Inclusion

Treating Employees with Dignity and Respect: The Impact on the Quality of Life on People with Intellectual and Developmental Disabilities

--Manuscript Draft--

Manuscript Number:	DSP-SPECIAL-ISSUE1-INCLUSION-S-23-00019R3
Article Type:	Research Article
Keywords:	people with intellectual and developmental disabilities; Direct Support Professionals; quality of life; personal outcomes; organizational culture
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Manuscript Region of Origin:	UNITED STATES
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Abstract

This study examined the impact of human service providers treating their employees with dignity, respect, and fairness on the quality of life of people with intellectual and developmental disabilities (IDD). We analyzed Personal Outcome Measures (n = 3,898 people with IDD) and Basic Assurances (n = 387 providers) data using multilevel logistic regressions. When providers treated their employees with dignity and respect, people with IDD were more likely to have the following outcomes present: health; continuity and security; realize goals; free from abuse and neglect; respect; decide when to share information; housing choice; fair treatment; rights; and choose services. How organizations treat their employees not only affects those employees, but also impacts the quality of life of people with IDD.

Keywords: people with intellectual and developmental disabilities; direct support professionals; quality of life; personal outcomes; organizational culture

Human service provider leadership, from executive level to middle management to frontline supervisors, play a critical role in shaping organizational culture at service provider agencies, which can influence the service delivery of employees on the frontline and in turn, the quality of life outcomes for people with intellectual and developmental disabilities (IDD). Leadership controls organizational policies and practices that can either uplift or poison work cultures. They are responsible for congruency between formal culture — an organization's mission statement, policies, and training (Felce et al., 2002) — and informal culture — staff members' shared ways of working (Hastings, 1995) — at an organization (Humphreys et al., 2020), as well as recruiting workers whose values align with that culture (Bigby & Beadle-Brown, 2016). Leadership are essential to higher level processes like building relationships with and between their staff, fostering empowered workers, and guiding service delivery decisions (Bigby & Beadle- Brown, 2018; Parish, 2005), and also decisions related to day-to-day operations, like salaries, training, resources provided, coaching and mentoring, and scheduling (Bould et al., 2019; Claes et al., 2012; MediSked, 2016).

Many of these leadership decisions have been found to affect staff satisfaction (Ford & Honnor, 2000), productivity (Jeon et al., 2010), and retention (Houseworth et al., 2020). In fact, relationships between managers, supervisors, and coworkers impact direct support professionals' (DSPs') job satisfaction and commitment to their role and organization (Ducharme et al., 2007; Ford & Honnor, 2000; Gray-Stanley et al., 2010; Mascha, 2007). Supportive leadership has also been found to moderate factors associated with work stress and depression in professionals working directly with people with IDD, resulting in stronger mental health for employees (Gray-Stanley et al., 2010). These findings align with the results in literature outside of the IDD services sector. The global analytics and organizational advisement group Gallup has

demonstrated the positive impact of cultivating relationships between managers and subordinates and among coworkers on employee engagement and performance across sectors (Wagner & Harter, 2018). Research from education (Farinde-Wu & Fitchett, 2016), nursing (Nei et al., 2015), and child welfare (Benton, 2016) have also demonstrated a positive relationship between leadership and culture, such as employees being more likely to stay in their jobs when they feel supported and empowered by organizational leaders.

In contrast, an investigation of job satisfaction of direct service employees by Ford and Honnor (2000) found that lack of support from central leadership and immediate supervisors resulted in staff feeling like second-rated employees, feelings of frustration and being taken for granted, and feelings of powerlessness. Many support staff did not feel involved in decision-making, felt isolated, craved encouraging and systematic feedback about their performance, and did not feel like they had opportunities for advancement (Ford & Honnor, 2000). Feeling disconnected and undervalued by leadership, along with other organizational variables like a negative view of the organization, need for more support, and limited or no time off, has been found to contribute to burnout and staff turnover (Houseworth et al., 2020; Skirrow & Hatton, 2007), which can decrease quality of life for the people with IDD they support (Friedman, 2021).

Poor leadership and organizational cultures not only lead to undesirable results among organization employees, such as support staff, but also negatively impact the outcomes of people with IDD (Bigby & Beadle- Brown, 2018; Claes et al., 2012; Friedman, 2021; Humphreys et al., 2020; President's Committee for People with Intellectual Disabilities, 2017). Ineffective supervision and management, intimidation of staff, and lack of senior management involvement in service delivery have all been associated with increased abuse in group home environments supporting people with IDD (Marsland et al., 2007; White et al., 2003). Similarly, lack of

leadership supported training and instruction has resulted in time-wasting practices, inaccuracy and non-compliance regarding paperwork, and increased mistakes on the frontline that could lead to poor service quality and even harmful medical and behavioral outcomes (Quilliam et al., 2017).

