behavior in front of patients.

Supervision observations are categorized into "active" and "passive."

Criteria for "active" supervision: In general carrying out ward work or ward routines such as preparing clothing, cleaning, etc. in the presence of patients.

Criteria for "passive" supervision: In general watching patients, not interacting with patients, interacting with other employees instead of patients

Comparison of before and after observations: After each observation has been categorized and sub-grouped a numerical evaluation is possible. If the teaching has been successful, the sub-groups "reinforcing adaptive behavior" and "active supervision" will show a significant percentage of increase and the sub-groups "reinforcing maladaptive behavior" and "passive supervision" will show a significant decrease.

The informal evaluation consists of the HIST observations of patient care, patient behavior, staff behavior, and the continuing involvement of the ward personnel with HIST. The HIST staff also leaves a ward with certain feelings or hunches about our ultimate success. These hunches are largely correct but occasionally they are surprisingly incorrect.

Wards are selected for HIST participation in a variety of ways. Initially, wards were selected by a vote of personnel on the wards concerned. Selection now is a matter of some negotiation and largely is based on administrative concern for a ward. In some cases training has been done as a result of a ward team's request; at other times a supervisor or A.S.N.S.* has requested that we take a ward other than the

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scheduled ward because the ward is doing poorly, has extreme behavior problems or because patients are not reaching their potential.

In any case after a ward is selected the ward and shift charges are given pre-training. The pre-training consists of teaching some of the techniques, getting acquainted, sharing problems, and attempting to teach the charge the different ways a ward must be run for specialized patient programs. Ward administration changes radically when the patient care program becomes as highly individualized as successful behavior shaping demands. More specifically the pre-training consists of teaching:

Individualization of patient care - This portion of the program includes instruction in establishing programs for groups of patients; solving problems of individualized nursing care and consistency in individualized care with the use of nursing care plans; and the use of the problem solving technique in planning for nursing care.

Ward administration and special programs - This portion of the program deals largely with establishing communication channels on a ward; use of activity schedules; methods of expediting change on the ward level; and organizing routine work around a patient care program.

Seminars in program implementation - Before and after the HIST staff completes training on a ward the administrative personnel for the ward are invited to seminars for the purpose of exploring further how a program can be continued on a ward; how the unmet goals of the staff can be met or changed to more realistic goals; how to continue to evolve a program that will include other disciplines such as rehabilitation, recreation, and school programs.

The team is also consulted, and a contract is agreed upon. The contract specifies that all personnel will receive behavior shaping instruction, and in addition the ward team may select other subjects from the curriculum based on the needs of patients on the ward. Such subjects will be approved by the ward physician and nursing supervisor and will become an integral part of the nursing care. The clinical use of the subjects taught will be discontinued only if approved by the ward physician.

Classes on the ward in small groups are then given. The classes are lecture discussion types; handout material is distributed and quizzes are given. The nitty-gritty of the program consists of the clinical instruction. Clinical instruction usually consists of demonstration, return demonstration, and criticism. With HIST, the aspect of criticism is further elaborated, in that every interaction between employee and patient is subject to scrutiny. The continual pressure to reinforce, ignore, avoid negative instruction, break skills down according to successive approximation and teach, teach, teach is very demanding. Personnel are warned that they will not be happy with us, that they will be tense and uncomfortable. They are also encouraged to verbalize the anger we arouse, the patients arouse and to question everything. The first week or two is an exhausting ordeal for everyone, but by the end of the first seven days employees usually see a very noticeable change in patient behavior and this change is extremely reinforcing.

There are several factors on a ward that are extremely important in determining if the ward will successfully complete and continue a program. The general level of patient care must be assessed before a program begins. If patients are in groups, are clean, dressed, and have some sort of training program, then the likelihood of success is improved. If the ward is disorganized, patients are not grouped, and if patients are dirty and not dressed, then the function of the HIST staff is changed. A workable group routine must be established and adhered to: times for toilet training, dressing, bathing, and other grooming activities must be allotted. The charge must be taught to focus on patient care, not housekeeping or keeping personnel happy. In addition, middle management must be made aware of the problems and must be involved in the problem solving process.

Another factor that will affect the ward is hospital "politics." In every institution there is an area not defined by organizational charts of lines of authority where power exists and where many of the decisions about wards or special programs are made. This area of interaction, conflict, and compromise has a communication system, the

"grapevine." It is not an area that can be ignored in the hope that it can be extinguished since it seems to be self reinforcing. Specialized programs must be aware of what's happening, what's on the grapevine, and at times must utilize this phenomenon. The rumors on the grapevine reflect the thoughts and anxieties of the most important personnel in patient care areas as well as the fears of the necessity to change long established patterns of behaving.

Another factor that must be closely examined on a ward is the communication system. Ideally for any program the team communicates, the nursing personnel tell each other what has happened, and everyone concerned has some voice in decisions made about patient care. In reality communication may be at a bare minimum. On some wards as one person walks on duty the other person walks off without a comment about patient behavior. A ward charge or ward physician may need to be so authoritarian that people are intimidated and cannot communicate or on the other hand the ward charge might be so poor at holding meetings that a gossip filled report may occur without mentioning patients. If these or other situations are present channels and methods of communicating must be established. The HIST staff establishes "programming" meetings where group leaders and shift charges from both shifts attend to plan group and individual care. These nursing care plans are written and then placed in a folder so that other personnel may read them and so that continuity of care can occur.

The attitudes of personnel on a ward are important. If personnel are satisfied, think they have a great program, and think that nothing more can or needs to be done on a ward, then part of the HIST staff's function is to point out areas where improvement is needed. At times anxiety is deliberately created about methods and procedures so that personnel will develop a felt need for improved services. If personnel are demoralized and hopeless about solving patient care and ward problems, the approach is encouraging and helpful. For HIST purposes the situation is best when personnel are neither self satisfied nor demoralized but are aware that improvement in care is possible and necessary and where

an "experimental" attitude can be inculcated.

Overcoming resistance to change is one of the major problems any program faces day after day. The HIST staff has developed some approaches that work very well with ward level personnel. Personnel are told from the beginning that they will be angry with the HIST staff, that the HIST staff will be critical of them, that they will not always like the HIST staff, and that the demands HIST makes are difficult but good for patients. Personnel are encouraged and sometimes forced to talk about their feelings. Resistance still occurs but is greatly lessened as a result of these approaches. Perhaps the most discouraging type of resistance on the ward level occurs when an individual professes ignorance and/or stupidity; extra training, conferences, and classes are arranged without success and then the instructors determine that the person has never tried because they "philosophically disagree" with reinforcement. Such people are usually transferred to another ward or shift or assignment where their "philosophical disagreement" can come face to face with hard physical labor.

Communications, organization of care, and attitudes of personnel are all extremely important in the success as well as in the failure of establishing behavior shaping programs. It is necessary to explain now that among the problems usually blamed for failure is lack of personnel. This has not been a factor in HIST success or failure. However, the inability to keep or maintain a trained staff is detrimental to behavior shaping. If supervisors "raid" the core staff of a ward for other wards, make unnecessary personnel changes, or "float" from ward to ward, no program can succeed but behavior shaping will completely fail since behavior shaping demands staff acquainted with patients, trained in the technique, and motivated to teach patients.

HIST has not always been successful and at some times has had astounding failures. Although it is our natural inclination to blame these failures on others, we do realize that in each case we have played an important part. Each of us has failed as an instructor when we have been unable to overcome our dislike for an individual. Other reasons

have been the inability on our part to convince physicians, supervisors, or patient care personnel that the technique was successful and that we were not demanding too much when we asked for cooperation. At times we have met our own needs by "taking over" instead of teaching and helping; at other times we have caused animosity by reporting personnel for unacceptable treatment of patients. There have been other personal reasons for failure but perhaps a closer analysis of cases will be more instructional.

The first ward that failed to carry on the program was extremely interesting in that on analysis every possible factor that could cause failure was present and we were unaware of these factors.

This ward was selected because of obvious interest on the part of personnel, a new ward charge had introduced new programs with success, and because the division administrative staff were eager and supportive.

Each employee was interviewed, observations by a trained observer and the HIST staff were completed, and all five subjects were chosen by the personnel.

Observations revealed that approximately 61% of all employee-patient interactions reinforced maladaptive behavior, patients were rarely in groups, care for the majority of patients consisted of dressing, feeding, bathing, and supervision. The only active training was for a select few capable patients who could work, and some training in table manners for the general population. Staffing was excellent in comparison to other wards of a similar population.

Classes in all five subject areas were taught on the ward at hours convenient to the staff. Clinical instruction was given on a one-to-one basis in the patient care groups. While the HIST staff was actively involved, most personnel utilized the techniques they had been taught. Active training and instruction werecompleted in three months, and gradual withdrawal of HIST involvement was begun. As the HIST staff began withdrawing a marked regression in program implementation was noted.

Counseling meetings, and conferences with the ward charge were not effective in revitalizing the program on the morning shift. The evening shift, however, continued and maintained the program without

difficulty. The regression in program was largely in not maintaining patient care groups, not teaching self-help skills, and in not carrying through on sensory-motor training.

The HIST staff errors consisted of getting too close and friendly with personnel so that we could not be critical enough; not taking remedial measures in teaching the ward charge how to organize and in not requesting assistance from middle management soon enough. By the time the evaluation procedure had been completed, the ward staff was alienated, hostile, and refused any assistance that could have been given. The HIST staff was also alienated but after a cooling off period we began to examine the causes of failure and as a result changed the methods of teaching.

This examination of what caused failure and what helped in success has become a routine part of the program and is essential. In every case where we have succeeded or failed we have asked ourselves what did we do right or what did we do wrong or did we do enough. On one ward we had presumed that we had not been successful because some employees remained hostile and rather non-cooperative. Within a month after we left, we changed our opinion. The ward charge had decided that the program was extremely beneficial to patients and that employee happiness was not as important as patient treatment. This decision was her decision and she acted upon it without prodding. In this case what we had done right was convince her the technique was good and what we had done wrong--even with all the warning signs present--was not to allow this person to carry out her responsibility as ward charge while we were present.

One of our most problematic areas has been with middle management personnel. The HIST program is extremely threatening to some of these personnel, because they feel the reins of power and control slipping from their hands. In other cases regardless of their position they show what we consider poor judgment in establishing unrealistic programs that are impossible for personnel to execute. Demoralization of the ward personnel may then result.

Realistically we are a threat because the curriculum for ward administration is directly aimed at their area of interest. We

frequently find that the opposition to new techniques is in actuality a power play and not an opposition to new techniques. We have no hard and fast way to solve these problems. We work on them as they arise and to remedy the opposition from ignorance we have planned seminars for these personnel. One of the best ways to handle these problems is to get and keep these personnel involved, to make it their program,and at times to make them feel competitive of another ward.

Follow-up on programs is done on an informal basis. The ward personnel telephone for questions to be answered, the HIST staff drops by for a visit. During these follow-up visits it is immediately apparent if behavior shaping is being continued. If behavior shaping is continued we find that patients and personnel are quiet and occupied; there is no yelling at patients; personnel are glad to see us, point out improvements in patients, and are friendly. If behavior shaping is not continued,patients mob strangers, are noisy, personnel are brief and not happy to see us but act angry or ashamed.

In addition to these visits, participation in ongoing classes is an indication of success as is consultation about problems with patients or personnel.

In summary, the three most important factors in establishing a behavior shaping program are communications on the ward and between instructor and ward personnel, organization of routine ward work,and follow-up to teach, reteach and enforce programs. The establishment and maintenance of such programs is difficult and time consuming but reinforcing when improved patient care results.

OPERANT CONDITIONING TRAINING PROGRAM

Lawrence Payne, Psychiatric Consultant

Pacific State Hospital

The Operant Conditioning Training Program began its evolution some time after a visit to Pacific and Patton State Hospitals by Dr. Lewis Carpenter of Napa State Hospital representing the Department of Mental Hygiene's Bureau of Training. The knowledge and experience of Pacific and Patton in the administration and implementation of operant conditioning techniques wereconsidered the primary factor in possibly beginning a training program. The Bureau of Training expressed the desire to facilitate the dissemination of the techniques of operant conditioning in the treatment of mental illness and mental retardation. Proven success of operant conditioning programs at Pacific and Patton would provide the basis for an excellent training program. The Department of Mental Hygiene sought to utilize the knowledge and techniques available at these institutions. Both Pacific and Patton have well-established, on-going programs which have overcome technical and administrative difficulties. With the experience and quality of the operant programs at Pacific and Patton, the DMH felt that excellent training facilities were available for training personnel from other hospitals.

The DMH intended to have trainees, who were mental health practitioners, undergo a nine-week training course and, upon return to their home hospitals, establish and administer a program in operant conditioning. The trainees would utilize their knowledge and experience obtained through the training program in the theory and practice of operant techniques to teach other mental health practitioners at the trainees' hospitals.

