A study of line staff's participation in the planning and implementation of educational programs for mentally retarded people in an institution.

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A STUDY OF LINE STAFF'S PARTICIPATION IN THE
PLANNING AND IMPLEMENTATION OF EDUCATIONAL PROGRAMS
FOR MENTALLY RETARDED PEOPLE IN AN INSTITUTION

A Dissertation Presented

By

John Frederick Houchin, Sr.

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirement for the degree of

DOCTOR OF EDUCATION

September 1987

Education
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ABSTRACT

A STUDY OF LINE STAFF'S PARTICIPATION IN THE
PLANNING AND IMPLEMENTATION OF EDUCATIONAL
PROGRAMS FOR MENTALLY RETARDED PEOPLE
IN AN INSTITUTION

(September 1987)

John Frederick Houchin, Sr., B.S., The Ohio State University
Ed. D., University of Massachusetts
Directed by: Professor Atron A. Gentry

This dissertation focuses on the job role of the direct care staff and its effect on their job satisfaction. The concept of providing the direct care staff with a job description and a role that directly involves them in the development, design, implementation, and follow up modification of individual educational/training programs for the mentally retarded will improve the direct care staff's satisfaction with the job.

Data was collected over an eighteen month period regarding the effect on the direct care staff of a Day Services Department of an institution for people with mental retardation. Job descriptions and functions of the direct care staff in the Department were modified to give them direct input in the decision making process for development, design and modification of programs provided by that service.
This study examined the attitudinal and behavioral responses of the direct care staff to their new role. The attitudinal aspect was evaluated through responses from direct care staff to a post change questionnaire regarding their feelings to the change and its effect on their satisfaction in the job. The behavioral aspect was assessed through evaluation of the withdrawal data from pre-post reorganization and seven months after the change.

The findings would seem to suggest important implications and ramifications for organizational developers for program systems serving people with mental retardation. The study indicates that the direct care staff, although willing to participate in the processes that allow them to have some control over their work environment, have doubts about their ability to participate in the new role. This situation is sometimes compounded by the reaction they receive from their supervisors and professional staff at the institution.
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The opportunities for treatment and education available to people with mental retardation have undergone tremendous change during this century in both ethical and educational realms. During the first decade of this century, the major tendency was toward the institutionalization of people with mental retardation as an attempt to isolate them from society. Educational programs and opportunities were minimal while the most that could be desired was that the custodial care being provided would at least be humane. The efforts today are oriented toward deinstitutionalization, with various options and alternatives such as the group homes, natural homes, and foster home care. Current educational opportunities are diverse, with input from various disciplines such as speech pathology, medicine, special education, psychology, recreation and so forth. With the passage of Public law 94-142, the social movement towards better care and services is now encouraged.

Educators who work with people who have varying degrees of mental retardation often find themselves faced with myriad problems. People with limited intellectual development present a broad range of challenges to an educational staff. The teaching
strategies and curricula for working arrangements to deal with people who have mental retardation include more than the primary academic pursuits. People with mental retardation frequently need training in the most basic human skills such as toileting and personal hygiene, eating, dressing, as well as academic and vocational skills. For educational direct care staff (i.e., attendant staff hired to work directly with the person) the role of observable progress, frequent disillusionment and inconsistencies within the environment make continual support and knowledge of teaching most important.

While information is available for teaching people with mild levels of mental retardation, people with severe and profound mental retardation have too frequently been ignored by all except those responsible for their direct care and treatment.

Educational facilities for people with mental retardation, particularly for those people who are severely handicapped, have had onerously slow development. It is noted that from the beginning (i.e., the establishment of the first residential schools in Massachusetts) in 1884 until around 1900, almost all of the American schools gave priority to children with mild mental retardation, those who were most capable of improvement. Later those with the more severe/ profound levels of mental retardation received attention. Adults were also included in the custodial programs. Residents with Down's syndrome came to form a major component of the institutional population, since their prognosis and treatment was regarded as inconceivable.
In 1866, Langdown Down raised the issue of a particular syndrome known as Down's syndrome. He offered four classifications of idiocy which were Caucasian, Ethiopian, Negroid, and Mongolian. Later he modified his tone and provided a new label which was more attractive to his colleagues. He described idiocy in three distinct forms: 1- Congenital idiocy, which included microcephaly and hydrocephaly; 2- Developmental idiocy, which was a function of one's tendency to experience mental breakdown and anxiety associated with such phenomena as cutting teeth and puberty; and 3- Accidental idiocy, which is the result of circumstances such as physical injuries and illnesses. Down's doctrine was based on etiology (i.e., review of the causes of idiocy meant to categorize them); therefore, he encouraged the use of the medical model of treatment.

In America public classes for children with mental retardation were opened and were based on the European models of the last decade of the nineteenth century. This addressed several problems, three of which were (1), the disruption of the family unit caused by institutionalization; (2), the lack of education of children with mental retardation caused by the change from educational to custodial treatment; and (3), the rising costs of institutions that were rapidly growing, rapidly both in size and numbers.(1)

The works of Maria Montessori (1876-1952) opened a new vista in the education of mentally handicapped individuals. She served in the asylums for the mentally retarded in Rome. She
studied the methods of such people as Itard and Seguin and established the Orthophrenic School for the Care of the Feeble-Minded in Rome. Two of her perennial services to the field were her attention to well educated, qualified teachers and her continued emphasis that mental retardation was an educational rather than a medical issue. Her emphasis on training is still the fundamental concern for Universities.

She emphasized that mental retardation is fundamentally a cultural issue. Therefore education can serve as a key to resolve and rectify it. She held that, education could provide solid answers to the problem of mental retardation. Thus, any group of people labeled as retarded do not necessarily have medically based disabilities. There are often insufficient programs for their vocational, educational, social, and psychological demands. Therefore, the time honored motto, "Once Retarded-Always-Retarded" received an irrecoverable blow. Eugenics and bio-medical interpretations of mental retardation were seriously challenged.

For historical purposes it may be said that the year 1956 is a convenient demarcation line between the premodern and modern history of programs and institutions for people with mental retardation. Before this time institutions were exclusively custodial and administrators of public schools refused to admit children with mental retardation. In 1956 Congressman Fogerty, a powerful political figure, recruited a large number of allies. He succeeded in procuring $250,000 for the National Institute of Mental Health and
$500,000 for the National Institute of Neurological Disease and Blindness for mental retardation research.

With the election of John F. Kennedy in 1960, the volume of legislation and the extent of the public support for training, services and research relating to handicapped children increased dramatically. In 1966, the Bureau of Education for the Handicapped was established in the Office of Education and thereby attracted large sums of money for purposes of training, research, teaching, and demonstrating problems. During the period of 1963 and 1975 we saw ratification of landmark legislation setting forth support for early screening, assessment, and treatment programs for younger children. In 1972, a federal court ruled that Public Schools are required to provide education for all children, regardless of how severely retarded they are, and in 1975 Congress passed the Education for All Handicapped Children Act (P.L. 19-142), which made education for all handicapped as a national policy.

Numerous studies concerning many dimensions of mental disabilities were conducted in the 1960s and early 1970s. Several anthologies and research articles appeared during this period (e.g., Clark and Clark, 1965; Ellis, 1963; Sterens and Heber, 1964). A summary of the characteristics of mental handicaps can be consulted in Hurt (1969). In the late 1960s and early 1970s advocacy for the mentally handicapped became the watch-word. Revelations reflecting the squalid conditions that prevailed in many state institutions for people with mental retardation (e.g., Blatt and Kaplin,
1966) drew public attention. Sympathizers became more politically active in raising human rights issue in favor of people with mental retardation. Thus, the right of people with mental retardation to be educated became a significant issue.

The notion of "normalization" as an educational process came into vogue. Normalization was predicated on the Montessori and Dewey premises that mentally retarded people had educational and cultural deficiencies and could be improved through properly educated direct care staff. Thus, section 504 of the Rehabilitation Act of 1973 (Public Law 93-112) legislated equal rights of all including children with mental retardation. Public law 94-142 (1975) guaranteed without discrimination, free and appropriate education for people with mental retardation.

Special institutions and classes had long been under serious assault for maintaining a practice that "labeled people", for not being productive classes enhancing student's general development, and for including excessive numbers of minority clients. The decline of special classes for children with mental retardation was correlated with the expansion of resource services.

It was recognized that mental retardation was a concept that tended to separate a group of people, and to justify social action in regard to those who are different from normal constituencies.

The roles of direct care staff (i.e., the line staff person who provides the direct and continuous, eight-hour service) have
historically reflected the medical or educational methodologies of mental health services.

From the inception of the institution and asylum, these individuals, as a group, were perceived as the necessary, uneducated entities of the system. They were regarded as no more than custodians of the retarded. With the advent of the reform movements, a demand for increased integration of people with mental retardation was accompanied by a thrust to initiate a shift in the role and responsibilities of the direct care staff. An instance of this was reflected in the redefinition of the role described by the community based "house parent". Since then, these personnel have assumed more pedagogical function with their residents.

Prior to this shift the house parents' clinical work with the residents was the responsibility of the Clinical Social Worker. It was believed that the Social Worker had appropriate educational training credentials to be able to work with the clients (i.e., the residents of a facility). Therefore, these social workers were considered to be "qualified" to act as service provider. (4)

In conjunction with the increase in the high esteem for Social Workers there appeared a denigration of those people who were committed to work most directly with people with those who exhibited mental retardation. (5) Thus, if it is maintained that there exists between care takers and people with mental retardation a reciprocal relationship. The denigration of one party (i.e., the direct care staff) will be directly correlated with the other party (i.e., the
people with whom the direct care work). There is a transactional process operating between direct care staff and participants.

In this study, the investigator attempts to show how such an international trend influences the system and how negative or positive evaluation of direct care staff leaves an undeniable impact on their performance. One can philosophically state that if one's job and status are judged as valuable, then the clients with whom one is working are valued by her/him accordingly. If the job that one is doing is stigmatized then the clients with whom one is working will be denigrated.

Dignifying the role and status of direct care staff will directly influence their performance in a constructive way. If staff implement a pedagogical role rather than a custodial role, then they act in accordance with what is expected of them and thereby their satisfaction with their job is enhanced. If staff are trained and assigned to valuable educational functions; they will act accordingly. Axiomatically, direct care staff are the ones most directly concerned with the care and education of people with mental retardation and their effectiveness depends upon the extent to which administrators and society accept their roles and responsibilities. The environment which administrators and society help create can encourage or discourage the development of ideas, the adoption of innovations, and the promotion of cooperative working arrangement. Administrators and society can facilitate or hamper the degree of success of direct care staff in meeting the needs of people with
mental retardation. Administrators therefore have a direct responsibility for providing the conditions and resources that will contribute to effective functioning on the part of direct care staff.

**Background**

This study will examine the Direct Care provider staff as they function in a State-operated residential facilities for developmentally disabled persons. When these facilities were created, the role of the direct care staff person was typically to maintain order, enforce rules and provide custodial care for these people. Today the role of the direct care provider staff is to maintain a positive approach and to provide education for the mentally retarded persons in his/her charge. It is essential, therefore, to probe into techniques and methods that can be used to secure full involvement of the direct care staff, and thereby appreciate the effects of the techniques used in relation to this process.

Through the ages people who were mentally disabled have been viewed with a combination of dread and loathing. Their fate has been one of neglect, exclusion, and bad treatment. History has recorded instances of socially sanctioned brutality based on an assumption that mental disorders have supernatural causes such as demoniac possession.
The history of care for people with mental disorders reflects humanity's cultural roots and diversities. The earliest known mental institutions were established in Baghdad (A.D. 918) and in Cairo. In Europe in the Middle Ages, mental disorders were closely associated with demoniac possessions. Thus, belief in demoniac reasons for mental disorders attained its apex during a period of preoccupation with sorcery and witchcraft starting from the 15th century through the 18th century in Europe and Colonial North America. (6)

During the Middle Ages, individuals exhibiting mental retardation were not differentiated from those who had mental illness. Both groups were treated in the proverbial mad house. It was reported during that time that these places treated people worse than criminals serving time in the Jail. Treatment included beatings by the staff usually occurring when the conduct of the patient annoyed them. (7) This form of treatment eventually led to the forced submission and silence of the patient.

These mad houses routinely shackled the patients. Inmates were often believed to be destitute of human characteristics and their staff were indifferent if not atrocious.

In 1547, the British established the first public asylum for the insane and mentally retarded. This facility was based on the Arabian approach utilizing the concept of a tranquil environment to help cure the maladies of the insane and mentally retarded. The asylum was named "St. Mary of Bethlehem," often mispronounced as "Bedlam". Because of this facility's reputation for inhumane
treatment, the mispronounced name (Bedlam) came to mean a place where the treatment included cruel and brutal acts toward the patients. (8) The staff in many cases were criminals who were offered the opportunity to complete their sentences as staff of Bedlam. Reports also indicated that other individuals hired to staff the facility had "undesirable qualities". (9)

In 1606, The King of France ordered all persons who were mentally ill or mentally retarded to be placed in the Hôtel Dieu Hospital in Paris. It was hoped that this facility would provide the necessary treatment to help these people. This did not occur, however, and the patients were provided with limited medical attention and limited personal attention by the staff. (10)

These accounts are representative of the early history of institutions and asylums. In general the staff provided minimal treatment; and brutal or neglectful acts were prevalent. This may have been because staff received minimal guidance and the adverse methods used were acceptable at that time. The defined purpose of the staff seemed to be that of a disciplinarian (i.e., maintaining peace and order) with a free reign.

During the Nineteenth Century the development of institutions for the mentally retarded took a different path. In 1837 Edward Seguin initiated a new concept in relation to the education of people with mental retardation. Seguin brought his skills and knowledge from Europe to the United States in 1848. Upon his arrival in this
country, Seguin became involved in the establishment of the first U. S. institution in Barre, Massachusetts. (11)

Seguin maintained that an institution should be a place where mentally retarded persons are provided with an education that would enable them to grow to be productive members of the society. As a part of this process, he felt that the attendant staff (direct care providers) should constitute a vital part of the system. It was the attendant who was cognizant of the circumstances and could assist the administration in making decisions. (12)

Subsequently, major issues regarding effective use of the attendant (direct care provider) staff were of great concern. Tuke reported in 1882 that the maltreatment of the patients in many mental retardation institutions was the result of inferior, uneducated, and uncaring staff. Tuke maintained that because of this the treatment provided for the patients in the institutions was inadequate and included brutal acts towards the patients. (13)

Although people like Seguin and Tuke were advocating the education of mentally retarded persons, at the turn of the twentieth century, the prevailing attitude toward mentally retarded persons was one of isolation. It was commonly heard that society must be protected from these individuals. The shift in attitude and approach toward the treatment of the mentally retarded influenced the type of direct care personnel that were employed within the institutions.