Conversely, high performing leadership, from executive leadership to frontline managers, has generally been found to be a catalyst to quality work and positive outcomes for people with IDD (Northouse, 2019). Beadle-Brown et al. (2015) and Bigby and Beadle-Brown (2016; 2018) found that when supervisors of DSPs demonstrated "practice leadership" — conceptualized by the alignment of values and practice towards people with IDD and coworkers through support, coaching, modeling, and supervision — quality of services increased. Gillett and Stenfert-Kroese (2003) compared group home services having similar structures, resources, and resident characteristics and found that the services that had higher ratings in positive culture supported residents who also had better quality of life outcomes. Bigby and Beadle-Brown (2016) found similar results of differing cultures between underperforming and better performing group homes in their research. Humphreys et al. (2020) found that effective team leadership significantly predicted people with IDD who lived in group homes' engagement in activities.

Leadership can have powerful cascading effects on organizational culture that can then influence service delivery and the outcomes of people with IDD (Agranoff, 2013; Thompson Brady et al., 2009), but the specific factors that drive internal variations in culture that promote positive results are still being explored. Disability scholars are increasingly encouraging researchers to directly connect the practices of leadership to the experiences of adults with IDD who use services to better understand factors that contribute to quality of life outcomes (Amado et al., 2013; Bigby & Beadle-Brown, 2016; Bigby & Beadle- Brown, 2018; Schalock &

Verdugo, 2012; Thompson Brady et al., 2009). For these reasons, the aim of this study was to examine the impact of organizational culture, more specifically of organizations treating their employees with dignity, respect, and fairness, on the quality of life outcomes of people with IDD. To do so, we analyzed secondary Personal Outcome Measures (POM) and Basic Assurances data from 3,898 people with IDD served by 387 human service providers.

Methods

Data and Participants

This study is a secondary data analysis of data that were originally collected between January 2015 to October 2022 from organizations that provide services to people with IDD, including: residential services; employment and other work/day services; family and individual supports; behavioral health care; service coordination; case management; non-traditional supports (micro-boards and co-ops); and human services systems. The people with IDD lived in and their human service organizations operated in 29 states and 2 Canadian provinces: Alabama; Arkansas; Colorado; Connecticut; Florida; Georgia; Illinois; Indiana; Iowa; Kansas; Manitoba; Maryland; Massachusetts; Minnesota; Mississippi; Missouri; Nebraska; New Jersey; New Mexico; New York; North Dakota; Ohio; Ontario; Pennsylvania; South Carolina; South Dakota; Tennessee; Utah; Vermont; and Wyoming. The data included 3,898 people with IDD (level 1 data) served by 387 human service providers (level 2 data).

Among people with IDD (level 1), the average age was 46.72 (*SD* = 16.25; ranged from 18 to 92; Table 1). Most people with IDD were men (55.5%), White (76.9%), communicated primarily through verbal/spoken language (82.9%), and lived in provider owned/operated homes (e.g., group homes; 55.6%). The most common form of decision-making authority was full/plenary guardianship (38.1%). In terms of complex support needs – a proxy for impairment

level – 9.0% of people had complex medical support needs (12+ hours of skilled nursing care), 18.4% comprehensive behavior support needs (24-hour supervision due to risk of harm), and 6.6% had *both* support needs. Slightly less than half of the provider organizations (level 2; 45.6%) provided services in *both* urban and rural areas, 27.4% in only rural areas, and 27.1% only urban areas. The provider organizations served an average of 424.49 people each (*SD* = 1,427.86; ranging from 1 person to 22,000 people). The most common types of services the organizations provided were community-based day activities (76.9%), staffed residential supports (73.9%), and community-based employment (64.4%).

Measures and Variables

Quality of Life Outcomes (Level 1: Individual)

The data about people with IDD's quality of life outcomes came from the POM, a validated, person-centered quality of life tool (Friedman, 2018; The Council on Quality and Leadership, 2017). Developed in 1993 based on focus groups about what really mattered in people with disabilities' lives, the tool has since been refined through pilot testing, a Delphi survey, commission of research and content experts, feedback from advisory groups, validity and reliability testing, and 30 years of administration. The current version of the POM includes 21 quality of life outcomes: people are safe; people are free from abuse and neglect; people have the best possible health; people experience continuity and security; people exercise rights; people are treated fairly; people are respected; people use their environments; people live in integrated environments; people interact with other members of the community; people participate in community life; people remain connected to natural support networks; people have friends; people have intimate relationships; people decide when to share personal information; people

perform social roles; people choose where and with whom to live; people choose where to work; people choose services; people choose personal goals; and, people realize personal goals.

