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SGPS 9105A: Value of residential care: Review and strategies to advocate for better wages for PHSS

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Value of Residential Care: Review and Strategies to Advocate for Better Wages for PHSS

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1. Purpose of the Literature Review

This paper reviews the academic literature to provide a better understanding of wage and retention issues in residential care programs, specifically those that care adults with developmental delays and complex physical needs. Though such issues have been taken up in literature across Canada (Squires et al., 2015; British Columbia Ministry of Health, 2017; Alberta Government, 2017), this review pursues a focus on literature relevant to Ontario. The purpose of this review is to develop a base of knowledge regarding the state of residential care programs for adults with disabilities in Ontario. As well, to investigate the status, specifically the social, economic, and perceived community value, of residential care programs for adults with disabilities more broadly. In seeking to establish this base of knowledge, this literature review is aimed at addressing the social issue of the underrepresented value of residential care and residential care labour. Connectedly, this review aims to facilitate understanding around the current state of wage inequality, staff retention issues, and funding availability for residential care programming.

This literature review has been performed with specific consideration given to the context of Participation House Support Services (PHSS), of the Participation House Foundation. PHSS operates under the vision to “be a leader in building healthy, caring, sustainable communities for individuals with complex developmental and/or physical needs through public engagement and philanthropy.” PHSS supports over 200 individuals, operating over 50 fully accessible homes with 24-hour care in locations throughout London, Ontario and the surrounding region. In its *2017-2018 Annual Report* the PHSS treasurer’s report indicates that 56% of revenues come from the Ministry of Community & Social Services (MCSS) and the Ministry of Children and Youth Services (MCYS), 35% of revenues come from the South West Local Health Integration Network (LHIN), while the remaining 9% is funded through other sources including grants, donations, and interest. The allocation of this funding is heavily directed towards staff salaries, training and benefits at 85%, while building occupancy draws 6%, supplies 5%, and office and other operating costs drawing 4% (PHSS, 2018). PHSS employs 504 individuals, 163 full-time staff and 341 part-time staff (PHSS, 2018). PHSS has identified issues of

wage equality, social undervaluing, staff retention, and funding as major concerns for their foundation and programming.

The literature review is the first step in addressing the following research question: **How to raise awareness and support advocacy towards government bodies and funding agencies regarding increasing wages of residential care support workers to address issues of staff retention?** The review is organized in the following manner. First, we provide information and rationale regarding the methods used to conduct this literature review, including key search terms used and locations searched. Second, we provide a review of literature relating to supportive care in Ontario, Social Role Valorization (SRV), female occupations and value, burnout and compassion fatigue, and workplace experience. Third, we provide an analysis of this literature including a description of the way the literature operates to support advocacy work in relation to residential care such as that provided by PHSS. We also describe here some possible areas for additional and/or new bodies of literature to investigate. Fourth, we make suggestions for potential approaches and/or strategies for advocacy on the issues identified by PHSS. Fifth, some organizations local to PHSS are listed in order to assist in the beginning stages of identifying potential advocacy partners. The paper is concluded with recommendations for both future research and those taking up the next steps of this work.

2. Methods of Literature Review

This literature review was carried out through the investigation of several bodies of literature. The research and review was approached thematically. These themes include approaches to residential care for developmentally disabled adults, residential care and social value, and social role valorization, caregiving labour as it pertains to job experience, gender, compassion fatigue, and burnout. Searches were carried out in both broader internet searches and academic venues. Broader internet searches allowed us to gather information and literature from governmental websites such as Alberta Government, British Columbia Ministry of Health, institutional reports, and advocacy work done for other residential care programs. Searches done through academic venues allowed us gain information and to make connections between various bodies of scholarship with relevance to this social issue. Academic databases searched included, but are not limited to, Google Scholar, Western University's main catalogue, as well as more specialized databases including SCOPUS, Business Source Complete, Medline, and Cochrane. Search terms used include, but are not limited to, the following: residential care in Ontario; residential support and developmental disabilities and Ontario; social value and persons with intellectual/developmental disabilities; social role valorization; residential care staff/labour/worker and workload; occupational feminization; gender pay gap; residential care staff and job satisfaction; residential care and qualification.