Experience has shown, without question, that there must be administrative support and understanding if a program is to succeed. Since it is often necessary to re-assign personnel and to sometimes make certain alterations of physical facilities, administrative personnel

from each of the two participating hospitals, Fairview and Metropolitan, were asked to attend the program for the first five days.

During the first five days of the program the administrators and trainees were exposed to the historical development of conditioning techniques in both theory and practice. Films, discussion periods, demonstrations,and reading materials were presented to them. They visited numerous wards at Pacific and Patton where they were able to witness the application of operant conditioning techniques to a wide range of hospital populations.

In order to provide a complete picture of how an operant program is viewed and its administrative requirements considered, the administrative experiences and application of ward programs were elaborated from medical director to ward technicians. The experiences and knowledge of the medical director of the hospital, division medical supervisor, ward physicians, nursing supervisors, ward charges and ward technicians were presented and a well-rounded program of introduction and explanation was obtained. Virtually all administrators from Pacific who have been and are exposed to operant conditioning programs presented an overview of the functions they perform.

The principles of operant conditioning are adaptable, demanding, measured,and rewarding. With the elaboration of these principles, the instruction began on a ward for profoundly retarded, school age boys. The first step in the practical application of operant techniques should involve evaluation of those residents who will be receiving treatment. Each practitioner was assigned one child with whom he or she was to work. Utilizing a ward which had previously received federal funds under a Hospital Improvement Project, the training started with the evaluation of each of the boy's self-help skills. Medical records,which include the child's history, psychological evaluation,and ward notes were referred to. In this way the trainees obtained a general idea of the child's developmental history. With the help of a ward technician, each child was evaluated and his abilities and amenability to training discussed. In the evaluation procedure each child is given a number of commands and his response (or non-response) to each is noted. What is attempted here is to establish a level (baseline) at which the child is functioning

when given a command. These commands begin with the most basic "look at me" and successively increase in difficulty (e.g., "stand-up," "sit down," "come to me," etc.) until the point is reached where the child no longer makes a correct response. Some residents do not respond to the initial command while others may respond to "stand-up," "sit down," and "come to me" but are unable to respond correctly to dressing commands. We use these basic commands and the responses to them in order to establish control over the resident's behavior. Four correct responses out of five commands is satisfactory evidence that the child is able to properly respond to the given command. Food in the form of soft candy, sugar-coated cereal, or small spoonfuls of the regular meal is used to reinforce the responses.

Following the Breland-Colwell program (Bensberg, 1965) self-help skill training sessions were held daily for three weeks. The trainees, under the direction of a training assistant with a background in operant conditioning, worked with their assigned children 15-20 minutes per session. The training assistant worked with each trainee during each session by demonstrating and explaining each step in the operant procedure. We found it valuable to have the trainees observe each other during these sessions. This enabled them to be constantly exposed to operant techniques and definitely facilitated their learning. Daily ward notes were kept in separate notebooks. These were, for the most part, detailed progress reports which described the performance of the child during each session. At any time, then the trainee could refer to these notes and obtain further understanding of his or her child's behavior.

Hour-long discussion periods, under the direction of the training assistant, were held each day. During these periods of informal discussion many topics relevant to operant conditioning programs were included. Topics such as physical plant planning, supply acquisition, ward staff planning as well as the theoretical and applied aspects of operant conditioning were discussed. The ward charge from the training ward and the chief psychologist also participated in these discussions. With all of these people contributing to the discussions, many valuable ideas and experiences were presented.

By using residents with very little self-help abilities and noticing their improvement in dressing, eating habits and toilet training, the

trainees were given adequate proof of the effectiveness of operant conditioning. It was through working with the resident assigned each of them that the trainees witnessed these changes in self-help abilities. Also, each trainee was brought face-to-face with his or her own attitudes during the twice per day session.

In the third through fifth weeks behavior modification training was begun on another ward. This training, which was directed toward behavior problems rather than self-help training, was done in the afternoon and was simultaneous with the self-help skill training, thus retaining the total continuity of the program. For this phase of the training program we used an adolescent-young adult ward which had many behavior problems among its residents. The trainees were taught how to use operant techniques to extinguish maladaptive behaviors and condition socially acceptable behavior. Pacific's HIST staff (see article by Barbara Bailey, this monograph) directed most of this training.

Teaching operant conditioning by first using basic skill training (dressing, eating, toileting) provided the practitioners with a basic awareness of the importance of reinforcement contingencies and laid the groundwork for training on a token economy ward. (For a detailed description of the token economy program see article by Lois Sibbach, this monograph). Here, the trainees were each assigned to a group leader. They were given programs for each of the residents in their assigned groups. These programs include target behaviors for reinforcement and extinction and the reinforcement schedules. The trainees worked closely with the group leaders and gained valuable experience at the applied level. They were taught how to design and write individual programs, observed the off-ward activities and workshops, and they were also present at, and contributed to the administrative and inter-shift meetings held on the ward. The trainees received a totally rounded program on this ward.

During the sixth week, while on the token economy ward, the trainees were shown in-home training of retarded children by Jane Maxwell, a public health nurse on Pacific's staff. This training involves the teaching of parents in the application of operant techniques to self-help skill training and in sensory-motor training. The Pomona Valley Sheltered Workshop, where a number of residents from Pacific are

employed, was visited by the training group during the sixth week also. Here they saw the many types of jobs retarded individuals can perform extremely well and receive monetary reimbursement for their work.

The final three weeks of the program were spent at Patton where theoretical, laboratory, and practical experience were gained with the mentally ill. Discussion seminars were held in which the trainees were further exposed to the theory and applications of operant conditioning. The new closed-circuit monitoring system was tested and its operation begun while the trainees were at Patton. This system involves the use of television cameras for observation of the residents' behaviors. From a monitoring station isolated from the residents, observation and recording of behavior are accomplished. Using a sophisticated system of programming, monitoring devices and remote control makes this token economy program unique. Tokens are dispensed to the residents by remote control; the frequency and amount of tokens dispensed are dependent upon the reinforcement schedule for each resident. The uniqueness of this token program enabled the trainees to become more aware of the possibilities of operant conditioning programs.

On the final day of the nine-week program, the administrators were asked to return to Pacific in order to obtain a clear understanding of what the trainees thought of the training program and what recommendations the trainees would have regarding the practical measures necessary for implementing and maintaining an operant conditioning program at their respective hospitals. An in-depth understanding of the didactic, practical, and administrative aspects of such a program is necessary in order to gain administrative support. All of the trainees expressed the desire to be used as a training team, their intent being to go onto different wards and instruct personnel in the use of the techniques they had learned. This team approach, it was felt, would not only be more effective from a teaching standpoint but would also be the most effective means of helping the hospital residents. Other suggestions included staggered time shifts for ward personnel, acquisition of partitions for dividing ward areas, obtaining appropriate clothing for use in training and every day use, follow-up consultations by the Pacific staff and most important of all, administrative support from each of

their hospital's staff. The trainees expressed their satisfaction with the training program but added that they thought more mental health practitioners and psychologists should receive similar training.

We have just finished training a second group from Napa State Hospital. This group of trainees are the ward personnel and supervising personnel from the only ward at that institution which has a total population of mental retardates. The training these personnel received was the first training they were given in the use of operant conditioning. This group will now be able to apply the techniques they learned to residents on their ward. With the projected addition of other wards for the mentally retarded at Napa, this group will become the teachers for personnel who will staff these wards.

As this program continues we anticipate more trainees from other state hospitals and foresee improved resident care as a result of more effective techniques. In the future we expect to see hospitalized individuals functioning at their highest level as a result of more highly skilled personnel.

THE CROSS CULTURAL USE OF OPERANT CONDITIONING

Lloyd H. Cotter, MD

In 1966 I left my part time position of Pacific State Hospital staff doctor and my private practice of psychiatry to go to South Vietnam for two months. I went there as a volunteer physician in the State Department's Project Vietnam program of medical assistance for Vietnamese civilians.

I had seen operant conditioning demonstrated with autistic and retarded children at Pacific State Hospital and on a token economy ward at Patton State Hospital. I hoped that it might be used with good results in the entire mental hospital for which I was bound in South Vietnam.

My confidence in this plan was not bolstered by the briefing given by the military surgeon general in Saigon. He assured us that we could never hope to understand the oriental mind during our two-month tour--that he had been there 4 years and it was still an enigma to him.

I, however, found the 3 psychiatrists and other hospital personnel at the Bien Hoa Mental Hospital quite open, cooperative, and friendly. They were willing to try any program that might help with the deplorable condition and prognosis of the majority of the hospital's two thousand patients. Idleness and lack of any treatment program other than custodial care was their lot. Due to inflation, the hospital's monetary allotment for food was inadequate. The patients in their idle state had little choice except to endure and die. And die they did at a rate of 5 times normal due to their malnutrition and beriberi.

A token economy program was started for all the physically well patients in the hospital. The details of our trials and tribulations have been described in another paper.* However, I can summarize by stating that we were successful in getting all these patients into

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*Cotter, L. H. Operant conditioning in a Vietnamese Mental Hospital. American Journal of Psychiatry, 1966, 123, 420-426.

occupational therapy programs, including particularly food-growing projects to better the food supply and diet, and a Montagnard bow-and-arrow manufacturing project to bring in cash through sales to American servicemen. For his day's work each patient earned his meals and a piastre. Food, soft drinks, cigarettes, clothing, etc. could be purchased with their earnings in the newly established patients' store.

As the program progressed we noticed that some of the patients who went to the fields with the food-growing teams were doing no work. Thereafter, until their productivity was satisfactory, they did not receive their meals on the ward. Instead, each of these patients was assigned a patient helper who was given special instruction. Each patient helper was to carry his patient's food to the field and immediately feed him a lick of food each time he did a lick of work. As the patient's productivity improved he was gradually fed larger amounts at greater intervals. Finally, these patients learned to put in 3 hours morning work for their noon meal, and 3 hours work in the afternoon for their dinner. Many of the patients, after becoming established in the program, expressed their gratitude freely concerning the beneficial change in their lives.

It gave us a good feeling of accomplishment to be able to discard the outmoded "illness" model of hospitalized mental patients and instead utilize the rehabilitative effects of productive activity for all the physically-well patients. The former was resulting in psychological and physical deterioration. The latter reversed this process.

Although the work was done in a cultural and economic situation highly remote from the American experience, the basic treatment philosophy of the token economy program applied extremely well. This supports the picture of the operant conditioning approach as a very powerful and effective technique, as well as the fact that humans are humans the world round.

OPERANT CONDITIONING TREATMENT PROGRAMS: OBSTACLES, PROBLEMS AND ISSUES*

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The development of an operant conditioning treatment program at Porterville State Hospital began in 1965. It began as an informal investigation of reinforcement patterns on a ward for disturbed adolescent retardates and has evolved into a comprehensive treatment program involving one ward for male adolescent retardates with behavior problems. The growth of this program parallels the development of operant conditioning programs at Pacific State Hospital. Both hospitals operated independently in this respect but developed similar programs that differ only in a few basic aspects of methodology. The similarities between the two hospitals provide a unique opportunity to compare the growth of operant conditioning. The purpose is to offer a form of validation to the cogent points made by Dr. Ball in his introductory remarks and to offer additional comments that might be of assistance to others.

The program at Porterville State Hospital operates as a Hospital Improvement Project that began in 1966. The most conspicuous treatment modality is a token economy that carries with it the usual reinforcement theory conceptions of behavior and resultant program requirements. Behavioral growth is shaped by consequences in the environment and hence consequences must be made contingent upon behavior in a programmed developmental manner. The target population is male adolescent retardates who exhibit behavior problems of sufficient magnitude to impede their progress in the hospital and placement in the community. One ward of 42 patients is the base of the program with behavior being monitored when patients are involved in off-ward programs such as School or Vocational Rehabilitation. The project director is the medical director, the co-director

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the chief psychologist, and the project coordinator, a clinical psychologist. Twenty-two psychiatric technicians carry out the program along with involvement of a half-time psychiatric social worker, one and a half teachers, a quarter-time rehabilitation therapist and full-time secretary. The responsibility of initiating, modifying, and coordinating the program rests with the project coordinator.

OBSTACLES RELATED TO PEOPLE

In spite of this superlative staffing our experience with administrative aspects of the program is very similar to that reported at Pacific State Hospital. Perhaps the most important lesson is that the program must have administrative support. Unfortunately, support does not come automatically, or as a result of a well articulated program. It must be earned by discussion, information sharing, and participation. Nursing supervisors, in particular, have vast influence in state hospitals, and they must be won over in order to maintain a consistent program. At the ward level, support of the nursing personnel is more complicated. Not only must effort be made to have them accept the orientation of the program but efforts must also be made to maintain their interest over a long period of time. Increased responsibility has been effective in addition to a more meaningful involvement in decision-making. We too have learned that frequent innovations and exploration of new ideas is essential to sustained interest. Participation in professional meetings and submission of papers for publication by nursing personnel also serve to reward all staff members.