POM administration occurs in three steps. In the first step, a certified reliable interviewer has an in-depth conversation with the person with IDD about each of the outcome areas, following open-ended prompts. In the second step, the interviewer speaks with someone who knows about the person with IDD's organizational supports and asks them questions about these supports. During the last stage, if needed, the interviewer may participate in observations or conduct record reviews; otherwise, they complete decision trees (see The Council on Quality and Leadership (2017) for decision-trees) based on all information gathered to determine if each of the 21 outcomes is present (1) or not (0).

Organizations' Treatment of Employees (Level 2: Organizational)

The data about organizations' treatment of employees came from the Basic Assurances (The Council on Quality and Leadership, 2015), an organizational assessment of non-negotiable requirements for service and support providers. Developed in 1971 based on feedback from practitioners, providers, government personnel, advocacy organizations, people with disabilities, and family members about high quality service standards, the Basic Assurances has been refined based on pilot testing, a Delphi survey, development of a conceptual framework, stakeholder interviews, reviews by experts, and 50 years of administration.

The current version of the Basic Assurances contains 10 factors: rights protection and promotion; dignity and respect; natural support networks; protection from abuse, neglect, mistreatment and exploitation; best possible health; safe environments; staff resources and supports; positive services and supports; continuity and personal security; and basic assurances system (a quality assurances monitoring system). To make determinations on factors and

subfactors (called indicators), expert reviewers collect data from the following sources: interviews with people with IDD; focus groups with people with IDD; interviews with organizational leadership; focus groups with employees; reviews of the providers' policies, regulations, data, and records; and observations. Using this information, the expert reviewers determine if each of the factors and indicators are present or not (see The Council on Quality and Leadership (2015) for probes for each indicator).

Within the factor on staff resources and supports (Factor 7), the Basic Assurances measures if "the organization treats its employees with dignity, respect and fairness." As part of information gathering for this indicator, the expert reviewers conduct focus groups with DSPs and frontline supervisors to determine if they feel valued, how they are shown they are valued, if they feel their pay and benefits are fair, if they receive adequate and valuable training, what their relationships with managers are like, if they have work-life balance, if they are supported to be effective leaders and managers, and what they would like to maintain or change about the organization (K. Dunbar, personal communication, May 23, 2023). In addition to focus groups, the reviewers also interview individual employees to determine how they feel they are treated, as well as conduct observations in various settings to determine if interactions between employees, including with their managers, are respectful and offer autonomy. Finally, the expert reviewers conduct record reviews; they review employee handbooks to examine information about insurance, time off and holiday policies, and employee disciplinary procedures, among others, to establish if they are fair and supportive or punitive. Reviewers also examine employee files and employment reviews to determine if there is a focus on deficiencies, or strengths, encouragement, and goals – to get an overall sense of how supportive organizations are for their employees.

The reviewers use all of the aforementioned evidence to determine if the indicator "the organization treats its employees with dignity, respect and fairness" is present at an organization from an employee-centered perspective; they do so while measuring the general culture of dignity, respect, and fairness at the organization, as well as by examining if the following probes within this indicator are met (1.) the organization provides staff with personnel policies and procedures or a handbook that informs them of its personnel practices, benefits, pay plan, due process procedures, and opportunities for continuing education; (2.) the organization's personnel policies, procedures, and practices meet all state and federal fair labor laws; (3.) the organization provides staff a job description that describes the position's duties and responsibilities; (4.) staff performance with respect to the job description is evaluated during a probationary period and annually thereafter, and performance evaluations include staff's objectives for professional and personal growth; and (5.) the organization has an employee incentive program that includes tangible and intangible rewards important to support staff. If the organization meets these conditions, especially numbers 4 and 5, as well as has an organizational culture of dignity, respect, and fairness, the indicator "the organization treats its employees with dignity, respect, and fairness" is considered present (1); if they do not, it is considered not present (0).

Analyses

Data were analyzed using SPSS27. We first analyzed descriptive statistics. Then, we examined the impact of organizations treating their employees with dignity, respect, and fairness on the quality of life outcomes of people with IDD. As a result of the nested structure of the data between individuals with IDD and provider organizations, we used multilevel logistic regressions. In the first round of models, we ran intercept-only unconditional models with each POM outcome area (in separate models) as the primary outcome and the random intercept to

examine the variation in the corresponding outcomes by provider. In the second round of models, we entered all sociodemographic variables as fixed-effects. In the third round of models, we added the variable about organizations treating their employees with dignity, respect, and fairness as a fixed-effect variable. To indicate variance in quality of life outcomes attributed to different providers, we calculated intraclass correlation coefficients (ICCs) using the following formula:

$$ICC = \frac{Residual\ variance}{Residual\ variance + (\pi^2/3)}$$

To determine if each of the consecutive models improved goodness of fit, we calculated likelihood-ratio tests (LR χ^2 [1]) by subtracting the deviance of each model. Confidence intervals (CIs) for all odds ratios (ORs) were set at 95%.