3. Review of Literature & Emergent Findings

In each of the following sections, we review the academic literature broadly to provide the readers with a broader understanding of the issues at hand. Within each section, we relate these findings in the context of PHSS and their issues to better understand how to best advocate for better funding for the organization and summarize the suggestions in the final section.

3.1 Supportive Care in Ontario

Public healthcare in Ontario is administered by 14 Local Health Integration Networks (LHIN), which are non-profit organizations funded by the Ministry of Health and Long-Term Care. The South West LHIN is responsible for planning, organization, and distributing funding for healthcare services in southwest Ontario. This includes the city of London, which resides in Middlesex County, where PHSS is based, and extends to the Bruce, Elgin, Grey, Huron, Norfolk, Oxford, and Perth counties (South West LHIN, 2018). Home and Community Care LHIN – formerly Community Care Access Centre – coordinates home healthcare services like supportive living programs, such as those provided by PHSS to people with disabilities.

Here, we use the term supportive care to refer to home care for persons with chronic health concerns, such as significant physical or developmental disabilities, living in supportive housing. Workers who provide care to people with chronic conditions in supportive housing can be referred to as personal support workers; however, the term is not a regulated professional title (Sethna, 2013). Other titles that have been used to describe the role include home care worker, health care assistant, and home health aide (Zeytinoglu, Denton, Brookman, & Plenderleith, 2014). There are approximately 90,000 support workers in Ontario, and of this number, 26,000 are employed in supportive home care for community organizations like PHSS (Ontario Ministry of Health and Long-Term Care [MOHLTC], 2011b).

Support workers like those employed by PHSS are incredibly important in the lives of individuals with disabilities of any type (Hastings, 2010). Primarily, home support workers carry out tasks supporting clients' day-to-day living such as bathing, getting dressed, toileting, cleaning,

cooking, shopping, and administering medication (Briar, Liddell, & Tolich, 2014; Lum et al., 2010; Saari, Patterson, & Kelly, 2018; Zeytinoglu et al., 2014). In recent years, the roles of support workers in Ontario have expanded to require more complex care tasks, including administering injections, caring for wounds and injuries, and performing lifts and transfers (Denton, Brookman, Zeytinoglu, Plenderlieth, & Barken, 2015; Saari et al., 2018; Zeytinoglu, Denton, & Brookman, 2014). In short, support workers wear many colloquial 'hats', acting at different times like chefs, chauffeurs, nurses, housekeepers, and counsellors.

Restructuring of the home health care industry in Ontario towards a "market-modelled system", including initiatives such as the introduction of "competitive bidding", has created lasting changes in the nature of long-term supportive care (Aronson, Denton, & Zeytinoglu, 2004; Ontario Health Coalition, 2005; Zeytinoglu, Denton, Plenderlieth, & Chowhan, 2015). Notably, in the past, home care was served almost entirely by non-profit community agencies, but recent years have seen these local non-profits lose contracts to increasing numbers of for-profit agencies (Ontario Health Coalition, 2005). This restructuring has increased employment instability for support workers, contributing to job retention issues as support workers move to other sectors (Ontario Health Coalition, 2005).

Non-standard hours and job insecurity are common features of support work in Ontario and the rest of Canada (Zeytinoglu et al., 2015). These can be respectively defined as part-time (guaranteed regular work) or casual (irregular) hours, and worker perceptions of insecurity in their current workplace (Zeytinoglu et al., 2015). Job insecurity, low wages, and lack of benefits are three of the most common reasons for support workers leaving the home care sector (Lum, Sladek, & Ying, 2010; Ontario Health Coalition, 2005). Home care support workers report that they are underpaid compared to support workers in hospital settings (Laucius, 2018), and almost two-thirds (65%) report that their pay is too low (Lum et al., 2010). When retention is low, recruitment also suffers, as recruitment strategies are less successful (Lum et al., 2010). Poor employee retention and high turnover rates present problems not only for organizations like PHSS, but also for clients receiving care, who have formed supportive relationships with their care providers and are subject to

disruptions when workers leave the sector. Improving retention rates for support workers thus helps ensure continuity of care for this vulnerable population. Ensuring fair compensation for support workers represents one way to improve job retention and improve the lives of both workers and clients.

