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"We're Human": An Analysis of Formal and Informal Training Methods for Direct Care Staff Working with Dual-Diagnosis Populations

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**“WE’RE HUMAN”: AN ANALYSIS OF FORMAL AND INFORMAL TRAINING
METHODS FOR DIRECT CARE STAFF WORKING WITH DUAL-DIAGNOSIS
POPULATIONS**

A thesis submitted to
the Graduate College of
Marshall University
In partial fulfillment of
the requirements for the degree of
Master of Arts

In
Sociology

By
Adam Clay Stephenson

Approved by
Dr. Donna Sullivan, Committee Chairperson
Dr. Marty Laubach
Dr. Maggie Stone

MARSHALL UNIVERSITY
DECEMBER 2017

APPROVAL OF THESIS

We, the faculty supervising the work of Adam Clay Stephenson, affirm that the thesis, "*We're Human*": *An Analysis of Formal and Informal Training Methods for Direct Care Staff Working with Dual-Diagnosis Populations*, meets the high academic standards for original scholarship and creative work established by the Department of Sociology and Anthropology and the College of Liberal Arts. This work also conforms to the editorial standards of our discipline and the Graduate College of Marshall University. With our signatures, we approve the manuscript for publication.

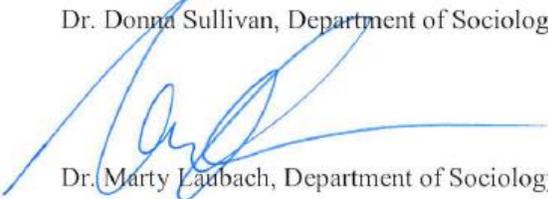


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TABLE OF CONTENTS

Abstract	vii
Chapter 1	
Introduction & Literature Review	1
The Social Capital of Special People	2
Deficiencies and Targets in Training Programs	3
Formal vs. Informal Training Methods	4
Training Delivery Methods	5
Theoretical Framework	6
Chapter 2	
Methods	10
Data Collection	10
Coding	12
Chapter 3	
Results and Analysis	15
Productivity When There Is No Product	18
Clans, Clients and Consent	21
Social Role Valorization and Job Training	23
Chapter 4	
Conclusion	26
Strengths and Limitations	27
Implications for Further Research	27
Implications for Direct Care Training Policy	28

References	31
Appendix A: Office of Research Integrity Approval Letter	34
Appendix B: Semi-Structured Interview Guide	35
Appendix C: Codebook	36
Appendix D: Informed Consent for Participants	38

Abstract

Direct care staff, or DCS, are individuals tasked with providing a number of care services to individuals with disabilities in various settings. This study focuses on a group of direct care staff working at a day habilitation program in central West Virginia. Training techniques used to prepare these workers for a diverse array of roles are reviewed comparatively and through a sociological theoretical lens utilizing perspectives from Bandura (1977), Laubach (2005), Marx (1964), and Wolfensberger (1983). Semi-structured interview results indicate that formal training is driven by a less valorous view of disabled individuals as a class than informal training; that informal training is driven by social learning; that direct care workers do not experience alienation of their labor as intensely as those in other professions; and, that in residential direct care settings, clients act as brokers for the transaction of consent between the informal periphery and the administrative clan. Implications are discussed in the conclusion.

Chapter 1

Introduction & Literature Review

Direct care staff, or DCS are individuals tasked with the care of the elderly or disabled in various settings. This study focuses on the training practices for DCS working in residential settings with dual-diagnosis populations. In the United States, individuals who demonstrate permanent intellectual and developmental disabilities which manifest prior to the age of twenty-two are eligible for Title XIX Medicaid Waiver services, which fund the majority of such residential centers; however, persons without dual diagnoses and those who are funded by sources other than Medicaid waivers may also receive services in these settings (WVBMS 2015).

Direct care staff in the United States are trained according to standards outlined on a state-by-state basis. These standards are promulgated either by state legislatures or by a state department, such as the Department of Health and Human Resources. While many requirements of this training are universal or near-universal, each set of standards is established uniquely. Additionally, some states require the issuance of licensure to practice as a direct care worker, while others simply require that agencies employing staff complete certain training modules, acquire certification (such as CPR/First Aid) or both.

In addition to completing various training modules before entering the job site, most DCS are also required to “shadow” with qualified staff for a number of hours determined individually by agencies before they may work unsupervised. Part of this experience is reviewing any person-centered plans, behavioral plans, social history, background and intake documents, medication lists, and other information pertinent to the care of the individuals to whom the DCS will be assigned. New DCS may also learn how to perform their jobs through informal socialization in the workplace. Because this occupation involves dealing with people living their

everyday lives, the number of potential scenarios for which a DCS must be prepared is immeasurable.

The purpose of this study is to provide a broad overview of themes pertaining to both formal and informal training methods for DCS; how those training methods utilize concepts of disabled individuals as a cohort in the framework of social role valorization; how working in an occupation focused on the care of people affects feelings of alienation; and how informal workplace relationships may affect the dynamic of training method efficacy, especially those relationships which resemble Laubach's (2005) theory of the consent deal.

The Social Capital of Special People

Discerning the amount of income generated from the labor of direct care workers is a matter of subtracting the paid wage from billable units. The subsequent income goes toward the payment of some managerial personnel -- although some other personnel, such as behavior support professionals and service coordinators also bill clients for services, some of which are not optional -- as well as maintenance personnel, office buildings, utilities, and other overhead costs (WVBMS, 2015)

According to the West Virginia Bureau of Medical Services, direct care staff working in an unlicensed residential home in the state of West Virginia presently bill at a rate of \$5.01 per 15 minutes (or "per unit" of service). This means that a company paying its direct care workers a wage of \$10.46 (the lowest wage paid by the federal government for its most basic, entry-level positions) will net \$9.58 of income per hour of labor, per staff. Aside from utilizing auxiliary services such as behavior support, speech therapy, occupational therapy, or physical therapy, direct care agencies must minimize wages in order to maintain overhead costs (USG OPM, 2017).

If income provides little incentive for direct care workers to continue in their chosen field, then perhaps prestige plays a role. Smith and Son (2014) utilized GSS data to measure occupational prestige of all census occupation codes. Direct care workers report under Census 2010 code 4610, which had an occupational prestige score of 4.9. Other occupations sharing this rank include army private, loan processor, game warden, and real estate agent. As prestige was scored on a scale of 1-9 in this dataset, direct care workers landed slightly above the midway point, and just above the mean prestige score for all measured occupations, 4.8.

