A REVIEW OF CURRENT INFORMATION ABOUT THE CAREERS OF THE DIRECT SUPPORT PROFESSIONAL WORKFORCE IN THE MENTAL HEALTH, DEVELOPMENTAL DISABILITIES, AND SUBSTANCE ABUSE SERVICE DELIVERY SYSTEMS

A REPORT FROM

The Southeastern Pennsylvania Behavioral Health Industry Partnership

OCTOBER 2007

by

Richard C. Baron

UPenn Collaborative on Community Integration

Department of Psychiatry – University of Pennsylvania

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Table of Contents

Executive Summary 1

Findings 2

Introduction 5

The Contours of the Direct Support Professional Workforce 8

- Finding 1: Demographic Composition of the Workforce 8
- Finding 2: Roles and Responsibilities of the Workforce 11
- Finding 3: Wages, Benefits and Economic Opportunities 13
- Finding 4: Turnover Rates, Impact and Response 14
- Finding 5: Research Needs: Existing Career Paths 16
- Finding 6: Career Development Opportunities in the Field 17

The Challenges of Building Career Paths 17

- Finding 7: Current Direct Support Professional Training 18
- Finding 8: Defining Direct Support Professional Competencies 20
- Finding 9: Accessible, Affordable and Accommodating Training 23
- Finding 10: Developing Academic Credentials for the Workforce 25
- Finding 11: Improving Wages, Benefits, and Economic Opportunities 28
- Finding 12: Research Needs: Demonstrating Training Outcomes 29

Investing in the Direct Support Professionals: A Vision Statement 32

References 34

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Cheryl Feldman
October 2007

Executive Summary

At the heart of this report is an enduring respect for the women and men of the direct support professional workforce in the mental health, developmental disabilities, and substance abuse (MH/DD/SA) service delivery systems. While some provide hands-on assistance and others facilitate independent functioning, with some working in hospitals and others in community settings, under either close or distant supervision, *all* are relied upon by the programs that employ them to display a high degree of competence and compassion in their ongoing and intimate relationships with the people they assist.

Nonetheless, the direct support professional workforce is rarely recognized as a critically important profession, nor are individual workers respected and rewarded as they deserve. Although there is accumulating evidence that a better trained, recognized, and financially compensated direct support professional workforce can increase the quality of care that is offered to consumers and decrease the costs associated with job turnover and vacancies in the field, those who work in the field are often neglected. There is growing unease about the current state of affairs: consumers are concerned that poorly trained staff and rapid staff changes limit the ability of the workforce to be genuinely effective, and both public and private service agencies bear substantial costs when job turnover and staff vacancies are continuing problems. Workers in this field are dissatisfied as well, both with the lack of respect they receive within the helping professions and with the low rates of pay, inadequate benefits, and limited career opportunities available to them.

The Southeastern Pennsylvania Behavioral Health Industry Partnership was born out of these concerns. The Partnership was established under a grant from the Pennsylvania Department of Labor and Industry and coordinated by the District 1199C Training and Upgrading Fund, a labor management educational trust of the National Union of Hospital and Health Care Employees (AFSCME) and 50 Delaware Valley healthcare employers. The Partnership seeks to explore opportunities for establishing more effective and rewarding career paths for the direct support professional workforce, particularly in Pennsylvania.

This report, commissioned by The Partnership, was designed to provide its members with a current update on the status of the workforce, and answer two overarching questions: first, what do we know about the current workforce — its demographic composition, the responsibilities of its workers, and the working conditions under which they labor? And, second, what are the prospects — and requirements — for developing more effective career paths for this critical sector of the MH/DD/SA service delivery system? The report draws upon the published literature as well as individual interviews and focus groups with key administrators, consumers, and workers in the field. While not exhaustive, the report captures the major issues and most significant challenges ahead, and can be used to broaden the discussion and establish a meaningful agenda for change.

Findings

Finding 1. The MH/DD/SA direct support professional workforce is sizable, diverse, unique to each system of care, and likely to find jobs in the expanding long-term care field equally attractive. Although definitive data on the workforce remain elusive, best estimates suggest there are approximately a million people nationally in the direct support professional MH/DD/SA workforce. It is a diverse group. Women comprise about 80% of the workforce. Most workers are white, although the local workforce reflects the ethnic and economic realities of its community. Educational levels vary as well, for while the great majority of workers have "some college" credits, there are some who have not gone beyond high school and others with bachelor's degrees. Most observers in the field expect their recruitment of new workers to be increasingly challenged in the years ahead by the rapidly expanding field of long-term care for the elderly, which draws upon the same portion of the U.S. labor market.

Finding 2. The roles and responsibilities of the MH/DD/SA direct support professional are increasingly demanding: regardless of job title, most workers are asked to provide both direct care and/or rehabilitation supports. A common theme in the literature has been the expanding responsibilities of the direct support professional. Workers were once limited to hands-on tasks (helping consumers with dressing, eating and exercise, or providing fundamental supervision in a variety of hospital and community settings), but are now asked to play rehabilitative roles as well: to encourage consumer independence and empowerment, to facilitate group sessions or participate in case conferences, and to reflect the prevailing values of these consumer-centered human service environments. Although job titles vary widely, most direct support professionals are expected — as one worker interview for this study phrased it — "to deliver master's level care for high school diploma salaries."

Finding 3. MH/DD/SA direct support professional wages remain low, often below the poverty level for a family of four, with few opportunities for significant raises over time. A wide range of national and state studies agree: direct support professionals in community programs average $8 - $9 an hour and those in institutional settings average $14 - $16 an hour. Although healthcare and other benefits in most settings are considered adequate, wages for many direct support professionals in community programs may be below the federal poverty guidelines for a family of four. Wages in both settings are generally flat: an experienced and long-time direct support professional is often making only marginally more than an inexperienced newly hired worker, and occasional across-the-board raises and new-program-wage increases are generally eroded over time without substantial annual cost-of-living and tenure raises.

Finding 4. Staff turnover within the MH/DD/SA direct support professional workforce is high, driven by low wages, attenuated career paths, little professional regard, and better economic opportunities in other labor markets. Turnover within the direct support professional workforce is quite high, with reports varying from 40% to 90% annually. It should be noted that institutional programs — with higher pay rates and more opportunities for internal career advancement — report significantly lower staff turnover rates. But the prob-

lem remains ubiquitous in the field. Many agencies report that a good deal of administrative time and money is spent managing ongoing recruitment for new staff, covering persistent vacancies in some areas, and compensating for the problems of staff hired despite the lack of suitability. More importantly, the quality of care — in settings in which the strength of the relationship between staff and consumer can be critical — is eroded by rapid turnover in these basic staff positions.

Finding 5. There are no reliable data on natural career paths for the MH/DD/SA workforce. The field has little information on how individuals enter, change roles within, and leave (and/or return) to the workforce. There is a scarcity of data on the natural career paths of the workforce: the field knows very little about how or why new workers enter the field, how people feel about their jobs and why they leave the field, nor about where they go. It is unclear whether turnover rates reflect worker movement out of human services to the commercial sector or lateral moves to other MH/DD/SA agencies or to other human services systems.

Finding 6. There are no formal career paths that provide an opportunity for the MH/DD/SA direct support professional workforce to demonstrate increasing competency and receive appropriate professional recognition and economic rewards. Very few MH/DD/SA employers of direct support professionals have structured any meaningful internal career paths for this workforce; nor is there either a regional or a national structure that suggests to incoming workers that they can shape a rewarding and progressive career for themselves rather than simply accept what for many may be only another in a string of short-term and dead-end jobs. To the extent that a career path does exist, it is often no more than one or two steps high, with the level of supervisor often the limit of what a direct support professional can achieve without attaining additional academic credentials.

Finding 7. Current training for the MH/DD/SA direct support professional workforce is minimal — a patchwork of initial orientation and continuing education programs that are neither comprehensive nor focused on career development. The current training offered to direct support professionals in the field is widely considered to be only a patchwork of individual programs of little lasting value. Requirements for entry into the field are often minimal (e.g., a GED and twelve college credits are required by Philadelphia's Community Behavioral Health program in some mental health settings); orientation training for new workers is rudimentary and often focused on prescribed topics on basic issues (e.g., cardiopulmonary resuscitation [CPR], confidentiality, restraints, etc.); and ongoing training — while widely available from a variety of public and private programs — is rarely part of a comprehensive training agenda or representative of current knowledge in the field.

Finding 8. Although the competencies required of the MH/DD/SA direct support professional have now been well-defined, no national standard has been established across fields to provide a widely recognized credential for workers. A number of excellent statements of competencies exist in each of the MH, DD, and SA fields, although no national standards nor widely recognized training programs in those competencies have been firmly established for the direct support professional workforce. Despite the availability of competency statements, competency-based training programs, and certification processes for those who complete training, direct support professionals do not, in general, have access to a formal credentialing process that has meaning to current and future employers, leading to career advancement or wage increases.

Finding 9. To be effective, training for strongly motivated direct support professionals must utilize more interactive, long-term approaches and rely on the commitment of employers to respond to the unique needs of adult learners. Effective training programs in the field must respond to the well-documented demands of adult learners. Orientation training and continuing education programs for the direct service professional seek to engage learners with work and family responsibilities. Therefore, the training offered must not only be focused on key competencies and relevant to current work demands but also flexible. While the workers must have a strong commitment to the learning process, employers must insure that the training is accessible, affordable, and accommodating to their adult workforce.

Finding 10. Effective career pathways for the MH/DD/SA direct support professional workforce link training achievements to academic credentials for a wide range of the workforce. Although current training providers in the field often offer certificates of completion and diplomas certifying competencies, very few offer the academic credentials that remain the keys to career advancement. There are a small number of one-year certificate programs and two-year associate's programs in the field offering academic recognition (and that can be used in moving toward bachelor's degrees and beyond); but the development of career pathways is stymied by the scarcity of accessible, affordable, and accommodating academic credentialing for workers.

Finding 11. Low wages and flat salary structures not only limit the ability of the field to recruit and retain a more competent and compassionate workforce, but also decrease worker interest in their own professional development. Low wages and flat salary structures play a key role in staff turnover and staff dissatisfaction. Although such extrinsic factors are somewhat balanced by the intrinsic value of engagement in a field of work that many enjoy or may feel is their "calling," the development of career pathways — with training, enhancements in job responsibilities, and credentialing in place — must be accompanied by commensurate raises in wages and benefits for the direct support professional workforce to emerge as a central partner in the MH/DD/SA fields.

Finding 12. The literature on the benefits of improved training and expanded career pathways for the MH/DD/SA workforce currently only suggests, but does not yet fully demonstrate, the advantages of a new approach. Current small studies only suggest, but do not yet provide compelling evidence, that an investment in the development of a comprehensive career pathway for the MH/DD/SA direct support professional workforce will have substantial benefits. But more research is needed to demonstrate that training and career development will improve the quality of care delivered to consumers, decrease the costs associated with rapid turnover and persistent vacancies, and improve the commitment of workers to the field. Knowing more about the current workforce and existing career paths, as well as about the impacts of career paths on the field, will help frame future career investments.

