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Training direct care staff to increase positive interactions with individuals with developmental disabilities



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ABSTRACT

This study tested the effects of direct training on direct care staff's initiation of positive interactions with individuals with developmental disabilities who resided in an intermediate care facility. Participants included four direct care staff and their residents. Direct training included real-time prompts delivered via a one-way radio, and data were collected for immediate and sustained increases in rates of direct care staff's positive interactions. Additionally, this study evaluated the link between increased rates of positive interactions and concomitant decreases in residents' challenging behaviors. A multiple baseline design across participants was used and results indicated that all direct care staff increased their rates of positive interactions during direct training. Moreover, all but one participant continued to engage residents in positive interactions at levels above the criterion during the maintenance phase and follow-up phases. The direct care staff member who did not initially meet the criterion improved to adequate levels following one brief performance feedback session. With regard to residents' challenging behaviors, across phases, residents engaged in low levels of challenging behaviors making those results difficult to evaluate. However, improvements in residents' rate of positive interactions were noted.

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1. Introduction

Federal funding agencies such as the Medicaid Title XIX program require intermediate care facilities for individuals with developmental disabilities (ICF-DD) to adhere to guidelines that ensure the safety and well-being of residents. One requirement of the Medicaid Title XIX program is the provision of an active treatment framework (Parsons & Reid, 1993; Sturme, 1995). Active treatment refers to the broad range of structured and unstructured training opportunities provided to individuals residing in ICF-DD facilities. An overarching goal of active treatment is to improve the lives of individuals with developmental disabilities by engaging individuals in meaningful, adaptive, and age-appropriate activities throughout the day. The active treatment framework stipulates that staff members regularly engage residents in rehabilitative training tasks and leisure activities, while encouraging positive interactions with peers and staff members (Reid, Parsons, Green, & Schepis, 1991). Researchers have found that active treatment results in improved outcomes for individuals with developmental

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disabilities (Mansell, Elliott, Beadle-Brown, Ashman, & Macdonald, 2002; Sturmey, 1995). More specifically, individuals with developmental disabilities who receive active treatment may possess more adaptive behaviors and often exhibit fewer challenging behaviors (Kurtz, Boetler, Jarmolowicz, Chin, & Hagopian, 2011; Matson, Kiely, & Bamberg, 1997).

Mealtime provides multiple opportunities for direct care staff (DCS) to provide active treatment because individuals with developmental disabilities often exhibit a range of challenging behaviors (e.g., rapid eating, pica, aggression) during mealtime (Chadwick, Jolliffe, & Goldbart, 2002; Fodstad & Matson, 2008; Jenson et al., 1992;). One resource efficient strategy to decrease challenging behaviors while increasing adaptive behaviors during mealtimes might be to train staff to increase positive interactions with supported individuals. In addition to being resource efficient, increasing positive interactions between DCS and residents is consistent with active treatment requirements. Increasing positive interactions between DCS and individuals with disabilities has resulted in favorable client outcomes such as greater life satisfaction and sense of belonging (Jahoda, Cattermole, & Markova, 1990). Conversely, Carsrud, Carsrud, & Standifer (1980) reported that when staff ignored individuals with developmental disabilities, the individuals exhibited decreases in pro-social and constructive behaviors.

Although positive interactions often result in beneficial outcomes, researchers have found that DCS seldom initiate interactions with individuals with disabilities (Chan & Yau, 2002; Repp, Felce, & de Kock, 1987). For example, Chan and Yau (2002) found that interactions between staff and residents only occurred in 37.2% of the intervals observed and non-interactions occurred in 62.8% of intervals. Most often, staff initiated interactions, which centered on nursing care activities that were brief and neutral in affect (Chan & Yau, 2002). Additionally, some researchers have found that DCS were more likely to direct commands than engage in conversation with residents (Veit, Allen, & Chinsky, 1976). Researchers have also found that most interactions between staff and residents occur during structured training time as opposed to unstructured times such as mealtimes and leisure times (Daily, Allen, Chinsky, & Veit, 1974; Kuder & Bryen, 1993).

