INDIVIDUALS WITH MENTAL RETARDATION: ASSESSMENT AND RESEARCH PLAN

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Abstract:
Adults with developmental disabilities, specifically mental retardation, face a number of biopsychosocial issues. Institutionalization and the subsequent policy changes made that affect this population have overlooked their basic needs, leaving it difficult to experience a high quality of life for individuals with developmental disabilities. Through social work education and work experience, I have realized a strong interest in working with this population. This project is an accumulation of research I have done for my Social Work 410 and 440 classes, as well as additional research added after the fall semester, 2002.

Acknowledgements:
I would like to thank Dr. Patchner for being a wonderful mentor, offering guidance and patience in working with me on this project as well as my SocWk 410 and 400 professor, Judy Gray. Larry Weishaar (Vice President of Support Services, ResCare, Inc.) has my great appreciation for aiding me in my quest for demographic and statistical information regarding consumers of ResCare, Inc.
Introduction:

In today’s society, many groups and individuals suffer injustice. One minority group particularly at risk in society are individuals with mental retardation. The purpose of this project is to examine and assess the issues facing this population and apply that knowledge in a research plan for this writer’s place of employment, ResCare. Adults with a diagnosis of mental retardation face many problems; in part, these problems are due to limitations from their diagnosis, others are a result of their environment and social interactions. As from the ecological perspective, different systems influence one another (Hepworth, Rooney, & Larsen pp 19-20). If one system is out of balance, it will be detrimental to the individual’s rights to self-determination and to experiencing a life of quality (Hepworth, Rooney, & Larsen pp 20).

Demographics:

Statistics from a 1993 Morbidity and Mortality Weekly Report state that mental retardation is the most common developmental disability. Approximately 1.5 million individuals (ages 6-64) are diagnosed with mental retardation, with 7.8 adults (ages 18-64) out of 1000 diagnosed with mental retardation in the state of Indiana. Geographically, the mental retardation diagnosis is the most common in West Virginia (15.7% of adults). It is more common in males than females by an approximate ratio of 5:1 (DSM-IV pp 44); the prevalence is similar in both individuals of high and low socioeconomic classes (DSM-IV pp 44), and individuals of all racial/ethnic backgrounds are afflicted equally with this diagnosis.
This particular paper is focused on the middle-aged to older (ages 30-64) adult population, but children are constantly adding to the number of individuals diagnosed with this disability and the statistics are growing. Unfortunately, the majority of this population is extremely limited in terms of education and financial resources due to society’s views on this population. The majority of their income comes from stipulations in the Social Security Act and is limited to SSDI, Medicaid/Medicare, and SSI. For individuals with a diagnosis of mild to moderate mental retardation, the likelihood that they will have jobs in the community is high compared to individuals with a diagnosis of severe to profound mental retardation. There are other factors in regards to their income such as: help from family; work in private sheltered workshops, and friends.

Unfortunately, the stigma attached to mental retardation, the history of institutionalization and isolation from the rest of society has strongly influenced middle-aged to older (typically ages 30-64) adults in this population, these factors will later be discussed in greater detail.

**Assessment Issues:**
The issues people with developmental disabilities face are numerous. They are forced to adapt to biophysical problems and psychosocial issues that mainstream society take for granted. First and foremost, these individuals have a lower level of intellectual and emotional functioning that makes seemingly common, straightforward issues extremely difficult to resolve.
The DSM-IV states that mental retardation is characterized by “significantly sub average intellectual functioning” (defined by IQ being below 70). There are accompanying limitations in the individual’s adaptive functioning (how effectively individuals deal with life demands) in a number of areas such as: health and self-care, communication, social/interpersonal skills, and use of community resources (DSM-IV pp 39). There are varying degrees of severity and individuals are usually diagnosed with one of the following categories: mild mental retardation (IQ: 50-55 to approx. 70), moderate retardation (IQ: 35-40 to 50-55), severe mental retardation (IQ: 20-25 to 35-40), and profound mental retardation (IQ: below 20-25). Again, this diagnosis affects all facets of their lives; however, further elaboration will focus on self-care and access to adequate health care, their ability to communicate wants and needs, and their social relationships (DSM-IV pp 41).

A major problem concerning individuals with a diagnosis face is that they are “among the most overlooked and ignored population groups in the world” (Voelker, Goldsmith pp 433). Specifically in regards to diagnosis of mental illness, this population is excluded from studies and individuals are difficult to treat since measurement of the effects of medications are so complex, due to their lack of communication skills and other factors (Voelker, Goldsmith pp 433). Mental illness is understood to be four times more common in individuals with a diagnosis of mental retardation in relation to other populations (Voelker, Goldsmith pp 433). The medical profession has only recently addressed this issue. In the past, symptoms of mental illness displayed by individuals diagnosed with mental retardation were associated with behaviors caused by the MR
diagnosis. This in turn raises another issue: finding medical professionals willing to work with and treat individuals whose “behaviors” may be problematic.