Moving Forward

Over the past two years, The Partnership has worked to develop a sustaining vision of the core elements of the "career path" approach to the MH/DD/SA direct support professional workforce. At the center of this vision is the building of a front-line workforce with the professional commitment and human compassion that many current direct support professionals already demonstrate on a regular basis. However, the vision presented here goes further, outlining a common set of goals for a new and more productive approach to the direct support professional's career development.

The Partnership believes that a workforce development system better geared to the future needs to be oriented around five core values:

- **careers** – No one should enter the field without a sense that there is an abundant opportunity for each person to develop a career, rather than only to serve time in a short-term or dead-end job, with a measure of consistent support designed to encourage professional upgrading throughout the years.

- **competency** – One of the core supports offered to the direct support workforce must be competency-based training, focusing on current knowledge, new and/or evolving approaches, and — most of all — the day-to-day requirements of the job, developing both generic direct support skills and more targeted competencies for specific job roles.

- **commitment** – Career development is a cooperative venture between the employee and his/her employer, in which employers must offer robust training supports (e.g., release time, on-the-job training and assessment opportunities, enhanced supervision, and financial assistance) that are key elements in training for adult learners.

- **certification** – All training should be seen as part of a broader certification process — related to licensing or the award of a formal academic degree — providing direct support workers with a permanent, transferable recognition of their status applicable to other MH/DD/SA jobs and other human service settings.

- **compensation** – Increased competencies, improved on-the-job performance, and extended job tenure must be recognized not only by new titles and broader on-the-job responsibilities, but — most critically — with appropriate increases in wages and benefits.

For such a workforce development system to evolve it will require much new work in the field, and The Partnership recognizes that this is likely to be a long-term process. Every profession has faced similar challenges, and the road to more widespread recognition has taken each profession considerable time and a considerable financial investment (Wilson, May 2006). However, failure to move forward promises another generation of workers who either make unreasonable sacrifices to continue to work with the consumers they are committed to or who simply give up and move on. We owe consumers, and we owe the direct support professional workforce engaged with them every day, much more.

Introduction

At the heart of this report is an enduring respect for the men and women of the direct support professional workforce in the mental health, developmental disabilities, and substance abuse fields. This report represents an initial commitment to insure that members of this critically important workforce receive both the professional regard and the economic reward they deserve. It seeks to define and support career paths for direct support professionals that implicitly acknowledge their developing competencies and that raise their wages accordingly. There is accumulating evidence that a better trained and better compensated direct support professional workforce will both improve the quality of care and lower provider costs associated with staff turnover and recruitment. But creating and encouraging career paths not only promises better consumer outcomes at more affordable costs, it offers oft-neglected direct support professionals real recognition of their value.

Background. The direct support professionals that are the focus of this report are, most often, both non-degreed and unlicensed, working in the tremendously demanding fields of mental health,

developmental disabilities, or substance abuse services. They may be in either hospital settings or community programs, working as state employees or with nonprofit providers, and carrying responsibilities within clinical settings, residential programs, employment services, or any of many other treatment and rehabilitation programs. Their work is sometimes individual hands-on work and sometimes primarily focused on group interactions, often routine but sometimes exceptionally demanding, and is completed with either close or informal oversight. What is generally true, however, is the degree to which direct support professionals frequently have intimate and intensive relationships with the consumers they serve, spending most of their days working closely with and for consumers. The various service systems that employ direct support professionals rely upon both their competence and their compassion.

Nevertheless, this significant portion of the workforce has rarely been the focus of concerted attention. Despite the fact that their work remains as demanding as ever and pay scales continue to be low and flat, there has been too little effort to comprehensively address the growing concerns — among consumers, providers, and the direct support professional workforce itself — about what many now see as a troubled arena. Consumers, along with their family members, express concern that untrained direct support workers, and the rapid turnover among them, impacts the quality of care (Test, 2003): those without the most fundamental skills or a rough familiarity with innovative approaches cannot deliver the quality of services consumers now demand (J. Rogers, Rogers, S., 2003). Similarly, provider agencies recognize that unprepared direct support workers may impact their financial bottom line, through both the increased costs associated with high turnover rates and the awareness of the ". . . growing evidence that education and training have an impact on worker productivity" (Uhalde, 2003).

Many direct support professionals feel discouraged and disaffected, in part because ". . . their work has been largely unacknowledged and there is a general lack of understanding about their contribution to patient care" (Spilsbury, 2004). Despite occasional pay increases (in Pennsylvania and elsewhere), and generic training mandates, direct support professionals are often left to their own devices in developing competencies and framing a career for themselves. The Southeastern Pennsylvania Behavioral Health Industry Partnership, established under a grant from the Pennsylvania Department of Labor and Industry in 2005, was developed to take the first steps in designing and implementing a career ladder for the direct support professional workforce, initially for workers in Southeastern Pennsylvania but ultimately for the Commonwealth as a whole. The Partnership was coordinated by the District 1199C Training and Upgrading Fund, a labor-management educational trust fund of 50 contributing employers and the National Union of Hospital & Health Care Employees (AFSCME, AFL-CIO). The Partnership drew together representatives of government, nonprofit providers of services, unions, consumer groups, employers, and direct support professionals to carefully examine the current state of affairs and assess the best strategies for moving forward. A Partnership participant list can be found in the Acknowledgements found at the beginning of this report.

To help them move forward, The Partnership commissioned this report as a way to better understand the current composition and status of the direct support professional workforce in the mental health, developmental disabilities, and substance abuse (MH/DD/SA) fields; learn more about the challenges of defining and creating career ladders

where none had existed before; and articulate initial next steps. This report draws on a variety of informational sources: the published literature on workforce issues in the MH/DD/SA arenas; monographs and position papers from labor, advocacy, and professional organizations; interviews with system administrators and program directors; discussions with leaders in the mental health consumer movement; and focus groups with direct support professionals themselves. We believe that the report, while not exhaustive, captures the major issues and most significant challenges ahead. It is offered less as a definitive statement of the direct support professional field and more as a base of information and observation that can generate further discussion and debate.

The Issues in Perspective. The specific "findings" of this report — there are a dozen of them, summarizing both the available data and expert opinions in the field — are best understood within a broader perspective. Four key issues should be noted:

- **The problems confronting the direct support professional workforce are not new.** There has always been a sharp division within these fields between those with formal professional degrees and those without such training, as well as clear distinctions — in responsibilities, pay, professional regard, and social status — between those providing treatment and/or rehabilitation services and those providing direct support. What is new, however, are two emerging realities. First, there has been a gradual increase in treatment and/or rehabilitation responsibilities (once considered the exclusive domain of degreed personnel) assigned to direct support workers — or, as one member of a focus group expressed it, "a demand for master's level skills for high school salaries." Second, the recruitment of direct support workers into the MH/DD/SA fields will face increasing competition from the explosive growth anticipated in the long-term care field serving older adults and those with physical disabilities. Drawing on the same segment of the labor force, long-term care may heighten the problems providers face in finding and retaining workers who are competent and compassionate (Health Workforce Solutions, 2005).

- **The problems confronting the direct support professional workforce are not unique.** There have long been concerns about the adequacy of preparation and subsequent competence of other professional elements within the MH/DD/SA workforce. A recent report reviewing workforce issues in the mental health field (The Annapolis Coalition, 2006) focused primarily on the mental health core professions — psychiatry, psychology, social work, psychiatric nursing, counseling, marriage and family therapy, psychosocial rehabilitation, school psychology, and pastoral counseling — and reported widespread concerns about the inadequacy and variability of professional training, the irrelevant and out-of-date preparation received in both pre-service and in-service training programs, the crisis in compensation (when compared to other professional fields), and the relevance of professional training to required on-the-job competencies. Indeed, the entire human services arena struggles to balance the need for a skilled workforce with increasingly limited funding for services.

- **There are few safe generalizations about the MH/DD/SA workforce: it is and will remain diverse.** Generalizations in this arena are inherently unwise, for several reasons. First, the mental health, developmental disability, and substance abuse systems are often quite different from one another, especially with regard to direct support professional issues. The numbers of people in each workforce, the roles that they play, and their relationships to other professionals differ from field to field. Second, the direct support professional workforce within each field is quite diverse along even the most basic dimensions. Educational levels, work responsibilities, and job tenure in each field stretch along a continuum, suggesting that no single approach to career lad-

ders will likely meet the needs of everyone in the field. Finally, innovative workforce developments in one field — such as the emphasis on "peer specialists" within the mental health arena (Institute for Recovery and Community Integration, 1999) — may have no parallel in other fields; and there are few standardized job descriptions or compensation packages that stretch across the MH/DD/SA fields.

- **There is only a patchwork of data with which one can begin to grasp the contours of the field.** The collection and analysis of workforce data in the MH/DD/SA field are rudimentary at best. This is an issue as critical to workforce development planning in the core professions as to the direct service professional (Institute of Medicine of the National Academies, 2006). There are simply no authoritative workforce data that embrace the universe of direct service professionals. Instead, some studies address the MH/DD workforce in the community; others look at DD workers in both institutional and community settings; and still others focus on the substance abuse arena exclusively. This is true with regard to both national and state data, as well as for Southeastern Pennsylvania. At the same time, there is a rich mixture of small studies and large sample research initiatives, each addressing separate workforce development issues. Although the general outlines of the field can be suggested, these are only approximations of the complex reality of a direct support professional workforce in search of a coherent identity.

The Contours of the Direct Support Professional Workforce

What, then, do we know about the careers of direct support professionals? Despite the scattered nature of the information available about the MH/DD/SA workforce, the data that do exist and the expert opinion from varied observers of the field give us a broad sense of the current realities: the workforce is sizable and diverse; those in the field work under a myriad of job titles but are generally experiencing an increase in responsibilities; they are, nonetheless, often poorly paid; the high rate of job turnover is both disruptive to consumer services and agency operations; and there is neither an established career ladder for direct support professionals in the field nor any reliable data on where those people who leave the field find other employment. Without a concerted initiative, this is a field of professional endeavor likely to face still more severe challenges in the years ahead.

Finding 1. The MH/DD/SA direct support professional workforce is sizable, diverse, unique to each system of care, and likely to find jobs in the expanding long-term care field equally attractive.

Sizable. The size of the MH/DD/SA direct support professional workforce is significant, although reliable data — at national, state, and/or regional levels — are more a matter of approximation than certainty. Information from four different, and well-regarded, data sets is reviewed here: each approaches the field from different vantage points and with differing definitions, but the common elements would support the notion that the workforce in this segment of the labor market is significant.

