Assessment and Recommendations for Abuse Training at Oregon State Hospital

Terry Kester, Abuse Training Project Coordinator
Office of Investigations and Training
Health Services of the
Oregon Department of Human Services

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Introduction

This report summarizes information gathered pursuant to the Report to the Governor: Review of Policy and Protocol Regarding Reports of Patient Abuse or Neglect at Oregon State Hospital, December 3, 2004. Its purpose is to help inform an expanded curriculum for staff training at Oregon State Hospital (OSH).

Managers and frontline caregivers employed by the hospital were asked for their ideas about how to improve the hospital's efforts to recognize, report and reduce the risk of abuse. See Appendix B for topics to include in abuse training and Appendix C for thoughts about the frequency and duration of training.

We solicited input from OSH consumers and their families to understand their needs and identify their suggestions. Other interested parties from the mental health community were also consulted about their ideas to improve the hospital abuse training program.

The methodology included individual interviews, group interviews, and telephone interviews. Individuals were selected for interview based on recommendations from OIT and OSH and are believed to be a representative sample of the hospital and the mental health community. Participation in OSH general orientation, education day, and classes in Boundary Issues and Stages of Change brought additional perspective.

Other institutions contacted included Napa State Hospital, Arizona State Hospital, and Western State Hospital. DHS Seniors and People with Disabilities and the Eastern Oregon Psychiatric Center provided examples of their curricula.

We would like to thank all participants for giving of their time and sharing ideas to improve hospital training and ultimately for making it a safer place for all those who live and work there.

Summary of the Key Points and Suggestions

What follows is a summary of the key points and suggestions by participants in the assessment process. (See Appendix A for representative sample statements supporting each point.)

1. Frontline caregivers need access to abuse training because they bring the least amount of education and experience and are the least likely to receive additional training at the hospital.

2. Veteran staff members need additional training about abuse so they can support hospital policies and help new staff adapt to their new and evolving responsibilities.

3. Abuse training needs to be more frequent to keep the topic fresh in people's minds.

4. Abuse is a difficult topic for people to consider. Presentations need to engage the trainees and keep their interest.

5. Competency is difficult to measure and track. Suggestions for demonstrating competency included observing line staff in patient interactions, written tests, and making abuse competency a separate part of the annual performance evaluation.

6. Having a firm understanding of the definitions of abuse is critical to understanding how to recognize abuse.

7. Retribution and retaliation should be discussed.

8. Encouraging staff to report abuse means highlighting the benefits of reporting, building trust, and improving communication about the process of investigation.

9. Reporting abuse is a sometimes misunderstood process. Hospital policy states that the report is to go directly to the Superintendent.

10. The investigation process can be mysterious for hospital employees.

11. Reducing the risk of abuse depends on staff member's self-knowledge, communication skills, boundary issues, and power and control issues.

12. Patients, their families and friends have similar needs to hospital staff, they want to know what the definitions of abuse are, how to report abuse, and how to reduce the risk of abuse.

Recommendations

There is general agreement that more than 1.25 hours of training should be required. Optimally 6 hours of training at general orientation is recommended (see Appendix C for summary of responses). The training should include:

- Competency pre-test
- Overview of abuse in the hospital
- Hospital policy on abuse
- Case studies of abuse definitions which tie the case to hospital policy and provide opportunities for positive role modeling to improve the outcome of the case study
- In-depth information on mandatory reporting and its ethical and legal implications
- How to make an abuse report along with practice in making the report and to whom
- Understanding feelings about caregiving including self-evaluation and self-care planning
- Discussion of intervention strategies for reducing risk of abuse
- Reviewing for the competency examination
- Taking the competency examination
- Getting feedback for future curriculum improvements

One hour of semi-annual continuing education in recognizing, reporting, reducing the risk of abuse is also recommended (see Appendix C). This might take the form of:

- Reviewing case studies demonstrating the definitions of abuse by:
    - Tying hospital policy to the abuse demonstrated
    - Illustrating examples of reported abuse
    - Testing the employee's understanding of the abuse, how to report the abuse, and what could have been done to reduce the risk of abuse occurring

    - Developing a library of cases so that no case is repeated in any 3 year cycle
- Designing a method to turn incidents and allegations of abuse into case studies with tests, and add them to the library of cases
- Creating and encouraging staff to use self-directed learning modules for remedial and make-up training

Training principles and activities that would maximize retention and application of the information presented include:

- Allotting adequate time for meaningful discussion because it promotes higher level thinking and deeper processing
- Engaging students by, for example:
    - Starting presentations with an image or short video clip related to the day's concept
    - Introducing frequent activities
    - Having employees participate by developing questions they think are important for everyone to know about the material, planting questions, requesting examples of topics being discussed, giving exercises to do in a workbook, forming ad hoc discussion groups, etc.
- Creating a memorable experience by
    - Letting trainees "see" an abusive event, discuss the roles of the patient and the caregiver in the event, and suggest more positive ways to respond
    - Developing a manual with specific "action" areas to fill out to receive competency in abuse training
- Presenting different approaches to the topics of abuse and neglect at continuing education trainings
    - Developing a library of topics from which to choose
    - Rotating videos, role play, written case studies, self-directed modules, and include discussion groups
    - Breaking courses by the EDD into smaller segments and make them mandatory
- Taking the needs of adult learners into consideration

Consider additional approaches to risk reduction and management by:

- Developing a mentoring program for new staff to supplement the formal learning opportunities
- Initiating a frontline manager's training curriculum

Training DHS consumers and families including:

- Offering training periodically so that patients can participate when they are able
  - Explaining verbally, in writing, and through visual means how to report abuse and to whom to report
- Training family of new patients including:
  - Listing of phone numbers and names of people they could contact with their concerns
  - Describing definitions in clear, simple terms
  - Offering training periodically

Testing competency suggestions include:

- Administering written pre-tests and post-tests at each training event
- Scoring these tests, and if an employee achieves a post-test passing score, for example 70% correct responses, they would be certified as competent in the abuse training
- Basing questions on scenarios of abuse and appropriate responses to those scenarios
- Re-testing at abuse related trainings

Introduction to Appendices

How Information Was Gathered and Recommendations Developed

Information was gathered from group interviews, individual interviews, telephone interviews, and survey questionnaires. The Abuse Training Project Coordinator of OIT conducted all interviews. Questionnaires were submitted through family groups associated with the hospital. Information was gathered from May 24, 2005 through July 27, 2005. Examples of interview questions are available to interested people.

Six group interviews were conducted. Group interviews were attended by between 5 and 34 participants. The participants characterized as "managers" represented the largest groups. These groups included leadership of the Forensics Program, the Recovery Program, and the Social Workers. The smaller groups consisted of the families of clients in the Recovery Program, the Friends of Forensics, and a group of clients chosen by the Consumer Advocate to represent consumers. All frontline caregivers were interviewed individually. Other managers, consumers, former consumers, and mental health advocates were interviewed individually.

Telephone conversations with state mental hospitals in California, Arizona, and Washington revealed that their abuse training in general orientation is very similar to our current program. Napa State Hospital in California indicated that they spend one hour on abuse training conducted by the Hospital Police. It consists of a video that takes most of the time. Participants are sent away with a 50-page curriculum created by the California Department of Justice (CDOJ). This curriculum is recommended by CDOJ to "be incorporated into a facilities other in-service training that is designed to address some of the important abuse related items." This is to be completed within 6 months of the beginning of employment. Arizona State Hospital indicated that they concentrate primarily on how to report abuse and their training materials reflect the laws and the 5-page form that must be filled out when reporting abuse. A telephone conversation with

the CEO of Western State Hospital in Washington indicated that most of their abuse related training was done on the wards and is ward specific.