In combination with Medicaid footing the bill for treatment, with only a limited number of medical providers accepting Medicaid as payment, individuals with a diagnosis of mental retardation are the many times overlooked and ignored population by the medical community. This may mean searching high and low for a qualified, willing medical professional to care for the individual’s concerns. A possible solution offered by an article in the Journal of the American Medical Association suggests for the individual diagnosed with mental retardation to have an advocate/family member present at appointments and meetings (Voelker and Goldsmith pp 435). However, it is just not that simple.

The history of individuals with a diagnosis of mental retardation is a troubled one. Not only did institutionalization serve to isolate individuals with a diagnosis of mental retardation from mainstream society, but it also forced families to sever ties (Smith pp 42). In the beginning of the 19th century, society viewed individuals with mental retardation as simply “mentally deficient” and “subhuman” and linked these individuals with promiscuity, crime, poverty, and ultimately, the decline of civilization (Wehmeyer pp 106). Society’s historical solution was to send this people away from civilization, castration to prevent further production of deficients, and ignoring their existence (Smith pp 43). At the time, medicine and treatments were not readily available to individuals to treat behaviors and the stigma attached to the “mentally ill” led families to turn their children over as wards of the state (www.interactivist.net/housing/deinstitutionalization).

Biklen and Knoll list a number of injustices institutionalization forced upon individuals
with mental retardation: toxic medication administration in place of social interaction and activities, residents becoming more and more isolated from their families the longer they live in the institution. Incidents of physical, emotional, and sexual abuse were also not uncommon in institutions (Biklen and Knoll pp 8-9).

In the 1940s-1950s, parents begin keeping their children with a diagnosis of mental retardation in the home viewing them as “holy innocents” or “eternal children” (Wehmeyer pp 106), until they were unable to care for their children or even more unfortunate, upon their death. At this point, these individuals were again admitted into the institutional setting (Smith pp 40-41).

From the late 1950s-1970s, radical change occurred, with the government producing legislation in order to protect individuals with disabilities and thus the process of deinstitutionalization began (Wehmeyer pp 108). This was meant to be a process of normalization; the principle is to create conditions of normalcy (what individuals without disabilities experience) for individuals with a disability (Wehmeyer pp 108). The Developmentally Disabled Act mentions the least restrictive environment, the setting “least restrictive of the person’s personal liberty, and this act lead to the creation of a continuum of residential settings for individuals with developmental disabilities (Taylor pp 28). Least Restrictive Environment Continuum includes a number of residential settings: Public Institutions continue to house a large number of individuals with developmental disabilities and is the most restrictive environment. The argument behind these institutions is that some individuals are too severely disabled to live in the community; however, they also serve as a placement for those waiting to be out in the community, to whom the institutional setting is ridiculous (Taylor pp 28). The most
common placement has individuals with developmental disabilities residing with family members within the community. This setting can be the least restrictive for some individuals, but there are other options (Taylor pp 28). Group homes and supported living sites can offer opportunities for interactions with peers, and aid them in being more included in the community with the aid of trained staff. The first attempts at normalcy, the first group homes, were actually just smaller scale versions of their counterpart: institutions. The intentions of normalcy were well and good, but for individuals living their lives without family, friends, or loved ones; this left them alone and without an advocate. In the past, adults living in group homes often had no outside contacts perhaps due to the gap created by spending the majority of their lives in institutions and away from their loved ones (Smith pp 48). Often no social histories can be found, making it difficult to re-establish ties with family. The past and current living situation of many individuals living with this diagnosis creates a lonely existence and a problematic situation.

The point to the above history description is this: adults diagnosed with mental retardation are often dependent on their service system. In addition, these dependent individuals are very limited in their social networks and friends (Amado pp 82). The resulting loneliness is a contributor to their health problems as well as negative behaviors, which in turn makes finding adequate treatment difficult (Amado pp 82). In working with this population, it is extremely important to make sure that the individual’s mental and physical health needs are met; which means ensuring adequate social supports.
Social Work Intervention:

Two agencies located in Muncie to serve this population and meet the needs stated above are Hillcroft Services and the Isanogel Center. Hillcroft offers a variety of services focused on meeting the psychosocial needs of the population they serve. Behavior management training enables consumers to express their wants and needs in a more productive manner. A developmental sheltered workshop strives to help individuals develop communication skills, community training, and paid working skills. Group homes offer opportunities in developing money management skills, personal care, and other daily living skills. For the families of individuals with developmental disabilities, Hillcroft Services offers respite care to give caregivers a break. OBRA (Omnibus Budget Reconciliation Act of 1987) is legislation which mandates that individuals with developmental disabilities living in nursing homes continue to maintain activity in the community, develop daily living skills, and maintain cognitive/sensory stimulation.