It appears that introduction of operant conditioning programs typically raises issues over who has control of the program. These issues are raised not only because of the inherent nature of these programs but also because it usually represents the first time a psychologist has assumed a major role in a ward program in terms of theoretical orientation, development, and application. Many aspects of these programs are contrary to the medical and institutional models and hence cause administrative clashes. Details of operation may be changed by negotiation but essential features cannot be compromised or the basic integrity of the program falters. This is the reality of the situation not because operant conditioning is the best approach but

because once a program is adopted, changes should come about as a result of systematic evaluation rather than petty arguments. In order to protect program integrity, necessary authority should be delegated to the person with the appropriate knowledge and responsibility for the program. Because operant conditioning is a psychological technique, it usually happens that psychologists have been thrust into that role. At Porterville such authority has not been formally delegated. Clashes must be worked out by discussion and a heavy dose of cooperation. This approach works well because the project director is the medical director who has always been strongly supportive, but were that not the case the situation would be more volatile. However, in the future it is anticipated, due to the shortage of trained psychologists, that training programs in operant techniques will make it possible for other mental health professionals to be program directors and coordinators with psychologists available as consultants on both theory and application.

The various types of destructive resistance identified at Pacific State Hospital have also been experienced at Porterville. Differences over treatment philosophy are the most frequent difficulties. In spite of an agreement to follow a systematic program there are always individuals who will disagree on the basis of personal experience, anecdotal evidence, and common sense. Sincere attempts to point out the inappropriateness of these arguments in a gentle manner and a dogged determination to follow the program faithfully are useful measures.

This type of resistance focuses on a phenomenon that typically develops around a new program. A program is set up for a neglected and often troublesome population. Before the program everyone politely turned their backs on this group or offered minimal assistance and involvement. A new program, however, quickly becomes a target for disagreement and elicits an abundance of contrary information and opinion and becomes the occasion to air pet theories and techniques. All of a sudden, everyone is an expert, as long as he doesn't have to follow it up with action. When the program is successful then the reverse happens. Everyone agrees with it and the person who originated the program becomes last among the crowd of others who now want to stand in the limelight.

The question of how to introduce an operant program into an

institution is difficult to answer as Dr. Ball has suggested. In addition to involving the administration and training individuals of high potential, the judicious choice of a target population can ease matters considerably. The suggestion is to select a group that is ignored by others because of difficulties of treatment, organization, etc. Some obstacles are removed quickly because staff is grateful for any attention to that group. When severe opposition is met, one can always argue that no one else had any better ideas. And, besides, when you are successful, it stands out as a major accomplishment. With a successful background you are then ready to take on bigger problems.

PROBLEMS RELATED TO THEORY

The concepts of operant conditioning are easy to grasp, the implications for treatment are readily understood, but translation into a viable program can be very frustrating. The application of theory presents a number of problems that are related to existing reinforcement systems and characteristics of institutions.

A program of contingency management would be relatively easy to operate if it were not for the existence of previously established competing reinforcement systems. In most institutions rewards are commonly given in a non-contingent manner which does little to promote growth. In addition, requirements for rewards are usually not systematically increased. The result is a low rate of growth that fosters dependency rather than independency. Likewise, punishments are often inappropriate or at least inconsistent. A program that calls for realignment of contingencies must realign the behavior of project staff in relation to patient behavior. When this can be accomplished, then negative influences outside the program must be altered. For example, the ward program might provide for a movie on Saturday if a specified grade level has been met at school all week. However, the patient's involvement in another program might call for a movie simply because he did not cause any trouble recently. In one case the contingency plan is clear and promotes achievement; in the latter case the plan is vague and perpetuates the belief that the good patient is the quiet patient. Involvement of other services with the program helps to avoid some of these inconsistencies.

The use of reinforcements as they occur naturally in the environment is an obvious program maneuver. Material goods, privileges, and events that already exist in the institution can be organized into a meaningful reward structure. Experience in the Porterville program has indicated a number of weaknesses in programming the material reinforcements into contingency plans. Some events are "time-locked" and occur only at certain times. It is difficult to make them immediately contingent on desirable behavior. Individual differences are not always met, and little opportunity for choice exists for the patient. The number of reinforcements available during any one day is also very limited. In order to circumvent these problems a token economy has been established that gives more flexibility to treatment plans.

The nature of total institutions makes it difficult to arrange for generalization of recently acquired behavior from the hospital to the community. Living conditions in institutions are usually not at all similar to home situations. A frequent observation is that a patient might behave one way in the hospital and another way at home. The dissimilarity between environments is one antecedent factor relating to the differing behavior, and inconsistent reward systems might aggravate the situation. In efforts to facilitate generalization of behavior, investigators have employed half-way houses, developed project environments that resemble community homes (e.g. Lent, 1968), or at least maximized community contacts by means of field trips, visits, tours, and participation in community activities (Shelton, 1967).

Some behavior problems that caused hospitalization might be suppressed or at least greatly reduced by the hospital environment. Promiscuous sexual behavior, drug abuse, and certain types of theft might not be exhibited because opportunity for expression does not exist in the hospital. Behavior problems that are of low frequency but high social impact then become difficult to treat. Negative consequences for inappropriate behavior become infrequent and futile in view of the reinforcing properties of the behavior. One drastic solution is to structure the environment so that expression is possible and then contingencies may be applied. Success or lack of it then becomes readily apparent.

There are many negative emotional reactions to the use of operant conditioning methods. Perhaps the most strenuous reaction is described in a controversy between Lucero, Vail, and Scherber (1968) and Ball (1968). Lucero et al. claim "that operant conditioning can be dehumanizing and can at times lead to a total loss of human values." They also complain about the use of electric shock grids, physical restraints, prolonged seclusion, and deprivation. In examining the moral and ethical issues the authors are concerned about how much can be justified when methods may be undesirable. As a result of their concerns a work-shop was organized to establish a set of standards for operant conditioning programs in Minnesota hospitals. The standards restricted the use of aversive reinforcement to special cases, denied the use of deprivation, and advocated the use of positive reinforcements.

In response to the unreasonable stance on deprivation by the Minnesota policy, a series of cogent arguments regarding the theoretical and ethical aspects of the practice were offered by Ball (1968), Miron (1968), Cahoon (1968), and Bragg and Wagner (1968). The question of responsibility to the public and to patients was discussed by Shelton and Ray (1968). The rebuttal by Lucero and Vail (1968) can be summarized by their statement that "A 'treatment' measure used in a public facility that is bizarre or cruel or otherwise impossible to explain to the public--even if it gets results--is of nature against the public interest." With regard to deprivation they believe that there is no justification for depriving patients of conditions or goods that are theirs by right. The policy which they have described is now the standard for all of Minnesota's state mental institutions. A more expanded description of this controversy is described elsewhere by Ray (1968).

There are at least two important implications of this controversy. The first is that operant conditioning programs should be presented in an honest, straight-forward manner that acknowledges limitations particularly when controversy surrounds the project. Communication between the program and the rest of the hospital should be frequent and honest. A mature, responsible image is much better than a defensive stance based on complaints about interference and

resistance from others. The second implication is that programs should include specific provisions for the rights of patients and protect them from abuse. To say that patients are safe because they are cared for by professional persons is unacceptable. Internal safeguards might include an independent committee from within the institution that would review methods of handling issues such as discipline, deprivation, negative reinforcement, and isolation. The committee might also observe the program in operation on a variable interval schedule to check for potential patient abuse. Another possibility is the provision of a clear channel of communication for patients directly to this committee. Patients with specific complaints should be given the opportunity to have them discussed and investigated. In this way, any problems that do develop will be handled immediately at the local level and will not be allowed to be compounded into serious incidents. Provisions such as these not only have considerable therapeutic value but also indicate a responsible attitude to the administration.

Another issue that causes much concern is the practice of withholding basic biological reinforcers such as food in order to bring behavior under contingency control. Some investigators feel that it is necessary to control food in this manner. Others feel quite comfortable in using other deprivations but balk at withholding food because of considerations of patients' rights and dignity. A compromise position is to use the maneuver as a last resort after all other methods have failed. In the Porterville program it has not been necessary to control food in this manner. Effective manipulation of other rewards has usually been successful. An additional consideration relevant to this matter is that to force a patient to make a dichotomous choice about food may produce further asocial or maladaptive behavior motivated by a desire to beat the system.*

The fact that so many operant conditioning programs currently exist in spite of the problems, obstacles, and issues indicates that operant conditioning is more than a fad. The initial innovative trial stage has been passed through in California state hospitals. It is now expedient to consolidate and clarify applied techniques and expand operant technology to other problem patient groups in hospitals and in the community.

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*See Editors Note next page.

*Editor's Note: In developing my own position regarding the possible abridgement of the patient's rights and dignity as the result of food control I was considerably influenced by the following case report. It involves self-help skill training with a 6-year-old, blind and deaf patient who had successfully evaded all attempts at training her to feed herself with a spoon. The therapist described the situation and the training technique as follows:

> "... table manners are appalling. She puts her hands in our plates and helps herself, and when the dishes are passed, she grabs them and takes out whatever she wants. This morning I would not let her put her hand in my plate. She persisted, and a contest of wills followed... I locked the dining room door and proceeded to eat my breakfast... was lying on the floor, kicking and screaming and trying to pull my chair from under me. She kept this up for half an hour, then she got up to see what I was doing. I let her see that I was eating, but did not let her put her hand in the plate. She pinched me, and I slapped her every time she did it. Then she went all around the table to see who was there, and finding no one but me, she seemed bewildered. After a few minutes she came back to her place and began to eat her breakfast with her fingers. I gave her a spoon, which she threw on the floor. I forced her out of the chair and made her pick it up. Finally I succeeded in getting her back in her chair again, and held the spoon in her hand, compelling her to take up the food with it and put it in her mouth. In a few minutes she yielded and finished her breakfast peaceably."

The above is a quotation from the report of Anne Sullivan describing her work with Helen Keller. Although punishment is not involved, Sullivan's technique of teaching independent spoon feeding otherwise closely approximates that utilized in some of our own operant programs. Her technique unquestionably entailed "deprivation" in Vail's sense of the term. But did it lead to "dehumanization?" The international acclaim earned by Anne Sullivan for her humanitarian efforts suggests otherwise. Yet if a present day Anne Sullivan attempted such a treatment approach with a Helen Keller on the wards of a Minnesota State hospital, she would be in imminent danger of being fired because, "deprivation is never to be used." What I am suggesting, of course, is that the Minnesota "guidelines" resolve nothing. We need to probe more deeply beneath the surface and set aside invective, emotionalism, and premature formulations, all of which resolve nothing and serve only to delay a

discussion of truly critical issues.

Even among those actively involved in token economy programs there exists, as between my Porterville colleagues and myself, genuine disagreement regarding food control. In some instances we have found that food control has, in fact, resulted in further maladapative behavior. But the effect is far from universal. In any event, I will let appropriate empirical data settle the question of the practical significance of this variable (see footnote, page 4). The utility of food reinforcement in self-help skill training with the most profoundly retarded is an entirely different question, however. - Thomas A. Fall.

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POLICIES AND PROCEDURES

WEEKLY ADMINISTRATIVE MEETINGS

This meeting is held every Tuesday, at 1:00 p.m. Present are the Project Director, ward psychologist, ward charge, afternoon charge, their relief charges, representatives from nursing supervision and social service. The purpose of the meeting is to discuss and resolve administrative problems. Notes are transcribed and posted for all staff to review.

INTERSHIFT MEETING

This meeting is held weekly on Tuesday, at 2:00 p.m. All staff are encouraged to attend. The topics of discussion relate to programs, milieu problems, staff communications, etc.

LEAVES FOR RESIDENTS

Residents may have one Definite leave per month. These should fall on a weekend whenever possible in order to keep as much continuity in an individual's program as possible. Longer visits may be arranged when it is felt that a lengthy visit has particular merit for a resident. The Team reserves the privilege of limiting or withholding visits and/or leaves if a resident's performance is not felt to be adequate. A visit may be cancelled even to the time a parent arrives on the ward. (This decision is to be made at the Charge's discretion). However, whenever possible, parents should be informed of cancellation, by telephone or letter, before they arrive.

VISITORS

We have an "Open Door" policy, not only in respect to the ward residents, but extended to people who would like to visit the ward and find out about the Program. Visitors on the ward should be welcomed, but they should also be told what we expect of them, as their behavior might be reinforcing to maladaptive behavior displayed by residents. At the Charge's discretion, visits may be refused if, at the time of the visitor's arrival, it is deemdd advisable and to the resident's advantage and/or safety not to allow a visit. Example: if a visitor is obviously drunk. (Whoever is Acting Charge at the time may be assured of total backing in whatever decision is made. The visitor may be referred to Dr. Bell or Mr. Hasazi if so desired).

CHARTING

Each staff member is expected to chart on his/her group weekly. The best time for this weekly entry is the last working day of the week. Other Nursing Notes should be written for any of the following reasons:

1. Unusual incident or accident.
2. Acting-out behavior resulting in need for seclusion.
3. Seclusion: anyone in seclusion is to be offered fluids and bed pan once every hour while secluded. Estimates of intake and output, as well as general description of behavior should be included in Nursing Notes.
4. Noted improvement in behavior or response to program.
5. Comments pertaining to behavior when out on Company or Definite Leave.