Results

The quality of life outcomes most present among people with IDD were people are safe (80.07%), people use their environments (66.96%), and people have the best possible health (65.88%), while the least present were people choose where and with whom to live (25.69%), people choose services (26.98%), and people perform different social roles (35.08%; Table 2). In our sample, 85.03% of provider organizations (n = 301) treated their employees with dignity, respect, and fairness, while 14.97% (n = 53) did not.

We used multilevel logistic models to examine the impact of organizations treating their employees with dignity, respect, and fairness on the quality of life of people with IDD. In the first round of unconditional null models, ICCs (ranged from 10.84% to 34.33%) indicated a significant proportion of each of the 21 quality of life outcomes were attributed to differences between providers (Table 3). The second round of models incorporated individual and organizational sociodemographic characteristics; the addition of sociodemographics significantly

improved the goodness of fit of all 21 outcome models (LR χ^2 [1] ranged from 5,816.91 to 6,944.34, $p < 0.001$ for all).

The third round of models incorporated organizational treatment of employees, which improved the goodness of fit for all 21 outcomes (LR χ^2 [1] ranged from 608.78 to 727.33, $p < 0.001$ for all). Controlling for all sociodemographics, when organizations treated their employees with dignity, respect, and fairness, people with IDD were significantly more likely to have the following outcomes present: people have the best possible health (OR[CI] = 1.54 [1.02, 2.34]); people realize personal goals (OR[CI] = 1.63 [1.08, 2.46]); people experience continuity and security (OR[CI] = 1.71 [1.05, 2.77]); people are free from abuse and neglect (OR[CI] = 1.75 [1.07, 2.88]); people are respected (OR[CI] = 1.82 [1.11, 3.01]); people decide when to share personal information (OR[CI] = 1.98 [1.15, 3.41]); people choose where and with whom to live (OR[CI] = 2.27 [1.18, 4.38]); people are treated fairly (OR[CI] = 2.55 [1.49, 4.37]); people exercise rights (OR[CI] = 2.58 [1.49, 4.45]); and people choose services (OR[CI] = 2.69 [1.39, 5.20]).

Discussion

Organizational culture impacts the quality of supports people with IDD receive. Therefore, the aim of this study was to examine how organizations treating their employees with dignity, respect, and fairness impacted the quality of life outcomes of people with IDD. We found that when employees were treated well, people with IDD were more likely to have many quality of life outcomes present, regardless of their support needs or other sociodemographics. Organizational values and practices matter, not only to the people who work there, but also the people with IDD they support. This cascading effect is exemplified by our finding that when

employees were treated with dignity, respect, and fairness, the odds of people with IDD being respected increased by 82%.

How employees are treated contributes to burnout and turnout (Houseworth et al., 2020; Skirrow & Hatton, 2007), which in turn threatens the continuity and security of people with IDD. While poor treatment of employees by their employers contributes to significant disruption in people with IDD's lives, hindering people with IDD's mental and behavioral health (American Psychological Association, 2020; Centers for Disease Control and Prevention, 2020), positive treatment of employees can help shield people with IDD from these changes by increasing their continuity and security.

As indicated by our findings, the impact of positive employee treatment can extend far beyond the continuity and security of people with IDD. In fact, positive treatment of employees also correlated with outcome areas often associated with disparities among people with IDD, such as health, and abuse and neglect. For example, people with IDD are significantly more likely to be victims of abuse, neglect, mistreatment, and exploitation than people with other disabilities and nondisabled people (Baladerian et al., 2013; Shapiro, 2018; U.S. Department of Health and Human Services et al., 2018). Moreover, people with IDD face a number of health disparities compared to nondisabled people, including poorer health outcomes and shorter life expectancies, due in part because of health care access issues and social exclusion (Centers for Disease Control and Prevention, 2017; O'Leary et al., 2017; Ouellette- Kuntz, 2005; Taggart & Cousins, 2014). Yet, in this study, when organization employees were treated with dignity, respect, and fairness, the odds of people with IDD being free from abuse and neglect increased by 75%, and having the best possible health increased by 54%. These relationships may be due in part to the relationship between turnover and poor staff treatment – turnover stretches current

DSPs thin and also requires new DSPs to be brought in that may not be as experienced or familiar with the needs of the person with IDD they are supporting. In addition, when treated positively, DSPs may be less likely to take their own frustrations out on people with IDD via abuse and neglect, and may make fewer mistakes that hinder people's health. As a result, how employees are treated by their employers may serve as a social determinant of health of people with IDD who receive services – "conditions in the environments in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks" (United States Office of Disease Prevention and Health Promotion, n.d., n.p.). As such, treating organization employees with dignity, respect, and fairness may play a role in promoting health equity for people with IDD.