Researchers have evaluated various strategies to train DCS to implement interventions with integrity. Treatment integrity is the extent to which an intervention is implemented as intended (Gresham, 1989). Several training studies have evaluated impact of didactic training, video training, modeling, feedback, and in vivo training on institutional staff's treatment integrity for behavioral interventions (e.g., Green, Parsons, & Reid, 1993; Parsons, Reid, & Green, 1993; Schepis & Reid, 1994; Sigafos, Roberts, Couzens, & Caycho, 1992). Unfortunately, there are some concerns regarding previous staff training research. First, many of the training packages that have been evaluated are time and resource intensive and may span several weeks (e.g., Macurik, O'Kane, Malanga, & Reid, 2008; Parsons et al., 1993; Sack, McLean, McLean, & Spradlin, 1992). Second, multi-component training packages have seldom undergone component analyses, which may yield more streamlined approaches to training that are time and resource efficient. Third, many of the studies that evaluated staff training have also failed to include adequate follow-up data (e.g., Green et al., 1993; Macurik et al., 2008; Schepis & Reid, 1994). Follow-up data are important to conclude whether the effects of training can be maintained without systematic feedback. Fourth, many studies have also failed to include data for resident behavior (e.g., Green et al., 1993; Macurik et al., 2008; Schepis & Reid, 1994). Therefore, it is impossible to conclude whether the intervention that the staff were trained to implement produced meaningful changes in resident behavior and acquisition of adaptive skills. Fifth, some studies have included pre-post pencil and paper measures of skill acquisition rather than direct measures of treatment integrity (e.g., Durnin & Freeman, 2005; Macurik et al., 2008), and unfortunately pencil and paper measures of skill acquisition may not indicate whether or not staff actually accurately implemented the intervention with supported individuals.

Finally, some staff training studies have included classroom-based training (e.g., Crosland et al., 2008; Guercio et al., 2005; Macurik et al., 2008; Parsons et al., 1993; Schepis & Reid, 1994) which removes staff from the residents they support and requires others to compensate for the staff while receiving training and also limits the extent to which staff receive training under conditions that are analogous to the situations in which they interact with supported individuals. In situ training may result in rapid skill acquisition and maintained implementation (Dufrene et al., 2012; Dufrene, Lestremau Harpole, & Zoder-Martell, *in press*) because intervention skills are learned in the context of relevant stimuli which may evoke implementation behaviors following training (Stokes & Baer, 1977).

Although conducted in a school setting, the training procedures employed by Dufrene et al. (2012) may be well suited to training DCS and would potentially address several of the limitations to the current institutional training literature. Dufrene et al. evaluated in situ training procedures to increase head start teachers' use of praise and effective instruction delivery. Dufrene et al. delivered real-time prompts via a one-way radio during ongoing instructional activities in the classroom, which resulted in increases in teacher praise that were maintained immediately after training and at 1-month follow-up. Additionally, as teachers increased their use of praise, children exhibited fewer disruptive behaviors.

Dufrene et al. (*in press*) replicated Dufrene et al. (2012) in two alternative classrooms for students with Emotional and Behavioral Disorders (EBD) and results were similar. Specifically, in situ training with prompts from a one-way radio resulted in immediate increases in teacher praise for both teachers. However, one teacher maintained increased praise rates following training for more than 1 month, while the other teacher's praise rate returned to baseline levels. For the teacher whose praise returned to baseline levels, additional training and performance feedback resulted in increased praise that maintained for more than 1 month. Moreover, for both classrooms, when teacher praise increased and was consistent, students' engaged in few disruptive behaviors. The primary limitation of Dufrene et al. (*in press*) and Dufrene et al. (2012) is related to the potential for sequence effects since all teachers received didactic training prior to in situ direct training. Additionally, both studies were conducted in educational settings (i.e., Head Start, alternative elementary campus), so it is

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