RESPONSIBILITY LEVELS

There are three (3) levels of responsibility for ward residents. They are as follows:

1.	Campus alone	This level entitles resident to Campus Card. Resident must be a member of Green group.
2.	Campus with one (1) other Resident	This level entitles resident to Campus Card. Resident must be a member of Blue group.
3.	Campus with staff	No Campus Card. Red group.

Lateness in returning to ward or acting-out behavior while on Campus may result in the loss of a resident's campus card for a specified length of time. The time for which the card is rescinded should be made clear to the resident, as well as the reason for loss of privilege. The same should be communicated to staff, via Intershift Book, and the list posted in the Office.

JOB CARDS

Each resident is responsible for her own Job Card, and must pay for replacement of a lost or damaged card. Charges are dependent upon the Group in which the resident is functioning.

Staff members are to check out assignments as to accuracy and completeness. If a task is done appropriately, the resident is to be paid as soon as possible (except Green groupers), and the card is to be marked "pd." If a task is not done, the square is to be marked with an "x."

LOST AND FOUND

Carelessness in leaving personal possessions in halls, the day hall, and yard has been minimized by putting them in the Lost and Found -- located in the ward store. Twice daily during regular store hours, items may be retrieved after a token payment commensurate to each group's economy.

MEDICATION ADMINISTRATION

Searching for and/or nagging residents to take medications is minimized by:

(1) Changing medication hours to coincide with mealtimes. (With ward physician's permission). Medications are dispensed adjacent to dining room door.

(2) If a resident bypasses medication person and enters dining room, the meal is to be missed. Tokens paid for the meal are NOT refunded.

(3) Fining for refusal to take medications.

REASSIGNMENT OF GROUPS

Group leaders are given a new group every two months. Lists are posted by the 20th of the month prior to new assignment so that all staff have ample opportunity to review programs and ask questions of staff currently assigned to a group.

Requests to work with specific residents will be considered.

Group membership will be changed occasionally. An attempt is made to vary the group composition in terms of problems presented by residents, program structures, and group membership (Red, Blue, and Green).

BEDTIME FOR RESIDENTS

Bedtime is regulated by group membership.

Red group - 8:30 p.m.
Blue group - 9:30 p.m.
Green group - 11:00 p.m.

In the summer when daylight hours are longer, bedtime hours are prolonged one-half hour. Daytime "sleepyheads" will have individual bedtimes set.

Red and Blue group members may pay 5¢ to stay up ½ hour later if they have completed all of their tasks. This is a relaxation time and may not be used to do tasks. All residents may stay up for the "Saturday Night Movie" if they are watching TV.

OVERTIME PAY

Any Blue or Green group member who volunteers to work Saturday, Sunday, or a Holiday, will receive time and one-half pay, BUT:

(1) Must not have any "X"s on job card for previous three days.

(2) May not work on overtime days to pay off outstanding fines incurred during the previous week.

EARNING EXTRA MONEY

All residents may earn extra money by doing odd jobs on the ward or doing errands. Residents must have completed all tasks on their job cards for the time of day before doing extra jobs.

DOING ANOTHER'S JOB

When residents refuse to do an assigned task, a volunteer may be solicited. Only those who have done a reasonable number of their own tasks will be considered. Volunteer will be paid the amount other resident would have received.

When a RESIDENT solicits a volunteer to do a task for her, she will receive an "X" on her job card for the task not done and must pay the amount on her job card to the volunteer, plus ½ again as much. (She has taken a Holiday from her job).

NAPPING

No permission slips will be given to nap before lunchtime.

Excessive napping with or without permission may indicate that:

(1) Resident is lazy/low motivation.

(2) An earlier bedtime is indicated.

(3) Night time sleep pattern is disturbed (illness, anxiety, too strenuous a program).

(4) Medication dosage should be evaluated (is this a side effect or cumulative effect)?

After determining that resident is getting adequate sleep, is reasonably motivated, and seems to rest well at night, problem should be brought to the ward charge's attention and discussed with the ward physician, so that he may rule out illness and/or re-evaluate medication.

Occasional napping without permission will result in a fine.

RED GROUP CLOTHING

Each Red group member is issued seven "state" or hospital-provided dresses. The resident's initials are marked on the front and a day of the week on the back. Each girl is expected to be wearing the dress coinciding with the correct day of the week. It must be clean and ironed. Inspection is made at morning room check and job cards marked appropriately--"pd" for the correct, clean, ironed dress and "X" if it is not. Tokens are given or collected accordingly. Residents are not penalized at subsequent room checks when an incorrect dress has been noted at morning room check.

It is hoped that this routine will:

Help residents learn days of the week.

Become more aware of how clothes look in terms of color, pattern and care.

Encourage better grooming, impress that people notice what one is wearing.

Increase washing and ironing skills.

Eliminate argument that, although same dress was worn yesterday, it was washed and ironed last night. (Impossible for staff to monitor all residents' activities, and word must be taken even if condition of garment is suspect).

SLEEPING LATE ON WEEKENDS

Green group members may sleep later on weekends without penalty. On these days they are assigned no early morning tasks, nor do they have morning room check.

CIGARETTE LIGHTERS

Green group members ONLY may carry cigarette lighters providing:

(1) Lighters are surrendered at bedtime.
(2) Are not carelessly left lying around.
(3) They do not allow members of Red or Blue groups to use them.
(4) Smoking is done only in day hall, dining room, or in yard.
(5) Lighters are not misused.

If any of above are violated, lighters must be turned in immediately, to be kept for a penalty period of not less than one week. They may or may not be returned to resident, depending upon the seriousness of the situation.

WEIGHT RECORD

Because of the involvement of possible food deprivation residents are weighed once weekly, not monthly as is usually the case.

Residents with a tendency to overeat at mealtime or spend most of their tokens on candy and treats are charged for gaining weight. Generally, 5c per pound or portion gained is charged, but for continued excessive gains larger fines may be imposed on an individual basis.

Those for whom gaining weight is difficult are paid 5c per pound gained. "Picky" eaters are also reinforced with tokens for eating foods not especially liked.

BORROWING OR LENDING MONEY

Residents may lend or borrow money or tokens from each other. They must take the responsibility of repayment, or non-payment, as the case may be. Staff will not interfere or reimburse a lender who was not repaid. An exception might arise if an affluent resident is giving tokens to someone who is consistently shirking her responsibilities.

STEALING

Staff does not investigate claims of stealing unless a resident is caught doing so by a staff member. Responsibility for locking valuables in their lockers is assumed by the residents.

If someone is observed stealing by staff the resident's name is put on a "Stealing List" which is posted for all to see. At the end of each month a Resident's Court, under staff supervision, decides an appropriate penalty. Penalties range from suspension of privileges through doing extra ward tasks without pay, no dessert at dinner, reimbursement for the theft, extra exercise periods, or whatever is especially meaningful to the thief, i.e., TV or transistor radio is taken away for a brief period.

PROGRAM REVISIONS

Corresponding group leaders from day and afternoon shifts meet with the ward psychologist and ward charge every sixth week to review their group's programs and initiate required revisions. This policy tends to keep programs current within a six-week period. If emergency revisions are necessary for any resident a special meeting is held.

Residents concerned attend and are free to express concerns, ask questions, and offer suggestions. The standard suggestion is, "Promote Me."

Programs are discussed with residents and revisions explained. Talks focus on general behaviors and tasks. More subtle behavior shaping techniques and final revisions are conducted after residents are excused from the meeting. Revised programs are again reviewed with residents when they go into effect.

GROUP NOTEBOOKS

Five binder notebooks containing programs by group are available in the office. Correspondence between group leaders concerning their respective groups is clipped in the notebooks, as reminders for future program changes.

All staff are encouraged to leave suggestions, even if pertaining to residents not in their groups.

Any staff who wish may attend meetings for other than their own groups.

MEALS MISSED

A daily record of residents who do not eat is kept. Two symbols are used to denote whether the meal was missed by choice or was missed because of no funds:

+ = meal missed by choice, had ample funds.
o = meal missed, no tokens.

It is important that this daily record be accurate. The ward physician should be advised if meals have been missed for more than two days. He will wish to evaluate if health is in jeopardy if the situation continues.

WARD BOUNDARIES

Residents are considered to be "on the ward" if they are within areas adjacent to the building. (Refer to Ward Boundary Map).

If residents leave the immediate area without first gaining permission, they are considered "Off-ward without Permission." Being off the Hospital grounds without permission is considered AWOL. The following penalties may result for each infringement:

Off Ward Without Permission -

This may include being anywhere on the grounds (or on the ward roof) and may involve sneaking away to the Canteen, park, to visit on other wards, meeting friends, not returning from an errand, school, activity, or appointment within a reasonable time, and running off the ward as the result of a tantrum.

Fines are levied by group membership:

Red group - 10¢

Blue group - 20¢

Green group - 50¢

If a tantrum has precipitated the behavior or a resident has not returned from an activity, staff make a reasonable search of the grounds and return the resident to the ward if found. If the resident is not found, she is considered AWOL. (Security Officer AWOL notified, joins search).

<u>AWOL</u>

<u>Off the hospital grounds</u> without permission. When the resident is returned:

1. Immediately demoted to the Red group (temporarily).
2. Fine of $1.00 is charged.
3. Discussion of AWOL is ignored.
4. Residents encouraged to ignore runaway for 24 hours.
5. Resident may leave her room only to work on assigned tasks.
6. May purchase meals when fines are paid. Eats in dining room.
7. May be given extra jobs to pay fines if she has completed a reasonable number of her own jobs for the time of day.
8. Length of time in Red group is dependent upon individual cases.

SECLUDING RESIDENTS

When residents are secluded for tantrum behavior which may result in injury to self or others:

1. Remove all furniture from room.
2. Remove resident's shoes. (Furniture and shoes have been used to break door windows.
3. Lock door. Unlock when resident has been calm for at least [illegible] minutes. DO NOT CONVERSE WITH RESIDENT. UNLOCK DOOR AND WALK AWAY.
4. Resident has the chore of returning furniture to room, making bed, putting things in order.
5. If window of door has been broken, resident will pay a token cost for repairs. Green group - 50¢, blue group - [illegible], Red group - 10¢.

   Perhaps something can be taught about consequences of destructive behavior and destroying others' property.

6. If resident has destroyed her peer's property a token reimbursement may be charged, payable to peer, and within the economics of each group.

BUSSES - TRAINING RESIDENTS

1. Ascertain bus fare and bus numbers. Teach residents these facts.
2. Discussion with residents should include: consideration of what they want to purchase, how to budget money, time to be at the bus stop for return trip.
3. Acquaint residents with landmarks, such as large bus sign in front of Pomona Bus Station, which can be seen from the Mall.
4. Residents are accompanied by Staff Member the first and second trips. Give residents correct change and have them imitate actions of staff.
5. Place fare for return trip in envelope and give to resident. Emphasize that it is their responsibility to take care of it.
6. Have residents telephone the ward upon arrival in town. Use of the telephone can be taught on the ward with a practice phone.
7. Write telephone number on a piece of paper for residents to keep on their person.
8. If resident cannot read, teach her to dial "operator" and ask "Pacific State Hospital, Ward 43."
9. Resident should be acquainted with Public Rest Rooms, Pay Telephones.
10. Teach frequent time checks so as not to miss bus.
11. Familiarize residents with where they may wait for bus to return to the hospital.
12. Residents should ask bus driver, on boarding the bus, if he will let them off at "the Mall" and, on returning, at "Pacific State Hospital."
13. The ticket counter in the Bus Station will also help with any directions or problems.
14. If a bus is missed, residents should be assured that another will come later. They are to wait at the Bus Station.
15. Trips should be scheduled frequently so procedures are not forgotten.
16. Traffic lights and rules of crossing the street should be taught and reviewed before each trip.

17. Upon returning, staff should initiate review of day's activities.
18. Identification jewelry, recklace or bracelet, can be made with name and Hospital phone number, as an extra precaution.
19. Acquaint residents with The Mall in relation to the Bus Depot.
20. On second and subsequent trips encourage residents to take the initiative.
21. When resident makes first trip without staff, follow in car and observe.

DINING ROOM EXPECTATIONS

Each resident should contribute to appropriate dinner table conversation.

Girls should be helped to use appropriate silver for the food being eaten, and also to hold utensils properly.

Talking while chewing should be discouraged.

Loud boisterous behavior, such as yelling across the room to someone at another table, should be discouraged.

Staff members who are in the dining room or those who are eating with residents should observe for the behaviors listed above. They should make suggestions for improvement of eating habits and set appropriate examples for residents to follow.

Residence

Twice monthly there will be a dinner party at the residence. The women who attend will be chosen on the basis of their efforts to improve and actual improvement noted in dining room behavior and eating habits. Another group of women will be chosen to help prepare and serve the meal. This situation will be reversed at the second monthly dinner.