Positive treatment of organization employees also significantly improved the odds of people with IDD exercising their rights and being treated fairly (receiving adequate due process) by 158% and 150% respectively. While this again suggests the benefits of treating employees positively, it is also concerning that human and civil rights, which should be inalienable, depended on how organization employees were treated by their employers. Yet, the denial of people with IDD's civil rights have long been linked to attitudes and paternalism, a removal of autonomy based in condescension (Carey, 2003). It may be that poor treatment of employees contributes to paternalistic custodial models of care in organizations – ones that focus on safety, routinization, supervision, and efficiency rather than support (Carlson, 2010; Johnson & Bagatell, 2017; Spagnuolo, 2016; Trent, 1994) – because employees may fear punishment so focus solely on mitigating risks. In addition, if an employee is not being treated well, they may not make the extra effort as managing people and doing things on people's behalf is often easier than giving them opportunities to learn, make informed choices, and control their own lives. In

fact, better treatment of employees was associated with more person-centered practices, as indicated by increased likelihood of people with IDD choosing where they lived, choosing their services, and realizing their goals. In contrast to custodial models of care, person-centered practices put people with IDD in control of their lives and facilitate self-determination and empowerment, resulting in better outcomes and quality of life (Center for Medicaid and CHIP Services, n.d.; Friedman & VanPuymbrouck, 2018; Heller et al., 2012; Kietzman & Benjamin, 2016; Swaine et al., 2016; Timberlake et al., 2014).

Limitations

When interpreting the findings from this study, several limitations should be noted. People with IDD volunteered to participate in POM interviews; as such, there is a chance of self-selection bias. Basic Assurances surveys are often used with organizations who are pursuing accreditation and therefore, may not be representative of all human service providers. As this was a secondary data analysis, we did not have the ability to ask additional questions or add additional variables. For example, we did not have information about the specific wages or benefits provided to staff at human service organizations to use as covariates in the analyses. There may be factors that were not explored in this study that impacted the relationship between the treatment of employees, and the quality of life of people with IDD. This was a cross-sectional analysis and causality cannot be assumed.

Implications for Practice

Given the transformative nature of treating employees with dignity, respect, and fairness on not only those employees, but also people with IDD, it is important human service organizations foster respective, inclusive cultures. Leaders can treat employees with dignity and respect by creating a culture of inclusivity in the workplace that allows space for “authentic

otherness" (Gardiner, 2017). An inclusive environment necessitates a caring and holistic perspective from leaders who see their employees as people who should be treated ethically, not as instruments to be used or means to an end. Leaders of these environments consciously give a voice to marginalized populations with different perspectives and encourage meaningful and sometimes uncomfortable conversations about how to advance inclusivity (Gardiner, 2017). An inclusive environment encourages DSPs to offer suggestions and be involved in decision making, which could help simplify procedures and personalize services, leading lead higher levels of job satisfaction and organizational commitment and better service delivery (Hewitt et al., 2008; Johnson et al., 2021). Johnson et al. (2021) found in their interviews with both DSPs and frontline supervisors that fostering inclusive environments was often not happening because the demands of these roles leave little time for DSPs to give feedback to managers or contribute to organizational conversations. Increasing technology and remote support services for people with IDD shows promise for increasing independence (Tassé et al., 2020), which could free up time for DSPs to interact more with managers. Future research should investigate different ways organizations can practically implement strategies that allow every employee to be heard.

Another component of respectful and fair treatment of employees is adequately preparing them to do their jobs. Training leads to higher job satisfaction, more self-efficacy and confidence, and less burnout among DSPs (Britton Laws et al., 2014; Ejaz et al., 2008; Hasan, 2013; Hewitt & Lakin, 2001; Hewitt & Larson, 2007; Keesler, 2016; Taylor, 2008). Providing opportunities for growth through competence-based training and participatory management practices shows respect by recognizing the potential of every employee as an emerging leader (Johnson et al., 2021; Macbeth, 2011). In addition to helping with personal growth and creating pathways for career advancement (Britton Laws et al., 2014; Firmin et al., 2013; Hasan, 2013;

National Direct Service Workforce Resource Center, 2013), increased DSP training and its impact on DSPs result in improved services and outcomes among people with IDD (Britton Laws et al., 2014; Friedman, 2020; Robbins et al., 2013). For example, while people with IDD highly appreciate interpersonal skills in their support staff, like patience, listening ability, respect, availability, accessibility, and trust, frontline managers rarely mention the importance of a trusting relationship and these social skills (Pallisera et al., 2018). Working toward advancing inclusion necessitates emotional support training and interpersonal training for employees; as such, programs that directly address relationships and organizational culture should be incorporated into employee training.