Recreation programs offer individuals many choices in activity, ranging from development of motor skills, community involvement, social skills, and travel (www.hillcroft.org). The Isanogel Center offers individuals with developmental disabilities a number of opportunities for social growth and development of physical and motor skills to maintain their overall well-being. Some examples include: summer day and residential camps, arts and crafts activities, opportunities for social interaction at dances, campfires, and shopping excursions (www.isanogelcenter.org).

Family members, friends, or the individuals seeking the services can contact these agencies for a list of current activities. Also, professionals can refer consumers; such as, their social worker, case manager, group home supervisor, or support associate.
Some limitations of these agencies are that some individuals are not in the loop of information and do not have access to information regarding events/activities or may not have the money to participate or utilize these services. The primary role of a social worker in these agencies would be that of a program director, establishing and maintaining the quality of services and doing outreach to locate and involve individuals not readily visible in the community, those in rural areas, in group homes, and those individuals living on their own with minimal assistance.

One intervention strategy that has been and continues to be common is advocacy. *Case advocacy* is working with and on behalf of individuals to assure that they receive services beneficial to them and that those services are delivered in a way that maintains and enhances their dignity (Hepworth, Rooney, and Larsen pp 450). Often, consumers are overlooked and do not receive the services to which they are entitled. For individuals with a diagnosis of mental retardation, being overlooked can be extremely detrimental to their overall well-being. A radical example would be the case of John Lovelace, an individual who had lived his life in and out of institutions. Upon deinstitutionalization, he was admitted to a group home and after some years, a “No Code” was ordered (Smith pg 10). What this means is that no extreme measures would be used to extend this man’s life, no effort to resuscitate him in the event of a cardiac arrest (Smith pp 10). “No codes” are only supposed to be ordered when the individual’s quality of life would not be enhanced by extreme measures. His self-appointed case advocate challenged John’s case: later, he accomplished the recall of the order. Medical professionals were later embarrassed by this “oversight” and quickly covered up their mistake (Smith pp 34). If this “oversight” occurs once, it is too often, but unfortunately it did happen and continues
this “oversight” occurs once, it is too often, but unfortunately it did happen and continues to occur. There simply are not enough case advocates for individuals with developmental disabilities.

*Class advocacy* is social action to influence change on a larger scale such as in policy, practice or laws (Hepworth, Rooney, Larsen pp 450). Some examples of techniques of this intervention include: establishing a relationship with other agencies (contacting when they are not adequately meeting constituents needs), appealing to review boards to get cases heard, pursuing legal action when consumers’ rights are violated, and forming coalitions by connecting with other agencies (Hepworth, Rooney, Larsen pp 452). Some other techniques include gathering information through surveys and studies to gain validity, educating the community through forums and addressing the public in conferences, contacting public officials and filing complaints, and organizing consumer groups and using their collective voice to make an impact (Hepworth, Rooney, Larsen pp 453). Since the early 1990s, there has been a development in the advocacy movement for people with developmental disabilities, a definite shift from advocacy by others to self-advocacy by the individuals (Wehmeyer pp 113). This idea fits well with class advocacy, the technique being helping consumers organize and use their collective voice to be heard.

**Questions/Areas for Assessment:**

Two definite areas for assessment would be social supports (Amado pp 81) and their overall biophysical well-being (Voelker, Goldsmith pp 434). As elaborated on in the assessment issues, individuals with developmental disabilities suffer from a number of
manifest themselves in the physical well-being of the individual and cause further problems regarding their health. When interviewing a consumer with a diagnosis of mental retardation, it would be imperative to have as thorough a biopsychosocial history completed. Some preliminary questions to ask would be:

- Were they in an institutional setting?
- Do they have any recurring medical issues?
- Do they have a dual-diagnosis of mental illness?
- If not, is there reason to suggest they need further psychological evaluation?

Also, the social worker should make home visits to the consumer's residence to get a feel for the structure of the home and supports available to the consumer on a regular basis. Group homes are strictly regulated and staff in them must document information daily about the consumer's well-being and current issues in the client's life (writer's personal experience). The consumer's case manager should have access to this information in order to form an effective plan of action for the individual. This information is vital to know before a helping relationship can be established between the consumer and the professional. In these circumstances, the consumer may not always be able to verbalize answers to important questions, and/or may be eager to please those closest to him/her (Smith pg 31-33) and not give a completely accurate picture of their living situation.

Some questions to ask the consumer would be:

- Do you like your home?
- What do you like about your home?
- Do you have housemates?
- How do you get along with your housemates?
How are you feeling?
Do you have many friends?
Do you have any family?
How do you feel about your family/friends?
Can you tell me about them?
What do you like to do?
What don’t you like to do?
How often do you get to things you enjoy/that are fun?