Dinner in Town

For those women who demonstrate an ability to conduct themselves in an acceptable manner at both parties, the opportunity for a dinner trip into Pomona will be offered.

WARD STORE - "THE PINK ELEPHANT"

Residents may buy certain items from the PINK ELEPHANT on the installment plan. The items that may be bought are: (priced by Group rates)

ITEM	GREEN GROUP	BLUE GROUP	RED GROUP
Bedspreads	$3.00	$1.00	--
Curtains	1.00	.50	.25
Shoes	2.00	.75	.30
Radios	4.00	2.50	2.00
Clocks	5.00	3.00	--

Or any item which costs 50c or more. All *items brought back from visits will be purchased through the "PINK ELEPHANT." The item should be marked with the resident's name, the date, and the price. These items may be and should be encouraged to be purchased via contract. Any item remaining in "PINK ELEPHANT" for one month will be returned to the parents.

In General:

The Staff Member selling the item will explain installment plan buying and then draw up the "Contract." The weekly installments should not extend beyond four (4) weeks, but can be paid off at any time before final payment due. The original copy of the contract to remain in the Store, the carbon copy to be given to the Resident. The Resident will forfeit item if final payment not made on "Final Due Date."

CONTRACT

NAME:_____

ARTICLE:_____

DATE OF PURCHASE:_____

PAYMENT:

#1_____ #4_____

#2_____ #5_____

#3_____ #6_____

FINAL DUE DATE:_____

TOTAL PRICE:_____

STAFF INITIALS:_____

RESIDENT'S SIGNATURE:

_____

*With the exception of Christmas, birthday, and other special occasions.

Consent for Token Economy Project*

January 27, 1967

I, the undersigned, in my capacity as legal guardian consent to have

_____ included in the Token
(Name)

Economy Program. I understand that this program will involve earning tokens by appropriate behavior in order to pay for privileges, meals, and living accommodations. I understand visiting privileges and home leaves are encouraged, but such privileges will be dependent on the decision of the staff based on the need and behavior of the individual patient.

_____

_____

*See next page for revised consent form currently in use.

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY RONALD REAGAN, Governor

DEPARTMENT OF MENTAL HYGIENE
PACIFIC STATE HOSPITAL
BOX 100
POMONA, CALIFORNIA 91766

Consent for Token Economy Project

I, the undersigned, in my capacity as legal guardian, consent to have

_____ included in the Token
(Name)

Economy Program. I understand that this program will involve earning tokens by appropriate behavior in order to [illegible] for privileges, meals, and living accomodations. I understand visiting privileges and home leaves are encouraged; but such privileges will be dependent on the decision of the staff, based on the need and behavior of the individual patient. Leaves may be requested for one weekend per month (Friday evening to Sunday); visits for the day on Saturday or Sunday.

I am aware that this program is directed toward either return home or family care placement; and that, whenever,upon the decision of the Ward Team, it is thought that such placement is appropriate, such plans will be made.

_____

_____

880 PS (3-12-69)

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY
RONALD REAGAN, Governor
DEPARTMENT OF MENTAL HYGIENE
PACIFIC STATE HOSPITAL
BOX 100
POMONA, CALIFORNIA 91766

November 7, 1967

Dear _____:

In order to facilitate our ward scheduling over the Christmas Holidays, we would appreciate knowing any plans you might have for Definite Leave for your daughter _____, at that time

Please advise us by December 10, 1967, as no requests for Leave may be arranged after that date.

Thank you very much.

Sincerely yours,

_____
Lois Sibbach, R.N.
Charge Nurse, Ward 43
Token Economy Program

LS:rrg

STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY RONALD REAGAN, Governor

DEPARTMENT OF MENTAL HYGIENE
PACIFIC STATE HOSPITAL
BOX 100
POMONA, CALIFORNIA 91766

May 27, 1968

Dear _____:

The Residents of Ward 43 will host a dinner party to parents on Sunday, June 9, 1968 and again on Tuesday, June 25, 1968. You may choose to be entertained by your daughter and to sample her cooking on either of these two dates.

Please let me know if you can attend, and which day will be more convenient for you.

Sincerely,

_____
Patricia Marks, R.N.
P.M. Charge, Ward 43
Token Economy Program

RSVP by Monday June 3, 1968, if you plan to attend on June 9th.

RSVP by Wednesday June 19, if you plan to attend June 25th.

PM:rrg

REINFORCEMENT/FINE SLIPS

Reinforcement/Fine Slip

Name_____ Date:_____

Amount Fined:_____

Amount Reinforced:_____

Reason:_____

_____

_____

Signature:_____

/ / 68

Initial: _____

Issued for:
Appropriate behaviors, inappropriate behaviors, non-completion of tasks when payment cannot be made immediately.

PERMISSION SLIPS

P E R M I S S I O N S L I P

DATE: _____

_____ MAY LIE

DOWN UNTIL _____

_____

(SIGNATURE)

LS:rrg
Nov. '67

Issued to resident after group leader ascertains that a reasonable number of tasks for the time of day have been completed.

Nap cost - 5¢/hour.

P E R M I S S I O N S L I P

DATE: _____

_____ MAY

USE RECORD PLAYER UNTIL _____.

_____

(SIGNATURE)

LS:rrg
Nov. '67

No charge for use of record player if reasonable number of tasks are done

P E R M I S S I O N S L I P

DATE: _____

_____ MAY WATCH

TELEVISION UNTIL _____.

_____

(SIGNATURE)

LS:rrg
Nov. '67

No charge for watching TV if reasonable number of tasks are done.

ACTIVITY LIST

ACTIVITY:_____

DATE OF ACTIVITY:_____

SRTs REQUIRED:_____

BE READY BY:_____

RESIDENT	SRTs PAID

ALTERNATES

:rrg
June, 1968

Activity Lists are posted in a place convenient for residents. Sign up is on a first come, first served basis in most instances.

DAILY WARD JOBS

_____	Clean bathroom sinks, drinking fountain	AM & PM
_____	Clean toilets	PM
_____	Sweep and mop bathroom floor and shower floor	AM
_____	Sweep and mop dining room floor after meals	
_____	Sweep and mop long hall	AM & PM
_____	Sweep and mop short hall	AM & PM
_____	Sort linen and bag it	PM
_____	Empty trash cans	AM & PM
_____	Wash tables after meals	
_____	Straighten Day Room furniture, dust, ashtrays	MORNING
_____	Straighten Day Room furniture, dust, ashtrays	AFTERNOON
_____	Straighten Day Room furniture, dust, ashtrays (sweep if necessary)	NIGHT - PM
_____	Set tables before meals, pour milk	AM NOON PM
_____	Sweep and mop Day Hall	AFTERNOON
_____	Sweep and mop Day Hall	NIGHT
_____	Clean area around trash cans and rose yard	PM
_____	Fold towels, cloths, rags	AM
_____	Stock shelves and bathroom with toilet paper and towels	AM
_____	Sort dirty linen (private)	PM MON.,WED.,FRI.
_____	TAKE (Private) clothes to laundry	TUES.,THURS. P.R.N.
_____	Sort and fold clean laundry	
_____	Wash Bank windows, door and cupboards in back hall	

Sweep and mop back hall, Med. Room, Staff Restroom	AM
Sweep and mop back hall, Med. Room, Staff restroom	PM
Clean blackboards	PM
Shower Monitor	PM
Shower Monitor	AM
Clothes Room	6:30 to 7:30 PM
Utility Closet	AM & 9:00 PM
Clean Office	9:00 PM
Clean Coffee Room	9:00 PM
Clean Wastebasket	3 x week
Scrub bathroom tile	AM
Clean front steps	PM
Buff 1 x week	
Clean shelf in back hall	AM & PM
Fold sheets	1 x week
Clean yard, pick up papers, trash	AM
Staff bathroom	8:00 PM
Empty, clean ash trays	10:00 PM
Water garden - at Sunset	

APPENDIX

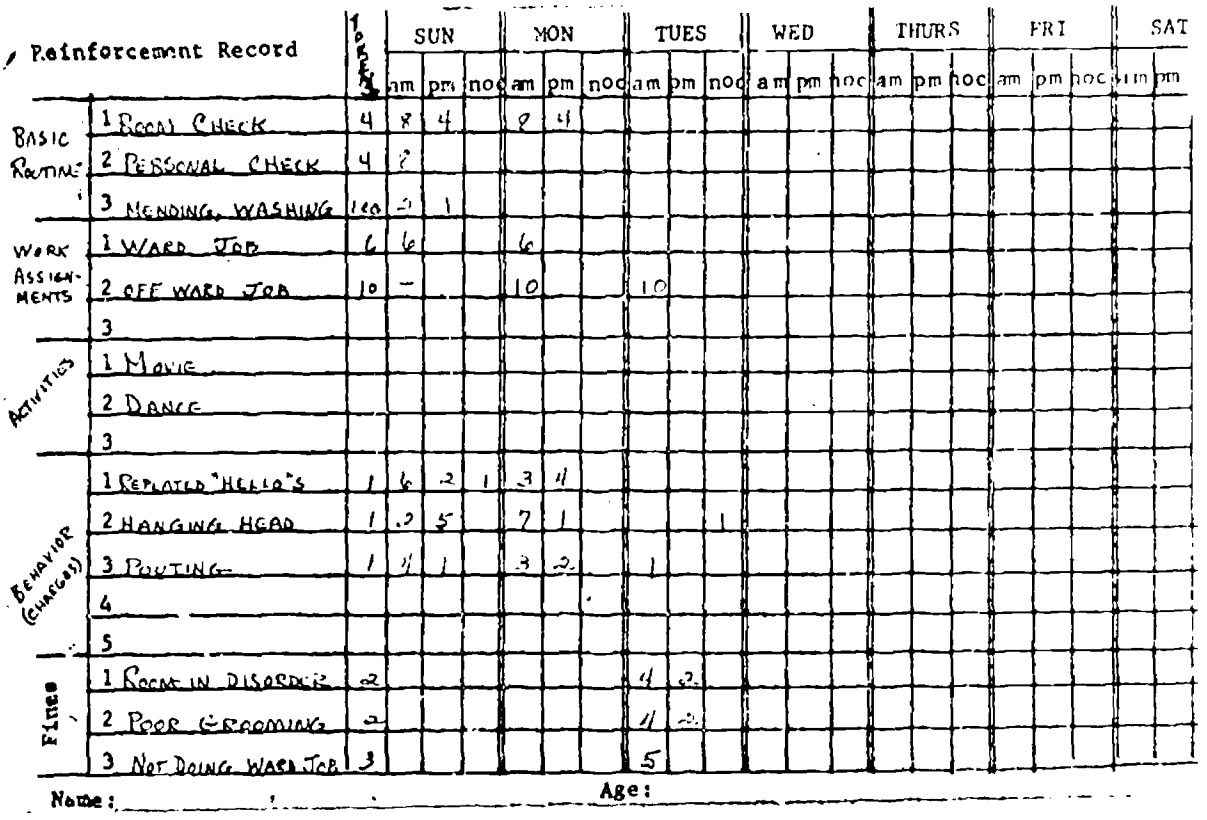
Appendix A

BEHAVIOR TO REINFORCE, STRENGTHEN	REINFORCEMENT SCHEDULE
1. Any effort toward improved grooming. 2. Industry and motivation related to work situations.	1. Give much praise and reinforce with 1 token intermittently - up to 5/day. 2. Reward intermittently up to 5/day.
CAMPUS PRIVILEGES: Alone	BEHAVIOR TO EXTINGUISH
	1. Tantrums 2. Poor grooming, hygiene
NAME:	AGE:

FIRST "PROGRAM" FORMAT USED.
Initial observations were noted as well as subsequent emerging behaviors.

Appendix B

REINFORCEMENT RECORD



Reinforcement Record		Points	SUN			MON			TUES			WED			THURS			FRI			SAT	
			am	pm	noc	am	pm	noc	am	pm	noc	am	pm	noc	am	pm	noc	am	pm	noc	am	pm
BASIC ROUTINE	1 Room Check	4	8	4		8	4															
	2 Personal Check	4	2																			
	3 Mending, Washing	100	-1	1																		
WORK ASSIGNMENTS	1 Ward Job	6	6			6																
	2 Off Ward Job	10	—			10			10													
	3																					
ACTIVITIES	1 Movie																					
	2 Dance																					
	3																					
BEHAVIOR (CHARGES)	1 Repeated "Hello's	1	6	-2	1	3	4															
	2 Hanging Head	1	-2	5		7	1				1											
	3 Pouting	1	1	1		3	-2		1													
	4																					
	5																					
Fines	1 Room in Disorder	-2							4	-2												
	2 Poor Grooming	-2							1	-2												
	3 Not Doing Ward Job	3							5													

Name: _____ Age: _____

As programs became more intricate, this record was replaced with job cards upon which these notations were listed. Staff and later residents carried the job cards with them.