In a national study of only the mental health workforce (Robiner, 2006), analysis of 2002 data from the Bureau of Labor Statistics suggested that there were somewhat more than 500,000 mental health professionals (e.g., psychiatrists, psychologists, psychiatric nurses, social workers, etc.) with advanced degrees in their fields, but that there were nearly as many psychiatric aides, psychiatric technicians, and health and human services technicians providing a range of supportive services in both institutional and community settings. The authors of the study

noted the problems they had faced in making their projections of both the current and future size of the workforce:

> *Estimating the size of the mental health workforce is difficult because it is not a unitary entity. Instead, it is a chaotic amalgam of separate disciplines with ambiguous boundaries of overlapping roles and scopes of practice . . . However, of the mental health personnel reviewed, the direct support professional workforce is predicted to offer the greatest growth in the next decade, though they may increasingly work outside of the hospital environment (Robiner, 2006).*

Indeed, in a separate study of only the national developmental disabilities workforce (S. A. Larson, Hewitt, A. S., Lakin, C. K., 2004), also based on data from the Bureau of Labor Statistics, the authors estimated there were 110,000 direct support professionals in institutional settings and approximately 400,000 direct support professionals in community residential settings, with another 200,000 workers in vocational and other programs.

We could find no reliable estimates of the size of this workforce in the substance abuse field, but several of those interviewed suggested both a much smaller workforce overall and far fewer direct support professionals, particularly now that professional licensing in the field has forced individuals in recovery from their addictions who once dominated substance abuse service delivery to either acquire professional degrees or change jobs.

It should be noted that these MH/DD/SA workers are part of a much larger and growing direct support professional workforce. The Robert Wood Johnson Foundation, focusing on the frontline worker who provides hands-on assistance both to infirm older adults and to individuals with significant physical disabilities, estimates the national direct support professional workforce — excluding those working in the developmental disabilities field — at approximately 4.7 million workers (Robert Wood Johnson Foundation, 2006).

In Pennsylvania, an excellent study by the General Assembly's Legislative Budget and Finance Committee (Pennsylvania General Assembly, 1999) looked specifically at the direct support professional workforce, but only with regard to mental health and development disability programs in community settings. Based on surveys of local programs statewide, they estimated there were 33,000 direct support professionals at that time: 60% were in MR residential settings; 13% were in MH residential settings; 6% were in vocational programs of one kind or another; and 17% were in mental health partial hospitalization and day hospital programs. The study attributed the lower percentage of direct support professionals in MH partial and day hospitals to the state licensing requirements for those programs, which require a higher percentage of degreed personnel.

- **Diverse.** Each of the studies cited above addresses the demographic characteristics of the direct support professional workforce, with similar results from study to study:

  gender: Reflecting the human services environment as a whole, the MH/DD/SA direct support professional workforce has substantially more women than men, often as much of a disparity as 80% women and 20% men, across most settings.

  ethnicity: The national and state workforce is overwhelmingly white, with perhaps only one-third of the workforce composed of people from minority backgrounds. However, the local workforce often reflects local ethnic and income distribution data, so that in those counties in Pennsylvania where there are significant numbers

of people from economically disadvantaged minority communities, there is likely to be greater representation of those groups in the local direct support workforce.

education: Educational attainment varies as well. On the one hand, nearly everyone in the workforce had at least a high school or general equivalency diploma; on the other hand, the great majority of individuals in the workforce did not have either a bachelor's or advanced degree. The Robert Wood Johnson study (2006) estimated that 93% of the national direct service professional workforce – across all fields – had less than a bachelor's degree. In the Commonwealth's study, they found significant educational differences between the MH and DD environments: only 16% of those in MR residential facilities had a two-year associate's degree or higher, while 44% of those in MH residential facilities had an associate's degree or higher, 34% of those in vocational programs had an associate's degree or higher, and fully 71% of those in MH partial hospitalization and day programs had at least an associate's degree.

- **Unique.** It should be stressed that while the mandate of The Partnership has been to explore the current status of the MH/DD/SA direct support professional workforce (Southeastern Pennsylvania Behavioral Health Industry Partnership, 2005) and to examine the prospects for more supportive career ladders for the men and women in this arena, these are three quite distinct professional environments, with little linkage among their workforce policies and practices. While they may primarily draw on the same segment of the labor force overall, there is currently no knowledge about the numbers of men and women with experience in more than a single system; nor is there anything to suggest that the systems themselves have taken any initiative to coordinate their approach to recruiting, training, or supporting these workers. Indeed, as we shall see later in this report, there has been little work to define common roles or responsibilities, develop parallel competency-based training, or conceptualize the MH/DD/SA workforce as a single entity.

  Further, there is a growing need for direct support professionals with competencies in working with individuals with dual diagnoses. There is an emerging recognition that some percentage of those with developmental disabilities also struggle with psychiatric problems and/or physical disabilities, and a far more prevalent acknowledgement that direct support professionals are working with a significant number of people with both psychiatric issues and substance abuse problems. There are no data available that provide a sense of the numbers of direct support professionals who are asked to develop the kinds of competencies that would allow them to work effectively with these consumers.

- **Competition.** While there are varied opinions about the potential growth of the MH/DD/SA workforce in the years ahead, there is reasonable unanimity of opinion about the competition for workers that provider agencies are likely to experience in recruiting new workers. With regard to the prospects for growth within the field itself, some of those who were consulted for this report suggested an inevitable growth in the number of direct support professionals, particularly as institutional care continues to decline and the reliance on smaller community-based facilities

continues to increase (A. Hewitt, Lakin, C. K., 2001). Estimates of the scale of the anticipated growth vary considerably, depending upon the portion of the workforce under consideration. Several informants to this study suggested that a hoped-for increase in community programming might be at least stalled or steadied by state budget considerations. The reluctance of state legislators to expand the number of community programs perceived as costly might be supported by an increasing reliance on programs that can quickly move their consumers toward more independent lifestyles (Baron, 2007).

At the same time, there is strong agreement that with or without an expansion of the number of MH/DD/SA direct support professionals, there is likely to be strong competition for workers from the long-term care field. One report (Health Workforce Solutions, 2005) projects a 50% increase in demand within the long-term care field over the next decade. The demand for workers to meet the needs of infirm older adults who wish to remain in their own homes is likely to make that field a strong competitor for direct support professionals. At present, both fields draw on the same segment of the labor market – those without formal degrees and modest financial expectations – and many MH/DD/SA agencies are already reporting difficulties in recruiting direct support professionals who they feel are appropriate for the responsibilities entailed. This appears to be a somewhat less critical issue for the direct support professional workforce in institutional settings, where pay scales, unionization, and the opportunities for career advancement within the institution are greater.

Finding 2. The roles and responsibilities of the MH/DD/SA direct support professional are increasingly demanding. Regardless of job title, most workers are asked to provide both direct care and treatment and/or rehabilitation supports. The roles and responsibilities of MH/DD/SA direct support professionals vary quite widely, from system to system, from agency to agency, and, often enough, from one individual to another working side by side. In part, this definitional problem stems from what many in the field believe is an underlying strength: provider agencies have been given the authority to establish job titles and determine core responsibilities as they feel best suits the needs of their consumers. Within both state institutions and community programs there is tremendous variability in both job titles and job responsibilities for this portion of the workforce.

Job Titles. As a consequence, each workforce survey is often forced to develop its own typology of direct support professionals. A partial listing of job titles — drawn only from the surveys cited in the previous section — reveals a wide range of titles but very little about the day-to-day work entailed:

> *psychiatric aides, residential workers, human resource assistants, orderlies and attendants, support staff, mental health workers, crisis response technicians, drug and alcohol counselors, direct care staff, vocational counselors, partial hospitalization staff, supports coordinators, direct service providers, therapeutic support staff, etc.*

It should be noted that the "direct care staff" identified in one agency are likely to have a set of day-to-day responsibilities at some variance with the day-to-day responsibilities of "direct care staff" in another agency. A particular state agency may attempt to impose some order on this confusion, establishing particular job titles with particular roles, but this is often side-stepped by individual agencies as they work at making sense within their own environments. Of course, similar problems exist within the traditional professional fields: two individuals with social work degrees may have widely different job titles and responsibilities, and even new job titles designed to fill a crucial gap in service delivery systems – such as "case manager" – are quickly reinterpreted at the local level to meet local needs.

Further, new job roles in the direct support professional environment emerge regularly. An important new category – the peer specialist – has been created within Pennsylvania's mental health workforce. For nearly two decades the mental health field has attempted to transform itself to a "recovery-oriented" system, one that recognizes the strengths of consumers, empowers them to take command of their own recovery, and supports their decision-making roles both in their own lives and in the shape of the mental health service delivery system. As part of this thrust, consumer-run services have been greatly expanded across the Commonwealth; and, more recently, the state's Office of Mental Health and Substance Abuse Services has begun funding "peer specialist" positions to capitalize on the demonstrated capacity of mental health consumers to provide important supports and services to one another (Institute for Recovery and Community Integration, 1999). However, the counties and individual agencies will bear primary responsibility both for delivering training and for defining the roles and responsibilities of each peer specialist. As a consequence, the roles of these new direct support professionals are likely to vary from site to site as the program develops over the next few years (J. Rogers, Rogers, S., 2003).

Job Responsibilities. Broad definitions that attempt to capture the field have emerged, through two sources. On the one hand, several skilled observers of the field have sought to define the essence of this demanding work, and a few of those definitions are provided here. On the other hand, there have been a number of efforts in recent years to formally assess the competencies required of direct support professionals (as a precursor to establishing either training curricula or assessment tools), although these competency statements (reviewed later in this report) often focus on only one work environment — MH, DD, or SA — at a time.

The College of Direct Support Professionals (National Clearinghouse, 2007) — which has been of interest primarily to the developmental disabilities field — offers a useful generic definition:

> *Direct support professionals provide guidance and support to people who need help to be self-sufficient . . . including people with physical, psychiatric, or cognitive disabilities, or chronic illness; children and youth who are at risk, and families who need assistance in supporting family members. It is a profession that demands complex skills and knowledge, ethical judgment, and the ability to create long-term relationships of trust and mutual respect.*

The first part of the College's definition focuses on the elements of traditional direct support services – the day-to-day care involved in helping people with their personal hygiene, eating, use of leisure time, dressing, control and safety, medication management, etc. The second part of the definition, however, acknowledges that these basic responsibilities are increasingly being expanded to include work roles once the domain of degreed personnel. Hewitt and Lakin addressed this shift — this "pushing down" of responsibilities to the direct service professional level — as follows:

> *Today, in addition to meeting people's basic health, safety, and care needs, Direct Support Professionals have responsibilities to support people to develop and achieve their own personal goals, to balance rules with choices, to connect with peers, friends, and family members, and to be full and active citizens in their communities. They carry out these expanded responsibilities with less supervision and increasingly while working alone. . . . These expanded responsibilities and the increased isolation of Direct Support Professionals have not been accompanied by increased qualifications, education, or training . . . and many report that their training has been insufficient to prepare them for their job responsibilities (S. A. Larson, Hewitt, A. S., Lakin, C. K., 2004).*

The concern expressed so succinctly above — of increased professional responsibilities without the requisite training and supervision — is at the core of The Partnership's concerns, and speaks to the need to develop career ladders that involve relevant training for their expanded roles, regular opportunities for feedback and on-the-job support, and a reasonable wage reflecting these enhanced roles and competencies.

