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**A Conceptual Model of Quality Service Provision for People with Intellectual  
Disability and Challenging Behaviours: Enhancement and Enrichment through  
Service User and Other Stakeholder Consultation**

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## **Abstract**

People with intellectual disability and challenging behaviour are one of the most disenfranchised groups in society. How they are supported through services has a primary role in changing this outcome. While legislation provides frameworks for quality service provision for people with disabilities, they do not identify the mechanisms specific to the cohort that can address this disenfranchisement. As such, it is paramount to develop an understanding of quality service provision specific to those with intellectual disability and challenging behaviour.

To identify the factors required for quality service provision for people with ID and CB, a three-stage design incorporating participants from various stakeholder groups (n=7) was undertaken. Study one involved data collection from CEOs and managers (n=55) of service provider agencies using a Delphi study, and clinicians and senior practitioners (n=85) using survey methods. Study two incorporated interviews conducted with families/carers of service users (n=11), advocates (n=10), support workers (n=13) and supervisors (n=11) who had provided services to the cohort, complemented by survey data (n=102). Study three involved data collection with service users with intellectual disability and challenging behaviour (n=14) through focus groups.

The results of this research led to the identification of processes and practices associated with and impacting on quality service provision that were not identified through the literature review. Further, it identified agents that are formative to the production of quality services.

The outcome of this research is a model of quality service provision for the cohort that conceptualises quality as a continuous process and includes factors across socio-political systems that are formative to, and impacting on, quality service provision. The developed model has significant implications for service provider agencies, service user consultation, government, substitute decision making, and the National Disability Insurance Scheme.

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No publications.

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No publications included.

**Contributions by others to the thesis**

No contributions by others.

**Statement of parts of the thesis submitted to qualify for the award of another degree**

None.

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intellectual disability, challenging behaviour, quality, service provision,

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## List of Abbreviations

<b>ABA</b>	Applied Behavioural Analysis
<b>ADV</b>	Advocate
<b>CB</b>	Challenging Behaviour
<b>CEOs</b>	Chief Executive Officers
<b>CRPD</b>	Convention on the Rights of Persons with Disabilities
<b>DCCSDS</b>	Department of Communities, Child Safety and Disability Services
<b>DSA</b>	Disability Services Act
<b>FAM</b>	Families
<b>HSQF</b>	Human Services Quality Framework
<b>ID</b>	Intellectual Disability
<b>ISP</b>	Individual Support Plan
<b>NDA</b>	National Disability Agreement
<b>NDIA</b>	National Disability Insurance Agency
<b>NDIS</b>	National Disability Insurance Scheme
<b>NSDS</b>	National Standards for Disability Services
<b>OH&amp;S</b>	Occupational Health and Safety
<b>PCP</b>	Person-centred Planning
<b>PBS</b>	Positive Behaviour Support
<b>PBSP</b>	Positive Behaviour Support Plan
<b>SU</b>	Service User
<b>SUP</b>	Supervisors
<b>SW</b>	Support Worker
<b>UDHR</b>	Universal Declaration of Human Rights
<b>UN</b>	United Nations
<b>WHO</b>	World Health Organisation

## Chapter One: Introduction

This chapter provides an introduction to the thesis. Key terms are defined and the rationale and significance of the research is explored with relation to the current and historical service provision, legislation governing service provision, and outcomes for quality service provision. An overview of the research and structure of the thesis is also provided.

### Rationale and Significance of the Research

People with intellectual disability (ID) and challenging behaviour (CB) are one of the most disenfranchised groups in society (Carter, 2006; Royal College of Psychiatrists, 2007; Townsend, 2011). How they are supported through services has a primary role in changing this outcome. While legislation provides frameworks for quality service provision for people with disabilities, they do not specify the mechanisms specific to the cohort that can address this disenfranchisement. As such, it is paramount to develop an understanding of quality service provision specific to ID and CB. This thesis identifies the factors required for quality service provision for people with ID and CB and synthesises these into a model of quality service provision for people with ID and CB.

### Definitions, Prevalence and Impact

**Disability.** Disability is identified by the World Health Organization (WHO) as an 'umbrella term' that incorporates impairments, activity limitations, and participation restrictions (World Health Organization, 2015). Disability is conceptualised as an interaction between a person's impairment and environmental and social barriers (World Health Organization, 2015). The experience of disability thus varies according to factors including: health conditions; environmental factors, such as social attitudes and legal structures; personal factors, such as gender, age and profession; and, participation.

The prevalence of disability in Australia is reported at 18.5% of the population, with 88% of people with a disability having limitations in self-care, mobility, communication or restriction in schooling or employment (Australian Bureau of Statistics, 2014). The impact of disability includes higher rates of poverty, physical, emotional and sexual abuse, and barriers to education and employment (Goggin & Newell, 2005).

**Intellectual disability.** Intellectual disability (ID) is a sub-group of disability and has a prevalence of 1-3% in the general population (The University of Queensland, 2002). ID is defined in Queensland legislation (Disability Services Act 2006) as a disability

"attributable to an intellectual or cognitive impairment, or a combination of impairments" (Queensland Government, 2006, p. 22). It is characterised by significant limitations in intellectual functioning and adaptive behaviours such as conceptual, social, and practical skills (American Association on Intellectual and Developmental Disabilities, 2013). The typical support needs for people with ID include support for daily living activities - such as self-care, mobility and communication - and "managing emotions and relating to other people", which encompasses interacting with other people, making and maintaining relationships (Australian Institute of Health and Welfare, 2008, p. 2). Like many other people with disabilities, people with ID face formidable barriers including poverty, physical, emotional and sexual abuse, and obstacles to getting access to education and employment. In addition, people with ID often have limitations in exercising self-determination in all aspects of life ranging from major life decisions to more mundane areas such as where and when to eat (Gardner, Carran, & Taylor, 2005; Robertson et al., 2001b).

**Challenging behaviour.** The focus of this thesis is people with an ID who also have CB. The prevalence of CB is 5.7-12% of people with ID, with ID and CB being between 1.9% and 5.9% people per 10,000 of the general population (Emerson et al., 2001a; Lowe et al., 2007). CB is defined as:

culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities.  
(Emerson 1995, as cited in Emerson & Einfield, 2011, p. 3)

Types of CB include self-injury, physical aggression, stereotyped mannerisms, violent outbursts and property destruction (Rojahn, Matson, Lott, Esbensen, & Smalls, 2011; Symons, Sperry, Dropik, & Bodfish, 2005). The impact of CB includes social and material deprivation, isolation, exclusion from community participation and dispossession of individual choice (Allen, James, Evans, Hawkins, & Jenkins, 2005; Bailey, Ridley, & Greenhill, 2010; Clement & Bigby, 2011; McDermott, Bruce, Fisher, & Gleeson, 2010; Robertson et al., 2001a). People with ID and CB often have poor health outcomes, are likely to experience abuse and neglect, and are often subject to restrictive practices that risk physical and psychological harm (Bailey, Hare, Hatton, & Limb, 2006; Carter, 2006; Clement & Bigby, 2011; Emerson et al., 2000a; Sabaz, 2012; Webber, McVilly, & Chan, 2011). Further, they have an increased risk of contact with police and the criminal justice system (Sabaz, 2012), out of area placement (Mansell, Beadle-Brown, Skidmore, Whelton,



& Hutchinson, 2006), re-institutionalisation (The University of Queensland, 2002) and unmet service needs (Clement & Bigby, 2011; Sabaz, 2012).

People with ID and CB are considered one of the most vulnerable groups in society (Carter, 2006; Royal College of Psychiatrists, 2007; Townsend, 2011). They lead more restricted lives and have poorer quality of life than those with ID alone (Department of Health (UK), 2007; Felce, Lowe, & Jones, 2002a; Harvey, Boer, Meyer, & Evans, 2009). How people with ID and CB are supported, such as through service provision, has a primary role in changing this outcome.

### **International Legislation Governing Service Provision for People with Disabilities**

Recognition of the disenfranchisement experienced by people with disabilities led to the development of international human rights legislation by the United Nations (UN). In 1948 the ***Universal Declaration of Human Rights*** (UDHR) was championed by the General Assembly of the UN. The UDHR provided universal recognition that basic human rights and fundamental freedoms are inherent to all people (The United Nations, 2010b).

However, this was criticised for failing to address the specific needs of vulnerable groups, including people with IDs (Barnes & Mercer, 2010). As a result, in 1971 the General Assembly of the UN adopted the ***Declaration on the Rights of Mentally Retarded Persons***. This 'guaranteed' rights respecting the dignity of the 'mentally disabled', including the right not to be exploited and abused, the right to economic security, the right to a decent standard of living and the right to proper medical care and therapy (The United Nations, 2004). However, it was later recognised that:

existing human rights treaties had not comprehensively addressed the protection of the rights of persons with disabilities; and persons with disabilities had underutilized the various protection mechanisms under those treaties.  
(The United Nations, 2010a, p. x)

To improve the protection of the rights of people with disabilities, the 2006 ***Convention on the Rights of Persons with Disabilities*** (CRPD) was developed. The purpose of the CRPD "is to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity" (The United Nations, 2006, para. 2). The CRPD details the rights that all persons with disabilities should experience, and provides international obligations to ensure they are respected (The United Nations, 2010a). Thus, the convention adopts a rights-based approach which is founded on inclusion and equality (Tanner, 2007). There are eight general principles that underlie the CRPD:

- respect for inherent dignity, individual autonomy including the freedom to make one's own choices, and independence of persons;
  - non-discrimination;
  - full and effective participation and inclusion in society;
  - respect for difference and acceptance of persons with disabilities as part of human diversity and humanity;
  - equality of opportunity;
  - accessibility;
  - equality between men and women, and;
  - respect for the evolving capacities of children with disabilities and respect for the right of children with disabilities to preserve their identities.
- (The United Nations, 2006)

Australia became a signatory to the CRPD, but not its optional protocol when it opened on March 30, 2007. Ratification of the convention took place on July 18, 2008 (Tanner, 2007). Through ratification of the CRPD, there is now a legally binding imperative to ensure people with disabilities have outcomes, including societal participation and inclusion, equal to other citizens. Promotion of these outcomes is supported through Federal and State legislation governing service provision.

### **Federal and State Legislation Governing Service Provision for People with Disabilities**

Legislative frameworks governing the provision of disability services are the Commonwealth's National Disability Agreement (NDA), the National Standards for Disability Services (NSDS) and the National Disability Insurance Scheme (NDIS). State based legislative frameworks include the Queensland *Disability Services Act* (2006) (DSA) and the Human Services Quality Framework (HSQF).

The **NDA** provides the specificity for funding, monitoring and provision of services for people with disability, and came into effect on 1 January, 2009 (ACT Government, 2011). The objective of the NDA is that "people with disability and their carers have an enhanced quality of life and participate as valued members of the community" (Department of Social Services (Cth), 2014, p. 3). Under the NDA financial arrangement, the Commonwealth Government has responsibility for employment services for people with disabilities and income support for people with disabilities, their carers and families. The State/Territories responsibility under the NDA is to provide - and fund non-government organisations to provide - accommodation services, respite care services, and community access and support services (Department of Social Services (Cth), 2014).

The **NSDS** are national quality standards for funded specialist service providers and disability support organisations. Provision for these standards are made within the

*Disability Discrimination Act (1992)*. The purpose of the NSDS is to "promote and drive a nationally consistent approach to improving the quality of services" (Department of Social Services (Cth), 2009, p. 4). The NSDS contains six standards: rights; participation and inclusion; individual outcomes; feedback and complaints; service access; and service management. Each of the standards includes a description of intended rights and outcomes for consumers and standards for service (Department of Social Services (Cth), 2012). The intended rights and outcomes for consumers and standards for service, for each of the six standards, are detailed in table 1.1

Table 1.1  
*National Standards for Disability Services*

Standard					
Rights	Participation and Inclusion	Individual Outcomes	Feedback and Complaints	Service Access	Service Management
<b>Rights for people</b>					
I have the right to exercise control and choice when I use services or supports. I also have the right to dignity of risk and to be free from discrimination or harm.	I have the right to participate in my chosen community. I also have the right to decide how I have contact with family, friends and community.	I have the right to lead and direct decisions about my life and how the services I use support me.	I have the right and freedom to give positive and negative feedback about all aspects of my supports and services. I also have the right to independent advice and support to provide feedback or make a complaint when I need it.	I have the right to access services based on fair and equal and transparent criteria, and support for referral when a service is not available.	I have the right to services and supports that are effectively managed, regularly reviewed, accountable and contemporary.
<b>Outcomes for people</b>					
I can make choices about the services and supports I use, and how I use them. When I use a service or support, I am respected and safe.	I follow my interests, with the support of my services, family, friends, carers or advocates.	I use services and supports which build on my strengths and support me to reach my life goals.	I have a range of ways to speak up about my supports and services and play an active role in working out how things will improve. I know how to access independent support and advice when providing feedback or making a complaint.	I understand what the service offers, access to the service is fair and equal and I am supported with other options when I can't access a service.	My strengths and needs are effectively supported through soundly managed services.
<b>Standards for services</b>					
The service promotes individual rights to freedom of expression, self-determination and decision-making and actively prevents abuse, harm, neglect and violence.	The service works with individuals and families, friends and carers to promote opportunities for meaningful participation and active inclusion in society.	Services and supports are assessed, planned, delivered and reviewed to build on individual strengths and enable individuals to reach their goals.	Regular feedback is sought and used to inform individual and organisation-wide service reviews and improvement.	The service manages access, commencement and leaving a service in a transparent, fair and equal and responsive way.	The service has effective and accountable service management and leadership to maximise outcomes for individuals.

Source: National Standards for Disability Services (Department of Social Services (Cth), 2012)

The **DSA** (2006) is the principle Queensland legislation governing funded service provision for people with disabilities. The objects of the *DSA* are:

- (a) to acknowledge the rights of people with a disability including by promoting their inclusion in the life of the community generally; and
- (b) to ensure that disability services funded by the department are safe, accountable and respond to the needs of people with a disability; and
- (c) to safeguard the rights of adults with an intellectual or cognitive disability including by regulating the use of restrictive practices by funded service providers in relation to those adults—
  - (i) only where it is necessary to protect a person from harm; and
  - (ii) with the aim of reducing or eliminating the need for use of the restrictive practices.

(The State of Queensland, 2011, pp. 18-19)

The *DSA* specifies the rights of people with disabilities when accessing services, for example the right to services that support their quality of life and full participation in society. With regard to people with ID and CB, amendments to the *DSA* have resulted in the incorporation of legislation regarding the use of restrictive practices such as seclusion, containment (chemical, mechanical and physical restraint), and restricting access to objects. In accordance with the amendments:

- A positive behaviour support plan must be developed prior to application for approval or consent for use of restrictive practices.
- Authorisation for the use of restrictive practice must be obtained from the relevant statutory authority, with prior assessment and positive behaviour support plan being carried out by the disability service provider.
- The use of restrictive practices is only considered appropriate if necessary to prevent self-harm or harm to others, and is implemented in the least restrictive way.
- Immunity, and retrospective immunity, provisions for disability service providers using restrictive practices, if acting within legislative requirements. (Disability Services Queensland, 2008)

The **HSQF** is the Queensland Governments "system for assessing and promoting improvement in the quality of human services delivered with department investment" (Department of Communities, 2015, para 1). The HSQF sits within the framework of the *DSA* (2006) and incorporates a continuous improvement framework, a set of quality standards, and an assessment process to monitor performance against these standards. The six standards are: governance and management; service access; responding to individual need; safety, well-being and rights; feedback, complaints and appeals; and human resources. Each of the standards includes a description of expected outcome for consumers, context and indicators of practice. The outcomes, context and indicators for each of the standards are shown in table 1.2.

**Table 1.2**  
*Human Services Quality Framework*

<b>Standard</b>					
Governance and management	Service access	Responding to individual need	Safety, wellbeing and rights	Feedback, complaints and appeals	Human resources
<b>Expected Outcome</b>					
Sound governance and management systems that maximise outcomes for stakeholders.	Sound eligibility, entry and exit processes facilitate access to services on the basis of relative need and available resources.	The assessed needs of the individual are being appropriately addressed and responded to within resource capability.	The safety, wellbeing and human and legal rights of people using services are protected and promoted.	Effective feedback, complaints and appeals processes that lead to improvements in service delivery.	Effective human resource management systems, including recruitment, induction and supervisory processes, result in quality service provision..
<b>Context</b>					
The organisation maintains accountability to stakeholders through the implementation and maintenance of sound governance and management systems. These systems should reflect the size and structure of the organisation and contribute to maximising outcomes for people using services.	I follow my interests, with the support of my services, family, friends, carers or advocates.	I use services and supports which build on my strengths and support me to reach my life goals.	I have a range of ways to speak up about my supports and services and play an active role in working out how things will improve. I know how to access independent support and advice when providing feedback or making a complaint.	I understand what the service offers, access to the service is fair and equal and I am supported with other options when I can't access a service.	The organisation has human resource management systems that ensure people working in services (including carers and volunteers) are recruited appropriately and are suitable for their roles within the organisation. Once appointed, people working in the organisation have access to support, supervision, opportunities for training and development and grievance processes.
<b>Indicators</b>					
The organisation: <b>1.1:</b> has accountable and transparent governance arrangements that ensure compliance with relevant legislation, regulations and contractual arrangements. <b>1.2:</b> ensures that members of the governing body possess and maintain knowledge, skills and experience required to fulfil their roles. <b>1.3:</b> develops and implements a vision, purpose statement, values, objectives and strategies for service delivery that reflect contemporary practice. <b>1.4:</b> management systems are clearly defined, documented, monitored and (where appropriate) communicated including finance,	<b>2.1:</b> Where the organisation has responsibility for eligibility, entry and exit processes, these are consistently applied based on relative need, available resources and the purpose of the service. <b>2.2:</b> The organisation has processes to communicate, interact effectively and respond to the individual/s' decision access and/or exit services. <b>2.3:</b> Where an organisation is unable to provide services to a person, due to ineligibility or lack of capacity, there are processes in place to refer the person to an	The organisation: <b>3.1:</b> uses flexible and inclusive methods to identify the individual strengths, needs, goals and aspirations of people using services. <b>3.2:</b> formulates service delivery that respects and values the individual (e.g. identity, gender, sexuality, culture, age and religious beliefs). <b>3.3:</b> has processes to ensure that services delivered to the individual/s are monitored, reviewed and reassessed in a timely manner. <b>3.4:</b> has partnerships and collaborates to enable it to effectively work with community support networks, other organisations and government agencies as relevant and appropriate.	The organisation: <b>4.1:</b> provides service in a manner that upholds people's human and legal rights. <b>4.2:</b> proactively prevents, identifies and responds to risks to the safety and well-being of people using services. <b>4.3:</b> has processes for reporting and responding to potential or actual harm, abuse and/or neglect that may occur for people using services. <b>4.4:</b> People using services are enabled to access appropriate supports and advocacy. <b>4.5:</b> has processes that demonstrate the right of the individual to participate and make choices about the services received.	The organisation: <b>5.1:</b> has fair, accessible and accountable feedback complaints and appeals processes. <b>5.2:</b> effectively communicates feedback, complaints and appeals processes to people using services and other relevant stakeholders. <b>5.3:</b> People using services and other relevant stakeholders informed of and enabled to access any external avenues for appropriate supports for feedback, complaints or appeals processes and assisted to understand how they access them. <b>5.4:</b> demonstrates that feedback, complaints and appeals processes lead to improvements	The organisation: <b>6.1:</b> has human resource management systems that are consistent with regulatory requirements, industrial relations legislation, work health and safety legislation and relevant agreements awards. <b>6.2:</b> has transparent and accountable recruitment and selection processes that ensure people working in the organisation possess knowledge, skills and experience required to fulfil their roles. <b>6.3:</b> provides people working in the organisation with induction, training and development opportunities relevant to their roles

<p>assets and risk.</p> <p><b>1.5:</b> Mechanisms for continuous improvement are demonstrated in organisational management and service delivery processes.</p> <p><b>1.6:</b> encourages and promotes processes for participation by people using services and other relevant stakeholders in governance and management processes.</p> <p><b>1.7:</b> has effective information management systems maintain appropriate controls of privacy and confidentiality for stakeholders.</p>	<p>appropriate alternative service.</p>	<p><b>3.5:</b> has a range of strategies to ensure communication and decision-making by the individual is respected and reflected in goals set by the person using services and in plans to achieve service delivery outcomes.</p>	<p>within the service and that outcomes are communicated to relevant stakeholders.</p>	<p><b>6.4:</b> provides ongoing support, supervision, feedback and fair disciplinary processes for people working in the organisation.</p> <p><b>6.5:</b> ensures that people working in the organisation have access to fair and effective systems for dealing with grievances and disputes.</p>
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Source: Human Services Quality Framework (Department of Communities, 2012a)

The **NDIS** was developed in response to the Productivity Commission's (2011b, p. 2) inquiry into disability care and support, which exposed the current disability support system as "inequitable, underfunded, fragmented, and inefficient and give people with a disability little choice". The NDIS is governed under the Commonwealth *NDIS Act (2013)*. The *NDIS Act* has a number of objectives, including to:

- support the independence and social and economic participation of people with disability;
- provide reasonable and necessary supports, including early intervention supports, for participants in the National Disability Insurance Scheme launch; and,
- promote the provision of high quality and innovative supports that enable people with disability to maximise independent lifestyles and full inclusion in the mainstream community.

The NDIS has commenced at a number of trial sites, with full rollout expected to commence from July 2016 (National Disability Insurance Agency, n.d.).

## **Service Provision for People with Disabilities**

**History of service provision.** Prior to the 1980s in Australia, the primary model of service delivery for people with ID was institutional care. The institutions were "epitomised by harsh and inappropriate treatment, the violation of human rights and improper incarceration of those with mental illness and intellectual disability" (Chenoweth, 2000, p. 81). People with ID and CB were more likely to be institutionalised, and were subject to higher incidences of abuse and restrictive practices (Carter, 2006; Young, 2001).

Emerging ideologies such as normalisation led to the process of deinstitutionalisation which entailed relocating people with ID into group homes in the community (Chenoweth, 2000; Young & Ashman, 2004). People with ID and CB, however, remained in institutions for longer (Bostock, Gleeson, McPherson, & Pang, 2001; Harries, 2008; Young, 2001; Young & Ashman, 2004).

A review of service provision for people with ID and CB, post-deinstitutionalisation, was conducted by Hon W.J. Carter Q.C. in 2006. The report highlighted significant gaps in legislative requirements and service delivery to this cohort, identifying service delivery as often crisis driven and reactive. Further, restrictive practices were frequently inappropriate and contravened legislative requirements developed with regard to human rights principles (Carter, 2006). Key recommendations included that positive behaviour support as evidence based practice be widely adopted and that there be departmental regulation of restrictive practices. These were legislated in amendments to the *DSA 2006 (Qld)*, as discussed in the previous section.

**Current service provision.** Current services for people with disabilities can be categorised as specialist disability services and non-specialist services. The majority of people with disabilities access non-specialist mainstream services, such as health care, privately or publically funded (McIntosh & Philips, 2002). People with disabilities whose support needs are not met through mainstream services access specialist disability services. Specialist disability services include:

- **Accommodation support:** services that provide accommodation, and/or enable a person to remain in their existing accommodation, and/ or services that enable a person to move to more suitable or appropriate accommodation;
  - **Community support:** services that provide the support needed for people with disabilities to live in a non-institutional setting;
  - **Community access:** services that provide opportunities for people to gain and 'use their abilities to enjoy their full potential for social independence';
  - **Respite care:** providing a short-term stay for people with disabilities who are typically cared for by families or voluntary carers;
  - **Employment services:** specialised employment help to enable people with disabilities to gain meaningful employment, including open employment, supported employment and targeted support;
  - **Advocacy, information and alternative forms of communication:** including information/referral and mutual support/self help groups;
  - **Other support services:** training and development and peak bodies; and,
  - **Income support:** disability pension for people with disabilities who meet eligibility criteria.
- (Australian Institute of Health and Welfare, 2015)

The majority of funding for specialist disability services is for to accommodation support, followed by community support (Australian Institute of Health and Welfare, 2015). For the period 2013-2014 this was \$3.5 billion and \$1.3 billion respectively.

People with ID comprise the largest group of service users, being 54.5% (Australian Institute of Health and Welfare, 2015). Given that the support needs for people with ID is greater for other disability groupings, and that they have a reduced quality of life, an understanding of quality service provision is important. However, people with ID and CB have a poorer quality of life than those with ID alone and lead more restricted lives (Department of Health (UK), 2007; Felce et al., 2002a; Harvey et al., 2009). Therefore, it is paramount to develop an understanding of quality service provision that can enable outcomes equal to other citizens.

### **Quality Service Provision for People with Intellectual Disability and Challenging Behaviour**

Current legislation identifies outcomes for a quality service for people with disabilities as including: full and equal enjoyment of all human rights (CRPD); and inclusion in the life of the community (DSA). These outcomes are not contradictory but reflective of quality of life specific to people with ID (Schalock et al., 2002), which is an outcome identified by the NDA.

As such, quality of life is the primary outcome for service provision for people with ID, however, for people with ID, CB is a barrier to quality of life (Baker & Daynes, 2010; Carr et al., 2002; Jones, 2013) and it is well established that environmental factors, such as service delivery, can impact on CB incidence (Carter, 2006; Disability Services Commission, 2009; Emerson, McGill & Mansell, 2013). Thus, the quality of service provision has a direct relationship to CB. Given this, outcomes for a quality service for this cohort include both increased quality of life and decreased CB.

The NSDS and HSQF provide generic frameworks for quality service provision for people with disabilities. However, the applicability of these frameworks for people with ID and CB are limited as they do not prescribe the practices and processes that are required to meet the outcomes specific to this cohort. This thesis develops a model of quality service provision for people with ID and CB.

### **Overview of Research Design**

This thesis provides the results of research that was conducted with key stakeholders in service provision for people with ID and CB. The research commenced with a Delphi



study with Chief Executive Officers (CEOs) and managers of service provider agencies, followed by a survey completed by clinicians and senior practitioners. Focus groups and interviews were then undertaken with service users, families/carers of service users, support workers, supervisors and advocates. A survey was developed from the focus group and interview data, and completed by families/carers, support workers and supervisors, and advocates. This research resulted in the development of a model of quality service provision that reflected both the literature and the opinions of key stakeholder groups.

### **Structure of Thesis**

The next chapter provides a review of literature related to quality service provision for people with ID and CB and proposes a model of quality service provision. The methodology for this research is then detailed, followed by method and results for each of the studies. The findings from the research are discussed with reference to the literature and the enhanced and enriched model of quality service provision is detailed. Finally, implications of this research are detailed with reference to service provider agencies and governing agencies.

## Chapter Two: Literature Review

This chapter provides a review of the literature related to quality service provision for people with ID and CB. First, features of a quality service are discussed followed by factors that limit and enable quality service provision for the cohort. These are then conceptualised into a model of quality service provision.

### Features of a Quality Service

The literature related to service quality and service provision for people with disabilities indicates that quality services incorporate three elements.

**A quality service meets specified outcomes.** Quality is a factor of meeting or accomplishing specified service outcomes or indicators (O'Brien, 1989; Osborne, 1992; Wilding, 1994). This understanding is drawn from outcome focused frameworks for quality services which include the NSDS (Department of Social Services (Cth), 2012), the HSQF (Department of Communities, 2014), Wilding's Key Elements of a Quality Service (Wilding, 1994) and O'Brien's Five Service Accomplishments (O'Brien, 1989). However, service literature indicates that while a quality service meets specified outcomes, these outcomes should not produce a 'ceiling effect' whereby agencies do not work towards outcomes beyond those which are specified (International Institute for Educational Planning (UNESCO), 2011; LaVigna, Willis, Shaull, Abedi, & Sweitzer, 1994; Weinbach, 2003).

**A quality service has alignment between inputs, processes and outputs/outcomes.** The constituent elements of services are agency inputs, service processes and outputs/outcomes (Donabedian, 1980; Martin, 1993; Osborne, 1992; Schalock & Verdugo, 2012a). Inputs are resources, material and policies; processes are throughputs and include practices; and outputs/outcomes are agency outputs and personal outcomes for service users (Kettner, Moroney, & Martin, 2008; Packard, 2009). Alignment between the constituent elements, as shown in figure 2.1, can ensure that processes are adopted that effectively translate inputs into outputs/outcomes and aid agencies in working towards successful outputs/outcomes (Austin, Brody, & Packard, 2009; Mertens & Wilson, 2012; Owen, 2006; Schalock & Verdugo, 2012b; Stufflebeam & Shinkfield, 2007). Through alignment, quality service can meet specified outcomes. Quality, conceptualised as constituent element alignment, is drawn from models including: Osborne's Quality Dimensions (Osborne, 1992); Schalock and Verdugo's Measurement Framework (Schalock & Verdugo, 2012a); Townsend's Systems Framework (Townsend,

2011); the Total Quality Management framework (Martin, 1993); Donabedian's Quality of Care framework (Donabedian, 1980) and Packard's Organizational Performance Logic Model (Packard, 2009).

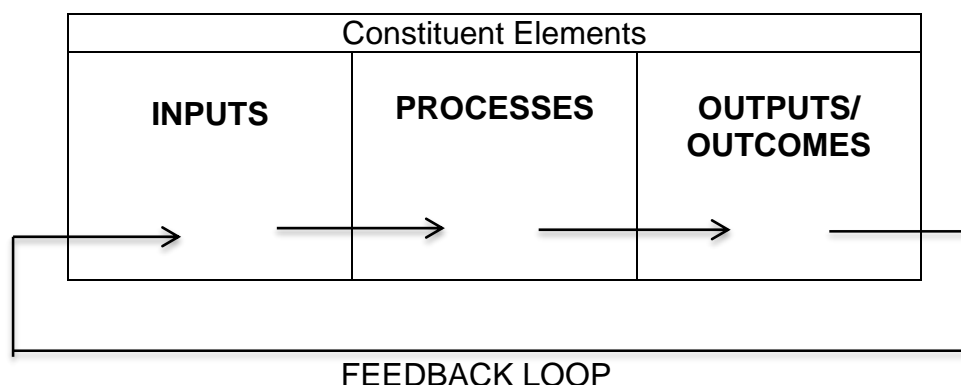


Figure 2.1. A conceptual framework for service quality

**A quality service attends to continuous quality improvement.** Quality improvement is significant in the current customer-value paradigm, which requires continuous improvement in both consumer outcomes, and efficiency and cost control (Kettner et al., 2008; Schalock, 1999). Continuous quality improvement is enabled through a feedback loop, as shown in figure 2.1 (Martin, 1993). This is a mechanism that allows service outputs/outcomes to be 'fed-back' into service inputs, which is then informative in the process element (Martin, 1993). This feedback may be either be reinforcing or corrective (LaVigna et al., 1994). This may enable specified outcomes to be met while agencies continue to work towards outcomes beyond those that are specified. Continuous quality improvement through a feedback loop is a feature of quality service models including Packard's Organizational Performance Logic Model (Packard, 2009) and the Total Quality Management framework (Martin, 1993).

### **A Conceptual Framework for Quality Service Provision for People with Intellectual Disabilities and Challenging Behaviour**

The previous section has identified three key features of quality services. In combining these features, a conceptual framework for quality service provision has been developed, as shown in figure 2.1. This is a construction of quality based in the literature and the ensuing section identifies factors that are significant to quality service provision, and apply these within the framework. The subsequent section identifies factors within agency control that limit/enable quality service provision for the cohort, followed by identification of factors outside of agency control that limit/enable quality.

The conceptual framework for identification of limiting/enabling factors adapts

Shogren et al.'s (2009) use of Bronfenbrenner's theory of human development. In the application, the authors applied Bronfenbrenner's theory to identify factors within systems that influence outcomes for people with ID. In adaptation for this thesis the *mesosystem*, which relates to service provision, is the central system and impacts and is impacted by factors in various systems. In this systems approach, the system levels are the *macrosystem*, which is the socio-political environment, and the *chronosystem*, which represents change over time. Figure 2.2 illustrates this systems approach to quality service provision.

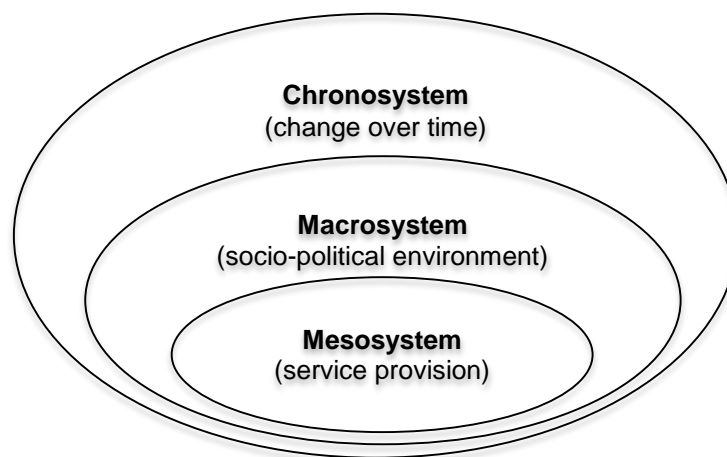


Figure 2.2. A systems approach for service quality

### **Factors Significant to Quality Service Provision for People with Intellectual Disabilities and Challenging Behaviour**

A review of the literature indicates 14 factors as significant to quality service provision for people with ID and CB. Consistent with the framework for quality service provision discussed above and shown in figure 2.1, these factors have been categorised as inputs, processes and outputs/outcomes. An overview of the quality factors are shown in table 2.1, are discussed sequentially below, and are situated within a systems approach in the ensuing section.

While a comprehensive set of factors that have a direct impact on service provision have been elicited from the literature, as discussed below, the literature does not indicate whether these factors in isolation or which combinations of factors have more or less of an impact on quality service provision. In addition, despite the importance of the clients' voice as being central to service delivery, there is a paucity of literature regarding the primacy of the voice people with ID and CB.

Table 2.1  
*Factors Significant to Quality Service Provision for People with ID and CB*

Input Factors	Process Factors	Output/Outcome Factors
Funding	Management Practices	<b>Personal Outcomes</b>
Mission/ Values Statements and Organisational Policy	- Leadership	- Quality of Life
Government Policy	- Flexibility	- Reduction in CB
Service User Needs and Desires	- Organisation of Staff	<b>Organisational Outputs</b>
Physical Resources	- Supervision and Feedback	- Organisation Economy
Human Resources	- Financial Management	- Compliance with Government Standards and Policies
	In-Service Training	- Service User Judgments of Quality
	Individualisation	
	Supportive Staff-service User Interactions	
	Evidence Based Practices	
	Inter-sectoral/agency Collaboration	

**Input factors.** Inputs represent an agency's resources and raw materials (Kettner et al., 2008). The input factors may be prescribed to agencies (such as policy) or available to agencies (such as funding). Input factors are generally consistent across the human services sector and service industries. Those that have been identified in the literature are:

- **Funding**, which represents the financial resourcing available to agencies, including fundraising and charitable donations (National Disability Services, 2009; Packard, 2009; The University of Queensland, 2002);
- **Mission and/or values statements and organisational policy.** Mission and/or values statements are an organisational statement of purpose that clarifies goals for staff, service users and the community (Nankervis & Matthews, 2006). These goals may be immediate or prospective (Dykstra, 1999). An indicator for practice in the HSQF is the development and implementation of an agency's vision and purpose statement that reflects contemporary practice (Department of Communities, 2012a). Organisation policies are often reflective of mission statements and detail organisational plans, instructions, intents and processes. These are mandated in the HSQF and NSDS;
- **Government policy and legislation** which includes the *Disability Discrimination Act 1992* (Cth); the *Disability Services Act 1986* (Cth); *DSA 2006* (Qld); the *Work Health and Safety Act 2011* (Qld); the HSQF; and the NSDS (Department of Communities, 2015; Packard, 2009; Townsend, 2011);
- **Service user needs and desires.** Knowledge of service user needs and desires is mandated under the HSQS and NSDS and central to current approaches to service planning and delivery (Department of Social Services (Cth), 2012; Nankervis, 2006);
- **Physical resources**, which include material resources available to service provider agencies including facilities (such as residences and offices) and equipment (such as hoists, vehicles and computers;(Kettner, Moroney, & Martin, 1999; Packard, 2009);
- **Human resources** are the personnel directly employed by, or associated with, the agency (Larson & Hewitt, 2005; Packard, 2009; Townsend, 2011). With reference to services for people with ID and CB, persons associated with but not employed by agencies include members of Specialist Response

Services who provide "clinical support and expert advice to disability service providers" (Department of Communities, 2013, para. 4).

**Process factors.** Process factors are processes and practices undertaken in service provider agencies (Gardner, 1999b; Kettner et al., 2008; Osborne, 1992; Packard, 2009). The processes and practices significant to quality services for people with ID and CB - as identified through the literature - include specific management practices, in-service training, individualisation, supportive staff-service user interactions, evidence based practices and inter-sectoral/agency collaboration.

**Management practices.** The practices of management refer to the co-ordination of activities with an agency and include leadership, supervision and co-ordination of staff, problem solving, planning and budgeting, ensuring compliance with quality standards, and evaluation (Austin et al., 2009; Department of Communities, 2012b; Packard, 2009). Management practices have been inextricably linked to the production of quality within disability service organisations, and are formative in producing quality outcomes (Brown & Brown, 2003; Campanella, 1999; Department of Health (UK), 2007; Dykstra, 1999; LaVigna et al., 1994; Packard, 2009; Schalock & Verdugo, 2012a, 2012b). As highlighted by LaVigna et al. (1994, p. xiv):

A review of the literature, however, clearly shows that, although human service supervisors, managers and administrators tend to blame low wages, bad attitudes, lack of skills, poor communication, insufficient resources, and other factors outside their control for in-consistency and poor quality in services provided, the real culprit seems to be poor management practice.

The significant management practices identified from the literature are: leadership; flexibility; organisation of staff; supervision and feedback; and financial management.

*Leadership.* Effective leadership is not easily defined as this is dependent on the requirements of the personnel to be 'led'. However, effective leadership may be considered the by-product of understanding the needs of personnel, and knowing how to effectively meet these needs (Guttman, 2008). Practices of leadership include mentoring, coaching, inspiring, empowering and collaborating (Schalock & Verdugo, 2012b).

Effective leadership has been identified in the management literature as significant to the production of quality. With regard to ID services, Clement, Bigby, and Johnson (2007) identified effective leadership as crucial to obtaining desired outcomes for service users. Further, Schalock and Verdugo (2012b) consider effective leadership as a prerequisite for quality improvement and facilitative of evidence based practices. Similarly, Austin et al. (2009) consider leadership essential to service effectiveness (a measure of quality services). Lastly the emotional support of staff - an aspect of leadership - has been

identified as a characteristic of exemplary services for people with ID and CB (Department of Health (UK), 2007).

*Flexibility.* Flexibility is a management practice associated with adaptability and responsiveness (Austin et al., 2009). Changes to models of support require that management maintain a degree of flexibility (Department of Health (UK), 2007; Larson & Hewitt, 2005; Schalock & Verdugo, 2012b). Specifically, Brown and Brown (2003) indicate that management must have the flexibility to allow adaptations to interventions and supports that may contravene organisational policy in order to enhance quality of life for people with disabilities. Further, Gardner (1999a) suggests that quality is enhanced and outcomes are realised when processes are individualised, which requires non-rigid organisational approaches. In describing characteristics of exemplary services for people with ID and CB, it was indicated that:

Successful services.. (are) committed to meeting their complex needs over the long term: so tend to ignore professional or organisational boundaries.  
(Department of Health (UK), 2007, p. 12)

Further, flexibility is required in the application of occupational health and safety legislation as these often contradict disability standards (ACROD, 2004; Clement et al., 2007; Productivity Commission, 2011b).

*Organisation of staff.* The organisation of staff refers to (a) staff placement within organisations, either to teams or to particular service users, and (b) the clear communication to staff about their roles within the team or with the service user. Research conducted by Buntinx (2004, 2008) indicated that in residential facilities for people with ID, the number of staff moving within organisations (such as to other teams), was five times higher than the number of staff who left the organisation. This discontinuity negatively impacts on service user outcomes (Aarons & Sawitzky, 2006; Mansell & Beadle-Brown, 2009; Social Policy Research Centre, 2009).

Similarly, role ambiguity, where staffs are unsure about their role, can lead to reduced quality outcomes. Role ambiguity has been demonstrated to lead to staff stress and turnover (Devereux, Hastings, & Noone, 2009; Hatton et al., 1999a; Hatton et al., 2001). In turn, stress increases negative interactions with service users (Devereux et al., 2009; Skirrow & Hatton, 2007), compromises the quality and quantity of staff interactions (Hastings, Horne, & Mitchell, 2004), and prevents staff dealing appropriately with challenging behaviours (Devereux et al., 2009).

*Supervision and feedback.* Supervision and feedback is a management practice that supports and develops the skills, values and knowledge of individuals, groups and teams (Gray, Field, & Brown, 2010). It is considered one of the most important drivers in ensuring positive outcomes for service users (Children's Workforce Development Council (2007) and is well documented in the management literature (Burke & Krey, 2005; Mosley, Mosley, & Pietri, 2010; Wiener, Mizen, & Duckham, 2003). Supervision and feedback has been identified as a factor significant to quality provision in disability services by numerous authors in the Australian context (Bigby, Clement, Mansell, & Beadle-Brown, 2009; Clement & Bigby, 2008) and internationally (Berkery, Tiernan, & Armstrong, 2009; Bigby et al., 2009; Mansell, 2006; Mansell & Beadle-Brown, 2009; Mansell, Beadle-Brown, Whelton, Beckett, & Hutchinson, 2008; Skirrow & Hatton, 2007; West, Guthrie, Dawson, Borrill, & Carter, 2006).