Seniors and People with Disabilities provided me with 5 videos and examples of training they provide their new employees. This information may be relevant to gerontology units at OSH and includes examples of how to use videos and case studies in abuse related training.

During a visit to Eastern Oregon Psychiatric Center materials for mentoring new employees were obtained. The mentoring system has been used in the past at the Psychiatric Center. They currently use it to train new employees in the Training Center. The Superintendent is considering reinstating the mentoring program in the Psychiatric Center. The program could be easily adapted for OSH purposes.

An internet search of "patient abuse training" resulted in three articles all describing the same training. The Center for the Rights and Interests of the Elderly developed this training for nursing assistants in nursing homes. The articles describe an 8-module training program lasting 8 hours. The program is well tested and is available commercially. It comes with a video that depicts an abuse scenario from the perspectives of the resident, the charge nurse, the director of nursing, the administrator, a family member, and a state investigator. The website is: www.carie.org.

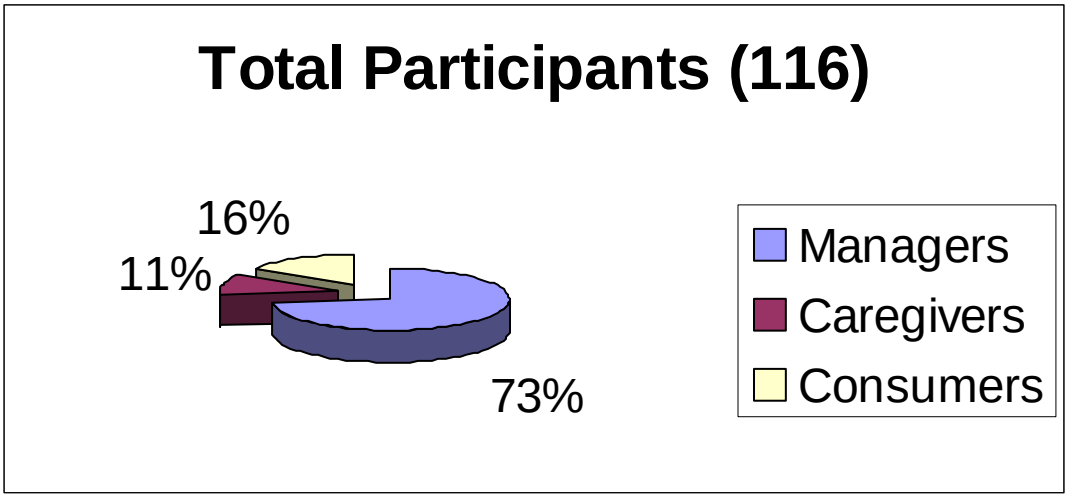
Assessment Participants

A total of 116 individuals participated. Based on each person's relationship with OSH, they were classified as managers, frontline caregivers, or consumers.

Managers included program directors, unit directors, supervising registered nurses, physicians, and social workers. 85 managers participated in individual interviews and group interviews.

Frontline caregivers included floor nurses, mental health technicians, and mental health coordinators. Frontline caregivers were the hardest to schedule for interviews because they are in high demand. They could not be interviewed in groups. 13 frontline caregivers participated in individual interviews.

Consumers included current patients from the forensics program, former mental health hospital patients, family members of current patients in the adult transitional program and the forensic program, and friends of current patients at OSH. Consumers and family members represented organizations including the National Alliance for the Mentally Ill, Choices for Change, and the EAST Program for people with psychoses. 18 consumers participated in individual, telephone, and group interviews.



Appendix A: Summary of Quotes

Quotations representing the key points and suggestions follow.

1. Frontline caregivers need access to abuse training because they bring the least amount of education and experience and are the least likely to receive additional training at the hospital.

   "Line staff needs training to improve and develop skills. Some wards are under-represented in voluntary training so we need mandatory training to increase the overall training level of the line staff."

   "They need to know about victims and victim's responses."