Questions should be straightforward and simple. Typically, social workers would use open-ended responses (Hepworth, Rooney, & Larsen pg 159), but under certain circumstances involving this population, it would be more beneficial to ask more close-ended questions to keep the consumer from getting confused. Allowing them to talk about things they do/do not like will be important in helping match them up with services that would be beneficial to them and their right to self-determination (Amado pp 83). If available, it would be helpful to have an advocate (i.e. family member, case manager) present at the interview (Voelker, Goldsmith pp 84), but that is not always possible.

Also, an observation of the living situation would be helpful. It is important to respect the consumer’s right to confidentiality and there is a line professionals do not want to cross, but simultaneously, it is important to get as accurate a picture of the consumer’s life.
**Summary of Social Work Intervention:**

Adults with a diagnosis of mental retardation face a number of significant issues that make leading a healthy, fulfilling life difficult. Two of perhaps the most problematic areas are in regard to their biophysical well-being and their psychosocial well-being. For years, this population has been ostracized by society, and deinstitutionalization has attempted to reintegrate them; however, the damage has been done and there continues to be a stigma attached to the mental retardation diagnosis and individuals suffer for it. The social work profession needs to be more involved in the process. Associates provide most of the care for individuals in group homes with limited education regarding the issues individuals with mental retardation face. Outreach programs and seminars should be given to keep associates up to date, knowing what progress has been made, current issues and ultimately, where community resources are located.

In working with this population, it is important to remember that certain conditions are common amongst this population. Additionally, a lack of social supports contributes to deteriorating physical and psychological well-being of the individual. Being sensitive to these issues will hopefully allow for a successful helping relationship between the professional and the consumer.

Applying the knowledge gained in the during the process by targeting psychosocial issues, is extremely beneficial in identifying a specific service delivery problem.

**History of Organization**

ResCare, Inc is a company that provides services and supports to individuals with disabilities and at-risk youth. The company is the leading provider of services to
individuals with intellectual disabilities and is located in 32 states, serving over 26,000 people. Jim Fornear founded the company in 1976, opening a Job Corps site and in 1978 opened its first operation for individuals with a diagnosis of mental retardation (ResCare website). In 1992, the company had operations in six states and Puerto Rico and served 1,378 people and since then ResCare has grown significantly, becoming a profitable business providing much needed services (ResCare website).

ResCare is a for-profit business and receives funding from state contracts (Medicaid/Disability), insurance, private pay, and is a stockholding company (ResCare website).

**Services/Goals of Organization:**

The company is broken down into three primary areas of services. The Division for Persons with Disabilities focuses on individuals with mental illness, intellectual disabilities, and acquired brain injuries (ResCare website). Some of the services provided include supported living, supported employment and rehabilitation programs, community group homes, and facility based operations. The Division for Training Services is federally funded and provides opportunities for educational training, and employment. The Division for Youth Services aids at-risk youth and young adults by providing educational, training, and treatment programs (ResCare website).

The goal of the Division for Persons with Disabilities is to provide services to individuals with intellectual disabilities, acquired brain injuries, and mental illness that enhance their quality of life by insuring that they are living in the least restrictive environment and achieving their rights to self-determination and autonomy. In-home services allow
individuals to stay in their own homes and receive services such as respite care for family members, personal care and hygiene, housekeeping, habilitation, and attendant care. Supported living services are customized to the individuals’ needs. Usually, a supported living apartment or house accommodates two to three individuals with 24hr support or as little as a few hours per week depending on the individuals’ situation. Group homes consist of six to eight individuals and staff encourage individuals to maintain a normal household and assist them in taking care of their personal needs. Large facilities cater to a greater number of people (35 or more) and are sometimes operated for the state in which it is located. The facility has a homelike atmosphere and the staff stress the individuality and right to choice of each person. Vocational day programs enable individuals to have a more active role in the community by providing training to gain employment and interact with their peers. Job Corps is a residential, educational, and training program for unemployed and uneducated youth (16-24) and is a part of US Department of Labor (ResCare website). The Division of Youth Services provides a broad range of services to at-risk youth including juveniles in the justice system, youth no longer able to live in the home, disadvantaged youth, and children with developmental disabilities (Rescare website).

**Consumer Demographics and Research:**

As stated above, the company provides a wide variety of services to many populations. The focus of this paper is consumers with mental retardation and mental illness; however, demographic data is currently being compiled into the company database so the following statistics are not holistic or representative of the entire population served or the
population of interest (Weishaar 11/22/02). In the past, the information was at the operational level and demographic data for the entire company is not available at this time, nor is a complete demographic analysis. From the Consumer Demographics Database in the Old Central Region (Kentucky, Indiana, Illinois) is a sample breakdown of 1,877 consumers' ages:

<table>
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<th>Age Range</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;20</td>
<td>4%</td>
<td>72</td>
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<tr>
<td>31-40</td>
<td>14%</td>
<td>269</td>
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<td>41-50</td>
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<td>16%</td>
<td>300</td>
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<tr>
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<td>8%</td>
<td>154</td>
</tr>
<tr>
<td>71+</td>
<td>9%</td>
<td>174</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>1877</td>
</tr>
</tbody>
</table>