*Financial management.* Financial management refers to the division of financial resources and allocation to various purposes within agencies. These purposes include in-service training, hiring of staff, external evaluations and audits. The way funding is allocated can impact service outcomes. This is supported by the The University of Queensland (2002) who indicated that while financial resourcing is significant to quality provision, quality outcomes are impacted by how funding is utilised. The significant funding allocations required within services to produce quality outcomes relate to the hiring and/ or training of management staff and the provision of 'quality' in-service training (Dowey, Toogood, Hastings, & Nash, 2007; Finn & Sturmey, 2009; Grey, Hastings, & McClean, 2007; Grey, McClean, & Barnes-Homes, 2002; McClean et al., 2005; McKenzie, Sharp, Paxton, & Murray, 2002; McKnight & Kearney, 2001).

*In-service training.* In-service training is education that is arranged by service provider agencies and takes place within the agency context. In-service training is typically designed to achieve organisational goals by extending or updating the competencies of staff (Nankervis & Matthews, 2006). Within disability service agencies, in-service training may relate to occupational health and safety, evidence based practices, beliefs and attributions, organisational procedures and policies, and best practice for challenging behaviour. There are a number of techniques that can be utilised in the conduct of training including direct instruction, role-play, modeling and peer-to-peer processes (Finn & Sturmey, 2009; Grey et al., 2007).

In-service training has been demonstrated as a practice that facilitates quality outputs/outcomes in ID services (see Dowey et al., 2007; Finn & Sturmey, 2009; Grey et al., 2007; Grey et al., 2002; McClean et al., 2005; McKenzie et al., 2002; McKnight &



Kearney, 2001). Further, this has been identified as a characteristic of exemplary services for the cohort:

These services also invest heavily in training for the direct care staff of the service. Most of this is specially designed in-service training, reflecting some dissatisfaction with the very limited competence in work with people who have challenging behaviour produced by traditional professional training. (Department of Health (UK), 2007, p. 14)

The retention and use of skills and knowledge gained from in-service training has been considered to be dependent on supervision and feedback post-training (Ager & O'May, 2001; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; LaVigna et al., 1994; Nankervis & Matthews, 2006).

**Individualisation.** With regard to service provision for people with disabilities, individualisation refers to practices that reflect the needs and aspirations of service users. The current framework for this is person-centered planning. Person-centred planning focuses on the service user including their vision for the future, likes and dislikes, what and who is important to them and their strengths (Nankervis, 2006). It reflects a shift from a 'one size fits all' approach in services to an emphasis on self-determination and inclusion (Department of Human Services (Vic), 2012; Thompson et al., 2002).

Person-centred plans are formalised through individual support plans which identify the support mechanisms within services that are required to actualise the goals of the service user (Thompson et al., 2002). These support mechanisms refer to both resources and strategies. The impact on quality service outcomes, however, is limited by the quality of the plan, its implementation, the availability of resourcing, and the commitment and ability of staff (Department of Health (UK), 2007; Department of Human Services (Vic), 2012; Nankervis, 2006; Thompson et al., 2002).

Despite the issues associated with effective implementation of individual support plans, 'true' individualisation has been identified as a characteristic of exemplary services for people with ID and CB (Department of Health (UK), 2007).

**Supportive staff-service user interactions.** Staff-service user interaction refers to dealings directed by staff to service user, service user to staff, and/or reciprocal exchanges. These interactions may be formal, such as direct assistance, or informal, such as 'a casual chat' (Jahoda & Wanless, 2005). Here, 'supportive' staff-service user interactions refer to interactions that are characterised by respect and caring, and reflective of individualisation and evidence based practices. Supportive staff-service user interactions are a significant process factor in quality service provision because they are

critical to the facilitation of outputs/outcome factors such as service user judgments of quality and personal outcomes.

First, staff-service user interactions are significant to consumer opinions of service quality. As highlighted in Marquis and Jackson's (2000) research with 50 service users:

'quality' in human services is primarily linked to relationships with service personnel who have the potential to create experiences of personal growth or systematic abuse (p.422).

Second, as stated by Lambrechts, Kuppens, and Maes (2009, p. 620) "previous research has identified that staff–client interactions play an important role in the origin and maintenance of CB". This is supported by a number of authors (see Arthur-Kelly, 2006; Grey et al., 2002; Hastings, 1997, 2002, 2005; Hastings & Remington, 1994; Lambrechts et al., 2009; McDonnell, 1997; Snow, Langdon, & Reynolds, 2007). Thus, interactions that are supportive of evidence based practices (described below) and individualised services which "support the person to achieve a good quality of life" (Department of Health (UK), 2007, p. 13), are significant to quality outputs/outcomes.

**Evidence based practice.** Evidence based practice is the use of practices and procedures to support clients that represent current best practice, as determined by studies that utilise reliable and valid methods and are based on clearly articulated and empirically supported theory or rationale (Perry & Weiss, 2007; Schalock, Verdugo, & Gomez, 2011). With regard to ID and CB, positive behaviour support (PBS) is widely recognised as best practice (Grey & Hastings, 2005; LaVigna & Willis, 2012). PBS encompasses strategies and methods for improving the person's quality of life as a primary goal, and decreasing behaviours of concern as a secondary goal (Carr et al., 2002; Department of Human Services (Vic), 2011). PBS includes the systematic gathering of relevant information, conducting a functional behaviour assessment, designing support plans, implementation and ongoing evaluation. PBS has been evidenced as significant to quality outcomes such as service users' increase in quality of life and reduction in CB (Grey & Hastings, 2005; LaVigna & Willis, 2012).

**Inter-sectoral/agency collaboration.** Inter-sectoral/agency collaboration refers to the co-operative and coordinated relationship between sectors and agencies to achieve outcomes for service users. In relation to disability services this includes the sectors of health and education, and various agencies whose core business relates to psychology and psychiatry, occupational therapy, language pathology and general practitioners. Inter-sectoral/agency collaboration has been linked to the provision of 'exemplary services' for people with ID and CB (Department of Health (UK), 2007) and 'high-performance teams'

(Schalock & Verdugo, 2012b). Further, poor inter-sectoral/agency collaboration has been identified as impacting on service user outcomes (Gardner et al., 2005; Townsend, 2011).

**Output/outcome factors.** Outputs/outcomes are the product of processes undertaken by agencies. In ID services, these incorporate personal outcomes for service users and organisational outputs (Schalock & Verdugo, 2012b), and are discussed sequentially.

**Personal outcomes.** Personal outcomes refer to service user outcomes that are directly attributable to service provision by agencies (Schalock et al., 2002). The personal outcomes specific to people with ID and CB are **increased quality of life** and **decreased CB**. As discussed earlier, quality of life is a primary outcome for service provision, as mandated under the CRPD, NDA and DSA. As also discussed, CB can be an outcome of poor quality service provision (Carter, 2006; Disability Services Commission, 2009; Emerson, McGill & Mansell, 2013) and is a barrier to quality of life (Allen et al., 2005; Bailey et al., 2010; Clement & Bigby, 2011; Emerson & Einfield, 2011; Sabaz, 2012). As such, decreased CB is also a primary outcome for quality service.

**Organisational outputs.** Organisational outputs are measures of an agency's processes. A review of the literature indicates organisational outputs for service quality as related to: organisational economy, compliance with government standards and policy, and service user judgments of quality.

*Organisational economy.* ID service literature indicated organisational economy as incorporating (a) *effort*, such as units of service, (b) *efficiency*, such as cost per unit, administrative costs, and responsiveness, (c) *staff-related measures*, such as staff development activities, employment duration, job satisfaction, attitudes and procedural fidelity, d) *program options*, such as employment and community living alternatives, and e) *network indicators*, such as agreements among partners and agencies and data sharing agreements (Kettner et al., 2008; LaVigna et al., 1994; Schalock, 1999; Schalock & Verdugo, 2012a, 2012b). However, organisational economy may also relate to input factors such as the agency's mission and value statements and agency policies and protocols.

*Compliance with government quality standards and policy.* Compliance with government quality standards and policy is identified as an output factor for two reasons. First, non-compliance raises potential for litigation and the discontinuation of funding (Department of Communities, 2012a). Second, compliance provides a measure of quality assurance for service users, funding bodies and government bodies. For agencies, the

incorporation of compliance with quality standards and policy as an output is informative in developing policies and procedures that are associated with quality.

*Service user judgments of service quality.* Consumer judgments of service quality have been identified through quality services literature as significant (Packard, 2009; Parasuraman, Zeithaml, & Berry, 1985; Wilding, 1994). Eliciting service user perspectives of services is identified as significant in disability and ID literature (McGlaughlin, Gorfin, & Saul, 2004; O'Reilly, 2007; Shaddock, 2006). This is included as an output factor for two reasons. First, consumer judgments are a mechanism to develop more appropriate services for people with ID (McGlaughlin et al., 2004, p. 710). Second, as mandated under the NSDS, the service user "has a range of ways to speak up about (my) supports and services and play an active role in working out how things will improve" (Department of Social Services (Cth), 2012, p. 18).

### **Factors that Limit/Enable Quality Service Provision for People with Intellectual Disabilities and Challenging Behaviour**

The previous section has identified factors internal to agencies that are significant to quality service provision. This section identifies factors that limit/enable quality service provision. A review of the literature indicates 20 factors as being limiting or enabling to agency production of quality services. To identify factors that are within agency control and those outside of agency control, a systems approach was used as a conceptual framework (see previous section A Conceptual Framework for Quality Service Provision for People with Intellectual Disabilities and Challenging Behaviour). Accordingly, table 2.2 organises the 20 factors as belonging to one of three systems levels: (1) the *mesosystem*, which relates to service provision, (2) the *macrosystem*, which is the socio-political environment, and (3) the *chronosystem* which represents change over time (Shogren et al., 2009). Note that factors in the mesosystem are within the agency's control, whereas factors in the macrosystem and chronosystem lie outside the agency's control.

Table 2.2

*Factors Limiting/Enabling Quality Service Provision for People with ID and CB*

<b>Mesosystem Limiting/enabling Factors</b>	<b>Macrosystem Limiting/Enabling Factors</b>	<b>Chronosystem Limiting/Enabling Factors</b>
Commitment to, and capacity for, quality improvement and measuring outcomes/outputs Ability to acquire funding Staff stress and turnover Staff levels/ ratios Staff experience and qualifications Staff attitudes Staff beliefs and attributions regarding CB Organisational culture Staff fidelity to programming	Current Knowledge Funding Workforce issues Neo-liberalism Policy and legislation	Theoretical models of disability Systems change Provision across lifespan Prevention and Technologies Societal and family outcomes Population need and demand

**Mesosystem limiting/enabling factors.** The mesosystem refers to service factors within the agency. A review of the literature indicates the following nine mesosystem factors that limit or enable quality service provision.

***Commitment to, and capacity for, quality improvement and measuring outputs/outcomes.*** A commitment to continuous service improvement is a feature of a quality service (see section 'features of a quality service'). Literature in human services and ID indicates the measurement of organisational outputs and personal outcomes as necessary for quality improvement (Campanella, 1999; Schalock, 1999; Schalock & Verdugo, 2012b). However, there are limits to any one agency's commitment to (and capacity for) being able to measure outcomes, and to analyse and utilise the data (Mertens & Wilson, 2012; Shaddock, 2006).

***Ability to acquire funding.*** Funding for hiring staff, training staff, and in-service training is considered significant to quality service provision (Dowey et al., 2007; Finn & Sturmey, 2009; Grey et al., 2007; Grey et al., 2002; McClean et al., 2005; McKenzie et al., 2002; McKnight & Kearney, 2001). However the current funding of disability services is considered inadequate (Office of the Public Advocate, 2009; Roth, 2007; Social Policy Research Centre, 2009; The University of Queensland, 2002). Therefore, the ability of agencies to acquire additional funding through the form of grants and donations may limit/enable quality service provision.

***Staff stress and turnover.*** Stress is characterised by feelings of exhaustion, and associated with attitude and behavioural change (Innstrand, Espnes, & Mykletun, 2002). The long term consequence of stress is burnout, which comprises feelings of emotional exhaustion, loss of feelings of accomplishment on the job, and negative, cynical and

depersonalizing attitudes towards service users (Skirrow & Hatton, 2007). Stress and burnout are positively associated with turnover.

Staff stress impacts on quality outcomes because it results in negative interactions with ID service users (Devereux et al., 2009; Skirrow & Hatton, 2007). In particular, stressed staff interact less frequently with service users, and engage in less positive interactions (Hastings et al., 2004). Stress has also been identified as impeding staff in appropriately dealing with CB (Devereux et al., 2009). There are also direct costs associated with stress and turnover, such as the recruitment, training, and monitoring of new staff (Hatton et al., 2001).

**Staff levels/ ratios.** A significant portion of agency funding is for the employment of support workers. Given finite funding of agencies, the apportioning of staff ratios may limit/enable quality service provision. Not having adequate staffing levels consistent with the needs of service users leads to reduced outcomes for service users (Felce, Lowe, & Jones, 2002b; Social Policy Research Centre, 2009; The University of Queensland, 2002). However, increasing staff-to-client ratios beyond their needs does not positively correspond with increased outcomes for service users (Felce et al., 2002b; Jones et al., 1999; Robertson et al., 2001b; Stancliffe, Harman, Toogood, & McVilly, 2011). The ratio of staff to service users is thus limiting/enabling to quality service provision.

**Staff experience and qualifications.** The Office of the Public Advocate (2009, p. 13) indicates quality of supported accommodation as dependent on the skills, experience and qualifications of staff. However, with specific regard to qualifications, studies in ID services have not equivocally supported qualifications as necessary for quality service provision (see Felce et al., 2002a, 2002b; Mansell et al., 2008; Robertson et al., 2000; Robertson et al., 2001b). Similarly, experience has been implicated in service user engagement in meaningful activity in some studies (see Felce et al., 2002a; Felce et al., 2002b; Mansell et al., 2008) but not in others (Mansell, Beadle-Brown, MacDonald, & Ashman, 2003).

Nonetheless, the acquisition of staff with limited qualifications and experience requires an investment in in-service training, supervision and feedback. Due to these associated costs, experience and qualifications are identified as a limiting/enabling factor in quality service provision.

**Staff attitudes.** Attitudes are an individual's viewpoint or disposition toward a person, object or idea (de Boer, Piji, & Minnaert, 2012). Mansell et al. (2008) found that positive staff attitudes towards community care, rights of the service users, and treatment of ID service users was significant to staff's ability to engage service users in meaningful

activity. Elgi, Feurer, Roper and Thompson (2002) determined that positive staff attitudes towards community inclusion of people with ID was significant to staff-initiated social interactions, which in turn was significant to community activities. In the Australian context, Bigby et al. (2009) concluded that staff attitudes that were reflective of values underpinning policy and service delivery goals were enabling of service user outcomes.

**Staff beliefs and attributions regarding challenging behaviour.** With regard to CB, attributions are judgments about the cause of the behaviour, and beliefs are underlying cognitions about the behaviour, which may include causation (Snow et al., 2007). Staff beliefs and attributions are considered formative to the appropriateness of responses to CB (Grey et al., 2002; Lambrechts et al., 2009). Specifically, attributing CB as internal to the client, rather than considering factors in the environment that serve as a catalyst for the behaviour, may facilitate an inappropriate response (Weigel, Langdon, Collins, & O'Brien, 2006). Incorrect attribution is reinforcing and maintaining of CB (Grey et al., 2002; Hastings, 1997, 2002, 2005; Hastings & Remington, 1994; Lambrechts et al., 2009; McDonnell, 1997; Snow et al., 2007). Further, internal causations are significant contributors to staff stress (Allen, 1999; Hastings & Brown, 2002), which is further associated with less positive interactions and reduced frequency of interactions with service users (Hastings et al., 2004). Thus, staff beliefs and attributions are limiting/enabling to quality service provision.

**Organisational culture.** Organisational culture refers to the shared assumptions, beliefs and values that influence the behaviour of people working within an organisation (Hartnell, Ou, & Kinicki, 2011). Research in ID services supports the notion that culture should be consistent across staff operating at different job levels within agencies (Hatton et al., 1999b) and influential to staff behaviour (Bruggemann, 2010; Carnaby & Cambridge, 2002).

Gardner (1999a) suggests that without the integration of the organisation's values and standards into organisational culture, "organisational missions remain unrealised and the work content does not change" (p.198). This is supported by Schalock and Verdugo (2012b) who indicate that to develop values-based business, these values need to be developed and fostered within the organisational culture. Further, as organisational culture is shared, a culture of reciprocal learning across all divisions of staff can be facilitated (Nankervis & Matthews, 2006). In this regard, organisational culture can facilitate quality outcomes/outputs, however the fostering of conducive organisational culture may limit quality outcomes.

**Staff fidelity to programming.** Fidelity is the extent to which techniques and programs, such as PBS, are implemented in accordance with the specified guidelines and methods (Fagan, Hanson, Hawkins, & Arthur, 2008). Poor fidelity decreases the effectiveness of the programs and results in reduced outcomes for service users (Fagan et al., 2008; Fixsen et al., 2005; Owen, 2006; Palinkas & Soydan, 2011). The extent to which programs are implemented may depend on various factors, such as the quality of the in-service training, staff beliefs and attributions, and organisational culture.

Staff fidelity to programming can be measured at an organisational level using fidelity checklists and measures (see Fixsen et al., 2005; LaVigna et al., 1994), observation procedures, self-report and interviews (Owen, 2006). This information can then be used for evaluative purposes (Fixsen et al., 2005). Because quality outcomes may be enhanced by the measurement of staff fidelity to programming, this factor is identified as a limiting/enabling agent in quality service provision.

**Macrosystem Limiting/Enabling Factors.** The macrosystem represents the socio-political environment. A review of the literature indicates five factors within this system that can limit/enable agencies' capacity to produce quality services.

**Current knowledge.** Current knowledge is the extent of existing information regarding ID and CB, and the provision of quality services to this cohort. Limitations in current knowledge have been identified in the areas of: prevention; assessment; effectiveness of systems, treatments and practices; best practice; management systems and processes conducive to quality outcomes; utilisation of technologies; and evaluation methodology (Fixsen et al., 2005; Forrester-Jones et al., 2006; Moss, Bouras, & Holt, 2000; Townsend, 2011). Thus, current knowledge can limit/enable quality provision of services.

**Funding.** Inadequate funding is considered to limit agencies' capacity to provide quality services (Office of the Public Advocate, 2009; Roth, 2007; Social Policy Research Centre, 2009; The University of Queensland, 2002). As such, levels and models of funding are identified as a quality limiting/enabling factor.

**Workforce issues.** Workforce issues relate to the capacity of disability service agencies to recruit and retain staff with appropriate skill and/or training. The ageing of Australia's population is considered to limit agency capacity to *recruit* staff as population need and demand for disability services increases and labour participation decreases (Disability Services Commission, 2012; National Disability Administrators, 2006; Productivity Commission, 2011b). Agency capacity to *retain* staff has been linked to innate features of the sector, such as emotional and physical demands, low wages, and



high rates of stress and burnout (Disability Services Commission, 2012; National Disability Administrators, 2006; Productivity Commission, 2011b). Workforce issues exist in the macrosystem but are significant to agencies' ability to provide quality services as the sector is characterised by high levels of staff-service user interactions (Chism, 1997; Martin, 1993). However, the 'quality' of this interaction is dependent on a number of factors including the recruitment and retention of appropriate staff (Fixsen et al., 2005; Marquis & Jackson, 2000). Given this, issues related to workforce capacity are considered enabling/limiting factors in agencies' capacity to provide quality services.

**Neo-liberalism.** Neo-liberalism is a political philosophy that emphasises economic liberalisation, free trade, open markets, privatisation, deregulation and decreasing the size of the public sector in favor of the private sector (Apple, 2001; Dowse, 2009; Reinders, 2008; Swenson, 2008; Wiesel & Fincher, 2009; Williams, 2004). The current socio-economic climate in Australia, as with many Western countries including the USA, Canada and the UK, is largely dominated by neo-liberalism (Van Gramberg & Bassett, 2005). It is considered to underpin the mechanisms of the Western parliamentary democratic system; economics; distribution of goods and services; schooling systems; separation of powers; the legal system, and societal thinking (Dowse, 2009; Reinders, 2008; Swenson, 2008; Wiesel & Fincher, 2009). Literature identifies this as a political philosophy that will continue with globalisation, as stated, "processes associated with globalisation intensify the agenda of neo-liberalism to fundamentally determine their everyday social arrangements and experiences (of people with ID) ... in western democracies such as the USA, the UK and Australia" (Dowse, 2009, p. 571). As such, neo-liberalism is pervasive and continuing so is located to the macrosystem, and impacts on quality provision of services as neo-liberalistic agendas emphasise efficiency.

**Policy.** International and local legislation and policy provide frameworks and directives within which service provider agencies function. Thus, it is considered a limiting/enabling factor to quality provision of services.

**Chronosystem Limiting/Enabling Factors.** The chronosystem represents change over time. A review of the literature indicates six factors within this system that can limit/enable agencies' capacity to produce quality services.

**Theoretical models of disability.** Theoretical models of disability shape individual and collective actions (Senge, 2006) (Schalock, Verdugo, Bonham, Fantova, & Van Loon, 2008), ID policy and funding (Schalock et al., 2008; Shaddock, 2006), and service processes, cultures and design (Schalock et al., 2008; Shogren et al., 2009). As such,

change in theoretical models of disability over time can limit/enable quality service provision.

. **Systems change.** A systems level approach to quality service prescribes the understanding that the systems are inter-related (Schalock et al., 2008). Change within a system level thus indicates prospective change within another. To highlight, historical changes in theoretical models of disability (chronosystem level) have led to modifications to policy and funding of disability services (macrosystem level). This has impacted agencies in the quality provision of support.

. **Provision across lifespan.** This refers to services, both specialist and mainstream, provided to service users over time (Townsend, 2011). This factor is informed by the service user's quality of life across time and experiences of service quality. Provision across lifespan is additionally informed by other chronosystem agents, such as prevention and technologies, and systems change. With regard to ID and CB, provision of services and service responses to CB have been implicated as limiting/enabling agencies' capacity to produce quality outcomes for service users (Carter, 2006).

. **Prevention and technologies.** Innovation and research have led to augmented technologies, and preventative and corrective techniques for people with ID and CB (e.g. PBS). However, technological advances and research regarding based practices continue to change over time. Given this, prevention and technologies may limit/enable the provision of quality services.

. **Societal and family experiences/ outcomes.** Societal and family experiences are changes in society and family outcomes over time as a result of service provision. Current services have been criticised for lack of support for families and carers, and deficiencies in societal outcomes for people with disabilities (Productivity Commission, 2011b). This recognition has been formative to the development of the NDIS. Thus, as societal and family experiences and outcomes change, so does funding and legislation guiding service provision. As such, societal and family experiences/ outcomes may limit/enable quality service provision.

. **Population need and demand.** Population need and demand is the requirement for services for the cohort. Need and demand for services change over time and are impacted by other factors such as prevention and technology (Townsend, 2011). High level of unmet need within the disability population has been identified as an impetus for the NDIS. In the current system, however, high levels of population need and demand have led to crisis driven service responses, which is significant to agencies' capacity to produce quality outcomes (Carter, 2006; Productivity Commission, 2011b).

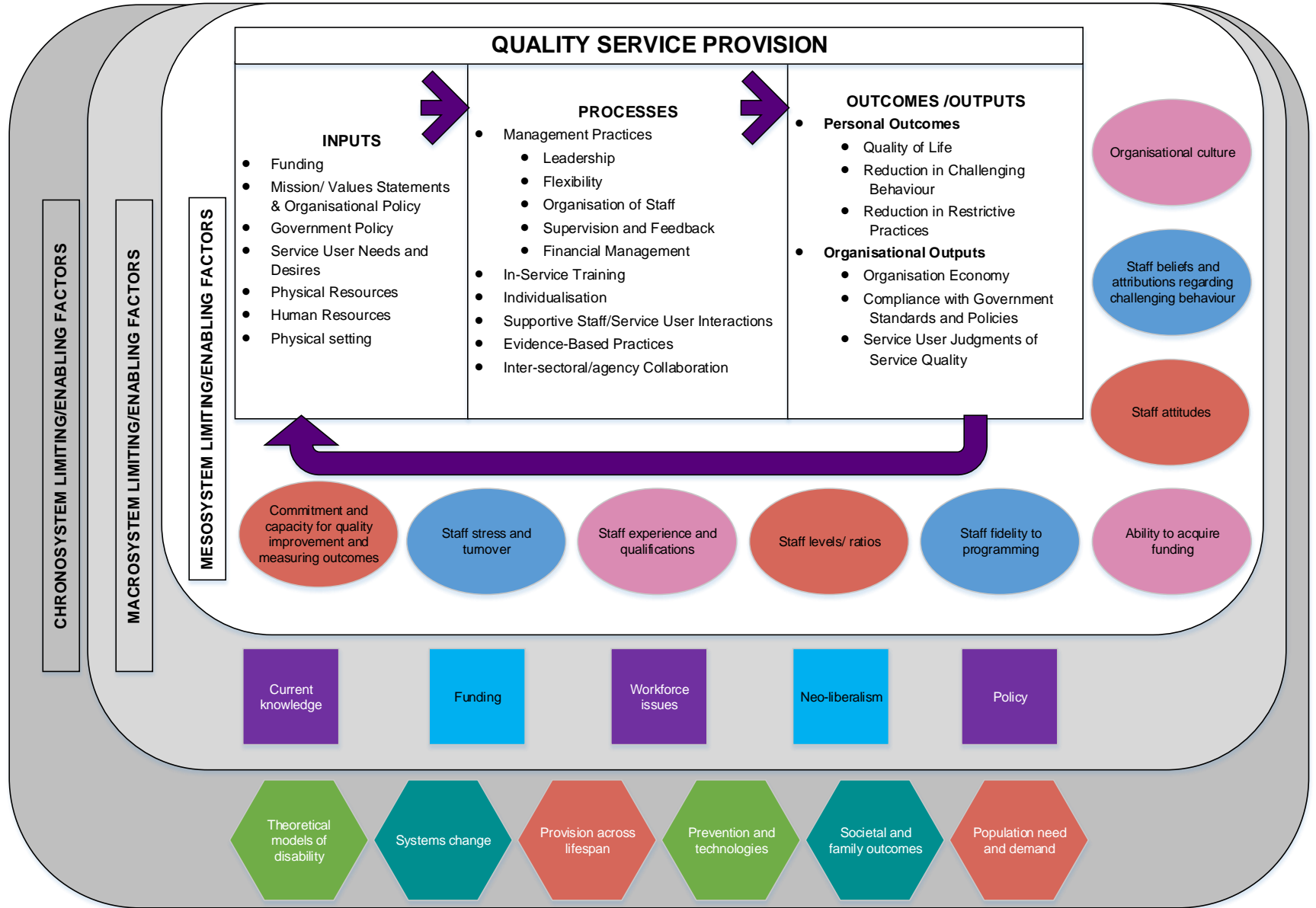
## **A Conceptual Model of Quality Service Provision for People with Intellectual Disability and Challenging Behaviour**

How people with ID and CB are supported through services has a primary role in changing their disenfranchisement. It is therefore paramount to develop an understanding of quality service provision specific to ID and CB. The previous sections have developed conceptual frameworks for understanding quality, and were used as a framework to enable comprehensive identification of factors significant and limiting/enabling to quality service provision.

The conceptual frameworks and identified factors have been developed into a conceptual model of quality service provision for people with ID and CB, as illustrated in figure 2.2. This shows the mesosystem, being the agency level, in the centre as this is the location for quality enhancement. This level shows the factors internal to agencies that are significant and limiting/enabling to quality. In recognition that factors within various systems limit/enable agencies capacity to produce quality, factors within the macrosystem (socio-political environment) and chronosystem (change over time) have been identified through the literature and incorporated in the conceptual model.

However, while this conceptual model provides a basis for the understanding quality and associated factors, these factors have not been comprehensively tested within the context of services for people with ID and CB.

Figure 2.3: A conceptual model of quality service provision for people with ID and CB



## Chapter Three: The Current Research

This chapter describes the research undertaken. An overview of the elements of the research in relation to the research questions is given, followed by the methodological approach, incorporating design, methodology for each of the three studies, and methodological considerations.

### Research Aims and Questions

How people with ID and CB are supported through services has a primary role in addressing the disenfranchisement experienced by this cohort. A conceptual model of quality service provision for people with ID and CB was developed from the literature. However, the factors associated with quality service provision identified in the model have not been comprehensively tested. Further, prior research has not explored the subjective opinions of stakeholder groups with regard to these factors. In addition, quality outcomes for service users are indicators of quality services so it is necessitated that end-user perspectives are included. The direct experience from people with ID and CB, however, has not been included previously as part of the research agenda into quality services for this cohort. Therefore, the data collected directly from service users can be used to refine, confirm or challenge elements in the conceptual framework.

The aims of this research are:

**Research Aim 1:** to enhance and enrich the model of service quality developed from the literature through consultation with stakeholder groups.

**Research Aim 2:** to explore service users' perceptions of what constitutes quality service provision.

**Research Aim 3:** to compare and contrast experiences of and opinions about quality related factors, as reported in the literature, by service users, and by other stakeholder groups.

**Research Aim 4:** to articulate a comprehensive model of service quality that incorporates the perspectives of service users and other stakeholders.

To meet these aims, four research questions were developed and a multi-study design was adopted. The overall research method targeted different stakeholders in the provision of services to people with ID, including direct recipients of services.

Figure 3.1 shows the research questions and the design of three studies, with data collected from different stakeholder groups for each study. As shown in figure 3.1:

**Research Question 1:** What factors are regarded as significant to quality service provision for people with ID and CB, according to:

- CEOs and managers of service provider agencies
- clinicians and senior practitioners;
- frontline supervisors and support workers in agencies; and
- families/carers of service users with ID and CB?

To address this question, study one incorporated quantitative data collection from CEOs and managers in stage one, and clinicians and senior practitioners in stage two. Study two incorporated qualitative and quantitative data collection from support workers, supervisors, families/carers and advocates.

**Research Question 2:** What factors internal to agencies are regarded as limiting/enabling in quality service provision for people with ID and CB, according to:

- CEOs and managers of service provider agencies, and clinicians and senior practitioners;
- frontline supervisors and support workers in agencies; and
- families/carers of service users with ID and CB?

To address research questions one and two, study one incorporated quantitative data collection from CEOs and managers in stage one, and clinicians and senior practitioners in stage two. Study two incorporated qualitative and quantitative data collection from support workers, supervisors, families/carers and advocates.

**Research Question 3:** What aspects of quality service provision are significant to service users with ID and CB?

This was addressed through study three which incorporated qualitative data collection from service users.

**Research Question 4:** What are the similarities and differences between stakeholder groups and service users' perceptions with regard to significant quality and limiting/enabling factors in services for people with ID and CB?

This question was addressed through comparisons of data from study one, two and three.

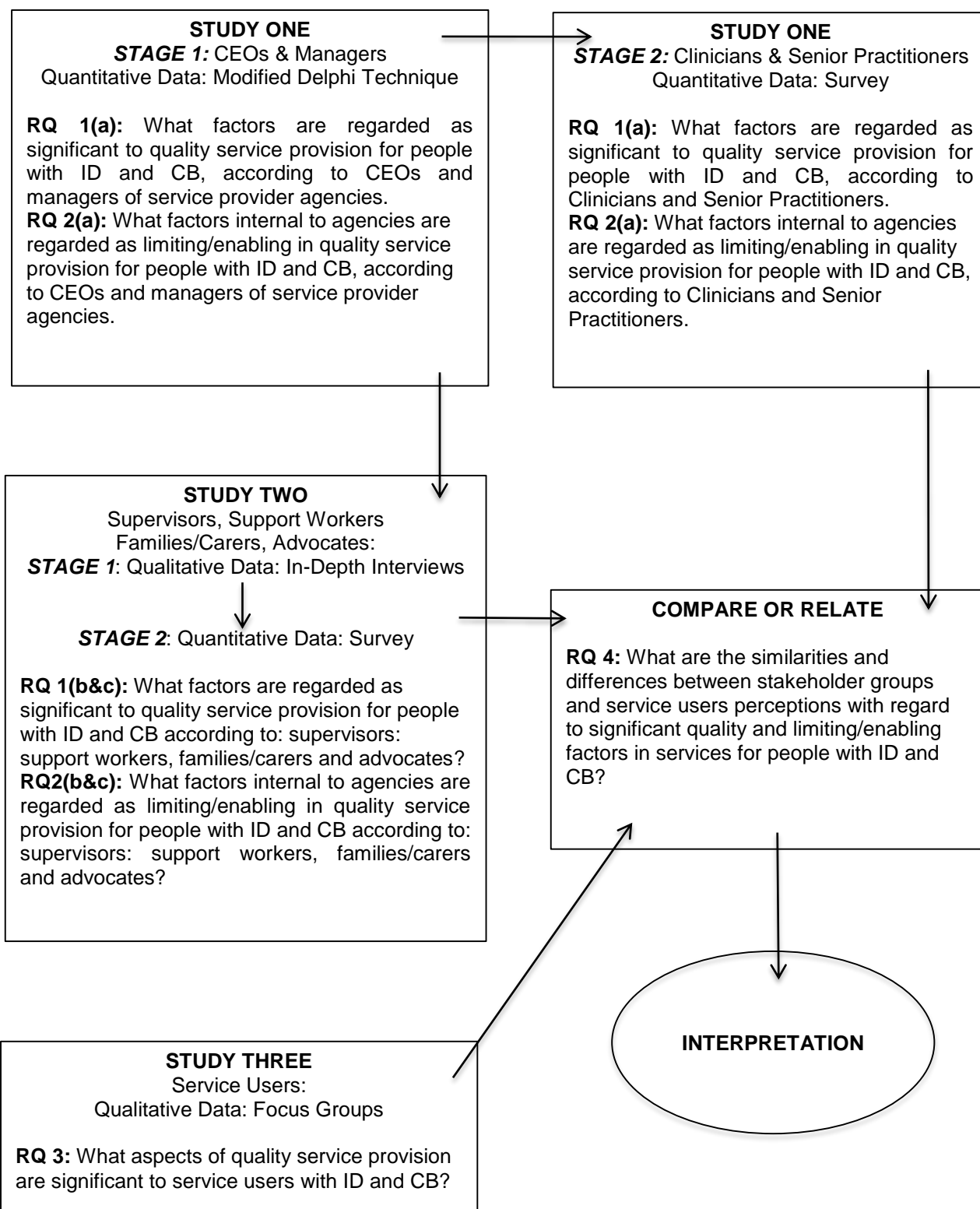


Figure 3.1. The research design

## **Methodological Approach**

**Design.** The overall design of the research, as illustrated in figure 3.1, was convergent parallel mixed methods with elements of sequential exploratory and sequential explanatory strategies.

***Convergent parallel mixed method*** designs involve independent data analysis for each study in the research and use a combination of qualitative and quantitative data collection (Creswell, 2011a; Hesse-Biber, 2010). In this research, there was autonomous data analysis for each study, and both qualitative and quantitative data collection methods were used. This design was adopted as it enabled examination of the similarities and differences between participant groups for the three studies prior to interpretation, and allowed the most appropriate methods of data collection to be utilised for each of the studies (Creswell, 2011a; Hesse-Biber, 2010; Kroll & Neri, 2009).

***Sequential explanatory*** strategies involve quantitative data informing qualitative data collection. In this research, the quantitative data collected from study one was informative to qualitative data collected in study two, as indicated in figure 3.1 with an arrow between study one and study two. The effect of which was pragmatic as factors identified as significant by study one participants could be explored with study two participants (Kroll & Neri, 2009).

***Sequential exploratory*** strategies involve qualitative data collection informing quantitative data collection (Hesse-Biber, 2010; Kroll & Neri, 2009). Study two involved qualitative data collection informing quantitative data collection, as shown in figure 3.1 with an arrow between the data collection techniques. This was utilised to ensure that the survey terminology was appropriate and the content was comprehensive, in order to enhance validity and generalisability (Creswell, 2011a; Hesse-Biber, 2010; Kroll & Neri, 2009).

**Specific methodologies.** The methodologies used were as follows.

***Modified Delphi.*** A Delphi is a group facilitation technique that aims for expert consensus of opinion through a series of surveys, commonly referred to as rounds (Hasson, Keeney, & McKenna, 2000; McKiernan, 2008; Powell, 2003). In the first round of a Delphi, an open-ended survey is used to provide specific information regarding the subject under investigation. The results are then converted into a structured survey adopting rank order or rating scales for items. In the second round, the structured survey is sent to the Delphi panelists along with a summary of the findings from round one (Hasson et al., 2000; Hsu & Sandford, 2007; Keeney, McKenna, & Hasson, 2011). Through this, the respondent group is given the opportunity to re-evaluate their "original



answers based on examination of the group response” (Clayton, 1997, p. 377). The iteration of structured survey redevelopment and feedback is continued until consensus is reached (Forsyth, 2010; McKiernan, 2008; Powell Kennedy, 2004) or until a pre-determined number of rounds have been completed (Keeney et al., 2011; Williams & Webb, 1994).

The methodological value of a Delphi technique includes the ability to achieve convergence of opinion through group interaction, but without group influences such as coercion to conform to others opinions and dominant individuals (Hasson et al., 2000; Hsu & Sandford, 2007). Further, through the iterative nature of a Delphi and the feedback mechanism, participants can identify items they "may have missed or thought unimportant" (Hasson et al., 2000, p. 1010). Thus, a more complete understanding of phenomena can be gained.

In application to this research, a modified Delphi was used for study one stage one data collection with CEOs and managers of service provider agencies. Given the substantial amount of research literature indicating factors associated with quality service provision for the cohort, the Delphi did not follow the traditional methodology of commencing with an open-ended survey. Rather, the Delphi commenced with a structured survey based on factors identified as associated with quality as gleaned from the literature. According to Hsu and Sandford (2007, p. 2) this is "both and acceptable and a common modification of the Delphi process format". However, a qualitative component was added to enable participants to identify factors associated with quality that were not evident in the literature (Hasson et al., 2000). The pre-determined number of rounds was set at two to reduce participant fatigue (Hsu & Sandford, 2007; Keeney et al., 2011).

A modified Delphi technique was considered the most appropriate method of data collection for a number of reasons. First, the use of surveys, in contrast to interview/focus group techniques, enabled the inclusion of participants who may have otherwise been excluded due to time constraints and geographical location (Forsyth, 2010; Keeney et al., 2011). By utilizing this method, a greater number of respondents were able to participate thereby increasing the validity and generalisability of findings. Second, the iterative nature of the Delphi technique enabled the identification of factors not evident in the literature, and the level of consensus to be evaluated in subsequent rounds (Hasson et al., 2000; McKiernan, 2008; Powell, 2003).

**Survey.** Survey is a method of collecting data from people about who they are, how they think and/or what they do (Balnaves & Caputi, 2001). The methodological value of

surveys include the capacity to collect data from a large number of geographically dispersed populations and participant anonymity (Creswell, 2011b; Hesse-Biber, 2010; Singh, 2007).

Surveys were used for study one stage two, which incorporated data collection with clinicians and senior practitioners, and study two stage two, which incorporated data collection with support workers, supervisors, families/carers and advocates. This method of data collection was used for two reasons. First, these stages were confirmatory rather than exploratory, with quality associated factors having been explored in the first stage of the studies. Second, it enabled data collection from participants who may have been excluded due to time constraints, issues of anonymity and geographical dispersion (Creswell, 2011b; Hesse-Biber, 2010; Singh, 2007).

**Interview.** Interviews are "guided question-answer conversations" or structured and purposeful interchanges of ideas and views (Tracy, 2013, p. 131). The methodological value of interviews include the capacity to collect rich and in-depth data and the exploration of complexities of the phenomenon under investigation (Berg & Lune, 2011; Pugach, 2001).

Interviews were used for study two stage one data collection with support workers, supervisors, families/carers and advocates. This was the most appropriate method of data collection for a number of reasons. First, while factors associated with quality were gleaned from the literature, the comprehensiveness of these factors had not been explored with stakeholders with direct contact with service users with ID and CB. Second, through interview methodology, the complexities of quality service provision, including interaction between quality associated factors, could be explored (Berg & Lune, 2011; Pugach, 2001; Silverman & Patterson, 2015). Third, terminology used by the stakeholder groups had not been investigated thus a survey may have lacked construct validity (Creswell, 2011a; Hesse-Biber, 2010; Kroll & Neri, 2009).

**Focus group.** Focus groups have been defined as "carefully planned series of discussions on a defined area of interest in a permissive, non-threatening environment" (Krueger & Casey, 2000, p. 5). The purpose of a focus group is to encourage divergent thinking and disclosure of personal perceptions (Larson, Grudens-Schuck, & Lundy, 2004; Luttenbacher, Cooper, & Faccia, 2002). The methodological value of focus groups is the capacity for a range of opinions to be expressed and the stimulation of the ideas that may not be elicited through alternative qualitative data collection techniques (Grudens-Schuck, Lundy, & Larson, 2004; Johnson & Turner, 2003; Vaughn, Schumm, & Sinagub, 1996).

Focus groups were the method of data collection for study three, which involved data collection with service users with ID and CB. People with ID are often excluded from

research because of cognitive and linguistic difficulties (Boyden, Muniz, & Laxton-Kane, 2012; Lloyd, Gatherer, & Kalsy, 2006); the potential for acquiescent and socially desirable responses (McGlaughlin et al., 2004); and difficulties "in making quantitative judgments" (Bergstrom, Hochwalder, Kottorp, & Elinder, 2013, p. 251). There is a growing body of research identifying focus groups as an appropriate method of data collection for people with ID that may assuage cognitive and linguistic difficulties (Boyden et al., 2012; Gates, 2011; Gates & Waight, 2007; McGlaughlin et al., 2004; Ramcharan, Nankervis, Strong, & Roberston, 2009; Stevens, 2006). Also, by bringing together numerous participants, potential perceptions of imbalance in the power relationship between moderator and participant was reduced and disclosure was encouraged (Krueger & Casey, 2000; Larson et al., 2004). Adaptation of focus group method to accommodate the needs and preferences of participants with ID and CB is discussed in chapter six, with limitations highlighted in chapter eight.