   "It is not all about patients. It is about a kind and dedicated staff that we can do a better job of educating and supporting."

   "A key issue with abuse at the hospital is the level of education of line staff."

   "Staff education levels are highly varied which create differences in skill levels. Line staff are usually the least skilled, and need the most training and support from managers. But, training takes a lot of time and we have patients who need care."

2. Veteran staff members need additional training about abuse so they can support hospital policies and help new staff adapt to their new and evolving responsibilities.

   "Veteran staff rarely attend voluntary training, but we need to get the newest information to older employees. They can serve as leaders in culture change."

   "Seasoned employees feel their knowledge is not valued, but what we need to say is, 'Here is new information with different actions that is the current best way to do things.'"

"Old time employees teach the newly hired employees the old ways, rather than helping the new employees understand the new models the hospital is adopting."

"Old school staff can intimidate new employees into doing things their way by telling them that 'we don't do it that way around here.'"

"Veteran employees show new caregivers the 'real' way to do things and create pressure on the ward to do things the way they have always been done."

"Old school staff members need to learn to generalize and not be so concrete. Some are crystallized in twenty year old thinking, when they need to be able to apply ideas across settings and to think on their feet."

3. Abuse training needs to be more frequent to keep the topic fresh in people's minds.

"The hospital should have monthly committee meetings on abuse like we do safety and other programs. Each ward should send a representative whose responsibility it is to report back to the ward what was discussed in the committee."

"Seclusion and Restraint and Fire training are done once a month and so should this. Monthly training to keep it fresh."

"We should have quarterly scenarios. Include a response sheet with a month to complete it. The responses would become a part of competency."

"Abuse training should be twice per year or quarterly. Each ward should include it in their inter-shift meetings monthly, with day and evening .5 hours overlap. Even if abuse is just brought up that briefly, it would be helpful."

"The hospital should do abuse training every 2-3 months after an extensive remedial training."

"All training, but maybe especially abuse training, should be innovative and theatrical. It should be once a month and needs to be incorporated into a tracking system."

"Training twice per year, with sensitivity training, will reinforce and keep abuse in front of staff. Then staff will keep each other in check."

"Quarterly training, with the amount of time spent might change as employees get more proficient at recognizing and reporting abuse."

"Train quarterly with rotating themes and different information at each presentation."

4. Abuse is a difficult topic for people to consider. Presentations need to engage the trainees and keep their interest.

"People learn best by discussion. We need to talk about situations and what could be done differently and situations and scenarios are the best way to do this."

"Give us examples, and let us interact. Show situations, and ask, 'How would you handle this?' This stimulates critical thinking and talking. Once people get warmed up they can bring personal examples from their daily experiences. That way they could get clarification and ask questions about what is going on in their ward, More talking helps for things to sink in."

"You could have a video with questions like, 'What would you do?'"

"Discussion with examples of what staff are looking for and concerned about. What happens in an allegation? Discussion to clarify what abuse is."

"Show examples, making it live, and tie it to the spectrum of possibility from therapeutic to abuse. Give situations of disrespect versus abuse. Talk about boundaries and things people relate to. Let them see, 'What's in it for me?'"

"Videos of incidents and role plays of incidents let people see what abuse is. We need to watch, hear, and see it to believe it. Then we need to discuss and brainstorm to remember it."

"Abuse training needs to be more dynamic. People tune out when policy is read word for word. PowerPoint would be better. Talk about and give examples of gray areas with real life abuse, such as observed withholding of things from the client. People think hitting is abuse while yelling or withholding is not."

"Staff needs brochures and video with discussion. The more discussion the better people remember. Right now we just watch a video, then sign off on it and no one retains anything."

"Get people to open up and get into a discussion. Take it away from being personal by role-playing how to separate rights and abuse. Clarify the difference between rights versus privileges."