Included with this paper is a copy of the consumer profile, the intake assessment used to gather this data. As previously stated, the information is gathered at the time of intake and is updated by staff at the operational level, and will be the individual operation’s responsibility to maintain the database (Weishaar 11/22/02). The data collection is performed internally and many of the individuals have been referred by the state, and their records are voluminous. The software currently utilized is an ACCESS database formulated by ResCare staff, and they are going to be transferring that information into a new software package HCS, a statistical package designed to keep track of consumers, billing issues, determine cost of services, incident management (determining which
clients are more at risk for certain incidents and injuries), and insurance
claims/information (Weishaar 12/1/02).

The information provided in the previous population assessment can serve as a
supplement for the lack of data available from ResCare, Inc.

The company evaluates the effectiveness of their services through the Support Services
Department, which is divided into three main categories: Quality Management and
Assurance, Customer Satisfaction, and Employee Training. Surveys are administered to
consumers, their families/guardians, advocates and others regarding satisfaction with
services, wants and needs. Individuals’ progress reaching their potential is monitored
through individual support plans (ISPs) and are evaluated and updated by the program
director of each site.

One of the important values of social work is confidentiality (NASW Code of Ethics).
The same value holds tremendous importance in service delivery to this population.

ResCare has extensive policy and procedures to ensure that this right to privacy is not
violated. Data entered into this database would be restricted to trained staff and the
information gathered would be used for the sole purpose of enhancing the quality of
services provided to consumers by ResCare (ResCare HR Policy Manual). In conducting
research with this company, it would be extremely important to respect the
confidentiality of the consumers and insure that the consumers are not victim to any
abuse/exploitation inadvertently in the process.
Identification of Practice Problem:

A major practice problem of this company and others serving this population is the high rate of employee turnover. In a recent survey of Medicaid agencies and State Units on Aging found that 42 out of 50 states found hiring and maintaining adequate number of direct care associates was a “major issue” (Bratesman 12/8/00). Annual turnover rates for direct care aides vary anywhere from 40-100 % (Bratesman 12/8/00). Possible causes of this issue are: low wages, lack of benefits, difficult working conditions, limited opportunities for career advancement, and competition from other fields of work (Bratesman 12/8/00). An issue mentioned above, advocacy, is affected by this. Consumers often need help insuring that their needs are met and it is the duty of direct care staff to aid them in their quest. These individuals have been isolated and kept away from mainstream society in institutions and primary social contact is limited to their fellow housemates, co-workers (at workshop), and the staff that aid them in their daily living. The constant string of new direct care staff assisting the individual would be unfamiliar to the individual, their needs, level of functioning, and ultimately, they may fail to notice and report a major problem with the consumer or even possibly hinder reaching their full potential (Bratesman 12/8/00). The high turnover rates make it difficult for consumers to trust direct care staff and for direct care staff to feel comfortable and knowledgeable enough to advocate on behalf of the consumer. Not only are high turnover rates detrimental to the well being of the consumers, it depletes needed funds from agencies providing these services (RTC Rural website).

In the past, staff turnover in direct care was associated with employee “burnout” (Razza pp 284). However, a more likely cause would be a correlation between a number of
factors such as: poor working conditions, lack of benefits, personality conflicts, inadequate training, etc (Razza pp 286). Many state governments and the federal government have been designing policies directed at improving working conditions, benefits, and wages for direct care staff.

Although an exact statistic for employee turnover is unknown: this problem exists at ResCare and has been disruptive to the well being of the individuals this writer serves with direct care in a group home setting.

As seen in the sampling of demographic data, most of the individuals served by ResCare’s Division for Persons with Disabilities are older and previously lived in state institutions. The social isolation makes this population easily overlooked. Depending upon the severity of the intellectual disability, the individual may or may not be able to advocate effectively on their behalf. For those in group homes, facilities, and supported living situations, it is the duty of direct care staff to advocate on the individual’s behalf in situations on a daily basis: at the doctor’s office, in the home, in government policy, and within the services system they utilize.

**Plans in Action:**

In Maine, there are a number of plans in action to combat the problem (Bratesman 12/8/00). Maine and fourteen other states have initiated “wage pass-throughs”, meaning the legislature passed a bill for a $.50 cent/per/hour wage increase, improving the wages by 7% in the average hourly wage (Bratesman 12/8/00). To address the issue of limited career advancement, Maine has introduced initiatives to create a “ladder” to allow for promotions and greater wages and responsibilities of direct care staff (Bratesman
Maine also initiated a cross-training/cross-certification plan allowing individuals to be certified in multiple fields, allowing for more flexibility in their career choices (Bratesman 12/8/00).