### **Methodological Considerations**

**Theoretical framework.** A theoretical framework is an articulation of the philosophical assumption on which the study is based (Lopez & Willis, 2004). The framework represents the ontological, epistemological and theoretical worldviews that guide the research (Staller, 2010). Acknowledging and presenting the theoretical framework provides clarity regarding "how the knowledge produced by the study is to be valued and used" (Lopez & Willis, 2004, p. 726) as well as enhancing transparency (Malterud, 2001; Staller, 2010).

The theoretical framework for this research was phenomenology. Phenomenology is an approach that refers to the understanding of how the everyday inter-subjective world is constituted (Schwandt, 2003). This approach emphasises individual experiences, perceptions and encounters. The epistemology of phenomenology adopts a constructionist perspective. A constructionist epistemological perspective regards knowledge as socially constructed by individuals, rather than externally discovered (Goulding, 1999, 2005). Because epistemology is believed to be subjective, phenomenological ontology considers there to be multiple realities (Laverly, 2003). Consequently, phenomenological research focuses on the individual's subjective perceptions and understanding of phenomena (Berg, 2007; Moghaddam, Walker, & Harre, 2003; Owens, 2007). For this research, adopting a phenomenological theoretical framework afforded an in-depth understanding of the multiple subjective 'realities' of

factors associated with quality service provision, thereby enhancing the literature based understanding.

The application of phenomenological theory allows for both descriptive and interpretive approaches. Descriptive phenomenological theoretical frameworks allow the researcher to present the critical features of a phenomenon, as described by individuals (Goulding, 1999; Larkin, Watts, & Clifton, 2006; Maggs-Rapport, 2000). In contrast, an interpretative phenomenological approach goes beyond describing participants' experiential claims by incorporating overt interpretation by the researcher (Goulding, 2005; Maggs-Rapport, 2000; Owens, 2007). The interpretation involves the processes of coding, organising and integrating data (Reid, Flowers, & Larkin, 2005), and through this the meaning of participants' narratives is revealed (Crist & Tanner, 2003; Morse, 2003). An interpretative approach was adopted for this study as these processes enabled the identification of commonalities within stakeholder groups' perceptions of quality service provision, as well as the exposition of differences between stakeholder groups.

**Ethics.** Prior to the conduct of the research, ethical clearance was sought and granted from The University of Queensland's Behavioural and Social Sciences Ethical Review Committee. Gatekeeper approval was also sought from the agencies from which participants were recruited. Informed consent was obtained from participants prior to conduct of interviews with consent implied on completion for surveys. Issues of consent for data collection with service users with ID and CB are discussed in chapter eight.

During the research process, the anonymity of participants was assured through de-identification procedures. All data were de-identified using numeric coding for participant and stakeholder group. Additionally, the audio-recordings for qualitative data collection were destroyed after transcription.

**Rigour.** Rigour is the means by which integrity and competence of the research process is demonstrated (Tobin & Begley, 2004). As identified in the previous section, this research was situated in an interpretative phenomenological theoretical framework. Accordingly, the criteria for which rigour can be established for mixed-methods interpretivist research is trustworthiness, which can be measured by confirmability and transferability (Giddings & Grant, 2009). Confirmability is concerned with establishing that interpretations are clearly derived from the data (Tobin & Begley, 2004) and is related to audibility and credibility. Transferability is the extent to which findings may be generalised (Morrow, 2005). The strategies and practices adopted in this research that demonstrate confirmability and transferability were researcher reflexivity and triangulation. These are discussed sequentially.

**Researcher reflexivity.** Reflexivity is a process of critical reflection undertaken by the researcher. Reflexivity requires the values and position of the researcher to be consciously examined and any potential bias and prejudice be made explicit (Creswell & Miller, 2000; Northway, 2000). Through this procedure the effect of researcher bias may be minimised and the validity, credibility and confirmability of the research are increased (Baxter & Eyles, 1997; Morrow, 2005). Validity refers to the extent to which the results may be considered an accurate account of the explored phenomenon (Silverman, 2000). Through the adoption of the reflexive process it is more likely that the findings will be informed by the data than by the researcher's preconceptions (Fossey, Harvey, McDermott, & Davidson, 2002; Gergen & Gergen, 2003).

Consistent with the phenomenological theoretical framework, the researcher engaged in bracketing. Bracketing, a term coined by phenomenologists, is the process of suspending or bracketing beliefs about the phenomenon being explored through research (Cutcliffe & McKenna, 1999; Laverly, 2003; Morrow, 2005). Bracketing was ensured through the researcher engaging with a number of academic researchers to explore presuppositions and suppositions thereby enabling the researcher to bracket these accordingly. These related to the researcher's opinion of what different stakeholder groups would consider significant to quality service provision and had the potential impact data collection and analysis as study two and three were carried out concurrently. In addition to bracketing through engagement, bracketing was facilitated through triangulation, which is discussed below.

**Triangulation.** Triangulation is a procedure used to assess the consistency of data and interpretation of data by determining convergence (Cutcliffe & McKenna, 1999; Madill, Jordan, & Shirley, 2000). Convergence in triangulation provides evidence of accuracy and objectivity (Madill et al., 2000). Through triangulation processes the credibility, dependability and validity of findings are increased (Baxter & Eyles, 1999; Creswell & Miller, 2000; Fine, Weis, Weseen, & Wong, 2003). The processes of triangulation utilised in this research were investigator triangulation and methodological triangulation (Tuckett, 2005a). Investigator triangulation was undertaken through inter-coder reliability and transparency, and methodological triangulation was quantified through three triangulation procedures (Giddings & Grant, 2009; Hammersley, 2008; Tuckett, 2005a). These are discussed sequentially.

**Investigator triangulation.** Inter-coder reliability enhances the credibility of the findings and increases audibility (Morrow, 2005; Ryan & Bernard, 2003). Inter-coder reliability for the qualitative data component of this research was assessed through code

verification (Gatfield, 1997), as illustrated in figure 3.2. Verification is a process between an independent researcher and the primary researcher. As illustrated by arrowed lines in figure 3.2, if the independent researcher does not agree with the coding, discussion between the two parties takes place. If the independent researcher then agrees with the coding, consensus is reached. If not, the coding is amended and the independent researcher either agrees or disagrees. If the independent researcher disagrees, discussion followed by amendments is repeated until consensus is reached. This process was used for qualitative data components in studies one, two and three.

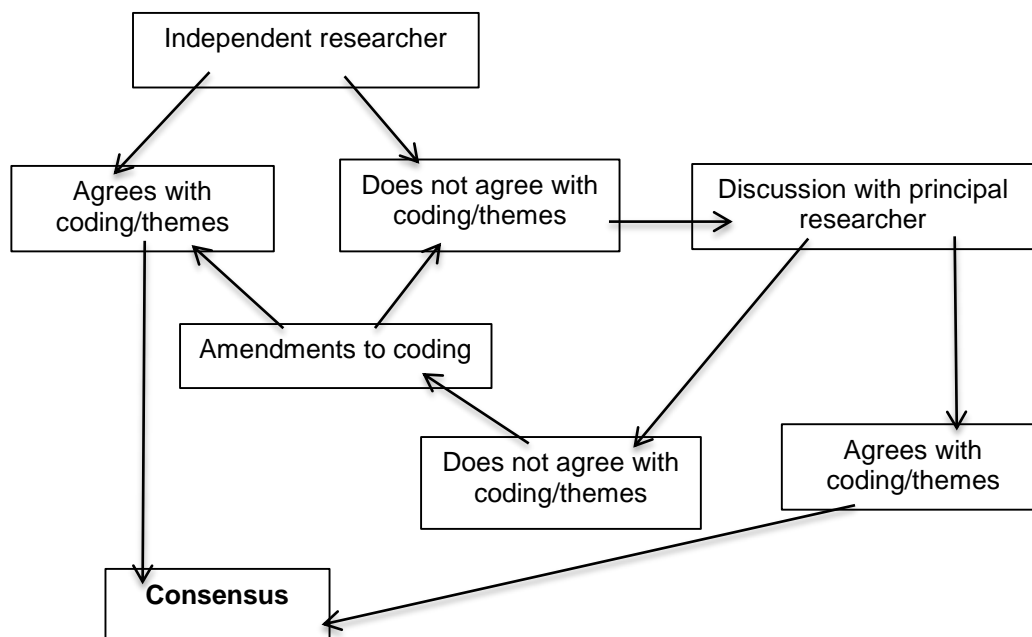


Figure 3.2. Qualitative data coding reliability model (adapted from Gatfield, 1997).

Investigator triangulation was also enhanced through transparency. Accordingly, the methods of research and data analysis have been comprehensively reported, and direct verbatim statements from participants have been used throughout the presentation of results (Yardley, 2000).

*Methodological triangulation.* Methodological triangulation is the process of using more than one method of data collection or sources of data to enhance the validity of findings (Giddings & Grant, 2009). Triangulation is traditionally undertaken by collecting data using qualitative and quantitative methods. In application to this research, various qualitative and quantitative data collection methods were used.

Methodological triangulation was augmented through formal member checking (Tuckett, 2005b). This process was undertaken with study two participants who engaged in interviews or focus groups. To ensure that interpretations made by the researcher accurately reflected the views of participants (Creswell, 2011b; Creswell & Miller, 2000),

descriptions of the themes generated for each stakeholder group were returned to participants. Participants were informed of the purpose of member checking and asked to contact the researcher if they felt the researcher's interpretation was not reflective of their thoughts or opinions. The researcher was contacted on one occasion with the respondent indicating one themed factor as more significant than another. As the degree of significance of factors/themes was not an aim of study two, no changes to the themes were made.

## Chapter Four: Study One Method and Results

Study one was undertaken in two stages. Stage one involved a two-round modified Delphi, with data collected from CEOs and managers of service provider agencies. Stage two comprised a survey undertaken with clinicians and senior practitioners. This chapter describes participant demographics; method of data collection; procedure; analysis, and the results for each stage. Further, comparison between samples is made.

### Stage One, Round One: Modified Delphi

**Participants.** The participants were CEOs and managers (n=29) of agencies (n=17) that provided services for people with ID and CB. As can be seen in table 4.1, participants comprised four CEOs and 25 managers, who had spent an average 5.3 years working in their current role and an average of 15.0 years working in the disability sector. The majority of participants identified in age range of 40-59.

Table 4.1  
*CEO and Manager Demographics Round One*

	n= 29
<b>Age</b>	
< 30	1 (3)
30-39	5 (17)
40-49	8 (28)
50-59	9 (31)
60 +	5 (17)
<b>Gender</b>	
Female	21 (71)
Male	8 (28)
<b>Job Title</b>	
CEO	4 (14)
Manager	25 (86)
<b>Number of Years in Current Role</b>	
Range	17.0
$\bar{x}$	5.3
sd	4.7
<b>Number of Years Working in Disability Sector</b>	
Range	33.0
$\bar{x}$	15.0
sd	10.5

Figures in brackets indicate percentage of participants



**Measures.** The survey (Appendix A) was developed from a review of the literature regarding quality service provision for people with disabilities, and exemplary services for people with ID and CB. Due to the ambiguity of the term 'quality' service provision, quality outcomes for service users was adopted as a proxy. It is considered that this may have increased the accuracy and validity of factor identification due to non-ambiguous concept construction. This was sanctioned by the expert panel (n=10) who also assessed the survey to evaluate its face validity. Minor changes to the wording of a number of items were subsequently undertaken. The survey comprised five sections.

- **Section 1: Demographic questions.** Participants were asked eight personal and organisational questions.
- **Section 2: Questions regarding the extent of contribution of process, output and limiting/enabling factors to quality outcomes for service users.** Participants were asked to rate the extent to which 33 factors contributed to positive outcomes for service users. Positive outcomes were defined for participants as (a) increased quality of life, (b) decreased frequency or severity of challenging behaviours, and/or (c) decreased use of restrictive practices. A five-point likert scale was used with response options of 1=not at all, 2= just a little, 3= moderate amount, 4= quite a lot, 5= a great deal. The factors were organised into relational categories (Keeney et al., 2011) of: funding; management practices; organisation of staff; programs and practices; in-service training; staff; and overarching organisational practices.
- **Section 3: Statements regarding strength of agreement with contingent relationships.** Participants were asked the extent to which they agreed with eight statements about contingent factors relationships, being relationships between factors, and/or between factors and quality. For example, participants were provided with the statement 'increases to funding does not necessarily mean increases to the quality of services'. A five-point likert scale was used with response options of 0=neither agree nor disagree, 1= strongly disagree, 2=disagree, 3= agree, 4=strongly agree.
- **Section 4: Rank ordering input factors.** Participants were asked to rank order input factors (resources and raw materials) from the most important (1) to the least important (9) to achieving positive outcomes for service users.
- **Section 5: Qualitative question regarding factor omissions.** Participants were asked to identify factors critical to quality outcomes for service users that were not identified in the previous subsections.

The survey was administered through SurveyMonkey with participant consent implied on participation.

**Sampling and recruitment.** A purposive sampling procedure was utilised to recruit participants. Purposive sampling procedures are used to identify participants who may have information relevant to the research question (Guarte & Barrios, 2006; Silverman, 2000). The inclusion criteria used to identify participants was (a) current employment as a CEO or manager with responsibility for multiple service functions, and (b) current

employment in an agency that has provided services in Queensland to people with ID and CB.

To recruit participants, a letter of invitation to participate, an information sheet about the research and a gatekeeper approval form was posted to the CEO of disability service agencies (n=188). CEOs were asked to complete Gatekeeper approval forms if the agency currently or previously provided services to people with ID and CB. Gatekeeper approval forms were returned from 17 agencies. To enhance the number of participating agencies an email with gatekeeper approval and study information forms attached were sent to the CEO of agencies who did not return gatekeeper approval forms. It was anticipated that providing study information and approval forms in both mail and online methods may have increased participation, no further approval forms were received.

After gatekeeper approval was gained, a link to the survey was sent to the CEOs of agencies and they were asked to forward the survey link to managers who met the criteria for participation.

**Analysis.** The quantitative data was analysed using SPSS 22.0. The small sample size and narrow sample selection criteria precluded statistical analysis beyond descriptive statistics. As such, descriptive statistics, including rank order by mean score and cumulative frequencies, were undertaken to assist with interpretation (Great Brooks Consulting, 2005; Okoli & Pawlowski, 2003; The Council on Quality and Leadership, 2010).

To aid in analysis, a consensus level of 75% of agreement was set. Consensus levels for Delphi studies are identified in the literature as ranging from 50-100% (Okoli & Pawlowski, 2003; Powell, 2003; Williams & Webb, 1994), therefore it was decided that 75% would reflect the majority while dismissing outlier data.

Missing data was not included in the analysis and was classified as missing at random (Higgins, Deeks, & Altman, 2011). Specifically, casewise deletion was undertaken (n=4) when demographic information was completed but no responses were recorded.

Qualitative data was analysed using thematic analysis procedure with manual coding. Thematic analysis is a variation of content analysis, in which trends and patterns are identified (Berg, 2007). The analysis involved the identification and classification of patterns from the qualitative data. Where appropriate, the patterns were then combined into themes, according to their relatedness to the larger units. Sub-themes were then identified and related to established meta-themes (DeSantis & Ugarriza, 2000).

**Results.** The distribution of factors that were assessed for contribution to positive outcomes for service users are shown in table 4.2. All of the factors, with the exception of

'funding from grants and fundraising' and 'individualised funding', attained consensus. This indicates that the respondents rated these factors as associated with positive outcomes for service users.

Table 4.2  
CEOs and Managers Round One: Distribution of Factors

Factor	mean	sd	% of p's rating 3, 4, and 5 n=29
<b>Funding</b>			
<i>Funding allocations</i>	3.71	1.27	75
Funding from grants & fundraising	2.93	1.22	62
Individualised funding	3.04	1.26	68
<b>Management Practices</b>			
<i>Leadership</i>	4.41	0.82	97
<i>Flexibility</i>	4.24	0.91	93
<i>Supervision &amp; feedback</i>	4.17	0.89	97
<b>Organisation of Staff</b>			
<i>Match between support worker and service user</i>	4.48	0.87	93
<i>Role clarity</i>	4.59	0.73	97
<i>Allocation of staff to teams</i>	4.11	0.92	93
<i>Staff to service user ratio</i>	4.36	0.78	100
<b>Programs &amp; Practices</b>			
<i>Programs &amp; service delivery based on service user needs and desires</i>	4.69	0.76	97
<i>Staff interactions with service users are respectful</i>	4.79	0.56	100
<i>Staff adherence to evidence based practices</i>	4.57	0.79	96
<i>Quality of written plans</i>	4.31	0.89	93
<i>Providing &amp; supporting service users in various community settings</i>	4.28	0.89	97
<i>Functional assessment and PBS</i>	4.00	1.10	90
<b>In-Service Training</b>			
<i>Training based on staff development needs</i>	4.00	0.85	97
<i>Training specific to working with the cohort</i>	4.07	1.09	86
<i>Training for OH&amp;S requirements</i>	4.10	0.90	97
<b>Staff</b>			
<i>Staff qualification in disability</i>	3.44	0.89	85
<i>Staff qualifications or training in working with the cohort</i>	3.52	1.15	79
<i>Staff attitudes</i>	4.75	0.59	100
<i>Staff beliefs &amp; attributions regarding challenging behaviour</i>	4.28	0.92	93
<i>Prior experience in disability services</i>	3.00	1.00	79
<b>Organisational</b>			
<i>Collaboration with other disciplines</i>	3.82	1.16	79
<i>Compliance with Government standards &amp; service agreements</i>	4.07	1.02	93
<i>Compliance with legislative &amp; reporting requirements</i>	4.38	0.68	100
<i>Organisational effort</i>	4.48	0.78	97
<i>Organisational efficiency</i>	4.52	0.78	97
<i>Measuring staff-related outputs</i>	3.83	1.04	93
<i>Measuring service user outcomes</i>	4.38	0.94	93
<i>Utilising data to inform changes</i>	3.90	1.01	90
<i>Organisational values and culture congruence</i>	4.52	0.74	97

Item scaling: 1= not at all, 2= just a little, 3= moderate amount, 4= quite a lot, 5= a great deal

Items in italics denotes factor attained consensus ( $\geq 75\%$  participants rating item as 3, 4 or 5)

Note: see Appendix A for item wording on survey

With regard to assessment of input factors, consensus was met for the factor ranked first, as shown in table 4.3. This was the factor 'knowing the needs and desires of service users', and was signified as the most important input to achieving positive outcomes for service users.

Table 4.3  
*CEOs and Managers Round One: Rank Order of Input Factors*

Factor	mean
<i>Knowing the needs and desires of service users</i>	2.10
Personnel within the organisation	3.55
Funding	4.52
Mission statements	5.21
Organisational policies	5.24
Physical resources	5.34
The environmental context	6.03
Consultant allied health	6.10
Government Policies and Standards	6.90

*Items in italics denotes factor attained consensus (≥75% participants in agreement with rank order)*

The distribution of contingent relationships is shown in table 4.4. Consensus was reached for four of the eight of the statements. These were: management practices (statement i); commitment and capacity to measure service user outcomes (statement iv); commitment and capacity to measure organisational outcomes (statement v); and the quality of the person-centred and/or support plans (statement vi).

Table 4.4  
*CEO and Managers Round One: Distribution of Contingent Factor Relationships*

Statement	mean	sd	% of p's rating 3 and 4
			n=29
<i>i. Management practices are more important than factors outside of the control of management</i>	4.00	1.05	75
ii. Staff turnover is related more to stress and burnout than features of employment in the sector	2.97	0.94	30
iii. Increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users	3.17	1.20	41
<i>iv. An organisation's commitment and capacity to measure service user outcomes can enable quality outcomes for service users</i>	4.34	0.72	93
<i>v. An organisation's commitment and capacity to measure organisational outcomes can enable quality outcomes for service users</i>	4.17	0.71	90
<i>vi. Staff implementation of person-centred plans and/or positive behaviour support plans is dependent on the quality of the plans</i>	4.50	0.51	100
vii. Increases to funding does not necessarily mean increases to the quality of services	3.55	1.12	66
viii. Service user/family control of how funding is spent increases quality outcomes for service users	3.34	0.81	41

Item scaling: 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree

Items in italics denotes statement attained consensus (≥75% participants rating 3 or 4)

Open-ended questions related to the identification of factors critical to quality outcomes for service users that had not been included in the survey. Eleven themes were generated with 10 themes identified as having been included as a factor in the survey or unrelated to this research. The remaining theme 'consistent application of evidence based

practices by agencies and family members', was indicated by 7% of the respondents (n=2). The importance of this factor to positive outcomes for service users was assessed in round two.

### Stage One, Round Two: Modified Delphi

**Participants.** The participants were CEOs and managers (n=26) of service provider agencies (n=14) that provided services to people with ID and CB. Table 4.5 shows the participants were two CEOs and 24 managers, who had spent an average of 3.6 years working in their current role, and an average of 15.6 years working in the disability sector. The majority of participants identified in age range of 50-59.

Table 4.5  
*CEO and Manager Demographics Round Two*

	n=26
<b>Age</b>	
< 30	2 (8)
30-39	6 (23)
40-49	6 (23)
50-59	8 (31)
60 +	4 (15)
<b>Gender</b>	
Female	21 (81)
Male	5 (19)
<b>Job Title</b>	
CEO	2 (8)
Manager	24(92)
<b>Number of Years in Current Role</b>	
Range	11.5
$\bar{x}$	3.6
sd	3.2
<b>Number of Years Working in Disability Sector</b>	
Range	38.0
$\bar{x}$	15.6
sd	11.2

Figures in brackets indicate percentage of participants

**Measures.** Consistent with a modified Delphi technique, results of the round one survey formed the basis for developing the second round survey (Appendix B) (Keeney et al., 2011). Specifically, factors that reached consensus ( $\geq 75\%$  of respondents rating the factor  $\geq 3$ ) were included in the round two survey for further evaluation (Powell, 2003; Scheibe, Skutsch, & Schoder, 2002). Statements regarding contingent factor relationships that did not meet consensus were included in the round two survey with a qualitative component, to allow rationale for responses to be explored (Linstone & Turoff, 2002; Scheibe et al., 2002).

After this process, the round survey comprised four sections:

- **Section 1: *Demographic information.*** Participants were asked six personal and organisational questions.
- **Section 2: *Rank ordering of process and output/ outcome factors.*** Participants were asked to rank 30 factors in terms of their importance to quality outcomes for service users with ID and CB. The factors were organised into the relational categories (Keeney et al., 2011) of: management practices (rank 1-3); organisation of staff (rank 1-4); programs and practices (rank 1-6); in-service training (rank 1-3); staff (rank 1-5), and; overarching organisational practices (rank 1-9). Consistent with Delphi methodology, the factors in the relational categories were listed in order of highest to lowest for each category based on the mean scores from round one (Okoli & Pawlowski, 2003) with text indicating to participants that these were ordered based on the results of the previous survey (Hasson et al., 2000).
- **Section 3: *Rank order of input factors.*** Participants were asked to rank order agency input factors from the most important (1) to the least important (9) to achieving positive outcomes for service users. These were listed in order of highest to lowest for each category based on scores from round one, with the description of how to complete the section stating that were ordered in importance based on round one (Hasson et al., 2000; Okoli & Pawlowski, 2003).
- **Section 4: *Statements/ questions regarding contingent relationships.*** Participants were provided with four statements which related to contingent factor relationships, being relationships between factors, and/or between factors and quality. Participants were provided with the response options of 1=agree and 2=disagree, and were asked to provide a qualitative rationale for their response in order to determine underlying reasons for disagreement. For example, participants were provided with the statement 'increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users' and asked to agree/disagree and write why/why not. The statements were those that had been included in the previous survey but had not reached consensus, with the description of how to complete the section stating this (Hasson et al., 2000; Okoli & Pawlowski, 2003). Participants were also asked to indicate strength of agreement for one question which was identified through qualitative factor omissions in round one. A five point Likert scale was used for this statement with response options of 1=not at all, 2= just a little, 3= moderate amount, 4= quite a lot, 5= a great deal.

The survey was administered through SurveyMonkey with participant consent implied on participation.

**Sampling and recruitment.** The sampling and recruitment procedure used was the same for that of round one. In brief, a purposive sampling procedure was utilised (Guarte & Barrios, 2006; Silverman, 2000) with a link to the survey sent to the CEOs of agencies that provided Gatekeeper approval (n=17), for distribution to potential participants.

**Analysis.** The analysis procedure was the same as round one. Casewise deletion was undertaken when demographic information was completed but no responses were

recorded (n=25), and when responses were recorded but not demographic information (n=1).

**Results.** Mean scores of factors associated with quality outcomes showed a clear hierarchy of factors within each relational category, as shown in table 4.6. Comparisons of rank order for round one and round two showed stability of opinion between rounds. As shown in table 4.6, the factors ranked first, second and/or third, were the same for both rounds. Sampling differences between round one and two are not examined as Delphi data is cumulative.



Table 4.6  
*CEO and Managers Round One and Two: Factor Distribution Comparisons*

Factor	mean	Rank order by mean	
		survey 2 n=29	survey 1 n=26
<b>Management Practices</b>			
Leadership	1.81	1	1
Flexibility	1.85	2	2
Supervision & feedback	2.35	3	3
<b>Organisation of Staff</b>			
Match between support worker and service user	1.88	1	2
Role clarity	1.92	2	1
Staff to service user ratio	2.88	3	3
Allocation of staff to teams	3.31	4	4
<b>Programs and Practices</b>			
Programs & service delivery based on service user needs and desires	1.38	1	2
Staff interactions with service users are respectful	3.08	2	1
Staff adherence to evidence based practices	3.38	3	3
Quality of written plans	3.54	4	4
Providing & supporting service users in various community settings	4.69	5	5
Functional assessment and PBS	4.92	6	6
<b>In-service Training</b>			
Training specific to working with the cohort	1.16	1	2
Training based on staff development needs	2.08	2	3
Training for OH&S requirements	2.76	3	1
<b>Staff</b>			
Staff attitudes	1.46	1	1
Staff beliefs & attributions regarding challenging behaviour	2.15	2	2
Staff qualifications or training in working with the cohort	2.96	3	3
Staff qualification in disability	4.08	4	4
Prior experience in disability services	4.35	5	5
<b>Organisational</b>			
Organisational values and culture congruence	2.08	1	1/2
Organisational effort	2.23	2	3
Measuring service user outcomes	3.04	3	4/5
Compliance with legislative & other reporting requirements	5.35	4	6
Collaboration with other disciplines	5.54	5	9
Organisational efficiency	5.81	6	1/2
Compliance with Government standards & service agreements	6.42	7	4/5
Utilising data to inform changes	6.69	8	7
Measuring staff-related outputs	7.85	9	8
<b>Agency Input Factors</b>			
Knowing the needs and desires of service users	1.08	1	1
Personnel within the organisation	2.63	2	2
Funding	4.50	3	3
Mission statements	5.29	4	4
Organisational policies	5.33	5	5
Physical resources	4.96	6	6
The environmental context	6.42	7	7
Consultant allied health	6.63	8	8
Government Policies and Standards	8.17	9	9

The distribution of contingent relationships is shown in table 4.7. Consensus was reached for one of the four statements. Specifically, 80% of respondents indicated that 'increases to funding does not necessarily mean increases to the quality of services' (question statement c). Consensus was also reached for the question added to the round two survey based on qualitative data from round one. The question 'to what extent does 'consistent application of evidence based practices by agencies, and family members contribute to positive outcomes for service users' reached a consensus level of 98% ( $\bar{x}$ =4.48,  $sd$ =0.77). Analysis of qualitative responses to open-ended questions did not provide themes that reached consensus.

Table 4.7  
CEOs and Managers Round Two: Distribution of Contingent Relationships

Statement/ Question	% Agree	% Disagree
a. Staff turnover is related more to stress and burnout than features of employment in the sector, such as emotional and physical demands of the job, low wages etc.	48	52
b. Increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users	54	46
c. <i>Increases to funding does not necessarily mean increases to the quality of services</i>	80	20
d. Individualised funding, i.e. funding provided and controlled by service users and/or their substitute decision maker, increases quality outcomes for service users	57	43
		% of p's rating item 3, 4 or 5
e. <i>To what extent does consistent application of evidence based practices by the agencies providing different services to a service user and families, contribute to positive outcomes to service users?</i>		98

Item scaling for question e: 1= not at all, 2= just a little, 3= a moderate amount, 4= quite a lot, 5= a great deal  
Italics denotes statement attained consensus ( $\geq 75\%$  of participants rating item 1=agree, or 3,4 or 5 for questions e)

## Stage Two: Survey

**Participants.** The participants were clinicians and senior practitioners (n=85) who had worked with adult service users with ID and CB. Table 4.8 shows the participants were 73 clinicians and senior clinicians, nine managers/directors and two 'other'. The category of 'managers/directors' included: team leaders; case managers; clinical services managers, and; directors of clinical practice. The category of 'other' included resource officers. The area of clinical discipline was identified by 43 participants, with the majority of identifying psychology as their discipline.

The majority worked in metropolitan/urban areas, were female and identified in age range of 30-39. Participants had spent an average 4.3 years working in their current role and an average of 10.5 years in the disability sector.

Table 4.8  
*Clinician and Senior Practitioner Demographics*

	n= 85
<b>Age</b>	
< 30	21 (25)*
30-39	28 (33)
40-49	18 (21)
50-59	14 (17)
60 +	4 (5)
<b>Gender</b>	
Female	68 (80)
Male	17 (20)
<b>Primary Place of Work</b>	
Metropolitan/ Urban	71 (84)
Rural and Remote	14 (16)
<b>Number of Years in Current Role</b>	
Range	25.0
$\bar{x}$	4.3
sd	4.1
<b>Number of Years Working in Disability Sector</b>	
Range	35.0
$\bar{x}$	10.5
sd	8.9
<b>Job Title</b>	
Clinician/ senior clinician	73 (86)
Manager/ Director	9 (11)
Other	2 (2)
<b>Discipline</b>	
Psychology	17 (40%)
Speech Language	10 (23%)
Occupational Therapy	8 (19%)
Social Work	7 (16%)
Physiotherapy	1 (2%)

Figures in brackets indicate percentage of participants

**Measures.** The measure was the survey used for the second round of stage one, with the addition of seven open-ended questions asking participants to identify factors critical to quality outcomes but not identified in the relational categories or the survey as a whole. For example, 'please list other staff factors that are critical to quality outcomes for service users'. The survey was administered through SurveyMonkey with participant consent implied on participation.

**Sampling and recruitment.** A purposive sampling procedure, described above, was used to recruit participants who were currently employed as a clinician or senior

practitioner and had provided services in Queensland to adults with ID and CB. Clinicians and senior practitioners working within the Disability Services division within the Queensland Government's Department of Communities, Child Safety and Disability Services (DCCSDS) were targeted as this organisation has the largest cohort of clinicians and senior practitioners.

To recruit participants, approval was first sought and gained from the gatekeeper within the Queensland DCCSDS. After this an email and link to the survey was distributed to potential participants by the designated person within DCCSDS.

**Analysis.** Analysis procedures were the same as for stage one, round one. No casewise deletion was undertaken.

**Results.** Analysis of the data showed a hierarchy of the factors that were identified as associated with positive outcomes for service users. Table 4.9 shows the factors, means scores and rank by mean score. As shown on this table, rank ordering based on mean scores provided each factor with a distinct rank. Factors ranked first for each category were: leadership; match between support worker and service user; programs and service delivery based on service user needs and desires; in-service training specific to working with the cohort; staff attitudes; organisational values and culture congruence; and knowing the needs and desires of service users.

Table 4.9  
*Clinicians and Senior Practitioners: Distribution of Factors*

Factor	mean n=85	rank by mean
<b>Management Practices</b>		
Leadership	1.83	1
Flexibility	2.04	2
Supervision & feedback	2.14	3
<b>Organisation of Staff</b>		
Match between support worker and service user	1.82	1
Role clarity	1.93	2
Staff to service user ratio	2.94	3
Allocation of staff to teams	3.32	4
<b>Programs and Practices</b>		
Programs & service delivery based on service user needs and desires	1.69	1
Staff interactions with service users are respectful	2.23	2
Staff adherence to evidence based practices	3.72	3
Quality of written plans	4.06	4
Providing & supporting service users in various community settings	4.17	5
Functional assessment and PBS	5.13	6
<b>In-service Training</b>		
Training specific to working with the cohort	1.53	1
Training based on staff development needs	1.82	2
Training for OH&S requirements	2.65	3
<b>Staff</b>		
Staff attitudes	1.37	1
Staff beliefs & attributions regarding challenging behaviour	2.36	2
Staff qualifications or training in working with the cohort	3.04	3
Staff qualification in disability	3.87	4
Prior experience in disability services	4.32	5
<b>Organisational</b>		
Organisational values and culture congruence	2.45	1
Organisational effort	2.74	2
Measuring service user outcomes	3.20	3
Compliance with legislative and other reporting requirements	5.30	5
Collaboration with other disciplines	4.51	4
Organisational efficiency	5.64	6
Compliance with Government standards & service agreements	6.69	7
Utilising data to inform changes	6.90	8
Measuring staff-related outputs	7.52	9
<b>Agency Input Factors</b>		
Knowing the needs and desires of service users	1.42	1
Personnel within the organisation	2.76	2
Funding	4.33	3
Mission statements	6.31	8
Organisational policies	5.56	6
Physical resources	5.07	4
The environmental context	6.14	7
Consultant allied health	5.54	5
Government Policies and Standards	7.87	9

The distribution of contingent relationships is shown in table 4.10. Consensus was reached for one of the four statements. Specifically, 84% of respondents indicated that 'increases to funding does not necessarily mean increases to the quality of services.

Consensus was also reached for the question added to the survey based on qualitative data from round one of stage one with CEOs and managers. The question 'to what extent does 'consistent application of evidence based practices by agencies, and family members contribute to positive outcomes for service users' reached a consensus level of 98% ( $\bar{x}$ =4.27,  $sd$ =0.84). Analysis of qualitative responses to open-ended questions did not provide themes that reached consensus.

Table 4.10  
*Clinicians and Senior Practitioners: Distribution of Contingent Factor Relationships*

Statement/ Question	% Agree n=85	% Disagree n=85
a. Staff turnover is related more to stress and burnout than features of employment in the sector, such as emotional and physical demands of the job, low wages etc.	58	42
b. Increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users	31	69
c. <i>Increases to funding does not necessarily mean increases to the quality of services</i>	84	16
d. Individualised funding, i.e. funding provided and controlled by service users and/or their substitute decision maker, increases quality outcomes for service users	68	31
	% of p's rating item 3, 4 or 5	
e. <i>To what extent does consistent application of evidence based practices by the agencies providing different services to a service user and families, contribute to positive outcomes to service users?</i>	98%	

Item scaling for question e: 1= not at all, 2= just a little, 3= a moderate amount, 4= quite a lot, 5= a great deal  
Italics denotes statement attained consensus ( $\geq 75\%$  of participants rating item 1=agree, or 3,4 or 5 for questions e)

### Comparison Across Samples

Comparisons and aggregation was undertaken using stage two data from clinicians and senior practitioners, and the second round of stage one data from CEOs and managers. The second round data was used as Delphi methodology emphasises later rounds as more 'correct' (Hsu & Sandford, 2007). Comparisons of data showed a high degree of stability in opinion. With regard to rank order of factors that were identified as associated with quality service provision, the top three ranked factors for each factor grouping were the same between groups. This is shown in table 4.11 which illustrates the rank order by mean for both surveys, and the aggregated rank order by mean. As illustrated in the table, the majority of differences were within one mean rank. The exception was to with respect to agency input factors, where there was a difference of more than one mean rank order for the factors 'mission statements', 'organisational policies', 'physical resources' and 'consultant allied health'. Rank order based on aggregated mean scores, however, provided a clear hierarchy of factors, as shown in table 4.11.

Table 4.11  
*CEOs and Managers, and Clinicians and Senior Practitioners: Factor Distribution Aggregation*

Factor	Rank order by mean		Rank order by aggregated mean n=111
	Stage One Round Two n=26	Stage Two n=85	
<b>Management Practices</b>			
Leadership	1	1	1
Supervision & feedback	3	2	2
Flexibility	2	3	3
<b>Organisation of Staff</b>			
Match between support worker and service user	1	1	1
Role clarity	2	2	2
Staff to service user ratio	3	3	3
Allocation of staff to teams	4	4	4
<b>Programs and Practices</b>			
Programs & service delivery based on service user needs and desires	1	1	1
Staff interactions with service users are respectful	2	2	2
Staff adherence to evidence based practices	3	3	3
Providing & supporting service users in various community settings	5	4	4
Quality of written plans	4	5	5
Functional assessment and PBS	6	6	6
<b>In-service Training</b>			
Training specific to working with the cohort	1	1	1
Training based on staff development needs	2	2	2
Training for OH&S requirements	3	3	3
<b>Staff</b>			
Staff attitudes	1	1	1
Staff beliefs & attributions regarding challenging behaviour	2	2	2
Staff qualifications or training in working with the cohort	3	3	3
Staff qualification in disability	4	4	4
Prior experience in disability services	5	5	5
<b>Organisational</b>			
Organisational values and culture congruence	1	1	1
Organisational effort	2	2	2
Measuring service user outcomes	3	3	3
Collaboration with other disciplines	5	4	4
Compliance with legislative & other reporting requirements	4	5	5
Organisational efficiency	6	6	6
Compliance with Government standards & service agreements	7	7	7
Utilising data to inform changes	8	8	8
Measuring staff-related outputs	9	9	9
<b>Agency Input Factors</b>			
Knowing the needs and desires of service users	1	1	1
Personnel within the organisation	2	2	2
Funding	3	3	3
Physical resources	6	4	4
Consultant allied health	8	5	5
Organisational policies	5	6	6
The environmental context	7	7	7
Mission statements	4	8	8
Government Policies and Standards	9	9	9

Comparisons of data for contingent relationships showed the same statement as reaching consensus. As shown in table 4.12, this statement was 'increases to funding does not necessarily mean increases to the quality of services'. Consensus was also reached for both groups for the question 'to what extent does 'consistent application of evidence based practices by agencies, and family members providing different services to a service user and families, contribute to positive outcomes for service users?'

**Table 4.12**  
*CEOs and Managers, and Clinicians and Senior Practitioners: Distribution of Contingent Relationships Comparisons*

Statement/ Question	CEOs and Managers n=26	Clinicians and Senior Practitioners n=85
	% of p's rating "Agree"	
a. Staff turnover is related more to stress and burnout than features of employment in the sector, such as emotional and physical demands of the job, low wages etc.	48	58
b. Increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users	54	31
c. Increases to funding does not necessarily mean increases to the quality of services	80	84
d. Individualised funding, i.e. funding provided and controlled by service users and/or their substitute decision maker, increases quality outcomes for service users	57	68
	% of p's rating item 3, 4 or 5	
e. To what extent does consistent application of evidence based practices by the agencies providing different services to a service user and families, contribute to positive outcomes to service users?	96	98

Item scaling for question e: 1= not at all, 2= just a little, 3= a moderate amount, 4= quite a lot, 5= a great deal

## Summary

This chapter has presented the participant demographics; method of data collection; procedure; analysis, and the results for study one. The distinction between factors as either significant to or limiting/enabling quality was not assessed, however, the results indicated 40 factors as associated with the provision of quality services for people with ID and CB. There was a high degree of consistency between groups, with the greatest differences relating to which resources and raw materials (input factors) are the most critical to service user outcomes.



## Chapter Five: Study Two Method and Results

Study two involved data collection with advocates, families/carers, support workers and supervisors in two stages. Stage one involved data collection through interviews, with stage two data collected through a survey. This chapter describes the participant demographics; method of data collection; procedure; analysis, and presents the results sequentially for each stage. The results from both stages are analysed and compared with other stakeholder group data and the literature in chapter seven.

### Stage One: Interviews

**Participants.** The participants were 10 advocates, 11 families/carers, 13 support workers, and 11 frontline supervisors (N=45), as shown in table 5.1. The majority of all of the participants were female with the mean age for the groups ranging from 38.5 to 61.9. The groups working in disability services had a mean number of years working in the disability sector ranging from 6 to 27 years, and working in their current role as ranging between 4.4 and 4.7 years.

The majority of participants working in service provider agencies had formal qualifications, with support worker qualifications being in areas directly related to the sector. Half of the supervisors had qualifications in areas directly related to the sector.

Table 5.1  
*Interview Participant Demographics*

	Advocates n=10	Family/Carers n=11	Support Workers n=13	Supervisors n=11
<b>Age</b>				
< 30	0	0	3	2
30-39	2	0	3	1
40-49	0	1	4	5
50-59	7	3	3	3
60 +	1	7	0	0
$\bar{x}$	50.7	61.9	38.5	43.9
<b>Gender</b>				
Female	9	7	8	9
Male	1	4	5	2
<b>Number of Years in Current Role</b>				
Range	17.4	-----	14.75	12.5
$\bar{x}$	4.7	-----	4.4	4.7
<b>Number of Years Working in Disability Sector</b>				
Range	24.0	-----	14.75	14.6
$\bar{x}$	16.6	-----	6.0	27
<b>Highest Qualification</b>				
High School or equivalent	0	8	3	1
TAFE	3	1	9	4
Undergraduate Degree	4	2	0	4
Postgraduate Degree	2	0	1	2
Did not disclose	1	0	0	0

**Protocol.** The method of data collection for stage one was in-depth interviews, using a semi-structured protocol. This was considered necessary as a structured protocol would not have elicited in-depth discussion or allowed the researcher flexibility to elicit further information from participants (MacNaghten & Myers, 2004). In contrast, an informal structure may have resulted in the in-depth discussion of topics not relevant to the research question (Berg, 2007; Johnson & Turner, 2003). By adopting a semi-structured protocol the researcher was able to provide focus for the interview while ensuring the questions were relatively consistent for all interviews.