Finding 3. MH/DD/SA direct support professional wages remain low, often below the poverty level for a family of four, with few opportunities for significant raises over time. National data — in the same set of reports cited above — provide confirmation of a generally low but somewhat variable compensation picture for this workforce. Most national studies indicate wages for those who work in community settings in the \$8/hour - \$9/hour range and wages for those who work in institutional settings at \$14/hour to \$16/hour, with the significant differences between community and institutional compensation attributed to the more highly unionized workforce in state-operated institutional settings (Health Workforce Solutions, 2005). It should be noted, however, that benefit packages, and particularly health care coverage, are often more generous than the individuals in this workforce could expect outside of the human services arena. This may encourage longer job tenure, in both community and institutional settings, than would otherwise be the case.

Somewhat less well-paid and without adequate benefit packages are the 29% of the direct support professional workforce in part-time positions. However, several of the experts interviewed for this report estimated that many individuals hold down more than one job, and often those working part-time in the MH/DD/SA direct service workforce, have other full-time positions in the field. This suggests that the overall compensation package is considered by the workers to be too low to allow them to work only one job, with unknown impacts on the quality of their work in either their part-time or full-time positions.

The best data on wages and benefits in Pennsylvania can be found in the Budget and Legislative Committee's 1999 report (Pennsylvania General Assembly, 1999) that focused on mental health and developmental disability direct support professionals working in community settings. At that time, local programs reported state wage and benefit data quite similar to the national data: community workers overall earned \$8.13/hour, or \$15,854 annually, for full-time work, which the authors of the study point out is a wage level below the 1998 federal poverty guidelines for a family of four. The report is also valuable in detailing significant wage differences within the workforce: MR residential workers were the lowest paid in the study, and MH partial hospitalization and outpatient staff were the best paid, reflecting the differences in educational attainment within these cohorts.

It should be especially noted that both national and state data report essentially flat wage rates: that is, the direct support professional new to the field is earning only slightly less than the more experienced direct support professional co-worker who has been in the field for five or 10 or 20 years. Those in the focus groups convened to contribute to this study were especially concerned about what they saw as a failure by their employers to recognize with increased wages the increased skills represented by a direct support professional who has worked with consumers for a decade or more. Although some members of the direct support professional workforce move up to supervisory positions, the data and the focus group participants agree that it is only a two-step career ladder: without more formal educational requirements, "supervisor" is as far as direct support professionals can move within their profession, and as much recognition as they can expect to receive. At the same time, as one of those interviewed for this report

noted, funding for new programs often permits agencies to increase wages for newly created positions. But these enhanced wages are often eroded over time without annual increases.

Finding 4. Staff turnover within the MH/DD/SA direct support professional workforce is high, driven by low wages, attenuated career paths, little professional regard, and better economic opportunities in other labor markets. Studies within the long-term care field suggest that turnover within the direct support professional workforce has increased to such a degree that there are measurable negative impacts on both client care (Stone, 2001) and agency operations. Accordingly, there have been a number of studies – utilizing both large data sets and individual agency reports – to capture the scope of turnover, its costs, and explanations for this troubling development (Barry Associates, 1999; Colorado Department of Human Services, 2000; Johnston, 1998).

Scope of the Problem. Rates of turnover for direct support professionals are indeed high. It should be noted that this is a growing problem across the human services, as well as across low-wage work in general, and not one particular to the MH/DD/SA workforce. For instance, in looking at the long-term health care field, researchers from Better Jobs/Better Care found agencies across the nation reporting turnover rates varying from 40% to 90% annually; and the Philadelphia Inquirer (Von Bergen, 2007) recently reported that the home health aide data found not only that one-third of workers leave the field within three months, but that nearly half are gone within a year.

Within the MH/DD/SA arena, comparable rates bedevil program managers. In the DD field, for instance, most estimates (S. A. Larson, Lakin, C. K., 1999) report turnover rates among the direct support professionals in residential settings ranging from 40% to 70%, while others estimate an average 58% turnover in one year within community agencies of all kinds. The problem is compounded by a startlingly high turnover rate of 27% among the front line supervisors of these direct support professionals (S. A. Larson, Lakin, C. K., 1999).

In the Pennsylvania study of MH and DD community workers (Pennsylvania General Assembly, 1999), 28% of the agencies responding to the survey estimated annual turnover rates of 50% or more in the 1988-1993 period. The authors of the study concluded that, by the end of the 1990s, only one-third of the direct support professional workforce had job tenure in excess of three years, one-third had been in place for less than three years, and one-third had come and gone from the agencies in three months or less.

While both national and state data do report high rates of turnover within the workforce, the data also reveal that significant numbers of workers do remain in place, without substantial salary increases or role enhancements, some for five or 10 or more years, in both institutional and community settings. There is no compelling data on why those who stay long-term do so. On the one hand, job tenure appears to be higher for those working in institutional settings, where higher wages and benefits are offered. Several other explanations were offered by those interviewed for this study. For some, these jobs have become a calling that draws either on the workers' religious orientations or personal skills. For others, either the workers are doubtful that they will find better-paying jobs in the external competitive labor market or are reassured by the benefit packages they receive. Participants in the focus group of direct support professionals interviewed for this study suggested that longer job tenure often

reflected the presence of strong and supportive relationships that develop among co-workers.

Reasons for Leaving. There is substantial survey research and expert speculation on the reasons direct support professionals leave their jobs at such substantial rates. Most in the field attribute high turnover to low salaries: where there are better-paying jobs available, many make a straightforward economic decision and move on (Banaszak-Holl, 1996; Wunderlich, 2001). Although low wages are undoubtedly a strong precipitating factor, the Pennsylvania study (Pennsylvania General Assembly, 1999) indicates that low wages can only account for about 17% of the variance, and that a range of other reasons must push people to leave. The literature (A. Hewitt, Larson, S., Sauer, J., O'Nell, S., 2001; S. A. Larson, Lakin, C. K., 1999; Test, 2003) suggests a variety of issues:

- The demands of the job are often cited: consumers can be difficult and disruptive, and more than one focus group participant identified the physical demands and physical dangers in institutional and residential programs as ongoing concerns.
- Several studies and observers suggest that the lack of respect and professional regard accorded direct support workers forced many out of the field, particularly when newer (and younger) hires received comparable wages and responsibilities.
- The failure to provide meaningful training, the lack of supervision and support (particularly in residential settings), and the absence of a visible career ladder providing a sense of upward mobility are also frequently cited as reasons to move on.
- It should not be forgotten that some percentage of the direct support professional workforce leave these jobs for entirely personal reasons – family crises, health care problems, spouse relocation, a decision to retire or refocus, etc. – as do many persons in other low-wage job categories.

As a consequence, improved recruitment and retention strategies have begun to take center stage at professional conferences. The concern in some quarters has been that provider agencies have sometimes become so desperate to fill vacancies that they hire individuals without the personal attributes and capacity for growth that these important jobs require. In Pennsylvania, 50% of agencies responding to the workforce study said that the quality of applicants for direct support professional jobs had decreased over the past decade (Pennsylvania General Assembly, 1999). Agencies have begun to think more seriously about on-the-job training, supervision and support, and retention initiatives to hold the best workers in place.

The Impact of Turnover. Turnover is seen to have negative impacts on the field, with regard both to the quality of care that agencies are able to offer consumers and to the costs to agencies of ongoing recruitment and training. In a 2003 Congressional Direct Support Professional Recognition Resolution, the Congress noted:

> *. . . the sense of the Congress that community inclusion enhances lives for individuals with mental retardation and developmental disabilities is at serious risk because of the crisis in recruiting and retaining direct support professionals, which impedes the availability of a stable, quality direct support workforce (Robert Wood Johnson Foundation, 2006).*

Although comprehensive data on the impact of high turnover on client care is scarce, the logic of the argument made within the MH/DD/SA field is clear: if the demands of the job have shifted from only direct care to more frequent "relationship building," then continuity of care has become a critical issue. Working to build trust, to encourage

consumers to take risks, to work toward long-range goals together – all are undermined by an ever-changing direct support workforce. On the other hand, there are some generic data on the costs of turnover and recruitment. One study (S. A. Larson, Hewitt, A. S., Lakin, C. K., 2004) – across all direct support professional fields – places the national costs of recruitment for vanishing workers at $4.1 billion annually. This figure is inclusive of both "hard costs" (e.g., advertising) and "soft costs" (e.g., interviewing applicants and orientation training for new staff). Indeed, the costs associated with turnover are such that a number of provider agencies in the MH/DD/SA field have formed cooperative recruitment programs (Jackson, 2007) or undertaken extensive public relations campaigns (Parker, 2005).

Finding 5. There are no reliable data on natural career paths for the MH/DD/SA workforce. The field has little information on how individuals enter, change roles within, and leave (and/or return) to the workforce. There are no longitudinal data on the natural career paths of individuals in the MH/DD/SA direct support professional workforce. Any effort to develop a more formal and supported career path for the men and women in this segment of the labor force ought to begin with a clear sense of how careers have — or have not — developed naturally. There are several areas of exploration that may be most appropriate for more qualitative study in the years ahead:

- **Why and how do individuals enter the MH/DD/SA direct support professional workforce?** We know very little about the men and women who enter the field. Although prior educational attainment data are available, there is no sense of the prior work, career trajectories, or complex motivations that bring people to their first entry-level direct support job in the field. Neither are there data on how this workforce finds that first job, whether through personal contact with other workers, access to job postings in newspapers or online, or some other means. It is also unclear whether those who make the first hiring decisions have developed — albeit informally or unconsciously — a set of standards that go beyond the fairly standard assurances of a high school diploma and the absence of a criminal record.

- **Are there natural career trajectories that describe differing cohorts of the direct support workforce?** Data are currently unavailable — beyond point-in-time studies of the current job tenure of individuals — that describe over time how direct support professionals move in and out of jobs in the field. There is currently no information on whether or not there are clusters of workers in different cohorts and what their group characteristics might be. What characterizes those who come and go quickly vs. those who stay for a while vs. those who make a long-term commitment to the field? Are there groups who move in and out of the field – working in an MR residential facility, leaving after 18 months for a clerical job in the community, coming back to another residential facility — vs. those who move from job to job within the MH/DD/SA fields? And what are the implications — for quality care, worker training, and agency costs — of these patterns?

As the Annapolis Report on the mental health workforce suggests (The Annapolis Coalition, 2006), it may be that such data are largely unavailable within the core professions as well. But the problems facing the lower-paid direct support professional — who typically has little in the way of academic qualifications — in building an upwardly mobile career are surely more profound. While it is true that the core professions are attracting fewer recruits and retaining fewer seasoned workers than in the past, their career options are inevitably more open. For the direct support professional, meaningful options, either within or outside of the field, are far more circumscribed.