"PowerPoint is the best way to present information. Consumer presentations should be included more. Staff need simple handouts to take with them. You could make cards with important issues: responsibility for reporting, etc. Laminate the cards and verify by personal contact that everyone knows what is on the card and is using it. E-mail reminders would be powerful."

5. Competency is difficult to measure and track. Suggestions for demonstrating competency included observing line staff in patient interactions, written tests, and making abuse competency a separate part of the annual performance evaluation.

"The easiest way to test competence is written tests. If they had the time to do it as a role-play where managers set up a scenario and staff role-play. Managers and staff rate staff's response to the scenario. It would have to be done well. Also you could observe people in the care environment more pointedly. Supervisors would need to be trained in observing and assessing."

"You could have a scenario or an expanded example with mandatory passing like ProACT. You could give a behavioral and paper and pencil test to reinforce the learning. Providing workbooks with content, and then questions every 10 or so pages works great. It took 3 years to get ProACT into practice."

"Hospital staff are test averse. The best way would be to give a pre-test. Then go over the results. Then post-test and compare the results."

"Give pre- and post-tests during trainings. Competency should be a part of yearly evaluations, including any allegations of abuse; staff to staff and staff to patient interactions; and charting efficiency. Evaluations should be done by the supervising RN for line staff and by the unit director for professional staff."

"Paper and pencil tests are easiest to administer. Role-playing with a written or verbal response would be good. Today you get little feedback."

"At Fairview, monitors went out to the unit, to sit and observe. They were not looking at specific individuals, but had specific things to look for: types of patient interaction, the number of interactions, and staff doing what they are supposed to do. They collected data and the data was reviewed in staff meetings to tighten up operations."

"You should give a quiz with 20 multiple choice questions, and you must answer correctly at least 15 to pass. If you don't pass you get to take a refresher. Attendance in an abuse class is not enough to be competent."

"I see this being at two levels. First, the definitions of abuse, which could be determined with multiple choice and true/false questions relatively easily. The second tier should be specific situations that demonstrate how the participant would assess them. They would demonstrate what actions they would take. Some of the items would be black and white, and some would be questionable."

"Spread the training over several days so that a scenario on day 1, would lead to a discussion on day 2, and so on, with a test on day 3."

6. Having a firm understanding of the definitions of abuse is critical to understanding how to recognize abuse.

   "To recognize abuse you need to understand the boundary concept. Teach the poles from therapeutic to cruel. Look at 4 domains on that continuum: the therapeutic pole; guarding against abuse happening; becoming vulnerable for abusive behavior; the abuse pole."

   "Recognize that abuse starts with knowing the definitions of neglect, verbal, and physical abuse. Use specific examples for the type of unit. For instance, in gerontology show abuse in physical care, feeding, monitoring for falls. In the adult units show abuse in attentiveness during one-on-ones."

   "For recognizing abuse for staff, they should know the basics: statutes, OAR, and hospital policy. They should know what the public expects. You want them to know the bottom lines of rules. Show people what's right and what's not using quotes and outcomes."

   " In recognizing abuse knowing the situations is most important. Knowing that deliberate, malicious intent is important. Knowing what is therapeutic versus non-therapeutic is a gray area in recognizing abuse. Cussing at a patient is wrong."

   "Recognizing abuse means knowing about physical, verbal, sexual, and neglect. Must learn what they are. Case studies would really be helpful here. They would help show what it was. Group discussion could then be used to dissect it."

   "If I question it, something might not be right. If you wouldn't do it yourself, it might be abuse. If someone tells you, report it. For verbal abuse: don't say what you would not say in front of your boss. For sexual abuse: boundary issues, too much time with one patient, and

doing favors. For physical abuse: keep your hands to yourself. If you feel like you are going too far, do something. For abuse by neglect: make sure patient needs are met, even when you don't want to do it."

"If it doesn't look right and doesn't feel right, it isn't. Check with the person you're reporting or the supervisor to see if it is a part of the treatment care plan. It is okay to question."