The questions contained in the semi-structured protocol were two general open-ended questions which directly related to the research questions. Probing questions that were asked related to the categories developed in study one. These were: funding; management practices; organisation of staff; programs and practices; in-service training, staff, and; organisational.

**Sampling and recruitment.** To recruit participants, a purposive sampling procedure was used. Purposive sampling procedures employ specific criteria to identify participants

who have may have information relevant to the research question (Guarte & Barrios, 2006; Silverman, 2000). The inclusion criteria used to identify participants from the different stakeholder groups were:

- **Supervisors:** (a) current employment in an agency that provides services to people with ID and CB for at least six months, and (b) supervises support workers who work with people with ID and CB.
- **Support workers:** (a) current employment in an agency that provides services to people with ID and CB, and (b) a minimum of bi-weekly contact with at least one adult service user with ID and CB, for at least six months.
- **Families/Carers:** is a family/carer of an adult service user who has ID and CB.
- **Advocates:** currently, or previously, has provided advocacy services to an adult service user who has an ID and CB.

To recruit support workers, supervisors and families/carers, the six service provider agencies operating in Queensland who had the highest proportion of service users with ID and CB were asked to provide gatekeeper approval. These agencies were identified by an expert panel (n=2) who worked in the DCCSDS and had worked extensively with NGOs regarding service provision to people with ID and CB. They were targeted for participation as they were identified as having a significant portion of their service provision to people with ID and CB. This enabled issues central to this thesis to be addressed and allowed a comprehensive range of factors, including factors unique to agencies, to be identified.

Gatekeeper approval was granted from five agencies, and letters of invitation to participate and consent forms were distributed to potential participants through these agencies. Families/carers were additionally recruited through the peak state-based carer organisation and via snowball sampling, in which participants recruit potential participants (Tashakkori & Teddlie, 2010).

To recruit advocates, study information and gatekeeper approval forms were sent to the manager/CEO of agencies (n=13) that provided advocacy services to people with disabilities. Five agencies returned gatekeeper approval forms.

While recruitment was not limited to adults, only persons aged 18 or above chose to participate.

**Implementation.** The interviews with frontline supervisors, support workers and advocates were conducted in-person with one to three participants per interview. Participants were given the choice to be interviewed with others or alone, however only participants from the same stakeholder group and agency were interviewed at the same time in order to allow comparisons between stakeholder groups and agencies. The

interviews were conducted at the facility where the participants worked to enable environmental familiarity (Larson et al., 2004).

The interviews with families/carers of service users with ID and CB were conducted in-person or over the phone. Conducting phone interviews enabled the participation of those who would otherwise have been excluded due to time and location constraints (Williams & Webb, 1994). In-person interviews were conducted at a location chosen by the participant to enhance environmental familiarity (Larson et al., 2004). Four interviews were conducted in-person, and four via phone. The number of participants for interviews with families/carers were either one or two.

The length of time for interviews varied from 23 to 61 minutes. The average length of interview for advocates was 52 minutes, 50 minutes for families/carers and supervisors, and 42 minutes for support workers. To assist in data analysis, the interviews were audio-recorded and transcribed. Audio-recording was deemed the most appropriate method for recording as videotaping is considered more intrusive to participants. Video-taping participants inherently increases the formality of a session, thereby decreasing the likelihood of disclosure taking place (Macnaghten & Myers, 2004). Formal consent was gained from participants prior to participation.

**Analysis.** Qualitative data were analysed using NVivo 10 Data Analysis Software Package. The interview proceedings were transcribed and broad-brush coding was initially undertaken. Broad-brush coding involves coding data into broad topic areas to give an overview of the range and depth of topics covered (Bazley & Richards, 2000). Concept coding was then undertaken. Concept coding involves exploring the data to generate categories and sub-categories "up" from the data, and also serves to confirm broad-brush codes (Auerbach & Silverstein, 2003; Bazley & Richards, 2000). The reliability of codes, otherwise known as themes, was assessed through code verification with an independent researcher. In application to this research, the themes and verbatim quotes to illustrate the themes were presented to the independent researcher. Areas of disagreement were discussed, with agreed amendments including the titles of a number of themes, and collapsing of a number of sub-themes into meta-themes.

**Results.** Themes were established by grouping together alike data (Auerbach & Silverstein, 2003; Ezzy, 2002). The themes were identified and then categorised as sub-themes, limiting/enabling themes or impacting and forming themes. *Sub-themes* were those acknowledged through responses as processes and practices directly associated with quality service provision. *Limiting/enabling themes* were those identified as impacting the application of quality associated processes and practices. These were classified as

internal limiting/enabling themes (i.e., factors within agency control), and external limiting/enabling themes (i.e., factors outside of agency control). *Impacting and forming themes* were those formative to and pervasively impacting the provision of quality services.

In each category, themes were then grouped into larger units called meta-themes, where appropriate (Auerbach & Silverstein, 2003; Ezzy, 2002). For the purpose of clarity, sub-themes became individual meta-themes where there they could not be grouped with other related units into a meta-theme. The following sections detail the results of interviews separately for each stakeholder group.

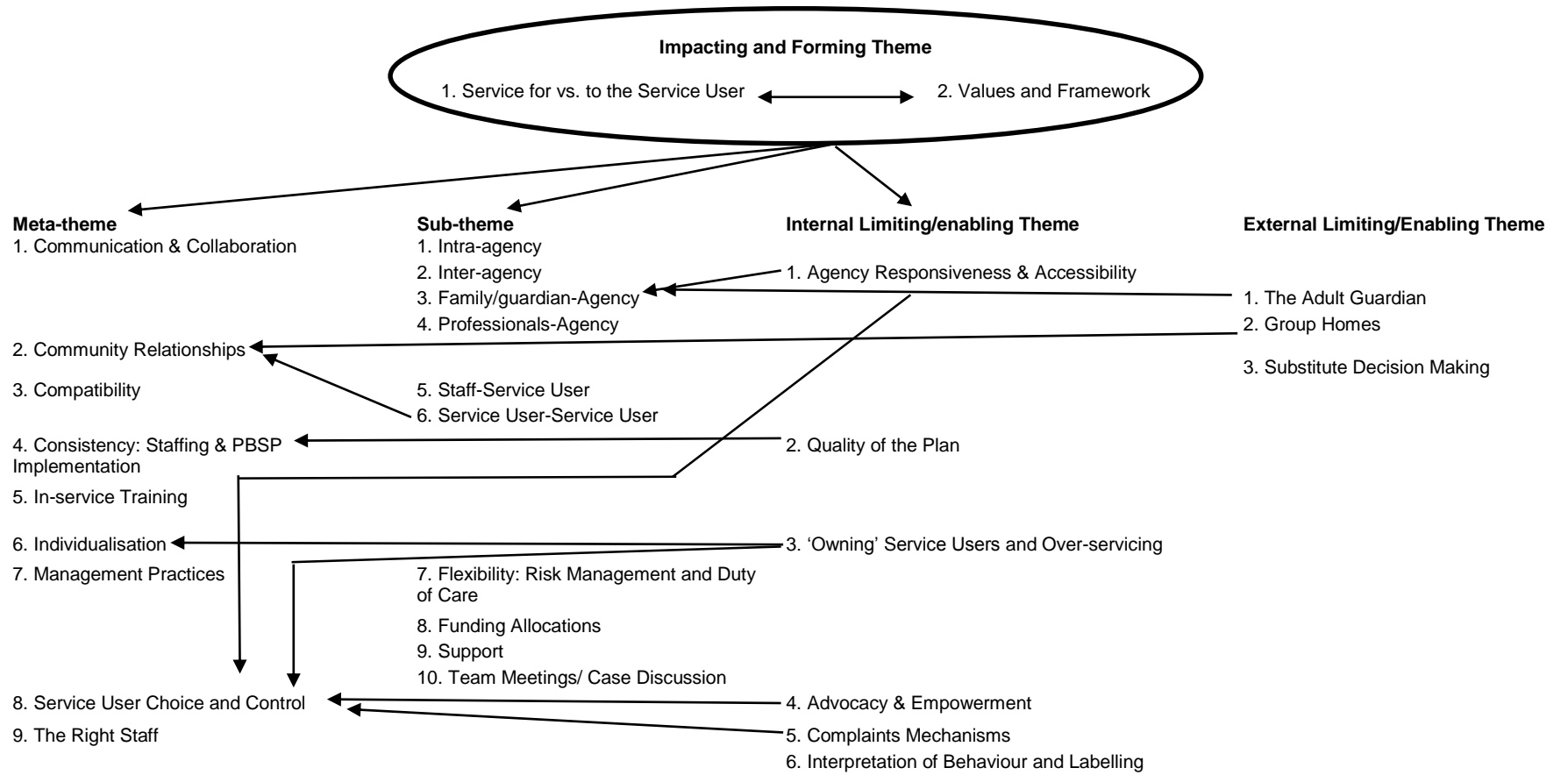
**Advocates.** Using the conceptual framework for quality as described in chapter two, analysis of the data identified two impacting and forming themes, nine meta-themes, and 10 sub-themes contained within the meta-themes. These are indicated as significant to quality service provision. Analysis of the data also identified nine limiting/enabling themes categorised as six internal limiting/enabling themes (meaning within agency control) and three external limiting/enabling themes (meaning outside of agency control). Table 5.2 lists all of the themes and shows their classification as impacting and forming, meta-theme, sub-theme, internal limiting/enabling or external limiting/enabling.

Table 5.2  
*Themes from Interviews with Advocates*

Impacting and Forming Theme	Meta-theme	Sub-theme	Internal Limiting/enabling Theme	External Limiting/enabling Theme
1. Service for vs. to the Service User 2. Values and Framework	1. Communication & Collaboration	1. Intra-agency 2. Inter-agency 3. Family/guardian-Agency 4. Professionals-Agency	1. Agency Responsiveness & Accessibility 2. Quality of the Plan 3. 'Owning' Service Users and Over-servicing 4. Advocacy & Empowerment 5. Complaints Mechanisms 6. Interpretation of Behaviour and Labelling	1. The Adult Guardian 2. Group Homes 3. Substitute Decision Making
	2. Community Relationships			
	3. Compatibility	5. Staff-Service User 6. Service User-Service User		
	4. Consistency: Staffing & PBSP Implementation			
	5. In-service Training			
	6. Individualisation			
	7. Management Practices	7. Flexibility: Risk Management and Duty of Care 8. Funding Allocations 9. Support 10. Team Meetings/ Case Discussion		
	8. Service User Choice and Control			
	9. The Right Staff			

Interactions between themes, as derived from the participant verbatim quotes, are illustrated in figure 5.1. In this figure, interactions are depicted with lines, and arrowed lines highlighting one-way or two-way directional impacts. The interactions are discussed in the ensuing sections.

Figure 5.1. Interaction between themes from interviews with advocates



*Impacting and forming theme 1: service for vs. (versus) to the service user.* An overarching theme consistently identified by participants was the dichotomy of service provision *to* the service user, versus service provision *for* the service user. It was indicated that quality provision is impacted and formed by the attitude of service delivery to 'passive recipients' or to service users who can and should be active participants in the how, what, when or who of service delivery. The theme service for vs. to the service user is illustrated in the following quotes.

ADV 6: service providers need to see themselves as employees for hire... instead of having ownership over someone's life... that is controlling every aspect of a person's life.

ADV 7: So it is about a service for the client not to the client... partnership mentality- between the service user and agency.

*Impacting and forming theme 2: values and framework.* Participants from all advocacy agencies identified values and framework of the agency and staff to be significant to outcomes for service users. Values and framework refers to the permeation of the rights of people with disabilities in all aspects of service planning and delivery. As indicated:

ADV 7: It is a presumption of not having capacity, rather than having capacity and not understanding the legal framework or a rights based framework. It seeps down to so many levels...

ADV 2: If the management don't have a good framework and values and a commitment to protecting and ensuring people's rights are met, your staff aren't... you won't be able to support your staff in the right way.

*Meta-theme 1: communication and collaboration.* This theme reflected the importance of effective communication and collaboration within agencies, between agencies, between agencies and families/carers of service users, and within the sector. The sub-themes contained within the meta-theme are described below.

*Sub-theme 1: intra-agency.* A number of participants indicated communication and collaboration within the agency as significant. Participants referred to the need for effective communication and collaboration within support worker and supervisor/manager teams, and between levels of management. To highlight, participants indicated:

ADV 5: The information about the clients is not filtering up and if it is filtering up there is a block... they've raised issues with the managers and they've said they'll look into it but then nothing happens.

ADV 4: The feedback that I got from staff was they couldn't approach their manager because (then) they were deemed as not being an appropriate staff member.... the person would get over medicated...



*Sub-theme 2: inter-agency.* A number of participants identified communication and collaboration between agencies that may be providing services to a service user, as important to outcomes. For instance:

ADV 9: A service user receives services from two agencies simultaneously, one decided we will need to go to places where there are less likely to be babies... workers from another funded organisation are saying 'we are not going to stop her from going up and talking to babies, we are going to model for her the appropriate way to do it. Where does the balance go?

ADV 3: In this area (district) the services work really well together, the agencies themselves... but they are so good at saying they work well together and attending meetings but the clients get left behind and forgotten about.

*Sub-theme 3: family/guardian-agency.* Participants from all advocacy agencies identified the need for agencies to communicate and collaborate with families/guardians. A number of participants indicated that advocates often get involved in situations where effective communication and collaboration between families and agencies has not taken place. For example:

ADV 10: Effective communication, and real communication between service providers, families and support networks. They may communicate but it is not effective and you find the client's support networks are disassociated from the service provision itself.

ADV 4: Communication is the main thing that is missing. Mostly between the management of the service and the client and family.

Communication and collaboration between the agency and the family/guardian was considered to be limited/enabled by (a) whether the agency is accessible to the family/guardian and responsive to their input and suggestions (see internal limiting/enabling theme 1), and (b) in instances where the service user has an Adult Guardian appointed by QCAT (Queensland Civil and Administrative Tribunal), whether the Adult Guardian genuinely consults with their trustee (see external limiting/enabling theme 2).

*Sub-theme 4: professionals-agency.* Participants from one advocacy agency identified the need for communication and collaboration between the agency and other professional sectors, such as occupational therapy. To illustrate, it was stated:

ADV 4: With OTs (occupational therapists) as well, the agencies just couldn't get it together- the outcome was poor because it took 5 months... they (the specialists and agencies) are not communicating. If there is no rapport it seems to break down.

ADV 3: I have one now where the lady wants to open the door- that is the goal! It is go to LifeTec and get an aid... This staff member said they never knew they

could do that. They are delivering the programs but they don't have the information or skill to know where to go to get that sort of stuff.

*Meta-theme 2: community relationships.* A number of participants considered community relationships to be significant to outcomes for service users. This was referred to with regard to enabling and enhancing relationships between service users and people in the mainstream community. Included in the interviews was:

ADV 1: I think supporting people on an individual basis and becoming part of the community and the generic things are happening in their community. Like going to the gym and having a personal trainer and getting to know their personal trainer and getting to know someone else.

ADV 2: Of course friendships and relationships are important to quality of life, for people to feel valued... it is about one-on-one making those relationships with people in the community.

Community relationships was considered to be limited/enabled by being placed in groups homes (see external limiting/enabling theme 2) and non-compatibility with co-tenants (see sub-theme 6).

*Meta-theme 3: compatibility.* Compatibility between staff and service users, and between co-tenants, was considered significant to service user outcomes. Sub-themes are described below.

*Sub-theme 5: staff-service users.* A number of participants identified the compatibility of staff and service users to be significant. Specifically, the match between the needs and desires of the service user and the support staff was referred to. As stated:

ADV 3: A lot of the agencies are now employing different nationalities that have no experience and can't speak English. That is not okay because we've got clients that are already isolated. If the support workers can't talk to them and a team leader comes in once a week- it is not enough. That would be fine for a family that spoke that language but they don't match them.

ADV 4: I have one client who is profoundly deaf but texts all the time, I 'talk' to him everyday. They put a worker with him... but the worker couldn't text so my client was completely cut off. His behaviour started escalating- he was lonely! No one picked it up.

*Sub-theme 6: service user-service user.* The compatibility between service users co-tenancing was identified as significant to service user outcomes. Incompatibility was considered to result in challenging behaviour and limiting/enabling to the development of relationships within the community (see meta-theme 2). Quotes that illustrates this theme included:

ADV 10: I think the mismatching the people that they are putting people in homes with.... they had different interests and they tried to cater to each of them

which was great but in the end one of them said 'I hate living with her' (they changed her living arrangement) and it was quite amazing in the transition in her behaviours from quite complex to then living quite a normal life....

ADV 2: In group homes often people are grouped together, say four people with autism and challenging behaviour, and one of those features is that they want a lot of structure and not being interfered with and needing their own space but not being able to respect other peoples space. That causes CBs and often people are being assaulted in those group homes.

*Meta-theme 4: consistency- staffing and PBSP implementation.* A number of participants identified that to produce quality outcomes for service users, the consistent implementation of PBSPs is required, as is continuity of staff members providing service to the service user. As suggested:

ADV 3: It has to be a priority but they don't guarantee that you will get the same 3 people. They don't like to give the same people because they say they will get too close to that person but when you're looking at CB continuity is the key to any outcome.

ADV 5: ...they can pull out all the beautiful paperwork and plans but it doesn't get implemented.

Consistency in PBSP implementation was considered to be limited/enabled by the quality of the plan, specifically that they are succinct and understandable by support workers (see internal limiting/enabling theme 2).

*Meta-theme 5: in-service training.* The majority of participants considered in-service training to be significant to outcomes. It was identified that support workers should have training in 'valuing the person and empathy'/ human rights frameworks, CBs and strategies, restrictive practices, and understanding of a person's specific disability. Further, the majority of participants indicated that in-service training was lacking in service agencies. As suggested:

ADV 2: You tend to find that if someone has significant CBs, ... you don't see good training for staff...

ADV 5: It doesn't happen a lot and that is the things that support workers say- they want more training but they're not getting it

*Meta-theme 6: individualisation.* Participants from all advocacy agencies considered individualisation significant to outcomes and central to reducing CB and restrictive practices. To highlight this theme, participant quotes included the following.

ADV 5: ... we had a person with a high use of restrictive practices in one agency, they were moved and haven't had a restrictive practice. The difference was that one... was willing to listen to the person and take into account the person's ideas, the family's ideas and they worked with him around what he

wanted, rather than what the agency wanted.

ADV 3: They have an interest in life, that the care plans reflect that- it is fluid, not structured. Just like we would live. You would see a lot of behaviours go down.

Individualisation was identified as being limited/enabled by agencies viewing themselves as decision makers over what and how services should be provided to service users (see internal limiting/enabling theme 3).

*Meta-theme 7: management practices.* This meta-theme encompasses participant dialogue related to the practices of management. The practices identified as significant related to flexibility: risk management and duty of care; funding allocations; support; and team meetings/case discussion. These sub-themes related are discussed below.

*Sub-theme 7: flexibility- risk management and duty of care.* Most participants identified flexibility with regard to risk management and duty of care as significant. It was considered that rigid interpretations of risk management and duty of care sometimes impacted the rights of services users. As stated:

ADV 7: Misunderstanding duty of care vs. the right to take risk. The limitations for the individual because of duty of care to be able to make choices, even though it might be a bad choice... the whole risk management focus of management of services vis-à-vis balanced with some semblance of rights of people within the services.

ADV 8: If they are scared they go to their lawyers who don't have any human rights framework whatsoever... minimise risk to the organisation without having a sensible discussion of what is the actual risk.

*Sub-theme 8: funding allocations.* A number of participants identified funding allocations as a management practice significant to outcomes. Specifically, it was suggested that agencies should have a judicious approach to allocating funds to administrative expenses, and flexibility with funding allocations to meet the needs of service users.

ADV 5: I don't think the money being provided to support is actually going to the support, I know there are administrative costs... a wiser use of the funding.

ADV 9: I think it is about being resourceful... and flexible. They might say this money is only for this or this but if they wanted they could be flexible.

*Sub-theme 9: support.* A number of participants identified the management practice of support to be important. Support was identified as an ongoing cultural practice between supervisors and support workers. Dialogue related to this sub-theme included the following.

ADV 5: ... that has been fed back to me (from support workers)- they would like if higher management asked them how they are going. A lot of it is to do with support because it can be daunting particularly with CBs, it is the immediate and post- situation. I know some organisations do de-briefing sessions but not all organisations....

ADV 4: Organisations need to connect with their staff in terms of training and setting up the culture of round table- that support for each other as colleagues. You need a culture of support...

*Sub-theme 10: team meetings/case discussion.* Participants from two advocacy agencies identified meetings between supervisors and support workers, and case discussion between people involved in service provision to a service user as important to outcomes. Specifically it was said:

ADV 8: They would benefit from that... having case discussion weekly or fortnightly...

ADV 1: Not having the opportunity... maybe somebody else is more successful (with the client) and ask someone and talk to each other

*Meta-theme 8: service user choice and control.* Service user choice and control was considered significant to service user outcomes by participants from all advocacy agencies. It was considered that service users should have choice and control over aspects of their lives including their friends, living environments, and support workers. Further, that a lack of choice and control can result in incidents of CB. As suggested:

ADV 6: ...people need to be at the helm of their own life and giving them supports to be able to do that.

ADV 1... all had to go to the shops together but obviously they didn't want to do the same things there (there were significantly different ages)... That sparked CBs at the shops so they weren't allowed to go anymore.

Service user choice and control was considered to be limited/enabled by a number of factors, being (a) service user knowledge and accessibility of the complaints mechanisms, (see internal limiting/enabling theme 5), (b) the extent to which they are empowered to understand options and/or can access advocacy (see internal limiting/enabling theme 4), (c) providing too much service (see internal limiting/enabling theme 3) and (d) in instances where the service user has an adult guardian appointed by QCAT, whether the Adult Guardian genuinely consults with their trustee (see external limiting/enabling theme 1).

*Meta-theme 9: the right staff.* All participants considered that having the 'right' staff employed in the agency to be significant to service user outcomes. Experience and

qualifications were not considered necessary, however the qualities that were consistently identified as essential were as follows.

- Values and Framework.

ADV 6 ...it is more about qualities, people who like people, a strong sense of social justice.

ADV 2: Well first of all you have to have staff who, they don't necessarily have to have certificates, but the right values and framework to guide their practice. That is the most important thing.

- Ability to maintain confidentiality.

ADV 6: I've born witness to workers standing around exchanging information that neither needed to know and it was gossiping.

ADV 1: The workers aren't careful about how they talk about that. They will go in and have a whine about the family in front of the person with the disability.

*Internal limiting/enabling theme 1: agency responsiveness and accessibility.*

Communication and collaboration between agencies and the family/guardian was considered to be limited/enabled by whether agencies are receptive to input from the service users family/guardian, and whether the agency is accessible to the family/guardian. Participant quotes that illustrates this theme included:

ADV 10:... the family has (provided) things that would be helpful like this is a list of questions, laminated, with yes and no and flipcharts, all those sought of things but they are not used. She has been battling the facility (for them to be used) for 2 years.

ADV 5: Being a little bit more accessible to people so they feel they can go back to the service provider with a concern or question. At the moment they don't feel like that so it puts up a barrier... there needs to be respect and rapport development between the service providers and the individuals and families.

*Internal limiting/enabling theme 2: quality of the plan.* All participants who discussed PBSPs indicated that implementation of the plans was limited/enabled by the quality of the plan, referring to length and accessibility. To highlight, a number of participants said:

ADV 3: PBSPs are in the draw. They don't understand them. Too big, too complicated.

ADV 9: The (PBSPs) I have seen are the most unhelpful mountain of unhelpful information. They are far too big... They are inaccessible, which support worker is going to sit there and read a 60 page document to work out...

*Internal limiting/enabling theme 3: 'owning' service users and over-servicing.* This theme refers to agency perception of proprietary rights to service provision for an individual and the provision of service beyond service user needs. This was identified as limiting/enabling the degree of service user choice and control over who, how and what services were delivered. Participant verbatim quotes that illustrates this included:

ADV 9: Our mantra in mental health was do yourselves out of a job but disability services mantra is not this person is my meal ticket, I'm coming into their house and staring at them for 5 hours a day whether they need it or not.

ADV 1: They have a lack of choice and control and sometimes that is a result of having too much support.

*Internal limiting/enabling theme 4: advocacy and empowerment.* Advocacy and empowerment refers to the extent to which service users are empowered to understand options and/or access advocacy. This was identified as limiting/enabling the extent to which service users had choice and control. As suggested:

ADV 4: ...the client being trained on choice, how to choose something. To give them information in flexible ways- I'd rather work with you and not you. Teaching them that they can have choice and control because they've never had it.

ADV 6 ... the person (service user, should be) the driver of their life, and some people may not be able to articulate that in the moment and don't have family around them they should have access to an advocate who can get to know them and help them articulate...

*Internal limiting/enabling theme 5: complaints mechanisms.* Service user choice and control was considered to be limited/enabled by service user knowledge of, trust in, and accessibility of the complaints mechanisms. Specifically, participants suggested:

ADV 8: it is not made clear to them how to do that, or the methods of complaint are inaccessible... if there are so few successful complaints that is known quickly.

ADV 3: Sometimes when I say to a client "it's okay we can get your support worker changed" they say "you can't do that- they'll be mean to me, don't do that. Don't come to the house cause they'll be mean to me". They are frightened.

*Internal limiting/enabling theme 6: interpretation of behaviour and labelling.* Participants from all agencies identified the interpretation of CB and labelling as a significant limiting/enabling factor. It was indicated that behaviour is often attributed as internal to the service user and this can be a result of labelling. Further, through incorrect interpretation of behaviour and labelling, inappropriate responses are facilitated and

service user expectations and opportunities are limited. To highlight, a number of participants said:

ADV 7: It is applying those listening skills to the behaviours instead of interpreting them as bad. That is the fundamental problem as I see.

ADV 2: ... the expectation (once labeled as CB) are that the person is difficult and are then treated differently and may not have be offered the same opportunities in things they are interested in. I think their lives are then limited by the expectations of others around them...

*External limiting/enabling theme 1: the Adult Guardian.* Where service users had an Adult Guardian appointed by QCAT, the Adult Guardian was identified as limiting/enabling communication and collaboration between the agency and family/guardian, due to unavailability of the Guardian. This was further identified as limiting/enabling service user choice and control in situations where the Guardian has not appropriately consulted with their client. As suggested:

ADV 6: I've had so many people complain to me that the Guardian won't listen... I question what training Guardians have.

ADV 2: The Guardian that is appointed often consults with the service provider, rather than the individual.

*External limiting/enabling theme 2: group homes.* Living in group homes was identified by a number of participants as limiting to service user outcomes and potentially causative in CB. Further, living in group homes was considered to be limiting in the development of relationships with people in the community. To highlight, it was stated:

ADV 6: I would like to know how many people labeled as CB and living under restrictive practices did not have that happen to them till they were forced to co-tenant.

ADV 2: Often the house is noisy because there are four people living together who shouldn't be living together... . If you have one or two people living together it is very different and you can support people to develop relationships with the neighbours and be involved in activities locally.

*External limiting/enabling theme 3: substitute decision making.* A number of participants identified substitute decision making as limiting/enabling. Specifically, it was identified that QCAT processes and proceedings impacted service user outcomes due to formality, inconsistencies, and tribunal members' understanding of human rights. For example:

ADV 2: The outcome can often be greatly different depending who is on at the tribunal. They say it is informal but it is very formal and that can be difficult for the families. Often DSQ (Disability Services Queensland) has a lawyer but the



service user doesn't. The Guardian that is appointed often consults with the service provider, rather than the individual.

ADV 7: ... (human rights frameworks) at every level, including QCAT- sector wide... I support anyone who is going to QCAT and there is no traction if you raise human rights violations... It is in the legislation but everyone is blind to it.

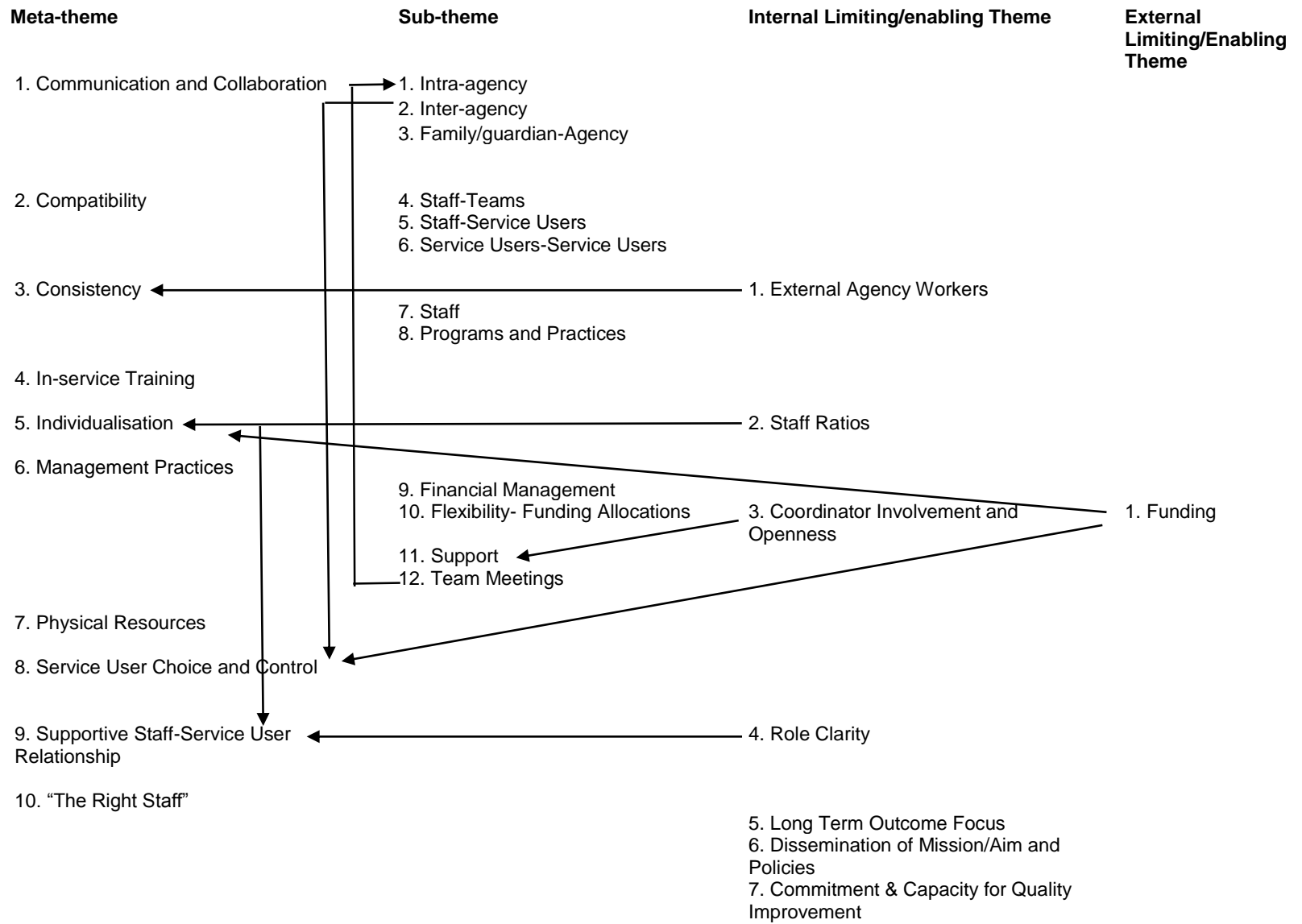
**Support Workers.** The analysis of interview data from support workers was informed by the conceptual framework for quality services, detailed in chapter two. Data analysis led to the identification of 10 meta-themes, 12 sub-themes which are significant to quality services, and eight limiting/enabling themes. The eight limiting/enabling themes were categorised as seven internal limiting/enabling themes, meaning they are within the control of agencies, and one external limiting/enabling theme, being outside of the control of agencies. Table 5.3 lists the meta-themes, sub-themes, and limiting/enabling themes elicited from the data. Each of the meta-themes and associated sub-themes contained within them are discussed below, followed by internal then external limiting/enabling themes.

Table 5.3  
*Themes from Interviews with Support Workers*

Meta-theme	Sub-theme	Internal Limiting/enabling Theme	External Limiting/enabling Theme
1. Communication and Collaboration	1. Intra-agency 2. Inter-agency 3. Family/guardian-Agency	1. External Agency Workers 2. Staff Ratios 3. Coordinator Involvement and Openness	1. Funding
2. Compatibility	4. Staff-Teams 5. Staff-Service Users 6. Service Users-Service Users	4. Role Clarity 5. Long Term Outcome Focus 6. Dissemination of Mission/Aims and Policy	
3. Consistency	7. Staff 8. Programs and Practices	7. Commitment and Capacity for Quality Improvement	
4. In-service Training			
5. Individualisation			
6. Management Practices	9. Financial Management 10. Flexibility- Funding Allocations 11. Support 12. Team Meetings		
7. Physical Resources			
8. Service User Choice and Control			
9. Supportive Staff-Service User Relationship			
10. "The Right Staff"			

Figure 5.2 visually illustrates the interactions between themes, that is how they impact and/or limit/enable other themes and service user outcomes. Interactions are depicted by lines indicating interaction, and arrowed lines demonstrating one-way directional impact.

Figure 5.2. Interaction between themes from interviews with support workers



*Meta-theme 1: communication and collaboration.* This theme reflected the importance of effective communication and collaboration within agencies, among agencies, and between agencies and families/carers of service users. The sub-themes contained within the meta-theme are described below.

*Sub-theme 1: intra-agency.* Communication and collaboration among support workers, and between support workers and supervisors, was considered significant by the majority of participants. A number of participants also suggested that communication and collaboration between all levels of staff was significant. The benefits of communication and collaboration included: enhancing teamwork; sharing information and ideas; and, problem solving. This theme is illustrated in the following quotes.

SW1: It is communication between staff the housemates that you work with, and also communication between staff amongst themselves. You don't have that dynamic working properly on all of those levels it is going to fall apart.

SW10: What makes this particular program work so well is the staff and the management. We are a very strong team and that is what I mean, it is a team here. If something is not working there are always suggestions to make it work.

Participants from agencies where multiple services were provided, such as accommodation support and day services, indicated effective communication and collaboration between the services to be significant to outcomes. Communication and collaboration was considered to be associated with having team meetings in which ideas and information are shared (see sub-theme 12).

*Sub-theme 2: inter-agency.* A number of participants considered communication and collaboration between agencies providing services as important to outcomes. It was indicated that this can increase service user activities and friendship groups. As indicated by two participants:

SW 13: I just think accessing the other organisations that they might be eligible to be able to join in with in activities and socialising and community access. I have seen that with a lot of the clients that do have more... .. And yeah what other agencies are offering as well.

SW 9: We are supporting the individual in their whole life, we are just a snippet of that. Inter-agency, in terms of other disability service providers- it depends on the outcome but a lot of our ladies are wanting to develop their social circle. It is important that we branch out and see beyond this organisation.

Communication and collaboration between agencies was identified as impacting service user choice and control of friends and friendship groups (see meta-theme 8).

*Sub-theme 3: family/guardian-agency.* A number of participants considered communication and collaboration between the agency and families/guardians as

significant to service user outcomes. It was indicated that they should be 'on the same page'. To illustrate:

SW 8: It is really difficult when we hear one thing from the service user and one from the family. Our loyalties lie with the service user. We want what they want for themselves.

SW 1: Parents should also be educated about possibilities how the (outcomes) of their children could be improved.

*Meta-theme 2: compatibility.* Compatibility was considered significant to service user outcomes by the majority of participants. The interview data indicated that there should be compatibility between the staff on teams, between support workers and service users, and among service users. These sub-themes are discussed below.

*Sub-theme 4: staff-teams.* Participants in one agency identified compatibility between staff working on teams to have benefits including teamwork and collaboration. This theme is illustrated in the following quotes.

SW 8: I have seen staff come and go and I have seen some terrible group dynamics- the bitching and the lack of communication because I don't like you so I am not going to tell you and watch you fall flat on your face. It really does affect the service user

SW 9: You want a good dynamic between the people you work with and the people you work for

*Sub-theme 5: staff-service users.* The majority of participants considered the compatibility of staff and the service users with whom they work as significant to service user outcomes. Compatibility was identified as being needed between staff and staff attitudes, and the service user's needs, interests and personalities. As suggested:

SW 12: ... with different clients -that they actually suit that client's needs

SW 2: ...like with (the residents of the house) who have their own personalities the (staff member's) attitude and the way that they work is going to be detrimental in the long run to the care and the support of these housemates.

*Sub-theme 6: service users-service users.* Compatibility between service users, such as those attending services together or co-tenanting, was considered significant to service user outcomes by a number of participants. Compatibility was considered with reference to behaviours, communication and interests. To highlight:

SW 8: I think of one person in particular, one person's behaviour in a house is impacting the other residents to the point where they want to eat dinner outside so they don't have to be in the same room.

SW 3: ...we have people who don't communicate with people who are very very capable and we don't have program suited for both. People are always missing out...

*Meta-theme 3: consistency.* Participants considered consistency to be significant to service user outcomes. Consistency was identified with regard to constancy of staff members and implementation of programs and practices, as discussed below. However, consistency was considered to be limited/enabled by the use of external agency workers (see internal limiting/enabling theme 1).

*Sub-theme 7: staff.* The consistency of staff members for service users was considered significant to service user outcomes particularly the reduction of CB. This is illustrated by the following quotes.

SW 4: I think with a consistent staff then we can minimise those behaviours

SW 3: is my observation that consistency in staff is definitely a big part of it. Especially when you have CBs

*Sub-theme 8: programs and practices.* The consistent application of programs and practices was considered significant by the majority of participants. Most participants did not refer to PBSPs or specific programs, however it was clearly indicated that no matter what the programs or practices were, they needed to be implemented consistently. As stated:

SW 3: You definitely need consistency in approach, consistency in rules, consistency in routines. When you have those elements and you have teamwork then you definitely have a greater reduction in behaviours.

SW 2: I would say that consistency is key... whatever program there is... it needs to be followed otherwise it fails.

*Meta-theme 4: in-service training.* In-service training was considered significant by the majority of participants. In-service training topics identified as important were: behaviour support; manual handling; first aide; workplace health and safety; medication; and, policy and procedures. The majority of participants indicated that they required more in-service training with specific regard to the cohorts that they work with. Included in the quotes that related to this theme were the following.

SW 2 ... in-service training has been covered to meet the standards where I feel like education on what is autism I find lacking...

SW 4: Within the training thing I think that a little bit more training on...

SW 3: ... Specific behaviours or conditions.

SW 4: Yeah.

*Meta-theme 5: individualisation.* A number of participants considered individualisation to be both motivating for the service user and central to outcomes. For example:

SW 13: ... if we can get them into routines that they agree with and things that they would like to do – that is focused around the client – for me I think that makes a big difference.

SW 8: If they don't want to do it there is not going to be an outcome because they don't want one... I think it starts and ends with the individual...

The extent of individualised programs was considered to be limited/enabled by staff ratios (see internal limiting/enabling theme 2) and funding available to agencies (external limiting enabling theme 1).

*Meta-theme 6: management practices.* Most participants discussed the importance of management practices, specifically: financial management; flexibility with funding allocations; support; and team meetings. These sub-themes are discussed below.

*Sub-theme 9: financial management.* Participants from multiple agencies considered appropriate financial management to be significant to service user outcomes. It was indicated that inappropriate financial management, including high administrative costs, led to reduced capacity to meet the needs of service users. This theme is illustrated in the following quotes.

SW 1: I have first time had opportunity to see what funding department in this organisation is doing. I was astonished at how poorly it is done

SW 4: ...we need funding for materials and paints and those things always run out.... I think if they got funding for the year it should be spread out throughout the year so there is no lack of resources. Resources are very important and if we don't have...

*Sub-theme 10: flexibility- funding allocations.* A number of participants considered flexibility with regard to funding allocations to be significant. Flexibility was identified as being required to channel money to meet the needs of certain service users, and in allocating an individual's money into more effective areas. As stated:

SW 13: Money really needs to go for their needs and sometimes I just don't see that happening. Two workers might be there to calm the person down... that money is probably better off going into professions such as psychology or psychiatrists for that sort of stuff.

SW 8: In terms of funding for staff as well, we have a client who is approved for one on one for 12 hours a week and he was attending full time, requiring two on one support. That is a cost we had to wear...

*Sub-theme 11: support.* Support from management was referred to by the majority of participants. Support was referred to as incorporating:

- Being “backed’ up
- Availability
- Listening to ideas/ problem solving
- Understanding
- Trust

Participant quotes included the following.

SW 12: being available for staff which betters themselves for that company and for the client

SW 10: ...there are so many things that they do, I like that they have a lots of trust in us, they don't come and hover...

The provision of support was considered to be limited/enabled by whether the coordinator is actively involved with the team and is open to support workers ideas (see internal limiting/enabling theme 3).

*Sub-theme 12: team meetings.* Team meetings were considered by participants from multiple agencies to be significant to service user outcomes with the benefits including the sharing of information and ideas, problem solving and enhancing communication and collaboration between team members. Verbatim quotes related to this theme included the following.

SW 6: I think that is part of meetings because we do share things that work for us...

SW 11: I start my job with (name deleted) 2 weeks ago but I had meeting with supervisor and other workers and it is good.... First of all talking about plan and after that every worker talking about their experience and sometimes they found very very good idea after this meeting.

*Meta-theme 7: physical resources.* Physical resources were considered significant by a number of participants. Physical resources that were referred to included equipment and consumables, such as paints and pens. As stated:

SW 4: ...if we were able to get our hands on not just paints and pens and stuff but other stuff – I think it would be a lot better and we could do a lot more with the clients.