Currently, there is legislation pending in US Congress regarding the crisis of finding and maintaining adequate direct care support staff in long term care facilities (ResCare Website). Titled the “Direct Support Recognition Act”, the legislation states that the federal government and states “should make it a priority to ensure a stable, quality support workforce for individuals with mental retardation or other developmental disabilities that advance our nation’s commitment to community integration for such individuals and to personal security for them and their families.” The resolution calls for increased funding for wages of direct care staff and improved benefits (ResCare press release). This resolution does little to address recruiting and training needs and does not allot an increased amount of funds, but does demand increased acknowledgement of direct support workers and respect for the work that they do.

ResCare itself has formulated a plan of action, directed at improving the quality of services they provide to consumers. There are CITA awards available for staff to give to each other, thanking them or congratulating them on a job well done, and Team Member of the Month awards, which give direct care staff the privilege of knowing that their work is respected and appreciated. Team members from other houses do evaluations of each other, letting direct care staff know of any potential issues they see, and good things that they recognize. There is also the opportunity to take on more responsibility and establish a growing career at ResCare, in a hierarchy of positions catered to experience as well as education. One area that is this writer sees as lacking is in recruitment and training of
direct support personnel. Most of the care for individuals in group homes is provided by associates with limited education regarding the issues individuals with mental retardation face. Outreach programs and seminars should be given to keep associates up to date, knowing what progress has been made, current issues and ultimately, where community resources are located.

**Relevance to Social Work:**

The NASW Code of Ethics states that it is “the primary mission of the social work profession to enhance human well-being and empowerment of people who are vulnerable, oppressed, and living in poverty” (NASW Code of Ethics). Individuals with mental retardation are one of the most vulnerable populations, due to their social history and related stigma, lack of human relationships and support networks, ability/inability to communicate their needs and wants. The current issue of employee turnover in direct support care for these individuals should be of extreme importance to the social work profession because of the possible neglect inflicted upon the vulnerable population by inadequate services provided by disenfranchised direct support staff.

Advocacy is a key component of the social work profession. Social workers are needed in the fight for social justice within this population and this can be achieved through a number of advocacy techniques. Case advocacy is the work with individuals, class advocacy is working for a larger population or group of individuals, and the ultimate goal is for the ability for the individuals to be effective self-advocates, collaborating with social workers to be heard (Hepworth, Rooney, & Larsen pp 452-453). The Support Associate or other direct care provider, is the ultimate link to effective advocacy on
behalf of individuals with mental retardation. Social workers must tap into this resource and share their knowledge with direct care staff, through training effective advocacy skills. Also, social workers can find a kindred spirit in direct support staff, due to being underpaid, under-respected, and the history of fighting for recognition for themselves and the people they serve.

**Research Plan:**

First and foremost, this writer does not believe that this issue can be addressed by using one research method. Secondary data analysis, the use of data collected in previous studies and not by the present analyst, will be useful in establishing a hypothesis for ResCare's problem with direct care staff turnover rates (Graves, IUPUI Online library).

**Research Hypothesis #1:**

The existence of certain variables (low wages, lack of training, poor recruitment efforts, lack of recognition, and difficult working conditions) directly increases the rate of turnover among support associates at ResCare, Inc.

It would then be beneficial to administer a survey to former and current ResCare employees asking them a series of questions regarding their time spent with the company. Sample questions could include:

Do you feel your rate of pay is/was adequate for your position?

Do you feel you were prepared for your position in training?

**If not, what could/should have been covered?**

How did/do you feel about your supervisor?

**Are they available when needed?
**Helpful in solving problems?**

**Overbearing?**

Did you receive proper recognition for a job well done?

The data would be collected by telephone, with Quality Management Team at the regional level making the calls. This method of collection would yield the most replies, whereas a written, mailed survey would not have as good return rate. Factor analysis, the technique based on how well factors are related to one another, would be the test analysis best suited to this research question (Salkind, 270). Hopefully, a pattern between variables will emerge, without one particular variable being the sole cause of the employee turnover rates.

Already in past research, it has been shown that a number of variables cause high turnover rates among direct support professionals across the country, but it is important to include that past research in formulating a new, specialized research plan for ResCare.

As previously stated, this writer recognizes an issue in recruiting Support Associates. A possible way to analyze the importance of this problem would be to formulate a survey research plan to record recruitment efforts on the part of ResCare, Inc. This survey would be administered in the beginning of employment and kept as a part of the employee’s file in Human Resources and maintained/updated as their career with the company progresses. Further analyzation would incorporate job satisfaction rates in correlation to job referral.

*Research Hypothesis #2*
Part 1: Support Associates recruited through employment agencies, career services at universities, employee referrals, and guidance services in high schools will have lower turnover rates than Support Associates referred by advertisements in newspapers.

Part 2: Support Associates recruited through employment agencies, career services at universities, employee referrals, and guidance services in high schools will have higher job satisfaction rates than Support Associates referred by advertisements in newspapers.