At a meeting in 1906, of the American Association on Mental Deficiency (AAMD), the president of the organization gave a speech
suggesting that the direct care staff should not be trained. The reason given was that young enthusiastic people should be hired and when that enthusiasm was depleted they should move on to other jobs. (14) This encouraged constant staff turnover.

In the 1920s, it was recognized that the staffing problems were due to inadequate compensation, lack of benefits, long working hours, and few days off. These conditions became indicators of direct care staff's incapacity to effectively do their job. The rate of turnover for direct care staff was reported as high as 200 percent in the institutions. (15)

During this time administrators of the institutions were concerned about the caliber of the staff in the facilities. One Superintendent described the direct care staff as "people whose only concern was to go to work on pay day to get their check". (16)

With a society being protected from mentally retarded persons, and high staff turnover, the emphasis in these facilities was confined to custodial aspects. As the the size of the facilities expanded, the staff became more detached from the residents. The ability to train and educate staff dwindled even more than before. (17)

In the 1960s another shift in the approach and attitude toward treatment of mentally retarded persons in institutions took place. The emphasis was now more educational. This led to the class action lawsuits of the early 1970s. In most cases the plaintiffs pleaded for more appropriate treatment.
The staff of the institutions would be changing their interactions from those of custodial overseers to the more positive interactions of an educator. This was a drastic change compared to the previous way the residents were treated. Therefore, the managers of the institutions had to assume the role of change agents to insure that the edicts of the litigation were implemented.

Regulations and standards were eventually established. Two of the well known examples are those established by the Joint Commission on the Accreditation of Hospitals (JCAH), and those concerning Intermediate Care Facilities for the Mentally Retarded (ICF/MR). The latter were standards established by the Federal Government under Title XIX to guide funding for those institutions that provided health and training services. (18)

The Joint Commission on Accreditation of Hospitals is an organization which has as its main function the evaluation of hospitals throughout the country vis-à-vis the developed accreditation standards. In the late 1960s this group obtained a federal grant to establish standards for institutions that provided services to the mentally retarded. (19)

These new standards included newly prescribed roles for the direct care staff which were defined in the Title XIX Federal Medicaid regulations as follows.

§ 442.433 Responsibilities of living unit staff.
(a) The living unit staff must make the care and development of the resident their primary
responsibility. This includes training each resident in activities of daily living and in the development of self-help and social skills.

(b) The ICF/MR must insure that the staff are not diverted from their primary responsibilities by excessive house keeping or clerical duties or other activities not related to residents.

(c) Members of the living unit staff from all three shifts must participate in appropriate activities related to the care and development of the resident, including, at least referral, planning, initiation, coordination, monitoring, and evaluation. (20)

The roles are defined in the JCAH standards as follows:

2.1.1 The primary responsibility of the living unit staff shall be to devote their attention to the care and development of the resident.

2.1.1.3 Living unit personnel staff shall train the residents in activities of daily living and in the development of self-help and social skills.

2.1.2 Members of the living unit staff from all shifts shall participate with an interdisciplinary team in appropriate referral, planning, initiation, coordination, implementation, follow through, monitoring, and evaluation activities relating to care and development of residents. (21)

As a result of implementing the new roles of living unit staff a new vista of expectation was opened. The role of the attendant/ direct care staff was now defined in terms of the resident's educational needs.
Problem Statement

Although the importance of direct care staff in providing training and educational services to the mentally retarded in institutions has been shown to be significant, the research and literature in relation to the changing needs of this level of staff has remained negligible. In a review of literature in the American Association of Mental Deficiency journals from 1970 to 1982, it was found that less than 6 percent of the articles dealt with relevant research and study on administration.(22) The major portion of these articles involve research about staff attendance as an evaluation tool for job satisfaction.(23) What is lacking in the literature is discussion and research on what will lead to job satisfaction of staff in developmental disabilities programs.

This study will look at a change made in the direct care staff's role, taking into consideration the information available in the literature and research on how direct care staff react to having a well defined role and proper staff development with an education underpinning.

The problem is one of determining the effects of full participation versus non-participation by direct care staff in the process of developing, designing, implementing and modifying
individual treatment plans of mentally retarded people who display varying degrees of retardation.

With the emphasis which Mental Retardation Institutions place on the effective services (treatment/education/healthcare), the administrators need feedback on what are the reactions to the concepts set forth in the literature. Administrators need more knowledge about the effects of involving the direct care staff in the education process—what is needed to bring about change and how that involvement influences job satisfaction.

Baumeister and Zaharia, Bailey, Jr., Helsel-DeWert, Thiele and Ware have done research on the direct care staff’s involvement in the institutional program process. All have indicated that there is a need to study the processes of effectively integrating the direct care staff. This study will address the problems relating to the integration of the direct care staff into the educational process and the ways and methods of achieving such an integration.

**Purpose of the Study**

The purpose of this study is to understand the effects of establishing specific job responsibilities for direct care staff in a residential institution for developmentally disabled adults. These job specifications provide the staff with a role that involves direct responsibility for residents and participation as team members in
the process of educating and training those persons assigned to their care.

Over the last two decades there has been an emphasis on the direct care level of staff involved in decision making for residents. This study is concerned with the issues and implications of staff involvement and will investigate the actions of the direct care staff. This will involve interpreting the following areas:

1. Type of staff development needed to implement change;
2. Effective ways of presenting this new process to the direct care staff;
3. Effects of this process on job satisfaction;
4. Types of support needed in the implementation of such a process;
5. Staff readiness for such a change;
6. Staff’s reaction to the process; and
7. Effect of this process on self esteem.

The above research on these seven statements constitutes the essence of this study and may pave the way for a better understanding of the dynamics of the direct care staff's transformation from a passive (directed to do) recipient in program development, to that of active (some directing and decision making) participant.
This study will especially attempt to establish a tentative connection with the educational needs of direct care staff leading to the enhancement of their self consciousness and appreciation.

Through an historical study, the researcher will interpret the events that occurred in a program system that attempted to include the direct care staff in the entire program. The purpose of the Day Services Department program's design was to improve the self-esteem and consciousness of the direct care staff so their attitude towards work would be one of participation and interaction.

The author wishes that the study provide a constructive perspective regarding the application of appropriate mechanisms to integrate the direct care staff into the decision making process of their agency. As a consequence it is hoped, that the implementation of this process paves the way for an understanding of how to enhance self consciousness and esteem in the direct care staff.

Definition of Terms

A number of terms appearing in this paper require some clarification. Therefore, an attempt will be made to provide a list of definitions to some of the terms used in this paper as follows.

1. Absenteeism: The term "Absenteeism " represents the time that an employee has not reported for work. Such time off from work is categorized to include sick time, leave of absence, approved
leave (due to the vacation policies of the Institution staff could use vacation time to cover absences), absent without leave, and tardiness.

2. **Custodial care:** The term "Custodial care" is defined as services that foster dependency on staff for daily life activities, e.g., staff feeding, bathing, and dressing the person.

3. **Developmental Disabilities/Mental Retardation:** The terms "developmental disabilities" and "mental retardation" will be used synonymously. In the review of the literature the classic definition for mental retardation is, "... significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior, manifested during the developmental period." (24)

For the purpose of this study "Developmental disabilities/Mentally Retarded" is defined by the Commonwealth of Massachusetts as, "... a person with inadequate development or impaired intelligence which subsequently limits ability to learn and/or to adapt as judged by established standards available for the evaluation of a person's ability to function in the community." (25)

4. **Developmental Services:** This term is the title of the centralized services that provide daily programming (education, employment, and retirement) for those who live in the facility in question.

5. **Direct Care Staff:** The term "direct care staff" represents those staff in the institution who provide direct "hands on" service to
the residents of the facility. To list a few, there are many variations of this title, i.e., aide staff, attendant, primary care staff, and para-professional. It is the responsibility of this staff to attend directly to the specific needs of the residents.

In this study, the term "direct care staff" represents those individuals, assigned to the day program, who are responsible for providing the hands-on training and education of the resident in the day program system.

6. **Habilitation:** The definition for "habilitation" is one established by the Joint Commission on Accreditation of Hospitals/ Mental Retardation Council which is as follows. Habilitation is "the process by which the staff of an agency assists an individual to acquire and maintain those life skills that enable the individual to cope more effectively with the demands of his or her own person and environment and to raise the level of his or her physical, mental, and social functioning. Habilitation includes, but is not limited to, programs of formal, structured education and treatment." (26)

7. **Institution:** The term "Institution" denotes a residential facility for people who exhibit developmental disabilities (e.g., mental retardation). These facilities are responsible for providing services in accordance with Federal and State regulations. They are also subject to mandates prescribed by the judicial system.

8. **Interdisciplinary Team:** The definition for "Interdisciplinary Team" established by the Joint Commission of Accreditation of Hospitals' Accreditation Council for Mental
Retardation and Developmental Disabilities in 1978 will be used. The term "Interdisciplinary Team" means: a group of individuals who are drawn from those professions, disciplines, or service areas that are relevant to the identification of an individual's needs. This Team designs programs to meet the individual needs, does periodic reviews of the individual's response to the programs, and revises program plans accordingly. A complete team must include direct-care staff. (27)

9. Job Role: The term "job role" is the specific job responsibilities of an employee as established by the individual job description.

10. Professional Staff: The term "professional staff" represents the employee groups (Psychologist, Speech and hearing Therapist, Occupational Therapist, Physical Therapist, Nurses, and Doctors) who required licenses or certifications to practice a profession. In this study these employees were assigned to the Clinical Resource Department.

11. Resident: The term "resident" is a descriptive name for individuals who are residing in an institution.

12. Resident's Needs: Historically "resident's needs" were defined as bathing, changing, feeding, dressing and caring (custodial, residential care) for the developmentally disabled individual. At the present time "resident's needs" are defined as training and educating the developmentally disabled individuals in day and residential
programs with support to become independent in their personal and self care skills.

13. **Satisfaction:** The term "satisfaction" in this study represents the direct care staff's comfort in their participation in their job.

14. **Services:** The term "services" is defined as the network of both the specialized and the routine interventions that are provided for those individuals in the institution. Some instances of these services are psychological, educational, habilitative, residential living, and health care services.

15. **Supervisor:** The term "supervisor" in this study represents the Teachers and Vocational Instructors in the Day Services Department at Belchertown State School. Their job was to provide supervision to direct care staff, organizing and implementing educational/vocational training programs in their assigned classroom/training areas, as well as administering (i.e., ordering supplies, maintenance request, etc.) those areas.

16. **Training/Staff Development:** These terms represent services provided for the direct care staff to aid with the improvement of their skills, knowledge, and abilities to competently do their job.

17. **Turnover:** The term "turnover" is defined as a rate established by dividing the number of staff leaving (e.g., resigning, transferring, dismissal, etc.) in a job category, during a specific time, by the average number of staff in that category.
18. **Withdrawal Behavior**: This term represents staff's varying degree of retreat from one's participation in their job.
CHAPTER II

REVIEW OF LITERATURE

Direct Care Staff's Role

Since the inception of institutions for people with mental retardation, direct care staff working at these facilities have been categorized as less than desirable employees. With the opening of the first residential institution in the United States during the 1840s, questions were raised about the caliber of the attendant (direct care) staff. In early European facilities, especially those in England, it was often asserted that there existed inadequate facilities and the direct care staff acted brutally to the residents. It was also reported that direct care staff were poorly trained. They were mostly undirected and often lacked interest. (28)

At the 1906 convention of the American Association of Mental Deficiency, Mogridge, the president of the organization, in his presentation, as reported in the book A Century of Concern, suggested that direct care staff should not be trained for long term employment. According to Dr. Mogridge young people should be hired with the hope that they would show enthusiasm for a few years. They would then move on to other careers. (29)
The idea that Mogridge presented in the early 1900s was a major problem by the 1920s. Because of inadequate compensation, insufficient benefits, long hours, and few days off, the institutions had turnover rates as high as 200 percent. Some Superintendents advocated reform to change the quality of the staff at that time. One Superintendent described the direct care staff as people whose only interest was to go to work on pay day: otherwise they had no interest in their jobs.

One may construe from these findings that persons in the job category of direct care attendant were often unintelligent, lazy, and uncaring. It was not until the 1960s that the importance and potential of the direct care staff were recognized.

In 1967 Earl C. Butterfield, in his famous article entitled "The Characteristics, Selection, and Training of Institutional Personnel," published the first comprehensive study of direct care staff in terms of characteristics and possibilities for professional development. The article was a study of literature and research that had already been published on the subject of direct care involvement in public institutions. In his research, Butterfield discussed the factors that have direct impact on the quality of direct care staff, including training.

According to Butterfield, some of the circumstances that influence direct care staff are the economic situation surrounding the institution, and the pool of available applicants for the positions.
Butterfield also maintained that inadequate and irresponsible staff would contribute to a high rate of staff turnover as well as to a low level of direct care staff functioning. (34)

In his study, Butterfield suggested that there exists no adequate study and research to clearly appreciate the effects of the demands placed on the direct care staff. He felt that the functions of direct care staff required detailed analysis in order to promote an understanding of what are the appropriate characteristics of an excellent staff. (35)

In addition, he believed that the adequate educational support for direct care staff was one of the major factors that contributed to the quality of staff, and to their turnover. Another factor that might affect the direct care staff's attitude toward their job was the degree of involvement in program planning (i.e., education and vocational planning). He maintained that this was an area that needed to be explored. (36)

In 1967, Lawrance Goodman and Irene Arnold published an article entitled "Training and Utilization of Non-Professional Personnel in Services for the Mentally Retarded". In this article they expounded on the theme that direct care staff could be effective in implementing resident education and training. According to Goodman and Arnold, "it is our contention that nonprofessional workers can serve a potentially important function in a broad span of programs in the following ways: (1) assisting the professional directly, (2) providing service apart from the professional
relationship but enhancing treatment goals, (3) carrying out important forms of help that the professional cannot offer." (37)

Examples of the above three categories are: (1) to have the direct care staff working directly with the Occupational therapist in implementing a specialized program; (2) to implement signing programs to establish continuity in language programs; and (3) to provide the bridge between the brief sessions with a specialist and implementing the knowledge in the general environment.