Deficiencies and Targets in Training Programs

Research has highlighted some of the strengths and weaknesses of DCS training programs in various settings and geographical locations. Unstandardized training programs have been criticized by researchers such as Styron, Shaw, McDuffie, and Hoge (2005, p. 633). Writing that informal or non-uniform training modules “may negatively affect client care, staff recruitment and retention, and the effective use of scarce resources,” they suggest the use of competency tests and portable training units as a more efficient means of increasing DCS competency.

Tayab and Narushima (2015) studied the cultural competency component of a training program based in Ontario, Canada. The authors found that, even though the program had been designed to specifically increase the cultural competency of direct care workers, those who took the training often left without any useful increase in knowledge on the topic. This study suggests that some aspects of training, such as cultural competency, may better be learned through an informal network or social learning in proximity to culturally diverse populations.

Others have suggested that training is most effective when it is tailored toward the specific population with whom a DCS will be working. Taylor, Keddie, and Lee (2003)

researched the effect of a specially designed program that taught DCS about sex offender populations. They found that the platform typically increased workers' favorability toward these populations in pre and post-tests. Similarly, van Oorsouw, Embregts, Bosman, and Jahoda (2010) found that training programs that outline the specific needs of populations based on diagnoses not only increased the level of satisfaction staff experienced with their training, but also increased the effectiveness of behavioral intervention on the part of those staff.

Formal vs. Informal Training Methods

There is some debate in the literature as to whether stronger formal, legal requirements for direct care training are beneficial or not. For example, Way, Stone, Schwager, Wagoner, and Bassman (2002) examined a cohort of 10,000 individuals who received training under new standards from the NY Office of Mental Health (OMH). They found that the process improved staff communication and interaction, generated greater respect for inpatient populations, and improved cultural competency among those trained.

Contrastingly, Zeytinoglu, Denton, Brookman, and Plenderleith (2015) found that roughly a quarter of personal service workers in Ontario were deterred from the profession by the implementation of a task-shifting policy. This policy requires such workers (whose job duties are essentially equivalent to those of a direct care staff) to take on peripheral tasks normally performed by a specialist such as a skilled nurse or therapist. The training for these skills typically takes place in a formal setting. The authors also note that this deterrence may have been more motivated by rate of pay than by the new program. Even so, it is notable that this task-shifting policy resulted in direct care workers taking on additional specialized care needs for which they were trained through formal programs.

Kelly and Bourgeault (2015) explore the possibility of a training model that encourages self-monitoring for staff over agency oversight and licensure. Their study is framed around the transition of Ontario's training policy from a requirement of one in three potential policies to a universal policy. The intention of this policy shift was to cover potential training gaps resulting from any of the previously available models. The authors found that, although this shift did help to cover gaps in knowledge, it did not address many of the problems in long-term care settings.

Training Delivery Methods

A meta-analysis of themes in direct care training programs (van Oorsouw, Embregts, Bosman, and Jahoda, 2009) revealed that combining in-service training and on-the-job coaching was most effective in creating positive staff behaviors. The most important element in such training, according to the authors, was the utilization of verbal feedback on the part of supervision – both encouraging and corrective. These results complement the findings of Adkins (1996) who found in a longitudinal study that individual verbal feedback was the most effective method of training. This result is also echoed by van Oorsouw et al. (2009) and Colón-Emeric, Toles, Cary, Michael, Batchelor-Murphy, Yap, Song, and Anderson (2016) who found that administrative feedback was of significant importance in the direct care worker training process.

While these researchers have highlighted the importance of communication between staff and administration, other researchers such as Kontos, Miller, and Mitchell (2010) and Janes (2006) found that a personal relationship with clients was an important component of DCS training as it allows staff to become accustomed to the specific needs of the individuals for whom they care. In these results, the person receiving services, in addition to the supervisor, takes ownership of directing and evaluating the care provided by staff. The familiarity created in this style of interaction, which is more akin to one individual getting to know another individual

than a worker learning about a product, leads to a more complete understanding of the idiosyncrasies of the client, including his or her maladaptive behaviors and extraordinary care needs.

Serving as something of a synthesis between these, Jerome, Kaplan, and Sturmeiy (2015) discussed an experiment in which three staff were assigned to the study of behavioral tracking plans using three different training methods. They found that all three individuals increased their efficacy in tracking behavioral data, and suggested that training in this particular area is of the greatest importance in regard to the management of client needs and problem behaviors.

Theoretical Framework

In order to examine the influence of informal training networks in direct care settings, a theoretical framework is used that at once considers Bandura's social learning theory, Wolfensberger's social role valorization, and Laubach's consent deal.

Bandura (1977) writes that learning occurs when individuals observe the behaviors of others and the outcomes of those behaviors. Bridging the gap between behavioral and environmental social learning theory, Bandura's theory explains that individuals are constantly negotiating behavioral schemas using environmental feedback. The four stages of Bandura's social learning model are attention, retention, reproduction, and motivation. In attention, social scripts or environmental contexts cue the learner in as to whether something is novel, unexpected, or out of the ordinary. In retention, we absorb the method with which the attention-stage stimulus is dealt. In reproduction, we put those skills to task or rehearse doing so mentally. Finally, we are motivated to perform learned tasks by observing whether doing so is met with reinforcement or punishment for others in our environment. This idea is evident in residential

direct care settings, wherein service professionals are constantly learning how to react to a broad spectrum of actions by persons served, as well as those actions taken by co-workers.

Perhaps instrumental in this negotiation is Laubach's writing on the consent deal in the workplace. Laubach posits that, within the workplace, stratified groups known as "informal periphery," "conventional core," and "administrative clan" interact continually according to a measurable factor called *consent*, defined as an "exchange of autonomy, voice, and schedule flexibility for intensified commitment" (Laubach, 2005, p. 1536).

Laubach defines these groups in terms of their commitment to the workplace and, in turn, the importance relegated to them – whether manifest in tasks assigned, level of supervision, or nature of informal communications. The informal periphery, for example, consists of individuals who were, in his study, either "temporary or part-time workers or permanent workers who were treated as contingent" (Laubach, 2005, p. 1543). These individuals were always under close scrutiny by supervision, and were provided few meaningful tasks. Contrastingly, the administrative clan consisted of individuals who dealt with the highest order of administrative tasks, enjoyed relaxed supervision, and an "in-group" appearance (Laubach, 2005, p. 1544).

In this study, the borders of these three groups are evaluated in the context of the unique structure of direct care agencies. Such companies lack the forced physical proximity of an office building, as residents may be dispersed across cities, counties, or even states within a single agency. The observation and communication, which are essential to the consent deal, may manifest altogether differently in this unconventional setting.