Appendix C

RED GROUP

I. GROOMING
   A. Daily shower - in A.M.
   B. Room checks - 3 x per day - 30 minutes before meals
      1. Person
         a. Use of deodorant, toothbrush, comb, lipstick
         b. Must have had A.M. shower to pass "person"
      2. Clothes
         a. Clean STATE dress - must be marked with corresponding day of the week.
         b. Dress ironed
         c. Wash and iron own clothes
         d. Any clothes replacements needed will be purchased from the ward store
      3. Shoes - reasonably clean and/or polished
      4. Clean room
         a. No dirt on floor, no dust, bed made appropriately
         b. Locker clean - clothes folded on shelves - neatly hung on hangers
         c. Room orderly

II. ON-WARD JOB ONLY - rotate job assignments p.r.n.

III. PRIVILEGES
   A. Meals
   B. On-ward Recreation
   C. Television - may watch if reasonable number of tasks done
   D. Record Player - pay to use on half hour basis. Must have permission slip
   E. Naps - none before lunch. Pay by the hour. Must have permission slip
   F. Ward parties
   G. Canteen - Must be accompanied by staff. May not go if there is no money on Canteen Card
   H. Leaves and visits

I. Movie - weekly

J. Residence - may go as an "alternate" if Blue or Green group member does not go. Must use SRT as payment to go.

K. Off grounds trips. Must use SRT as payment to go.

L. Telephone calls. Use SRT as payment for call. May make one call per month, limited to 5 minutes conversation.

IV. Campus WITH STAFF ONLY

V. INDIVIDUAL PROGRAMMING

VI. SALARY SCALE

A. Meals - 10¢

B. Pay on sliding scale if some attempt has been made to do a task

VII. NO GUESTS FOR MEALS

BLUE GROUP

I. GROOMING

A. Daily shower - in P.M.

B. Person, clothes, shoes, room, on-ward job - same as for Red group

C. Wear own clothing. Must buy replacements at ward store

II. OFF-WARD JOB

A. Supervised by Ward 43 staff

B. Ward 5 or Workshop on Ward 28

III. PRIVILEGES

A. All of Red Group Privileges - PLUS:

B. Residence - pay tokens instead of SRTs to go

C. Dances

D. Hollywood A-go-go

IV. Campus WITH ONE OTHER RESIDENT

A. May drop to "staff only" occasionally if is irresponsible

B. Frequent loss of campus privileges will result in demotion to Red group

V. INDIVIDUAL PROGRAMMING

VI. PAY SCALE
  A. Off-ward jobs - sliding scale; better performance, more pay.
    1. Ward 5 job pays tokens only
    2. Workshop pays tokens in same manner as Ward 5 job, also pays 20¢ an hour real currency
  B. Meals - 20c

VII. GUESTS FOR MEALS
  A. May have one guest per month. Must pay for guest's meal
  B. Arrange with guest, inform staff one day in advance

GREEN GROUP

I. GROOMING
  A. Shower - minimum of 1 per day - choice of A.M. or P.M.
  B. Room checks done on random basis. If fail room check, will have continuous room checks until passes
  C. All expected of other groups

II. OFF WARD JOB
  A. No staff supervision
  B. "Docked" if late to work
  C. If not already assigned to job paying real money, will rotate to Workshop for one month periods. Will work afternoons on regular off ward assignment
  D. Pay - $2.00 a day in tokens + real money when in workshop

III. INDIVIDUAL PROGRAMMING

IV. PRIVILEGES
  A. All afforded Red and Blue Groups, plus more specialized off-grounds activities
  B. Plans for alone into City for shopping, lunch

V. SALARY
  A. Weekly basis
  B. $25.00 per week.

VI. CAMPUS ALONE - If abuse privilege, Campus Card may be suspended for a period of days

VII. GUESTS FOR MEALS
  A. May have one guest per week. Must pay for guest's meal.
  B. Arrange with guest, inform staff one day in advance.

Appendix D

ACTIVITY PRICE LIST

ACTIVITY	GREEN GROUP	BLUE GROUP	RED GROUP
Movie	.25	.10	.05
Dance	.50	.20	no
Residence	.50	.10	SRTs
Canteen	no charge	.20	.10
Walk	no charge	.20	.05
Library	no charge	.20	no
Trips	SRTs	SRTs	SRTs
Dinner Guests	.50	.20	nb
Visits	.50/day	.25/day	.15/day
Leaves	.25/night	.10/night	.05/night
Off-ward Parties	.50	.20	no
Cigarettes	1.00/pack	.05/cig.	.05/cig.
Shopping trips	.50	.25	no
Visits to other wards	no charge	.20	no
Beauty Shop	.25	.20	.05
App't with Doctor	.50	.25	.10

This price list remained in effect until the time when all fining was discontinued. All off-ward activities were then made dependent upon the payment of Special Reinforcement Tokens (SRTs).

Appendix E

DINING ROOM PROCEDURE

Green Group	Blue Group	Red Group
Price of meals - 50¢	Price of meals - 20¢	Price of meals - 10¢
Dishes - Residence type Regular silverware	Dishes - Plastic dishes Regular silverware	Dishes - Plastic trays Regular silverware
Table decorations - Tablecloth Centerpiece	Table decorations - Plastic placemats	Table decorations - none
Type of eating - Family style *Charge 20¢ for every pound or fraction of a pound gained	Type of eating - may have seconds of main dish only. *Charge 10¢ for every pound or fraction of a pound gained	Type of eating - tray with fixed amount. No seconds. Employee at each Red Group table
May eat off ward	May eat off ward	No off-ward meals
May have guests ad lib. Also pay for guest's meal. Must make reservation	May have guests occasionally. Also pay for guest's meal. Limit to 2 x per month. Must make reservation	No guests
Special dinner parties Female guests on ward Male guests - residence Family - residence	Special dinner parties Female guests on ward Male guests - residence Family - residence	No special dinner parties

*Weighed once weekly.

Table Manners

No talking with mouth full.

Table posture - No elbows on table

Proper use of napkin

Chewing with mouth closed

No food spilled on clothing

Dessert depends upon appropriate manners.

Appendix F

WORK EVALUATION

RESIDENT'S NAME:_____

DATE:_____ TECHNICIAN'S INITIALS:_____

1. Physically goes to work: .05 _____

2. Amount of supervision required to do job - not supervision to and from, or for getting along with others - supervision required to do a task. _____

.00	.05	.05
Total, or very frequent close supervision.	Average amount - definitely supervised but can be left alone.	Minimal, works quite independently

3. Initiative shown - does Resident go to job and begin it herself and find another appropriate new job when finished _____

.00	.05	.05
Has to be led to each job. Runs away or leaves	Average. Told what to do	Starts job, and occasionally finds new things to do.

4. Getting along with other Residents and with Staff. _____

.00	.05	.05
Excessively sassy	Gets along all right	Pleasant - can even take some stress.

5. The degree to which a girl tries to do a good job - a measure of effort - not output. Each girl judged against amount of effort she herself can make. _____

.00	.05	.05
Makes no effort	Average for <u>this</u> girl	Tries very hard to do well.

6. Actual productiveness - a measure of how much a Resident accomplished, not how hard she tries. _____

.00	.05	.05
Almost nothing accomplished	Average amount done.	Gets a great deal of work done.

TOTAL PAID: _____

LS:rrg
6-6-68

Appendix G

REASONS TO REWARD WITH SPECIAL REINFORCEMENT TOKENS

WARD 43

Adeline

1. Speaking distinctly, easily heard (but not shouting).
2. Neat, attractive appearance.
3. Acceptance of criticism without hanging head and pouting.
4. Mature behavior when talking with Staff (no nicknames, clinging and patting, ogling).

Gloria

1. Cheerfulness and cooperativeness with Staff and Residents.
2. Cleanliness - no body odor, good oral hygiene.
3. Friendship with other Residents (besides Carol and Nedelle).
4. Helping other voluntarily.
5. "Grown-up" behavior in peer interpersonal relationships.
6. Speaking up clearly.

Debra

1. Helping Staff and Residents with a positive attitude.
2. Acceptable behavior on Off-Ground Trips.
3. "Grown-up" behavior when meeting people or when in a new situation.
4. Positive interaction with other Residents.

Joyce

1. Refraining from verbalizing under stress conditions.
2. "Appropriate" conversation with Staff.

Sharon

1. Appropriate conversation and interaction with Staff.
2. Attention to personal grooming.
3. Quietly and cheerfully carrying out assigned duties.
4. Appropriate participation in group activities.
5. Care of own room.

Carol

1. Responding to Staff in whole sentences, preferably 5 or more words.
2. Initiating conversation with Staff.
3. Socializing with Residents on a verbal level - not giggling.
4. Indications of responsibility - e.g., completing task with minimal supervision.
5. Interaction with Residents other than special group of friends.

Joyce

1. Speaking with other Residents and with Staff. Eye contact.
2. Walking with group.
3. Cooperation and cheerfulness with other Residents and Staff.
4. Developing friendships among Residents.
5. Cleanliness and good grooming.
6. Dependability when on off-ward errands. Promptness in returning.

Nedelle

1. Immediate positive verbal responses when spoken to or asked questions - (instead of deep frown and silent stares).
2. Mature attitude on ward and during Off-Ward Trips. (Absence of giggling, clinging, calling Staff "Mommy," infantile playing with peers, including slapstick games, hide and seek, etc.).
3. Any effort to be helpful to other Residents.
4. Positive attitude toward participation in Off-Ward activities.

Lana

1. Speaking in normal tones.
2. Positive changes in appearance. (Hair especially well-done, posture, walking without dragging feet).
3. Appropriate handling of stressful situations. (No whining, rocking, hyperventilating, twisting hair, shouting and crying).
4. Ability to come into the office (when invited) and not make comments or attempt to sleep on desk, bookcase, or lean against wall.

Joan

1. Cheerfulness and cooperativeness with Staff or Residents.
2. Planning ahead and doing a job with less than usual supervision.
3. Saving and banking money.
4. Acceptable behavior in public - Off-Ward with other Residents, etc.
5. Acceptable behavior away from Hospital, e.g., Home Visit.
6. Not over-indulging in coffee when it is available.

Sylvia

1. Cheerfulness and cooperativeness with Staff and Residents.
2. Bowel and urinary continence - reinforce for clean and dry bed at A.M. Room Check.
3. Good table manners.
4. Acceptable behavior during Home Visit. Briefly interview Sylvia and mother on return and reinforce immediately.
5. Good Off-Ward school performance.
6. Reading to other Residents.

Maureen

1. Ability to tolerate criticism without being irritated.
2. Does not get angry when anger could be expected.
3. When she handles her anger effectively - when she leaves the scene instead of expressing hostility directly toward someone.
4. Ability to take responsibility, stick to a task, and do job well.
5. Punctuality.

Loretta

1. Making decisions independently (without others' influence).
2. Punctuality and thoroughness in doing assignments.
3. Mature behavior in stress situations.
4. Taking initiative in her responsibilities.

Betty

1. Increased speed in ironing, hair-setting, completion of tasks without wasting time or complaining.
2. Any offer of help to others without suggestion from Staff to do so.
3. Accepting suggestions from Staff without repeated arguing.
4. Cessation of repeated questioning after something has once been explained.
5. Positive social interaction with peers and Staff; smiling, etc.
6. Appearance, including hair, clothes, posture, make-up.

Pamela

1. Cheerfulness and cooperativeness with Staff and Residents.
2. Any obvious courtesy shown to Residents.
3. Any effort shown on her part to try and control her emotions.

Julia

1. Talking slowly and clearly.
2. Not whining and blowing up in stress situations, i.e., interaction with Pam and Joan.

Iris

1. Prompt completion of any task. Initiative.
2. More mature behavior when talking to Staff. (No poking to get attention, calling Staff "Hey," interrupting Staff and other Residents).
3. Proper use of Residents' and Staff's names.

Margaret

1. Cooperativeness with Residents in a positive manner.
2. Accepting criticism without pouting or anger.
3. Doing a job, even though she doesn't want to do it.

Appendix H

Ward 43 Date_____ SPECIAL REINFORCEMENT TOKEN

RESIDENT	STAFF	TIME	S.R.T.	DESCRIPTION OF EVENT

Appendix I

I. SUGGESTED SCHOOL PROGRAM

A. Language Development.

There is a suggested language deficiency on almost every girl's chart. This is universal among retarded children. Since we encourage these children to verbalize as far as possible in all situations, I consider this the most important need.

1. Increasing vocabulary.
   a. Learning names of persons, things, places, and using correct names.
   b. Learning to listen to and follow directions.
   c. Making needs known with acceptable verbalization.
2. Improving speech.
   a. Eliminating baby talk, omissions, substitutions.
   b. Making correct sounds.
   c. Developing pleasant speaking voice.
3. Improving oral expression.
   a. Telling experiences, stories, etc.
   b. Participating in dramatic plays, discussion periods, group conversations, psycho-drama, etc.
4. Improving verbal socialization.
   a. Good manners.
   b. Carrying on conversation, playing with others, etc.

