

Department of Public Welfare  
Medical Services Division

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State Institution:  
Administrators, Medical Directors, Program Coordinators, Unit  
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Medical Services Division Staff  
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Minnesota Daytime Activity Center Association  
Association of Residences for Retarded in Minnesota  
Child Welfare Division, DPW  
County Welfare Departments  
American Association on Mental Deficiency, Washington, D.C.  
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From: Ardo Wrobel, Director, Mental Retardation Program Office

Subject: Plan for use of ADAPTIVE BEHAVIOR SCALE for Mentally Retarded Residents \*1)

In May, 1970, the Department of Public Welfare officially established its POLICY ON UNIT ORGANIZATION OF MENTAL RETARDATION PROGRAMS, which calls for "functional groupings of residents based on some common program needs, and of such size that it can deliver individually-planned services, and is organizationally sound". The policy further states that the department goal is to have an individual plan and program for each resident, each unit is to have a full-time unit director who is to have his duties clearly stated, and who is responsible for developing a program plan for the unit he directs. Such a plan is to include performance objectives of the unit in measurable terms, description of the plan to reach goals and objectives, intra-unit evaluation system, and other related requirements.

Adoption of the (AAMD) Adaptive Behavior Scale was a subsequent and deliberate effort to follow-up on matters related to unit program planning for individuals in the units, and requirements for measurable goals of the unit organization. Institution program coordinators adopted the idea that; 1) a state-wide instrument should be adopted to get basic data about the behavior levels dealt with daily, 2) such assessment effort should be used by the staff in each unit organization for purposes of program planning, and 3) a common instrument should be used by unit staff to compare functional levels between program units for purposes of organization of units, establishing goals, and the like.

\*1) Published by the American Association on Mental Deficiency, 5201 Connecticut Avenue, N.W., Washington, D.C. 20015, in 1969. The AB scale (which has separate materials for children 3 - 12 and adults 13 and over) resulted from a project jointly sponsored by the Parson State Hospital and Training Center, the American Association on Mental Deficiency, and the National Institute of Mental Health, Bethesda, Maryland.

The Adaptive Behavior Scale was adopted as a standard state-wide instrument for program development, bearing in mind that any scale applied to human beings is at best imperfect, and will not solve all problems of program planning, delivery and evaluation. Other instruments will continue to be used locally and specifically in order to get at some of the finer points of measurement.

Further, after some experience is gained in getting descriptive behavior data on residents in state institution programs, the feasibility of getting the AB scale applied to clients in Daytime Activity Centers, private institutions and facilities in the state will be explored. This, in addition to benefit to the residents, will give state-wide planners and agency staff an opportunity to study and analyze such information in order to help determine; 1) what the major and minor differences are between persons served in the various types of community facilities and programs, and 2) better understand the kinds of problems that need to be solved, organization of resources, and perhaps better shape future program standards for the various functional levels of retarded people.

Our first objective is the first-time application of the AB scale, now expected in February - March, 1971. This is viewed as getting basic assessment data on all MR persons served in state institution programs. Subsequent application on state-wide basis is thought to be desirable in order to assess program movement, however, it is felt by many that AB scale won't be able to show any significant changes in less than two or three years.

A state-wide standard body of descriptive data is necessary to better understand the kinds of problems that have to be dealt with, and for which decisions are often made without sufficient information.

Highly related also are various converging situations which indicate that systems serving MR people will be expected to be more accountable in terms of progress and improvements in services. Influences can be partially identified now, for example; 1) efforts toward developing program budgeting in the state, 2) requirements that show up in various federal resources used in various state programs through Title I, of the Elementary and Secondary Education Act, Hospital Improvement Programs, In-service Training of staff, Developmental Disabilities Act of 1970, and in general 3) more bang for the buck.

The specific role that the AB scale can play in all this is difficult to determine at this time. However, it is expected that this will become clearer as we get further into its application and study of information.

GOALS can be identified as follows; 1) knowing more about the system of retardation in the state, 2) program groupings within an institution, between institutions, or between state institutions and other facilities, 3) setting primary goals for residents, 4) research related to the first goal, and basic research by making sub-populations available to researchers, and 5) allocation of resources.

The AB scale is not expected to affect; 1) evaluation of how the system is working, and 2) whether or not the residents are making progress over a short range period.

### Analysis of the Adaptive Behavior Scale.

A supplementary instruction manual is being prepared for use by staff in applying the scale to residents, and for purposes of training the staff. This should help insure greater clarity and uniformity in the answers. Information from answer sheets will be put on computer (through work with G. Warren Peterson and Richard Swenson, DPW), and the answer sheets will then be returned to the unit staff for program use.

The scale will be applied to all retarded persons in identifiable program units in all state institutions. Because of the experience they will gain, staff may be of assistance in helping others apply and use the scale for program development, etc., in other settings in various community settings.

The scale is seen as having primary benefit to staff working directly with mentally retarded persons (hopefully including parents with retarded children at home). The scale will be helpful in providing a vivid description of the way the individual maintains his personal independence in daily living, and how he meets the social expectations of his environment - the very information most crucial for those in charge of the training and rehabilitation of retarded persons.

Part I of the AB scale is designed to assess the individuals skills and habits in ten behavior domains: independent functioning, physical development, economic activity, language development, number and time concept, occupation-domestic, occupation-general, self-direction, responsibilities, and socialization.

Part II provides measures of maladaptive behavior related to personality and behavior disorder in fourteen domains: violent and destructive behavior, antisocial behavior, rebellious behavior, withdrawal, stereotyped behavior and odd mannerisms, inappropriate interpersonal manners, inappropriate vocal habits, unacceptable or eccentric habits, self-abusive behavior, hyperactive tendencies, sexually aberrant behavior, psychological disturbances, and use of medications.

The scale can be administered by psychologists, teachers, nurses, social workers, day-care center instructors, aides, (parents) and others who have observed closely or personally know the daily behavior of persons to be rated.

Mr. Creighton Koski, Executive Director, United DAC of Duluth, Inc., is currently in the process of applying the scale to 87 persons served in DAC's. He is working with both parents and staff. His experience will be helpful in determining its use and value in the DAC setting. He is very optimistic about the value it will have in establishing goals, checking progress toward independence, and evaluation of the entire program. He plans to re-apply the scale to determine progress but cautions that training of staff and parents is very important in administering the scale.

It would be interesting to explore the possible benefit this may have for parents who have their retarded child living at home. With help from experienced staff in the institutions, DAC's, etc., home-based training goals could help improve the quality of life for the home and preparation for greater independence as the child grows older in his own home.

The plan is at this time to put information on computer only from state institutions. Other possibilities will be explored at a later date, and after we have more information about its potential.