7. Retribution and retaliation should be discussed.

   "When you do abuse training be sure and include passive retaliation against patients who report abuse."

   "Make sure you talk about retaliation versus distancing when you talk about abuse reported by patients."

   "If you work on the ward and report abuse management will probably let it leak within 36 hours, otherwise you can probably figure it out. We are not protected by whistle blowers agreements. You get labeled as a troublemaker and your safety is jeopardized. You find yourself alone."

   "I reported and I am still facing repercussions from some staff five years later."

   "Coworkers have your back so the risk of reporting is far greater than the risk that someone will not help you the next time you need it."

   "When someone reports abuse, they fear pay backs and that someone will go after them. There is real concern about retribution down line. Hard feelings get in the way of working relationships."

8. Encouraging staff to report abuse means highlighting the benefits of reporting, building trust, and improving communication about the process of investigation.

"Keep reporting in a positive frame with frequent training. Help staff function better. No one sets out to be abusive. Point out what is more important than fear of reporting: a safe environment for everyone."

"You will get more reporting if there are more avenues for correction before reporting. Do more training and salvage people where we can. We should work to increase everyone's ability to be therapeutic."

"Create a culture where respect and dignity are okay and anything else is not okay. Teach values and character. Focus on personal values and organizational values."

"We always punish and sometimes train. We need to train supervisors in how to welcome people back into the unit and how to get back into the team. We need training on how to lower walls constructed between the reporter and the alleged perpetrator. Currently there is no special training for managers."

"Ask, 'Would you like this to happen to a family member?' They need to realize that the result of an allegation is not up to them. Abuse is against hospital policy. You need to reduce the time it takes to complete an investigation. You could pass information along that it is important to cooperate so that investigations don't take so long."

"Ensure that they know their responsibility for reporting. Let people know that reporting abuse will make this a better place to be. Make sure supervisors have formal meetings with people who don't report abuse or who try to pass their responsibility on. Raise the issue of reporting in a positive light. When we have done this in the past people improved."

"Education is the best way to encourage and support reporting. It is important to talk about the process even though it is ugly."

"To encourage reporting find some positive way to talk about the subject, like Encouraging Therapeutic Interaction. Isolate the scary parts in one place like death is handled in ProACT."

9. Reporting abuse is a sometimes misunderstood process. Hospital policy states that the report is to go directly to the Superintendent.

   "Make reporting clear to us. We should report directly to the superintendent. But, that is not what's currently done. We report to the supervisor, who tells the unit director, who informs the program director."

   "To report you should go to your immediate supervisor, but there is reluctance on staff's part."

   "There are five ways to report. Staff should know what is going to happen. They should know the next steps. They should know how long it would take. They should get updates as the investigation progresses. This will bring increased cooperation."

10. The investigation process can be mysterious for hospital employees.

    "Staff should know what to do if they find themselves guilty of abuse. What happens with a report? Who is the Office of Investigations and Training and what do they do? What do they know anyway? Am I going to get fired? Is someone else going to get fired?"

    "Staff have questions about investigations and would like to know what the process is. Secrecy leads to managers not knowing what is going on, or which ward it happened on, or whether the people being asked for are witnesses or alleged perpetrators, or what."

    "Managers can't manage the situation because they cannot talk to the staff person and get that person in line."

11. Reducing the risk of abuse depends on staff member's self-knowledge, communication skills, boundary issues, and power and control issues.

"To reduce the risk of abuse you must consider power and control issues. Be specific about the kinds of allegations on a ward with information about cases. Make sure to include boundaries training."

"For reducing the risk of abuse you must know how to manage your own feelings. Keep what is going on at home out of the ward. Know what to do if you are losing it. Know how to get coverage in a physical intervention if you lose it. Know the distinction between patient rights and patient privileges."

"Don't get alone with a patient. Don't hide that you are having a bad day because it makes you vulnerable. Recognize the potential for bad choices on your unit."