Finding 6. There are no formal career paths that provide an opportunity for the MH/DD/SA direct support professional workforce to demonstrate increasing competency and receive appropriate professional recognition and economic reward. The portrait that emerges from the quantitative data and qualitative opinions cited above is of a direct support professional workforce in crisis, enmeshed in a system that often does not meet their needs nor address the issues of quality of care and agency economics that are foremost for consumers and nonprofit provider agencies. By moving toward the development of career ladders, The Partnership seeks to alter the current circumstances.

For all the competency and compassion of many of the workers in the field today, the workforce can best be characterized as troubled. These are often individuals from low-income communities with minimal educational achievements, earning much too little and facing few prospects for advancement. As a consequence, many individuals leave the field quite soon after beginning work; and — despite a commitment to their work and the consumers they serve — those who stay often feel trapped, with their careers stagnating. They receive minimal training, little encouragement to move forward, and slight support if they begin to fashion a more meaningful career for themselves. The impact — on their own sense of professionalism, as well as on the quality of care consumers receive and the costs entailed when agencies are constantly recruiting new personnel — is extensive.

These issues are likely to impact as well on consumers of mental health services who choose careers as peer specialists. In several states – Arizona, Georgia, Iowa, Michigan, North Carolina, Pennsylvania, and Washington — as well as the District of Columbia, the Centers for Medicare & Medicaid Services have made the services of certified peer specialists Medicaid-reimbursable; and these states and others provide training and certification programs to direct support professionals. But the workers involved are currently a small minority of the direct support professional workforce, and the program itself is too new to indicate that this individual credential will be useful as a first step on a progressive career path.

There are exceptions: the outstanding long-term orderly or residential staff member beloved of consumers and co-workers alike; a nonprofit agency that invests heavily in training and supervision; the beginnings of a three-step or four-step career ladder within a particular agency. But, this report suggests, these are only exceptions to a more sobering widespread reality. The next section of this report begins to articulate the challenges of meaningful change in this arena.

The Challenges of Building Career Paths

Over the past two years, The Partnership has worked to develop a sustaining vision of the core elements of the "career path" approach to the MH/DD/SA direct support professional workforce. At the center of this vision is the building of a front-line workforce with the professional commitment and compassion that many current direct support professionals already demonstrate on a regular basis. However, the vision presented here goes further, outlining a common set of goals for a new and more productive approach to the direct support professional's career development.

The Partnership believes that a workforce development system better geared to the future needs to be oriented around five core values:

- **careers** – No one should enter the field without a sense that, rather than only to serve time in a short-term or dead-end job, each person has abundant opportunity to develop a career, with a measure of consistent support designed to encourage professional upgrading throughout the years.

- **competency** – One of the core supports offered to the direct support workforce must be competency-based training, focusing on current knowledge, new and/or evolving approaches, and — most of all — the day-to-day requirements of the job, developing both generic direct support skills and more targeted competencies for specific job roles.

- **commitment** – Career development is a cooperative venture between the employee and his/her employer, in which employers must offer robust training supports (e.g., release time, on-the-job training and assessment opportunities, enhanced supervision, and financial assistance) that are key elements in training for adult learners.

- **certification** – All training should be seen as a portion of a broader certification process — related to licensing or the award of a formal academic degree — providing direct support workers with permanent, transferable recognition of their status applicable to other MH/DD/SA jobs and other human service settings.

- **compensation** – Increased competencies, improved on-the-job performance and extended job tenure must be recognized not only by new titles and broader on-the-job responsibilities, but — most critically — with appropriate increases in wages and benefits.

For such a workforce development system to evolve it will require much new work in the field. The Partnership recognizes that this is likely to be a long-term process. Every profession has faced similar challenges, and the road to more widespread recognition has taken each profession considerable time and required a considerable financial investment (Wilson, May 2006). However, to fail to move forward promises another generation of workers in a "hope-based" network of services who have little long-term hope with regard to their own careers. This section of the report addresses each of these issues. We begin with a review of current training requirements for the field, and systematically examine the accumulating evidence and arguments for an increased focus on careers, competencies, cooperation, certification, and appropriate compensation for the direct support professional workforce.

Finding 7. Current training for the MH/DD/SA direct support professional workforce is minimal — a patchwork of initial orientation and continuing education programs that are neither comprehensive nor focused on career development. No commonly accepted national standards of professional preparation or in-service training exist in the mental health, developmental disabilities, or substance abuse fields to govern the delivery of training for direct support workers (Council For Standards In Human Service Education, 2006; Workforce Strategies Initiative, 2007); and most states delegate authority for training — with minimal guidelines — to individual provider agencies. This is true with regard to pre-service training requirements as well as orientation training, and particularly true with regard to ongoing professional development for this segment of the workforce. One analyst in the field (S. A. Larson, Hewitt, A. S., Lakin, C. K., 2004) noted:

> *Well-developed pre-service training programs for Direct Support Professionals are rare. Ongoing training programs that target developing new skills rather than complying with mandatory topics are also rare. As a consequence . . . career paths are limited for direct support professionals. . . . Direct support professional training is commonly not transportable from one employer to the next and is rarely competency-based . . . nor integrates effective adult learning strategies.*

Entry. Pennsylvania faces similar challenges with regard to entry requirements, orientation training, and ongoing professional development. Entry requirements for direct support professional jobs vary from one field to another (Davis, 2006a, 2006b) but all share a relatively relaxed approach. In the mental health field, a high school diploma and 12 college credits are generally considered sufficient for many direct support workers, although in some settings one to two years of prior work is also expected. Requirements for entry into the developmental disabilities arena are less rigorous (a high school diploma or general equivalency diploma is often sufficient) for direct support professionals. And although counselors in the substance abuse arena are increasingly required to hold a Certified Addictions Counselor (CAC) certificate — which now requires a bachelor's degree — there are few rules governing the entry of less qualified personnel into direct support roles that do not require a CAC. Although both state and federal funding entities increasingly use their authority to set educational standards for provider agencies — requiring that a minimum percentage or number of employees have a bachelor's degree, for instance — those without a bachelor's face little pre-service training scrutiny.

Orientation. Orientation training varies tremendously from system to system and agency to agency. The state has established minimal training requirements, but these tend to focus on the basics of care — information on the specific disability groups served by the agency, fundamental practice issues governing safety and control measures — cardiopulmonary resuscitation (CPR), AIDS prevention, medications, the use of restraint — and the specifics of each agency's personnel policies and practice directives. What many observers at the national level have noted is the degree to which locally driven training often fails to address some of the key issues that go beyond basic care:

> *Although most states require training related to health and safety issues (e.g., first aid, CPR), little training is provided on how to assist individuals with disabilities to lead productive, self-directed lives in which they are fully involved in their communities (Jaskulski, 1996).*

There are at least two exceptions to this pattern in Pennsylvania that should be noted. First, there is an extensive training program for the new peer specialists across the Commonwealth: although the only academic qualifications for the position involve a high school diploma or GED (and, if the applicant is previously unemployed, 24 credits of post-secondary education), the orientation training involves a building of commitment to the concepts of recovery and the ability to engage other consumers in the recovery process (Institute for Recovery and Community Integration, 1999). There is also evidence (Barrett, 2000; Basto, 2000) that academic programming for consumers preparing for work in the behavioral health field can be very effective.

Second, the Commonwealth now requires new case managers to complete an eight-week orientation training that is quite comprehensive and specific. Funding for this extensive training of case managers has been built into the reimbursement rate for their employers. Although many MH/DD/SA agencies now include some orientation training around recovery, empowerment, and personal responsibility concepts for direct support professionals, there is no requirement to do so or consistency in execution.

Continuing Education. Similarly, continuing education is primarily left to the discretion of the individual provider agencies. Although the state, the county, or funders may require annual updates and retraining with regard to the basic training topics and also require a minimal number of hours of in-service training, content and format is almost entirely within the purview of the individual provider agency. Provider agencies may be reluc-

tant to substantially invest in training that goes beyond specific external mandates, for a number of reasons. First, agencies are always financially cautious, and current funding patterns — often paying by the service hour — leave the time invested in training as an un-reimbursable expense. Second, agencies question the efficacy of extensive training for direct support workers who they believe may not be with the agency beyond a few months or a year. Third, many believe that the workers themselves are not highly invested in building their own competencies and developing their careers.

Multiple Training Opportunities. On the positive side, training opportunities in Pennsylvania abound. The Commonwealth directly supports a number of nonprofit training centers in the mental health, developmental disabilities, and substance abuse arena, and there are at least a dozen independent nonprofit agencies with a primary or secondary training mission that provide an array of focused, short-term training programs in the field. Further, many universities and community colleges offer training programs targeted to providing either one-year certifications or two-year associate's degrees for the direct support professional workforce (Wohlford, 1993). Local, state, and national professional associations provide opportunities — in wide-ranging conferences and specialized workshops — for direct support professionals to enhance their knowledge base, gain new skills, and broaden their perspectives on their work.

In Philadelphia, for instance, the City's Department of Behavioral Health and Mental Retardation Services supports the ongoing training activities of the Behavioral Health Training and Education Network (BHTEN); and some of the larger nonprofit providers in the field have training units of their own, as well. However, there is little coordination among these trainers and training opportunities. Indeed, there may be considerable competition for state and county funding or for the scarce training dollars of providers. Direct support workers who pursue their own professional development are largely on their own. More critically, there is no way for training credits — and the growing base of knowledge and skills they may represent — to accumulate into permanent and portable credentials. This limits an individual's ability to demonstrate his or her competence when moving from agency to agency, or job to job (National Clearinghouse, 2007).

Finding 8. Although the competencies required of the MH/DD/SA direct support professional have now been well-defined, no national standard has been established across fields to provide a widely recognized credential for workers. One of the most significant shifts in our understanding of the work demands made on direct support professionals has been a disenchantment with training programs focusing only on general knowledge, and a growing enthusiasm for a competency-based approach. Competency-based training begins with an analysis of the actual skills required of any workforce in meeting its day-to-day responsibilities. Such training continues with curricula that address the development of those skills for on-the-job implementation, followed by a system for measuring how well trainees both learn about and are able to use those competencies at work, and, finally, development of rewards that are associated with the demonstration of those improved competencies.

Part of the excitement around competency-based training reflects increased concern about the ineffectiveness of current pre-service and in-service training programs based on the general knowledge model. Mental health program directors have long felt that the graduates of professional programs in the core mental health professions are poorly prepared. They complain that graduates have a knowledge base that finds little practical application in the field, and that graduate programs have been much too slow to change or to incorporate shifting

service philosophies (e.g., the growing emphasis on empowerment) or emerging best practice intervention models (e.g., motivational interviewing). This leaves local provider agencies with the responsibility to retrain new professionals with regard to the fundamentals of their actual responsibilities.