Sample survey questions:

How were you referred to this agency?

a. Employment agency          c. Guidance counselor          e. Other ________

b. Referral from employee      d. Advertisement

How does this job fit in with your personal morals and values? (Razza, pp 285-287)

What are your future expectations regarding your position? (Razza, pp 285-287)

Are you satisfied with your current rate of pay? (Razza, pp 285-287)

Are there opportunities for advancement for you within the agency? (Razza, pp 285-287)

The survey would be done at the regional level, and information kept in the Human Resource database. The Quality Management Team would perform data collection.

ResCare sends new employees to the regional office location to receive training on state standards regarding health issues, First Aid training, CPR certification training, and Anger Management and Self Defense techniques training; however, staff may not feel completely comfortable with their knowledge in these areas. Following training, the employee undergoes a period of job shadowing with a co-worker who has been a direct care provider for a certain amount of time (writer’s personal experience). Following that
period, the new employee is on a probationary type status for the first 3 months of employment.

Participant observation, observations made by non-participants who do not significantly interact with participants, and focus groups, “designed to obtain perceptions on a particular area of interest...” to add depth to the observations made in the participant observation data collection (UCLA Qualitative Tools for MultiMethod Research website). The non-participant data collectors would be peers (home supervisors, direct care staff from other homes) and Quality Management staff. For the focus group, the observers would discuss ideas for additional training to keep direct care staff up-to-date and assisting consumers effectively.

Summary:

Individuals with mental retardation and other developmental disabilities suffer a number of social issues inflicted upon them by past treatment and isolation. This project was a tremendous learning experience. One thing I really had a problem with was that from my personal experience with the company, I had all kinds of ideas regarding issues/problems associated with the application of services within the company. The difficult part was finding one particular problem that had previously been researched and recorded and applying that in my own format for analysis: basically, figuring out how to prove the issue really was a problem. It was very frustrating! Another thing I realized in my research is that many of the methods were applicable, but it was difficult to choose the best methodology to serve my purpose, so I applied several different methods for a more comprehensive approach to the problem (in the process confusing myself!).
I have acquired a great respect for agencies and professionals who rely upon data collected and analyzed, which is necessary to keep agencies up and running. One of the major problems I encountered was finding the information necessary to do this assignment from the agency. After many referrals and delays, I got the basic information included in this paper. Also, I noticed was that many individuals were not aware of the research and analysis part of operating an agency/company. Everyone was more than willing to help me, and I am thankful for their support in this project!
References:


Ball State University Social responsibility class (n.d.): *Camp Isanogel.* Retrieved 9/20/02 from website: http://www.isanogelcenter.org/.


Weishaar, L. Vice President for Support Services. Email correspondence. 11/22/02, 12/2/02.


# ResCare Consumer Profile

<table>
<thead>
<tr>
<th>Operation:</th>
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<table>
<thead>
<tr>
<th>Last Name:</th>
<th>Admission Date:</th>
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<tbody>
<tr>
<td>First Name:</td>
<td>Discharge Date:</td>
</tr>
<tr>
<td>Address:</td>
<td>Medicaid #:</td>
</tr>
<tr>
<td>City:</td>
<td>Medicare #:</td>
</tr>
<tr>
<td>State:</td>
<td>Social Security #:</td>
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<tr>
<td>Zip Code:</td>
<td>Other Benefits:</td>
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<table>
<thead>
<tr>
<th>Date of Birth:</th>
<th>Weight:</th>
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<tbody>
<tr>
<td>(mm/dd/yyyy)</td>
<td>Age:</td>
</tr>
<tr>
<td></td>
<td>Hair Color:</td>
</tr>
<tr>
<td></td>
<td>Gender:</td>
</tr>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>Race:</td>
<td>Caucasian</td>
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<tr>
<td>Height:</td>
<td>Ft.</td>
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<tr>
<td>Marital Status:</td>
<td>Married</td>
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<tr>
<td>Identifying Marks:</td>
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<table>
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<tr>
<th>Allergies:</th>
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</table>

<table>
<thead>
<tr>
<th>Primary Language:</th>
<th>English</th>
<th>Spanish</th>
<th>Other</th>
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<table>
<thead>
<tr>
<th>Guardian Status:</th>
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<tbody>
<tr>
<td>Guardian Name:</td>
</tr>
<tr>
<td>Guardian Address:</td>
</tr>
<tr>
<td>Guardian City:</td>
</tr>
<tr>
<td>Guardian State:</td>
</tr>
<tr>
<td>Guardian Zip Code:</td>
</tr>
<tr>
<td>Guardian Phone #:</td>
</tr>
<tr>
<td>Case Manager:</td>
</tr>
<tr>
<td>Case Mgr’s phone #:</td>
</tr>
<tr>
<td>Advocate:</td>
</tr>
<tr>
<td>Advocate’s phone #:</td>
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</table>