Wolfensberger's (1983) formulation of *social role valorization* is a framework through which we may view the disabled as an *a priori* valueless group from a societal standpoint. According to Wolfensberger, presentation or performance of schemas play an important role in

how individuals and social groups are defined by society at large. Individuals are perceived as being part of a social group based upon an amalgamation of clues in clothing, behavior, and so forth. Individuals or classes of people may be limited in the roles to which they are consigned. Consequently, valorizing the disabled as a class is a matter of advocating for their access to valuable roles. According to Wolfensberger, the value of these roles is as likely to be contained in the context of their title as it is in their utility. For instance, by supporting an individual's role as a "special class pupil" and focusing on their value as a "peer tutor," one can help to valorize the role of an individual (Thomas and Wolfensberger, 1999. p. 128). This study seeks to examine the identified benefits of formal and informal training techniques in diminishing valueless schematic performance and, consequently, devaluation of individuals with disabilities.

As more agencies providing direct care services work toward a model incorporating social role valorization as a means of reducing stigma for the disabled in public settings (Aubry, Flynn, Virley, and Neri, 2013; Wolfensberger, 1983, 2011a), the emphasis on the reduction of behaviors perceived to be maladaptive has certainly not waned. Models for the reduction of these behaviors without the use of aversive measures have emerged, such as *Positive Behavior Support* (Meyer & Evans, 1989). This behavioral support model is the state-mandated method for addressing maladaptive behaviors in several states, including West Virginia. The model differs from applied behavioral analysis in that it never includes aversive measures, and focuses on the simultaneous fostering of positive replacement behaviors while simultaneously removing potential maladaptive behavioral antecedents and setting events. Also integral to this method is the exploration of opportunities for personal choice and socialization, which are seen as necessary in both valorizing the individual and creating access to community areas where newly-developed, prosocial skills can be generalized.

Maladaptive behaviors are a constant focus of research literature in the area of long-term care (Colón -Emeric et al., 2016, Jerome et al., 2015, Heyvaert, Saenen, Maes, and Onghena, 2014). Indeed, some scholars such as Drinkwater (2005) have suggested that residential care which utilizes a social role valorization model defines an able person's relationship with another able person versus a person with intellectual disabilities based upon the assumption that the disabled person is not capable of valued or valorized behavior without assistance. Essentially, his criticism posits that this methodology insinuates persons with disabilities are inherently incapable of valued behavior without help from able persons.

This study will attempt to explain the ongoing negotiation of workplace schemas among direct care workers while giving consideration to their increased flexibility for those who have a stronger relationship with members of the "administrative clan." Furthermore, this study will explore how such a group is defined in the direct care setting, and what roles persons served play within it.

Chapter 2

Methods

This study broadly addresses employee training for direct care staff working with intellectually-disabled individuals receiving title XIX waiver services. The focus of the investigative portion of this research is threefold: first, to examine qualitatively the formal and informal training experiences of direct care staff; second, to understand the perceptions of participants' incentives for working in the field; and third, to trace patterns of communication in an organization where workers and supervisors do not often operate in proximal spaces.

In the interest of disclosure and objectivity, it should be noted that the author presently works in the direct care field as a behavior support professional, an individual who operates as a supervisor to direct care staff and who is also responsible for developing programming for shaping prosocial behavior and minimizing maladaptive behavior among clients, as well as maximizing the valued roles they take on.

Data Collection

Semi-structured interviews were conducted with a nonrandom purposive sample at a mid-sized day habilitation program in West Virginia. One difficulty in reaching the intended population of this study was a fear of divulging PHI, or protected healthcare information, which carries intense legal ramifications. The author utilized a professional connection with an agency Waiver director who was able to grant access to the facility in which the interviews took place. Despite the trust established in this connection, participants were still briefed on the importance of withholding any identifying information or PHI during the course of the interviews.

The seven participants interviewed for this study were selected based upon their dual experience of working with adults with intellectual and developmental disabilities in both

residential settings and day habilitation programs and represented not only the viewpoints of workers in either setting, but also a comparative knowledge of how the two settings differ. Participants ranged in age from their early twenties to their fifties. Four were female, and three male. Due to the small number of programs such as the one in this study, and due to the close-knit professional network of direct care workers in the state of West Virginia, further demographic data are withheld to ensure the anonymity of participants.

Any individual who works with a person with intellectual disabilities in a residential direct care setting is required by law to undergo a person-specific, or client-specific, training. Some agencies also carry internal requirements for *shadowing*, or working with an individual under the supervision of a seasoned staff member. Each of the individuals interviewed in this study underwent a shadowing process, ranging in length from four hours to forty hours before being allowed to work one-on-one with an individual receiving services.

The results and analysis of this study are meant to provide an illustration of the experiences of direct care workers in this specific setting, and are not generalizable to the greater population. These results might instead be utilized in direct care training curricula as well as to instruct the perspectives of researchers and supervisors whose responsibility is to administer those trainings. The results of these interviews were extremely consistent, and therefore constitute a certain level of theoretical saturation, despite the small sample size.

Researchers such as Robertson, Hatton, Wells, Collins, Langer, Welch, and Emerson (2011) have noted in literature review that studies concerning disability service workers frequently have small samples and utilize qualitative descriptions of services. Casey (2011, p. 57), in writing on burnout and retention of direct care workers, sought a small sample with an “intended ‘uniqueness’” to capture an array of experiences within the direct care field. Her

results, although not generalizable, were notably congruent with data-driven studies utilizing much larger samples.

Quantitative data collection is a commonplace practice in direct care settings. It is utilized in determining the effectiveness of program interventions, the fidelity of staff application of those interventions, and in tracking behavior. Unfortunately, because supervision and program administration are so frequently intertwined, this type of data is ripe for social desirability bias. Direct care staff may have incentive to report what they believe to be favorable results of program opportunities or behavioral interventions to cast themselves in a better light in the eyes of their supervisors, who are often the individuals processing this data. Qualitative data is collected through semi-structured interviews in this study, in part, to prevent such a bias from emerging.

Participants were interviewed one-on-one, face-to-face on September 15th, 2017 in a private boardroom at the facility. Each lasted an average of twelve and a half minutes. Interviews were recorded digitally and stored on a password-protected device. After all interviews were collected, they were transcribed verbatim. Recordings were then deleted.

Coding

The resulting transcripts of these interviews were then coded using *a priori*, holistic first-cycle codes (see Appendix C). This method of first-cycle coding is, as Saldaña (2013, p 77) writes, appropriate “when the researcher has a general idea as to what to investigate in the data.” Holistic codes were applied based upon themes first identified in the content of the semi-structured interview guide.