The Annapolis Coalition report (2006) noted that ". . . graduate programs have been slow to respond to numerous critical trends in practice, such as shared decision-making with persons in recovery, rehabilitation, resilience, and recovery-oriented approaches to care, and the (emerging) roles of peer support and peer specialists, etc." Similar concerns — about the irrelevance and out-of-date nature of much current training — apply as well to the preparation, orientation, and continuing education offered to direct support professionals. This is especially important in an environment in which some of the most fundamental changes in the mental health and developmental disabilities fields — the shift toward recognizing the importance of empowerment, self-determination, and recovery — often run counter to established views and cultural standards.

Within the MH/DD/SA fields, however, competency-focused work has been underway for some time, and a number of well-developed competency statements have emerged over the past decade. Although these are often separately developed — and disseminated — for each of the three fields (MH, DD, and SA), these competency statements have much in common. Nonetheless, no general or national standard has emerged, and we review here just a few of the more prominent statements of competencies that are in use today. Each is the result of collaborative activity and reflects field assessments — among direct support professionals and their supervisors — of day-to-day activities. Each of these efforts at defining competencies has begun to lead to well-defined training agendas — some offered online and others as the basis for local or regional training programs. Each attempts to strike a useful balance between basic hands-on skills (the traditional, major responsibilities of direct support professionals) and the more sophisticated skills now required of the workforce. Most include fundamental information about the cause, nature, and core treatments associated with mental illness, developmental disabilities, and substance abuse; and most now include, as well, a section on the importance of cultural competencies within the human services environment. Each reflects the observation that

> *. . . people who have not worked as or relied upon a direct support professional are often quite unaware of the skills, knowledge, attitudes, and dedication it takes to be a true direct support professional (National Clearinghouse, 2007).*

Mental Health. There have been a number of studies of the competencies required of mental health workers, in both community and hospital settings (R. D. Coursey, Curtis, L., 2000; K. Gill, 2006), with great consistency across these studies (despite differences in methodology) and a striking similarity in the breadth and depth of required competencies for the so-called entry-level worker. One of the most comprehensive approaches to articulating the "skills, knowledge, attitudes, and dedication" required in the mental health field has been that undertaken by the United States Psychiatric Rehabilitation Association (USPRA), formerly the International Association of Psychosocial Rehabilitation Services (IAPSRS). In particular, its seminal Role Delineation Study (IAPSRS, 2001) documented seven performance domains and the associated knowledge and skills necessary for the psychiatric rehabilitation practitioner: interpersonal competencies; professional and role competencies; community resources; assessment, planning, and outcomes; systems competencies; intervention; and diversity. USPRA subsequently developed a "CPRP [Certified Psychiatric Rehabilitation Practitioner] Preparation and Skills Workbook" (Salzer, 2007) that provides not only a review of some 69 different

tasks that might be expected of a skilled psychiatric rehabilitation practitioner, but also a set of readings and exercises to prepare new practitioners for an exam recognized by the USPRA certification process.

In a separate assessment of direct support professional competencies recently undertaken for The Partnership, which is sponsoring this report, Gill (2006) noted the continuing relevance of the USPRA designation of competency areas. His work goes somewhat further. In one arena, for instance, he provides a sense of the complexity of many direct service professionals' roles as they work to meet multiple responsibilities within the broad "intervention" competency: "facilitating or leading group activities, facilitating recovery groups, planning and conducting community outings, de-escalating crises, building community support networks, etc." Gill's list of "interpersonal" competencies is equally daunting, including "paraphrasing, gathering information, active listening, using person-first respectful language, observing behavior, avoiding escalations, communicating respect and communicating clearly."

Although 12 states, including Pennsylvania, now use USPRA's psychiatric rehabilitation certification as a requirement for funding of local psychiatric rehabilitation services, this excellent resource awaits the attention of the vast majority of other states, and is little used, if at all, outside the relatively limited number of community mental health agencies that are part of the long-standing USPRA network of psychiatric rehabilitation services. There are other competency statements in the field. One associated with the emerging roles and responsibilities of peer specialists places an emphasis on understanding mental illness, recognizing the possibility of change, developing a commitment to change, fostering change, understanding the mental health system, and developing professional ethics. Another listing of competencies, developed

by the Center for Mental Health Policy and Services Research of the University of Pennsylvania for managed care agencies, stresses similar competencies for both clinicians and rehabilitation personnel (R. D. Coursey, 1998). Although the USPRA competency statement provides the background for a certification process in the field of psychiatric rehabilitation, it remains — like many — only infrequently used for training new staff.

Developmental Disabilities. Within the developmental disabilities field, the clearest competency statement is available from the College of Direct Support Professionals (Taylor, 1996). It was developed by the Human Services Research Institute and intended as a more generic overview but is far more popular within the developmental disabilities arena than elsewhere. The document — the Community Support Skill Standards (CSSS) — was designed to help create a sense of the professionalism associated with direct support work, and provides a comprehensive competencies approach its authors see as relevant to "advocates, case managers, child care workers, companions, counselors, early intervention workers, family workers, housing specialists, outreach workers, peer facilitators, residential counselors, shelter workers, substance abuse counselors, job coaches, and vocational counselors."

The 12 CSSS standards embrace participant empowerment; communication; assessment; community and service networking; facilitation of services; community living skills and support; education, training and professional development; advocacy; vocational education; crisis intervention; organiza-

tional participation; and documentation. Hewitt and Lakin (2001) validated these 12 competency dimensions — and 42 separate skills standards — in a series of community worker surveys, but noted that little research exists that uses these standards to identify potential training needs. Indeed, although the CSSS has a variety of online and on-paper teaching/training resources available to both individuals and programs, it has not yet been used to establish national standards in the field. Individuals can take advantage of the online course of study and receive recognition for successfully completing the course, and community agencies can contract for training for their staff. It should also be noted that the direct support specialist position that is the focus of the CSSS process has been nationally recognized as an apprenticeable position (one recognized by the Office of Apprenticeship Training, Employment and Labor Services [OATELS] within the U.S. Department of Labor), in which cooperative efforts of employers and on-the-job training programs provide an opportunity for workers to learn and practice new skills (OATELS, 2007).

Substance Abuse. Considerably more successful has been the development of the Certified Addictions Counselor (CAC) program, which now requires that CAC applicants already possess a college degree. In Pennsylvania, however, the Pennsylvania Certification Board (PCB) (2007) has also established several competency-based certifications at the associate's level — for Associate Addiction Counselor and Associate Prevention Specialist, for instance — that define competencies at the non-degreed level. Separately, the federal Substance Abuse and Mental Health Services Administration undertook to define the competencies associated with the substance abuse field. Noting the variation in licensing and credentialing by the states, and the inadequacy of continuing education programs in the field (in which the numbers of hours of continuing education are specified but not the content), SAMHSA defined eight broad areas of competency: clinical evaluation, treatment planning, referral, service coordination, counseling, client/family/community education, documentation, and professional/ethical responsibilities.

The Challenge of Measurement. Much less developed is the ability of these systems of care to measure the degree to which workers in the field demonstrate the competencies that have been so well articulated (Welch, 2001). While most provider agencies may have annual (or more frequent) paperwork requirements to assess staff competencies, it is unclear how well training in competencies is reflected in on-the-job performance. While the next section of this report looks at what we are learning about the most effective ways in which to train around these competencies, it remains difficult for most systems to assess the degree to which workers in the field have learned new skills and are able to apply them consistently in their day-to-day work. We will later address the degree to which inconsistent, distant, or non-existent supervision of direct support professionals provides a real challenge to assessing the competence of their work. But the issue raised here is that those defining the required competencies of this workforce increasingly stress that course completion is not a substitute for ongoing on-the-job supervisory assessment of an individual's competency. For direct service professionals to advance — on the basis of improvements in performance rather than only tenure — a more responsive system must be in place.

Finding 9. To be effective, training for strongly motivated direct support professionals must utilize more interactive, long-term approaches and rely on the commitment of employers to respond to the unique needs of adult learners. There is little question that training of all kinds is most effective with a strongly motivated learner: someone who sees the link between the educational process and the development of new competencies, and the way in which those competencies can improve not only the quality of care available to consumers and the effectiveness of agency opera-

tions but also their own professional careers. It may be true that not every MH/DD/SA direct service professional is either inherently motivated or easily encouraged, so that, for them, even the best training will fail to generate the competencies and compassion required for the job. However, the absence of a defined system to capitalize on the motivation of direct support professionals leaves the field with far too many key staff who move in and out of direct service positions all too quickly, and just as many long-term staff who have long since ceased to extend themselves in their jobs. To invigorate the delivery of training to the direct support workforce, the field needs to draw upon what we know about effective training techniques, work-based learning approaches, and the supports employers will need to offer to these unique adult learners.

Effective Training. Research evidence has been accumulating for more than two decades that traditional training approaches and standardized teaching techniques are not effective. Studies in several fields (M. A. Hoge, 2005; M. A. Hoge, Huey, L. Y., O'Connell, M. J., 2004) indicate that the ongoing reliance – in pre-professional academic programs, orientation training for new staff, and continuing education programs for permanent personnel – on didactic presentations, one-shot training sessions, conference workshops, and outdated knowledge base leaves personnel throughout the human services field without the skills they need to meet their day-to-day responsibilities. The Annapolis Coalition noted that:

> *. . . there is a growing body of research demonstrating that the most common educational methods are not effective in building skills, changing the professional behavior of the trainee, or influencing consumer health care outcomes (Annapolis Coalition, 2006).*

The Coalition also noted that if these concerns about the limits of traditional educational techniques and the recognition that ". . . current training has not kept pace with change across the professions . . ." are significant issues for the core professions, they are still more troublesome for the less well-prepared direct service professional. What does work — educational research suggests — is a far more interactive training approach with ample opportunities for the practice of new skills and the commitment to use those skills — and assess their application — in the real world environment of the learner's day-to-day job (Raelin, 1997).

Further, effective educational programs ought to be inter-disciplinary, shaped by the demands of the job, responsive to the perceptions of consumers, and part of a long-term continuing education approach for the current workforce. Most importantly, each student ought to have multiple opportunities to receive feedback on his/her performance — within the training program as well as back on the job — from other learners, colleagues, and supervisory staff. Framing this kind of curriculum requires substantial commitment to the concept of "work-based training."

Effective skills training for an incumbent workforce must make an extraordinary effort to be based in the job itself. It relies, in part, on a partnership between the trainer and the workplace, with curriculum emphases and practice opportunities based on the "real world" environment in which direct support professionals are engaged. Geared to the competencies outlined in the previous section, work-based training relies on the trainees, their supervisors, and consumers for examples of the challenges to be faced and the strategies to be employed, and allows for ongoing use of these skills on the job.

Employer Supports. Finally, it is critically important for training programs for the incumbent direct support professional workforce to grapple creatively with the fact that although many of the jobs are considered entry-level positions, much of the workforce is composed of mature and experienced indi-

viduals who have considerable strengths and many skills but also a set of unique needs as adult learners. In studying welfare-to-work programs, Roberta Iversen (2006) has noted the "life-stage/job mismatch" of many training programs for welfare mothers. She suggests that the demands made on single women taking a first job after high school or college graduation — to work and continue their education — may not be feasible for many of those in their 30s and 40s, with children, homes, and relatives that all make competing demands on their time and their energy.