3.2 Social Role Valorization

The concept of social role valorization was developed by Dr. Wolf Wolfensberger (1983) and has been taken up extensively by scholars in the field of developmental and intellectual disabilities studies (Culham & Nind, 2003; Lemay, 2006; Neuville & Smith, 2008; Park & French, 1999; Thomas, 1999). Social role valorization (SRV) emerged from Wolfensberger's (1972) and Nirje's (1969) previous work on normalization.¹ SRV can be understood as the name ascribed to the concept for human interaction as it pertains to services and relationships for individuals with developmental disabilities. As described by Wolfensberger (2000) SRV is "a high-level and systematic schema, based on social role theory, for addressing the plight of people who are devalued by others, and especially by major sectors of their society" (p. 105). A key principle of SRV is that the welfare of individuals is inextricably connected to the social roles they occupy in society – that is individuals who occupy roles in society which are highly valued will be afforded the "good things in life" while those who occupy devalued roles will not (Wolfensberger, 2000, p. 105). In Wolfensberger's description devalued individuals includes those who are "perceived and interpreted *by others* as having lesser value than these others see themselves, or most other people, as possessing" (p. 106, emphasis in original). Thus individuals who are devalued in society include those who are impaired in some capacity (e.g. their bodies and/or minds), those who are disordered or whose behaviour runs counter to the societal "norm",

¹Normalization can be understood as a theory of human services which advocates for individuals with disabilities to have access to, and enjoyment of, the conditions of everyday living in as close a manner to those who are not disabled and the ways which they participate in society. For a comprehensive discussion on the topic see Nirje (1969), Wolfensberger (1972), and Wolfensberger, Nirje, Olshansky, Perske, & Roos (1972).

those whose physical characteristics are deemed abnormal or undesirable, people who resist the social order, the poor, individuals with few skills, and people who are unassimilated to the culture (Wolfensberger, 2000). Osburn (2006) has identified six ways such devalued individuals may experience marginalization and negative experiences in society, including

- 1) Being perceived and interpreted as "deviant," due to their negatively-valued differentness. The latter could consist of physical or functional impairments, low competence, a particular ethnic identity, certain behaviours or associations, skin color, and many others.
- 2) Being rejected by community, society, and even family and services/
- 3) Being cast into negative social roles, some of which can be severely negative, such as "subhuman," "menace," and "burden on society."
- 4) Being put and kept at a social or physical distance, the latter most commonly by segregation.
- 5) Having negative images (including language) attached to them.
- 6) Being the object of abuse, violence, and brutalization, and even being made dead. (p. 5)

SRV, then, conceptualizes the ways individuals with developmental disabilities are able to interact with the physical and social world around them. In 2005 Wolfensberger and Thomas offered an updated description of SRV, describing it as

the application of empirical knowledge to the shaping of the current or potential social roles of a party (i.e. person, group, or class) – primarily by means of enhancement of the party's competencies & image – so that these are, as much as possible, positively valued in the eyes of the perceivers. (as cited in Osburn, 2006, p. 4)

In this more recent definition SRV is understood explicitly in its relation to both the social roles individuals occupy in society and the relations between social roles and individuals and how this

impact the lives of individuals. Lemay (2006) has argued that SRV offers useful insights and tools for the analysis of social integration for individuals with developmental disabilities. Culham and Nind (2003) have argued that the concepts of normalisation, and later SRV, have functioned as an integral foundation to the ways services for individuals with developmental disabilities can and should be developed. Race, Boxall, and Carson (2005) have detailed the impact of SRV on the development of health policy in the United Kingdom. While Thomas (1999) has argued that the impact of normalisation, and relatedly SRV, can be credited for the taken for granted status of many service practices and provisions for individuals with developmental and intellectual disabilities today (e.g. home-like residences, presence in the community, etc.).