B. Perception Training.

1. Training in comparison, discrimination, and recognition.
2. Making letters and numbers (for non-readers and slower girls).
3. Learning concepts of quantity, size, amount, etc.

C. Academic Skills.

1. Learning to tell time, day, week, month, hour.
2. Learning to recognize numbers, count, use number concepts and combinations.
3. Learning to use, count, and budget money.
4. Reading.
   a. Names of people, streets, articles, labels on packages.
   b. Simple messages and notes.
   c. Community reading such as traffic signs, emergency signs, bus schedules, job applications, menus, etc.

5. Social Studies Activities.

   a. Simple geography of where we are - city, state, etc.

   b. Community resources such as police, hospitals, welfare, legal aid, recreation, etc.

   c. Job opportunities, work shops, etc.

   d. Practical arts dealing with home and housekeeping that are essential to girls going into foster homes.

   e. Basic safety education for community life.

   f. Health education that includes simple understanding of how disease is transmitted, avoiding drugs and medication except under direction, proper dress for community, reporting accidents.

D. Art Experiences.

   1. Music, dance, exercises, etc.

   2. Arts and crafts.

   3. Dramatic Play

II. PROJECTED ORGANIZATION OF PROGRAMS

A. My Role in the School Program.

   1. I would serve as teaching consultant for the ward.

   2. The girls would attend class with me one afternoon a week in small groups. At this time I would begin the unit of work for that week.

   3. The following day I would meet with the ward staff for an in-service training session. During this time I would explain the work for the week, demonstrate teaching techniques with girls and offer suggestions for carrying out lesson plans.

   4. During the rest of the week, I will visit and observe when possible, but NEVER take over class period and do the teaching.

   5. Because of the caliber of the ward staffing, I believe that the staff can effectively carry out a well organized school program without interference.

   6. I would hope that most problems and all suggestions from me could be handled during the period of weekly in-service training.

   7. I can adjust my working schedule in any way necessary to accomodate the needs of both the AM and PM shifts.

B. Materials will be supplied by the School Department whenever possible.

C. All class sessions will be held on the ward!

Prepared by Alice Watkins

Appendix J

GLORIA C.

SHAPE

Gloria will have 3 room checks (6:45, 11:30, 4:30) and will be paid or charged according to the following schedule:

I. Personal Hygiene. 10¢ paid her if fulfilled (all-or-nothing); 5¢ charged if not.
   a. Shower (at 6:45 check she is to report two showers: one the previous day, and one in the AM before the 6:45 check). Check body for cleanliness, especially her feet.
   b. No body odor; use of deodorant.
   c. Oral hygiene: teeth brushed regularly and gargle when appropriate.
   d. Hair well-groomed.
   e. Appropriate menses hygiene.
   f. Neat garments, outer and under. Clean dress daily.

II. Room. 10¢ paid her if fulfilled (all-or-nothing): 5¢ charged if not. In addition to regular room expectations (these should be increased as appropriate), there must be evidence of a flushed toilet, she must have a neat and orderly wardrobe, and the floor should be clean under her bed.

EXTINGUISH - charge as follows:

1. Pouting - 2¢
2. Negativism - 2¢
3. Sarcasm - 2¢
4. Hanging on staff - 2¢ (includes grinding teeth near staff)
5. Poor eye-contact (not looking directly at you) when speaking to her - 1¢
6. Hitting - 5¢
7. Tantrum (including slamming doors, throwing things, etc.) - 10¢. If the tantrum does not stop when ordered, she is to be placed in seclusion for a minimum of 1 hour (or longer if tantrum continues). Remove mattress.

- If Gloria gets in debt 10¢ or more that she can not pay, she is to pay off her debt by 1 hour of seclusion for each 10¢ owed. She must miss any event which coincides with her seclusion. Of course, if she can pay off her fines in tokens, she will not have to be secluded.

- If Gloria has not received any fines for 24 hours by the 4:30 check she is to be given a bonus of 10¢ and appropriately praised.

INCENTIVES

Every time Gloria leaves the ward for activities of her choice (school, dance, walk, canteen, outing, etc.), she must pay 10¢ for this privilege. In addition, she must be clean and well-groomed according to her personal hygiene schedule.

Other schedules not specifically mentioned will remain in effect.

5-31-67

Appendix K

DEBRA D.

A. BEHAVIORS TO BE POSITIVELY REINFORCED:

1. Helping staff and residents with a positive attitude.
2. Acceptable behavior on off-ground trips.
3. "Grown-up" behavior when meeting people, or when in new situation.
4. Positive interaction with other residents.

Debra is to be praised and/or reinforced with tokens - usually 5¢, but up to 35¢ for an outstanding behavior.

B. BEHAVIORS TO BE CONTROLLED:

1. Stealing.
2. Bullying other residents.
3. Lack of responsibility on off-ward job, particularly, but also on other tasks.
4. Excessive negativism or defiance of staff.

NOTE: STAFF SHOULD MAKE EVERY EFFORT TO IGNORE NEGATIVISM!

Behaviors to be controlled by: (a) sending to her room, with door closed but unlocked, for a period of time sufficient to cool off, (b) by fining an appropriate amount of money - dependent upon the severity and frequency of infractions. Fines should range from 5¢ to 15¢, and should be explained to her after she is calm.

If any specific unacceptable behavior persists, Debra may be required, for a minimum of three days, to wear State clothes. This may be done ONLY by the Shift Charge.

C. BEHAVIORS TO BE IGNORED:

1. Negative interaction with others.
2. Belligerence toward employees.

D. SPECIAL ASPECTS OF PROGRAMS:

Debra is to use a checkbook instead of tokens, with all reinforcement, fines, income and expenses duly noted.

E. GOALS:

1. Behavioral:
   If Debra is to be placed in a Family Care situation in the near future, she must have a more mature attitude and a greater sense of responsibility. Also a more clearly defined idea of right and wrong, and a knowledge of the consequences of going against the standards set by society.
2. Placement:
   Home being sought for Family Care placement.
   This should be stressed to Debra over and over again in reference to her program as a whole. She should be motivated to work toward this goal.

12-11-67

Appendix L

BETTY S.

A. BEHAVIORS TO BE POSITIVELY REINFORCED:

To be intermittently reinforced with verbal praise and/or SRI's when she demonstrates exceptional initiative. REINFORCEMENT ON SLIDING SCALE.

1. Increased speed in ironing, hair-setting, completion of tasks without wasting time or complaining.
2. Any offer of help to others without suggestion from staff to do so.
3. Accepting suggestions from staff without repeated arguing.
4. Cessation of repeated questioning after something has once been explained.
5. Positive social interactions with peers and staff; smiling, etc.
6. Appearance, including hair, clothes, posture, make-up.

B. BEHAVIOR TO BE PHYSICALLY CONTROLLED:

1. Extreme negativistic behavior which involves swearing at residents or staff; persistent arguing, ("Idon't see why I should have to," "I won't do").
2. Sitting in halls or day room griping for long periods (over an hour) instead of completing tasks.
3. Disruptive arguing with residents.
   If, after being given reasonable opportunity to resume assignments and/or settle down, she continues to be grossly negative, she is to go to her room and remain there until she has gained enough poise to continue with her assignments. If a negative period coincides with mealtime, she will remain in her room unless she feels capable of functioning positively. Her door is to remain closed (unlocked) while she is in her room.

C. BEHAVIOR TO BE EXTINGUISHED:

Ignore Without Comment:
Repeated questions about things you feel certain she already understands, i.e. feigning ignorance as to when she may have a cigarette.
Extinguish:
Procrastination, taking extraordinary time in ironing, hair-setting. (Use timer whenever possible. Charge-as if task not completed in time set).

D. SPECIAL ASPECTS OF PROGRAM:

Focus should be on strengthening the positive aspects of interpersonal relationships and socialization. Betty should be

reinforced immediately whenever she displays helpfulness, enthusiasm, promptness in completing tasks, participation in social activities, i.e. dances, movies, trips, residence visits, etc., without having had to be coaxed. An explanation of why she is being reinforced should be made.

TREATMENT OF NEGATIVE BEHAVIOR:

If sullen, brooding, and demonstrates an obviously negative attitude, but is still actively engaged in completing her assignments, she will be allowed to continue, BUT will not be allowed any interaction with staff. She will be ignored whenever she asks questions, starts conversation. Response by staff will be made ONLY if she demonstrates politeness and absence of hostility and negativism.

E. GOALS:

1. Behavioral - development of positive social skills, strengthening of interpersonal relationships, more budgeting of time in relation to task completion without intermittent procrastination.
2. Placement - direct placement from Hospital to Family Care. Plans now in progress for placement.

Appendix M

ACTIVITY PRICE LIST

	Cost in SRTs		
	Green	Blue	Red
Movie	3	3	2
Dance	3	3	no
Residence overnight	2	2	2
Residence for evening	1	1	1
Canteen - 30 minutes	2	3	3 with staff
Walk - 1 hour	2	2	2 with staff
Dinner guests - at residence	3	2	no
Dinner guests - on ward	2	3	no
Visits - for the day	2	2	2
Leaves - overnight or longer	4	4	4
Off ward parties	1	1	no
Swimming pool - 1pm to 3:30 pm	2	2	2
Off grounds activities			
Half day (includes evening activity.	2	2	2
All day	4	4	4
Appointment with doctor	1	1	1
Appointment at beauty shop	1	1	1
Visits to staff on other wards	2	2	no
Bicycle riding - 1 hour	1	1	1 with staff

Green group members have been charged less SRTs in some instances because they are employed off the ward for several hours a day and do not have an opportunity to receive SRTs for that period.

Appendix N

RATING SCALE (where applicable)

Performed independently	= 1
Performed with minimal direction from staff	= 2
Totally dependent on staff for direction	= 3
If not observed	= 0
If questionable	= ?

Use back of sheet for additional remarks; i.e., 32. No toilet paper available. Did not request same.

ACTIVITIES OF DAILY LIVING	DAYS	PMS*	NOCS**
1. Arises within ½ hour			
2. Washes hands after toileting			
3. Washes face			
4. Brushes teeth			
5. Applies deodorant			
6. Combs hair			
7. Makes bed			
8. Changes sheets (weekly or PRN)			
DRESSING AND CARE OF CLOTHES			
9. Wears proper underclothes (including bra, panties, slip)			
10. Wears clean, neat dress or sport outfit			
11. Wears shoes (in good condition)			
12. Colors match			
13. Selects clothes appropriate for activity/occasion			
PUNCTUALITY, EATING HABITS			
14. On time to get medications			
15. Washes hands before meals			
16. Arrives promptly for meals			
17. Assists with setting up for meals			
18. Handles all eating utensils with ease			
19. Demonstrates polite table manners (define)			
20. Assists with cleaning up after meals			
21. Avoids interfering with eating of others			
22. Talks with peers at mealtimes			
GROOMING; HYGIENE			
23. Showers daily			
24. Proper menstrual hygiene (define)			
25. Shaves legs, underarms			
26. Washes own hair p.r.n.			
27. Ladylike posture when seated			
28. Sets own hair			
29. Applies makeup properly			
30. Cares for own nails (define)			
31. Flushes toilet after use			
32. Uses toilet paper after elimination			
33. Demonstrates reasonable modesty			

*PMS = afternoon shifts

**NOCS = night shifts

CARE OF OWN ROOM				
34. Makes bed				
35. Sweeps floor				
36. Dusts furniture				
37. Keeps locker, bedside stand in order				
38. Hangs up or folds clothes				
PARTICIPATION IN WARD ACTIVITIES, TASKS				
39. Demonstrates initiative in joining activity				
40. Makes constructive use of free time				
41. Participates readily				
42. Follows directions				
PREPARATION FOR H.S.				
43. Washes face and hands				
44. Brushes teeth				
45. Wears proper noc clothes (?)				
46. Time of H.S.				
47. Sleep pattern (check one): restless soundly short interval				
48. Continent				

/11t

Appendix O

PACIFIC STATE HOSPITAL

INTER-OFFICE MEMORANDUM

To Treatment Program Planning Committee Date 9-20-65

From Thomas S. Ball, Ph.D.

Re Token Economy (Operant Conditioning) Program

We propose that a pilot research and demonstration "Token Economy" (operant conditioning) program be established on a ward at Pacific State Hospital for a trial period of six months. Since there is ample evidence from studies originating at Patton, Parsons, and elsewhere that a program of this type is potentially of great value, it is assumed that every effort should be made to provide a successful demonstration supported by scientific evidence of efficacy. Once such a demonstration is successfully made the pilot ward could serve as a training center for personnel from wards to which it could subsequently be "exported." However, experience has demonstrated that loosely controlled programs based on the Patton model can and do fail.

The following features are seen as basic requirements for a token economy program:

1) Employees and patients must be selected in terms of their appropriateness for the program. Existing ward employees and patients would remain only if they fulfill the necessary requirements of the project director.