SW 12: There is a client that I worked with at the moment who is in a wheelchair, (he needs) a new vehicle for transport... He's been waiting 5 years for it now.

*Meta-theme 8: service user choice and control.* Participants acknowledged the need for service user choice and control over the outcomes for service provision, which support



workers they have, and what activities they participate in. Quotes contained within this theme included:

SW 8: Their personal desire to want that outcome... That is their individual choice that they are entitled to... If they don't want to do it there is not going to be an outcome because they don't want one.

SW 10: It is directly hearing what they want from us. It is not asked telling them we've got this suggestion, it is them to us.

Service user choice and control was identified as impacted by communication and collaboration between agencies (see sub-theme 2) as this enables service users having more choice of activities and friends.

*Meta-theme 9: supportive staff-service user relationship.* The majority of participants considered a supportive relationship with service users to be significant to outcomes. A number of participants considered 'bond' and 'rapport' was necessary to getting good outcomes, while other participants described the relationship as 'encouraging', 'supportive of their needs' and 'family like'. As stated:

SW 10: If you haven't got that bond and rapport with them you are not going to get as far as someone who does.

SW 11: I think when I am working with these people, I think the people is one of my family member. Then I am thinking it is very easy to communicate with them, they have accepted me.

*Meta-theme 10: the right staff.* The majority of participants considered that the 'right' staff have to have the 'right' personal qualities. These were identified as including:

- Calmness
- Willingness to learn
- Patience
- Compassion and passion
- Empathy and understanding
- Open-mindedness
- Commonsense
- Flexibility
- Ability to maintain confidentiality

It was identified that qualifications were not significant to outcomes. However, experience or exposure to people with disabilities was identified as important. As said:

SW 6: Because with the qualifications you don't have real experiences in supporting people with a disability.

SW 7: Yeah, that is just the theory but you need the experience to learn what works for each particular client.

*Internal limiting/enabling theme 1: external agency workers.* A number of participants indicated that the consistent implementation of programs and practices was impacted by the use of external agency workers. Quotes that illustrates this includes the following.

SW 7: Not long after I started I read file notes about workers from another company that were filling in. They let her into the office because it was hot weather (contrary to policy)...

SW 2: ... there have been cases where I have actually said that the agency do not send them... their attitude and the way that they work is going to be detrimental in the long run to the care and the support of these housemates

*Internal limiting/enabling theme 2: staff ratios.* Staff ratios were considered to limit/enable the extent to which program delivery is individualised. To illustrate, it was stated:

SW 5: I haven't had the experience of less than one-to-one but I think you can't give them the attention. If they have a CB the...

SW 7: Definitely. I think that one worker to two clients is okay but getting up to three clients is too much to give quality programs.

*Internal limiting/enabling theme 3: coordinator involvement and openness.* The management practice of support was considered to be limited/enabled by the involvement of the coordinator and their openness to listen to support workers and uptake ideas. As stated:

SW 3: Having our coordinator involved, he/she understands what we are going through... and we can go to him/her and he/she will understand everything – if we have any issues or anything like that.

SW 1: If I as a support worker come and bring a new idea... (management need) flexibility and open-minded to new changes, to new improvement, to new approach, to new challenges, to new technology.

*Internal limiting/enabling theme 4: role clarity.* Support worker clarity regarding professional boundaries and expectations was considered limiting/enabling to the development of supportive staff-service user relationships. To illustrate:

SW 5: I think all of us struggle with the professional boundaries.(and) making a relationship. If I make a good relationship he/she will be fine and very nice for me but sometimes that good relationship can be opposite to policy of organisation. It is hard to make a good balance between those things.

SW 1: ... I think that really lately roles are not clean. We don't know what support worker is at all anymore.

*Internal limiting/enabling theme 5: long term outcome focus.* Participants from three agencies identified having a long-term outcome focus for service users, such as independence, as being limiting/enabling to outcomes for service users. As said:

SW 1: The organisation should look to improve the way to help clients to be independent. Not quality service, or how many activities do they have... they should look that way to be independent adults who can live with minimal support.

SW 2: Not what is required to meet the standards but a more long-term outcome....

*Internal limiting/enabling theme 6: dissemination of mission/aim and policies.*

Participants from a number of agencies considered the dissemination of the missions/aims and policies throughout the agency as limiting/enabling. To illustrate, it was stated:

SW 4: I think authenticity, they need their policies to be straight and everyone to know their policies

SW 1: What is the aim (of the agency), what they want to give on the bottom line clients... that for me is crucial....

*Internal limiting/enabling theme 7: commitment and capacity for quality*

*improvement.* A number of participants considered the willingness and ability for the agency to improve, even in areas they were performing adequately, to be important. As suggested:

SW 1: (There needs to be a) willing(ness) to go out there and open organisation and then make change

SW 12: ... a lot of them (supervisors) are closed minded to new ideas because what is in the system is actually working.

*External limiting/enabling theme 1: funding.* Participants considered the funding available to agencies as limiting/enabling to the extent to which (a) services are individualised, and (b) service users have choice and control. As stated:

SW 13: I think it (funding) has a big impact (on outcomes) because they are so restricted financially and having other places to go to that might be fun and like respite, and things like that, make a big difference.

SW 8: There is a lack of funding so for him to access the community, he needs two on one, because there is life beyond the computer screen. I think it is important that he experience that- it is unfortunate that it is money that stops him leaving a normal life.

**Supervisors.** Analysis of the data, informed by the conceptual framework for quality described in chapter two, identified 10 meta-themes, 16 sub-themes which reflect factors

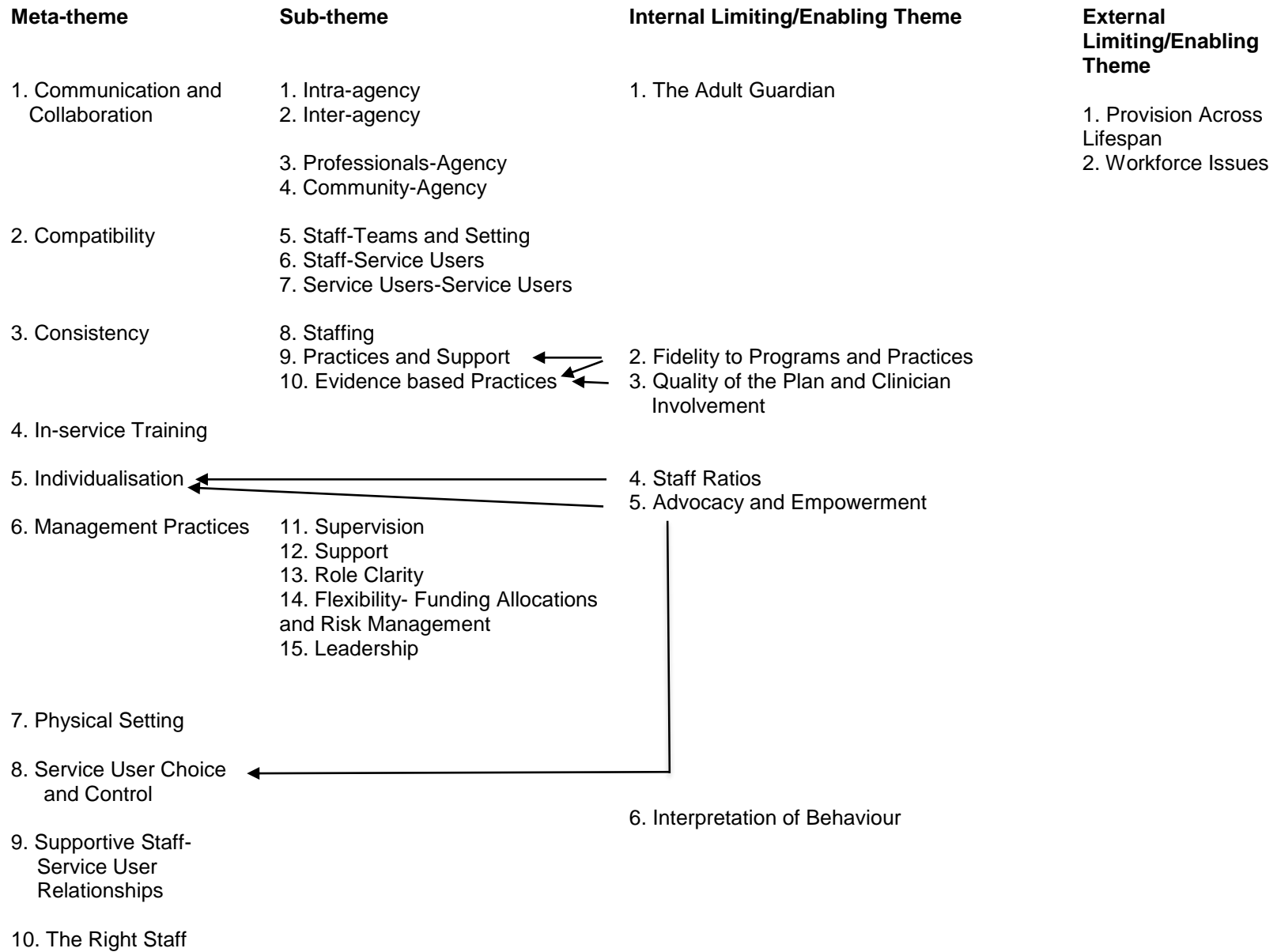
significant to quality, and a further eight themes which were categorised as limiting/enabling to agency production of quality services. The limiting/enabling themes were identified through analysis as incorporating six internal limiting/enabling themes, meaning they are within agency control, and two external limiting/enabling themes, being outside of agency control. Table 5.4 lists all of the themes and shows which sub-themes contained within the meta-themes.

Table 5.4  
*Themes from Interviews with Supervisors*

Meta-theme	Sub-theme	Internal /enabling Theme	External Limiting/enabling Theme
1. Communication and Collaboration	1. Intra-agency 2. Inter-agency 3. Family/guardian-Agency 4. Professionals-Agency 5. Community-Agency	1. The Adult Guardian 2. Fidelity to Programs and Practices 3. Quality of the Plan and Clinician Involvement 4. Staff Ratios	1. Provision Across Lifespan 2. Workforce Issues
2. Compatibility	6. Staff-teams and setting 7. Staff-service Users 8. Service Users-Service Users	5. Advocacy and Empowerment 6. Interpretation of Behaviour	
3. Consistency	9. Staffing 10. Practices and Support 11. Evidence based Practices		
4. In-service Training			
5. Individualisation			
6. Management Practices	12. Supervision 13. Support 14. Role Clarity 15. Flexibility- Funding Allocations and Risk Management 16. Leadership		
7. Physical Setting			
8. Service User Choice and Control			
9. Supportive Staff-Service User Relationships			
10. The Right Staff			

The interactions between themes, and between limiting/enabling themes, as derived from participant quotes, is illustrated in Figure 5.3. Specifically, interactions are depicted with lines with arrowed lines depicting one-way directional impacts. These interactions are described in text form in the ensuing sections.

Figure 5.3: Interaction between themes from interviews with supervisors



*Meta-theme 1. communication and collaboration.* This theme reflects the importance of effective communication and collaboration within agencies and between agencies, the sector and the community. The sub-themes contained within the meta-theme are described below.

*Sub-theme 1: intra-agency.* The majority of participants considered collaboration and communication within all levels of the agency and between services provided by an agency as significant. It was identified that effective communication and collaboration leads to teamwork, “pooling of ideas”, problem solving, and sharing of information and resources. The impact of poor communication and collaboration was identified as compromised plan implementation, service users missing medical appointments and poor working atmosphere. This theme is illustrated in the following quotes.

SUP 7: We always talk to each other as well because there is often things I come up with and another coordinator might have a great idea too.

SUP 6: ...our top management might not be having that much contact with service users but as long as you have that strong communication between each different link... that is going to get good outcomes.

*Sub-theme 2: inter-agency.* Communication and collaboration between agencies providing services to the same service user was indicated as significant as it enables better service user outcomes, problem solving and the ‘pooling of resources’. As indicated by a number of participants:

SUP 6: It would be good to establish some relationships where we could almost pool our resources with other organisations

SUP 10: the communications can be a problem and quality of service that is offered... the other service user just park (him/her) there and do nothing much with (him/her)

*Sub-theme 3: professionals-agency.* The majority of participants considered communication and collaboration between agencies and sectoral disciplines as significant to CB incidence. The professional disciplines referred to included speech therapy, psychology, psychiatry, nutrition and occupational therapy, DCCSDS, family planning and youth services for people with disabilities. To illustrate, it was stated:

SUP 9: he/she will go to a psychiatrist and he/she (says) he/she needs respite! He/she doesn't have any funding for respite! He/he wound up... we start the old cycle again!

SUP 8: ...we found that a lot of clients exhibit CB when they come into the adult model because they don't understand what the changes going to be for them.

*Sub-theme 4: community-agency.* The utilisation and access to ordinary community facilities, resources, events and people within the community was considered significant to outcomes by a number of participants. Participants indicated communication and collaboration between the agency and the community as vital to this. Quotes contained within this theme included:

SUP 5: ...link them into the mainstream rather than just be friends with people who have a disability.

SUP 6: ...we really need to develop our rapport with other community organisations and understanding of those places and hopefully more in unison.

*Meta-theme 2: compatibility.* Compatibility was considered significant to service user outcomes by the majority of participants. Compatibility was identified as required between staff and the teams in which they work, the setting in which they work, staff and service users, and between service users co-tenanting. These sub-themes are discussed below.

*Sub-theme 5: staff-teams and setting.* Compatibility between staff on teams, and staff and the setting where they work, was considered significant by a number of participants. They discussed that to find the best match, support workers were often trialed with a number service users and in different settings. The benefits of an appropriate match was identified as teamwork. As stated:

SUP 8: They would rather sacrifice the shift, not because of the client, but because they didn't want to help the (other) staff.

SUP 1: They are tried here and here and there and they look for the match.... she worked in some of the houses and found that respite was best for her.

*Sub-theme 6: staff-service users.* Compatibility between support workers and service users was considered significant to outcomes. It was indicated by a number of participants that the staff-service user match is, and should be, informed by the needs and interests of the service users. To illustrate:

SUP 8: We try as best we can to get the best match that we can have for a worker and a client.

SUP 2: We are focusing in our program on the happiness and satisfaction of the clients. That is why we try and roster the same staff- the ones that get along with the client. If they are happy then give them that staff.

*Sub-theme 7: service users-service users.* The compatibility among service users was considered significant to service user CB and quality of life. Quotes contained within this theme included the following.

SUP 4: I think also what impacts on the individual as well is that they are living with people that are not matched.... like, they are not compatible. .... I do



think there are lots of people that are not compatible with each other. If you are in a house with someone who is non-verbal and you are able to speak, what quality of life is that, they can't have a conversation!

SUP 11: .... We have a person who is up all night screaming, what happens to the other person in the house? You've got disturbed sleep and that would make some behaviours, it is just what I've seen.

*Meta-theme 3: consistency.* Consistency of support was considered significant by the majority of participants. The consistency of support was referred with regard to staff, programs and practices, and evidence based practices. These were identified as sub-themes as discussed below.

*Sub-theme 8: staffing.* The stability of staffing was considered significant by a number of participants. It was indicated that instability of staff can result in confusion for the service user and CBs. As stated:

SUP 5: And to be consistent because it is confusing when the service user in one home have all these different staff coming and going. There is no consistency and continuation.

SUP 10: The consistency of the team.... it is quite good to get a stable team on board because they understand and it does reduce behaviours

*Sub-theme 9: practices and support.* Consistency of practices and support was considered significant, with consistency identified as being required in regard to dietary restrictions, routines, specific aspects of routines and general support. This theme is illustrated in the following quotes.

SUP 2: (His/her CB has been greatly reduced) to have diabetes controlled... for everyone to apply that (eating program) consistently has made a huge difference.

SUP 8: He/she used to escalate to a point and then just go right out and it would take him/her a long time to bring him/her back down to where he/ she needed to be. We were able to close that by the consistency... we will always be the same and we will follow the system that he/she can always come back to.

Consistency of practices and support was considered to be limited/enabled by support worker fidelity to the established programs and practices (see internal limiting/enabling theme 2).

*Sub-theme 10: evidence based practices.* The participants indicated evidence based practices to be significant to outcomes, and included PBSPs, Applied Behavioural Analysis and Functional Assessment and Positive Behavioural Intervention. However, it

was indicated that evidence based practices need to be applied consistently to be effective. To illustrate it was said:

SUP 1: Staff compliance with the intervention is a huge one and the biggest issue....

SUP 2: ... consistency and compliance.

SUP 10: If they are not doing the plans that clinicians spend hours doing....

SUP 11: ...there is no point doing it...

SUP 10: ...there is no point doing it..

Consistency of evidence based practices was considered to be limited/enabled by support worker fidelity to the plan (see internal limiting/enabling theme 2) and the quality of the plan and clinician involvement (see internal limiting/enabling theme 3).

*Meta-theme 4: in-service training.* In-service training was considered significant by the majority of participants. Mandatory training such as medication and fire-safety were also considered necessary. It was indicated that other training should be based on the needs of the service users or staff deficits. To highlight, participants indicated:

SUP 6: It is really looking at the needs of who we are supporting and training from there.

SUP 3: (we decide what training to provide by) observation, their error, people asking questions, by supervision, by appraisals with the staff, by talking to the staff.

*Meta-theme 5: individualisation.* Individualisation was identified as significant by a number of participants, with specific reference given to PCPs and ISPs. The benefits were identified as giving direction and focus for service users and staff. As stated:

SUP 5: It gives a person a sense of direction and focus.... That is how a PCP works... It is important to outcomes. When they achieve it, the person is happy because it is what they wanted to do.

SUP 6: I think the PCP itself (is necessary to getting good outcomes)-yes. Once we have it in place it gives us something strong to work towards.

The extent to which service delivery is individualised was considered to be limited/enabled by staff ratios (internal limiting/enabling theme 4), access to external advocates and empowering clients to understand PCP processes (internal limiting/enabling theme 5).

*Meta-theme 6: management practices.* This meta-theme encompasses participant quotes related to the management practices of: supervision; support; role clarity; flexibility with funding allocations and risk management; and, leadership. These sub-themes are discussed below.

*Sub-theme 11: supervision.* Supervision was considered significant by a number of participants. Supervision was referred to in terms of formal supervisory meetings and identified as a way to monitor and improve staff performance. This theme is illustrated in the following quotes.

SUP 4: Supervision is important because you can tell if they are getting exhausted or they are not enjoying things.

SUP 3: I think it (supervision) probably is (important) to outcomes because you cannot provide a high quality service if you have poor staff. You need to improve your staff.

*Sub-theme 12: support.* Support from management and support for the staff they manage was referred to by the majority of participants. Support was referred to as incorporating:

- “Backing” up staff and being “backed’ up
- Support for decisions
- Availability and involvement when required
- ‘Open door’ policy
- Understanding for need for time off
- Trust

To highlight, participants said:

SUP 1: I think that for me it has been the biggest thing, that I can go up to the Manager of Disability Service Operations and say, "I made this decision at the time, this is why I made it." Although he/she might not necessarily agree with it he/she will support the decision.

SUP 11: But what I have found very the best thing for them (the support workers) is exactly what we find good about (our manager), which is being always available.

*Sub-theme 13: role clarity.* Staff knowing the specificity of their job, including professional boundaries, was considered significant to quality outcomes for service users. Quotes contained within this theme included the following.

SUP 6: If there is very structured roles, and I am not saying you can't be flexible, but everybody's roles have to be very very clear and stuck to in a sense.

SUP 8: It is probably the most pivotal... everybody knowing their roles....

*Sub-theme 14: flexibility- funding allocations and risk management.* The management practice of flexibility was referred to by a number of participants. Flexibility was identified as being needed with regard to (a) funding allocations, to ensure that the

needs of service users could be met across the client group, and (b) in risk management.

To highlight, participants said:

SUP 6: We have some service users being pooled from the block funding, others who come under day respite funding.... It is good if services can be quite flexible with how that looks.

SUP 2: (Support workers often feel) It is easier not to take them out because then they might have to write an incident report. You are trying to teach that it is okay, everyone is going to have CB, and you do. But, it is okay because by the incident you learn to do things differently... They are scared of pushing...

SUP 1:... the boundary.

*Sub-theme 15: leadership.* Aspects of leadership that were identified as significant included leading by example and providing understanding as to the purpose of PBS. As stated:

SUP 1: I have had a lot of comments from people saying that I won them over when I was on my hands and knees cleaning the toilet. That's when they thought that okay they might listen.

SUP 2: ... on my whiteboard, I do (a PBS flowchart) while I'm there with them.... you can see the light go on in their minds.

*Meta-theme 7: physical setting.* The physical setting was considered significant by participants from one agency. Specifically, it was indicated that the physical space should facilitate privacy and retreat. During the interviews it was said:

SUP 2: They can have their CBs on their own and not hurt anyone else.

SUP 1: Space is a big one.... It is being able to retreat and have your privacy when you want to.

SUP 3: ...If you got that many people with CBs because the structure of the house is not facilitating them, there isn't enough space... There needs to be (space for) them to express themselves, to get away from each other, whatever.

*Meta-theme 8: service user choice and control.* Choice and control of service provision was identified as significant to service user outcomes. It was indicated that challenges or CBs are often a result of limited choice and control. As stated:

SUP 9: In the case with one of my clients.... A lot of it (his/her behaviour) is because he/she wants to gain control... we have worked really hard on structure, balance and choice ... things to allow him/her to feel that she is more in control.

SUP 8: Where we have had challenges with the client is that they have got no ownership in my life or they have very limited. Because of that they are only acting in the way they know how which is what I want is some kind of ownership over my life so I'm gonna make some kind of decision, whether it is the right decision or whatever decision.

Service user choice and control was identified as being limited/enabled by external advocacy, staff empowering service users or advocating on their behalf (see internal limiting/enabling theme 5).

*Meta-theme 9: supportive staff-service user relationship.* A supportive staff-service user relationship was considered significant to service user outcomes. A supportive relationship was described as being 'friendly', 'caring', 'trusting', and open. To highlight:

SUP 5: And them being comfortable (with the support worker) and you being comfortable with your worker. You need to have that connectedness and develop a rapport. It is not here just to deliver a service, you are here as a friend, an advocate.

SUP 10: .. and for the people we support as well.... I've got one very high behavioural (client) and (he/she) will ring me up on a daily basis and it could be a debrief... but it is important for (him/her) and (she/he) will then tell me what he/she likes or doesn't like or what is going on...

*Meta-theme 10: the right staff.* Participants indicated that having the right staff as impacting service user outcomes and identified these staff as not necessarily having experience and qualifications. As stated:

SUP 4: ...sometimes with qualifications you can have them but have no idea of the hands on.

SUP 3: Experience, but also pretty in-experienced people are good too because you can train them.

It was clearly expressed that in the context of service user outcomes that the 'right' staff have to have the 'right' personal qualities. These were identified as:

- Caring
- Flexible and adaptable
- Compassionate/ empathetic
- Calm
- Level headed
- Ability to maintain confidentiality

Agency capacity to employing the 'right' staff was considered to be limited by having a small pool of potential workers to choose from (see external limiting/enabling theme 2).

*Limiting/enabling theme 1: the Adult Guardian.* For service users with an Adult Guardian appointed by QCAT, the Guardian was considered as limiting/enabling due to the Guardian having an inactive role. Quotes related to this theme included the following.

SUP 4: Some of the Adult Guardians do not really take a role in that because they have so many.

SUP 8: No disrespect to The Adult Guardian but we have Adult Guardians making decisions for people that they haven't seen their client for three

years!...I've got one of my clients who has a way of acting out against his/her adult guardian in the system ... He/she may go off and refuse service and... see a friend over there which she is not approved to.

*Limiting/enabling theme 2: fidelity to programs and practices.* Support worker fidelity to programs and practices was identified as limiting/enabling the consistent implementation of programs and support, and adherence to evidence based practices. As stated:

SUP 9: They walk in and look at the plans and say no- I'll do it with the way it was with the last client.

SUP 1: And the key thing that I have found is that you will approach something in a team meeting. You will agree on an intervention...

SUP 2: ... and they will just do whatever they want...

SUP 1: .... and then they refuse to engage in it.

*Limiting/enabling theme 3: quality of the plan and clinician involvement.* The quality of the plan and clinician involvement with service users in plan development was considered limiting/enabling factor to the consistent implementation of evidence based practices. Quotes indicated that a. the plans need to be of a length and language that is accessible to the support workers and b. the clinician needs to know the service user and provide support to those implementing the plan. To highlight:

SUP 7:...they wrote the plan from their history and we implemented.....just did not work and totally escalated them more.

SUP 11: they are too big and too hard to follow... one person's interpretation might be different from another one

*Limiting/enabling theme 4: staff ratios.* Staff to service user ratios were considered to limit/enable individualisation, with quotes indicating that staff ratios should be based on the needs of the individual. It was further indicated that low staff ratios can lead to reactive responses and not facilitative of outcomes for service users. To illustrate, it was stated:

SUP 5: A lot of our service users don't have the one-on-one funding, they are the ones that need the hours, they need one-on-one. We try to do something- we write up a plan of support for them to become independent or minimise anxiety or whatever it is. But there is never enough hours to put that in place.

SUP 1: ... you often have a house with four individuals in it and two support workers, what we would like to implement takes a lot more one-on-one than we are practically able to do. So you end up falling back a lot more on your reactive strategies than your teaching strategies, just from a practicality standpoint.

*Limiting/enabling theme 5: advocacy and empowerment.* Advocacy provided by staff or external advocates, and the empowerment of service users to understand their

rights, was identified by participants as limiting/enabling individualisation and service user choice and control. Participants said:

SUP 6: I think we need to consider advocacy and how we can get external advocates. There is one service user for instance who absolutely hates the work she is doing at the moment but her family members say that she has to work. They come up with all these reasons as to why... ultimately she doesn't want to do this job and it is finding... how do we then... advocate for her. Staff being advocates can be tricky.

SUP 8: ...gets frustrated because (he/she) doesn't know how to articulate, not even to an Adult Guardian. It will be a matter of us sitting down with (him/her) and saying- 'what do you want?'. What (he/she) is wanting is not what the Adult Guardian is approving... What I do then is read that back to the Adult Guardian.

*Limiting/enabling theme 6: interpretation of behaviour.* Participants from a number of agencies identified the interpretation of service users' behaviour to be limiting/enabling. It was indicated that often CB is attributed internally to the client, rather than to medical issues. As stated:

SUP 9: The things they miss is a genuine sickness.... it is something that we forget, that actually exacerbates (his/her) behaviour straightaway.

SUP 11: We have to make sure their health is fine because that could trigger all sort of reactions.

*External limiting/enabling theme 1: provision across lifespan.* A number of participants indicated service user previous service provision as limiting/enabling to outcomes. Specifically, the challenge to changing maladaptive behaviour patterns and mistrust for service providers was discussed. As stated:

SUP 7: A lot of guys (service users) think we are hiding things from them...

SUP 8:...and that is because historically that is what they have been led to believe. Whether it is here or where they came from... It has taken time to break down those barriers.

SUP 1: A lot of our guys... are in their 50s plus side they missed out on a lot of the intervention stuff back in the day...

SUP 2: ...so if hitting the car to dent it gets you a good outcome 44 years then it is really hard to change that behaviour. It's screaming or yelling gets you what you want for 44 years it is really hard to change that.

*External limiting/enabling theme 2: workforce issues.* A number of participants considered the small number of potential workers to impact on outcomes for service users.

SUP 1: It depends, see a lot of the time, and this is just being truthful, a lot of the time you have such a small pool to choose from that you just take the best if got.

SUP 2: I've had to re-advertise (for support worker positions)... you may have to do interview six of the best and then none of them are okay so you can re-advertise. People are waiting for service provision because you are just trying to find someone.

**Families/Carers.** Using the conceptual framework for quality as described in chapter two, analysis of the data identified one impacting and forming theme, nine meta-themes, and seven sub-themes. These are identified as significant to quality. In addition, seven limiting/enabling themes were identified. The limiting/enabling themes were categorised as internal to agencies, meaning that they are within agency control. The themes are listed in table 5.5.

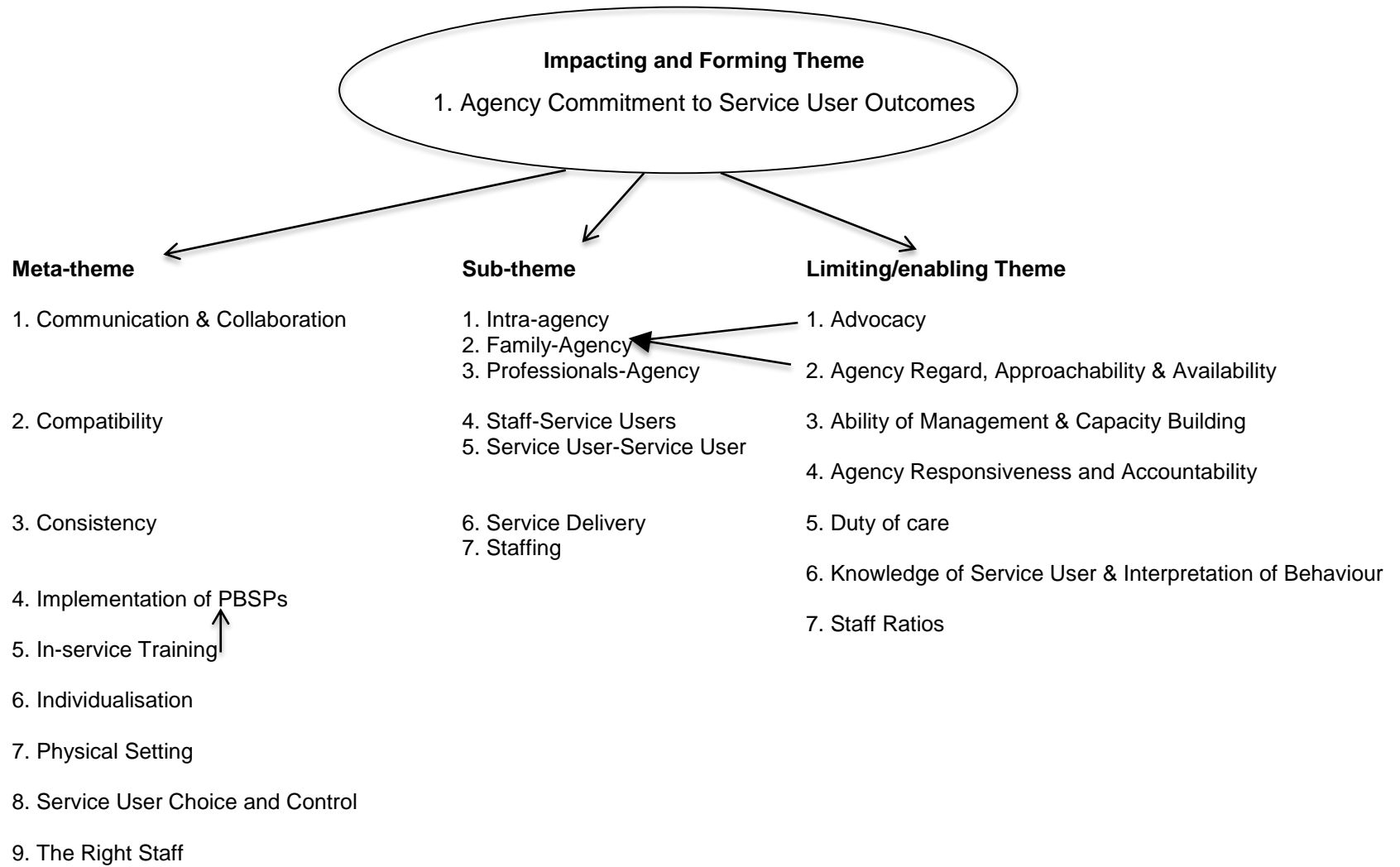


Table 5.5  
*Themes from Interviews with Families/Carers*

Impacting and Forming Theme	Meta-theme	Sub-theme	Limiting/enabling Theme
1. Agency Commitment to Service User Outcomes	1. Communication & Collaboration	1. Intra-agency	1. Advocacy
		2. Family-Agency	2. Agency Regard, Approachability & Availability
		3. Professionals-Agency	3. Ability of Management & Capacity Building
	2. Compatibility	4. Staff-Service Users	4. Agency Responsiveness & Accountability
		5. Service User-Service User	5. Duty of care
	3. Consistency	6. Service Delivery	6. Knowledge of Service User & Interpretation of Behaviour
			7. Staffing
	4. Implementation of PBSPs		
	5. In-service Training		
6. Individualisation			
7. Physical Setting			
8. Service User Choice and Control			
9. The Right Staff			

Figure 5.4 provides an overview of the interactive, impacting and formative relationships between the themes, with interactions depicted with lines and arrowed lines showing one-way directional impacts.

Figure 5.4. Interaction between themes from interviews with families/carers



*Impacting and forming theme 1: agency commitment to service user outcomes.* An overarching theme consistently identified by participants was the commitment of the service provider agency to achieving outcomes for the service user. It was indicated that some agencies were not service user focused and had a lack of capacity to achieving outcomes. Quotes related to this theme included the following.

FAM 3: They are truly person-centered... they are devoted to (him/her)

FAM 4: .. and to (his/her) quality of life

FAM 8: I don't think they should have offered to taken (him/her) on because they didn't have the training... I think they wanted to expand and they were looking for other people to join their service.. and (he/she) had a large funding package. It was best for the service, not for (him/her)

*Meta-theme 1: communication and collaboration.* Communication and collaboration within the agency, and between agencies, families and professionals, was identified as significant. These sub-themes are discussed sequentially.

*Sub-theme 1: intra-agency.* A number of participants identified communication and collaboration within agencies as significant to outcomes. A lack of communication and collaboration was considered to lead to missed medical appointments and confusion between support workers and other levels of staff. To highlight:

FAM 1: There regularly seems to be breakdown in communication between the various levels of the staff, the supervisor/ manager level and the direct care staff. It can lead to confusion at times.

FAM 2: ... often (he/she) might have to go to a GP appointment and whoever was on at the start of the week might know about it and they wouldn't book the appointment, they would leave it for the next person to do it and the next person wouldn't know anything about it. You'd find out a week or two later that she hasn't been to the GP or dentist.

*Sub-theme 2: family-agency.* All participants identified communication and collaboration between agencies and families as significant to service user outcomes, with participants indicating that some agencies did not respond to families or respect their input. It was said:

FAM 3: The agency involves us in everything. They want our input, they want the best for (the service user). They listen to us and want us involved.... we are part of the team.

FAM 9: When I go there I ask the question and they don't get back to me

It was indicated that communication and collaboration is limited/enabled by the extent to which families advocate for the service user (see limiting/enabling theme 1) and agencies 'trust' input from families, are approachable and available (see limiting/enabling theme 2).

*Sub-theme 3: professionals-agency.* A number of participants expressed the importance of having a collaborative relationship between the agency and professionals in sectors such as occupational therapy and psychiatry. Two participants indicated that a lack of collaboration was a result of agency resistance. As stated:

FAM 7: (that collaboration) doesn't occur here at all, unless you seek it of your own volition it doesn't exist...

FAM 8...everytime (he/she) sees the clinical psychologist she writes notes of suggestions of what could work better for (him/her) but I just think all these services it is about ticking the boxes and having the paperwork there. .... the professionals get very upset because they are same thing again and again but it is not being acknowledged or acted on.

*Meta-theme 2: compatibility.* The importance of compatibility was discussed by participants with reference to staff and service users and between service users attending services together or co-tenanting. These sub-themes are discussed below.

*Sub-theme 4: staff-service user.* The majority of participants identified the match between staff members and service users to be significant to service user outcomes. It was indicated that a poor match can result in CB. As indicated by two participants:

FAM 9: The workers are important because they are the one who make or break her because if (he/she) doesn't like a support worker (he/she) will have a CB, it's (his/her) way to tell me...

FAM 7: The individuals have to be able to get on with my son/daughter, there is no point having a clash of personalities

*Sub-theme 5: service user-service user.* Participants identified the match between service users to be important to outcomes. Compatibility was discussed with reference to motivating service users to achieve goals and incompatibility resulting in assault and inattention to the needs of individuals. To highlight:

FAM 9: The service (he/she) likes to attend, I think (he/she) would feel herself being part of the community and the group itself so (he/she) would be motivated to achieve (his/her) goals, there has to be compatibility.

FAM 6: (He/she) is incompatible with the other person he lives with. They live in the same house but totally separately. That is not a home.

FAM 3: At (a previous agency) the plans weren't followed.... he/she was constantly assaulted by the person he/she lived with.

*Meta-theme 3: consistency.* This theme reflected the importance of consistency in service delivery and staffing. These sub-themes are discussed below.

*Sub-theme 6: service delivery.* Consistency in the delivery of service and reliability for service provision, such as staff attending at the agreed time, was identified by a number of participants as significant. As stated:

FAM 10: I have arranged for somebody to be here with (him/her) and I have come home to find him alone, with no staffer! They don't show up!

FAM 11: They (the service provider) need to be accountable and consistent in their service, the standard of service.

*Sub-theme 7: staffing.* The majority of participants indicated continuity and consistency of staff members to be significant to service user outcomes. This is illustrated by the following verbatim quotes.

FAM 1: There is like a continuity in care staff. Residents are familiar with the staff and the staff are familiar with the residents. There are over 100 employees there but there are 3 or 4 with the odd casual. They have the small core that looks after each unit. For (him/her), (he/she) likes that.

FAM 2: Yes, that is a big thing for him/her because she doesn't like change.

FAM 1: That is one small thing that has led to good outcomes.

FAM 3: Some of the original people are still there so they have known (him/her) for 13 years... the consistency is what (he/she) needs and (he/she) has had that in a few of the people there... that is definitely important

*Meta-theme 4: implementation of PBSPs.* PBSPs were referred to by a number of participants. Poor implementation was considered to impact on service user outcomes, with a number of participants indicating that plans were not followed. To highlight:

FAM 8: With those agencies there was a behaviour support plan but they weren't followed. (He/she) ended up being locked up in the house and never went out.

FAM 10: ...none of the staff have ever even looked at it, they don't have time to look.... The information that we give is to an office but none of it is transferred to the person who is doing the actual caring.

Implementation of PBSPs was identified as being impacted by lack of in-service training in how to follow the plan (see meta-theme v).

*Meta-theme 5: in-service training.* In-service training was identified by a number of participants as significant to service user outcomes. Required training included diagnostic specific information, managing CB and implementing PBSPs. Quotes incorporated in this meta-theme is included the following.

FAM 8: The support workers need to have some training in looking after people like my (son/daughter). When it becomes more complex they need training in things like apsergers-some don't even know what that is....

FAM 10... staff didn't have the training to follow the (PBSP) plan.

*Meta-theme 6: individualisation.* Participants identified individualisation and the agency flexibility to the changing needs and desires of service user as important. A number of participants identified that a lack of individualisation contributes to CB. As stated:

FAM 3: The agency is flexible, as (his/her) needs change, so does the support.

FAM 7: With an ID not everyone is the same, their needs are different...

*Meta-theme 7: physical setting.* A number of participants whose family members lived in group homes identified the physical setting as significant. The physical setting was discussed in terms of meeting the needs of the service users, for example having space, and a 'homelike' environment. To illustrate:

FAM 5: (He/she) needs space where he can wander in the garden but (he/she) doesn't have that. We bring (him/her) home on weekends so he can have that.

FAM 2: It is set up like a normal home with a kitchen and lounge.... Yeah, they've got an outdoor dining table and inside. It is very homelike. I think that is how it should be.

*Meta-theme 8: service user choice and control.* Service user choice and control was identified by a number of participants as significant to service user outcomes. Most participants identified that inappropriate co-tenants and incompatibility between service users in day services reduced choice and control. As suggested:

FAM 10: (He/she) knows where (he/she) wants to live, in a larger facility with peers and (he/she) is not allowed.. (he/she) lived in a larger facility where... (he/she) had become independent.... (he/she) has lost all of those skills by being put in these small situations. (He/she) hates it and it does not work for (him/her)

FAM 2: Having choice over what they are doing is important, definitely. As long as someone is there to help them make good choices.

*Meta-theme 9: the right staff.* All participants considered the right staff to be significant to service user outcomes. Experience and qualifications were not considered necessary by the majority of participants. The qualities cited by the majority of participants as necessary for support workers was caring and commonsense. Other qualities included: nurturing; respectful; empathetic; ability to maintain disgression; and, having the 'right values'. Quotes related to this included the following.

FAM 6... they don't have to have any degrees or training, it has to be a caring and nurturing person and somebody who has the mentality to work out the needs of these people... they have to have commonsense

FAM 11:... people who are ordinary people and have a caring attitude or nature tend to get the best results. Definitely discretion, they also need to have empathy...

*Limiting/enabling theme 1: advocacy.* A number of participants identified that communication and collaboration with the agency was limited/enabled by them advocating for their family member. It was stated:

FAM 4: We bring (him/her) home on weekends so he/she can get washed properly... some of (his/her) hygiene needs are met that is only because of our involvement and pushing.

FAM 8: I communicate daily (with the agency), I don't know if they like it too much but I have to keep pointing out things that are going to lead to negative outcomes.

*Limiting/enabling theme 2: agency regard, approachability and availability.* Some participants indicated that a number of service provider agencies had mistrust for them, or did not treat them in a manner consistent with the legal guardianship they held. Further, that this was related to the approachability and availability of agency staff to families. Quotes highlighting this theme included the following.

FAM 10: When I would tell the caseworker something that had happened ... (the caseworker) would deny it ... The staffers at the meeting admitted that everything I had been saying was correct!

FAM 4: We can approach them if there are any problems and if they have problems with (the service user) they can approach us. Everything is very open.

*Limiting/enabling theme 3: ability of management and capacity building.* A number of participants identified the ability of management and their commitment to capacity building, such as through professional development, as limiting/enabling to outcomes. A number of families identified the management capabilities significant to outcomes for their family member as including leadership, teamwork and support from management. To highlight:

FAM 7: ... that is probably people being promoted into positions beyond their capability...