SRV has faced criticism from researchers and advocates in the field of disability and disability services. As Wolfensberger (1995ab, 2002) acknowledges SRV has been criticized from both the political left and right, for a variety of reasons. Wolfensberger (1995a) has address some misconceptions that can accompany the thoughts and actions of supporters of SRV and which have been drawn upon by its critics. This includes the positioning of SRV as an absolutist schema in which misinterpretations can occur, that is to say the mistaken interpretation that if value is ascribed to a person based on the company they keep than SRV indicates that two individuals with disabilities should not be in company (Wolfensberger, 1995a). Wolfensberger identifies such logic as deeply problematic instead suggesting advocates draw upon an "if this, then that" logic model which allows for the consideration of the potential outcomes of actions and thus allows for thinking about ways in which devalued individuals have increased opportunities for social role value (1995a). Wolfensberger (1995b) has also addressed critics who have suggested that SRV "endorses contemporary social values and socio-political power arrangements that oppress all sorts of people" (p. 365), making clear that SRV advocates for not placing devalued individuals at increased risk in society by "capitalizing upon [current] cultural values, *and* the need to change at least some of them" (p. 366). Wolfensberger, Thomas, and Caruso (1996) address the criticism of SRV which suggests that SRV can be used to "impose on devalued people what they – the teachers and implementers – value and want, but without regard for what devalued people themselves want and aspire to" p. 12). Moreover,

they respond to the criticism that individuals with disabilities, or devalued people as Wolfensberger et al., call them, would likely pursue different things that what is valued in society by the "white middle class." To this Wolfensberger et al. provide a simple argument which defends SRV as a tool which "can only describe" (p. 12), meaning that the course of action undertaken by individuals is not prescribed by SRV but instead by their own values.

The analysis of literature in the area of SRV has indicated that further research in the area of deinstitutionalization may be beneficial to the next steps of this project. The deinstitutionalization of individuals with developmental disabilities, that is to say the change of location in care from that of an institution to in community care, has been supported by the federal government in Canada since the 1980s (Lemay, 2009). The process has been controversial and there has been significant research undertaken and academic debate in the area (see, for example, Chowdhury & Benson, 2011; Felce, 2006; Lamb & Bachrach, 2001; Mansell, 2006; Mansell & Beadle-Brown, 2010; Mansell & Ericsson, 2013; Lerman, Apgar, & Jordan, 2003; Parish, 2005; Taylor, 2001).

3.3 Devaluation of "Pink-Collar" Labour

Related to the idea of SRV is the valuation of jobs predominantly occupied by women or "Pink-collar labour." While related to the concept of the gender-wage gap, the "occupational feminization of wages" (Addison, Orgul, Ozturk, & Wang, 2018) is a distinct concept. The focus of the former is that women, on average, make less money than men. The latter focuses on the idea that occupational feminization is inversely related to wages. That is, as jobs become occupied predominantly by women, the wages associated with those jobs decrease (or do not increase to the same degree) as jobs predominantly occupied by men. This raises the question, however of whether lower wages followed occupational feminization (i.e., people pay less because there are more women) or whether women self-select into lower-paying jobs. A longitudinal analysis of the 1983 – 2001 Current Population Survey in the United States has found no evidence that declining wages over time leads to occupational feminization, and some evidence that occupational feminization leads to a decline in wages (England, Allison, & Wu, 2007). Why does occupational feminization lead

to a decline in overall wages? There are four main explanations as to the source of this wage decrease in pink-collar labour (Murphy & Oesch, 2018):

1. Men invest more in job-specific skills while women focus on their family, and the wage differences can be attributed to differences in skill set.
2. Women forego higher wages for more family-friendly working conditions.
3. Pink-collar labour is culturally devalued, and the wages reflect the devaluation of this labour.
4. Differences in labour is due to male-dominant occupations having more effective unions to bargain for better wages.