Another beneficial technique to improve organizational culture is peer mentorship, such as in the Peer Empowerment Program, where there is a deliberate pairing of an experienced or skilled employee with someone less experienced as it offers "systematic ways to ensure that people get the support they need to excel in work and to prevent experiences of failure" (Taylor et al., 2001, p. 2). The Peer Empowerment Program, which follows a curriculum of activities, worksheets, and discussions, gives new hires a safe forum to give feedback and express anxieties and concerns, connect socially with colleagues, feel less isolated, and gain access to information and guidance on the workplace culture and norms. In exchange, the Peer Empowerment Program boasts benefits to mentors that includes recognition for advanced skills, opportunities to develop new skills, job advancement, renewed interest in job, and incentives, rewards, and bonuses, and benefits to employers of better service delivery, less staff turnover, and development of positive long-term relationships (Taylor et al., 2001).

Leaders can also show their employees respect with recognition and encouragement. Employees may feel unappreciated for the difficult work they do, which causes a disconnect

between employee, supervisor, and executive leadership, and may lead to lack of engagement and commitment to quality services (Johnson et al., 2021). Employee recognition programs, awards, and incentives can be used to increase employee motivation and retention (Hewitt & Lakin, 2001; Hewitt & Larson, 2007; Johnson et al., 2021; Macbeth, 2013; Winters et al., 2021). Leadership should find "specific, individualized, and tangible ways to authentically appreciate DSPs" (Johnson et al., 2021, p. 214), which could include organizational events where employees are recognized for their exceptional work, tangible items like pins or jackets to acknowledge years of service, and extra paid time off (Macbeth, 2013).

Treating employees with dignity, respect, and fairness also means having an organizational culture that encourages and fosters self-care (Keesler & Troxel, 2020; Lee & Miller, 2013; Orellana-Rios et al., 2018). Keesler and Troxel (2020) explain

> it is critical for organizations: to understand the importance of self-care to professional quality of life; to foster awareness of self-care among DSPs through education; to promote and reward self-care practices among DSPs; and, to provide opportunities for the integration of self-care into daily routines. (pp. 20-21)

Organizational cultures that promote self-care result in higher resilience and less burnout and stress among their employees (Keesler & Troxel, 2020), which in turn improves the outcomes of people with IDD.

Implications for Research

Expanding research about leadership practices in the IDD service sector is particularly important as recent studies have found that although best practices in supports have changed rapidly over the last several decades (Barnacet et al., 2021), many adults with IDD still lack meaningful choice and control over their services and lives (Friedman & VanPuymbrouck,

2018). Specifically, findings from the United States and the United Kingdom have shown that moving from segregated, congregate services to individualized supports is not sufficient to ensure that adults with IDD and their families have access to quality, person-directed services (Beadle-Brown et al., 2015; Mansell, 2006). As inconsistent access to quality services for people with IDD continues to be a pervasive issue in the IDD services sector (Braddock et al., 2017; Hewitt & Nye-Lengerman, 2019), effective leadership practices and intentional changes to organizational culture may contribute to more uniform, consistent service delivery resulting in better outcomes for people with IDD. While the need for dignity, respect, and fairness is universal, it is suspected that the strategies of building inclusive organizational culture, recognizing employee accomplishments, and supporting employees as emerging leaders may vary greatly depending on things like organizational structure, size, funding streams, receptiveness of staff, and more. As such, more research is needed to develop and test different approaches to these interventions, their effectiveness in different environments, and their cascading impact on people with IDD. Additionally, our research found that 15% of organizations in our sample did not treat their employees with dignity, respect, and fairness. The current study did not examine if there were specific detrimental policies or practices that may contribute to organizations falling short of promoting appropriate treatment of employees, which is another possible area for future research.