FAM 1: I think administration- they must have really wanted to provide a good service and they have delved into ways of doing this- going to seminars and things like that.

*Limiting/enabling theme 4: agency responsiveness and accountability.* The responsiveness of agencies and accountability to families and governing bodies was considered to be limiting/enabling to service user outcomes. Responsiveness was identified with regard to: the changing needs of service users; responding to complaints and feedback; advice from professionals and families; and, implementing programs. Participant quotes that highlighted this includes:

FAM 10: I went to pick (him/her) up early, the staffer was laying around watching television... out making personal phonecalls hidden behind a wall somewhere or sitting in (his/her) car listening to music... there is no accountability in the situations where there is one staffer.

FAM 11: They said about 6 months ago they were going to start up a music program... some weeks it is a hit or a miss, sometimes they might have a sing-a-long, but they haven't delved into like they had suggested 6 months ago...

*Limiting/enabling theme 5: duty of care.* Duty of care was identified as limiting/enabling to outcomes by a number of participants. For some participants, it was considered that agencies had neglected duty of care. However, other participants indicated that over-zealous duty of care resulted in limited outcomes. As stated:

FAM 5: Some are too risk adverse. (name deleted) is amazing... (our son/daughter) gets to do things (he/she) would never otherwise be able to do, like go to concerts.

FAM 10: ... there was a neglect of care, one of the residents did die. I picked up my (son/daughter) one day and (he/she) looked so ill, it turned out (he/she) had double pneumonia... none of the staff realised how ill (he/she) was... the doctor said (he/she) should be have been in hospital.

*Limiting/enabling theme 6: knowledge of the service user and interpretation of behaviour.* A number of participants identified knowledge of the service user and interpretation of behaviour as limiting/enabling to outcomes. It was indicated that these were inter-related, with some indicating a lack of knowledge of the service user often leading to inaccurate behavioral interpretations. As stated:

FAM 8: ... some of the workers come in and they think there is nothing much wrong with her and it leads to a terrible lot of outcomes that are not positive.

FAM 10: His needs, like putting him to bed early, but they take him out... they wondered why he/she was misbehaving- he wasn't getting his sleep...

*Limiting/enabling theme 7: staff ratios.* A number of participants identified staff ratios as limiting/enabling service user outcomes. The majority of these participants identified that higher staff ratios would increase outcomes. To illustrate, participants stated the following.



FAM 6: If there were better staff ratios there would be more community access

FAM 7: If there was more one-to-one support there would be better outcomes....

## Stage Two: Survey

**Participants.** The participants were eight advocates, 14 families/carers, 58 support workers, and 22 supervisors (N=102), as shown in table 5.6. The majority of all participants were female and the most common age group of all participants was 50-59. Most who worked in direct service delivery did so in accommodation services, with families/carers identifying accommodation and respite services as the most commonly used services by their family member. The location in which participants worked or their family member received services was predominately metropolitan/urban.

Table 5.6  
*Survey Participant Demographics*

	Advocates n=8	Family/Carers n=14	Support Workers n=58	Supervisors n=22
<b>Age</b>				
< 30	-	-	6 (10%)	4 (18%)
30-39	1 (7%)	-	7 (12%)	7 (32%)
40-49	2 (14%)	5 (36%)	9 (16%)	3 (14%)
50-59	5 (36%)	6 (43%)	22 (38%)	6 (27%)
60 +	-	3 (21%)	14 (24%)	2 (9%)
mode	50-59	30-39	50-59	50-59
<b>Gender</b>				
Female	8 (100%)	9 (64%)	38 (66%)	15 (68%)
Male	0 (0%)	5 (36%)	20 (34%)	7 (32%)
<b>Service</b>				
Accommodation Services	-----	6 (43%)	38 (66%)	17 (77%)
Respite Services	-----	7 (50%)	3 (5%)	3 (14%)
Community Support	-----	-	4 (7%)	1 (5%)
Community Access	-----	-	13 (22%)	0 (%)
Did not disclose	-----	1 (7%)	-	1 (5%)
<b>Service Location</b>				
Metro/urban	6 (75%)	12 (86%)	52 (90%)	20 (91%)
Rural Remote	2 (25%)	2 (14%)	5 (9%)	2 (9%)
Did not disclose	-	-	1 (2%)	-

**Measures.** Stage two was conducted using a survey (Appendix D). The survey was developed from analysis of the interview data. Accordingly, items were developed to address each of the sub-themes elicited from the interviews. The survey was submitted to a panel (n=9) comprised experts and families/carers of service users with ID to assess face validity. Minor changes were made to item wording and scale wording as a result.

The survey comprised four sections:

- **Section 1: Demographic questions.** All participants were asked four personal demographic questions. Participants were asked an additional 1-9

questions, dependent on stakeholder group, regarding their highest qualification and primary role in relation to the person with an ID and CB.

- **Section 2:** *Questions regarding the extent of contribution of factors to quality outcomes for service users.* Participants were asked to rate the extent to which 34 factors contributed to positive outcomes for service users. This was defined for participants as being increased quality of life, decreased frequency or severity of challenging behaviours and/or decreased use of restrictive practices. The factors were organised into relational categories (Keeney et al., 2011) of: communication and collaboration; compatibility; consistency; management practices; in-service training for support workers; and, other.

A five-point likert scale was used with response options of 0= unsure, 1= no contribution, 2= minor contribution, 3= moderate contribution, 4= major contribution.

- **Section 3:** *Questions regarding the impact of factors to quality outcomes for service users.* Participants were asked to rate the extent to which 24 factors impacted on the achievement of positive outcomes for service users, being increased quality of life, decreased frequency or severity of challenging behaviours and/or decreased use of restrictive practices. The factors were organised into relational categories (Keeney et al., 2011) of: staff, programs and practices; organisational; and, other.

A five-point likert scale was used with response options of 0= unsure, 1= no impact, 2= minor impact, 3= moderate impact, 4= major impact.

- **Section 4:** *Statements regarding strength of agreement with contingent relationships.* Participants were asked to rate the extent to which they agreed with five statements about contingent relationships.

A five-point likert scale was used with response options of 0= unsure, 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree.

**Sampling and recruitment.** The sampling and criteria for participation was the same as for stage one interviews. To recruit potential participants, a number of procedures were undertaken.

- The designated research contact within agencies that participated in the previous research (n=30) were sent an email with a link to the survey for distribution to potential participants. The stakeholder groups targeted through this recruitment process were families/carers, advocates, support workers and supervisors.
- Disability service provider networks were sent an email with a link to the survey for distribution to member agencies (n=119). The stakeholder groups sought through this process were advocates, families/carers, support workers and supervisors.
- CEOs of all advocacy agencies in Queensland (n=15) were sent an email with a link to the survey for distribution to potential participants. The stakeholder groups targeted through this recruitment were advocates and families/carers.
- The peak state-based carer body distributed information about the study and a link to the survey to potential participants through their website, ezine and social media sites, which include Facebook® and Twitter®. The readership of which was indicated as more than 3000 people.

- Snowball sampling, described above, was used to identify additional disability service provider agencies (n=2) who met criteria for inclusion. An email with a link to the survey was forwarded to the CEO for dissemination to potential participants,. The target stakeholder groups were families/carers, support workers and supervisors.

**Implementation.** The surveys were administered through SurveyMonkey with consent implied on participation.

**Analysis.** The data was analysed using SPSS 22.0. Descriptive statistics were reported with between group differences assessed using Fisher's Exact Test. This test was used as Chi Square assumptions were violated with expected counts less than five. Pairwise comparisons were made with items collapsed as significant/ not significant, or impacting/ not impacting to generate 2x2 contingency tables. Missing data was not included in analysis (Higgins et al., 2011) with casewise deletion undertaken when demographic information was completed but no responses were recorded (n=8).

**Results.** Analysis of the data indicated that all factors identified as associated with quality outcomes through the interviews were confirmed as important to quality through the survey. Table 5.7 lists these factors and shows the distribution. As shown in the table, each of the factors had a mean score of greater than three, which indicates the factor as making more than a 'moderate' contribution to quality outcomes for service users. The factor with the lowest mean score was 'communication and collaboration between the agency and other agencies or community groups' ( $\bar{x} = 3.09$ ,  $sd=.87$ ). The factor with the highest mean score was 'having the right staff' ( $\bar{x}= 3.81$ ,  $sd=.50$ ).

Table 5.7  
*Distribution of Factors Associated with Quality*

Factor	mean	sd	range
n=102			
<b>Communication &amp; Collaboration...</b>			
Between staff in teams	3.72	.57	2-4
Between families /carers and the agency	3.58	.68	1-4
Between levels of management	3.40	.77	1-4
Between the agency and other disciplines	3.33	.81	1-4
Between services provided to the same client	3.30	.90	1-4
Between the agency and other agencies or community groups	3.09	.87	1-4
<b>Compatibility...</b>			
Between staff working with the same client	3.65	.63	1-4
Between staff and clients	3.62	.65	1-4
Between staff and the setting where they work	3.48	.76	1-4
Between clients	3.46	.83	1-4
<b>Consistency</b>			
A consistent group of staff members	3.69	.64	1-4
Consistency in other practices and support	3.65	.67	1-4
Consistent implementation of PBSPs	3.64	.70	1-4
Consistency in delivering services	3.49	.74	1-4
<b>Management Practices</b>			
Role clarity, including PBSPs	3.66	.66	1-4
Case discussions and/or team meetings	3.61	.74	1-4
Flexible approaches to managing risk and duty of care	3.59	.65	1-4
Support for staff	3.54	.76	1-4
Leadership	3.53	.79	1-4
In-service training for support workers	3.53	.65	1-4
Flexibility with funding allocations	3.30	.90	1-4
Regular formal supervision meetings	3.22	.84	1-4
Effective financial management	3.10	.98	1-4
<b>In-service Training for Support Workers...</b>			
Specific to working with challenging behaviours	3.66	.66	1-4
Regarding the human rights of people with disabilities	3.57	.71	1-4
In understanding specific disabilities	3.56	.66	1-4
To meet OH&S requirements	3.40	.75	1-4
<b>Other</b>			
Having the right staff	3.81	.50	2-4
Individualised support	3.74	.60	1-4
A supportive staff-service user relationship	3.74	.49	2-4
The physical setting	3.67	.60	1-4
The client has choice and control	3.53	.74	1-4
Clients are supported to develop relationships with people in the community	3.46	.73	1-4
Physical resources	3.42	.79	1-4

Scale: 0=unsure, 1=no contribution, 2=minor contribution, 3=moderate contribution, 4=major contribution

Analysis of the survey data also confirmed that the impacting factors extracted from the interviews were rated as important factors. As shown in table 5.8, all factors attained a mean ranking of greater than three, indicating the factor as at least 'moderately' impacting on outcomes. The impacting factor with the lowest mean score was 'the Adult Guardian regularly consults with client' ( $\bar{x} = 3.03$ ,  $sd=.98$ ). The factor with the highest mean score was 'values and framework' ( $\bar{x} = 3.80$ ,  $sd=.49$ ), which specified the values and framework of the agency and staff.

Table 5.8  
*Distribution of Factors Impacting Quality*

Factor	mean	sd	range
n= 102			
<b>Staff, Programs and Practices</b>			
Accurate interpretations as to the functions of challenging behaviours	3.78	.49	2-4
Empowering clients	3.77	.50	2-4
Sufficient staff to client ratios	3.77	.52	2-4
In-depth understanding of client	3.75	.53	1-4
Advocating	3.73	.56	1-4
Honesty and honest feedback	3.72	.52	2-4
Having a long-term outcome focus for clients	3.69	.60	1-4
Staff turnover and stress	3.59	.73	1-4
Management capability and skills	3.56	.71	1-4
<b>Organisational</b>			
Values and framework	3.80	.49	2-4
Agency commitment to client outcomes	3.79	.51	1-4
Screening of staff	3.73	.61	1-4
Respect and regard for families	3.67	.64	1-4
Agency regard as employees of the client	3.64	.77	1-4
Responsiveness & accountability	3.62	.62	2-4
Agency's commitment and capacity for quality improvement	3.56	.70	1-4
Complaints mechanism & redress	3.48	.72	1-4
Fidelity to agency mission & policies	3.46	.74	1-4
<b>Other</b>			
PBSP author knows the client and is contactable	3.64	.73	1-4
Community regard for clients	3.53	.79	1-4
Quality of the PBSP	3.49	.65	2-4
PBS incorporates functional assessment of behaviour and Applied Behaviour Analysis	3.47	.75	1-4
The agency refers clients to better meet need	3.38	.93	1-4
The Adult Guardian regularly consults with client	3.03	.98	1-4

Scale: 0=unsure, 1=no impact, 2=minor impact, 3=moderate impact, 4=major impact

In addition to these factors, 'external agency support workers '(fill-in staff) and 'labelling' was identified as impacting service user outcomes. Table 5.9 shows the contingent relationship statements and the percentage agreement/ disagreement with these statements. As shown on this table, 'external support workers' and 'labelling' achieved consensus, with  $\geq 75\%$  respondents in agreement.

Table 5.9  
*Percentage Agreement with Factor Relationship Statements*

Statement	% of p's rating 1 & 2	% of p's rating 3 & 4
	n=102	
Too much support can limit client outcomes	42	58
Small agencies achieve better outcomes for clients	51	49
<i>Labelling a client can limit expectations</i>	24	76
Qualifications and experience is not as important as personal qualities	32	68
<i>Using external agency workers negatively impacts outcomes</i>	22	78

Item scaling: 1= strongly disagree, 2= disagree, 3= agree, 4= strongly agree  
 Items in italics denotes statement attained consensus ( $\geq 75\%$  participants rating 3 or 4)

Between group analysis for contingent factor relationships identified a significant difference for the statement 'having too much support can limit client outcomes'.

Significant differences was found between the support worker and advocate groups  $c^2(1, N = 49), p = .015$  and between the family/carer and advocate groups  $c^2(1, N = 16), p = .034$ . This statement was rated higher by advocates ( $\bar{x} = 3.43, sd = .53$ ) than support workers ( $\bar{x} = 2.38, sd = .94$ ) and families/carers ( $\bar{x} = 2.44, sd = .88$ ).

No factors beyond those included in the survey were identified through qualitative analysis. 29 responses were recorded with 90% (n=26) replicating factors included in the survey.

## Summary

This chapter has described the participant demographics; method of data collection; procedure; analysis; and results, for each stage of study two. Through stage one interviews the processes and practices that agencies should adhere to in order to provide quality services were identified. Those established by all groups included practices such as individualisation and hiring support workers that demonstrate faculty for empathy and commonsense. Factors that impact on agencies' capacity to adhere to these processes and practices were also identified, with those indicated by all groups including staff ratios and screening of staff. An important outcome of this study was the distinction of a number factors as formative to agencies in provide quality services. These related to the values and framework of the agency and the primacy of the service user in the provision of service.

Stage two entailed assessment of factors through survey. The results indicated 34 factors as associated with quality service provision and 26 factors as impacting quality service provision. There was consistency of stakeholder groups in rating the contribution

and impact of factors to quality service provision. The outcome of which shows stability of factors, while also highlighting the complexity of high quality service delivery.

## Chapter Six: Study Three Method and Results

Study three involved data collection through focus groups with service users with ID and CB. This chapter describes participant demographics, method of data collection, procedure and analysis, and presents the results.

### Participants

The participants were 14 service users with ID and CB. As shown in table 6.1, the average age of participants was 33 years and the majority were female. Participants' level of support needs, adapted from the Support Needs Intensity Scale (Schalock & Verdugo, 2012b), ranged from requiring assistance to complete most daily tasks to requiring infrequent assistance or supervision for daily living.

Table 6.1  
*Service User Demographics*

	Service Users n=14
<b>Age</b>	*
< 30	5 (42%)
30-39	4 (33%)
40-49	-
50-59	3 (25%)
60 +	-
$\bar{x}$	33
<b>Gender</b>	
Female	8 (57%)
Male	6 (43%)
<b>Level of Support Needs</b>	
1 = requires total support & intense supervision for all aspects of daily life	0
2 = requires extensive personal and/or constant supervision	0
3 = requires assistance to complete most daily tasks	5 (36%)
4 = requires minimal assistance & supervision to complete some tasks	5 (36%)
5 = requires infrequent assistance or supervision for daily living	4 (29%)

\* n=12, 2 unknown

All participants engaged in CBs with a number engaging in multiple types. The types of CB described by support workers or supervisors were: self-harm; inappropriate sexualised behaviours; physical aggression; verbal aggression; and defiance. Table 6.2 shows the frequency and severity of these behaviours, with the largest number of participants engaging in physical aggression and the most frequently occurring as verbal aggression and defiance. The highest rated severity of CB was physical aggression and inappropriate sexualised behaviours.



Table 6.2  
Service User Challenging Behaviour Classifications

	Self Harm n=3	Inappropriate Sexualised Behaviours n=1	Physical Aggression n=10	Verbal Aggression n=8	Defiance n=3
<b>Frequency</b>					
Less than once a month	2		5	1	
1 to 3 times a month		1	3	2	2
1 to 5 times a week	1		2	2	
Once a day or more often				3	1
<b>Severity *</b>					
$\bar{x}$	3.3	3.5	3.5	2.8	3.3

\* 1= not at all a problem, 5= an extremely serious problem

## Protocol

To explore service users' perceptions of what constitutes quality service provision (research question two), a semi-structured protocol was developed for the focus groups. To ensure that critical elements of service provision relevant to people with ID were incorporated, the subscales of the life satisfaction scale, developed by Bergstrom et al. (2013), were used as a framework. The subscales of this measure are housing environment, life, meals and recreational activities.

The semi-structured protocol had two components. The first component incorporated seven questions and subsequent probing questions (Appendix E). The questions were open-ended to reduce acquiescence, which has been identified as a barrier to interviewing people with ID (Bergstrom et al., 2013; McGlaughlin et al., 2004). Pictures were shown to participants to provide focus for each open-ended question (Gates & Waight, 2007).

The second component incorporated five video-recorded skits and open-ended questions (Appendix F). Video-recorded skits were used as this has been shown to reduce discomfort and provide focus when interviewing people with ID (Cunningham, McDonnell, Easton, & Sturmeay, 2003; Gates & Waight, 2007; Ramcharan et al., 2009). Of the five skits, two reflected benign elements of daily life, such as having receiving assistance to make a cup of tea. Three skits were more dynamic, with two involving CB, to elicit an understanding of service provision from the perspective of people who engage in CB.

The focus group protocol was submitted to an expert panel (n=4) for assessment of face validity, applicability and appropriateness. This panel constituted two advocates who had provided services to people with ID and CB, and two persons with experience in conducting focus groups with people with ID and CB. Minor changes to the wording of a number of questions were undertaken.

## **Sampling and Recruitment**

A purposive sampling procedure was used to recruit participants. Accordingly, specific criteria were used to identify participants who have may have information relevant to the research question (Guarte & Barrios, 2006; Silverman, 2000). The criteria was that the person (a) accessed government funded specialist services in Queensland, (b) had a diagnosis of ID, (c) engaged in behaviours that seriously jeopardised their safety or others, or resulted in significant limitations in access to ordinary community facilities, (d) could meaningfully participate in group discussion, and (e) had good expressive and receptive communication skills (as suggested by Barr, McConkey, & McConaghie, 2010; Cambridge & McCarthy, 2001; Hoole & Morgan, 2011).

Recruitment was conducted through the five service provider agencies who participated in stage one of study two. These agencies were utilised as they had been identified as having the highest proportion of service users with ID and CB. Gatekeeper approval was provided by the CEOs or ethics committees of these agencies, and participants who met the criteria were identified.

## **Implementation**

The number of participants in the focus groups ranged from two to four. In conducting focus groups with people with ID, size varies from two to nine (Clayton, 1997; Hsu & Sandford, 2007; Ramcharan et al., 2009; Scheibe et al., 2002). However, participant numbers were reduced to four due to sensitivity of the topic and depth of data required (Berg, 2007; Gates, 2011).

A number of participants indicated that they did not wish to participate in a focus group but were willing to be interviewed. For these participants, the focus group question protocol was used. The utilisation of the video-recorded skits was dependent on the cognitive and communication capacity of the service user. For example, the skits were not used for those who had capacity and inclination to engage in meaningful conversation with the researcher.

The focus groups and interviews were conducted within an environment where the participants were familiar, such as their homes and respite centres, in order to maximise comfort and enable participants to talk freely (Gates, 2011). In focus groups, only participants who knew each other were grouped together to further facilitate open discussion (Linstone & Turoff, 2002). Participants' support workers were at the location where the focus groups were conducted, and their presence during the focus group was dependent on the needs of the service users. From the participant responses, support

worker presence did not hinder participants openness to share positive and negative experiences of service provision, rather where support workers were actively involved in the focus group or interview they provided assistance to the researcher by rewording questions to suit the cognitive and communicative capacity of the participants. In addition, they aided the researcher to understand the dialogue provided the participants where the researcher has difficulty understanding specific words used the participant.

The focus groups and interviews were audio-recorded and transcribed, to assist in data analysis. Audio-recording was deemed the most appropriate method for recording as videotaping is considered more intrusive to participants. Video-taping participants inherently increases the formality of a session, thereby decreasing the likelihood of 'natural' discussions taking place (Macnaghten & Myers, 2004).

To minimise potential for causing distress to participants, a pre-consultation discussion was undertaken. The aim of this was first, to develop a rapport with the participant prior to interview and second, to conduct a brief interview with a person who knew the participant well (J. Slingsby, personal communication, February 2, 2014; Tassé, Schalock, Thompson, & Wehmeyer, 2005). The purpose of the interview was to identify (a) potential topics that may cause distress, (b) how the person communicates distress, boredom, frustration, anger and how to proceed if this occurred, (c) how to recognise if the person wishes to cease participation, (d) the ideal length of the focus group/interview.

Participant 'willingness to participate' was ascertained by having a staff member read and explain the research using an easy-access information sheet (Boyden et al., 2012; Gates, 2011). Formal consent was then gained from the participant's guardian or decision maker or from participants who had the capacity to consent, using an easy-access consent form (Boyden et al., 2012). Where formal consent was gained from a guardian or decision maker, participants signed an easy-access assent form, which provides informal consent. During the conduct of the focus groups, participants were reminded that they could withdraw at any time. Participants were told at the commencement of the focus group or interview and after each break that they 'don't have to keep talking' and asked if 'they would like to stop or continue talking' (McGlaughlin et al., 2004). No participants withdrew, however, one participant indicated they wished to cease the interview and continue on the next day.

A potential limitation to implementation was participant aptitude to understand the questions asked. Comprehension was aided by the focus group protocol which incorporated pictorial and video prompts and cues. However, participant understanding of the questions was informally assessed based on their responses to questions and where

required, the interviewer scaffolded questions. For example, if a participant did not respond to the question, 'what do you do during the day?', the interviewer asked, 'what did you do yesterday?' and 'what will you do tomorrow?'. The interviewer then referred to these activities specifically to discuss what they liked or do not like about doing those activities.

### **Analysis**

The data was analysed using the same coding strategy adopted for study two interview data. In brief, NVivo 10 Data Analysis Software Package was used and broad-brush followed by concept coding was undertaken.

### **Results**

Consistent with study two interview data, themes were established by grouping together alike data and categorised as meta-themes and sub-themes (Auerbach & Silverstein, 2003; Ezzy, 2002). Sub-themes were classified as individual meta-themes where they could not be grouped with other related units into a meta-theme. Analysis of the data identified eight meta-themes and 19 sub-themes, as shown in table 6.3.

Table 6.3  
*Themes from Interviews and Focus Groups with Service Users*

Meta-theme	Sub-theme
1. Consistency	1. Practices and Routines 2. Staffing
2. Complaints Mechanisms and Redress	
3. Daily Living	3. Cleaning 4. During the Day 5. Food/Cooking 6. Choice and Control of Daily Living
4. Family	
5. Friends	7. With other Service Users 8. In the Community 9. Staff as Friends
6. Housing Environment	10. Pets 11. Living Alone Vs. Co-tenancy 12. Compatibility with Co-tenants 13. Choice and Control of Housing Environment
6. Restrictions	14. Locked Doors 15. Restricted Access to Objects/ Food
8. Staff	16. Staff Attitudes 17. Staff Ratios 18. Staff Qualities 19. Supportive Relationships

**Meta-theme 1: consistency.** This meta-theme reflects the importance of consistent implementation of practices and routines, and consistency of staffing. These sub-themes are discussed sequentially.

**Sub-theme 1: practices and routines.** A number of participants discussed the need for consistency in practices and routines. This was discussed with reference to the how, what and when of daily living including cooking, shopping and personal care, and of day service programming. To highlight:

Interviewer: What didn't you like about that worker?

SU 7: They used to have different ways of doing things with me.

SU 6: I like the program (day service) mostly... I like it when they are organised and we know that on Monday we do this-on Tuesday we do this, and so on. What I don't like is when something gets changed...

**Sub-theme 2: staffing.** A number of participants conversed about consistency of staffing, indicating that having inconsistent staff can be challenging. For example:

SU 12: Sometimes I just don't feel that comfortable... With all of them. I don't feel comfortable with heaps of staff.

SU 6: ... so we are probably going to get relief staff and nine times out of 10 they don't know you from a bag of salt. It can be pretty full on.

**Meta theme 2: complaints mechanisms and redress.** Participants were asked 'who can you tell if you don't like what's happening?'. Nearly all participants expressed they could tell staff, with approximately half specifying the supervisor or coordinator. However, some of the participants who suggested they could tell staff also indicated that they would not tell them, didn't know their name, or found it difficult to "get in touch" with the person. To highlight:

SU 11: (name deleted) at the office. I've been trying to get in touch with her too but she doesn't call back.

SU 1: Can tell the supervisors here or the staff here.

Interviewer: Would you do that?

SU 1: No.

Some participants who indicated staff as someone they could tell if they didn't like what was happening, also suggested they could tell their mother or doctor.

With regard to redress, a number of participants indicated that there were responses to complaints, with others indicating there was no redress. As stated:

SU 6: If I don't get it I go to the supervisor and say look – this didn't happen. She then gets onto whoever it was that should have.... and she normally gets back to me and says that that happened for such and such a reason and...

SU 13: I tell everybody, the staff, but they have no bother.

**Meta-theme 3: daily living.** Many elements of daily living were discussed by participants. This included cleaning, what they did during the day, and food and cooking.

**Sub-theme 3: cleaning.** A number of participants discussed having to do cleaning at their residence. For some, this was part of their 'during the day' activities. A number of participants identified that they did not like doing chores, or considered that there were 'too many'. To highlight:

Interviewer: What type of things do you do during the day?

SU 10: House work.

SU 2: too many chores.

Interviewer: is doing some chores okay?

SU 2: Yeah

**Sub-theme 4: during the day.** All participants were asked what they do during the day. The responses related to supported employment, day service and non-centre based undertakings, termed 'other' below.

- **Supported employment.** Two participants indicated that during the week they worked at a supported employment service run through a disability service provider agency. They both indicated that they were contented with their work, with one stating that he/she 'liked' it. These participants identified recreational activities they did on the weekends as including shopping, bowling, barbecues in a park and football or bowling.
- **Day service.** Five of the participants identified day service as what they do during the day. Activities discussed included art, movies, sports, cooking, singing, and riding bikes. For a number of participants, they enjoyed the social aspect of attending a day service.
- **Other.** Half of the participants did not identify daily living as incorporating day service or employment. These participants indicated that they spent time at home doing activities such as cleaning and watching television, with the majority also indicating that they also spend time in the community doing activities or shopping.

**Sub-theme 5: food/ cooking.** The majority of the participants indicated that they liked the food at their residence. Terms used to describe the food included 'good', 'like it', and 'pretty okay'. In addition, the majority of participants expressed that they 'sometimes' participated in cooking. Participants who expressed dissatisfaction with the food were those who were not allowed to participate in cooking. As stated:

SU 13: No, a lot of onion and shallot... we want to cook it properly.

SU 12: It's like a dogs breakfast

**Sub-theme 6: choice and control of daily living.** This sub-theme relates to choice and control of 'during the day', food/cooking, and daily living routines.

*Choice and control of 'during the day'.* The majority of participants indicated that they 'liked' what they did during the day. Most participants in supported employment indicated satisfaction with work. With regard to day service, the majority identified a number of activities that they would also like to participate in. This is highlighted in the following quotes.

SU 6: .... I would really love if we could get Facebook.... It just means that in the day centre we can't keep in contact, we can't Skype our friends and things like that.

Interviewer: Are there other things that you would like to do?

SU 7: No.

Interviewer: What about swimming. Would you like to go swimming?

SU 7: Yeah!

For those who undertook 'other' activities during the day, the majority did not indicate that there were activities that they would prefer to do, or were happy with the frequency in which activities were undertaken.

*Choice and control of food/cooking.* The majority of participants indicated that staff decided when it is time to eat. Those that indicated when it is time to eat as their choice did not live in group homes. A number of participants expressed that they would like greater choice and control. To highlight:

SU 12: Yeah, what time you have to have breakfast, what time you have to have the medicine

Interviewer: That is what you don't like?

SU 13: Yes!

SU 12: Yeah!

Two participants indicated that what they eat/ drink is their choice. Of the rest, approximately half indicated that this was a supported decision, meaning they were able to choose from a number of options. The other half suggested that they had no choice and control over their meals/drinks, with a number expressing wanting to have choice and control, as indicated in the following conversations.

SU 4: I love a cup of coffee with sugar.

Interviewer: And do you get to have a cup of coffee with sugar?

SU 4: No... (it makes me feel) mad.

SU 12: Sometimes you get sick of having the same food all the time... That's one of the reasons why I would like to be more independent

SU 13: Yeah, like at home, and do what we want to do- make decision by our self.

*Choice and control of daily living routines.* A number of participants discussed choice and control over daily living routines. Participants from one residence discussed having no choice and control over aspects of daily living, such as being allowed to enter the kitchen and when to shower. Participants in other agencies also discussed choice and control over daily living routines, such as when to shower or whether to shave. To highlight:

SU 9: I shower every night and morning.

Interviewer: Is that your choice?

SU 9: No staff's choice

SU 10: (In my house) it's my choice

SU 1: ...yes I have (had arguments with people) here. Even this morning... because I did not want to have a shave.



All participants who discussed having a lack of choice and control in daily living routines lived in group homes.

**Meta-theme 4: family.** The majority of the participants discussed their family, with all indicating that they enjoy spending time with family members. Some participants communicated with family every day while others indicated they visited their family on occasions such as Christmas, birthdays and Easter. As stated in interview/focus groups:

Interviewer: How do you feel when you see them?

SU 2: Happy! (We go to) soccer game.. family grills

SU 5: Enjoy it. (I see them) every week, at choir... (I'd like to see them) more. I really want to go to their house.

**Meta-theme 5: friends.** Friends and friendship groups were discussed with reference to being friends with other service users, with people in the community and with staff. These sub-themes are described below.

**Sub-theme 7: with other service users.** The majority of participants identified their friends as service users with whom they currently lived with, or currently attended day services with. A number of participants also named people from school, previous day services, or previous co-tenants as their friends. However, while indicating these people as friends, most suggested that they no longer had contact with them. To highlight:

SU 9: (I met them) at the workshop I went to once. I went in the bus there, they picked me up and take me there. I don't see them anymore because I don't go to (name deleted) anymore.

Interviewer: How does it make you feel that you don't see them anymore?

SU 9: Upset.

SU 4: Yeah (I have a friend that doesn't live here.

Interviewer: How did you meet?

I Do you have some friends that don't live here?

SU 4: In school.... No (I don't see her anymore)

**Sub-theme 8: in the community.** Only two participants spoke about friends in the mainstream community. Both had met friends through a community group which partners volunteer support persons with people affected by mental health issues. One also referred to meeting friends through other community organisations and church, and the other from community activities such as catching the bus.

**Sub-theme 9: staff as friends.** A number of participants identified staff as friends, with one indicating his supervisor as his girlfriend. To highlight one participant said:

SU 14: He is my support worker and I love him by the heart... Friend, and I love him.

**Meta-theme 6: housing environment.** All participants talked about their housing environment. This was discussed with reference to having pets, their living arrangement, and with co-tenancy. These sub-themes are discussed below.

**Sub-theme 10: pets.** None of the participants living in groups homes had pets, however, the majority of participants who lived alone did. These participants identified having a pet as positive and enjoyed feeding and caring for their pets. To highlight:

Interviewer: How does it make you feel that you can have a cat at your house?  
SU 7: Warm and fuzzy.

Interviewer: Are there some things at your house that you really like?  
SU 10: Yeah. (Name deleted) that is from RSPCA.

**Sub-theme 11: living alone vs co-tenancy.** A number of participants lived alone. The majority of these participants had experienced living in group homes and preferred living alone. As stated:

SU 6: First of all I lived in the house with four people and I just didn't cope with that at all.... for three and a half years I was in the house... Yep, (I like having my own unit), very much so!

Interviewer: How does it make you feel to live by yourself?

SU 7: Good!

Interviewer: Did you like living with other people?

SU 7: No!

**Sub-theme 12: compatibility with co-tenants.** The majority of participants lived in group homes. The majority of these participants expressed that they did not like living with the people they co-tenanted with. While a number of participants indicated co-tenants as friends, all participants living in group homes indicated that they had experienced fighting/arguing and physical assault as either victims or perpetrators. Participant quotes included the following.

SU 12: Yeah one of the clients throws chairs, she hits and all that stuff.

SU 13: Yeah, many time she beat me... broken nose... one time before I went to get an x-ray and all the time watching.

SU 9: (Living with another person is) not good. Not with (name deleted) because he/she fights with me. He/she fights with me about staff, he/she will tell staff off. He/she slams the gate and scares me.

Participants also identified a lack of feeling safe and a lack of safety for their possessions, such as DVDs and games. To highlight:

Interviewer: Do you feel safe here?

SU 3: not when (name of co-tenant deleted) has a bad blow.... (I feel safe in my room) if he/she doesn't smash it down

Interviewer: Do you get along with (co-tenants name deleted)?  
SU 8: Not all the time, not if he/she goes in the (my) bedroom... He/she has gone in there and taken a couple of DVDs from my room and when the door is locked he/she has taken other things as well.

The participants who lived in their own home but had previously lived in group homes discussed problems with co-tenancy. For one participant this incorporated repeated acts of violence.

SU 6: First of all I lived in the house with four people and I just didn't cope with that at all.... for three and a half years I was in the house... (*Discussed experiences of violence from co-tenant*)...

Interviewer: So you didn't feel safe with the people that you lived with?

SU 6: yeah not with (service user name deleted)

Interviewer: Did you like living with other people?

SU 7: No.... sometimes it was a bit heavy

**Sub-theme 13: choice and control of housing environment.** A number of participants living in group homes indicated that they did not have choice and control over whom they lived with or where they lived and they wanted this choice. Quotes that indicated this included the following

SU 9: I can't move!. I don't like (names of co-tenants deleted) and there are 5 people in the units.

SU 12: I would like to move out of here because it's been too long in this type of place, it is not suitable for me, this is like a place for bad behaviours and I don't have bad behaviours... I don't mind (where or with whom) but just not like these people. These ones are getting too much, I've been here too long, I just have to watch and put up with.

**Meta-theme 7: restrictions.** This theme refers to restrictions experienced within residences. Restrictions were discussed in terms of locked doors and access to objects and food. These sub-themes are discussed below.

**Sub-theme 14: locked doors.** Participant discussion of locked doors referred to: the staff office within their residence; the front door; and, bedroom doors for which only staff have a key. The majority of the participants did not speak positively about these practices. To highlight:

Interviewer: So is your front door locked?

SU 14: Yes... (I feel) unhappy about that.

SU 13: They shut the door all the time (to the bedrooms) and they will open it for you!

Interviewer: Do you have a key?

SU 13: No!

**Sub-theme 15: restricted access to objects/ food.** The majority of participants discussed restricted access to knives, with others discussing restrictive access to food. The majority of the participants clearly expressed that they were happy or unhappy with these practices. The others' responses were more equivocal, however, indicating that they were understanding of why access was restricted. As stated:

SU 6: I am not allowed any knives. I can understand where they are coming from, for the safety of me but sometimes it would be nice to have a knife so you can cut your veggies, but I've got to have support.

SU 8: It's alright... I know there are good reasons that they are locked up for.

Of the participants who gave unequivocal responses, half considered restricted access to be appropriate. 'Comfortable', 'good' 'happy' 'alright' and 'safe' were terms used to describe their feelings towards restricted access to objects. Similarly, half of the participants who gave unequivocal responses identified restricted access as making them feel 'uncomfortable'. Quotes that indicated this included the following.

SU 2: feels good, the rules, people break the rules all the time... people get murdered and it is not good.

SU 12: I just don't feel that comfortable

**Meta-theme 8: staff.** This meta-theme includes quotes related to staff. In reference to staff, the sub-themes related to staff attitudes, staff ratios, staff qualities, and supportive relationships. These are discussed below.

**Sub-theme 16: staff attitudes.** The participants who talked about staff attitudes discussed that some staff could be antagonistic, incredulous and dishonest. They said:

SU 14: They think I am a brat.

SU 11: ... (one support worker was) lying to (the other support workers) what he did wrong. They didn't believe me (about) what was happening

**Sub-theme 17: staff ratios.** A number of participants indicated that one-on-one time with workers was significant to them. All of these participants lived in group homes. To highlight:

Interviewer: did you like him spending time with just you?

SU 3: Yep. Like today. .... we went to do a few things like go to the meat shop

SU 8: Sometimes we play monopoly together but not all the time... it doesn't happen that often.... it's only on night shift, it's only when (the co-tenant) goes to bed that I can actually play.

**Sub-theme 18: staff qualities.** The majority of participants indicated that the attributes of their favourite staff members included being: kind and talking 'right'; honest and respectful; and helpful and understanding.

SU 4: She is a kind person... They talk right and lovely to get to know

SU 11: Well (the way they talk) is getting better... When they talk cranky and mean it makes me think they are acting like my father way, my old man.

SU 2: They are honest with me.

SU 5: They are respectful

SU 7: The understanding. Helpful. Kind. That's about all.

SU 5: Too rush-full

**Sub-theme 19: supportive relationships.** While a minority of participants identified staff as friends, the majority of participants identified their relationships with staff as important. Aspects of the relationship that was identified as important included: doing individualised activities, helping with daily living and listening. These are discussed below.

- Individualised Activities

When discussing supportive relationships with staff, the activities that were commonly referred to included playing games such as monopoly. It was said:

SU 5: ... She's fun. she takes me places.... To places. To the shops.

SU 8: Sometimes we play monopoly together but not all the time.

Interviewer: Would you like more time when you and the worker can play monopoly?

SU 8: Yeah- but it doesn't happen that often.

- Helping

Participants indicated that they enjoyed it when staff helped them with the things they wanted help with. As stated:

SU 3: we always do things together, he always fixes my hard drive and put things on it .... she helps me clean up my room and the folding, I try my best.

SU 9: They help me with my dinner and my shower... They are kind (if) they do the internet for you.

- Listening

A number of participants indicated a supportive relationship as encompassing being listened to.

SU 1:... I can tell her about how I play with my Lego and how I play Bladestone.

SU 11: What (support worker's name deleted) is doing now. Listening to me.

## **Summary**

This chapter has identified the participant demographics; method of data collection; procedure and analysis; and the results of study three. The results indicated experiences of service provision as related to eight distinct aspects, being: consistency; complaints mechanisms and redress; daily living; family; friends; the housing environment; restrictions; and, staff members. Consistently discussed with regard to a number of these aspects of service provision was the desire for choice and control.

## Chapter Seven: Review of Findings and Discussion

This chapter provides a review of the findings and discussion. First, the research aim, intent and approach are discussed and overall results provided. Second, the requirements for quality service provision for people with ID and CB and the elements that impact the operationalisation of quality are discussed. Last, these requirements and impacting elements will form the basis for a model of quality service provision, with ensuing discussion of the various levels of its elements.

How people with ID and CB are supported through service provision has a primary role in addressing the disenfranchisement experienced by this cohort. Therefore, this research aimed to identify the elements within service delivery that could instigate quality provision for people with ID and CB. The intent of the research was to develop a model of quality service provision that could be used by service provider agencies and other stakeholder groups to appraise and achieve quality provision of service.

Research in the literature regarding service provision indicated a number of factors associated with quality. However, past research had not explored the comprehensiveness of these factors nor assessed the applicability to services specifically designed for people with ID and CB within the current socio-political environment. Further, the subjective experiences of service provision for people with ID and CB had not been investigated to any significant depth.

This research explored perspectives of quality service provision and experiences of service provision at multiple levels. Perspectives of quality provision of service were sought from CEOs and managers of service provider agencies, clinicians and senior practitioners, support workers and supervisors working in agencies, families/carers and advocates. Additionally, experiences were gained from service users with ID and CB.

Overall, the results indicated that quality service provision incorporated operations relating to staff relationships with service users, and service user relationships with others; management practices; individualisation; in-service training; consistency of staff and practice and support; service user choice and control; and the measurement of outcomes and outputs. Further, the results specified that quality is formed by a number of agents, which include: agency commitment and capacity for quality improvement; commitment and capacity to measure and outcomes/outputs; and their commitment to achieving good outcomes for clients. Other agents indicated as formative to quality were the values and framework of the agency and staff, agency regard as employees of the service users and client referral to other agencies.

It was found that there was a high degree of consistency between service user experiences of service provision and the opinions of staff, advocates and families. In terms of similarities, the requirements for quality services related to the desired qualities of staff, appropriate organisation of staff, and the need for supportive staff-service user relationships. Additional similarities included the requirements for individualisation of services, service user choice and control, consistency in service delivery, and physical settings facilitative of client need. The differences between experiences and perspectives related to organisational factors such as in-service training, staff values and organisational culture. These differences were viewed as a factor of the distance from direct service delivery, with service users directly experiencing services, and others being further removed. Organisational factors, such as in-service training, were not discussed by service users, indicating that these are not elements of service delivery experience.