Alfred A. Baumeister (1971), following Butterfield, in his review of American Institutions, "Residential Facilities for The Mentally Retarded", pointed out that direct care staff constituted the most vital non-trained personnel in the institution . (38)

In 1968, F. Hertzberg in his article "One More Time: How Do You Motivate Employees" for the Harvard Business Review, defined factors that enhanced a person's involvement in his/her job. Some of these were:

"1. How to remove some controls while retaining accountability (i.e. how to encourage independence while maintaining accountability);

2. How to increase accountability of individuals for their own word (i.e., how to develop a trust factor among employees);

3. How to grant additional authority to an employee in his activity (i.e., how to provide increased authority via increased opportunities in decision making);
4. How to introduce new and more difficult tasks not previously handled (i.e., how to broaden the employees' scope of job responsibility);

5. How to assign individuals specific of specialized tasks, enabling them to become experts (i.e., how to capitalize on individual skills and talents to ensure success)." (39)

R. C. Scheerenberger (1975), in his book, Managing Residential Facilities for the Developmentally Disabled, interprets Herzberg's principles for institutional work. Scheerenberger states that "each of the job enrichment programs represent variations of a common theme; increase employee participation, autonomy, responsibility, and ultimately recognition for tasks successfully completed. Further, these projects implicitly acknowledge the intelligence, sense of responsibility, and integrity of employees". (40)

During the past two decades, concepts and approaches to delivering services to the developmentally disabled in public residential facilities have been subjected to re-examination. The beginning of this process was in the early 1960s when President Kennedy established a special panel on Mental Retardation. In 1962 the panel presented a report which included institutions and services. The Committee deemed it important to define the purpose of residential facilities for mentally retarded people as follows:

The prime purpose of residential services for the mentally retarded is to protect and nurture the mental, physical, emotional, and social development
of each individual requiring full-time residential services. Inherent in this is the responsibility to provide those experiences which will enable the individual (1) to develop his physical, intellectual and social capabilities to the fullest extent; (2) to develop emotional maturity commensurate with social and intellectual growth; (3) where ever possible, to develop skills, habits, and attitudes essential for return to contemporary society; and (4) to live a personally satisfying life in the residential environment. (41)

With this declaration and the subsequent recognition of a need to improve the standards and conditions of the public institutions, we saw that in the 1970s several class action lawsuits were instituted. These lawsuits demanded that mentally retarded people in institutions receive appropriate treatment and training.

One of the mechanisms utilized to accomplish this task was the establishment of the interdisciplinary team approach to programming. The focus of this approach was principally on identifying the needs of the developmentally disabled individual by recourse to information sharing, not necessarily specific to each one's profession, an exchange of knowledge and experience leading to the development of an integrated and unified treatment (e.g., educational plan). (42)

This approach recognized the equal responsibility of all persons, both professional and para-professional (for this study the para-professional is the direct care staff), to work with a resident in
developing the program and implementing it. James Gardner, in *Program Issues In Developmental Disabilities* asserted that direct care staff must be active members of the team in order for it to be effective. (43) He stated, "...direct care staff would be more motivated to implement programs if they have contributed to program planning." (44)

This approach requires the direct care staff to be knowledgeable of the basic concepts and techniques of training and of educating mentally retarded people. Most direct care staff need training in the skills (e.g., observation techniques, teaching strategies, evaluation process and basic understanding of special educational and vocational techniques) that will enable them to be effective participants in the team. This parallels Herzberg's principles of staff involvement which were discussed earlier.

The transdisciplinary approach to program implementation, an extension of the interdisciplinary team, serves as the next step in the process of providing residents with effective educational programs. Although this approach was primarily developed by Dorothy Hutchison for use in the medical field, it has been recognized by educators as being effective in non-medical areas. Hutchison defines the transdisciplinary approach as the combination of "trans" and "disciplinary" forming an adjective, "relating to a transfer of information, knowledge and skill across disciplinary boundaries."(45)

Sirvis (1978), in his famous research entitled "Developing ISP's for Physically Handicapped Students: A Transdisciplinary View
Point," discusses the use of the transdisciplinary approach in education. "The transdisciplinary approach attempts to break the traditional rigidity of discipline boundaries and encourages a teaching/learning process between team members. It supports the development of staff that functions with greater unity... further, the transdisciplinary approach advocates that team members share information, and when appropriate to insure consistency in the child's program." (46) This sharing is referred to as "Collegial Instruction" and "Role Release" within the Transdisciplinary Model.

**Job Satisfaction**

The theoretical approaches described previously provide the administrators with viable mechanisms to support direct care staff with an environment that is conducive to job satisfaction.

In studies of job satisfaction, Zaharia and Baumeister (1978 and 1979); Porter (1973); and others have supported the assumption that job satisfaction is evidenced by the turnover rate and absenteeism that occurs within public institutions for the developmentally disabled.

In the study of "Organization, Work, and Personal Factors in Employee Turnover and Absenteeism," Porter and Steers (1973) focused on reviewing the studies of absenteeism and turnover. From this they concluded that there were distinguishing differences between absenteeism and turnover characteristics as they related to
job satisfaction. (47) Porter and Steers suggested that short term withdrawal from a job is evidenced by absenteeism. General dissatisfaction with the job is evidenced by the staff person leaving the job. (48)

In his article "Absenteeism and Turnover" appearing in Personnel Journal, Donald Hawk (1976) defines the instances of absenteeism and turnover as indicators of employee dissatisfaction with the job. (49) He states that absenteeism is a form of behavior that represents "an alternative to termination" (50) and is part of the continuum of withdrawal that ultimately leads to resignation or termination.

Hawk's typology of this subject points to the following three areas of absenteeism/turnover:

1. absenteeism variables;
2. absenteeism leading to staff turnover;
3. staff turnover variables.

Sub categories of the three areas are:

1. Supervisor style;
2. Interpersonal relationships;
3. Work conditions;
4. Salary;
5. Job expectations;
6. Man/job fit (i.e. appropriateness of individual for specific job);
7. Job design. (51)
The categories of job expectation, person/job fit, and job design involve having a well defined job description with a well developed staff education program. This would then promote job satisfaction.

Zaharia and Baumeister (1979) (utilizing the idea that staff turnover and absenteeism are indicators of withdrawal in staff) studied institutions to help describe the factors that cause direct care staff turnover and absenteeism. They pointed to three areas which were possible causes of turnover and absenteeism: extra-institutional factors, inter-institutional management, and personal characteristics of the technician staff. (52)

Zaharia and Baumeister further suggested that low status of the direct care staff (53) and an unclear role and responsibility had significant influence on job satisfaction. (54)

They indicated that withdrawal behavior might be controlled by recourse to a strong inservice training program that would raise the status of direct care staff to a professional level (55), and would provide a positive and rewarding environment. (56)

Charles Lakin, et al., in "Turnover of Direct Care Staff in a National Sample of Residential Facilities for Mentally Retarded People", (1982) studied the turnover rate of the direct care staff in institutions. The authors found that the turnover rate of staff in mental retardation institutions as compared to industry was high. They indicated that their study of data from 71 out of 75 public institutions suggested that employees should be oriented to their job and be trained in their role. (57) If direct care staff do not have an
understanding of their job functions and responsibilities, they will encounter problems in adjustment, and remaining in the job will become difficult for them.

The same conclusions were reached by Minge and Bowman (1969) in their study, "Attendant's View point of Causes for Short-Term Employment at an Institution." They reported that 52 percent of the respondents to their survey felt that the newly hired direct care staff were misled as to what their job functions and requirements were. Fifty-seven percent (57%) felt that a proper inservice training program would have addressed this issue if provided by the institution. (58) Minge and Bowman also found from their study that 69 percent of the respondents "... felt there was little opportunity for individual creativity and initiative." (59)

In 1979, Zaharia and Baumeister did a follow up to their original study of direct care staff turnover and absenteeism. In this study they looked at 12 public institutions and their rates of absenteeism and turnover. They examined at varying factors to determine what might have caused the high rate of these indicators of employee withdrawal. They found that urban facilities had a higher rate of turnover as compared to rural facilities. They also found that there was a greater turnover rate when there was a low staff to resident ratio (e.g., few direct care staff to many residents). (60)

Zaharia and Baumeister concluded that:
The negative correlation reported here between staff turnover and staff ratios suggests that a point of diminishing returns may exist; more specifically, the indiscriminate allocation of additional personnel into living units could be counter productive, by having a detrimental effect on staff motivation and participation in the job. (61)

In 1979 Zaharia and Baumeister in a subsequent study entitled "Technician Losses in Public Residential Facilities" completed a survey of the direct care staff to identify elements of direct care of staff satisfaction. They sent questionnaires to 500 direct care staff of three state facilities in Tennessee. One of the results indicated that there is a need to identify job roles so that staff can feel that they are contributing and valued employees. (62) Zaharia and Baumeister concluded that there was a serious need to design direct care staff jobs as a motivational tool. They suggested that there is an acute need for further research to be conducted regarding the ramifications of the increased emphasis on direct care staff, their job design and their potential. (63)

In 1983, Donald Bailey et al. in an interesting research called "Measuring Participation on the Interdisciplinary Team," appreciated the potential for staff interaction and its effect on the interdisciplinary team, and on that basis they developed a survey tool to assess the participation of staff members on the team. The observation tool consisted of seventeen items that were rated from 1 (inadequate) to 7 (outstanding). The items rated were:
1. Preparing reports
2. Submitting reports
3. Reviewing reports
4. Providing information
5. Delivering of information
6. Using technical terms
7. Seeking information
8. Suggesting goals and strategies
9. Providing feedback
10. Discussing within groups
11. Being flexible
12. Accepting responsibility
13. Suggesting interdisciplinary goals
14. Arrival and departure for meetings
15. Distracting behavior
16. Group position
17. Body language (64)

Bailey et al. realized that there was limited quantity of research on the interdisciplinary team and its effect on the members. It was hoped that by developing this evaluation process there would be better understanding of the team process and how the members interact. (65)

As part of an ongoing study, Bailey et al. studied 23 teams consisting of 154 participants in order to evaluate the individual team member's level of participation. The study focused on three
levels of staff as defined by Bailey et al. Professional (e.g., Psychologists, Vocational Specialists); Para-professional (those they classified as Educational Developmental Specialists); and Direct care (those classified as Health Care Technicians). (66)

Bailey et al. thus utilized a modified version of the assessment and evaluated the participation level of these three groups. The results indicated that the direct care staff, even though they were part of the team process, did not perceive themselves as active participants in the process. They felt that they were not free to actively share their views or to disagree with the group. This attitude was also felt by the para-professional staff.

In 1987, Browner et al. in a study "Stress, Social Support, and Health of Psychiatric Technicians in a State Facility" interviewed direct cares staff in a residential facility for the mentally retarded to determine their sources of stress. It was determined that the respondent's lack of control and influence over their environment was a major factor in job stress.(67) This information supported the conclusions of Sarata (1974) that staff are the most dissatisfied when their role does not allow them to be a part of the development of programs and procedure.(68)

It is Bailey's et al. concluding that there is a need to develop strategies to increase the quality of para-professional and direct care staff so that they might be viable and effective participants in the team process. (69)
To sum up, the literature has three main focuses: one, the discussion of the factors (i.e., degree of involvement in the planning, amount of training received, increased accountability, and enhancement of a sense of self-esteem) that influence the involvement of institutional direct care staff in their job; two, exemplary methods (i.e., Interdisciplinary and transdisciplinary models) of addressing these factors; and three, the review of the symptoms of job withdrawal (i.e., absenteeism and turnover) as they relate to direct care staff in institutions.

The notions that have been researched in this portion of the study will be used as base line data on what is needed for direct care staff to serve as an integral part of the program and management team. The results obtained in these studies will then be compared to the results obtained in this case study.

The emphasis of this study, to be conducted by this research worker, is to examine the effect of the participatory involvement of direct care staff (evaluating, planning, discussing, developing, implementing, and following up) in the programming of developmentally disabled person. This research will focus on the job satisfaction of the direct care staff as a result of their participatory involvement in the process of discussing, planning and evaluating the programs to be used for mentally disabled individuals. This research will examine the above process on the basis of field work and participatory observations to be documented.
CHAPTER III

METHODOLOGY

Introduction

The purpose of this study is to assess the impact on the direct care staff of a state institution, when they have their job role changed from one of custodial involvement (doing for the resident) to that of educational training (providing services that promote independence for residents).

Hypothesis

It is this study's hypothesis that the direct care staff in an institution will have better job satisfaction and attitude toward their job if they have a well-defined job role that directly involves them in the program decision-making process regarding the residents assigned to them. A well defined job role involving direct participation by the direct care staff constitutes the independent variable and job satisfaction and positive attitudes towards their career represents dependent variables of this study.
The impact of the job satisfaction will be revealed through the direct care staff's decrease in absenteeism and through their response to a questionnaire regarding their role and attitude about the change from mere subservient follower to that of an educator.

**Design of Study**

Because of the nature of this study, the Descriptive Model, as defined by John Best in *Research in Education*, (1981) will be used. Dr. Best describes the Descriptive Model as one that is nonexperimental because one is dealing with relationships that occur naturally and are not manipulated in an artificial environment. "The parameters as defined by Best are:

1. The events have already occurred and the researcher will define the variables to analyze;
2. There will be a hypothesis formulated and tested according to the data and information available;
3. The inductive method of reasoning to arrive at a generalization will be utilized;
4. Careful design will allow others who wish to replicate the study to do so." (71)

This model will be implemented throughout this study. The dynamics of a group (i.e., direct care staff in the Day Services
Department of Belchertown State School) will be examined. This study will specifically focus on job role and its relationship to job satisfaction. The study will probe and analyze the impact of varying factors (i.e., staff attitude toward their job) influencing the staff's roles and responsibilities. It will examine these factors over a period of eighteen months.

The method of gathering the data will include:

1. Questionnaires for direct care staff regarding their opinion of the change and its effect on their attitude about the job;
2. Review of data regarding the events that occurred before, during and after the change;
3. Content analysis of the absenteeism and staff turnover for direct care staff and notable trends of job satisfaction.