A second cycle of coding was applied to the text based upon these results. Two codes, GUARDIAN and ROLEVALOR occurred infrequently enough (two and three times,

respectively) that they were eschewed. The remaining eight codes were re-applied using an evaluation coding approach (Saldaña, 2013) in which dichotomous or descriptive data were applied to each quote. For example, quotes coded BEHAVIOR were re-coded as either BEHAVIOR: MAL or BEHAVIOR: PRO to indicate that the quote pertained to descriptions of maladaptive behavior or prosocial behavior, respectively. Alternately, the code CLIENT, which was applied to a more qualitatively diverse array of quotations, was re-coded as CLIENT: COMM, CLIENT: CARE, CLIENT: DISABLE, or CLIENT: PERSON to describe quotations which describe clients in terms of their being communicators, their care needs, their disabilities, or their being individuals beyond their disabilities. The development of these evaluation codes was based upon memos developed during the first cycle of coding.

This approach to coding yielded data which is comparatively rich, allowing the researcher to evaluate side-by-side the frequency of the descriptive qualities of participant's perceptions. Unfortunately, the small number of documents reviewed prevents any real qualitative or generalizable observations. This sample size may be viewed as appropriate, however, given that the codebook utilized in this study is insular and not concurrent with other studies.

Institutional Review Board approval was secured from the Marshall University Research Corporation to collect data via semi-structured interviews (see Appendix A). The author reviewed informed consent forms with participants, and encouraged participants to take their time reading over the forms before signing (See Appendix D). Due to the potential for disclosure of medical information protected under HIPAA, respondents were asked not to give any identifying information about individuals or agencies which might be used to establish the identity of any persons served. As a secondary guard against unlawful disclosure, the name of

the facility at which these individuals were interviewed, as well as the names of any past facilities which were mentioned, are redacted in all transcriptions. Pseudonyms were written to retain the confidentiality of participants. Participants were asked each of the twelve questions in the semi-structured interview (see Appendix B) guide as-written, but additional questions were also asked in most interviews as subject materials emerged. Exploratory subjects included what qualities make a good direct care worker, when and how workers set boundaries with clients, the importance of understanding maladaptive behaviors, and what types of behavior constitute active versus passive management.

Chapter 3

Results and Analysis

The participants interviewed for this study come from a day habilitation program, or *day-hab* in central West Virginia. The legal requirements for employment in such a setting include a high school diploma or GED, a criminal investigation background check resulting in a report of no felonies, a protective services record check, and proof of legal adult status. While there is no formal process of licensure in this state for direct care staff, some specific trainings are required, including: confidentiality; member rights; infectious disease control; CPR; first aid; Heimlich maneuver; recognizing and reporting abuse, neglect, and exploitation; and training on client-specific needs (WV BMS, 2015). Some modules of these training requirements, such as CPR, first aid, and criminal background checks, are transferrable between agencies. Others, such as confidentiality training and abuse, neglect and exploitation training, must be renewed annually and will not transfer if an individual leaves one agency to work for another. As previously noted, any individual providing care to persons with intellectual disabilities under title XIX waiver must undergo an informal, on-site training process known as “shadowing.”

Each of the twenty quotes which were coded ONJOB indicated that respondents felt on-site, informal training such as shadowing, was useful. On the other hand, of the eleven quotes coded PREEMPLOY, only six framed formal, pre-employment training as useful. One key difference between these two modes is that on-the-job training allows a new hire to witness behavioral interventions and care techniques in practice. Pre-employment training does not require the incoming direct care staff to observe individuals providing or receiving care.

This difference plays into a vital element of Bandura’s Social Learning model, which is that reproduction of behavior is contingent upon ability and motivation. In order to enact an

intervention either for the development of positive behavior, or to stave off injurious or unpleasant incidents, a direct care worker must retain a complete-enough understanding of how the intervention functions, and they must be sufficiently motivated *internally* to act. By witnessing these interventions in use on-the-job, direct care workers may develop confidence and motivation to utilize them when they are slated to work in the same setting under different conditions.

When asked whether they thought pre-employment training or on-the-job shadowing was more helpful in learning how to provide care for individuals, nearly every respondent answered that on-the-job shadowing was. Several respondents indicated that it was necessary to strike a balance between the two training methods:

I would say I got more information on-the-job, because every client is different – it really just depends on the client. But, like I said, there are some things that [are] universal, that you learn in training that is valuable too. But I'd say the majority of it is on-the-job.

When asked if formal, pre-employment training could possibly prepare an incoming direct care staff to work with individuals effectively, respondents stated overwhelmingly that general pre-employment training was not, but some indicated that client-specific training, which is a type of training that pertains to specific diagnostic and social information about clients with or without the client present, can be sufficient under certain conditions:

If they feel comfortable enough that they have enough knowledge to go in and work with this person, you know, maybe sometimes yes it is, and maybe sometimes it's not. It's just, it depends on us and how we feel.

Indeed, the need for trainings, which are tailored not only to the client but also the staff working with them, was a prevalent theme in several interviews.

If, in fact, direct care workers enjoy neither extraordinary levels of compensation nor great prestige, what keeps them in this occupation? All of the individuals interviewed for this

study had worked in the field at least nine months. One subject had eleven years' experience, and another had over twenty. Their statements may in fact hold the key to why individuals feel drawn to this position. Simply put, "not everybody is cut out to work with people with challenged issues."

Respondents nearly universally stated that being a direct care staff required special gifts or talents, and those who leave the field lack these qualities. These were described using different verbiage, such as "heart" or "willingness." Respondents also stressed the importance of having a personal relationship with clients that transcends the status quo, businesslike relationship most people in the service industry have with their clients. As this individual put it, "we're human... They need to know that you love and care for them. They deserve that."

The answer to what draws and keeps individuals in this profession might also be informed by the writings of Karl Marx. Marx writes of the alienation of labor experienced by workers in a capitalist economy:

The worker therefore only feels himself outside his work, and in his work feels outside himself. He is at home when he is not working, and when he is working he is not at home. His labor therefore is not voluntary, but coerced; it is forced labor. It is therefore not the satisfaction of a need; it is merely a means to satisfy needs external to it. (Marx, 1844/1964, p. 71)

The question is, then, does the direct care worker experience alienation in this way? One respondent, when asked whether having a personal relationship with one's client is essential to providing good services, essentially turns this line from Marx on its head:

When you walk in and you've had a bad day, and they serenade you, they hug you, they love you, they sing with you, they make your day. They make your day. You know, I never want to walk away from them, ever. When I wasn't with them, I was sad. I look forward to my job every day, you know, coming here. I make them happy, they make me happy.