Conclusion

Creating a positive culture leads to greater levels of employee satisfaction and lower turnover (Houseworth et al., 2020; Skirrow & Hatton, 2007). DSPs who like their workplace culture and feel supported and appreciated by leadership have higher resilience, less burnout, and are more satisfied with their jobs (Ford & Honnor, 2000; Keesler & Troxel, 2020). DSPs who are

supported and satisfied with their jobs are more likely to emulate positive work culture and improve the quality of life for the people with IDD they support (Bigby & Beadle-Brown, 2016). In fact, in this study, we found when organization employees were treated with dignity, respect, and fairness, people with IDD were more likely to be free from abuse and neglect, be healthy, experience continuity and security, exercise their rights and be treated fairly, be respected, decide when to share personal information, choose where and with whom to live, choose their services, and realize goals. Treating employees with dignity, respect, and fairness is good for business, good for employees, and good for the people with IDD being supported.

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Table 1
Demographics

Characteristics	n	%
Individuals (level 1; *n* = 3,898)		
Age (*n* = 3,591; M [SD])	46.72 (16.25)	
Gender (*n* = 3,860)		
Man	2,144	55.5%
Woman	1,716	44.5%
Primary communication method (*n* = 3,868)		
Verbal/spoken language	3,208	82.9%
Other	660	17.1%
Decision-making authority (*n* = 3,845)		
Full/plenary guardianship	1,466	38.1%
Independent decision-making	1,176	30.6%
Assisted decision-making	1,129	29.4%
Other	74	1.9%
Race (*n* = 3,850)		
White only	2,960	76.9%
Black only	635	16.5%
Latinx only	108	2.8%
Indigenous only	78	2.0%
Multiracial	32	0.8%
Asian only	18	0.5%
Other	19	0.5%
Complex support needs (*n* = 3,408)		
None	2,249	66.0%
Comprehensive behavior support needs	627	18.4%
Complex medical support needs	307	9.0%
Both	225	6.6%
Residence (*n* = 3,840)		
Provider owned/operated home	2,135	55.6%
Own home	722	18.8%
Family's home	581	15.1%
Host home or family foster care	117	3.0%
ICF/DD	99	2.6%
State HCBS group home	60	1.6%
Other	126	3.3%
Providers (level 2; *n* = 387)		
Geographic region (*n* = 340)		
Both urban and rural	155	45.6%
Rural only	93	27.4%
Urban only	92	27.1%
Total people served (*n* = 336; M [SD])	424.49 (1427.86)	
Services provided		
Community-based day activities (*n* = 337)	259	76.9%
Staffed residential supports (*n* = 337)	249	73.9%
Community-based employment (*n* = 337)	217	64.4%
In-home supports (own home or family home; *n* = 337)	206	61.1%
In-home day activities (*n* = 337)	164	48.7%
Respite care (*n* = 337)	143	42.4%
Facility-based work/day activities (*n* = 337)	140	41.5%
Transportation activities (*n* = 337)	128	38.0%
Behavior support services (*n* = 337)	122	36.2%
Therapies (e.g., psychology, physical therapy, occupational therapy, speech/language; *n* = 337)	92	27.3%
Host home, family foster care, or companion home (*n* = 337)	61	18.1%

Independent support coordination (n = 337)	48	14.2%

Table 2

Descriptive Statistics

Variable	% present
Quality of life outcomes of people with IDD (Level 1)	
People are safe (*n* = 3,893)	80.07%
People use their environments (*n* = 3,895)	66.96%
People have the best possible health (*n* = 3,889)	65.88%
People realize personal goals (*n* = 3,896)	61.45%
People are free from abuse and neglect (*n* = 3,893)	57.31%
People are respected (*n* = 3,891)	54.25%
People choose personal goals (*n* = 3,893)	52.07%
People interact with other members of the community (*n* = 3,891)	51.53%
People are treated fairly (*n* = 3,896)	51.23%
People decide when to share personal information (*n* = 3,892)	48.74%
People experience continuity and security (*n* = 3,893)	44.75%
People exercise rights (*n* = 3,892)	44.68%
People are connected to natural support networks (*n* = 3,893)	43.90%
People live in integrated environments (*n* = 3,893)	42.97%
People participate in the life of the community (*n* = 3,896)	38.76%
People have intimate relationships (*n* = 3,893)	38.48%
People have friends (*n* = 3,892)	37.85%
People perform different social roles (*n* = 3,891)	35.08%
People choose where to work (*n* = 3,888)	32.15%
People choose services (*n* = 3,892)	26.98%
People choose where and with whom to live (*n* = 3,893)	25.69%
Organizational culture (level 2)	
Organization treats employees with dignity, respect, and fairness (*n* = 354)	85.03%

Table 3

Impact of Organizational Employee Treatment on the Quality of Life of People with IDD