2) Patients must earn tokens as payment for food and living accomodations as well as privileges such as attending movies, going to the canteen, etc. Except at the beginning only rarely would a patient miss a meal. However, the principle "no token, no meal" must be clearly established.

   Fines for inappropriate behavior would be used but not in a punitive manner. Censure would be avoided but the patient would be made to understand that he would have to pay for the privilege of avoiding responsibility, e.g., if he wants to remain in bed during working hours and is not ill, he must pay for the privilege.

3) At the inception of the project the ward must be placed on a "closed ward" status. All off-ward activities must be suspended. These activities include leaves, direct contacts with parents, and off-ward detail assignments. It must be made clear that patients earn the right to go off the ward

and that, once earned, the right can be suspended. In practice, many patients will earn their way off the ward within the first few days, but the principle of control must be clearly established. At the outset and perhaps for the project's duration, off-ward detail assignments would be terminated and patients would perform all work on the home ward.

4) Ward living arrangements would be modified as facilities permit, to provide a hierarchical living arrangement corresponding to Patton's orientation, therapy, and ready-to-leave groups. Group placements would be based on objective evidence of advancement within the treatment program.

5) At varied intervals members of the psychology staff would be on the ward a total of at least 8 hours during the 24-hour daily ward schedule. With the approval of the ward physician, they would set criteria for and oversee the selection of patients and personnel and would supervise training, data collection, and program development.

6) The reinforcement program would not be initiated until behavioral baseline data were collected on all patients. These data would be valuable from a training standpoint and would be essential to the development of individualized reinforcement programs. The time interval of six months would begin at the completion of the baseline data collection and at the initiation of the reinforcement program.

7) Each patient would have a "tailor-made" program specifying behaviors to be extinguished or reinforced and the token "value" of each positive behavior. The patients would be apprised of these behaviors by group leaders. They would be informed of what is being reinforced at the time reinforcement is conferred.

8) Ward staff would attend a didactic and applied training course in operant conditioning and would attend group orientation sessions to increase sensitivity to nuances of patient's behavior. Once trained, the technician would become the group leader for six or seven patients and would be given considerable autonomy in providing "on-the-spot" reinforcement for appropriate behavior. He would also provide group discussion sessions in which patients would interact with each other in terms of personal reactions and evaluations of each other's behavior. The group leaders would assume responsibility for all phases of his patients' programs including such details as accompanying them to medical appointments. With appropriate consultations he would eventually assume the responsibility of designing reinforcement programs, preparing progress reports, and deciding when the patient was ready for promotion to a higher group.

9) Permission to include a patient in the operant program would be obtained by the ward social worker from parents or guardians.

10) Adolescent and/or adult mildly retarded patients would probably constitute the best experimental population. Patients with dietary related medical problems, e.g., diabetes, would not be included. Careful records of weight would be maintained throughout the period of the project. Making use of behavioral information provided by the psychology staff, the ward physician would continuously review each patient's status regarding tranquilizing medication.

11) Provision will be made for an hour overlap between a.m. and p.m. shifts to provide an opportunity for detailed exchange of behavioral information and for joint training sessions. Provision would also have to be made for switching personnel from one shift to another, as needed for purposes of training.

Ward 13C, despite certain disadvantages, e.g., off-ward dining, appears to be a suitable location for the pilot program. Through the use of partitions, areas could be set up for training sessions, group meetings, etc. It has a small patient population so that movement of both patients and personnel could be accomplished with a minimal disruption of hospital program. Because of the limited number of staff necessary, i.e., two technicians on both the a.m. and p.m. shifts and one on the night shift for a curtailed population of 15 patients, the effort involved in training and supervision of employees would not be excessive.

Dr. Schumann, who currently serves as ward physician on Ward 13C, has agreed to serve as physician-director of the pilot program. Miss Ann Townsend, ward social worker, is familiar with the objectives of such a program and would be willing to participate. Several of the patients currently on Ward 13C would be suitable for the program. Additional patients could readily be located, e.g., on Ward 1.

Ward 58 should also be considered as a possible location for this program. Although, in comparison with 13C, more administrative adjustments would be required, the ward facilities are exceptionally desirable.

TSB:es
Distribution: Dr. Schumann, Assistant Superintendent
Dr. Ellis, Ward Physician
Dr. Ball
Chaplain Costello
Mr. Cogburn, Social Worker
Mr. Bowling, Principal of Hospital School
Mrs. Grove, Supervisor of Rehabilitation Services
Mrs. Rose, Assistant Superintendent Nursing Services
Mrs. Boice, Medical Record Librarian

Appendix P

PACIFIC STATE HOSPITAL
(Inter-Office Memorandum) November 2, 1966

To: Dr. Valente, Assistant Superintendent, Dr. Walker, Associate Superintendent Dr. Schumann, Assistant Superintendent, Dr. Ball, Chief Psychologist, Mrs. Roberts, Superintendent of Nursing Services, Mrs. Grove, Supervisor of Rehabilitation Services, Mr. Brown, Chief Social Worker, Mr. Bowling, Principal of Hospital School.

From: C. V. Keeran, Administrative Associate Mental Retardation Program

Subject: Program on Token Economy
(Treatment Program Planning Committee)

The material in quotes are the minutes and recommendations of the Treatment Program Planning Committee. Dr. Bugh has approved all of the recommendations. He states that "decisions will be made with active participation of Division chiefs and Department heads." In the near future, you will be contacted by Dr. Ball, the Project Director, to facilitate the implementation of this program.

"The committee reviewed Dr. Ball's 'Program on Token Economy' dated 9/20/66.

It was recommended that Dr. Ball be Project Director of the program, that he select the personnel and patients to fit the program, and that he plan and conduct a training program required for all ward personnel. The Project Director will be the team leader and he will have members of the psychology staff on call for behavioral problems 24 hours a day. The physician's main role will be general medical care of the patient.

The committee felt that if the ward physician and personnel closely watch the medical condition of the patient, the principle of 'no token, no meal' can be clearly established. Previous experiences at Patton and Fairview have shown that no patient has ever missed more than one or two meals. Any patient who consistently misses meals is obviously not fitted for the program and will have to be dropped.

Care will be taken that positive attitudes are established in using tokens, and bribery and punishment will be avoided.

All parents of patients will be contacted and patients whose parents cannot cooperate with the program will not be used.

The nursing supervisor will have no direct administrative or supervisory involvement in the program. The ward may be converted to a closed unit or opened at the discretion of the Project Director. Patients' contacts with other hospital services will be subject to changes in accord with the goals of the program.

A meeting will be held in two weeks to discuss the final proposal by Dr. Ball.

Recommendations:

1. Dr. Ball, recommended Project Director, would select patients and personnel.
2. Drop from project any patient obviously not fitted for it.
3. No patient to be included in project if parents are not in agreement with aims.
4. Members of psychology staff to be on call for behavioral problems 24 hours.
5. Program to start on closed ward basis."

Appendix Q

PACIFIC STATE HOSPITAL

Inter-Office Memorandum

To: Steering Committee, Token Economy Program Date: January 23, 1967

From: Thomas S. Ball, Ph.D.

Some Critical Issues Regarding The Token Economy Program

The Token Economy Program is based upon a plan of 24-hour environmental control. A key element of this control is the requirement that patients, at a level commensurate with their abilities, earn tokens to pay for living accommodations including food. The program will begin on a closed ward basis, and the principle of "no token, no meal" will be strictly applied. Parental consent and the approval of the ward of origin will be obtained prior to placement but the patient herself will not participate in the decision regarding selection.

It is only natural that questions arise regarding the implications of a program that seeks so completely to control the patient's daily life. Among these are the following:

Question #1 - What does the "no token, no meal" provision mean in the individual case?

Individual "tailor-made" behavioral programs will be developed for each patient, e.g., a woman may be awarded a token for making her bed, wearing lipstick to a group meeting, greeting patients and personnel, etc. These tokens are used for purchasing meals, among other things. But what if mealtime approaches and the patient lacks a token? In this case, if the patient is willing to work, an opportunity to perform a chore within her capabilities will be provided so that she can earn payment for the meal. However, if she simply refuses to do anything to earn the meal, lacking payment, she will miss the meal. Does this mean that she may "hold out" until she suffers malnutrition? Actual experience with this kind of control with both chronic schizophrenics and retardates indicates that this simply does not happen. Experience shows that one and perhaps two meals are missed by a small minority of patients at the outset of a token program, but not more. It is also obvious that the planned weekly recordings of weight gains and losses will indicate if any significant weight changes are taking place. Such changes would have to be medically evaluated.

Question #2 - Might such controls be used to reinforce a repressive, "bughousing" approach to patients on other wards?

a) The answer to this question involves the ends toward which the Token Economy program is working. Thus, behavior will be modified, not as a matter of convenience for the patient's "caretakers," but toward the goals of personal and social development and self-realization. It is one thing, for example, to teach a hyperactive patient to remain seated so that he is no longer a "nuisance." It is yet another thing to establish the control so that he can then be taught to feed and dress himself.

But how can you determine if the goals of convenience rather than growth are not, in fact, being served? The answer to this lies in the development of a comprehensive, step-by-step program in the direction of increasing growth and autonomy and maintaining open and public records of individual progress. A systematic sampling of individual behavioral programs on a ward (with occasional requests for actual demonstrations of proficiency) would insure positive programming. For example, if a hyperactive child had several months previously learned to remain seated for periods of time but had learned nothing since, this would suggest a "convenience" orientation. As an additional safeguard we will insist that when token economy programs are established on other wards, the program will go as a complete "package" including the public, evaluative aspect.

b) Until recently, repressive, "bughousing" techniques have been officially prohibited as "abuse," but constructive alternatives have been conspiciously lacking. Aside from the application of physical and chemical restraints, with their negative implications, ward personnel have, in the main, been left on their own to deal with some of the severest, most frightening and frustrating behavior problems imaginable. Under such circumstances, if someone claims that the only way to handle a patient's severe temper tantrums is through a punch in the ribs, many may object to the technique, but no one can prove him wrong - because few people have interested themselves in tackling such problems on a scientific behavioral level. The punch is administered, the tantrum terminated, and the claim for the exclusive validity of the technique goes unchallenged. That the tantrum behavior may be treated through an "extinction" procedure involving no physical contact with the patient does not come to light, and the "bughousing" assumptions remain unchallenged. Built into the token economy approach is the explicit evaluation of constructive alternatives to the classical "bughousing" techniques.

c) Concern may be expressed over the fact that the ward staff will define the goals of personal and social development. For some, this may smack of 1984, of brain-washing, and of thought control.

Yet 1984 cannot exist unless the definers of behavioral goals set them in terms of making the individual subservient to some political end. In such a situation, a democratic review process is impossible. With the token economy, however, behavioral goals will be made explicit and open to inspection. Most of these goals will be of a most uncontroversial nature, e.g., brushing one's teeth, making one's bed. Some may have an element of controversy, e.g., should patients who resist attending religious services be paid a token for attending? By making goals explicit they will be subject to a review process.

The irony of the concern over thought control is that people seldom question the behavior that is established every day in our hospital under our present system. Many a character disorder has been systematically shaped by the very potent environmental influences that, at times, have prevailed in our setting. And, strangely enough, few question the dangers of an uncritical administration of TLC (Tender Loving Care). Yet there is ample evidence that TLC administered contingent to self-destructive or aggressive behavior, e.g., by rushing over to and comforting a child having a temper tantrum, serves only to fixate the behavior and thereby worsen the problem. Perhaps we should be as concerned about some of the kindly, well-meaning psychological "typhoid Mary's" in our midst as we are about the "bughousers."

Question #3 - Isn't the token economy a form of mechanistic, "animal training" approach to patients that denies the integrity of the individual?

Our answer to this is that the entire approach is oriented to learning and growth. We set aside the model of the retardate as a sick, mentally disabled, incompetent individual and focus upon his areas of intactness and growth potentials. We tell him, in effect, you are responsible for your own behavior and you are capable of attaining a higher degree of competence.

If we give a dole to a man capable of at least partially providing for himself, we satisfy his wants but foster dependency and rob him of his dignity as a human being. We have committed this error countless times with individuals labeled mentally retarded.

Question #4 - Since the patient has no choice regarding placement in the program, will he be deprived of the opportunity of making choices after he enters the program?

In addition to experiencing the reality of personal responsibility, the patient will be presented with an opportunity to make many choices in accordance with the consequences experienced in normal daily life in the community. For example, a patient who wants to remain in bed during working hours and is not ill may do so, but she must pay for the privilege. Similar consequences are

experienced by the non-retarded individual in business for himself, e.g., the dentist who takes the day off earns no money and has to pay overhead and living expenses from his cash reserves. If he takes too many days off he will find himself in a state of deprivation. So also will the patient who uses all her tokens as payment for "goofing off."

Many practical problems lie ahead of us in the implementation of this program. However, we feel that we are working toward implementing a concept, the application of which has great potentials for helping our patients on a direct, practical level. We have greatly appreciated the wonderful support that we have received up to this point.

TSB:es