As a consequence, there is much that the employer can do to make training programs feasible for the incumbent MH/DD/SA direct support professional — often a single woman with a myriad of personal responsibilities. Training should be:

- **accessible:** Employers can use a variety of approaches (e.g., on-the-job training; employer-sponsored release time for training sessions; evening and weekend training programs, with child care and transportation needs addressed); and, when feasible, more time-flexible distance-learning programs.

- **affordable:** Employers can financially support training by purchasing training services directly for their staff, or with individual stipends and scholarships, or generous tuition reimbursement and/or loan programs.

- **accommodating:** Some employees may have special needs, many require more remedial instruction to compensate for past educational system inadequacies, or may need to rely on counselor support to help them grapple with the stresses of returning to school.

All of these programs depend on effective and explicit partnerships between the direct support employee and the employer, and on their joint commitment to career development. Further, there is growing evidence (Adler, 2004) that agencies that provide direct support workers with career counseling – and several initiatives now utilize "career navigators" — are able to help workers keep their career development activities on track and improve job tenure (Cromwell, 2005).

Finding 10. Effective career pathways for the MH/DD/SA direct support professional workforce link training achievements to academic credentials for a wide range of the workforce. Even the most intrinsically motivated MH/DD/SA direct support workers who have access to a wide range of external supports encouraging their participation in training are likely to find their professional development aimless if it does not lead, in time, to the award of meaningful academic credentials. This is too often missing in the development of career pathways for this workforce. Yet without a serious commitment in this direction, the field will continue to cut short the professional development opportunities of the very men and women upon whom effective service delivery depends.

Framing Career Pathways. Competency-based training delivered in effective formats and supported by systems and employers is only a part of the challenge of framing career pathways. Whether referred to as "career pathways" or "career ladders," the opportunity for real upward mobility provides a powerful motivation for expanding competencies. While ". . . a career ladder provides employers with new and more reliable sources of skilled labor . . . it (also) serves as a road map that helps workers navigate through and up a labor market" (Mills, 2003). The Society for Human Resource Management (Young, 2003) recommends that employers in every labor market pay attention to the ubiquitous need for a sense of meaningful progress at work. Although written from the perspective of for-profit enterprises, the same is true in human services:

Organizations with highly engaged workforces perform better financially, with higher returns on invested capital, have greater competitive advantage, and, by just about any means, are better companies than less engaged companies. One of the significant elements identified as a component of engagement was future growth opportunity, which is defined as being a combination of learning and development beyond the current job, career advancement opportunities, and performance improvement feedback (Mills, 2003).

In most MH/DD/SA settings, the career ladder for direct support professionals consists of two steps: direct service and supervision. A few agencies have defined multiple stages within these two settings (e.g., Mental Health Worker I, II, III; or Residential Supervisor I and II) — based either on longevity, the completion of required training, or the mastery of specific competencies. Such programs are rare, and rarer still is the agency or system that defines the means by which the direct support professional can — with appropriate training and experience — move into the more traditional professions. It is the linkage of training to job mobility, in which promotion to new jobs means broader responsibilities, greater flexibility, or specialty assignments, that is the essence of a career pathway.

Linking Training to Academic Credentials. Most MH/DD/SA direct support professionals have access to — or are required to participate in — a wide range of professional development programs. The natural professional development of the long-term direct support worker – a combination of experience, required training, and less well-defined participation in workshops and conferences over the years – often provides the once-unskilled worker in the field with a wide range of effective competencies. Too often, however, there is little opportunity to accumulate those years of experience and training into a permanent and portable credential, one that facilitates the individual worker's upward movement not only within his/her initial agency, but within the broader MH/DD/SA labor market or, indeed, the human services field in general. To demand ongoing professional development activity on the part of the direct support professional without offering a substantial credential — and an academic credential in particular — puts the worker at a long-term professional disadvantage.

Several individual professional associations have begun to frame credentialing processes, often outside of the academic framework. USPRA offers psychosocial rehabilitation practitioners an opportunity to learn and be tested on psychiatric rehabilitation competencies, and to earn designation as a Certified Psychiatric Rehabilitation Professional (CPRP) — with one level focused on individuals without a bachelor's degree and one level focused on those who already have a bachelor's degree. The National Alliance of Direct Support Professionals offers course work — based on the CSSS (National Clearinghouse, 2007) — and testing that permit individuals to earn designation as a "registered," "certified," or "specialist" worker in the direct support professional field. The Certified Addictions Counselor designation is similarly tiered, and even includes an associate's level program for people who will be working with those dually diagnosed with psychiatric disabilities and substance abuse difficulties. But none of these helps the individual develop the kind of academic credential that is likely to provide the basis for long-term career advancement.

Pennsylvania has recently been discussing the need to establish a credentialing system for its long-term care workforce that is unique in its close attention to assisting workers in accessing career pathways that are linked to certified training at each level of the career ladder. The District 1199C Training and Upgrading Fund provides an excellent example of one such approach, insuring that its behavioral

healthcare technician graduates earn college credits through nearby Philadelphia University (Southeastern Pennsylvania Behavioral Health Initiative, 2007). An increasing number of working participants in the program have thus been able to earn associate's degrees in the behavioral health field and bachelor's degrees in more generic human services curricula. A variety of initiatives in other states — often focused on child care workers (Roder, 2006) or long-term care staff (Commonwealth Corporation, 2007) — are under way as well, often linked to community colleges and local four-year universities.

Human service environments continue to attach great importance to academic credentials as the framework for both entry into the field and upward mobility over time. It is the primary reason so few direct support professionals — who traditionally have had few opportunities to develop academic credentials while working — have been able to build effective careers. A few academic programs do exist, offering one-year certificates, two-year associate's programs, and both bachelor's and master's level educations for the individual entering the community mental health arena. Research indicates that such programs are effective in conveying fundamental principles, instilling new values, and building specific competencies (E. S. Casper, 2001; E. S. Casper, Oursler, J., Schmidt, L.T. & Gill, K.J., 2002; K. J. Gill, 2005; K. J. Gill, Murphy, A., & Birkmann, J., 2005).

The academic credentials such programs provide can be critical to a sustained and sustaining career. Without them, individuals often see their careers stymied. In this context, it is worth noting some cautionary lessons from the efforts of The Great Society (Armour, 2002) to create "new careers" for community members. Recognizing the benefits of the life experience and the local knowledge of community residents, antipoverty program workers in the 1970s were part of a New Careers movement that offered training, supervision, and job opportunities to a new corps of workers drawn from the community. Often without traditional academic credentials, the new workers entered anti-poverty programs with great hopes. Nonetheless, within a few years such programs had failed. Facing the fierce resistance of other traditionally trained human services workers and assigned only the most basic roles for fear they could not handle more demanding assignments, the "new careerists" found themselves both isolated and professionally stuck; and the new career program — and the new careerists themselves — gradually faded away.

Responding to a Diverse Workforce.
Strengthening the academic credentials of the MH/DD/SA direct service workforce is a central issue regardless of the prior training of this diverse workforce. An effective workforce development system will recognize the diversity of this workforce. There are four broad clusters of workers in the field for whom academic credentialing opens new career doors:

- **potential direct support workers in the field:** There is a substantial potential for expanding the direct support workforce by focusing attention on (and then providing training for) other potential workers. On the one hand, current and former consumers represent a ready workforce. On the other hand, other employees in the MH/DD/SA field — dietary, secretarial, and maintenance staff in institutional and community settings who may already interact with service consumers — may already feel comfortable with and demonstrate competence interacting with consumers, and may wish to move toward direct support roles. Training for both consumers and incumbent workers can quickly develop the fundamental knowledge and competency for direct support responsibilities.

- **entry-level workers making a long-term commitment to the direct support profession:** Within the incumbent direct support professional workforce are a number of individuals who — for a variety of reasons — may choose to remain direct support professionals and who wish to increase their knowledge base and key competencies but are not looking for substantial upward job mobility. It is critical that there be opportunities for them to stretch and improve as professionals, and to receive some form of professional and economic reward — creating training opportunities and career pathways within the direct support environment itself.

- **entry-level direct support workers seeking academic credentials:** A majority (although by no means all) of the current direct support workforce have entered the field without academic credentials but seek upward job mobility. Many have some college credits; but most have neither a certificate, a two-year degree, or a bachelor's. Providing training that results in formal credentialing — a one-year certificate indicating fundamental competencies or a two-year associate's degree in either a broad human services curriculum or a specific behavioral health arena — is likely to be of long-term value to the individual who wishes to remain in the field.

- **credentialed staff who wish to move forward in their careers:** A portion of the direct support workforce already have two-year degrees and are interested in both learning more and moving forward professionally. To support their career development, they need training that allows them to move from a two-year to a four-year degree relatively seamlessly, and that supports their professional advancement — perhaps, in time, leading them beyond the entry-level workforce and into one of the more traditional professional roles and/or post-graduate degrees.

While each of these groups deserve attention, Jobs for the Future (D. Seavey, 2006) emphasizes the benefits to the field to be obtained from a focus on the second and third categories identified above, addressing the needs of those with minimal academic credentials, whether they are seeking to remain in the direct support professional workforce or move from it to more professionally rewarding roles. Jobs for the Future calls for a

> *. . . focus on education and training programs as a matter of "low-income worker national policy" and [to] seek to "expand the scope of all federal training and education programs to reach incumbent workers, particularly those with low skill and income levels, and to help them advance to jobs that pay family sustaining wages," primarily through a strengthening of linkages with higher education programs and help to improve access, retention, and success for working adults pursuing skills and credentials.*

Finding 11. Low wages and flat salary structures not only limit the ability of the field to recruit and retain a more competent and compassionate workforce, but also decrease worker interest in their own professional development. While there is not a strong empirical literature that focuses specifically on the impact of wage levels on recruitment and retention of the MH/DD/SA direct support professional workforce, a combination of common sense, formative research, and consensus opinion make it clear that low wages and flat salary structures remain intricately related to the absence of professional development for this workforce. Bringing more qualified workers into the field and retaining them will require improved initial and

long-term salary structures. Encouraging workers to seek and benefit from training programs and academic opportunities will depend, to a substantial degree, on each worker's assessment of the economic value of his/her participation.

The previous section of this report provided ample evidence of the low and flat wage structures throughout the field – and, indeed, throughout much of the direct support professional workforce in every human services environment. While some analyses (Pennsylvania General Assembly, 1999) indicate that the degree to which wage levels impact retention is relatively low, and management theory suggests that worker retention is always a mix of extrinsic (e.g., economic) and intrinsic (e.g., satisfaction) factors, interviews with direct support workers themselves provide some measure of the continuing frustration they feel as their years in the field accumulate without either the professional recognition or economic rewards they believe they are due.