The direct care staff may not experience alienation because he or she does not create a tangible product. Whereas Marx' alienated worker has a specialized role, the purpose of which in the greater process of production is not always evident, a direct care worker must assist one or more individuals in taking on as many roles as are necessary for them to find fulfillment while remaining safe. The direct care worker may live vicariously through his client while working, or she may find great satisfaction and personal development in helping another individual develop, but the nature of the occupation does not readily provide opportunity for some workers to feel alienated. Other entry-level positions that pay similar or higher wages may not boast the same, nor might occupations whose prestige matches or exceeds that of the direct care staff.

Hochschild's (1983) study of emotional labor may shed some insight on this dynamic as well. The participants in this study spoke about establishing boundaries with clients in terms of personal information, physical proximity, and emotion. Although direct care agencies do not typically require direct care staff to produce a particular affect while administering services, the requirement of face-to-face interaction with clients necessitates emotional labor on some level. Perhaps in determining what attracts certain individuals to this work setting, the factor of tolerance for emotional labor comes into play.

Productivity When There Is No Product

At no point in any of the interviews conducted for this study did the author ask questions regarding the maladaptive behaviors of clients. Regardless, this was a theme that emerged repeatedly in each of the interviews conducted. Each of the 17 quotes coded BEHAVIOR during the first coding cycle were coded MAL during the second. The incidence of maladaptive behavior within a direct care agency can have a direct impact on its profitability as well.

Incidents involving maladaptive behavior, particularly external, violent behavior, can tie up agency resources for investigation, lead to staff turnover, result in injury and unemployment claims, and freeze monetary resources in the case of an Adult Protective Services investigation. This estimation does not even begin to account for the emotional and social harm to both client and staff that can result from a single restraint event (Link, Castille, & Stuber, 2008).

Leske (1995) found that patients who exhibited even negligible degrees of external maladaptive behavior could be labeled deviant, and would consequently receive lower-quality treatment from personnel in an inpatient mental hospital setting. While the direct care staff interviewed for this study did not work in such a setting, the same dynamic is evident in some of the interview responses given:

There's a couple here that you definitely have to watch. We have one that obsesses over a couple of girls, so you definitely have to keep your-- you don't have to keep your distance but you have to watch what you say, and just keep your guard up sometimes with them. That's the best way to put it.

...the bigger fella, used to be very violent. They told me he does this, and he does that. It's almost as if though, I felt like they were trying to scare me...

In a sort of inversion of the wage labor model, direct care agencies receive a payout per unit of service provided by a DCS (typically measured in fifteen-minute increments). The net profit created by a single worker is a matter of subtracting that employee's wage from the unit value billed. The amount of profit generated by a direct care staff cannot be increased by any means, save by lowering that staff's wage. The net profit, however, from a single unit billed can be lowered by incidental costs, many of which are precipitated by maladaptive behavior on the part of the client. Therefore, productivity in the direct care model is directly contingent upon the reduction of maladaptive behavior. Profits are not counted in terms of increases to net gains, but rather in minimization of losses.

Whether for issues of personal safety, implication in formal investigations, or maximizing corporate gains, the pressure on direct care staff to reduce maladaptive behaviors is certainly significant, and a salient subject clearly on the minds of the individuals interviewed for this study.

Subjects of this study spoke about the importance of behavior when asked which training method was more effective in their experience. When one respondent spoke about the importance of shadowing on-the-job, she was asked if they felt that there should be greater length requirements for shadowing. The interviewee responded, “Yeah, at least a week. I mean, because, the clients up here are awesome, but some of them have more behaviors than others, and we definitely need to know about those.”

Although there are many components to job shadowing, such as learning how to coach individuals in personal living skills, what levels of prompting or assistance to provide, schedules, and more, the subjects of this study focused primarily on the importance of learning about potentially harmful behavior.

Another individual responded, when asked whether pre-employment, classroom-style training was important, had the following to say:

Well, they give you lots of information about how to handle situations -- I think that is valuable, that definitely comes in handy if there's a behavior -- like, what you are allowed to do, because there are lots of things you're not allowed to do. Like, you're only allowed to have physical contact with them for like 60 seconds, and that's after you've gone through a bunch of other steps first.

Although this response highlights the degree to which maladaptive behavior is a focus of direct care staff, it also points out that formal and informal training addresses the problem of understanding and redirecting maladaptive behavior from two different angles. In the former, the direct care staff learn techniques and policies for reacting to and preventing maladaptive

behaviors. In the latter, they absorb through social learning a schema for how those behaviors are manifest in a particular individual receiving services, and how to best redirect those specific behaviors.

Some respondents clearly found that informal training was more useful in learning how to deal with maladaptive behavior than formal training. When asked if there were any aspects of formal training that were particularly useless in the field, one respondent spoke about a violent behavior intervention taught by a previous employer. According to the respondent this technique was useless “because, when someone comes after you aggressively, you automatically forget what you were trained.”

These findings are in agreement with van Oorsouw et al. (2010), who noted that training programs emphasizing the specific needs of populations increased the effectiveness of behavioral intervention. While informal, social-learning-based training was not addressed in this study, the identified relationship between understanding specific needs and applying more effective interventions was reflected in the statements of interviewees.

Although intuitively contradictory to van Oorsouw et al.’s findings, the findings of Styron et al. (2005) are also evident in this analysis. The authors’ observation that informal, non-uniform training modules negatively affected care and increased staff turnover is evident when considering that staff who are not properly trained on basic intervention techniques may not be able to handle the notable shock of dealing with idiosyncratic maladaptive behaviors in the workplace.

Clans, Clients, and Consent

Direct care agencies rely upon low numbers of incidents to keep profits well managed. It follows logically, then, that those who are skilled in preventing incidents would be highly prized

staff. However, to be highly prized as a staff member does not necessarily mean that one has a good relationship with one's supervisor or that one enjoys the associated perks. To more closely examine this trend, one might refer to Laubach's (2005) "administrative clan."

Interviewees in this study were asked whether they felt comfortable talking to members of supervision about work-related and/or personal matters. Later in the interview, they were asked whether they enjoyed flexibility with their schedule. Finally, respondents were asked whether they were willing to go the extra mile at their job, as in filling in schedule gaps, working with clients known to have difficult problem behaviors, and so forth.