The initial phase of the study will describe the role of direct care staff in the system prior to its reorganization. This will provide an historical perspective as to the responsibilities and expectations of the direct care staff. The conditions, expectations, and situation under which the direct care staff worked will be carefully examined.

The second phase of the study will describe the changes that ensued through a redemption of the role of the direct care staff. The methods reflected in the aforementioned literature will be employed to describe this process. For example, the study details the methods described in the literature including specifically defined jobs, training on these jobs, support and feedback, and direct involvement
of the direct care staff leading to their sense of responsibility and self respect.

The third phase of the study will review a questionnaire (appendix A) which was designed and conducted by the Day Services Department management team nine months after the change. This questionnaire intended to elicit responses from the direct care staff of their feelings regarding the change. It also enabled the direct care staff to provide feedback regarding their view in relation to the new requirements of the job and their implications on the staff's feelings about their worth.

The questionnaire consisted of 21 questions. The questions were developed to elicit information from the direct care staff about their perceptions of the job role, their response to that role, and their feelings about the change and how it affected them. The management team reviewed the questionnaire with a consultant to ensure that the information would be what was sought by the Department.

Because the basic reason for developing the questionnaire was to obtaining direct care staff's feelings about reorganization, the questionnaire followed an open ended format. The questionnaire was not developed as an experimental tool but one that would give the management team of the Day Services Department the needed feedback to evaluate the effect of the change on the direct care staff so that they would be able to make necessary adjustments to the system and recognize the errors made in the change.
The researcher, due to the historical nature of the study, took the responses obtained from this questionnaire and then evaluated each response for positive, neutral, or negatives feedback. This was accomplished by reviewing the written responses of the direct care staff, then evaluating the comments, in relation to their context.

The negative category represented responses that indicated the direct care staff's negative feelings regarding the question asked (e.g., "Treated as stupid", "no" - as answer, "lack of communication", "less effective" or "had time in the past").

The neutral category represented responses that were ambiguous not leaning toward the negative of positive (e.g., no change or unsure). It should be noted, that because of the polarized feelings of the respondents, this category was limited in its use. The new circumstances aroused them to express their negative or positive reactions (feelings).

The positive category represented responses that were of such a nature that the respondents information indicated the direct care staff's positive feelings regarding the question asked (e.g., "...able to deal with...", "seeing good changes", sharing techniques", or "doing a more effective job")

The fourth phase will constitute the statistical analysis of the staff absenteeism and turnover rate before and after the change and how this relates to their job satisfaction.

A comparison will be made of absenteeism before and after the role change. This information will reflect whether or not the direct
care staff’s participation in certain components of the residents’ program, will be related to their job satisfaction.

To establish the information and data on absenteeism the methodology, utilized by Zaharia and Baumeister (1978), in Table 1, will be applied.

**TABLE 1**

**ABSENTEEISM FORMULAS**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Formula</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lost Time Rate</td>
<td>( \frac{\text{Number of personnel lost}}{\text{Number of personnel hours}} \times 100 )</td>
</tr>
<tr>
<td>Frequency Rate</td>
<td>( \frac{\text{Number of instances of absenteeism}}{\text{Number of workers}} \times 100 )</td>
</tr>
<tr>
<td>Proportion of Absentee Group</td>
<td>( \frac{\text{Number of absent at least once}}{\text{Number of staff}} \times 100 )</td>
</tr>
<tr>
<td>Average Length of Absences</td>
<td>( \frac{\text{Number of personnel hours lost}}{\text{Total number of instances}} \times 72 )</td>
</tr>
</tbody>
</table>

An analysis of turnover rate of direct care staff before and after the change will provide insight regarding job satisfaction of the direct care staff. If as indicated in the literature, there is job satisfaction, then the rate of turnover will decrease with the change. The formulae utilized by Zaharia and Baumeister in their 1978 research of direct care staff withdrawal (i.e., job dissatisfaction) will be utilized. These formulae are presented in Table 2.
TABLE 2

TURNOVER FORMULAS

<table>
<thead>
<tr>
<th>Measure</th>
<th>Formula</th>
</tr>
</thead>
</table>
| Turnover rate            | \[
|                          | \text{Number of separations} \times \frac{100}{\text{Average of the number of workers at the beginning and end of the period}} \]
|                          |                                                                         |
| Resignation rate         | \[
|                          | \text{Number of resignations} \times \frac{100}{\text{Number of controlled separations}} \]
|                          |                                                                         |
| Transfer rate            | \[
|                          | \text{Number of transfers out of program} \times \frac{100}{\text{Number of controlled separations}} \]
|                          |                                                                         |
| Other types              | \[
|                          | \text{Number of dismissals/deaths/leaves/etc.} \times \frac{100}{\text{Number of controlled separations}} \]
|                          |                                                                         |
| Median length of         | \[
|                          | \text{The length of service above and below which service of leavers half the separated workers fall} (73) \]

The above data will provide the researcher with the insights necessary for the examination and establishment of appropriate strategies for addressing the issue of job satisfaction of the direct care staff of an institution. This analysis particularly relates to the specific job description which encompasses decision making about educational programs for developmentally disabled persons.
**Setting.**

**Location.** Belchertown state School is an institution for the mentally retarded located in Belchertown Massachusetts, a rural town in the western part of Massachusetts with a population of 7,500 people. Besides agriculture, the Institution is the primary industry in town. Because of the town's close proximity, within 20 miles of five college (Amherst, Hampshire, Mount Holyoke, Smith, and University of Massachusetts), those people who are not farmers or working at the State School work as staff in those colleges.

**Introduction.** Belchertown is a large institution that provides residential and day services to individuals with mental retardation who reside in the western part of Massachusetts. It was originally established in the 1920s to be a farm colony for Wrentham State School, situated in the Eastern section of Massachusetts. As a farm colony its focus was to train the residents to do farm labor (with no pay), to raise the crops and livestock for Wrentham.

During the 1930s it was determined that the western part of the state needed an institution to handle the mentally retarded residing in the cities of that area (Springfield, Pittsfield, and Northampton). At this time, Belchertown was converted from a farm
colony to being its own self sufficient institution for people with mental retardation, with appropriate administrative (medical) staff.

In the early 1970s the conditions prevailing in the institution (i.e., including inadequate educational and training services and the existence of grossly overcrowded dorm) led to a Class Action Lawsuit on behalf of the residents of Belchertown. Eventually a Consent Decree was executed in 1976 mandating the State of Massachusetts to provide adequate treatment and training for the people with mental retardation compelled to reside at the Belchertown.

**Resident Census Information.** The residents population of the institution at the time of this study was 432 persons. The youngest resident was 15 years old and the oldest was 73 years of age. The average age range of the population at that time was approximately 29 years. The resident population consisted of approximately 40 percent profoundly retarded, 52 percent severely retarded, and 8 percent moderately/mildly retarded individuals.

Over the past ten years the population of the institution had decreased from 1200 to 432. This was partly due to the Court Ordered Conceit Decree and partly due to the efforts of the administration of the institution to place residents into the community. The Population that remained at the facility were those individuals who were hard to place, i.e., those residents with severe disabilities or behavior disorders, those residents who's parents
refused to allow their son or daughter to leave, and those residents who refused themselves to leave.

**Organization System.** Belchertown's Administration consisted of three major divisions; Program, Administration, and Human Resources. Each Division was administered by an Assistant Superintendent.

The Administrative Division was responsible for providing the fiscal and maintenance support to the institution. While the Human Resources Division was responsible for dealing with the staff related issues (e.g., personnel, affirmative action, and staff development).

The Programming Division, which was responsible to provide direct services to the residents, was subdivided into six Departments; four Residential Units, the Day Services Department, and the Professional Resources Department. Each Department was headed by a Director. The Residential Unit were responsible for providing residential services (e.g., home based skill training—eating, bathing, leisure, or personal hygiene) to the residents. The Day Services Department was responsible for providing the educational/training services to the residents. And the Clinical Resources Department was responsible to provide clinical/professional services to the residents.

**Program System.** The institution's program design purported to be a Unit system. This meant that the professional staff were to be
assigned to the four Residential Units and were to work under the direction of the Unit Director. However, what was functionally in place was a Professional Department model; that is, the professional staff only responded to their individual department heads for direction.

The same was true for the program development system. Belchertown's policy stated that they were to use the Interdisciplinary/Transdisciplinary approach to services. However, because of a strong feeling for professional autonomy, the programing system actually embraced a multidisciplinary approach (i.e., each discipline developed their own program goals and objective for the residents without any coordination).

**Staffing.** In conformity with the Federal Court Consent Decree, the number of staff at Belchertown State School was increased drastically over a seven year period. In the early 1970s, the total number of staff approximately amounted to 580 covering 1200 residents. At the time of the study there were 1498 staff members at the institution. Table 1 indicates the number of employees by category. The overall ratio of staff (this ratio includes; maintenance, support, professional, direct care, administrative, and supervisory staff) to residents was 2.9 staff for each resident. The total number of programmatical staff (direct care, teachers, program supervisors, professionals) was 950, with a ratio of 2.2 staff for every one residents.
<table>
<thead>
<tr>
<th>Category of staff</th>
<th>Number of staff</th>
<th>Staff to Client Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>Direct Care</td>
<td>622</td>
<td>1 to .7</td>
</tr>
<tr>
<td>Direct care Supervisors</td>
<td>62.5</td>
<td>1 to 9</td>
</tr>
<tr>
<td>Teachers/Trainers</td>
<td>29.5</td>
<td>1 to 9.2</td>
</tr>
<tr>
<td>(Day Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Care Supervisors</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nursing staff</td>
<td>162</td>
<td>1 to 2.7</td>
</tr>
<tr>
<td>Professional staff</td>
<td>155</td>
<td>1 to 2.8</td>
</tr>
<tr>
<td>Para-Professional</td>
<td>46</td>
<td>1 to 9.4</td>
</tr>
<tr>
<td>Recreation therapists</td>
<td>35</td>
<td>1 to 6.2</td>
</tr>
<tr>
<td>Maintenance/Support</td>
<td>85</td>
<td>1 to 5</td>
</tr>
<tr>
<td>Clerical</td>
<td>86</td>
<td>1 to 5</td>
</tr>
<tr>
<td>House Keeping Staff</td>
<td>175</td>
<td>1 to 2.4</td>
</tr>
<tr>
<td>Administrative Staff</td>
<td>40</td>
<td>1 to 10.8</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>1,498</strong></td>
<td><strong>1 to .3</strong></td>
</tr>
</tbody>
</table>

The direct care staff represented 41.2 percent of the personnel at Belchertown. While the professional/supervisors consisted of 16.5 percent of the staffing.

The direct care staff represented 41.2 percent of the personnel, while the professional/supervisory staff represented
16.5 percent of the personnel at Belchertown State School. The remaining 42.3% were support and administrative personnel.

**Day Services Department.** The Day Services Department at Belchertown State School was established in 1982. Prior to that time, each Residential Unit was responsible for developing and implementing day services for their residents. The services provided by the Residential Units were selective (i.e., only certain residents were allowed to go to programs, the rest of them stayed in their living area) and some residents were not served due to lack of programs in their Unit, while the services required for them were available in the next Unit.

In 1982, the Superintendent centralized the day services into one department (Day Services Department). The services of the department incorporated the existing Unit programs under the centralized administration. This study, however covers the period of eighteen months after a management change in the department a year after the consolidation.

The Day Services Departments provided educational and vocational training services to 334 residents (98 additional residents received services from community based sheltered workshops or Bureau of Institutional Schools services). Table 2 indicates the type of staff assigned to the department and the number of full time equivalents (FTE's) assigned.
### TABLE 4
DAY SERVICES DEPARTMENT STAFFING

<table>
<thead>
<tr>
<th>Category FTE's</th>
<th>Number of FTE's</th>
<th>Number of FTE's</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Pre-Change</td>
<td>Post-Change</td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>76.5</td>
<td>88.5</td>
</tr>
<tr>
<td>Teacher/Trainers</td>
<td>29.5</td>
<td>29.5</td>
</tr>
<tr>
<td>(Direct Care Staff's Supervisor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clerical Staff</td>
<td>4</td>
<td>4.5</td>
</tr>
<tr>
<td>Housekeeping</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Management</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td><strong>TOTAL:</strong></td>
<td><strong>125</strong></td>
<td><strong>134.5</strong></td>
</tr>
</tbody>
</table>

The ratio of staff to residents in the Day Services Department varied based on the program to which the resident was assigned. The ratios ranged from one direct care staff to three residents in the basic skills program (i.e., a program addressing the needs of the most profoundly involved residents) to one direct care staff person to eight residents in the vocational services (this consisted of residents working in a small workshop environment). The teacher/trainer ratios was one to 16 for all program/classroom areas.
Limitations and Delimitations of the Study

1. This historical case study has certain limitations regarding objectivity of the data to be obtained. The process of using questionnaires for interpreting the attitude change of direct care staff necessitates subjective feedback from the staff.

2. This study may be generalized within certain frameworks. Some unique situations may influence interpretations when they are being applied to other residential facilities.

3. There exist some similarities and differences between most state institutions for mentally retarded people (i.e., locations and economic environment of each).

4. The scope of this study is limited to the functions and interpretations of those direct care staff who work in the course of the most intensive programming time. Direct care staff are on duty during various shifts that cover a twenty-four hour period and it may not be appropriate to generalize their interpretations of a certain group of subjects to those who work on other shifts.

5. In this study the staff's level of academic experience might be impacted by the proximity of the facility to the five (5) colleges in the Amherst area. This is evidenced by the number of staff who are working at the institution and simultaneously attending college. Those staff who are already college graduates working on advanced degrees also attest to this fact.
6. There are many factors that influence job satisfaction. In this study, factors such as economy, family problems, and salary will not be addressed. The study will focus only on the staff's attitude about the job and training.

7. The respondents in this study, in fact, do not represent the majority of the direct care staff of the Day Services Department. Therefore, my analysis only generalizes in case of the respondents. In other words, my study does not embrace all of the direct care staff's attitude and perceptions.
CHAPTER IV

FINDINGS

Introduction

Job satisfaction has conventionally been used to refer to affective attitudes or orientations of individuals toward their jobs. In studying job satisfaction researchers usually emphasize the importance of studying attitudes, feelings and perceptions of individuals toward their job. These studies suggest that affective reactions cause certain kinds of behavior, such as absenteeism and turnover. Though most of these studies fail to demonstrate a clear-cut relationship between satisfaction and job performance they have succeeded in stimulating an enormous amount of research on job satisfaction. Studies about job satisfaction have generally been practice oriented. Most researchers have studied the relationship between job satisfaction and variables such as age, education, job level, absenteeism rate, and productivity.