Murphy and Oesch (2018) sought to investigate these hypotheses using a series of nationally representative data sets across three countries: Britain, Germany, and Switzerland. They found that predominantly female-occupied jobs had substantially lower wages than predominantly male-occupied jobs. Additionally, these wage disparities did not disappear when controlling for job productivity, job-specific skills, overtime, childcare, etc. There was only partial support that the occupational wage differences were due to differences in skills investment, and no support that differences in on-the-job investment (i.e., higher wages vs childcare) and union membership contributed to the occupational disparity between male-and female-dominant jobs. Crucially, both men and women experienced lower wages as a function of their occupation's feminization, suggesting that while people may not be discriminating by gender *within* occupations, there is institutional and cultural devaluation of pink-collar labour that drives this wage disparity (Murphy & Oesch, 2018).

In the context of PHSS, it should not come as a surprise that the majority of their employees, especially those who work directly with their clients, are women. While there is some evidence to suggest that some of the wage disparities in male versus female dominant jobs are due to differences in skill acquisition (Murphy & Oesch, 2018), PHSS provides on-the-job training for their employees that make their employees valuable to other employers. Thus, in the context of the reviewed literature, the low wages for PHSS employee's work reflects devaluation of their labour, as their employees become highly skilled in ways that working as a PSW or DSW in other areas do not.

Given what has been reviewed so far, devaluation of their work hurts them two-fold: PHSS loses employees to other employers who can provide more comfortable working conditions, and they lose the resources they invested into training their employees while other employers benefit with little investment. An inherent limitation to PHSS is that they provide 24-hour care and service to their clients, so employees need to be on-call. Their competitors are able to provide better hours (e.g., 9 – 5 weekday jobs) because they do not provide 24-hour care. Given the greater investment PHSS has for their clients, the greater skill demand that this greater investment requires, and the amount of resources invested in training their employees, the government should invest more money to raise their employee's pay grade.

3.4 Burnout and Compassion Fatigue

The vast majority (95%) of Ontario support workers for people with disabilities report that they love their work (Hickey, 2010), and very few (18%) report client-care-related reasons when considering leaving their jobs (Lum et al., 2010). This indicates that staff retention issues do not reflect a lack of satisfaction with the expected tasks of support work, which employees find to be rewarding. However, this work is also demanding, both physically and psychologically. Burnout refers to workers' feelings of stress and exhaustion in response to workplace stressors. It is often conceived as having three characteristics of emotional exhaustion, depersonalization, and lacking personal accomplishment (Maslach, Jackson, & Leiter, 1996).

Burnout is not specific to helping professions. However, burnout rates are high among support workers for people with disabilities, both in Ontario and elsewhere (Devereux, Hastings, & Noone, 2009; Hastings, 2010; Hensel, Lunsky, & Dewa, 2011; Innstrand, Espnes, & Mykletun, 2002; Skirrow & Hatton, 2007). The exact mechanisms explaining burnout in support workers are not completely understood (Devereux et al., 2009). According to a review of 1,570 Ontario support workers, being high in prosocial motivation – the desire to help others – appears to have a protective effect for the worker-client relationship (Hickey, 2014). However, it does not have a protective effect for the organization-worker relationship, suggesting workplace factors such as appropriate

compensation, managing workload, and regular work hours could play larger roles in mitigating burnout. The restructuring of Ontario's home health care sector has also increased burnout and stress among support workers (Denton, Zeytinoglu, & Davies, 2003; Ontario Health Coalition, 2005).