Of the individuals interviewed, three responded that they had a personal relationship or were willing to discuss personal information with members of management. These three people also responded that they were willing to put in extra work, and that they experienced a good degree of flexibility with their schedules. Curiously, however, all respondents who stated that they were willing to pick up additional shifts and/or work with clients who exhibited exceptional maladaptive behaviors also said that they enjoyed perks such as schedule flexibility.

One explanation for this is that in direct care clients can function as members of the administrative clan despite the fact that they are not, themselves, employees. The structure of a direct care agency is often such that workers report directly to residential settings for duty. As was identified by van Oorsouw et al. (2009), people working in intellectual disabilities services often feel that they do not receive enough supervisory contact or feedback. Respondents in this study were no different, citing many instances in which they felt that supervisors were scarcely present in residential settings. Exposure to members of the administration of direct care companies is often a rare phenomenon for those who work with individuals in these settings. As supervisors are responsible for responding to all recorded incidents (in this context, incidents

refer to injuries, hospitalizations, elopements, and other critical occurrences), face-to-face time with supervisors hypothetically increases for staff who work with individuals more likely to instigate them. Working a greater number of shifts should, likewise, increase the likelihood of worker-supervisor interaction as well. Speaking on experiences with supervisors in residential settings, one respondent summed up this separation by stating, “now, they [supervisors] will show up and interact with you if, god forbid, an incident happens or something like that, and of course it all falls on the direct care worker.” Another had to say on the same topic, “uh, yeah, my supervisor doesn’t know the client nearly as well as I do. And that is because she spends most of her time in the office.”

While personal interactions between direct care staff and supervisors may be rare, supervisors are generally tasked with providing professional services and service oversight to clients in residential settings. Because of this, persons served may act as surrogates for assisting staff in transitioning from the “informal periphery,” through the “conventional core,” and into the “administrative clan” of the agency (or, of course, cause them to regress). By reporting to a supervisor that a particular staff has done especially well at helping them achieve goals or avoid having incidents, the client incentivizes the supervisor to develop a relationship with that staff and to consider them reliable. One respondent summed up this dynamic, stating “I think the longer that you work with a client, the less disposable you become -- they've been known to advocate for themselves.” On the other hand, if a client reports malfeasance or laziness on the part of the worker, he or she may fall under greater scrutiny.

Social Role Valorization and Job Training

Interviewees stated that formal training sessions prepared them for dealing with maladaptive behaviors in general, especially violent behaviors. On the other hand, on-the-job

informal training, such as social learning and shadowing, teach staff about the particular behavior or behaviors exhibited by an individual, and which subsequent interventions are used with the greatest success. If we examine these results through the lens of social role valorization, we see the tendency of informal training to valorize the individual by viewing them outside the context of a group performance and instead as whole individuals, while the formal training for behavioral intervention taught to all incoming staff assumes the tendency for disabled persons as a class to exhibit problem behaviors.

There is a formal training methodology that is used in several states, including West Virginia, that addresses the specific maladaptive behavior of individuals and mandates specific interventions that are designed with safety, freedom-of-choice, and efficacy in mind. Positive Behavior Support, or PBS, is philosophically rooted in the normalization/inclusion movement from which Wolfensberger developed social role valorization (Carr, et al., 2002).

Some individuals interviewed in this study noted that there are discrepancies between the expectations of agency management and those of direct care staff or the individuals they serve. One interviewee focused on the design of habilitation programs, which are intended to help individuals develop skills or skill sets through graduated prompting and assistance from staff:

So, some of the goals that are set by the company for the individuals that we serve are so far-fetched, and the company doesn't know that because they're doing everything on paper, and they're doing everything from what they've learned from school.

In addition to this person's assessment that management design these programs based on what they have learned from school, it could be considered that this tendency comes from an *a priori* judgment that individuals with disabilities are incapable of valuable behavior, and must be taught these in order to experience inclusion in society at large, as Drinkwater (2005) suggests is an implicit feature of residential direct care models.

This finding also speaks to Tayab and Narushima (2015) whose study showed that the training of cultural competency skills is perhaps best carried out through informal networks already connected to the populations caregivers seek to understand. This dynamic is wholly evident in the reality that informal, on-the-job training generates a shift of focus from the disabled as a devalued group to an individual capable of valuable action and, thus, valorization.

Additionally, Taylor et al. (2003) wrote of the efficacy of honing formal training content to include specific populations with whom direct care staff will work. In this context, these findings suggest that population-specific training could potentially act as a bridge between formal, pre-employment training which treats persons served as a cohort to informal social learning which exposes one individual (a worker) to another (a client). This dynamic is summed up in the response of a participant, who had worked for other agencies prior to working at the setting where the interviews took place, and was asked whether formal training or on-the-job training was more effective in teaching direct caregiving skills:

I think you probably need both, but if the person you're shadowing has been -- is effective at, you know, [giving care] because I've learned more just by shadowing, because I know that when we came in here, there wasn't a whole lot that they were able to tell me about the job, because everything's pretty well the same.

Chapter 4

Conclusion

Training methods for direct care staff working with dual-diagnosis populations must utilize a wide array of approaches because these workers do not do a one-dimensional job. This occupation defies conventional understandings of the structure of work environments. Its product does not alienate the worker, but allows them to foster meaningful social relationships and express a sentiment of humanity not feasible when working on an assembly line or as a clerk.

Workers absorb in formal training a set of skills applicable to work with individuals who are presumed to exhibit dangerous, problem, or maladaptive behaviors. Social learning both from other staff and from individuals served humanizes the individual and distinguishes them from this distrusted group, allowing the staff to deal with individual behaviors uniquely and to foster transcendence into a valorized role for the person served. Much of this transition occurs when workers observe and model the interactions between persons served and staff who are acquainted with them. New workers may not have schemas developed for interacting with this population, and may be prone to inappropriate reactions based upon their learned behavior from outside the care setting, or informed by the inherent devaluation of people with disabilities as a class.

Because the residential work sites of the direct care staff are often physically distant from one another, and because staff-to-manager contact is often scarce, persons served or clients act as informants for the development of building or destroying reputation and transference between periphery, core, and clan. In this way, although not employees, clients may themselves be members of any of these stratified groups within the agency.

Strengths and Limitations

The primary weakness of this study is that the sample size of interview subjects was relatively small and therefore, results are not generalizable. This sample size suits the aim of the study, however, which is to investigate at a bird's-eye level claims about formal and informal training techniques and to examine the experiences of direct care workers through a sociological lens. Interviews took place at a work setting, which was, at least in part, a subject of discussion throughout. Participants took time away from their work schedules to discuss these ideas, which means that the themes under discussion were fresh on their minds. This interview structure therefore provides some of the benefits of ethnographic research, in that the observer and the participant are actively submerged in the natural environment being studied.