	Model 1: null			Model 2: demographic covariates				Model 3: organization culture				
Quality of life indicator	Deviance (BIC)	Variance (residual)	ICC	Deviance (BIC)	LR χ^2 (1)	Variance (residual)	ICC	Deviance (BIC)	LR χ^2 (1)	Variance (residual)	ICC	Organization treats employees with dignity, respect, fairness (OR [CI])
Safe	18,726.21	0.68	17.04%	11,781.87	6,944.34***	0.64	16.35%	11,054.54	727.33***	0.63	16.16%	1.19 [0.71, 1.99]
Free from abuse and neglect	17,212.20	0.79	19.42%	10,993.32	6,218.88***	0.95	22.48%	10,384.54	608.78***	0.98	22.93%	1.75 [1.07, 2.88]*
Best possible health	17,443.44	0.51	13.31%	10,795.81	6,647.63***	0.54	14.08%	10,163.37	632.44***	0.48	12.73%	1.54 [1.02, 2.34]*
Continuity and security	17,006.84	0.64	16.28%	10,873.27	6,133.57***	0.82	20.03%	10,224.41	648.86***	0.76	18.73%	1.71 [1.05, 2.77]*
Exercise rights	17,371.13	0.76	18.79%	10,987.34	6,383.79***	0.91	21.67%	10,320.93	666.41***	0.86	20.72%	2.58 [1.49, 4.45]***
Treated fairly	17,298.65	0.92	21.83%	10,958.61	6,340.04***	0.98	22.95%	10,328.65	629.96***	0.94	22.20%	2.55 [1.49, 4.37]***
Respected	17,378.98	0.84	20.24%	10,884.88	6,494.10***	0.89	21.33%	10,255.16	629.72***	0.89	21.20%	1.82 [1.11, 3.01]*
Use environments	17,494.28	0.61	15.68%	10,933.14	6,561.14***	0.66	16.71%	10,284.75	648.39***	0.66	16.79%	1.53 [0.97, 2.42]
Live in integrated environments	17,713.29	1.72	34.33%	11,896.38	5,816.91***	1.92	36.84%	11,249.67	646.71***	2.08	38.77%	1.08 [0.54, 2.16]
Interact with other members of community	16,779.66	0.49	13.03%	10,670.80	6,108.86***	0.52	13.53%	10,049.65	621.15***	0.55	14.32%	1.17 [0.76, 1.80]
Participate in life of community	16,998.73	0.57	14.72%	10,832.76	6,165.97***	0.58	15.01%	10,199.47	633.29***	0.62	15.75%	0.90 [0.57, 1.40]
Natural supports	16,988.96	0.47	12.45%	10,869.38	6,119.58***	0.56	14.57%	10,244.97	624.41***	0.61	15.62%	1.10 [0.70, 1.75]
Friends	16,913.54	0.42	11.30%	10,824.72	6,088.82***	0.48	12.69%	10,189.92	634.80***	0.50	13.15%	1.34 [0.86, 2.10]
Intimate relationships	16,916.41	0.49	12.99%	10,798.79	6,117.62***	0.61	15.64%	10,139.58	659.21***	0.56	14.63%	1.26 [0.80, 1.97]
Decide when to share personal information	17,758.09	1.08	24.64%	11,030.91	6,727.18***	1.11	25.21%	10,364.28	666.63***	1.07	24.47%	1.98 [1.15, 3.41]*
Social roles	17,130.47	0.60	15.38%	10,867.33	6,263.14***	0.55	14.35%	10,191.35	675.98***	0.50	13.22%	1.33 [0.85, 2.07]

Choose where and with whom to live	18,190.69	0.75	18.64%	11,848.85	6,341.84***	1.31	28.48%	11,163.87	684.98***	1.32	28.56%	2.27 [1.18, 4.38]*
Choose where to work	17,456.88	0.62	15.94%	10,968.28	6,488.60***	0.71	17.71%	10,318.29	649.99***	0.74	18.42%	1.00 [0.62, 1.62]
Choose services	18,450.31	1.24	27.29%	11,696.65	6,753.66***	1.37	29.38%	10,983.15	713.50***	1.29	28.13%	2.69 [1.39, 5.20]**
Choose personal goals	17,020.79	0.79	19.32%	10,918.64	6,102.15***	0.95	22.46%	10,284.85	633.79***	1.04	24.00%	0.91 [0.55, 1.51]
Realize personal goals	17,016.50	0.40	10.84%	10,930.26	6,086.24***	0.42	11.20%	10,306.91	623.35***	0.43	11.51%	1.63 [1.08, 2.46]*

Note. *p<0.05. **p<0.01. **p<0.001. Models 2 and 3 control for: age; gender; communication method; decision-making authority; race; complex support needs; residence type; geographic region of provider (level 2); number of people served by agency (level 2); and services offered by provider (level 2).