There were also a number of differences between stakeholder groups who provided perspectives of quality service provision. These differences are highlighted in the ensuing sections which discuss the results in the categories of quality forming agents, process and procedural elements, resources and raw materials (the input factors), and service user outcome/agency productivities, (the output/outcome factors). To illustrate differences between the perspectives, support workers, supervisors, families/carers and advocates identified as significant the support needed for service users in developing friendships with people in the community. This, however, was not identified by provider CEOs, managers, clinicians and senior practitioners as an important factor.

### **Requirements for Quality Service Provision**

Identification of the factors internal to service provider agencies enables analysis and discussion of the requirements for the provision of quality services to the cohort. Using the conceptual framework for quality service provision developed in chapter two, research provides the following indicators:

**Forming agents.** These relate to factors which are formative to the process of generating quality service provision and the delivery of highly effective services is dependent upon the concretisation of these by the agency. The literature indicates the forming agents of a quality service to be: the commitment and capacity to measure outcomes and outputs; and an agency's commitment and capacity for quality improvement (Campanella, 1999; Mertens & Wilson, 2012; Schalock, 1999; Schalock & Verdugo, 2012b; Shaddock, 2006). These were supported in this research; however, an additional four agents were identified as formative to quality. These related to agency commitment to



service user outcomes, their position in relation to the service user and the values and framework of the agency. The agents' formative to quality services are interdependent and are as follows.

**Agency commitment and capacity to measure outcomes and outputs.** This research suggests that pivotal to delivering quality is an agency's commitment to, and developed capacity for, assessing the performance of service delivery through measured service user outcomes. These outcomes include quality of life and challenging behaviour incidence. Also central is both a commitment to, and the capacity to measure, outputs that impact service delivery including staff satisfaction and procedural fidelity.

In this research, measurement of service user outcomes and agency outputs were important to CEOs, managers, clinicians, and senior practitioners; however, service user outcomes were considered more imperative. Nonetheless, the literature identifies that performance of service delivery should be measured both in terms in outcomes and outputs (Campanella, 1999; Schalock, 1999; Schalock & Verdugo, 2012b).

**Agency commitment and capacity for quality improvement.** Indicated through this research is agency commitment and capacity for quality improvement being formative to quality services. This would necessitate the collection of data and its utilisation to inform change. However, direct experience of service delivery gained through this research would indicate that informal data collection should be used to facilitate quality improvement. This was highlighted through service user discussion of informal complaints not leading to appropriate changes. Agency commitment and capacity for quality improvement as formative to quality is supported by the literature. This literature highlights agency's utilisation of data for improvement as necessary for quality service production (Mertens & Wilson, 2012; Shaddock, 2006).

**Agency commitment to good outcomes for service users.** In this research a number of stakeholder groups indicated that agency commitment to positive outcomes for service users was formative to quality. Specifically, advocates, support workers, supervisors and families/carers raised this issue and identified that only a strong commitment to improvement in areas where the agency and staff performs adequately will enhance the overall service quality.

**Values and framework of staff and agency.** The values and framework of both the agency and the staff working within the agency were reported as being critical to quality. This was specifically those that promote and value people with disabilities and support and protect their human rights. A number of service users highlighted this as formative to quality through discussion of inappropriate staff attitudes towards them and

restrictions placed on them by the agency.

**Agency regard as employees of service users.** This study found that quality services may only be provided when an agency acts an employee of the service user rather than decider of the who, how, what and when of service delivery. This perspective is in contrast to delivering services to 'passive recipients'. The research indicated that this concept was central not only to outcomes for service users but the extent of choice and control experienced by service users. The latter was confirmed as imperative to service users who indicated that having a lack of choice and control over daily living, such as when to shower and enter the kitchen, what and when they eat was disempowering. Conversely, the concept of agency as service user employee was not identified as important in delivering quality services by CEOs, managers, clinicians and senior practitioners.

**Agency referral.** This study found that determinative to quality service provision is that agencies refer service user to other providers if their needs could be better met elsewhere. This was considered fundamental to the attainment of outcomes by advocates, support workers, supervisors and families/carers. However, is not consistent with government vacancy driven management of service provision in which a potential service user is allocated provision by an agency where a vacancy exists.

**Process factors.** Process factors include the operations, procedures and actions undertaken by agencies. Those considered in this research to be imperative to the delivery of quality service provision are discussed below.

**Individualisation.** This refers to the tailoring of services to the needs and desires of service users and was identified in this research and in the literature (Department of Health (UK), 2007) as being important to service quality. However, a number of service users reported current and previous experiences of physical and verbal assault from other service users, a lack of personal safety and inadequate security of possessions. In addition, a number of service users were unhappy with being told when and what to eat and drink and having restricted access, such as locked doors to their bedrooms. This suggests that while individualisation is important to quality, there is discrepancy between individualisation as a priority factor and the enactment of individualisation in service delivery.

The literature and government policy identify PCPs and ISPs as protocols that formalise to individualisation in services (Nankervis, 2006; Thompson et al., 2002). However, while supervisors made reference to these documents in the research interviews, few support workers referenced them. This does not infer that support workers

were not aware of these formalised documents, as interviews confirmed that the philosophical basis of PCPs and ISPs was engendered. Rather, it indicates that there is disconnect between individualisation in theory and the mechanisms that are supportive of individualisation. With attention focused on service user experience, the majority expressing dissatisfaction lived in group homes. Consequently, it is postulated that the experience of non-individualisation may result from living under 'blanketed' practices that apply in group homes.

***Supportive staff-service user relationships, and support to develop and maintain relationships.*** It was consistently shown that a supportive relationship between staff and service users was considered to be a requirement for quality services. Numerous stakeholder groups included care, respect and good rapport in their definition of supportive relationships.

However, a number of service users identified their relationship with staff as akin to that of the friend. While some service users also considered their friends to be others besides co-tenants and staff, they indicated that they no longer had contact with them. Thus, support to develop and maintain relationships with people other than staff is incorporated in this factor. This was upheld by supervisors, support workers, advocates and families/carers who identified service users' developing relationships with people in the community as a necessary requirement. Non-identification of this element by CEOs, managers, clinicians and senior practitioners highlights the need for reflective supervisory practice, which is identified as a significant requirement for delivering quality services (Berkery et al., 2009; Bigby et al., 2009; Clement & Bigby, 2008; Mansell, 2006; Mansell & Beadle-Brown, 2009; Mansell et al., 2008; Skirrow & Hatton, 2007; West et al., 2006).

The fact that staff-user relationship was found to be important in delivering quality services is consistent with the literature, indicating that staff often constitute the most frequent and enduring contacts for people with disabilities (Marquis & Jackson, 2000). This also reflects the social isolation experienced by people with disabilities and the centrality of relationships to quality of life, a point well documented in the literature (Emerson & McVilly, 2004; Schalock et al., 2002; Steering Committee for the Review of Commonwealth/State Service Provision & National Disability Administrators, 2000).

***Service user choice and control.*** In this research, supervisors, support workers, advocates, families/carers and service users identified choice and control as important requirements in delivering quality services. For service users this was discussed in terms of having little choice and control over activities of daily living, such as when to shower or what to eat, or in more significant choices, such as where and with whom they live. All

participants who expressed this lived in group homes. This indicates issues surrounding the compatibility of people living in group homes, and is supported by literature specifying that those in group homes have reduced choice (Emerson et al., 2001b; Stainton, Brown, Crawford, Hole, & Charles, 2001).

Other stakeholder groups, however, did not identify choice and control as important to quality. Choice in service delivery is an element of PCPs and ISPs so these groups may have not identified this as a distinct factor of quality service provision. Nevertheless, discrepancy between the theoretical and the experiential on service provision indicates a need for service user choice and control as a primary and distinct factor of quality.

**Consistency of staff members.** Consistency of staff members working with service users was identified as being significant in the delivery of quality personalised services. For a number of service users, having consistent support workers underlined their desire for continuity in practice and routines as well as the importance of their relationships with staff. This is confirmed in the literature which highlights both the importance of staff in the lives of service users (Marquis & Jackson, 2000) and consistency in support staff as critical to outcomes (Aarons & Sawitzky, 2006; Mansell & Beadle-Brown, 2009; Social Policy Research Centre, 2009). While consistency of staff was not identified as a quality factor by CEOs, managers, clinicians, and senior practitioners, this may be a result of their distance from direct delivery.

**Consistent practices and support, including PBS.** The results showed that central to quality is consistency in practice and support, both in setting boundaries and establishing routines, and in consistency in delivering services, such as following the set program. Service users discussed consistency with regard to the how, what and when of daily living, including cooking, shopping and personal care, and of day service programming. CEO, managers, clinicians, and senior practitioners did not identify this as important perhaps as a result of not being involved in day-to-day service delivery, however, this understanding should be developed through reflective supervisory practices. While the literature does not indicate consistency in practice as a requirement for quality, it clearly indicates PBS as the evidence based practice significant to quality outcomes for people with ID and CB (Grey & Hastings, 2005; LaVigna & Willis, 2012). The importance of consistent PBSP implementation, such as within agencies and by agencies providing different services to an end user, was indicated as being important by all groups in this research, with the exception of service users. However, it is recognised that discussion regarding the supports they receive may not have taken place.

This research supported the importance of PBS incorporating functional analysis and ABA. However, CEOs, managers, clinicians, and senior practitioners, ranked this lower than other factors, including individualisation and respectful interactions with service users. While person-centeredness is identified through the research and the literature as important, the literature also clearly indicates that PBS, incorporating functional analysis and ABA is critical to this cohort and the primary way to increase their quality of life (Carr et al., 2002; Grey & Hastings, 2005). The implication is that the quality outcomes for service users requires all stakeholder groups considering PBS incorporating functional analysis and ABA as critical to service provision.

***Management practices.*** A review of the literature indicates seven management practices associated with quality services while this research indicates that there are nine management practices. This research and the literature signify these are practices as differentiated, however, are all requirements for quality service provision.

***Leadership.*** This refers to knowing the needs of staff and addressing them through various practices (Clement et al., 2007; Schalock & Verdugo, 2012b). The view of leadership in the existing literature refers to such skills as coaching, inspiring leadership and support (Department of Health (UK), 2007; Schalock & Verdugo, 2012b). In both the current research and the previous literature, leadership is identified as a distinct and separate management practice that demonstrates best practice and is associated with high quality services (Department of Health (UK), 2007; Schalock & Verdugo, 2012b). With the exception of data from service users, this research identified leadership as a requirement of quality services and was cited as the most important management practice by CEOs, managers, clinicians and senior practitioners.

***Support for staff.*** In this research, support for staff was identified as a management practice associated with quality delivery while in interviews support for staff referred to management personnel being understanding, listening to their ideas, being available to them and involved when needed. This concurs with the literature, although it indicates support is a practice of effective leadership (Department of Health (UK), 2007; Schalock & Verdugo, 2012b). This offers a potential explanation as to why this factor was not identified as important by CEOs, managers, clinicians and senior practitioners.

***Flexibility.*** CEOs, managers, clinicians and senior practitioners identified flexibility with policy implementation as instrumental to achieving quality outcomes. The other groups, with the exception of service users, extended this understanding in their interviews to indicate that flexibility is required with managing risk and duty of care policies. Flexibility with regard to policy is supported in the literature (Brown & Brown, 2003); however, it also

indicates that flexibility is required with regard to agency approaches (Gardner, 1999a), professional or agency boundaries (Department of Health (UK), 2007), and Occupational Health & Safety legislation (ACROD, 2004; Clement et al., 2007; Shaddock, 2006; Stancliffe, Abery, & Smith, 2000).

*Organisation of staff and service users.* The findings from this research indicate the match between staff and service users as an important factor in service quality. Individual service users focused on the qualities they sought in staff, including the right attitude, kindness, helpfulness and understanding. Organisation of staff in terms of a match between staff on teams and individual staff and the setting in which they work was also an important factor. While, service users did not discuss these elements of staff organisation, it is considered that incompatible staff arrangements has the potential to significantly impact on the day to day life of the service user.

In addition, this research showed an appropriate match between service users living together or attending services together as a critical element of quality services. The impact of poor client matches was indicated by service users to lead to reduced individualisation, physical and verbal assault, lack of personal safety and insecurity over personal possessions.

The focus on staff and service users being central to quality service provision is supported in the literature, where appropriate matches are made between staff on teams and between staff and service users (Buntinx, 2004, 2008). This research also found that the match between staff and the setting, and between service users, was central and significant in the delivery of quality services.

*Role clarity.* Role clarity refers to staff knowing what they are required to do. A number of service users in this research discussed the importance of role clarity with regard to a desire for consistent programs and routines, while others discussed role clarity in PBSP implementation as critical to outcomes. ID studies indicate that role ambiguity can lead to staff stress and turnover which increases negative interactions with service users and compromises the quality, and appropriateness of these interactions (Devereux et al., 2009; Hatton et al., 1999a; Hatton et al., 2001). As such, role clarity may be considered necessary to induce supportive interactions and consistent PBS based responses to CB.

*Supervision and feedback.* This research highlighted the importance of staff supervision and feedback in quality service delivery. Although not directly discussed by service users, their desire for consistent routines and the importance of appropriate staff attitudes may support the requirement for supervision and feedback. While in interviews

with a number of supervisors, support workers' resistance to engaging in the process was confirmed, critical studies in the literature indicate that supervision and feedback is a significant requirement for delivering quality ID services (Berkery et al., 2009; Bigby et al., 2009; Clement & Bigby, 2008; Mansell, 2006; Mansell & Beadle-Brown, 2009; Mansell et al., 2008; Skirrow & Hatton, 2007; West et al., 2006).

*Case discussion and/or team meetings.* In this research, case discussions and/ or team meetings were considered an essential requirement for the delivery of quality services. Interviews indicated that this encouraged the sharing of ideas and practices that were 'working well'. Case discussion and team meetings were not identified as significant in the literature and was not supported by CEOs, managers, clinicians and senior practitioners. However, this may be a result of little interaction in the day-to-day delivery of services.

*Financial management.* Practice that related to sound financial management was considered to be important to quality, particularly in relation to low administrative costs and flexibility in the funding allocation, which could meet the client group needs. Interestingly, this was not identified as central to quality by CEOs, managers, clinicians and senior practitioners. While the specific aspects of financial management identified in this research was not apparent in the literature, there was support for effective financial management that allocates funding for the hiring and/or training of management staff (Social Policy Research Centre, 2009) and in-service training (Dowey et al., 2007; Finn & Sturmey, 2009; Grey et al., 2007; Grey et al., 2002; McClean et al., 2005; McKenzie et al., 2002; McKnight & Kearney, 2001).

*In-service training.* In-service training, critical to quality provision, was supported through research. Although in-service training was not something service users were aware of, the adequacy of staff training has the potential to impact their day-to-day lives. In-service training as a requirement for quality service provision for ID and CB services are highly consistent with the literature (Department of Health (UK), 2007; Dowey et al., 2007; Finn & Sturmey, 2009; Grey et al., 2002; McClean et al., 2005; McKenzie et al., 2002; McKnight & Kearney, 2001). In this research, important training was identified as including working with people with CB, training based on the development needs of staff and that required for OH&S. Advocates, support workers, supervisors and families/carers indicated critical training as including human rights support and specific disabilities care.

**Input factors.** Factors that represent an agency's resources and raw materials, which are either prescribed or malleable, represent input factors (Kettner et al., 2008). Significant inputs identified through this body of work are as follows:

***In-depth understanding of service user including needs, desires and history.***

Understanding these client-centred factors was supported in the research by those that deliver services. Notably, while CEOs, managers, clinicians and senior practitioners considered the needs and desires of service users to be important, other groups indicated that these factors as well as the history of service users was imperative to delivering services. This difference may reflect advocates', support workers', supervisors' and families/carers' considering that CB incidence may be a result of previous service delivery. Nonetheless, these findings are consistent with the literature which indicates that a knowledge of service user needs, desires and experiences is central to quality services for people with ID and CB (Department of Health (UK), 2007).

***Personnel within the agency.*** This research identified the choice of personnel to be of great importance to service delivery. While the literature showed the need for good choice of personnel within the agency to deliver best practice services (Larson & Hewitt, 2005; Packard, 2009; Townsend, 2011), service users indicated that personnel were central to their lives. They discussed 'good' personnel as being honest, respectful, understanding and helpful, and identified attitudes, kindness and the way they were spoken to by staff as important to service delivery.

***Funding.*** Funding was considered important to quality service provision in this research; however, CEOs and managers did not suggest that funding from grants and fundraising were central to quality delivery. This reflects agencies receiving the majority of funding from the government. Importantly, this research indicated that, while funding is important to quality, it does not ensure quality. It further indicated that the extent to which funding can facilitate quality pivots on the allocation of funds to various purposes. That position is upheld in the literature (The University of Queensland, 2002; Department of Health (UK), 2007; National Disability Services, 2009).

***Physical resources.*** Physical resources, including vehicles and materials, were identified as important to quality delivery: this is supported in the literature as an input factor in the provision of services (Kettner et al., 1999; Packard, 2009). Of interest however, was the fact that service users did not discuss this element, which may be a result of satisfaction with current resources to which they were exposed or that knowledge of other was beyond their knowledge or experience.

***Consultant allied health personnel.*** These personnel were identified as essential to achieving quality health outcomes in this research; which is consistent with the literature on exemplary services for people with ID and CB (Department of Health (UK), 2007). However, while central to quality, issues surrounding the availability of and accessibility to



allied health personnel, such as occupational therapists and psychiatrists, was discussed in interviews.

**Organisational policies and mission statements.** Agency policies include written plans, instructions and processes for staff while mission statements guide and direct future action and activity. Consistent with the literature, these are important agency factors in this research (Dykstra, 1999; Nankervis & Matthews, 2006). Significantly, however, advocates, supervisors, support workers and families/carers indicated fidelity to policies and mission statements as central to quality provision. This implies the requirement for effective dissemination of policy and statements and monitoring of fidelity.

**The environmental context.** The environmental context includes the location, size and the physical setting of the facility. This was supported as critical to outcomes in this research and is widely supported in the literature (Emerson et al., 1999; Emerson et al., 2001b; Emerson et al., 2000b; Kozma, Mansell, Beadle-Brown, & Emerson, 2009; Robertson et al., 2004; Stancliffe & Keane, 2000).

The impact of the environmental context was discussed by service users in terms of negative experiences of co-tenancy. The majority that lived in co-tenancy or had previously lived in these arrangements indicated their dissatisfaction with this, and a number expressed a desire for a different setting. This is interpreted as a result of inappropriate co-tenancies between service users. In interviews with those directly delivering services they cited appropriate physical settings as being those where CBs by one resident did not impact on the others. This furthers the understanding that an appropriate match between service users is critical to quality service provision.

**Government policy and standards.** These factors were identified as important in the research involving CEOs, managers, clinicians, and senior practitioners, though they were ranked as the least important input. Nonetheless, the literature supports the proposition that policy and standards are of importance in providing quality services to service users (Department of Communities, 2015; Packard, 2009; Townsend, 2011).

Further research findings that will be discussed relate to the factors of output.

#### **Output factors.**

**Agency economy.** This is a term coined by the author to indicate both the management of resources, finances, income and expenditure, as well as the orderly interplay between divisions within the agency. The important measures of economy identified through this research were agency effort in achieving service user outcomes; effective use of money; staff factors, such as employment duration and staff satisfaction; and, procedural fidelity.

The importance of these factors was supported by CEOs, managers, clinicians and senior practitioners, while service user data indicated these as being potentially critical due to their emphasis on fidelity to practice and routine procedures. This is supported in the literature, which also indicates program options and network indicators, such as interagency agreements, are significant (Kettner et al., 2008; LaVigna et al., 1994; Schalock, 1999; Schalock & Verdugo, 2012a, 2012b).

**Compliance with legislation, reporting requirements, government standards and service agreements.** Compliance was identified as important to quality services in this research and in the literature (Department of Communities, 2012a) yet this was not indicated as important to quality by those involved in direct service delivery. Potentially, this may be a result of these groups are unaware of requirements and standards, or find the associated paperwork burdensome. No matter the reason, compliance with government standards provides a degree of quality assurance and a legislative basis and framework for person-centred service delivery which all staff should understand in order to provide a minimum standard of quality.

Service user judgments of service quality were not identified through this research as important to quality service provision. The lived experience of services that has been gained through this research identifies a lack of choice, control and individualisation, as well as the lodging of complaints that do not lead to change. This supports that service user judgments should be considered pivotal to quality service provision. This is sustained by literature which indicates service user opinions of quality and client consultation as integral to high quality individualised services (McGlaughlin et al., 2004; O'Reilly, 2007; Wilding, 1994).

**Outcome factors.** The importance of measuring service user outcomes as important element of quality services was confirmed in this research. This converges with the literature which confirms the measurement of service user quality of life, restrictive practices and CB frequency and severity, as being significant to quality service delivery for people with ID and CB (Baker & Daynes, 2010; Royal College of Psychiatrists, 2007). Noted through this research, and discussed in the previous section entitled Forming Agents, is the fact that agencies need to commit to, and have the capacity for measuring these outcomes and utilising the data to inform change.

### **Elements Impacting Operationalisation of Quality Service Provision**

In addition to identifying the requirements for quality service provision, the results of this research indicate specific elements or factors that impact on the operationalisation of

quality service provision. Using the conceptual framework for quality service provision developed in chapter two, the impacting elements are discussed below.

**Communication and collaboration.** This research indicates that quality service provision was impacted by communication and collaboration among staff in teams, between families/carers and the agency, and within levels of management. Further, communication and collaboration issues were identified between the agency and other agencies or community groups, between services provided to the same client, and between the agency and professionals, such as occupational therapists and psychologists. Only the last element was supported by CEOs, managers, clinicians, and senior practitioners in this thesis and supported as an exemplary characteristic in the provision of services for people with ID and CB (Department of Health (UK), 2007).

**PBSP quality, author availability and contact with service users.** The quality of PBSPs was identified as important to quality service provision through this research. Service users did not discuss PBSPs, perhaps as a result their being excluded from discussion regarding the supports they receive. Through this research a quality plan was identified through interviews as being of reasonable length, uncomplicated and easy to understand. While PBSP quality was not consistently supported in the literature as impacting on the quality service provision, there is increasing evidence of the need for assessing the quality of plans (McVilly, Webber, Sharp, & Paris, 2013; Wardale, Davis, & Dalton, 2014).

Advocates, support workers, supervisors and families/carers also highlighted that PBSP implementation is impacted by the availability of the person who wrote the plan to facilitate appropriate implementation and make alterations. Research further showed that they plan to be implemented needs to be based on meetings with the client, rather than on previously formulated plans. However, this was not evidenced as a distinct factor in the literature.

**Capability and skills of management.** The capability and skills of upper management to effectively manage the agency was identified as impacting on quality service provision in this study. In contrast, in a review of the literature there is little reference to capability and skills of upper management with regard to quality provision for people with ID. Of interest, however, is the fact that in this study those in upper management did not identify this as an element impacting operationalisation even though other participants did.

**Responsiveness and accountability.** Responsiveness and accountability refers to both the agency and the staff acting appropriately to situations such as critical incidents

and to advice from professionals. This was identified as impacting on the quality of services delivered by advocates, support workers, supervisors and families/carers. Critical studies in service provision, however, did not indicate that this was a distinct factor.

**Long-term outcome focus.** Advocates, support workers, supervisors and families/carers highlighted that engendering a long-term outcomes focus for service users impacts on quality provision. This was identified through interviews as including the teaching skills to maximise service user independence. This may reflect an outcome focus engendered by these groups. The literature, however, did not identify this as a significant element of quality service provision.

**Staff ratios.** The research identified staff ratios as impacting on quality. Service users discussed this with regard to enjoying one-on-one time with staff. Other groups indicated that staff ratios needed to enable the teaching of skills and impact on the individualisation of service. These findings are supported by the literature which indicates the staff levels that are inconsistent with service user needs can lead to reduced outcomes (Felce et al., 2002b; Social Policy Research Centre, 2009; The University of Queensland, 2002).

**Fidelity.** Fidelity was identified through this research as impacting on quality service provision. Advocates, support workers, supervisors and families/carers agreed that fidelity was required with regard to mission and policies. CEOs, managers, clinicians, and senior practitioners, in contrast, indicated aspects of fidelity that impact on quality as values and frameworks and evidence based practices. The finding that fidelity, as well as agency mission and values, impacts on quality provision is supported through literature on organisational culture (Gardner, 1999a; Schalock & Verdugo, 2012b). Literature further indicates that fidelity to programming, as in evidence based practices, also impacts outcomes for service users (Fagan et al., 2008; Fixsen et al., 2005; Owen, 2006; Palinkas & Soydan, 2011).

**Honesty and honest feedback.** In contrast to the literature, advocates, support workers, supervisors and families/carers identified honesty and honest feedback as impacting on quality service provision. Reference was made to supervisors applying this principal with support workers and support workers being honest with supervisors regarding the delivery of service, which included program implementation.

**Respect and regard.** In this research respect and regard for the families and unpaid carers of service users was shown to as impact on quality. Specifically, it was indicated that respect should be given to the family/carer's input and that they should have access

to management. This impacting factor was not evidenced in the literature on service provision.

**Staff stress and turnover.** This was indicated through the research as impacting quality, yet it was not identified as impacting operationalisation at the CEO, manager, clinician and senior practitioner level. This may indicate that information regarding stress and turnover incidence is not reported to these groups. However, critical studies clearly indicate that not only does stress impede appropriate interaction with service users, but that turnover adds to the financial burden of organisations (Devereux et al., 2009; Hastings et al., 2004; Hatton et al., 2001; Skirrow & Hatton, 2007).

**Complaints mechanisms and redress.** Complaint mechanisms, both formal and informal, were identified as important in quality service delivery in this research. Although not identified by CEOs, managers, clinicians and senior practitioners, service users indicated that they knew the role of the persons to complain to but either did not know their names, did not know how to contact them, or had found these persons did not respond to their calls. Further, it was indicated that some complaints had not led to redress. This questions the extent to which services are truly person-centred and facilitate a culture of client-driven service delivery. Critical literature did not indicate complaints mechanisms as a distinct factor, however, is clearly supportive of truly individualised services.

**Staff attitudes and attributes.** Staff attitudes and attributes in these findings were shown in this research to impact on quality service provision. Importantly, CEOs, managers, clinicians and senior practitioners acknowledged attitudes supporting the rights of service users as the single most important staff factor. Service users highlighted the centrality of attitudes and attributes to service experiences, indicating undesirable attitudes as being antagonistic, incredulous and dishonest; and desirable attributes including kindness and understanding. Other groups in this research focused on the qualities of empathy and commonsense in support workers, while studies cited in the literature confirmed the need to direct attention to support worker attitudes. Other studies focused on the importance of attitudes in supporting recipients' human rights, the enhancement of community inclusion, and agreed values that underpin policy and service goals (Bigby et al., 2009; Egli et al., 2002; Mansell et al., 2008).

**Interpretation of behaviour.** CEOs, managers, clinicians, and senior practitioners in this research indicated beliefs and attributions regarding the causes of CB to be important; however, they did not rate PBS, which is the basis for appropriate attributions, as more critical than other factors. However, groups involved in direct delivery indicated accurate interpretations of the functions of CB to impact positively on quality provision.

This is consistent with the literature suggesting that accurate interpretation of behaviour is facilitative of positive outcomes for service users (Grey et al., 2002; Hastings, 1997, 2002, 2005; Hastings & Remington, 1994; Lambrechts et al., 2009; McDonnell, 1997; Snow et al., 2007).

**Advocacy and empowerment.** In this research, it was indicated that that advocacy on behalf of service users and empowerments impact on service quality. Further, interviewees indicated advocacy, provided formally or informally, as being required to the Adult Guardian, families/carers, agencies and governing bodies. It was also indicated that empowerment was required to enable service users to understanding their options and make decisions. However, advocacy and empowerment were not identified in the research literature to be significant factors in the delivery of these services, nor was this identified as important by CEOs, managers, clinicians and senior practitioners.

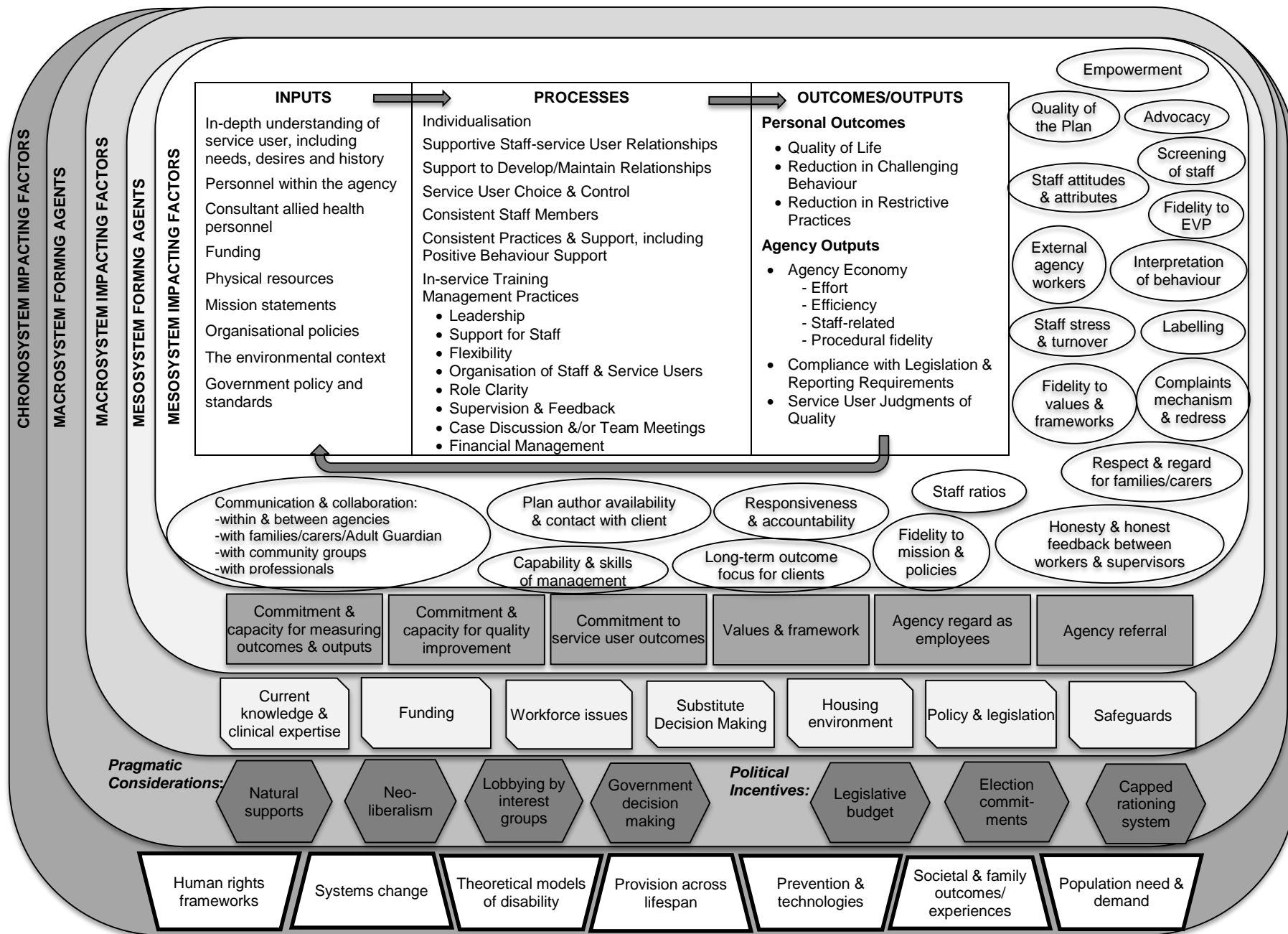
**Screening of staff and external agencies workers.** Those in this research involved in direct service delivery confirmed that potential staff screening and the use of external agency workers impacted on quality outcomes for service users. Surprisingly, such screening of staff was not supported in the literature.

**Labelling.** This factor was identified in interviews with advocates, and supported in subsequent data collection by other groups. The practice of labelling a person with CB was considered to potentially lead to discrimination because it may result in not thoroughly considering the meaning of the behaviour, limit expectations of service users and limit their opportunities. However, this was not evident in critical studies in ID and CB, or identified as important by CEOs, managers, clinicians and senior practitioners, though significant in this research.

### **A Conceptual Model of Quality Service Provision: Enhanced and Enriched through Service User and other Stakeholder Consultation**

The requirements for quality service provision and the elements that impact on their operationalisation have been identified through a review of the literature and this study. The original model, developed from the literature, was discussed with authority on departmental process and procedures in order to review the model and further develop it. The final model is a result of these process and is presented in Figure 7.1. Following this, the elements of the model are discussed in detail.

Figure 7.1. Conceptual model of quality service provision: enhanced and enriched through service user and other stakeholder consultation



**Constituent element framework.** The conceptual model, designed from the research findings and input from the literature, has taken a constituent element approach, the pivotal point being the delivery of quality services. Upon this, the functional relationship between the constituent parts of service inputs, processes and outputs/outcomes depend (Gardner, 1999b; Osborne, 1992). Outcomes and outputs, therefore, are measured and fed back into agency inputs through a continuous quality feedback loop. Thus, the constituent element framework was incorporated in the final model, shown in figure 7.1, through: the use of directional arrows between inputs, process and output/outcomes, the incorporation of a feedback loop, and inclusion of agents that are formative to quality improvement.

A constituent element approach was adopted for the final model for a number of reasons. First, it allows for logical sequencing of activity and examination of alignment between components (Schalock & Verdugo, 2012a, 2012b). Second, it enables a feedback loop for continuous quality improvement (Martin, 1993), which is significant for agencies in the current customer-value paradigm which requires continuous improvement in consumer outcomes, efficiency and cost control (Kettner et al., 2008; Schalock, 1999). Further, this framework enables agencies to identify areas for development, for the propagation of effective practices which can guide and strengthen decision-making, and to assist agencies in attaining successful outcomes (Austin et al., 2009; Mertens & Wilson, 2012; Owen, 2006; Stufflebeam & Shinkfield, 2007). Maintaining a constituent element approach to framing quality also has veracity for service users as it provides an instrument for the promotion of consumer sovereignty and enfranchisement.

**Systems framework.** A systems approach "attempts to view the world in terms of irreducibly integrated systems, focusing attention on the whole" (Laszlo & Krippner, 1998, p. 56). In framing quality service provision, factors emerged within various systems which impacted on, or were formative in, generating quality services. This was supported by qualitative data collection in which factors external to agencies were identified as impacting quality production. Further, the use of a systems framework increased the utility of the model for agencies, advocates, members of the community and governing agencies, including the National Disability Insurance Scheme (NDIS).

This framework requires the identification of systems levels and is based on Bronfenbrenner's (1979) conceptualisation of human development, comprising meso-, macro- and chrono-systems. Accordingly, the mesosystem is the agency level, the macrosystem represents the socio-political environment, and the chronosystem is the change in external systems and environments over time. The adoption of these levels are



shown in figure 7.1 as embedded circles surrounding agency provision of service, which is the mesosystem. Factors within the mesosystem were subject to this research. To ensure the accuracy and comprehensiveness of the factors within the macrosystem and chronosystem, the researcher engaged with an authority on departmental process and procedures. The authority had been a key figure in shaping the current iteration of service provision to people with disabilities in Queensland. The model of quality service provision discussed in chapter two was presented to the authority and discussion centred on the relevance of these factors to framing quality service provision in the current socio-political context. Further discussion centred on factors within the mesosystem and chronosystem that were not represented in the original model.

The systems levels and the factors existing within each level are discussed below, with reference to this research, the literature and the consultation with authority on departmental process and procedures.

***The mesosystem.*** The mesosystem is the agency level of quality service provision. Through amalgamation of the research findings and the literature, factors existing within the mesosystem that are associated with quality service provision include 23 factors, 21 impacting factors and six forming agents. These are situated with a constituent element framework to enable operationalisation.

***The macrosystem.*** The macrosystem represents current culture, society and the socio-political environment. The literature indicated five macrosystem factors that exist in this system and impact on agencies' production of quality services. Through consultation with an authority on departmental process and procedures, and additional external factors identified through qualitative data in this research, this has been extended to 11 factors. Consultation with the industry professional, however, identified distinction between impacting factors and forming agents; the former being factors that directly impact on agency production of quality services, the latter being those that are determinant to the impacting factors. The impacting agents identified as existing in the macrosystem are discussed below.

***Current knowledge and clinical expertise.*** Current knowledge is the extent of what is known regarding ID and CB, best practice, and the provision of quality services to this cohort. As identified through the literature, limitations in current knowledge include: prevention; assessment; effectiveness of systems, treatments and practices; best practice; management systems and processes conducive to quality outcomes; utilisation of technologies; and, evaluation methodology (Fixsen et al., 2005; Forrester-Jones et al., 2006; Moss et al., 2000; Townsend, 2011). Through consultation with the authority on

departmental process and procedures, this has been extended to include clinical expertise.

*Funding.* The literature indicates that inadequate funding impacts agencies' capacity to provide quality services (Office of the Public Advocate, 2009; Roth, 2007; Social Policy Research Centre, 2009; The University of Queensland, 2002). As identified in the research, funding impacts on quality related processes of individualisation and service user choice and control.

*Workforce issues.* As service delivery hinges on employing and retaining a suitable workforce, recruitment and retention had proved problematic. With current labour participation decreasing due to the ageing of Australia's population, agency capacity to retain and recruit staff diminishes (Disability Services Commission, 2012; National Disability Administrators, 2006; Productivity Commission, 2011b). A number of supervisors in this research cited the difficulty that the small potential employee pool presents.

*Substitute decision making.* The formal entity for substitute decision making is the Adult Guardian, appointed through QCAT. Identified in the research was a lack of consultation between the QCAT Adult Guardian and service users, the formality of tribunal processes, and an incomplete understanding of human rights.

*Housing environment.* In this research, group homes were shown to impact on service delivery and service user outcomes. Service users who had lived in independent environments but had experience of group homes clearly indicated preference for independent living. Further, a number of service users indicated they wanted to have choice over housing environment, which is a macrosystem factor as accommodation admissions determined by the department using vacancy driven management (K. Nankervis, personal communication, February 12, 2015).

*Policy and legislation.* Government policy was identified in the literature as a macrosystem impacting factor (ACROD, 2004; Clement et al., 2007; Productivity Commission, 2011b; Shaddock, 2006; Stancliffe & Keane, 2000). However, this is extended to include legislation relevant to the current Queensland political climate that agencies must work within to maintain funding. Policy and legislation was identified by the authority on departmental process and procedures as impacting on quality service provision, with felt effects dependent on the "sensitivity" of these directives to the provision of quality services.

*Safeguards.* These refer to the formal safeguards - like service standards, regulations and quality assurance systems- that provide departmental monitoring. While these were not shown to be significant in the literature, the department authority

suggested that, in fact, those imposed by the government do impact on the quality and delivery of services.

*Macrosystem forming agents.* The agents formative to quality service provision that exist in the macrosystem were split into two categories: pragmatic considerations and political incentives. Macrosystem pragmatic considerations include neo-liberalism, a political philosophy which emphasises efficiency and is in contrast to liberalism. This is formative to quality service provision as neo-liberalism imposes of a degree of constraint as well as restrictions within the market (Dowse, 2009; Swenson, 2008).

Through interview with an authority on departmental process and procedures, further pragmatic considerations were also identified as being: lobbying from special interest groups; government decision making; and natural supports. Decision making within government, it was suggested, referred to the disability service system that has been chosen by current or previous governments, and/or government understanding of effectiveness and efficiency. Further, natural supports were identified as service user assistance from natural networks, advocacy groups and community groups.

Macrosystem political incentives were identified by an authority on department process and procedure as including government election commitments; the capped rationing system (that determines how the department will allocate funding, the parameters for funding, and the prioritisation of factors); and the legislative budget (which calculates the funding available to the department inclusive of the government's election commitments).

***The Chronosystem.*** While the the chronosystem represents change that occurs in external systems and environments over time, a review of the literature indicated that the following six factors impact upon application of this system.

*Systems change.* Systems change indicated that change within one system (chrono-, macro-, or meso-system) indicates that there will be prospective change in another (Schalock et al., 2008): this has application for social systems.

*Theoretical models of disability.* These are the belief systems held by individuals of communities that shape individual and collective actions (Schalock et al., 2008; Senge, 2006). These impact policy, funding, service processes, service cultures and service design (Schalock et al., 2008; Shaddock, 2006; Shogren et al., 2009).

*Provision across lifespan.* Both the specialist and mainstream services that are provided to service users over time has been identified in the literature as impacting upon service provision, both positively and negatively (Townsend, 2011).

*Prevention and technologies.* Due to innovation and research that changes over time, it may be expected that augmented technologies and preventative techniques will become available that will augment service offerings and the need for services (Townsend, 2011).

*Societal and family experiences/outcomes.* It is accepted that changes within families and within communities occurs over time. This may result in a shift to informal support provided by families/carers and their outcomes, and societal outcomes for people with disabilities (Productivity Commission, 2011b).

*Population need and demand.* This factor takes account of current need and the changing requirement for disability service provision (Carter, 2006; Productivity Commission, 2011b).

*Human rights frameworks.* Through this research, human rights frameworks were identified as formative to agency provision of quality services. As they have and will continue to change over time, such as in the advent of Wolfensberger's Social Role Valorisation and ratification of the United Nations CRPD, this is categorised as a chronosystem factor.

## Chapter Eight: Implications for Practice and Conclusions

This chapter provides a discussion of the research and final conclusions. First, the implications for practice are highlighted with reference to service provider agencies, service user consultation, government, substitute decision making, and the National Disability Insurance Scheme. The limitations of the research are then identified, followed by future directions. Last, concluding comments are provided.