Although responses given are not generalizable, the similarity of dispositions indicated by the participants concerning the core strengths and weaknesses of formal and informal training methods, the intense focus on maladaptive client behavior, the need to view individuals in a strength-based, person-centered framework, and the importance of supervisory presence and positive client relationships indicates that results are reliable, valid, and might very well be replicated in a similar setting.

Implications for Further Research

Suggestions for further research stemming from this study include a more detailed examination of the total cost of incidents related to maladaptive behavior. Such behavior should be examined not only as a matter of fiscal damages, but in terms of the overall effect on personnel turnover, administrative involvement, emotional well-being, and so on. In addition to providing to the body of academic knowledge about direct care agencies, this information could be useful in adjusting services to maximize efficiency.

This body of knowledge would also benefit from the longitudinal, comparative study of mental health care providers operating in various states and provinces where the processes of licensure, training, and funding vary. The differences in these dimensions might manifest in countless aspects of services provided, from injuries to use of seclusion or restraint, to the success of supported employment programs and matriculation from support services to independent living. The role of clients or persons served in shaping the reputations of direct care workers could also be included in such a study.

The subject of quality of care, which is invoked throughout this study if not called upon specifically, should be examined through the qualitative experiences of direct care and long-term-care workers. Administrative and clinical approaches, which rely heavily upon pre/post data collection with a limited number of data points, cannot truly capture the experiences described by the subjects in this study. Meta-studies of these approaches only dilute the truth of client/staff interaction further. Ethnographic study of direct care workers, waiver participants, their families, and those in long-term care are invaluable, but in short supply.

Implications for Direct Care Training Policy

To make any outright policy changes based upon a study of this size is not necessarily advisable. Even so, the results of this study introduce several items which should be taken into consideration when developing training policy and programs.

First, the importance of training cannot be understated. The participants in this study indicated that one or both forms of training were vital in developing and understanding the diagnoses of individuals, the maladaptive behaviors they may exhibit, interventions for redirecting those behaviors, and general knowledge about the people receiving care. Training, generally speaking, is not a service for which agencies may bill Medicaid and is, therefore, not

profitable to an agency serving title XIX clients. Therefore, incentive exists for agencies to minimize the time that workers spend in training. Those who develop training policies should keep in mind that direct care workers who are underprepared to enter the work setting may increase margins of financial gain through a lack of training, but that this cost may be eventually incurred in the form of mishandled incidents, the provocation of maladaptive behaviors, or poor quality of service.

Second, the participants of this study underscored the necessity of on-site training such as shadowing in developing skills. Participants nearly universally indicated that more cerebral approaches to learning behavioral interventions and job duties pale in comparison to observing and repeating workplace behavior. A nuanced understanding of how to provide specific services for individuals with specific needs is, based upon the feedback provided in this study, easier to garner through informal training methods than formal ones.

Third, supervisors of residential settings should consider whether they have provided sufficient verbal feedback and physical presence in the homes which they manage. Most respondents felt that, in the residential setting, supervisors were not present enough, and they did not perceive supervisors to have a sufficient knowledge of clients receiving services. Although the supervisory structure of direct care agencies may allow supervisors to lead from afar, the experiences of the individuals in this study indicate that this results in a lack of useful feedback, a feeling of isolation or abandonment, and supervisors who are not seen as trustworthy or competent.

Finally, the finding that clients act as brokers in the exchange of workplace consent indicates that the active inclusion of clients is perhaps an overlooked resource in the evaluation of employee competency. Although this type of communication is noted in the responses of

participants in the study, it is not said to be explicitly sought. By integrating feedback from persons served both intentionally and rigorously in the review of employee performance, agencies might well not only develop a more candid illustration of a direct care staff's competencies and shortcomings, but deepen the degree to which a client is directly involved in the selection of his or her own assistants.

In all, the results of this study show that direct care workers are individuals who engage with their work on an entirely social level. Unlike an individual who develops products or works with materials, the direct care worker is inevitably engaged with their work using the same faculties with which they engage with a friend, lover, or family member – that is, to work in direct care is to work with human beings. Qualitative, phenomenological, and ethnographic study of both the direct care worker and the persons whom they serve is still needed to better understand how the direct care experience is perceived from both ends. Regardless, the constructs, schemas, and idiosyncrasies that define the worker's interaction with people outside of the workplace are inextricably carried into it. If we are to accept the sentiments of the participants in this study, those who train direct care workers deny or ignore this truth at their own detriment.

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APPENDIX A

OFFICE OF RESEARCH INTEGRITY APPROVAL LETTER



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Office of Research Integrity
Institutional Review Board
One John Marshall Drive
Huntington, WV 25755

FWA 00002704

IRB1 #00002205

IRB2 #00003206

February 21, 2017

Donna Sullivan, PhD
Sociology & Anthropology Department

RE: IRBNet ID# 1022936-1

At: Marshall University Institutional Review Board #2 (Social/Behavioral)

Dear Dr. Sullivan:

Protocol Title: [1022936-1] Legal, Bureaucratic, and Informal Systems in Direct Care Staff Training

Expiration Date: February 21, 2018

Site Location: MU

Submission Type: New Project APPROVED

Review Type: Exempt Review

In accordance with 45CFR46.101(b)(2), the above study and informed consent were granted Exempted approval today by the Marshall University Institutional Review Board #2 (Social/Behavioral) Designee for the period of 12 months. The approval will expire February 21, 2018. A continuing review request for this study must be submitted no later than 30 days prior to the expiration date.

This study is for student Adam Stephenson.

If you have any questions, please contact the Marshall University Institutional Review Board #2 (Social/Behavioral) Coordinator Bruce Day, ThD, CIP at 304-696-4303 or day50@marshall.edu. Please include your study title and reference number in all correspondence with this office.

APPENDIX B

SEMI-STRUCTURED INTERVIEW GUIDE

1. How long have you worked in direct care?
2. Do you think pre-employment training prepares staff for DCS work?
3. Did you find pre-employment training or on-the-job (informal) training more effective?
4. Was there anything in your pre-employment training that has been especially useful?
5. Was there anything in your pre-employment training that has not been useful?
6. Do you feel formal on-site training tells a DCS enough about a person served to work with him or her effectively?
7. Is having a personal relationship with clients important in providing the best care to persons served?
8. Do you feel supervisors should be more involved in day-to-day training with DCS?
9. Do you feel comfortable reaching out to your supervisor for any reason, even reasons which don't relate directly to your work duties?
10. Is your voice heard in the workplace?
11. How willing are you to "go the extra mile" at work?
12. Is your employer flexible with your schedule?