This study purports to deal with job satisfaction in a causal fashion. Moreover, its fundamental premise is the emphasis on a human affective experience.

The researcher also intends to suggest that job satisfaction ties directly with the concern about the quality of work life. Recognition
is given to the importance of the types of affective reactions that employee experience and to the fact that these affective dimensions are not always related to economic or material achievements.

The main purpose of reorganization in the Day Service Department of the Institution (Belchertown State School) was to improve the affective quality of work life for the direct care staff. The researcher maintains that job satisfaction is one measure of the quality of work life and is worth appreciating and increasing even if it does not directly influence outcome. Moreover, it is suggested that whatever experiences direct care staff have in the course of working have consequential effects on their life and, therefore, the effect of these experiences can not be overlooked if the quality of life is to be high in a society.

In this study, satisfaction is directly associated with absenteeism and turnover, both of which appear to be very costly to the institutions concerned. Since job satisfaction can directly and indirectly influence an organizations productivity and efficiency, there is an economic incentive for organizations to take job satisfaction very seriously. We must, therefore, discover the factors influencing job satisfaction. It can only be addressed if factors causing it can be pinpointed. This study is concerned both to establish a causal relationship between work life quality enhancement and job satisfaction. The factors related to job satisfaction of the direct care staff at Belchertown State School were explored through responses to a questionnaire.
The researcher suggests that when a direct care staff's perception of what his/her outcome level is and his/her perception of what his/her outcome level should be are compatible, the staff will be satisfied. When a staff feels his outcome level is falling below or above what he perceives it should be, then he will be dissatisfied.

The study indicates that the staff's perception of what his/her reward level should be is determined by a number of factors. The most important of which is perceived job input. These inputs consist of efficiency, competency, skills and experience that a direct care staff person brings to bear on his performance.

It is recognized that most people work at jobs they often find dissatisfying and that many look to their jobs for greater personal satisfaction that they find elsewhere. To ignore the satisfaction of people's needs in the work place is inevitably to bring about two undesirable results: staff will in one way or another increasingly remove themselves from serious work, and they will drag through each additional unrewarding day with increasing disenchantment.

Direct care staff generally display willingness to act to enhance their opportunities to take initiative, and of making creative impact (achievement motive), to appreciate the ties of affiliations, and to make decisions about their own destiny (which represents power motive). They decide between behavior bringing about achievement and that which is less productive; between behavior that is collaborative and that which is obstructive and expressive of animosity; and between behavior that introduces creativity and
mastery of the environment, and that which necessitates surrender to the wishes and directives of others.

It is held that the direct care staff are more likely to remain motivated, to keep more paths open to further satisfaction, and to become more productive if their motivation/or achievement, affiliation and power motives can be displayed and gratified in their work.

In summary, job satisfaction embraces job enrichment in the sense that it leads to the enhancement of task efficiency, greater scope for personal achievement and its recognition, more challenging and responsible work and more chances for individual growth and personal development. It is incidentally associated with issues such as pay, working conditions, and training.

Scope

One of the primary purposes of reorganization of the Day Services Department of Belchertown State School was to bring about a creative reform in order to improve the quality of work life, and thereby raise direct care staff's satisfaction and motivation. Before introducing such a reform, the mechanisms which would ensure full participation of the staff in the work process were examined. In fact, the reform aimed at staff participatory commitment as its essence.
Changes in the organization required modification and alteration of job descriptions.

In conceptualizing the modification in job descriptions consideration was given to staff motivation, job enrichment and satisfaction. It was assumed that the success or failure of any program depends on the abilities and enthusiasm of the direct care staff. An enthusiastic, motivated direct care staff could be educated rather easily in order to overcome any skill differences. Moreover, it was recognized that any and every philosophy addressing human behavior represents a conception of human nature at least as it pertains to the given situation. How direct care staff are viewed by their supervisors, professionals and peers was the key to appreciating the entire approach.

The fundamental assumption upon which the modifications of the direct care staff's job description in the Day Services Department were predicated, was that people are not basically indolent, egocentric, resistant to change, and dumb. Rather it was assumed that they are responsible, ambitious, and adequate. Given the opportunity, the direct care staff person will contribute to the department in terms of productivity, motivation, adaptability, and loyalty. In this model, McGregor's theory (1966) was applied. McGregor maintains that people are not by nature passive or resistant to organizational requirements and exigencies. The motivation, capability and potential for growth, the ability to assume responsibility and to contribute to the organization goals are intrinsic
in people. Supervisors, professional staff and peers should make it possible for direct care staff to appreciate and develop these professional assets for them selves.

Pre-reorganization Phase - Job Description and Role Standards

Before conceptualizing and formulating organization change, the Department's apparent assumption was that direct care staff were basically indolent, passive and lacked ambition. They were presumed to dislike responsibility, and preferred to be led; they were held to be fundamentally egocentric and indifferent to organizational change. Moreover, they were regarded as inherently opposed to full commitment. This attitude was evidenced by the supervisory and professional staff's almost never asking for input from the direct care staff on relevant program or system issues. From the supervisors perspective they worked as little as possible and would take a coffee/cigarette break at every opportunity.

The pre-reorganizational structure was based on the premise that the supervisor and professional staff can provide minutely detailed instructions and guidance to direct care staff, and needed to be closely supervise their activities, and by creating barriers between direct care staff exploit the discrepancies existing in the work force (see Appendix B- Pre Change Job Description). In most instances low regard was displayed for the direct care staff and their
position was considered as custodial rather than that of an educator/trainer.

The administration in the pre-reorganization changes phase was fundamentally "technocratic". It was aimed at establishing supervisory professional control and served the goal of enhancing the supervisors' and professional staff's power and status. Thus, the decision making power did not remain with the direct care staff but a group of individuals who had common professional backgrounds.

In the questionnaire, some respondents suggested that the system prior to reorganizational change promoted mediocrity, stifled initiative, and reduced the possibility of introducing change. The supervisors and professional staff became so entrenched in power/control, and used their positions in such a way that inhibited more qualified direct care staff in their fulfillment of their responsibilities.

The decision making role was vested in a small number of individuals who acted independently, with minimal input from the direct care staff. In fact, administration and management of the department was understood to reinforce the hierarchy of certain decision making functions.

Almost all respondents suggested that due to the professional and management climate of the department, full participation and commitment on the part of direct care staff was highly constricted. In other words, although the formal job descriptions for the direct care staff provided opportunities for limited input and assistance, in
reality this situation was not actualized. Some direct care staff's contributions were permitted. However, this was usually at the discretion of a few supervisors and with limited impact. Several responses to the questionnaire indicate that "Supervisors suppress creativity.", "Supervisors tell me what to do, they just run the whole show.", "Supervisors refuse to listen to my suggestions", "Professional staff walk in and tell us what to do and not listen to my suggestions." and "Supervisors twist situations to betterment for themselves."

With decision making and direction exclusively remaining with supervisors and professional staff, there was a moderate attempt to appreciate the motivational needs of the direct care staff in the pre-reorganization phase.

Half of the responses to the questionnaire however, suggests that the pre organizational phase represented a more positive job climate. It contained less job responsibility. They also suggested that the job roles were compatible with the level of their education and experiences. They had more direct interaction with the residents.

Post-Reorganization Phase - Job description and Role Standard

The reorganizational concept in the above mentioned Department was based on the concept of motivation and satisfaction. This next phase addresses such issues as productivity per man per
day, turnover, absenteeism, costs, and quality service delivery. The reorganization's objective was predicated on the belief that productivity was staff centered rather than job oriented and was encouraged by a system that was supportive and promoted more freedom among direct care staff. From this perspective direct care staff became viewed by supervisors as indispensable components of the department. Decision making regarding educational/training programs of individual residents and classroom services were to be conceived as a collective responsibility rather than the direct prerogative of the supervisor or professional staff (see Appendix C - Post change Job Description).

To fulfill this objective, a horizontal and lateral line of communications was established, considerable emphasis was placed on self-actualization of the direct care staff. However, this led to disenchantment of the professional staff as they came to perceive themselves as being degraded by being considered a peer with the direct care staff. While at the same time, it was also perceived by the professional staff that the direct care staff's supervisors now were elevated in status above the professional staff. (This was evidenced by many meetings between the Director of the day services department and the professional staff department Directors to discuss the issue of "loss of the status of professional staff").

Leadership processes were designed to insure interaction between individuals and to build up a sense of personal worth and importance. This approach was based on the conviction that leaders
are expected to encourage innovation and creativity by their staff, participation in program planning and in a more flexible pattern of interpersonal communications. It was presumed that communications flow not only up and down the hierarchy but across work groups among peers. Staff were believed to be motivated by participation and involvement in developing methods and evaluating process toward goals.

The objective of restructuring job descriptions was to define general role activities. However, job descriptions provided a general guideline for performances and suggested an activity approach to direct care staff role. Moreover, goal displacement ensued from the modification in the job description that was geared to performance and activity.

The analysis of the responses revealed more subtle shortcomings of a job description orientation to performance. They pointed that the professional staff, supervisory staff, and direct care staff were caught in the activity trap and thereby failed to agree on the output. Because of this problem, in most instances discrepancies resulted between direct care staff, professional staff and supervisory staff in major operational activities, and, further, they failed to agree on what would be the programs design. Due to an intimidation factor on the part of the professional staff and supervisory staff, in some instances, the direct care staff became passive in their attempt to fully participate in the program development. Although, the results of the questionnaire indicated that the respondents felt, on the
average, that they were "sometimes" able to participate. 50 percent indicated in their individual responses that their involvement with the professional staff was one of intimidation and degradation.

It should be pointed out, that a job analysis revealed certain areas necessary for effective performance of the role. In fact, standards emerged from a job analysis identifying areas in which effectiveness was required. The challenge in designing standards was to determine categories for effective performance (e.g., curriculum development, team process, teaching techniques, effective evaluation techniques, and preparation of documentation). Every effort was made to define areas in terms of effectiveness. In order to remedy the failures resulting from job description traps, attention was given to purpose so that conflict and ambiguity would decrease as objectives became clear (see Appendix D- Program Guidelines for Direct Care Staff). Consequently, individual performance should improve organizational productivity and at the same time ensure direct care staff's participation in the growth of the department. Objectives that were agreed upon prior to actual performance tended to facilitate congruence between actual performance and department improvement (see Appendix E- Direct Care Staff Job Competences).

Staff Development

Once a shift in role standards was initiated, urgent need arose to develop a cluster of staff learning experiences that were designed
to raise selective norms of direct care staff skills. The staff development that was proposed was ecological in nature and situation oriented. From this perspective it was presumed that everything is dialectically connected to everything else. A department, for example, is viewed as having many separate and independent functions; however, these functions do not operate in isolation, but rather they work interdependently. The core concept here is collective interaction. In other words, the department's new philosophy was based upon the belief that collaboration, cooperation, and concern for mastery of knowledge and competence within a friendly and nurturing atmosphere would maximize productivity and self-actualization.

The staff development concept was designed to ensure direct staff's involvement in goal setting, work process refinement, and evaluation. It was presumed that co-involvement was vital to organizational development. Internal organizational responsiveness was maintained through collaboration rather than imposition by authority, with a work focus on goal setting, planning, and acting. It was understood that creativity, responsibility and growth of the direct care staff and other staff are necessary consequences of staff responsiveness to changing conditions. More specifically, co-involvement places particular emphasis on developing staff potential.

Direct staff resocialization to a "shift" in the role standards was conceived to bear upon group development and willingness to engage constantly in open communication, to face problems, to become
involved in solutions, and to engage in constructive dialogue about resolution of such problems. It was maintained that such a dialogue permits direct care staff to perceive new possibilities as they entertain movements beyond the present notion of care. As a consequence of dialogue, disagreements between convictions about treatments, education and services gave rise to a more compatible relationship between new attitudes and real actions.

The transition in role required a reorientation to work patterns that would bring the staff together. One goal of such a reorientation was to enhance the appreciation for role coaching as a normal and necessary activity. It was assumed that whenever the supervisors, professionals and direct care staff became interconnected and were enabled to exchange views and thoughts with one another, it would be inevitable that criticisms would pass back and forth. It was supposed that the exchange of views and criticisms was viewed as a natural and constructive process. However, the senior staff and professional staff tended to be fearful of criticism and resisted the idea of being exposed to supervision and critical feedback. They purported to control the environment. Therefore, the response suggests that most of them (73 percent approximately) made every endeavor to block the progress of a healthy exchange of views and ideas.

The goal of the staff development program was determined by priorities generated within the goals of the reorganization of the department. Therefore, role transition concept, job description, and
role standards were subjected to critical reorientation. It was felt that a major overhaul in the above areas must be provided for the entire staff. Staff development activities were determined in part by an action plan developed by supervisory and direct care staff. For example, the primary classroom team (miniteam) perceived a need for an evaluation of the classroom climate and teaching effectiveness, and for the introduction of constructive approaches to resident education/training. Additionally the Interdisciplinary team (consisting of the direct care staff and professional staff) was perceived as the vehicle to develop specific approaches to the individual resident's education/training needs. The miniteam designed a plan to deal with teaching and learning activities, curriculum selection, diagnosis and evaluation, progress planning, and classroom management. Whereas, the Interdisciplinary Team (I.S.P. Team) designed individual education/training plans and individual teaching strategies.

Paradigm shift from custodial to that of educational was a developmental process. Hence, the staff development program was designed to facilitate the transition on a meaningful and collaborative basis. It was presumed that strong commitment to the goals of reorganization on the part of the staff and to the ways in which they needed to be organized to achieve those goals was axiomatic. Therefore, an orientation to the concept of reorganizational ecology was indispensable and the staff development program was
considered as an effective vehicle through which this goal could be achieved.

The responses provided to the questions indicate that the majority of the direct care staff were quite willing to participate in the process of collaboration, instructional skill development, communications, diagnosis based instructional programs, and personalized learning programs. Some of them explicitly displayed their enthusiasm for an instructional program that would respond to their educational and professional needs. In order to address the other needs of the direct care staff, the department developed a remedial writing skills program, and redesigned and simplified the documentation process. This simplification took into account the educational level of the individuals. The department also coordinated outside educational opportunities so that they could develop their academic and professional potentials and skills.