Care work has been described as being a combination of manual, emotional, and intellectual labour (Daly & Szebehely, 2012; James, 1992). In addition to helping with daily living tasks, support workers provide non-physical (i.e., social and emotional) support (Saari et al., 2018). This requires a high degree of compassion for their clients, who rely on their care providers to meet social and emotional needs, but the highly demanding nature of support work can deplete workers' capacity to meet these needs. Compassion fatigue is sometimes used interchangeably with burnout and is closely related (Sinclair, Raffin-Bouchal, Venturato, Mijobic-Mondejewski, & Smith-Macdonald, 2017). However, compassion fatigue can be distinguished from burnout in that 1) it is experienced specifically by those in helping professions and 2) while it is also brought on by acute workplace stress, it is uniquely characterized by diminished feelings of compassion for others (Sinclair et al., 2017).

Compassion fatigue can present with physical symptoms ranging from exhaustion and insomnia to headaches, stomach aches, and reduced immunity to illness (Sinclair et al., 2017). Psychologically, compassion fatigue can present with cynicism, reduced job satisfaction, anxiety, and diminished empathy (Sinclair et al., 2017). Compassion fatigue is often discussed in the nursing context, where workers must deal with mortality, vicarious trauma, and occasionally difficult or hostile clients (Sinclair et al., 2017). Both burnout and compassion fatigue represent threats to quality of care. Generally, younger and less experienced nurses report lower satisfaction and are more predisposed to compassion fatigue and burnout (Hunsaker, Chen, Maughan, & Heaston, 2014). Compassion fatigue and burnout both negatively impact employment retention and client outcomes for nurses (Burtson & Stichler, 2010; Potter, Divanbeigi, Berger, Cipriano, Norris, & Olsen, 2010). These experiences and risk factors can theoretically be extended to support workers. Given that workplace stress such as that experienced by PHSS's support workers can likely be mitigated by increased

compensation and improving other workplace factors, this is yet another reason for enacting advocacy efforts for increased funding.

3.5 Workplace Experiences

According to Squires et al. (2015), across all residential care settings, there is a widespread shortage of residential care providers and a high rate of turnover amongst the staff. This global issue is increasingly important to both developed and developing countries (Kingma, 2007) and of increasing concern in many countries (OECD, 2013). Cohen-Mansfield's (1997) and Donoghue's (2010) studies show that staff turnover in residential long-term care facilities ranges from 40% to 500%, which is exceedingly high compared to hospital nurses' retention rates. There are numerous factors that have been linked to turnover amongst residential care staff, but job satisfaction is the most frequently cited (Cavanagh & Coffin, 1992; Blegen, 1993; Irvine & Evans, 1995). This fact highlights the importance of understanding job satisfaction amongst residential care staff.

Job satisfaction is defined as a positive emotional state resulting from the appraisal of one's job or job experiences (Locke, 1969, 1976). Despite an increasing literature on professional nurses' job satisfaction, job satisfaction by nonprofessional nursing care providers and, particularly, in residential long-term care facilities, is sparsely described. Based on a systematic review of contributing factors, both individual and organizational, the group of researchers working in School of Nursing – University of Ottawa, Ottawa Hospital Research Institute, and Faculty of Nursing – University of Alberta pointed out that job satisfaction amongst residential care staff is very low (Squires et al., 2015). Through searching nine online databases, four main reasons of job dissatisfaction were identified, namely low empowerment and autonomy; heavy workload; low facility resources; and low satisfaction with salary and benefits. For example, given the heavy workload of the residential care staff, their low satisfaction with salary and benefits is evidenced by the wage, salary and benefits, with the average residential care aide hourly pay (no further benefit) of \$18.43 per hour across Canada; \$13.60 per hour in Alberta; and \$21.01 per hour in PHSS. Stacey (2005) also indicates that residential care workers, who are increasingly absorbing responsibility for care, are underpaid. Furthermore, Squires

et al. (2015) make the point that job satisfaction is closely related to the staff's organizational commitment, which figures out why the rate of staff turnover in residential long-term care facilities is so high. Brannon et al. (2007) add to this point that inequalities in wages and benefits, together with work overload, increased intent to leave among direct care workers. In addition, some researchers argue that not all dissatisfied staff will leave their job, but dissatisfaction may impact their work, their coworkers, and the quality of resident care delivered (Donoghue, 2010).