APPENDIX C

CODEBOOK

Cycle 1	Cycle 2	Description
BEHAVIOR		Description of observed or discussed client behaviors.
BEHAVIOR	MAL	Description of observed or discussed client maladaptive behaviors.
BEHAVIOR	PRO	Description of observed or discussed client prosocial or valorized behaviors.
BOUNDARIES		Description of the need to establish or eschew boundaries between client and worker.
BOUNDARIES	SEX	Description of the need to establish boundaries for sexual reasons.
BOUNDARIES	PERSONAL	Description of the need to establish or eschew boundaries concerning disclosing personal information.
CLIENT		Either a specific statement about a client or a statement about working with clients in general.
CLIENT	COMM	A statement about communicating with clients.
CLIENT	CARE	A statement about a client's or clients' care needs.
CLIENT	DISABLE	A statement about a client's disability including cognitive and behavioral impairment.
CLIENT	PERSON	A statement about a client as a person with whom the staff interacts.
NOTREADY		A statement about incoming staff being underprepared for work in direct care.
NOTREADY	BEHAVIOR	A statement about incoming staff being underprepared for work in direct care because of maladaptive behaviors.
NOTREADY	OTHER	A statement about incoming staff being underprepared for work in direct care for reason other than maladaptive behavior.

ONJOB		A value statement regarding on-the-job, informal training.
ONJOB	USEFUL	A statement that on-the-job, informal training is useful.
ONJOB	NOT	A statement that on-the-job, informal training is not useful.
PREEMPLOY		A value statement regarding formal, pre-employment training.
PREEMPLOY	USEFUL	A statement that formal, pre-employment training is useful.
PREEMPLOY	NOT	A statement that formal, pre-employment training is not useful.
QUIDPROQUO		A statement regarding an exchange of buy-in or dedication for flexibility from supervision.
QUIDPROQUO	YES	A statement that the staff exchanges buy-in or dedication for flexibility from supervision.
QUIDPROQUO	NO	A statement that the staff does not exchange buy-in or dedication for flexibility from supervision.
SUPERVISION		A statement concerning the efficacy or closeness of supervision.
SUPERVISION	NEAR	A statement that supervision is effective and/or present in the workplace.
SUPERVISION	FAR	A statement that supervision is not effective and/or present in the workplace.

APPENDIX C

INFORMED CONSENT FOR PARTICIPANTS

Informed Consent to Participate in a Research Study

Legal, Bureaucratic, and Informal Systems in Direct Care Staff Training

Donna Sullivan, Ph.D., Principal Investigator

Introduction

You are invited to be in a research study. Research studies are designed to gain scientific knowledge that may help other people in the future. You may or may not receive any benefit from being part of the study. Your participation is voluntary. Please take your time to make your decision, and ask your research investigator to explain any words or information that you do not understand.

Why Is This Study Being Done?

The purpose of this study is to find out how direct care staff feel about their employment training experiences, and how those experiences compare to on-the-job learning and training. The research also aims to see if there is any link between the involvement of management at the worksite and how satisfied and competent subjects feel at work.

How Many People Will Take Part In The Study?

About 15 people will take part in this study. A total of 25 subjects are the most that would be able to enter the study.

What Is Involved In This Research Study?

Participants will be interviewed by a researcher in a one-on-one setting. A set of twelve open-ended questions will be asked, and participants will be welcome to share any relevant information. Questions about related topics may be asked if they are introduced in the course of

the interview by the participant. As stated below, participants may refuse to answer any or all interview questions. These interviews will be recorded. All recordings will be stored digitally on a password-protected storage device, which will be kept in a secured (locked) location.

How Long Will You Be In The Study?

The study will be open for approximately 9 months. Interviews for the study will take about thirty minutes to one hour.

You can decide to stop participating at any time. If you decide to stop participating in the study we encourage you to talk to the study investigator as soon as possible.

The study investigator may stop you from taking part in this study at any time if he/she believes it is in your best interest; if you do not follow the study rules; or if the study is stopped.

What Are The Risks Of The Study?

There are no known risks to those who take part in this study. Many people find it beneficial to participate in a study such as this one.

Are There Benefits To Taking Part In The Study?

If you agree to take part in this study, there may or may not be direct benefit to you. We hope the information learned from this study will benefit other people in the future. The benefits of participating in this study may be: an increase in awareness of your own knowledge and habits in the workplace, and consideration of issues pertaining to the field of direct care.

What About Confidentiality?

We will do our best to make sure that your personal information is kept confidential. However, we cannot guarantee absolute confidentiality. Federal law says we must keep your study records private. Nevertheless, under unforeseen and rare circumstances, we may be required by law to allow certain agencies to view your records. Those agencies would include the Marshall University IRB, Office of Research Integrity (ORI) and the federal Office of Human Research Protection (OHRP). This is to make sure that we are protecting your rights and your safety. If we publish the information we learn from this study, you will not be identified by name or in any other way. The recordings resulting from interviews in this study will be destroyed immediately after they are transcribed. Transcriptions will be stripped of any personally-identifying information and/or any information which identifies a subject's employer.

What Are The Costs Of Taking Part In This Study?

There are no costs to you for taking part in this study.

Will You Be Paid For Participating?

You will receive no payment or other compensation for taking part in this study.

What Are Your Rights As A Research Study Participant?

Taking part in this study is voluntary. You may choose not to take part or you may leave the study at any time. Refusing to participate or leaving the study will not result in any penalty or loss of benefits to which you are entitled. If you decide to stop participating in the study we encourage you to talk to the investigator first.

Whom Do You Call If You Have Questions Or Problems?

For questions about the study or in the event of a research-related injury, contact the main researcher, Adam Stephenson at (304) 563-2472 during normal business hours. You may also contact the primary study advisor, Dr. Donna Sullivan at (304) 696-6394. You should also call the investigator if you have a concern or complaint about the research.

For questions about your rights as a research participant, contact the Marshall University IRB#2 Chairman Dr. Christopher LeGrow or ORI at (304) 696-4303. You may also call this number if:

- o You have concerns or complaints about the research.
- o The research staff cannot be reached.
- o You want to talk to someone other than the research staff.

You will be given a signed and dated copy of this consent form.

SIGNATURES

You agree to take part in this study and confirm that you are 18 years of age or older. You have had a chance to ask questions about being in this study and have had those questions answered. By signing this consent form you are not giving up any legal rights to which you are entitled.

Subject Name (Printed)

Subject Signature

Date

Person Obtaining Consent (Printed)

Person Obtaining Consent Signature

Date