The new orientation encouraged the direct care staff to share their educational and professional needs with the department so that it could address them. This was done as a part of a needs analysis which utilized several methodological instruments including interviews and questionnaires. Thus, these interviews and questionnaires provided additional insight into growth needs. These interviews were also useful in uncovering group problems.

The method of dialogue was useful in enabling the direct care staff to prioritize development needs. This process embraced a combination of personal reflection, small group dialogue, and whole
group dialogue. Thus, it paved the way for prioritizing staff instructional and learning needs.

In short, the staff developmental program took into account several dimensions of staff growth and improvement including training (input), supervision (teaching), and organization and productivity (output).

Principles of Productive Work Teams

One of the major goals of the reorganization was to build a capacity for working productively with department mini-teams. It was anticipated that patterns of collaboration would permeate the life of the day services department through a common goal focus, continuous dialogue, shared decision making, mutually planned action, and periodic reflection and feedback. Four strategies were developed to enhance mini-team growth: (1) helping the teams to plan, (2) helping the teams to conduct productive meetings, (3) assisting them to develop communication skills, and (4) assisting them to solve problems and resolve issues creatively.

Although the department focused on the team process, the direct care staff participation in the ISP (Individual Service Plan- the interdisciplinary team process) was not under the control of the day services department. Therefore training direct care staff how to be team members (i.e., the interactions, observations, and responses) was limited to the day services department. However, the actual
Integration and participation and team education for the ISP team fell under the scope of the professional services department.

The function of the teams was to facilitate the change described in the reorganizational goals and objectives. It relied on the participation of team members; trust in the proponents and leaders; and clarity about the change to the mini-teams. The teams functioning were viewed in terms of introducing change for the department relating to individual classroom goal structure.

Therefore, participation of all team members was viewed as critical to its healthy functioning. In order to facilitate this team process, consultants were retained to provide their expertise in the areas of team development, team participation and implementation of team process and the development of strategies to solve problems. The following elements were taken into account in building this system.

**Team size.** It was well understood that as team size increased beyond seven, there were positive and negative influences on individual and group performance. As the size of ISP increased, it was perceived that more demands were made of the leaders. Active members were more dominant in interaction. Ordinary or new members and the direct care staff tended to reduce their participation and, therefore, there was less exploration and adventure in the dialogues. The group atmosphere was less friendly.
It took longer to make decisions. Rules and practices, as a result, became more formalized.

**Group Roles.** Group productivity, in principle, hinges on the ability of the group to work through individual differences toward the achievement of the group's objectives and goals. In the ISP situation, it was the responsibility of the team to develop individualized goals/objectives and teaching strategies for individual residents. Program plans, and monitoring and modifying those plans were to ensure that individual residents received appropriate training and education aimed at enhancing their independent, cognitive and effective capacity.

**Development Phases.** It was hoped that most of the groups would pass through four interconnected phases:

1. (Conflict regarding process) conflict among the ISP team participants reduces effectiveness;
2. (Awareness) the group defined directions to respond to resident's needs and problems;
3. (Planning and implementation) they concentrated on the task of developing program services for the resident;
4. (Group productivity) finally, in some cases, direct care staff's cohesiveness and productivity emerge.
The primary challenge for the direct care staff was to channel their energies toward completing their responsibilities successfully. Collective activity often stopped when conflict appeared. By facing conflict and relating to the task, they had to engage in a constructive exploration of ways to resolve the conflict. Thus, greater cohesiveness and appreciation grew among some of the members of the direct care staff which led to productivity. Other staff avoided the team resolution of problems and conflicts, because they had failed to share their views, due to the fact that they were intimidated by the professional staff. Moreover, some of them indicated in their response to the questionnaire that they did not have sufficient training and education to effectively participate in such issues and problems independently. These feelings were exemplified by the following responses on the questionnaire regarding what the respondents felt deterred them from participating in the ISP team; "A put down feeling given by professionals on the team who think if you don't have a degree you don't know anything and the message is very effectively conveyed." and "Lack of experience at meetings and lack of educational skills."

The factors that decreased productivity and cohesiveness were disagreement over the ways to solve group dilemmas and problems, self-oriented and dominant behavior displayed by certain members of the direct care and unhealthy intra-group competition. Moreover, the undue interventions of the professional staff over management
in the process led to a sense of subjugation and subservience on the part of a majority of the respondents.

The undue influence exercised by the professional staff on the performance of the direct care, vitiated the latter’s morale and enthusiasm, thereby diminishing their sense of gratification. These circumstances reduced direct care staff’s productivity and their feeling of competence. It was obvious that when some direct care felt their own goals were in opposition to those of the professional staff and the management and that they had no significant control over their jobs or environment, a crisis of self confidence emerged.

**Absenteeism And Turnover**

**Turnover.** In the study turnover and absenteeism are regarded on the most drastic forms of direct care staff withdrawal behavior. Withdrawal, a failure to participate in the job implies a continuum of behavior ranging from tardiness, poor job performance, absenteeism and eventual termination. The net result of such behavior is a decision by the staff person not to participate fully in the job, producing a chronic series of personnel problems for the managers.

This study has focused on the relationship between turnover and job satisfaction. In other words, job satisfaction may serve as a tentative criterion for predicting drastic withdrawal behavior of direct care staff in the day services department. The researcher suggests that there exists a probable correlation between job
enrichment, satisfaction, and staff participation. Based on the findings of this study it may be argued that expresses intention to withdraw from the job may indicate the next stage after dissatisfaction has been experienced.

In short, on the basis of the findings of this study concerning the effect of job satisfaction on turnover, it appears that there are several factors contributing to job satisfaction, the most important of which may be said to be job content factor and personal factors.

Job content factors can represent a vehicle for the individual direct care staff to feel personal fulfillment and satisfaction on the one hand, and a continued source of frustration, failure, internal conflict, and therefore dissatisfaction on the other. Thus, job related factors such as overall reaction to job content, task repetitiveness, job autonomy and responsibility and role clarity may serve as causes for withdrawal behavior.

Absenteism is a less drastic withdrawal behavior. There are certain criteria used to distinguish absenteeism from turnover. The negative consequences for the direct care staff that are associated with absenteeism are usually much less than those associated with turnover. Absenteism appears more likely to be spontaneous, while the act of termination withdrawal can be more carefully calculated over time. Absenteism may from time to time indicate a substitute type of behavior for turnover. It may provide a limited chance of avoiding undesirable situation without the loss of job benefits.
The researcher statistically reviewed the rate of turnover during an eight month period prior to the change. During that period of time there was a 20 percent rate of turnover of the direct care staff in the day services department which could be broken down in table 5. Table 6, represents a statistical characteristics of the direct care staff who left during the pre change period.

**TABLE 5**

PRE CHANGE TURNOVER DATA

<table>
<thead>
<tr>
<th>Reasons</th>
<th>No. Staff</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resignations</td>
<td>8</td>
<td>53%</td>
</tr>
<tr>
<td>Transferred</td>
<td>6</td>
<td>40%</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

On the basis of the data in Table 6 it could be said that direct care staff who left the department prior to the change were people in their early thirties, the majority of whom had high school degrees and an average of five years of time invested in their work at Belchertown State School. In addition, the comparative male turnover (the department's percentage of male staff was 17.1 percent during the pre change period) was higher, as compared to that their female colleagues.
TABLE 6
PRE CHANGE TURNOVER STATISTICS
(DIRECT CARE STAFF)

<table>
<thead>
<tr>
<th>Age:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>19</td>
</tr>
<tr>
<td>Maximum</td>
<td>58</td>
</tr>
<tr>
<td>Median</td>
<td>28.5</td>
</tr>
<tr>
<td>Mean</td>
<td>33</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years at Belchertown state school:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Minimum</td>
<td>.5</td>
</tr>
<tr>
<td>Maximum</td>
<td>26</td>
</tr>
<tr>
<td>Median</td>
<td>3</td>
</tr>
<tr>
<td>Mean</td>
<td>5.7</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Percentage by Sex:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Women</td>
<td>60%</td>
</tr>
<tr>
<td>Men</td>
<td>40%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational experience:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>High School graduate</td>
<td>93%</td>
</tr>
<tr>
<td>Some college</td>
<td>6.6%</td>
</tr>
</tbody>
</table>

The researcher then looked at the turnover statistics during the eight month period after the reorganization. The data obtained were adjusted to account for the forced transfer of nine direct care residential unit staff to the day services department during the reorganization. Upon being placed to the department these nine staff members immediately transferred themselves back to the residential unit that they were previously assigned. The researcher adjusted the turnover statistics to reflect this situation.
During the eight month period after the reorganization, the turnover rate of the direct care staff was 15.6 percent. This figure is broken out further by percentage of resigned, transfer, and other in Table 7.

**TABLE 7**

**POST CHANGE TURNOVER DATA**

<table>
<thead>
<tr>
<th>Reason</th>
<th>No. Staff</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resigned</td>
<td>5</td>
<td>41.6%</td>
</tr>
<tr>
<td>Transfer</td>
<td>3</td>
<td>25%</td>
</tr>
<tr>
<td>Other*</td>
<td>4</td>
<td>33.3%</td>
</tr>
</tbody>
</table>

*(this represented 2 staff dismissed-15.6 percent, 1 staff removed from leave of absences positions-8.3 percent, and 1 staff died-8.3 percent)*

Table 8, represents a statistical characteristics of the direct care staff in the post-change period.

The above data suggests that the direct care staff person leaving the department after the change were, 40 years old females holding high school degrees, and had spent an average of seven years at Belchertown State School.

Comparing turnover statistics of the pre-reorganization phase with that of the post-reorganization period (Figure 1, Rate of Turnover: Resignations, Transfers, and Other) one finds a definite change in the level of direct care staff turnover and the type of
direct care staff person leaving. The turnover rate decreased from the previous rate of 20 percent to a level of 15.8 percent. (During this same time frame, the Belchertown State School rate of turnover for direct care remained at an average of 25.3 percent.)

TABLE 8
POST CHANGE TURNOVER STATISTICS
(DIRECT CARE STAFF)

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Age:</td>
<td></td>
</tr>
<tr>
<td>Minimum</td>
<td>27</td>
</tr>
<tr>
<td>Maximum</td>
<td>59</td>
</tr>
<tr>
<td>Median</td>
<td>37</td>
</tr>
<tr>
<td>Mean</td>
<td>40.25</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Years at Belchertown State School:</td>
<td></td>
</tr>
<tr>
<td>Minimum</td>
<td>.5</td>
</tr>
<tr>
<td>Maximum</td>
<td>16.5</td>
</tr>
<tr>
<td>Median</td>
<td>4.25</td>
</tr>
<tr>
<td>Mean</td>
<td>7.29</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Educational level:</td>
<td></td>
</tr>
<tr>
<td>High school education</td>
<td></td>
</tr>
<tr>
<td>with no degree</td>
<td>8.3%</td>
</tr>
<tr>
<td>High school degree</td>
<td>83.3%</td>
</tr>
<tr>
<td>College Degree</td>
<td>8.3%</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage by Sex:</td>
<td></td>
</tr>
<tr>
<td>Woman</td>
<td>83.3%</td>
</tr>
<tr>
<td>Men</td>
<td>16.6%</td>
</tr>
</tbody>
</table>
The distinct difference in the percentages of the two periods is exemplified by the differences of the rate in the sub categories of turnover (i.e., percent of transfer, resignation, and other). The rate of persons resigning decreased from 53.3 percent to 41.6 percent, the rate of persons transferring out of the department had the decrease from 40 percent to 25 percent, and the reverse trend occurred in the Other category, from 6.6 percent to 33.3 percent. The subsequent increase in the turnover rate of this category was due to two dismissals, one persons leaving during her leave of absence and one staff person dying.

The researcher concludes that the data indicates that there was a marked improvement in the level of turnover withdrawal in the day services department after the reorganization. Additionally, the type of person leaving the department after the change also shifted to one of an older, predominantly female, persons who had more longevity of service at the institution. This indicated to the researcher that the change was less palatable to those individuals who were accustomed to the custodial approach of the previous system.

Also, the average level of educational experience of the direct care staff was affected by the change. Table 9, indicates a transition trend (i.e., increase in the number of persons with higher academic backgrounds) in the educational experience of the direct care staff working in the department.
### TABLE 9
DIRECT CARE STAFF'S EDUCATION LEVEL
PRE AND POST CHANGE

<table>
<thead>
<tr>
<th>Level of Ed.</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than H. S. Degree</td>
<td>5.3%</td>
<td>6.2%</td>
</tr>
<tr>
<td>H. S. Degree</td>
<td>70.6%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Beyond H. S.</td>
<td>22.6%</td>
<td>30.6%</td>
</tr>
</tbody>
</table>

**Absenteeism Data.** The researcher reviewed three periods of absenteeism statistics during the 18 month period of the study. There was a 12 week period, 6 months prior to the change, a 12 week period after the change, and a 12 week period 7 months after the change (Figure 2, Rates ofAbsenteeism Pre/Post/+1, gives a graphic overview of the results). To insure that there was no other influence on the data, the researcher noted that there were consistent approaches to dealing with absenteeism during this period of time. The data presented in Table 10, reflects the percentage of sick time and absenteeism for the direct care staff in the day services department.

With the reorganization, an additional group of direct care staff were classified as substitutes (see Appendix F - Job Description Substitute Staff). These individuals were responsible for filling in for direct care staff who were absent or when there were vacancies.
This group was unique to the department's direct care staff constituency in the sense that they were merely practitioners. They had no resident programming responsibility. They essentially came into the class and did whatever the teacher/trainer instructed them to do. There were a total of 15 direct care staff assigned to this group. The data reflected in table 11 indicates this group's percentage of absenteeism.