There is also a simple issue of fairness: can the MH/DD/SA fields continue to build a competent and compassionate workforce asked to validate consumers' "potential for growth" without responding to some of the core issues of the professional development of the direct support workforce itself? While it is true that many people in the direct support field find their calling in their day-to-day responsibilities — feeling and acting on the compassion so essential to this work — would it not better reflect the values of the human services environment to support and reward professional growth appropriately?

While these arguments have been modestly successful in the past, leading to one-time pay raises and expansion of benefits in a variety of settings, the longer-term answer is likely to be found in strengthening the links among training, academic credentialing, career pathways, expanding job roles and responsibilities, and appropriate wage rates. These are not jobs that can be exported overseas, one respondent to this study noted: the answers have to be found in re-valuing and rewarding this work at home. We review in the next "finding" whether or not the costs of doing so can be justified in improvements to the quality of care offered and lessening of recruitment and turnover costs.

Finding 12. The literature on the benefits of improved training and expanded career pathways for the MH/DD/SA workforce currently only suggests, but does not yet fully demonstrate, the advantages of a new approach.
The paucity of research on the benefits of professional development and career pathways for the MH/DD/SA direct support professional workforce suggests both the inattention to this portion of the labor force and the difficulties of doing what is quite complex and long-term career research. Of particular importance is a warning from the Health Care Research and Training Institute in Massachusetts (working on training for long-term care direct support professionals) that "it is critical not to oversell what training programs can accomplish in the short run" (Flynn, 2005). While there are suggestions in the literature of the benefits that accrue from professional development programs, they are preliminary, and much new research must be done in the years ahead (S. Golonka, 2001; D. Seavey, Salter, V., 2006; W. D. Young, 2003).

Current Information. The literature in the field is rudimentary, based on small and hard-to-replicate studies, often drawn from other entry-level direct support professional fields, and pointing the way to a future research agenda. There are three broad measures of the benefits of professional development:

- **improvements to the quality of care offered to consumers.** One of the central arguments for increasing the investment in professional development for the MH/DD/SA direct support workforce is that effective, competency-based training will improve the quality of services offered to people in the mental health, developmental disabilities, and substance abuse service population. This would appear to be quite a reasonable argument, particularly if the training offered is congruent with the current values of the field, focuses on key competencies, and is able to be utilized and assessed in work settings: better trained workers deliver better care. Although the weight of evidence in the broader human services fields — as noted above — argues that little of what is offered can be characterized as "effective training," there is a small amount of literature in the long-term care field that suggests that training can indeed provide workers with new competencies for on-the-job utilization (Commonwealth Corporation, 2007).

More importantly, a number of studies provide strong evidence that academic programs — based on well defined competencies — are demonstrably effective not only in conveying new values but also in improving the quality of care offered by trainees on the job, and effective training does tend to be associated with improved consumer satisfaction with regard to the quality of care (E. S. Casper, 2001; Council For Standards In Human Service Education, 2006; R. D. Coursey, Curtis, L., 2000; K. J. Gill, Pratt, C.W., & Barrett, N., 1997). There is now little question that education in the specific competencies of psychiatric rehabilitation, for example, results in significant changes in the endorsement of the beliefs, goals, and practices of psychiatric rehabilitation. There is also little question that more educational exposure – more academic credits – in these competencies results in a stronger endorsement of these practices.

Part of the difficulty in developing more compelling research results lies in the methodological challenges involved: Abt Associates (Welch, 2001), for instance, has outlined the difficulty in measuring performance outcomes in the behavioral health environment. Abt asserts that it may be feasible to assess knowledge acquisition, attitude change, and skills development but far more daunting to find effective ways to measure on-the-job performance itself and its impact on consumer care. Others have argued (Bashook, 2005) that:

> *. . . one should keep in mind that assessment of competence before entry into practice is quite different from assessment of performance in practice.*

- **decreases in recruitment, replacement, and retention costs.** Much the same observation can be made with regard to whether career development programs — training, career ladders, wage raises — have a substantial impact on the costs borne by agencies in grappling with higher-than-usual direct support professional turnover. Earlier in this report we reviewed the substantial evidence that turnover is a significant and increasing problem in the field, and that many agencies assess the funds they expend in ongoing recruitment, finding short-term replacements for suddenly-absent staff, and framing more effective retention policies to be a considerable financial burden. Again, a number of studies — often of individual agencies, often in the long-term care field, and often with hard-to-replicate approaches – find that an agency's investment in career development can reduce overall administrative costs (S. A. Larson, Hewitt, A. S., Lakin, C. K., 2004), although the results are relatively small and the impacts relatively short-term.

One of the problems in such studies is the narrow time-frame used, with recruitment costs for one period of time (pre-training) compared with

recruitment costs a year or two later. Longer-term studies, and studies that explore whether direct support professionals leaving one agency are in fact moving not out of the field but laterally to other direct support positions, are rare. No unassailable empirical case can be made yet, although the common sense and initial data would tend to suggest that professional development efforts – whether focused on heightening professional regard or increasing wages — are likely to have a positive effect on retention.

- **increases in initial and long-term wage structures.** Finally, there are only a few studies that track the impact of professional development programs on the wages of MH/DD/SA workers, and most of those — often in the long-term care field — indicate that wage increases are relatively small and have a relatively limited impact (Commonwealth Corporation, 2007). There is some evidence (K. Gill, Turjanick, M., Bagherian, P., & Ali, D., 2005) that those who continue their education in the MH/DD/SA field to the master's level do see their wages rise significantly. There is also evidence that agencies that have instituted career ladders within the direct support environment often tie training to commensurate wage increases, although frequently only minimally, with little to indicate whether these jumps in responsibilities are followed by further job development.

Part of the difficulty here is that the studies undertaken are often within a single agency and do not follow workers from one job setting to another, where even modest wage hikes may be the primary motivation for leaving one job and taking another within the field. Nor do we know if an initial investment — on the part of provider agencies or individual workers themselves — is followed in a significant number of instances by more long-term professional development initiatives that help people move out of direct support roles and into one of the more traditional — and better-paid — professions.

A Future Research Agenda. In brief, then, the current empirical evidence for a greater public investment in direct support professional development is not yet compelling. There is an urgent need for more research, both to outline the issues and to demonstrate the impact of professional development along each of the three dimensions outlined above. At the most fundamental level, the field requires more baseline data to delineate the characteristics of the workforce, and to chart the current career pathways of those now in the field, the costs of training and professional development initiatives, and the methodologies for accurately assessing key competencies in the field. At the same time, we need to know more about the impact of effective professional development on the quality of care delivered in the field, the cost/benefit implications of system and/or agency investments in professional development of their direct support professional workers, and the likely economic benefits to the workforce itself.

Investing in the Direct Support Professional: A Vision Statement

For the work of The Partnership to move forward, it will be important to articulate a vision of what an effective career development system might entail. On the one hand, there is little question that there has been minimal, if any, attention paid to establishing career pathways for those in the MH/DD/SA direct service professional workforce. There is also an ongoing conviction that quality of care can be improved, the human resource costs of agencies can be reduced, and both the intrinsic and extrinsic needs of this workforce can be better met if the field improves its approach to direct service careers. On the other hand, because of the substantial challenges to be met in the process of improving the approach to this critical element of the workforce, The Partnership shapes its vision of the future within the following framework:

- First, we recognize that there will need to be a considerable investment – of time and energy, innovation and funding – to support such an effort. Although we refer here to the "direct service professional workforce," we are still some distance from more widespread acceptance of the direct service worker as a professional. We are still farther from establishing the key markers – such as consistent training, licensing, regulatory, and wage recognition – that frame other professions.

- Second, we choose to move forward, at this time, by focusing only on the mental health and substance abuse segments of the direct service professional workforce. There are two reasons for this: the complexity of the task itself and the differing needs of the MH, DD, and SA fields argue for a narrow initial focus; and the Commonwealth has begun to support the work of the College of Direct Support and its CSSS training for the developmental disabilities workforce.

- Third, we opt for a career development approach for the MH/SA direct service professional that initially addresses the needs of those without a bachelor's degree – those just entering the field, those in non-clinical roles within hospital or community mental health settings, consumers working either as peer specialists or in other direct service roles; and those individuals already within the direct services field but seeking ways to learn and earn more.

What, then, are the attributes of an effective career development system for the direct service professional workforce in the behavioral healthcare arena? We focus here on five particular issues: 1) defining career paths; 2) articulating and training for generic and specific competencies; 3) encouraging employer commitment to help direct service professionals advance their careers; 4) establishing a state-sponsored system for academic certification of training programs; and 5) linking career development to appropriate compensation.

Career paths are well defined for the direct service professional. Establishing well-defined career paths for the direct service professional in the behavioral healthcare environment will require a system that: a) articulates several levels of direct service work, each requiring different competencies and recognized levels of training; and b) is applicable across agencies, in both institutional and community settings. Designations (e.g., Mental Health Worker I, II, III) would be consistent across the field, even while each agency would continue to have flexibility in shaping specific job responsibilities. The Commonwealth would move toward regulatory action governing levels of staffing for each service, implicitly establishing a career path for direct service workers.

Competency-based training is at the core of career development. Each level of the direct service professional career path is linked to specific competencies, and each employee either receives appropriate and effective competency-based training for his/her job (and can demonstrate those competencies on the job) or is offered on-the-job training to acquire those skills, with training time included as part of the reimbursement rate received by providers. For the behavioral healthcare worker, training focuses less on the mastery of hands-on skills and more on the development of interpersonal and group processing skills that enhance consumers' recovery. Training in supervisory skills is also available, and training can be provided for both generic direct support skills and several specialty competencies (e.g., dual diagnosis).

Commitment from employers encourages employee career investment. There is strong support from employers for direct service professionals seeking career advancement. Support includes a focus on: a) affordability – employers offer on-site training, tuition reimbursement, scholarship support, etc.; b) accessibility – employers offer evening and weekend classes, day care and transportation assistance, distance learning opportunities; etc.; and c) accommodations – employers offer remedial learning opportunities, career counseling and academic support, etc. Utilizing the financial resources of employers, foundations, and the Commonwealth, the behavioral healthcare system invests in the competencies and advancement of direct service professionals.

Credentials toward academic degrees can be accumulated over time. A single state agency exists to accredit competency-based training offered by a wide variety of provider agencies, training programs, and academic institutions. Each training program awards credits that can be used toward the goal of a widely accepted academic credential – a one-year certificate, two-year associate's degree, or specialty award; and academic institutions accept credits from a variety of accredited providers toward the award of academic credentials. In addition, there is a pathway from the one-year and two-year credentials toward four-year degrees and advanced professional training.

Compensation increases significantly across the career path. Wage increases are associated with each step along the career ladder, so that movement within the direct service profession has both intrinsic and extrinsic value to the worker. State regulations support appropriate compensation that reflects competencies and levels of responsibility both within the direct service field and as individuals move on either to supervisory positions or to other professional identities within the field. This demonstrates a belief that career paths must reflect in wages the individual's value to the field.

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