### Implications for Practice

This research offers an understanding of the need for quality service provision for people with ID and CB, and provides an understanding of how quality can be attained. It also presents findings that impact on the delivery of services and upon service provider agencies as well as to service user consultation, government, substitute decision makers and the National Disability Insurance Agency (NDIS). The implications for each of these bodies are discussed sequentially.

**Service provider agencies.** This research has indicated that agencies should attend to the process factors identified as significant to quality outputs/outcomes. Process factors are the operations, procedures and actions undertaken by agencies and were identified as incorporating: individualisation; support for and supportive relationships; choice and control; consistent staff, practices and support; in-service training; and numerous management practices. To support appropriate application of these processes, however, service provider agencies need to ensure alignment between input, process and output/outcomes factors. Further, agencies need to monitor and measure the specified outcomes/outputs to enable continuous quality improvement. In addition, focus on those factors which have been supported as impacting the operationalisation of quality. These factors, identified through research included communication and collaboration, labelling, advocacy and fidelity to evidence based practices among others.

A significant implication for service agencies identified through this research is that agencies' capacity to provide quality services in effective, efficient and appropriate ways is formed by a number of agents. In line with the forming agents identified through this research, quality is dependent on agency commitment to service user outcomes, as well as a developed capacity for quality improvement and measuring outcomes and outputs. Further, quality is dependent on appropriate values and frameworks of the agency and staff, such as supporting and protecting the human rights of service users, and a position as employees rather than decision makers, such as of the who, how, what and when of

service delivery. Last, quality is dependent on referring service users to other agencies if their needs could be better met elsewhere.

**Service user consultation.** A significant outcome of this research is the demonstration that service users with ID and CB have capacity to articulate opinions with regard to service provision. This provides a rich understanding of the experience of service delivery methods and its association with desired services and quality. Accordingly, it was found in this research that many of the processes important to quality expressed by staff were also central to experiences of delivery. However, a key finding was that these were not actualised through services. For example, while individualisation was identified as significant to quality service provision by all stakeholders, the lived experience indicated that individualisation was not occurring in aspects of day to day living. To highlight, a number of service users expressed dissatisfaction with being told when and what to eat and drink and having restricted access, such as locked doors to their bedrooms. The disparity for quality in intent versus quality in experience emphasises the need for continuous consultation with service users with regard to service delivery. Further, that the information provided by service users be used for continuous quality improvement.

Also of significance from this research was that service user's identification of the need for specific decision making options as they did not have, but would like to have, choice and control over their housing environment, including who they lived with and where they lived. Further, those who lived in group homes commonly discussed fighting/arguing with co-tenants, physical assault and lack of safety, privacy and security of possessions. The implication for practice is that the current vacancy driven management for accommodation support is significantly limiting agencies' capacity to produce quality services, and impinges on service user's quality of life.

In addition, a number of service users in this research indicated a lack of a clear complaints mechanisms and/or no redress. The Queensland Disability Service Standard (QDSS), standard seven, 'complaints and redress' and the HSQF, standard five, 'feedback, complaints and appeals' (Department of Communities, 2012a; Disability Services Queensland, 2004). These both provide indicators that agencies must have accessible complaints and appeals systems and resolution processes. The implication of the findings from this research indicate that the Standards may not be reflective in the experience of service users with ID and CB.

**Government.** Identified through this research was the significance of measuring service delivery outcomes by employing agencies. Baker and Daynes (2010) and the Royal College of Psychiatrists (2007) indicate that there is an ethical obligation to measure the impact of interventions. However, service provider agencies are audited against processes, outlined in the Human Service Quality Standards (HSQF), rather than service user outcomes. Given that there is cost and expertise associated with measuring outcomes, there is no incentive for agencies to fulfill this ethical obligation if it is not a contractual requirement.

In addition, this research indicated communication and collaboration with other agencies, community groups and professionals, such as clinicians and therapists, as important to quality outcomes for service users. However, as with measuring service user outcomes, there is little incentive for agencies to undertake such networking.

The implication of these findings is that government bodies, and the National Disability Insurance Agency (NDIA), should reconceive the legislative standards for service provision as the mechanism to ensure quality service provision. As the primary funder of service provision, it is well within their capacity to ensure client outcomes through contract management with agencies.

**Substitute decision making.** This research established that service users had limited choice and control over how and what service were provided. For people with an impaired decision making capacity, a substitute decision maker is appointed to make decisions about where and with whom they live, and the services they receive. However, through this research it was identified that where service users had formally appointed substitute decision makers, there was a lack of engagement by the decision maker with the nominee which would enable decision to be made that reflect their needs, desires and wishes. The implication is that formally appointed substitute decision makers should have formal training that enables them fulfill their ethical obligation to their nominee.

**NDIS.** The NDIS represents a major reformation of the way disability services are structured and funded. A central objective of the NDIS is to "promote the provision of high quality and innovative supports to people with disability" (Australian Government, 2013, p. 3). Beyond the rhetoric of 'promoting quality', the NDIS provides a specific vehicle for the development of quality service provision, that is tailoring of support packages to individual needs, and the portability of packages across service providers through tiers of consumer choice (Productivity Commission, 2011c). Thus, service users are able to change service providers if they feel that service provision is not of quality. It is considered that this will "promote robust competition and targeted consumer protection mechanisms" (Productivity

Commission, 2011a, p. 498). Further, this will provide impetus and incentive for service agencies to provide services that are of high quality. Thus, the quasi-market structure of specialist disability services post-NDIS "directly links service provider's viability with their capacity to satisfy consumers' needs, rather than their ability to fulfill the administrative requirements issued by their funding body" (Productivity Commission, 2011a, p. 498).

While the relevance of the NDIS is unquestionable for the majority of people with disabilities, this research conducted on people with ID and CB has specific implications for the NDIS. Specifically with regard to consumer protection mechanisms and consumer choice. If people are not aware of their options or have not experienced different options, how are they afforded consumer choice? If they have a substitute decision maker that has not met them or rarely consult with them, then this 'tier' of consumer choice may continue the disenfranchisement currently experienced. Further, if they historically learned that complaints do not lead to redress, how are they afforded consumer protection?

In addition, a significant finding from this research was that people with ID and CB in group homes often experienced physical and verbal assault from other service users, a lack of personal safety and inadequate security of possessions. Incompatibility within group homes was identified as formative to this and is mostly likely an outcome by the vacancy driven management of accommodation services. The implication of this is that the NDIS should address service users being placed in accommodation services based on their needs, desires and preferences.

### **Limitations of the Research**

There were a number of limitations to this study. First, the data were collected in the State of Queensland over the time period of 2013 and 2014. Given this, the findings from this research are reflective of, and located within, the social-political status specific to Queensland during this time frame. However, the results are consistent with international research that is not bound by time specific socio-political context. Therefore while the findings, in terms of significant and impacting factors, are indicative of the Queensland context these can be applied broadly to services for people with ID and CB.

Second, interview and focus group participants (advocates, support workers, supervisors, families/carers) were all sited within the metropolitan/urban areas of Queensland, and the support workers and supervisors were sited within the capital city, Brisbane. While the interview data may not have included the perspectives of those in relevant rural/remote contexts, those in rural and remote locations participated in the survey which allowed for additional factors to be identified.



Third, the sampling criteria for service users included both capacity for meaningful participation in group discussion, and good expressive and receptive communication skills (as suggested by Barr et al., 2010; Cambridge & McCarthy, 2001; Hoole & Morgan, 2011). Further, only 14 service users participated in the research, all of whom received services within metro/urban areas. This coupled with inconsistencies between those interviewed and the literature indicate that the findings may not be generalisable to other service users. However, while not representative of all service users with ID and CB, the results may be considered indicative. Further, as the perspective of service provision for those with ID and CB is not evidenced in the literature, this research has provided a wider scope of understanding for quality service provision.

Fourth, the identification of between group differences for the study one group (CEOs, managers of service provider agencies) and study two group (advocates, support workers, families/carers and supervisors) was limited because of the different measures used for these groups. In addition, analysis of between group differences in study two was restricted due to the requirement to collapse the rating scale. This was a consequence of small respondent groups for advocates (n=8) and families/carers (n=14). These small respondent groups also limit the generalisability of the findings. Nonetheless, priority items by the different groups could be ascertained, and a comprehensive understanding of quality related factors gained.

Fifth, there was a small sample size for data collection undertaken with CEOs and managers of service provider agencies. Round one data was collected with 29 participants, and round two was collected with 26 participants. However, there was a high degree of consensus between round one and two, and between study one and two, which included 85 clinicians and senior practitioners. This indicates consistency and stability in opinion for stakeholder groups not directly involved in day-to-day service implementation.

Sixth, inter-rater reliability of qualitative data analysis was undertaken with an independent researcher, using a data coding reliability model. Rigour would have been enhanced by the employment of multiple raters. However, agreement between the coder and the independent researcher did not result in any changes, indicating the initial coding was appropriate.

Seventh, through the process of data collection, positive outcomes for service users was adopted as a proxy for quality service provision due to the nebulous concept of quality. This may have limited the identification of factors that are significant to, or impact on quality service provision. However, it is considered more likely to have increased the

accuracy and validity of factor identification due to non-ambiguous concept construction, and thereby increasing veracity of the conceptual model.

### **Future Directions**

A number of future directions are identified. First, the further development of protocols for interviewing/ conducting focus groups with people with ID, including those with CB, for use by researchers. This would also allow service provider agencies to monitor service satisfaction and effectiveness, and to develop truly individualised programs and practices.

Second, testing the generalisability and applicability of the developed model in rural/remote environments and in States and Territories other than Queensland. It could also be assessed in international contexts, as well as in services for other cohorts.

Third, determining the compatibility between the findings in this research and the National Disability Insurance Agency (NDIA) legislation, including the impending NDIA quality and safeguard framework.

Fourth, random sampling techniques and broader data collection could be utilised to allow multivariate analysis such as correlation, factor analysis, MANOVAs, multiple regression and/or principle component analysis.

Fifth, an action research approach to implementing the recommendations from this research in service provider agencies could be undertaken.

Last, a longitudinal study, as opposed to cross sectional analysis, could be conducted pre-and post NDIS implementation in Queensland.

### **Concluding Comments**

Provision of quality services for people with ID and CB is effected by various dynamic systems and requires a person-centred approach. The experience of service delivery, then, is primary and service user outcomes become the basic indicators of quality. This study has provided evidence that a number of service users with ID and CB are able to reflect on and discuss the service experience; for those who cannot there are a number of objective measures of quality of life, and other indicators that include challenging behaviour scales.

The factors that agencies need collectively to engender, embrace and apply are necessary to ensure quality service provision; these have been comprehensively presented. Further, aspects that may impact on effective delivery of services have been identified. These were situated in a dynamic, interactive model of quality service provision that can be used by agencies and governing bodies in order to both appraise and ensure

quality service provision that results in positive outcomes for service users with ID and CB. However, it must be noted that perspectives of quality are a factor of the distance from the point of delivery and the perception of the receiver, and that there is disparity between what is 'needed' for quality delivery and what was experienced in direct delivery.

In sum, people with ID and CB are reported in the research as having reduced quality of life and therefore an understanding of quality service provision is critical.

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## Appendix A

### Delphi Round One Survey for CEOs and Managers

#### Demographic Information

**1. Name of Organisation**

**2. Approximate number of service users receiving services from your organisation**

**3. Approximate proportion of service users with intellectual disabilities and challenging behaviour**

**4. Your job title**

**5. Number of years in current role**

**6. Number of years working in the disability sector**

**7. Gender**

Male

Female

**8. Age**

Less than 30

30-39

40-49

50-59

60+

The purpose of this survey is to determine what factors are critical to quality service provision for people with intellectual disabilities who exhibit challenging behaviour. Quality service provision for this group of service users can be determined by the following service user outcomes:

- increased quality of life,
- decreased frequency or severity of challenging behaviours, and/or
- decreased use of restrictive practices.

Please indicate to what extent each of the items below contribute to these positive outcomes for service users who have an intellectual disability and exhibit challenging behaviour.

#### FUNDING

#### **9. Funding allocations within agencies i.e. the proportion of funding allocated to various purposes such as in-service training, hiring qualified management etc.**

- 1: Not at all
- 2: A little
- 3: A moderate amount
- 4: Quite a lot
- 5: A great deal

#### **10. Funding from grants and fundraising**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

#### **11. Individualised funding: funding provided and controlled by the service users and/or their substitute decision maker**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

Please indicate to what extent the following items contribute to positive outcomes for service users with intellectual disabilities and challenging behaviour.

#### MANAGEMENT PRACTICES

**12. Leadership: understanding the needs of staff and meeting these needs through practices such as mentoring, coaching and inspiring**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**13. Flexibility of management i.e. having flexible rather than rigid implementation of policy in order to enhance service user outcomes**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**14. Regular (at least monthly) supervision and feedback i.e. the direct observation of staff performing their role and feedback based on this performance**

- 1: Not at all
- 2: Just a little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

Please indicate to what extent the following items contribute to positive outcomes for service users with intellectual disabilities and challenging behaviour.

#### ORGANISATION OF STAFF

##### **15. An appropriate match between the direct-care worker and the service user**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

##### **16. Role clarity: staff knowing what they are required to do**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

##### **17. Allocating staff to the right teams i.e. an appropriate match between staff team members**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

##### **18. Sufficient staff to service user ratios**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

Please indicate to what extent the following items contribute to positive outcomes for service users with intellectual disabilities and challenging behaviour.

PROGRAMS AND PRACTICES

**19. Programs and service delivery is based on the service user's needs and desires (person-centredness)**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**20. Staff interactions with service users are respectful and caring**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**21. Staff adherence to evidence-based practices e.g. Positive Behaviour Support Plans**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**22. The quality of written plans i.e. person-centered plans/ positive behaviour support plans are well written, understandable and accurate**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal



**23. Providing and supporting service users in various community options e.g. employment, accommodation and recreation**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**24. Functional assessment and Positive Behavior Support including Applied Behaviour Analysis**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

Please indicate to what extent the following items contribute to positive outcomes for service users with intellectual disabilities and challenging behaviour.

**IN-SERVICE TRAINING**

**25. In-service training based on the development needs of staff**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**26. In-service training that is specific to working with people who exhibit challenging behaviour**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**27. In-service training that is provided to meet occupational health and safety requirements**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

Please indicate to what extent the following items contribute to positive outcomes for service users with intellectual disabilities and challenging behaviour.

STAFF

**28. Staff have qualifications in disability, such as a Certificate III or IV in Disability**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**29. Staff have qualifications or prior training that is specific to working with service users with challenging behaviours**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**30. Staff have attitudes that support the rights of service users and community inclusion**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**31. Staff beliefs and attributions regarding the causes of challenging behaviour reflect Positive Behaviour Support**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**32. Staff have prior experience working in disability services**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

Please indicate to what extent the following items contribute to positive outcomes for service users with intellectual disabilities and challenging behaviour.

ORGANISATIONAL

**33. Collaboration with other disciplines, such as occupational therapists, psychologists and speech therapists**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**34. Compliance with Government standards and service agreements**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**35. Compliance with legislative and other reporting requirements, such as critical incident reporting and restrictive practice guidelines**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**36. The effort that an organisation goes to to achieve service user outcomes i.e. effort to place service users in more independent environments**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**37. Organisation efficiency i.e. how effectively money is used within agencies**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**38. Measuring staff-related outputs e.g. employment duration, staff satisfaction**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**39. Measuring service user outcomes e.g. quality of life**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**40. Utilising data from within the organisation to inform changes i.e. using staff satisfaction data for service improvement**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

**41. Congruence between the organisation's values and the organisational culture i.e. the shared values and attitudes of staff reflect the organisation's values such as person-centeredness, respect, equality**

- 1: Not at all
- 2: A little
- 3: Moderate amount
- 4: Quite a lot
- 5: A great deal

Thinking more about outcomes for service users with intellectual disabilities who exhibit challenging behaviour, please rate your strength of agreement with the following statements

**42. Management practices, such as leadership and flexibility, are more important to producing quality outcomes for service users than factors outside of the control of management, such as low wages and a lack of access to a skilled workforce**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly agree

**43. Staff turnover is related more to stress and burnout than features of employment in the sector, such as emotional and physical demands of the job, low wages**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly Agree

**44. Increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly Agree

**45. An organisation's commitment and capacity to measure service user outcomes, such as their quality of life, can enable quality outcomes for service users**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly Agree

**46. An organisation's commitment and capacity to measure organisational outcomes, such as staff satisfaction and efficiency, can enable quality outcomes for service users**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly Agree

**47. Staff implementation of person-centred plans and/or positive behaviour support plans is dependent on the quality of the plans e.g. concise, understandable and not complex**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly Agree

**48. Increases to funding does not necessarily mean increases to the quality of services**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly Agree










**49. Service user/family control of how funding is spent increases quality outcomes for service users**

- 1: Strongly disagree
- 2: Disagree
- 3: Neither agree nor disagree
- 4: Agree
- 5: Strongly Agree



To achieve positive outcomes for people with intellectual disabilities who exhibit challenging behaviour, which factors are the most to the least important?

**50. Please rank each of the following factors from the most important (1) to the least important (9) by allocating one number to each factor**

-  Mission statements i.e. . being a statement that outlines the agency's purpose and goals
-  Organisational policies, e.g. written plans, instructions and processes
-  Government policy and standards
-  Knowing the needs and desires of service users
-  Physical resources, such as equipment, computers, hosts and vehicles
-  Personnel within the organisation, such as direct care workers and supervisors
-  Consultant allied health personnel, such as occupational therapists and psychiatrists
-  The environmental context, such as location and size of the facility
-  Funding

**51. Are there other factors you think are critical to quality outcomes for service users with intellectual disabilities who exhibit challenging behaviour that have not been identified in this questionnaire?**

## Appendix B

### Delphi Round Two Survey for CEOs and Managers

#### Demographic Information

**1. Name of Organisation**

**2. Your job title**

**3. Number of years in current role**

**4. Number of years working in the disability sector**

**5. Gender**

Male

Female

**6. Age**

Less than 30

30-39

40-49

50-59

60+

Quality service provision for people with intellectual disabilities and challenging behaviour can be determined by the following service user outcomes:

- increased quality of life,
- decreased frequency or severity of challenging behaviours, and/or
- decreased use of restrictive practices.

Results from the previous survey indicated that the following factors are significant to quality outcomes for service users. These are currently ordered from the highest to lowest for each category, based on the mean scores.

PLEASE RANK ORDER EACH FACTOR, WITH 1 (ONE) BEING THE MOST IMPORTANT TO QUALITY OUTCOMES FOR SERVICE USERS. PLEASE NOTE: as you rank a response, the list order will change. For example, your rank one selection will move this factor to the first in the list and auto populate rankings for the remainder. Continue to rank order bearing in mind that as you rank factors the list will re-order.

### 7. Management Practices (Rank 1 to 3)

- Leadership, understanding the needs of staff and meeting these needs through practices such as mentoring, coaching and inspiring
- Flexibility of management i.e. having flexible rather than rigid implementation of policy in order to enhance service user outcomes
- Regular (at least monthly) supervision and feedback i.e. the direct observation of staff performing their role and feedback based on this performance

### 8. Organisation of Staff (Rank 1 to 4)

- Role clarity: staff knowing what they are required to do
- An appropriate match between the direct-care worker and the service user
- Sufficient staff to service user ratios
- Allocating staff to the right teams i.e. an appropriate match between staff team members

### 9. Programs and Practices (Rank 1-6)

- Staff interactions with service users are respectful and caring
- Programs and service delivery is based on the service user's needs and desires (person-centredness)
- Staff adherence to evidence-based practices e.g. Positive Behaviour Support Plans
- The quality of written plans i.e. person-centered plans/ positive behaviour support plans are well written, understandable and accurate
- Providing and supporting service users in various community options e.g. employment, accommodation and recreation
- Functional assessment and Positive Behavior Support incorporating Applied Behaviour Analysis

### 10. In-service Training (Rank 1-3)

- In-service training that is provided to meet occupational health and safety requirements
- In-service training that is specific to working with people who exhibit challenging behaviour
- In-service training based on the development needs of staff

### 11. Staff (Rank 1-5)

- Staff have attitudes that support the rights of service users and community inclusion
- Staff beliefs and attributions regarding the causes of challenging behaviour reflect Positive Behaviour Support
- Staff have qualifications or prior training that is specific to working with service users with challenging behaviours
- Staff have qualifications in disability, such as a Certificate III or IV in Disability
- Staff have prior experience working in disability services

### 12. Organisational (Rank 1-9)

- Congruence between the organization's values and the organizational culture i.e. the shared values and attitudes of staff reflect the organization's values such as person-centredness, respect, equality
- Organisation efficiency i.e. how effectively money is used within agencies
- The effort that an organisation goes to to achieve service user outcomes i.e. effort to place service users in more independent environments
- Compliance with legislative and other reporting requirements, such as critical incident reporting and restrictive practice guidelines
- Measuring service user outcomes e.g. quality of life
- Compliance with Government standards and service agreements
- Collaboration with other disciplines, such as occupational therapists, psychologists and speech therapists
- Utilising data from within the organisation to inform changes i.e. using staff satisfaction data for service improvement
- Measuring staff-related outputs e.g. employment duration, staff satisfaction

The results of the previous survey showed a lack of consensus regarding rank ordering of agency input factors. These items are currently in rank order using mean ranking scores from the first survey.

**13. Please rank these input factors from the most important (1) to the least important (9) to achieving quality outcomes for service users**

<input type="text"/>	1. Knowing the needs and desires of service users
<input type="text"/>	2. Personnel within the organisation, such as direct care workers and supervisors
<input type="text"/>	3. Funding
<input type="text"/>	4. Mission statements i.e. a statement that outlines the agency's purpose and goals
<input type="text"/>	5. Organisational policies, e.g. written plans, instructions and processes
<input type="text"/>	6. Physical resources, such as equipment, computers, hoists and vehicles
<input type="text"/>	7. The environmental context, such as location and size of the facility
<input type="text"/>	8. Consultant allied health personnel, such as occupational therapists and psychiatrists
<input type="text"/>	9. Government policy and standards

Results from the first survey indicated a lack of consensus for the following statements. Please indicate whether you agree/disagree with the statement and provide a rationale for your decision.

**14. Staff turnover is related more to stress and burnout than features of employment in the sector, such as emotional and physical demands of the job, low wages etc.**

- Agree  
 Disagree

Why/why not?

**15. Increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users**

- Agree  
 Disagree

Why/why not?

**16. Increases to funding does not necessarily mean increases to the quality of services**

- Agree  
 Disagree

Why/why not?

**17. Individualised funding, i.e. funding provided and controlled by service users and/or their substitute decision maker, increases quality outcomes for service users**

- Agree  
 Disagree

Why/why not?

**18. To what extent does consistent application of evidence-based practices by the agencies providing different services to a service user and families, contribute to positive outcomes to service users?**

- Not at all
- Just a little
- Moderate amount
- Quite a lot
- A great deal

Comment

## Appendix C

### Survey for Clinicians and Senior Practitioners

#### Demographic Information

**1. Your job title**

**2. Primary place of work**

Metropolitan / Urban

Rural and Remote

**3. Number of years in current role**

**4. Number of years working in the disability sector**

**5. Gender**

Male

Female

**6. Age**

Less than 30

30-39

40-49

50-59

60+



Quality service provision for people with intellectual disabilities and challenging behaviour can be determined by the following service user outcomes:

- increased quality of life,
- decreased frequency or severity of challenging behaviours, and/or
- decreased use of restrictive practices.

THINKING OF DISABILITY SERVICE PROVIDER AGENCIES, PLEASE RANK ORDER EACH FACTOR WITH 1 (ONE) BEING THE MOST IMPORTANT TO QUALITY OUTCOMES FOR SERVICE USERS. PLEASE NOTE: as you rank a response, the list order will change. For example, your rank one selection will move this factor to the first in the list and auto populate rankings for the remainder. Continue to rank order bearing in mind that as you rank factors the list will re-order.

### 7. Management Practices (Rank 1 to 3)

- Leadership, understanding the needs of staff and meeting these needs through practices such as mentoring, coaching and inspiring
- Flexibility of management i.e. having flexible rather than rigid implementation of policy in order to enhance service user outcomes
- Regular (at least monthly) supervision and feedback i.e. the direct observation of staff performing their role and feedback based on this performance

### 8. Please list other MANAGEMENT PRACTICES that are critical to quality outcomes for service users

### 9. Organisation of Staff (Rank 1 to 4)

- Role clarity: staff knowing what they are required to do
- An appropriate match between the direct-care worker and the service user
- Sufficient staff to service user ratios
- Allocating staff to the right teams i.e. an appropriate match between staff team members

### 10. Please list other factors, related to ORGANISATION OF STAFF, that are critical to quality outcomes for service users

### 11. Programs and Practices (Rank 1-6)

- Staff interactions with service users are respectful and caring
- Programs and service delivery is based on the service user's needs and desires (person-centredness)
- Staff adherence to evidence-based practices e.g. Positive Behaviour Support Plans
- The quality of written plans i.e. person-centered plans/ positive behaviour support plans are well written, understandable and accurate
- Providing and supporting service users in various community options e.g. employment, accommodation and recreation
- Functional assessment and Positive Behavior Support incorporating Applied Behaviour Analysis

### 12. Please list other PROGRAMS AND PRACTICES that are critical to quality outcomes for service users

### 13. In-service Training (Rank 1-3)

- In-service training that is provided to meet occupational health and safety requirements
- In-service training that is specific to working with people who exhibit challenging behaviour
- In-service training based on the development needs of staff

### 14. Please list other IN-SERVICE TRAINING that is critical to quality outcomes for service users

### 15. Staff (Rank 1-5)

- Staff have attitudes that support the rights of service users and community inclusion
- Staff beliefs and attributions regarding the causes of challenging behaviour reflect Positive Behaviour Support
- Staff have qualifications or prior training that is specific to working with service users with challenging behaviours
- Staff have qualifications in disability, such as a Certificate III or IV in Disability
- Staff have prior experience working in disability services

### 16. Please list other STAFF factors that are critical to quality outcomes for service users

### 17. Organisational (Rank 1-9)

Congruence between the organisation's values and the organisational culture i.e. the shared values and attitudes of staff reflect the organisation's values such as person-centeredness, respect, equality

Organisation efficiency i.e. how effectively money is used within agencies

The effort that an organisation goes to to achieve service user outcomes i.e. effort to place service users in more independent environments

Compliance with legislative and other reporting requirements, such as critical incident reporting and restrictive practice guidelines

Measuring service user outcomes e.g. quality of life

Compliance with Government standards and service agreements

Collaboration with other disciplines, such as occupational therapists, psychologists and speech therapists

Utilising data from within the organisation to inform changes i.e. using staff satisfaction data for service improvement

Measuring staff-related outputs e.g. employment duration, staff satisfaction

### 18. Please list other ORGANISATIONAL variables that you think are critical to quality outcomes for service users

**19. Please rank these input factors from the most important (1) to the least important (9) to achieving quality outcomes for service users**

<input type="radio"/>	Knowing the needs and desires of service users
<input type="radio"/>	Personnel within the organisation, such as direct care workers and supervisors
<input type="radio"/>	Funding
<input type="radio"/>	Mission statements i.e. a statement that outlines the agency's purpose and goals
<input type="radio"/>	Organisational policies, e.g. written plans, instructions and processes
<input type="radio"/>	Physical resources, such as equipment, computers, hoists and vehicles
<input type="radio"/>	The environmental context, such as location and size of the facility
<input type="radio"/>	Consultant allied health personnel, such as occupational therapists and psychiatrists
<input type="radio"/>	Government policy and standards

**20. Please list other INPUT factors that you think are critical to quality outcomes for service users**

**21. Are there other factors you think are critical to quality outcomes for service users with intellectual disabilities who exhibit challenging behaviour that have not been identified in this questionnaire?**

With regard to service provision for people with intellectual disabilities and challenging behaviours, please indicate whether you agree/disagree with the following statements and provide a rationale for your decision.

**22. Staff turnover is related more to stress and burnout than features of employment in the sector, such as emotional and physical demands of the job, low wages etc.**

- Agree  
 Disagree

Why/ why not?

**23. Increasing staff to resident ratios beyond the needs of service users can increase outcomes for service users**

- Agree  
 Disagree

Why/ why not?

**24. Increases to funding does not necessarily mean increases to the quality of services**

- Agree  
 Disagree

Why/ why not?

**25. Individualised funding, i.e. funding provided and controlled by service users and/or their substitute decision maker, increases quality outcomes for service users**

- Agree  
 Disagree

Why/ why not?

**26. To what extent does consistent application of evidence-based practices by the agencies providing different services to a service user and families, contribute to positive outcomes to service users?**

- Not at all
- Just a little
- Moderate amount
- Quite a lot
- A great deal

Comment

## Appendix D

### Survey for Advocates, Support Workers, Supervisors and Families/Carers

**What is your gender?**

Female

Male

**What is your age?**

Less than 30

30-39

40-49

50-59

60 +

**What is your highest qualification?**

School (did not complete high school)

School (completed high school)

TAFE

Undergraduate Degree

Postgraduate Degree

**What is the name of your highest qualification? (e.g. Cert 3 in Aged Care)**

**In relation to a person/ people with intellectual disability and challenging behaviour, what is your primary role?**

- Paid direct-care worker / support worker
- Supervisor/ coordinator working in disability services
- Advocate
- Family / unpaid carer of a person who receives disability supports



**What service do you mostly work or manage in?**

- Accommodation support services
- Respite services
- Community support services
- Community access

Other (please specify)

**What is your primary work location?**

- Metropolitan / urban area
- Rural and remote area

If unsure, please provide suburb or postcode

**Number of years in current role**

**Number of years working in the disability sector**

**Are you also a family member of, or an unpaid carer for, an adult with an intellectual disability who shows challenging behaviours?**

- Yes
- No

**Which of following disability services does your family member receive? (You can select multiple answers)**

- Accommodation support services
- Respite services
- Community support
- Community access

Other (please specify)

**Where does your family member receive the majority of their disability services?**

- Metropolitan / urban area
- Rural and remote area

If unsure, please provide suburb or postcode

**Where do you live?**

- Metropolitan / urban area
- Rural and remote area

If unsure, please provide your suburb or postcode

Positive outcomes for people with intellectual disabilities who show challenging behaviours are considered to be:

- increased quality of life;
- decreased challenging behaviours; and/or
- decreased use of restrictive practices.

In the following questions you are asked to rate the contribution of a number of items to the achievement of these positive outcomes. By contribution we mean how much does this help achieve positive outcomes for people with intellectual disabilities and challenging behaviours. For instance, if you were asked about funding and you believe that funding does not make a contribution to the achievement of positive outcomes at all, you would rate that as 'no contribution'. If you were of the view that funding always determines the achievement of positive outcomes then you would rate funding as a 'major contribution'.

### Communication and Collaboration...

	Unsure	No contribution	Minor contribution	Moderate contribution	Major contribution
Between staff in teams working with the same client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between various levels of management, e.g., information flows 'up and down'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between services provided to the same client, e.g., different agencies communicate about client goals and strategies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between the agency and professionals such as psychologists or occupational therapists	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between families /carers and the agency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between the agency and other agencies or community groups, e.g., they communicate about social events and activities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Compatibility...

	Unsure	No contribution	Minor contribution	Moderate contribution	Major contribution
Between clients attending the same service or living together, e.g., they get along well and are matched in terms of interests and/or abilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between staff and clients, e.g., they have a 'good' rapport and worker abilities/interests match the needs of the client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between staff working with the same client, e.g., they work well as a team	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Between staff and the setting where they work, e.g., staff skills and abilities match the residence or facility where they work	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thinking about disability services, please identify how much of a contribution each of the following makes to getting positive outcomes for people with intellectual disabilities who show challenging behaviours.

### Consistency

	Unsure	No contribution	Minor contribution	Moderate contribution	Major contribution
Having a consistent group of staff members working with a client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consistent implementation of Positive Behaviour Support Plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consistency in other practices and support across staff members, such as boundaries and routines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Consistency in delivering services, e.g., the set activity program is followed	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

### Management Practices

	Unsure	No contribution	Minor contribution	Moderate contribution	Major contribution
In-service training for support workers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Support for staff, meaning that management are available, understanding, involved when needed and/or listen to ideas	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Case discussions and/or team meetings to encourage sharing of ideas and practices that are 'working well'	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Regular formal supervision meetings between support workers and supervisors	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff know what they are meant to do and how to implement Positive Behaviour Support Plans	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flexible approaches to managing risk and duty of care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Flexibility with funding allocations in the agency to meet needs across the client group	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Effective financial management to ensure low administrative costs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Leadership, i.e., knowing the needs of staff and addressing these needs, such as through demonstrating best practice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thinking about disability services, please identify how much of a contribution each of the following makes to getting positive outcomes for people with intellectual disabilities who show challenging behaviours.

**In-service training for support workers....**

	Unsure	No contribution	Minor contribution	Moderate contribution	Major contribution
To meet occupational health and safety requirements, such as medication training	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
That is specific to working with clients with challenging behaviours, e.g., managing behaviours, how to implement support plans, restrictive practices	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Regarding the human rights of people with disabilities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In understanding specific disabilities, e.g., what is autism?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Other**

	Unsure	No contribution	Minor contribution	Moderate contribution	Major contribution
Clients are supported to develop relationships with people in the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Service provision is based on the needs and desires of each client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The physical setting, e.g. there is a homelike environment and personal space for each client in group homes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Physical resources, such as vehicles and materials, are available	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The client has choice over control, such as over what they do, when they do it and, if they live in group homes, who they live with	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
A supportive relationship between staff and the client, e.g., they have a good rapport and bond	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having the right staff, such as those with empathy and common-sense	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Please list items not previously mentioned that you think contribute to positive outcomes for adults with intellectual disabilities who show challenging behaviours**

As stated previously, positive outcomes for people with intellectual disabilities who show challenging behaviours are considered to be:

- increased quality of life;
- decreased challenging behaviours; and/or
- decreased use of restrictive practices.

In the following questions you are asked to rate the impact of a number of items to the achievement of these positive outcomes for people with intellectual disabilities and challenging behaviours. By impact we mean to what extent does this effect the achievement of positive outcomes for this groups of people. For instance, if you were asked about agency policy and you believe that agency policy does not impact the achievement of positive outcomes at all, you would rate that as 'no impact'. If you were of the view that agency policy always determines the achievement of positive outcomes then you would rate this as 'major impact'.

So, thinking more about disability services, please identify how much each of the following items impact on getting positive outcomes for people with intellectual disabilities who show challenging behaviours.

### Staff, Programs and Practices

	Unsure	No impact	Minor impact	Moderate impact	Major impact
Honesty and honest feedback, e.g., supervisors are honest with support workers, and support workers are honest with supervisors regarding implementation of programs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Empowering clients to understand their options and make decisions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Advocating for the client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having an in-depth understanding of the client, such as their history and needs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Accurate interpretations as to the functions of challenging behaviours, such as recognising if a behaviour is a result of a treatable illness like an ear infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sufficient staff to client ratios that enable the delivery of quality programs that includes teaching of skills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff turnover and stress	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a long-term outcome focus for clients, such as teaching skills to maximise independence	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Upper management have the capability and skills to effectively manage the agency	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Thinking more about disability services, please identify how much each item impacts on getting positive outcomes for people with intellectual disabilities who show challenging behaviours.

### Organisational

	Unsure	No impact	Minor impact	Moderate impact	Major impact
The agency and staff are responsive and accountable, e.g., they appropriately respond to critical incidents and advice from professionals	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The agency regards themselves as employees of the client, rather than the decision maker of what and how services will be provided	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Having a complaints process that is available and understandable to the client, and leads to a resolution	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Potential staff are appropriately screened	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Staff knowledge of and follow through with the agency's mission and policies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The agency's commitment to quality improvement and ability to turn ideas into change	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agency respect and regard for the families/ unpaid carers of clients, e.g., management is available and respect their input	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Agency commitment to getting good outcomes for clients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The values and framework of the agency and the staff, i.e., the organisation and staff value people with disabilities, support and protect their human rights	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



Thinking more about service provider agencies, please identify how much each of the following items impact on getting positive outcomes for people with intellectual disabilities who show challenging behaviours.

**Other**

	Unsure	No impact	Minor impact	Moderate impact	Major impact
For clients who have an Adult Guardian appointed by QCAT, the Guardian regularly consults with the client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The Positive Behaviour Support Plan is not too long, is easy to understand, and is not complicated	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The person who writes the Positive Behaviour Support Plan knows the client and is contactable	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The general public treat people with disabilities as part of the community	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
The agency refers clients to other agencies if they feel their needs could be better met elsewhere	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Positive behaviour support incorporates functional assessment of behaviour and Applied Behaviour Analysis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**Please list other items you think impact on positive outcomes for adults with intellectual disabilities who show challenging behaviours**



**Finally, please rate your strength of agreement with the following statements**

	Unsure	Strongly disagree	Disagree	Agree	Strongly agree
Having too much support, e.g., having too high staff to client ratios, can limit client outcomes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Small agencies achieve better outcomes for clients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Labelling a client as having challenging behaviours may result in people not thoroughly considering the meaning of the behaviour and/or limiting expectations and opportunities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Qualifications and experience of support workers is not as important as their personal qualities, such as empathy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Using external agency support workers (fill-in staff) negatively impacts on client outcomes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

## Appendix E

### Service User Focus Group Questions

<b>Life Satisfaction Scale Domain</b> (Bergstrom et al., 2013)	<b>Open Ended Questions</b>	<b>Probing Questions</b>
Housing Environment	<ul style="list-style-type: none"> <li>• What do you like about where you live? What don't you like about where you live?</li> </ul>	<ul style="list-style-type: none"> <li>• What do you like about the building/ house?</li> <li>• Can you tell me about the people you live with?</li> <li>• Can you tell me about your room?</li> <li>• What are some of the things in your room that you really like?</li> </ul>
Life	<ul style="list-style-type: none"> <li>• What do you do during the day?</li> <li>• Who is your favourite worker?</li> <li>• Do you have friends that don't live here?</li> <li>• Do you see your family very much?</li> </ul>	<ul style="list-style-type: none"> <li>• What do you like/ what don't you like about doing those things?</li> <li>• What are some things that you would prefer to do?</li> <li>• Why don't you don't do those things?</li> <li>• What do you like about _____?</li> <li>• Can you tell me about other people who work with you?</li> <li>• What are some of the reasons staff stop working here?</li> <li>• How did you meet them?</li> <li>• What do you like to do with them?</li> <li>• How often do you see them?</li> <li>• What is it like when you see them?</li> <li>• How often do you see them?</li> </ul>
Meals	<ul style="list-style-type: none"> <li>• What do you think about the food here?</li> </ul>	<ul style="list-style-type: none"> <li>• What are some things you like or don't like about the food?</li> </ul>
Recreational Activities	<ul style="list-style-type: none"> <li>• What do you like to do for fun?</li> </ul>	<ul style="list-style-type: none"> <li>• How often do you do _____?</li> <li>• How often would you like to do _____?</li> <li>• What are the things you would like to do that you don't? Why don't you do these?</li> </ul>

## Appendix F

### Service User Focus Group Skits

Skit Description	Life Satisfaction Scale Domain (Bergstrom et al., 2013)	Open Ended Questions
"Tea": depicted a service user asking a support staff member for a cup of tea. The staff member provides verbal prompts, and physical when required, to enable the service user to make the tea	Life	<ul style="list-style-type: none"> <li>• What happened in the video?</li> <li>• How do you feel when workers help you do things?</li> <li>• What are some of the things you need help with? How do people help you with that? Do you think you'll be able to do that by yourself one day, why/why not?</li> <li>• How do people find out what you'd like to learn to do?</li> <li>• What are some things you can do by yourself but you are not allowed to? How does that make you feel?</li> </ul>
"Hungry": depicted two service users finishing a snack but vocalising that they are still hungry. The worker informs them that they will have to wait until dinner, and that they need to have showers and tidy their room first. The service users become increasingly agitated.	Meals/ Life	<ul style="list-style-type: none"> <li>• What happened in the video?</li> <li>• Can you explain a time when that happened to you?</li> <li>• Who decides when it is time to eat?</li> <li>• How do you help with getting the food ready?</li> <li>• Who decides what everyone has to eat? How do they decide that?</li> <li>• In the video one person said, "you can't do that, I'm telling my mum". Who do you tell if you don't like what is happening?</li> </ul>
"More Coffee": depicted a service user finishing a cup of coffee and asking for another one. When the worker suggests she can have another one after lunch the service user swears and repeatedly hits the worker. The worker leaves the room shutting the door behind him.	Housing Environment/ Life	<ul style="list-style-type: none"> <li>• What happened in the video?</li> <li>• Why do you think she wasn't allowed to have more coffee? Does that ever happen to you?</li> <li>• At that place the coffee is locked up. How does it make you feel when things are locked up?</li> <li>• What did the worker do when she was hit? What else could he have done?</li> <li>• What happens if someone hits you? What does being safe mean to you?</li> </ul>
"Shopping": This skit depicts a service user requesting that a worker takes her shopping. The worker tells her that they can't as the bus is out. The service user continues to ask and the worker becomes more dismissive and threatens the service user that if she asks again she will 'never get to go to the shops'.	Recreation/ Life	<ul style="list-style-type: none"> <li>• What happened in the video?</li> <li>• How often do you go to the shops?</li> <li>• What are some of the things you like to do for fun, besides go to the shops? How often do you do that?</li> <li>• Do you think the worker was treating her nicely? What do you think about the way staff speak to you?</li> <li>• What do you think the worker should have done?</li> </ul>
"Photos": depicts a service user and a worker looking at pictures together and discussing them.	Recreation/ Life	<ul style="list-style-type: none"> <li>• What happened in the video?</li> <li>• What time of the fun things do you and the workers do?</li> <li>• What are some of the things you don't like to do? Why do you think you have to do them?</li> <li>• How much time do you have when it's just you and one staff member?</li> </ul>