<table>
<thead>
<tr>
<th>Date</th>
<th>Percent Sick</th>
<th>Percent Absenteeism</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-change</td>
<td>6.7</td>
<td>21.06%</td>
</tr>
<tr>
<td>Post-change</td>
<td>6.3%</td>
<td>16.2%</td>
</tr>
<tr>
<td>+ One</td>
<td>4.48%</td>
<td>12.66%</td>
</tr>
</tbody>
</table>

Because this group did not exist before the reorganization, their rate of absenteeism is incorporated in the total absenteeism of the direct care staff as reported in the pre-change statistics.
TABLE 11

SUBSTITUTE STAFF'S PERCENTAGE
POST AND + ONE SICK AND ABSENTEEISM TIME

<table>
<thead>
<tr>
<th>Date:</th>
<th>Sick Time Percentage</th>
<th>Absenteeism</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Post-change</td>
<td>2.4 %</td>
</tr>
<tr>
<td></td>
<td>+ One</td>
<td>7.2%</td>
</tr>
</tbody>
</table>

The data indicate that the level of withdrawal behavior exhibited by absenteeism decreased (16.2 percent to 12.66 percent) for those direct care staff people who directly participated in the development, designing, implementation, and modification of residents programming. The group that did not have any direct participation in program planning and modification display an increase (13.8 percent to 17 percent) in their absenteeism during the same period of time. Table 12, indicates the decrease in direct care staff's rates of absence while showing the increase in the substitute staff.

The data in Table 13, indicates the above difference between the direct care staff and the substitutes as it relates to the portion of staffing incidents and the average length of absences. In both situations the direct care staff responsible for participating in programming decreased while substitutes withdrawal behavior increased.
### Table 12

**Absenteeism Data**

<table>
<thead>
<tr>
<th></th>
<th>No. Staff Absent at Least Once</th>
<th>No. Staff Total No. Incidences of Absenteeism</th>
<th>No. Hours Lost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pre Change</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Care Staff:</td>
<td>46</td>
<td>76.5</td>
<td>86</td>
</tr>
<tr>
<td><strong>Post Change</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Care Staff:</td>
<td>39</td>
<td>75.5</td>
<td>63</td>
</tr>
<tr>
<td>Substitute Staff:</td>
<td>6</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>+ One Direct Care Staff:</td>
<td>35</td>
<td>75.5</td>
<td>62</td>
</tr>
<tr>
<td>+ One Substitute Staff:</td>
<td>7</td>
<td>10</td>
<td>15</td>
</tr>
</tbody>
</table>
RATES OF ABSENTEEISM
DIRECT CARE VS SUBSTITUTE STAFF,
PRE, POST, AND + ONE OF
CHANGE

FIGURE 2

![Bar Chart]

PERCENT

Direct Care Sick Direct Care Absent Substitute Sick Staff Substitute Absent

STAFF/TYPEx

- Pre Reorganization
- Post Reorganization
- +1 Regorization

FIGURE 2
<table>
<thead>
<tr>
<th></th>
<th>Percent Frequency of Absenteeism</th>
<th>Average Length of Absences (Hours)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre Change</td>
<td>60.13</td>
<td>6.85</td>
</tr>
<tr>
<td>Post Change</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Direct Care Staff</td>
<td>51.66</td>
<td>5.83</td>
</tr>
<tr>
<td>Substitute Staff</td>
<td>66.67</td>
<td>5.38</td>
</tr>
<tr>
<td>+ One Direct Care Staff</td>
<td>46.36</td>
<td>5.55</td>
</tr>
<tr>
<td>+ One Substitute Staff</td>
<td>70.00</td>
<td>5.89</td>
</tr>
</tbody>
</table>
CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

It is well understood that many traditional views about organizations are simply not germane to contemporary conditions. Improving the efficiency of organizations requires a reexamination of a number of assumptions. Hence mental retardation institutions, that as an organization, must examen the validity of its accountability of truth in administrative thought.

The fundamental characteristics of mental retardation organizations conventionally represented those traditional organization theories (i.e., decision making is highly centralized, with a strong down the line of authority and expects obedience from subordinates). The individual direct care staff person was held accountable for his/her individual productivity. There was strong emphasis on hierarchical supervision (both administrative and professional) to ensure that the assigned functions were performed in accordance with standard operating procedures. In such a context, creativity was usually suppressed, often characterized as "bad" or viewed as interfering, thus leading staff to feel suppressed, devalued and dissatisfied.
Obviously the rapidly growing conditions sharply vibrate the effectiveness of older concepts of organizational management and give rise to greater need for participants to be involved in their own destiny. In this way loyalty to and faith in the organization takes on a new dimension. Staff will seek new meaning and reward from their endeavor, new ways of finding satisfaction from their work and thereby greater enrichment and self achievement.

As a matter of fact, an organization, in my judgment, is not a mechanical system. An organization is a living social system which is predicated on interdependencies between individuals and groups with a shared sense of responsibility and control instead of competing for domination and subjugation. Conflict is natural to this living organism. Therefore, it is a legitimate phenomena to have internal dissatisfaction tolerated but external intervention rebuked.

The information gathered from the responding direct care staff did not support the researcher's views that by giving a role that would allow their participation in decision making process and therefore placing them in a position that would be more valued by the community, and consequently culminate in their satisfaction and self actualization.

Browner, et al.,(1987); Raynes, et al., (1977); and Holburn and Forrester (1984); conducted studies suggesting that the more staff is involved in decision making in their institutional environment the higher their satisfaction should be. Bailey (1985) in his study entitled, "Participation of professionals, paraprofessional, and Direct-
Care Staff Members in the Interdisciplinary Team Meeting, "(1985) concluded that there is a cultural difference between the professional and the direct care staff. That the institutional system needs to develop a mechanism to bring these two groups together for the benefit of the program.

The reorganization of the day service at the institution examined in this research, was aimed at implementing such a process through which the direct care would be placed in an environment that afforded them the right to actively participate in the decision making influencing their performance process. The other goal of this reorganization was to provide them with the opportunity to develop values previously given to only the supervisory and professional staff.

The data obtained from the study suggest that there was a positive behavioral response from the direct care staff in the day services department of an institution regarding their participation in program development, design, and modification. However, from the responses elicited there came a slightly negative attitude toward this same change on the part of a number of direct care staff.

**Attitudinal reaction.** The analysis of the responses to the questionnaire indicate that the direct care staff were less valued by their supervisors and the professional staff after the change. The direct care staff suggested through their responses that the
professional staff now had gained an opportunity (through team meetings and reviewing their paper work) to demean and demoralize the direct care staff by hinting that the latter were less educated and were therefore incompetent to be a part of the institution's planning community.

This was also reinforced by the reaction of the supervisory staff to the change. There were two inhibiting factors that precipitated the negative responses by the supervisory staff. One, was a conflict of group norms within the institution and the second was, the change in their job role.

The conflict of group norms led to the dilemma of group loyalty. One group represented a mechanistic approach to management which was highly technocratic. That the supervisors and professional staff can provide direct guidance and instruction to direct care staff, and the latter need close supervision. This approach represented the predominate structure of the institution.

The opposing spectrum, represented by the Day Services Department, maintained that productivity was staff oriented rather that job centered. From this point of view, direct care staff were perceived to be the crucial component of the department. Decision making regarding educational programs for individual residents and classroom services were to be regarded as joint responsibility rather than the direct monopoly of the supervisors and professional staff.

This conflict of norms created an atmosphere in which supervisors had to declare their loyalty. Naturally the supervisors
benefited by adhering to the predominate system (i.e., it was well entrenched) versus the newly established Day Services Department system.

The supervisors' also reacted to the loss of their direct participation (they now were supporters and reviewers of the direct care staff) in the planning process. The data indicates that the support on the part of some supervisory staff to the direct care staff dwindled. As a result, a gap emerged between a number of professional and supervisory staff and the direct care. The adverse process influenced job expectancies, requirements, group assimilation, and supervisory evaluations.

It was ironical that the professional staff felt that they were now down-graded to the rank of the direct care staff, because the direct care staff was now perceived as part of a higher echelon and, that the supervisors were catapulted to a higher status, due to their supervisory role over the direct care staff.

In other words, the majority of responses suggest that this goal (increase the value of the direct care staff) of the reorganization initiative was not fully achieved. The researcher concludes that the feeling of devaluation by the direct care staff was partly precipitated by the professional and supervisory staff's reaction to change.

The researcher concluded that the supervisors' feedback to their staff had direct effect on the staff's job performance. It could be suggested that supervisors' level of involvement with direct care staff was a factor that affected the staff satisfaction with their job.
On the basis of this study, it could be said, that in the short term the educational backgrounds differences between the professional staff and the direct care staff make it difficult to interact constructively in the process of program development, design, and modification.

To this researcher, involving the direct care staff in collective development, designing and modification of the program placed the professionals in a situation where they felt that their educational background was being depreciated. Therefore, they reacted by devaluing the direct care staff through lack of support and through their negative interaction to them.

The respondents verify that the majority of the professional and supervisory staff were non supportive and felt more hostile towards them after the change. The direct care staff felt that the new circumstances were more demeaning to them compared with their previous situation.

The role change did not, in fact, improve the way the direct care staff were valued by the organization. It is felt that this issue is not one of value for the direct care staff in the light of their new role, but it is the organizations perception that only one group was perceived enjoying change for the better, while other more professional staff were not enhanced in the same way.

The majority of respondents perceives this attitude on the part of the organization toward their job. As a result, the respondents expressed disenchantment with their new role.
Moreover, the respondents exhibited a certain degree of discomfiture toward the newly established responsibility of doing additional work (i.e., responsible for paper work that accompanies the role of participant in program development, design, and modification).

The respondents overwhelming indicated that direct interaction with the residents was the source of deep satisfaction for them. They felt that the new role took this part of their job away. To the researcher, this can be interpreted as a fear of the new level of responsibility on the part of the direct care staff. In other words, the new role moved them into the realm of educational skills not previously required of them. In the same vein, Brewner, et al., (1987) found that paper work was a cause of high stress for the direct care staff. This stress influence was reported by the respondents as a major reason why they did not perceive the new role as satisfying.

It maybe argued that the educational skill level of the direct care staff has a part to play in this issue. The information gathered in the study indicates that the direct care staff felt that they either lacked educational skills to do the job or that they would feel better if they were provided with more educational experience.

Although, the information obtained from the questionnaire revealed a feeling of overall disenchantment with the new role, the respondents did, indicate that they were pleased to be involved in the decision making processes. This leads the researcher to conclude
that the respondents attitudinal dissatisfaction with the new role did not have anything to do with participation in the decision making process. But, it was related to the fact that, 1- the new job provided less time for what they liked to do best (i.e., direct contact with the residents); 2-it placed them in a situation that they conceived themselves to be academically inadequate to do the job (i.e., to do the paper work, and to relate effectively with professional staff); and 3- that they were now demeaned by the professional/supervisory staff due to that groups perception that the direct care were improved in status while the professional/supervisory staff were denied importance and credibility.

**Behavioral Reaction.** The behavioral reaction of the direct care staff regarding the change in job role was measured in terms of, turnover and absenteeism. Turnover being one of the most drastic indicator of the direct care staff's withdrawal from the job, while absenteeism was used as a criterion to measure the less drastic form of withdrawal from the job.

The results of the turnover data indicate to the researcher, a positive reaction on the part of the direct care staff after the change in the organization allowing them to participate in the program development, design, implementation, and modification. This seems to be even more pronounced in the case of, the substitute staff in the department. That is to say, the latter had a turnover rate of 77.8%.
Of which 71.1% chose to transfer into the direct care positions of the department and 28.7% transferred out of the Department. Additionally, the average level of turnover for the institution remained at 25.3%.

To the researcher, one of the reorganization's effect on the direct care staff was that it provided an environment which reduced the overall dissatisfaction on the part of direct care staff and led to less drastic withdrawal behavior as a result.

Since the staff were not always willing to take excessive measures to exhibit their adverse reaction to their job (i.e., staff who had vested interest in a job, were not prepared to give up their seniority and benefits as a result of their disenchantment with their job. Absenteeism behavior is another way of measuring the less drastic expressions of staff dissatisfaction with their job. In this study, the percentage level of this type of withdrawal on the part of the direct care staff participation in the program planning decreased in the post-change period. Seven months after the change the level of absenteeism was 8.4 percentage point lower than that of the pre-change rate. The rate of withdrawal behavior of the substitute staff who did not participant in programming increased 9.8 percentage points during the same period of time.

The absenteeism data suggests to the researcher that the change also had a positive effect on the minor withdrawal of the direct care staff involved in the educational/training program development, design and modification of residents at Belchertown
State School. The decrease in the percentage of absenteeism indicates that even the minor expression of withdrawal behavior was decreased.

In sum, according to the turnover and absenteeism results, it was indicated to the researcher that the direct care staff were more satisfied with their role after the change than before.

Although, the attitude expressed by the respondents regarding the new role was one of less satisfaction, the behavior exhibited by the direct care staff indicated a decrease in withdrawal behavior. These findings would seem to have significant implications for administrative practices in the instruction of mentally retarded people.

It may be said that the direct care staff, with a set of well defined job responsibilities allowing them to directly participate in development, design, implementation, and modification of education/training program for residents in an institution, this is reflected by the decreased withdrawal behavior exhibited after the change. The new role provided them with an improved quality of life and the ability to have some direct control over their work environment. This represents the behavioral reaction of decreased withdrawal behavior.

However, they were less satisfied because of the way in which they were being treated by the work climate around them. It was felt that, the work climate (i.e., reaction by the professional and supervisory staff response, and academic requirements) caused them
(direct care staff) to have doubts about their ability to be involved in the development, design and modification of education/training programs at the institution.

This researcher feels that the direct care staff's doubts compounded with a new role led them to be under serious external stress and as a result of the new circumstances they revealed a degree of negative attitude.

Summary and Recommendations:

These findings would seem to suggest important implications and ramifications for organizational developers for program systems to serve mentally retarded persons. The data clearly indicates that for the staff currently employed in the field of mental retardation, the level of satisfaction with the job is consistently related to a set of variables including favorable climate and positive feedback from supervisors and professional staff. Moreover, variables such as direct involvement by the direct care staff is correlated with the level of job enrichment and thereby satisfaction.

However, variables such as the amount of resident contact, and the lack of resident progress may be associated with differences in the level of satisfaction. Therefore, administrative effort to enhance direct care staff satisfaction should not only embrace positive
working climate (i.e., supervisors' and professional staffs support) but also the attitude of direct care staff.

Moreover, in order to facilitate organizational change in institutions for mentally retarded people, appropriate educational arrangements need to be carefully designed and developed in order to reorient the staff to work patterns that have been formulated in the reorganization initiative. The researcher feels that staff development initiatives need to provide a more integrated, holistic framework. This is a challenge to be met by administrators of institutions for mentally retarded persons who are concerned to pool their efforts. Like wise, within each institution, there are steps to be taken in creating an environment within which direct care staff can function more effectively, while at the same time receiving a necessary inservice education.