<table>
<thead>
<tr>
<th>Burial Plan Info:</th>
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</table>

### Services Provided: (Check all that apply)

- GH-Waiver
- GH-ICF/MR
- Large-ICF/MR
- Private Contract
- Respite
- Supported Living
- Foster Care/Host
- Periodic In Home
- Supported Employment
- Competitive Employment
- Sheltered Workshop
- Support Coordination
- Other: _______
<table>
<thead>
<tr>
<th><strong>Level of MR</strong></th>
<th>□ Mild □ Moderate □ Severe □ Profound □ MR/MH</th>
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</thead>
<tbody>
<tr>
<td><strong>Mental Health Diagnosis:</strong></td>
<td>□ No □ Yes Specify: ___________________________</td>
</tr>
<tr>
<td><strong>Adaptive Level:</strong></td>
<td>□ Mild □ Moderate □ Severe □ Profound □ No Level Indicated</td>
</tr>
<tr>
<td><strong>Ambulatory Status:</strong></td>
<td>□ Ambulatory □ Ambulatory w/ Devices</td>
</tr>
<tr>
<td></td>
<td>□ Non-Ambulatory - Mobile □ Non-Ambulatory - Non-Mobile</td>
</tr>
<tr>
<td><strong>Communications:</strong></td>
<td>□ Verbal □ Communicates with Device □ Communicates with signs</td>
</tr>
<tr>
<td></td>
<td>□ Communicates with gestures □ Non-verbal</td>
</tr>
<tr>
<td><strong>Mealtime Status:</strong></td>
<td>□ Eats Independently (with or without adaptive equipment) □ Requires Support to Eat</td>
</tr>
<tr>
<td></td>
<td>□ Requires Physical Assistance/Equipment □ Requires Positioning Equipment</td>
</tr>
<tr>
<td><strong>Food Texture:</strong></td>
<td>□ Food eaten at normal consistency</td>
</tr>
<tr>
<td></td>
<td>□ Food consistency altered - □ Chopped □ Ground □ Puree □ Uses Thickener</td>
</tr>
<tr>
<td><strong>Toileting:</strong></td>
<td>□ Toilets Independently □ Requires Physical Assistance/Equipment</td>
</tr>
<tr>
<td></td>
<td>□ Scheduled Bowel Program □ Scheduled Bladder Program</td>
</tr>
<tr>
<td></td>
<td>□ Requires Prompts/Monitoring □ Incontinent/Requires Disposable Briefs</td>
</tr>
<tr>
<td><strong>Bathing:</strong></td>
<td>□ Independent □ Requires Support to Bath/Shower</td>
</tr>
<tr>
<td></td>
<td>□ Independent with Devices</td>
</tr>
</tbody>
</table>

**Related Conditions:** (Check all that apply)
- □ Autism
- □ Dementia
- □ Marfan's Syndrome
- □ Arthritis
- □ Down Syndrome
- □ Scoliosis
- □ Blind
- □ Epilepsy Controlled
- □ Tourette's
- □ Cerebral Palsy
- □ Epilepsy Uncontrolled
- □ Traumatic Brain Injury
- □ Congenital Hip Dislocation
- □ G.E.R.D.
- □ Tuberous Sclerosis
- □ Chronic Hip Dislocation
- □ Hearing Impaired
- □ Other
- □ Chronic Otitis Media
- □ Hydro Cephalus
### Health Concerns: (Check all that apply)

- [ ] Hepatitis B
- [ ] Cancer
- [ ] Chronic Constipation
- [ ] Colostomy, Urostomy
- [ ] Congenital Heart Defect
- [ ] Daily Respiratory Treatments
- [ ] Decubitus Ulcers
- [ ] Hepatitis C
- [ ] Indwelling Foley Catheter
- [ ] Psychotropic Meds Prescribed
- [ ] Req. Daily Catheterizations
- [ ] Req. Routine Positioning
- [ ] Diabetes/Insulin Dependent
- [ ] Diabetes/Non-Insulin Dependent
- [ ] Kidney Dialysis
- [ ] Osteoporosis
- [ ] Psychotropic Meds Prescribed
- [ ] Req. Daily Catheterizations
- [ ] Req. Routine Positioning
- [ ] Tube Feedings

### Behavior Concerns: (Check all that apply)

- [ ] Self Injurious
- [ ] Flight Threat
- [ ] Intermittent Explosive Disorder
- [ ] Aggression Towards Others
- [ ] Aggression Towards Property
- [ ] Sexual Perpetrator
- [ ] Other: __________________________

### Other Medical Complexities:

<table>
<thead>
<tr>
<th>Other Medical Complexities:</th>
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### Other Notable Information:

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<tr>
<th>Other Notable Information:</th>
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Signature of Person Completing Form __________________________  Date ____________

Demographics Form - revised 6/27/02