While there are many factors that contribute to retention issues in residential care work overall, it is important to contextualize these issues within PHSS. As Squires et al. (2015) notes, the staff's commitment to the organization is a strong predictor of retention rates. Many of the workers at PHSS find their work to be highly fulfilling, and the strain comes from the high workload required of them. PHSS as an organization has shown strong commitment to their workers—having offered higher wages to their employees relative to their competitors prior to the passing of [Bill C148](#). With the bill's passing, however, the wage differences between employers narrowed and no longer reflected the greater workload required of the PHSS staff, which may contribute to issues of job satisfaction and retention.

3.6 Summary

Residential care remains an important pillar in the healthcare industry, given the need for residential care programs, specifically for those individuals with developmental delays and complex physical needs, who want to receive care in a community setting rather than hospital, is increasing across Canada. In spite of this significant contribution to the social service sector, residential care workers in these fields are overworked and underpaid—a problem that also persists within Ontario. There is little evidence that the devaluation of these jobs stem from skills acquisition or employees forgoing higher wages for better family benefits (Murphy & Oesch, 2018). Indeed, within the context of PHSS, the workers are highly trained as their employees are trained to care for every aspect of their client's well-being, including those who are considered medically fragile and require complex care. Although job satisfaction can stem from a variety of sources, many workers at PHSS find their

work to be personally fulfilling. Though the high workload can lead to compassion fatigue and employee dissatisfaction, increased wages can help mitigate this effect. The employee's relative pay compared to other workers in similar organizations may also contribute to the retention issues, as PHSS workload is more demanding due to providing 24-hour care for their clients. As such, increasing wages to match the differential demands is important to maintain their job satisfaction. While advocating for more funding may be difficult, it is important to note that it is cheaper for the Ontario government to have residential care workers taking care of individuals with complex needs as they, on the one hand, meet the increasing demand of individuals wishing to receive care with a sense of community, and on the other hand, reduce the strain on the healthcare system. Thus, these contributions from residential care should be recognized and savings for the healthcare system should, in part, translate to better funding for these residential care employees.

4. Community Connections

Our team has begun a cursory investigation into possible community connections which may support the strategic planning and advocacy work of the subsequent research team. Some community and education organizations which may present opportunities for partnerships include the following:

- Fanshawe College (as an institution which trains PSWs and DSWs engaging Fanshawe in the strategic planning of advocacy may allow for a sharing of knowledge and communication regarding employment after graduation);
- Victorian Order of Nurses (an organization which provides residential care to Seniors, but employs PSWs and DSWs – may provide opportunity for communication about the funding and opportunities present in the two types of residential care organization);
- Middlesex Community Living/ Community Living Londond (an organization which supports individuals with developmental disabilities, may present opportunities for collaboration);
- Western University's Developmental Disabilities Program, Schulich School of Medicine & Dentistry (a program at Western which aims to develop and translate knowledge about developmental disabilities, may present opportunities for further research, knowledge sharing, and possible partnerships);
- Crest Support Services (an organization which supports individuals with developmental disabilities, may present opportunities for collaboration);
- Hutton House (an organization which provides programming for youth and adults living with disabilities, may present opportunities for knowledge sharing and collaboration);
- Alice Saddy Association (an advocacy organization which works with, and on behalf of, individuals with intellectual and developmental disabilities, may present an opportunity for collaboration and knowledge sharing);

- Ontario Partnership on Aging & Developmental Disability (an informal partnership organization which works in the areas of applied research, innovation in service delivery, and policy – may present an opportunity for knowledge sharing and collaboration).

We acknowledge that PHSS is likely aware of many or all of these organizations and present this list as a starting point for “Team B” and they undertake the initial stages of strategic planning.

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