The researcher feels that administrators should be aware that when they are addressing the direct care staff's role and satisfaction, this should not be done in a vacuum or in isolation. The adverse reaction of the professional and supervisory staff to the change could be reduced if they were given an active part in assimilating the direct care staff into their domain.

Last but not least, the researcher recommends that administrators work with the direct care staff in order to develop mutual appreciation for each other's role and a sense of professional support on the part of the supervisors and professionals. Finally more research needs to be conducted regarding the professional
staff's attitude toward full participation of the direct care staff in the interdisciplinary program development, design, implementation and modification.


5. Ibid., p. 314.


8. Ibid., p. 372.


10. Ibid., p. 43.

11. Ibid., p. 69.

12. Ibid., p. 70.
13. Ibid., p. 73.


23. Ibid., p. 4.

25. Massachusetts Department of Mental Health, *Department of Mental Health Mental Retardation Regulations 104 CMR 20.00-23.00*, (Boston: Division of Mental Retardation, 1979), p. 7.


27. Ibid., p. 173.


33. Ibid., p. 319.

34. Ibid.

35. Ibid., p. 320.

36. Ibid.


44. Ibid., p. 113.


48. Ibid.

50. Ibid.

51. Ibid., p. 294.


23. Ibid., p. 585

24. Ibid., p. 586

55. Ibid., p. 588.

56. Ibid., p. 579.


59. Ibid.


61. Ibid.

62. E. S. Zaharia and A. A. Baumeister, "Cross-Organizational Job Satisfaction of Technician-Level Staff Members," American Journal of Mental Deficiency 84 (1979) : 34.
63. Ibid.


65. Ibid., p. 235.


71. Ibid.


73. Ibid.


Bailey, Donald B.; Theile, Judith E.; Ware, William B.; and Helsel-DeWert, Majorie. "Participation of Para-professionals, Professionals, and Direct Care Staff Members in the Interdisciplinary Team Meeting." American Journal of Mental Deficiency 89 (1985) : 437-440.


Downing, Billie; Goetz, Tony; Pursley, Norman B; and Swann, John W. "Accountability in Administration: Responsibilities to Clients, Staff, and the Public." Mental Retardation (June) 1974) : 10-12.


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APPENDICES
APPENDIX A

QUESTIONNAIRE DAY SERVICE STAFF
QUESTIONNAIRE
DAY SERVICES STAFF

1. What is your understanding of what you are paid to do

2. Since the reorganization this past September are you clear regarding your role and responsibilities? (circle one)
   Yes  No  Unsure

3. Were you clear regarding your role and responsibilities before the reorganization in September? (circle one)
   Yes  No  Unsure

4. Do you feel that you personally have benefited from the reorganization of Developmental Services? (circle one)
   Yes  No

   If Yes, in what areas or ways (check all that apply)

   Promotion  
   More opportunities to learn skills  
   Clarity about role and responsibilities  
   Help me do more for the development of residents  
   Other

   If No, why do you feel it didn't change things for you?

   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
5. Do you feel that the "climate" in Developmental Services, as a place to work, has changed since the reorganization in September? (circle one)

- Improved allot for me
- Improved some for me
- No change that I experienced
- Somewhat more negative for me
- Allot worse for me

6. What has been the overall effect of the reorganization this fall on you in your job? (please be specific)

7. Is there anything about the way that Developmental Services is set up since the reorganization that helps you be more effective in doing your job?

   Yes  No

   If yes, What? (please be specific)

8. Is there anything about the way Developmental Services is set up since the reorganization that makes it more difficult for you to do your job effectively?

   _______________________________________________________________
   _______________________________________________________________
   _______________________________________________________________
9. What is your understanding of the changes intended by the reorganization regarding staff's job satisfaction?

10. Do you think the reorganization has had an effect on any of the following? Please indicate what type of effect.

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<th></th>
<th></th>
<th></th>
<th>Approach to working with residents</th>
</tr>
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<td>Yes</td>
<td>No</td>
<td>Unsure</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
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<td></td>
</tr>
<tr>
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<td>No</td>
<td>Unsure</td>
<td></td>
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<tr>
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<td></td>
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<th></th>
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<td></td>
</tr>
<tr>
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<tr>
<th></th>
<th></th>
<th></th>
<th>Work relationships with co-workers</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
<td></td>
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<tr>
<th></th>
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<th></th>
<th>Work relationship with Supervisor</th>
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</thead>
<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
<td></td>
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<tr>
<th></th>
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<th>Work relationship with staff outside the unit</th>
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<tbody>
<tr>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
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<tr>
<td>Yes</td>
<td>No</td>
<td>Unsure</td>
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</table>

11. In what skill areas could you use assistance in order to more fully develop your own capabilities and potential?

12. What contributes to your sense of self esteem in your role or job?
13. What about your job role do you find demoralizing or has a negative effect on your self esteem?

________________________________________________________________________

________________________________________________________________________

14. Before the reorganization in September, what about your job gave you a sense of accomplishment or satisfaction?

________________________________________________________________________

________________________________________________________________________

15. Has that changes since the reorganization of Developmental Services?

Yes  No

If Yes, What currently gives you a sense of accomplishment or satisfaction?

________________________________________________________________________

16. What could you do differently that would enhance your sense of self-esteem regarding your work?

________________________________________________________________________

17. Prior to ISP meetings, do you feel that you have sufficient preparation and discussion time with others from Developmental Services?

Yes  No  Sometimes

18. In ISP meetings, when you need to extend a discussion or negotiate to get a resident's needs better met or a priority of the Day Program/Developmental Services met, do you feel you have the:

Skills:  Yes  No  Sometimes
Information:  Yes  No  Sometimes
A. If you said No regarding skills, information or both, what do you need to be more effective?

B. If you said Yes regarding skills, information or both what ones or types of information and/or skills do you draw on?

C. If you said Sometimes regarding skills, information or both what tends to be missing when you feel you don’t have what you need?

19. In an ISP meeting to what extent do you feel free to comment in discussions or react/add to the objectives offered by others on the team? (circle one)

PERFECTLY FREE
GENERALLY FREE
SOMETIMES ONLY
OCCASIONALLY NEVER

20. In ISP meetings, what tends to deter your full participation? Please be as specific as possible or give examples.

21. In ISP meetings, what contributes to your ability to fully participate? Please be as specific as possible and/or give examples.
APPENDIX  B

PRE-CHANGE JOB DESCRIPTION

DIRECT CARE STAFF
Pre-Change Job description

Job description of the program aid 7/21/82

Personnel Management

1. Supervise float staff and other staff as assigned
   a. Orient staff to client's program
   b. Explain data collection procedure
   c. Communicate information regarding program issues.

2. Participate in regular program meeting, and others as requested.

3. Insure appropriate documentation of personnel issues affecting central day programs.

Day program development

1. Assist in the client assessment process by providing the program director and others with information about specific clients.

2. Assist the program manager in addressing clients day program objectives.
   a. Carry out activities assigned to implement clients objectives.
   b. Keep necessary data on assigned objective.
   c. Provide input to program director around clients progress, need for change in program, behavior.
   d. Write progress notes.
   e. Assist in maintaining updated daily schedules, including activities, time slots, documentation and routine.

3. Identify areas in which training is needed to carry out day programs.

4. Participate in On the job training.

5. Insure that programs are carried out.

6. will float to other programs as necessary.
7. Assist in caring out approved behavior programs and selected ADL (average daily living skills) programs.

8. Encourage clients to participate in decisions that affect them.

What is evidenced by the above job description is the direct cares participation in program development, design planning, and implementation also follow up (monitoring) is, input. In observation, the input was not solicited by the program supervisor, who was the individual responsible for the actual develop, etc.,.

The direct care staff was however responsible for the direct implementation of programs. Because of the way the job description was written and the clinical environment (only qualified person could write programs) the supervisors did all the development.
Post-Change Job Description

The job description developed and implement in the September 9/3/83 reorganization was;

1. To integrate appropriately with students/workers and to provide them with an effective role model.

2. To communicate information to appropriate persons regarding individual students/workers.

3. To promote the concept on independence in the most normative manner through participating in individualized programming for each individual.

4. To provide a positive atmosphere in order to help individuals students/workers feel positive about themselves and their progress.

5. To observe and document individual student/workers abilities, skills, like and dislikes. this will be done through an evaluation tool and assessment form which the aide will complete.

6. To provide information to the ISP (individual Service Plan) Team on individual's skills, abilities weaknesses and strengths of the resident to work as part of the team in developing appropriate goals for the individual.

7. To assume responsibility for the individual that the are assigned and to be aware of a general responsibility for all student/workers within a program area. (Each aide had a specific assigned residents that was permanent and the were responsible for those residents program development and participation on the ISP team for that client.)

8. To participate in programmatically processes of developmental services (i.e., evaluation, assignments, progress notes, program development, etc.,)

The job description focused on the change; aide staff were directly involved in the process of collecting and interpolating data,
developing, designing and implementing day program programs for clients. They are also directly involved in the monitoring of program response.

In addition to this each Direct care staff person was given specific case load of residents. They were responsible for the complete programming (according to the above job description) for those residents.
The following are guidelines for instructional Aides and Vocational Aides regarding their responsibilities within day programs:

1. To interact appropriately with students/workers and to provide them with an effective role model.

2. To communicate information to appropriate staff regarding the individual student/workers program progress.

3. To promote the concept of independence in the most normative manner through individualized programming for each individual you are assigned.

4. To provide a positive atmosphere in order to help individual students/workers feel positive about themselves and their progress.

5. To observe and document, on you assigned students/workers, abilities, skills, reaction to programs, likes, and dislikes.

6. To participate in your assigned students/workers individual ISP team: by providing information on the individuals skills, abilities, weakness and strengths, and response to programs; and by participating in the teams development of appropriate individual goals, objectives and programs for your student/worker.

7. To assume responsibility for the individuals that are assigned to you and to be aware of a general responsibility for all students/workers within a classroom/work area.
8. To participate in the programmatic processes of Developmental Services (i.e., evaluations, assessments, progress notes, program documentation, classroom mini-team meetings, ISP team meetings, and any special individual student/worker meeting.)

(8/06/83)
APPENDIX E

DIRECT CARE STAFF JOB COMPETENCIES
**DIRECT CARE STAFF JOB COMPETENCIES**

<table>
<thead>
<tr>
<th>Description of Function</th>
<th>General Competency Statement</th>
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<tbody>
<tr>
<td><strong>A. Day Program Development and Implementation</strong></td>
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<tr>
<td>1. Participates in residents' assessment process for those residents assigned.</td>
<td>- Knowledge of assessment process and ability to collect identified information.</td>
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<tr>
<td>2. Implement residents' day program objectives for residents assignment</td>
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</tr>
<tr>
<td>a. Carry out activities assigned to implement residents' objectives.</td>
<td>- Ability to summarize data for complete assessment.</td>
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<tr>
<td>b. Keep necessary data on assigned objectives.</td>
<td>- Knowledge of residents ISP objective and intervention strategies</td>
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<td>- Ability to follow directions.</td>
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<td></td>
<td>- Ability to organize and record information.</td>
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c. Provide input to program director around residents' progress, need information changes in program, behavior.

d. Write progress notes as assigned.

e. Complete assessments.

f. Assist in maintaining updated daily schedules, including activities (individual and group), time slots, documentation and routine housekeeping tasks.

3. Identify areas in which training is needed to carry out day programs, and participate in training as required.

4. Participate in on-the-job training.

5. Insure that programs are carried out, directly through monitoring programs, and working with residents.

- Knowledge and ability to write progress notes indicating such as, but not limited to, residents growth and/or program revision needs.

- Knowledge of most current day programs and routines.

- Knowledge of available training.

- Knowledge of program objectives and identify methods for reaching objectives.

- Thorough knowledge of resident as an individual and the ability
6. Under supervision of Teachers/Trainers develop teaching modules for residents in program areas

7. Carrying out approved behavior programs and selected ADL programs

8. Encourage residents to participate in decisions that affect them.

B. Personnel Management

1. Supervise other staff as assigned
   a. Orient staff to residents' programs.
   b. Explain data collection procedures.
   c. Communicate information regarding program issues.

to teach in the most appropriate and productive fashion.

- Basic awareness of program design and of program technique i.e., task analysis).
- Knowledge of program interventions and strategies.
- Basic understanding of behavior management.
- Knowledge of resident rights and responsibilities of staff to promote independence by providing options and alternatives.
- Ability to communicate and provide information as it relates to program assignments.
- Knowledge of policies and routines of day programming.
2. Participate in regular program meetings, and other program meetings as required.

3. Insure appropriate documentation of personnel issues affecting the Day Services Department.

C Related Duties

1. Assist the Teacher/Trainer in maintaining the program area and equipment according to health and safety standards.

2. Participate in the planning and coordination of program activities and schedules.

3. Maintain up-to-date knowledge of policies and procedures.

4. Attend ISP related meetings for those residents assigned.

- Knowledge of responsibilities in providing input and utilizing information received during program meetings or information sessions

- Knowledge of policies and procedures of Belchertown State School as they relate to resident services.

- Knowledge of health and safety standards.

- Knowledge of and ability to communicate suggestions and ideas.

- Knowledge of ISP process and role within this process.
APPENDIX F

SUBSTITUTE STAFF'S JOB RESPONSIBILITIES
SUBSTITUTE STAFF’S JOB RESPONSIBILITIES

Substitute staff's primary duties is to fill in for direct care staff who are absent from their assigned program area (e.g., out sick, on vacation, or attending required meetings).

The substitute staff will receive their assignment at the beginning of the day from the Assistant Section Coordinator.

Substitute staff will report to their assigned area and assume the specific duties of the direct care staff who they are filling in for.

Substitute staff will receive specific direction on who, what, when, where, and how from the teacher/trainer (supervisor), upon entering the program area.

Because of the substitutes limited knowledge of the individual residents, they will work under the specific direction of the teacher/trainer (supervisor).

Substitute staff will be responsible to implement programs, both specific and group, as defined by the supervisor in the area.

Substitute staff if not assigned to a specific class or program area will be assigned to assist in the following:

1. Monitoring residents on community trips,
2. Assisting in program areas where there are behavioral difficulties,
3. Free up direct care staff to do their paperwork,

Substitute staff will fill out the necessary daily documentation on residents they worked with during the day.

Substitute staff will participate in the same general training programs as the direct care staff.