"Reduce the chances of abuse with more interaction with patients. More social interaction with patients, like reading magazines, playing cards, etc., helps patients feel valued and respected. If you work well with patients you won't get charged with abuse. Anti-socials sometimes have boundary issues which patients use to manipulate staff, so the whole thing must stay within therapeutic boundaries."

"Communication skills are a great way to reduce the risk of abuse. Respect patients verbally. Using evidenced-based therapy and knowing boundaries reduces possible abuse."

"Self-checks, sensitivity training, and empathy training are needed to reduce abuse. Know the circumstances of frustration for the staff and patients. Don't be afraid to ask to take a break or leave the unit. Recognize your own stressors."

"Staff should go to consumer meetings and ask how these things could be done better. An environment without respect leads to violence. Staff need to know how to extricate themselves from situations where the same patient is asking the same questions repeatedly, instead of showing a lack of respect or being controlling."

"Staff always seem to have to have the last word and that sometimes provokes patients into more behavior. They talk about people according to diagnosis rather than as a person. Staff members do not apologize when they are wrong."

12. Patients, their families and friends have similar needs to hospital staff, they want to know what the definitions of abuse are, how to report abuse, and how to reduce the risk of abuse.

"Patients and families should look for things like you would in your home: changes in eating patterns, isolating, not interacting, and interacting differently are signs that abuse may have happened. Family needs to know to talk to RNs because MHTs can't discuss the medical side of things."

"For recognizing abuse for patients and their families they need to know the same fundamentals. They need plain language handouts."

"Patients and their families need to know that when they have a problem how to go to a staff person. They need to know how to advocate for themselves in places where they feel uncomfortable."

"We need to know what to look for. Who do we report to if you see abuse and are not comfortable: unit director, nurse supervisor, or social worker?"

"We need discussions about what is considered abuse. We need to know definitions and the context in which abuse occurs."

Appendix B: Topics Identified for Abuse Training

Topics	Caregivers	Managers	Consumers	Total Responses
Self-checking (self-control, introspection, recognizing frustration, alert for signs, EAP for stress, de-escalate, stress and burn-out)	11	14	5	30
Empathy (sensitivity, compassion)	12	4	1	17
Communication (tell the patients something other than "no")	5	9	0	14
Boundaries	5	3	2	10
Team building (teamwork)	2	3	1	6
Power and Control	1	1	3	5
Professionalism	3	1	0	4
Retaliation	0	0	4	4
Attitude	2	0	1	3
Respect	3	0	0	3
Change (coping with, culture, managing)	0	3	0	3
Diversity	0	3	0	3
Mental illness (diagnoses)	0	2	1	3
Recovery model	0	3	0	3
Assertiveness	1	0	1	2
Trust	1	1	0	2
Conflict resolution (managing difficult people)	0	2	0	2
Sanctuary model	0	2	0	2
Confidence	1	0	0	1
Taking criticism	1	0	0	1
Manipulation	0	1	0	1
Patient empowerment	0	1	0	1

Appendix C: Length and Frequency of Abuse Training Classes

Length of Class

	Caregivers	Managers	Consumers	Total Responses
Orientation				
4 Hours	3	5	1	9
3 Hours	2	3	0	5
8 Hours	2	1	2	5
2 Hours	1	2	1	4
16 Hours	0	2	1	3
1.5 Hours	2	0	0	2
24 Hours	0	1	0	1
Refresher training				
Spend more time	10	4	3	17
1 Hour	2	7	0	9
2 Hours	2	3	1	6
30 Minutes	2	2	1	5
4 Hours	2	3	0	5
1.5 Hours	2	0	0	2
15 Minutes	0	2	0	2
45 Minutes	0	1	0	1
Frequency of Classes				
Quarterly	8	23	6	37
Every six months	6	10	2	18
Monthly	4	10	4	18
Yearly	5	8	0	13
Every two months	1	4	2	7
Bi-weekly	1	0	0	1
Weekly	0	1	0	1