



Making Life Good in the Community: measures of resident outcomes and staff perceptions of the move from an institution

Department of Social Work and Social Policy, La Trobe University

Professor Christine Bigby, Dr Brian K Cooper and Dr Kate Reid

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The contributions of Tim Clement, Patsie Frawley, Alan Robertson and Silvia Warren to earlier reports are gratefully acknowledged.

Cover art

The cover art was painted by artist Alan Constable, a painter and ceramicist who has exhibited in Australian and overseas galleries. He has been a finalist in a number of mainstream art awards.

Based on imagery from newspapers and magazines, his recent paintings are notable for their vibrant kaleidoscopic effects and strong sense of colour and patterning. Though Constable's works are often centred on political events and global figures, his thematic concerns are frequently subjugated by the pure visual experience of colour and form. Despite the occasional gravity of his subject matter, there is a genuine sense of joy within Constable's paintings.

Alan Constable is a former resident of Kew Residential Services.

Executive summary

Kew Residential Services (KRS), formerly known as Kew Cottages, was the oldest and largest institution for people with intellectual disabilities in Australia. Its closure in April 2008 was a triumph and a key strategy of the Victorian Government's *State disability plan* (Department of Human Services 2002). It reflected the shift in policy from the congregation and segregation of people with an intellectual disability to deinstitutionalisation and its embedded visions of their equal rights and social inclusion. Most of the KRS residents were relocated to small group homes in the community across metropolitan Melbourne and rural Victoria. One hundred residents moved to 20 group homes in the new commercial housing development built on the 27-hectare KRS site, which were 'integrated into the new suburb on site' rather than forming a cluster development (u.d. Department of Human Services).

Professor Christine Bigby from the La Trobe School of Social Work and Social Policy led the Making Life Good in the Community research, which was funded by the Department of Human Services to examine outcomes for KRS residents who made the move to the community. Completed in 2008, the qualitative study examined life in five of the new group homes, investigated the concept of 'homeliness' and explored the role of the house supervisor. A book based on this research, *Group homes for people with intellectual disabilities: Encouraging inclusion and participation*, was published by the British publisher Jessica Kingsley (Clement & Bigby 2010a), as well as several refereed journal articles (Bigby et al. 2009c; Bigby & Frawley 2010; Clement & Bigby 2009) and a series of reports.¹ Inevitable slippage in building schedules delayed the move for some residents until April 2008, and the completion of the quantitative study, which required a follow-up survey one year after residents had moved.

This report now sets out the findings from that large-scale outcome survey that aimed to provide statistical indicators of changes to the quality of life of the former KRS residents who moved to group homes in the community.

¹ See (Clement & Bigby, 2007, 2008a, 2008b 2008c; Clement et al. 2006; Clement et al. 2008) available on <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/research,-data-and-statistics/making-life-good-in-the-community>

Method

A stratified random sampling strategy based on future service location was used to select 100 participants from the 330 residents who remained at KRS in January 2005.

On average participants had spent 37 years living at KRS, their mean age was 47 years, and 60 per cent had been assessed as having a moderate to severe level of intellectual disability. The term 'known locality' was used to refer to the sub-sample who moved to houses in the new commercial housing development given the familiarity to both residents and staff of that locality, while 'new locality' was used to refer to the sub-sample who moved to group homes in new unknown localities across Victoria.

Due to the death of some residents and missing data, at the time of the 12-month follow-up a full dataset was completed for 91 residents. A range of validated instruments based on those used by Emerson et al. (2000) were used to collect data about choice, homeliness, climate of the setting, adaptive behaviour, activities in the community and social networks. Data was collected prior to the resident leaving KRS (Time 1) and a year after they moved (Time 2) using face-to-face interviews with a staff member who knew the resident well. In addition, at Time 2 an open-ended 13-item questionnaire sought staff views on the move and their understanding of meaning of outcomes such as choice, community inclusion and participation for the resident about whom they had completed other measures. The study focused on social inclusion and engagement in meaningful activity, which meant data were not collected on all quality of life dimensions, most notably health was omitted. Descriptive and inferential statistics were used to analyse the quantitative data and content analysis for the qualitative data.

Findings

The findings are similar to earlier Australian and international studies. Unequivocally the people with an intellectual disability who left KRS to live in small group homes experienced an increased quality of life. Significant positive changes occurred in: the homeliness of their place residence; the degree of choice they exercised; their community utilisation and person/social responsibility; their use of community facilities for leisure purposes and other activities; and the size of their social networks. In the month prior to data collection at Time 2, for example, a significantly higher proportion of residents had had friends or family around for a meal, been to a social club, pub, hairdresser, concert or play. Significant reductions were found in maladaptive behaviour, depersonalisation and block treatment.

Staff perceived that, for residents, living in an improved and less stressful environment, and the possibility for greater individualised support were the main advantages of the move to small group homes. Only a quarter of staff saw no disadvantages, with a perceived reduction of access to specialist health care being the most commonly cited disadvantage perceived by staff. Most commonly staff perceived community inclusion for a resident to be the use of public and commercial facilities, and community participation to be activity in either the community or their home. Few perceived community participation as interaction with community members, and a majority saw resident characteristics as the major obstacle to both community inclusion and participation.

As in other studies variations were found among group homes. For example, the size of the social networks of the residents in the known locality were increased by the addition of non-co-resident friends with an intellectual disability. We have suggested this was due to their pre-existing friendships with former co-residents, who were now near neighbours, their familiarity with the facilities in the neighbourhood and the higher proportion of this group with a mild intellectual disability. In this study, like others, little progress was found on the dimension of community participation, which is understood as the inclusion of people without intellectual disability in residents' social networks. For example, only 5.6 per cent of residents had weekly contact with a friend or acquaintance without an intellectual disability; family contact had declined and only 24 (28.2 per cent) residents had at least weekly contact with a family member, friend or acquaintance without an intellectual disability outside their home. This contrasts sharply with the General Household Survey (ABS 2006), which found that 96 per cent of Australian adults had been in contact with a family member or friend outside their own household in the week preceding the survey. Our findings confirmed many of those from the qualitative components of the Making Life Good in the Community study that, despite improvements in various other quality of life domains, residents continued to live in a 'distinct social space' comprised of staff, family and other people with an intellectual disability.

Discussion and conclusion

There is little doubt that a move to small group living has improved the quality of life of these ex-KRS residents, or indeed that their presence in the community is a prerequisite to increased community participation. For some people with a disability, community presence may be sufficient to create self-directed opportunities to pursue interests and interactions that lead to community participation. But those with a more severe intellectual disability who live in group homes will always require paid or informal support to take advantage of opportunities for social interaction. For this group more intensive strategies that stretch far beyond physical access or presence are needed if they are to achieve community participation. These findings suggest little progress on this dimension and limited understanding by staff that community participation is essentially about fostering social connections and relationships between people with and without an intellectual disability. They suggest the need for 'dedifferentiated' disability policy and stronger practice guidance about the nature of community participation to take account of the differing pathways and support that may be required to achieve it and to reinforce that community participation is a policy aim that is equally applicable to all people with disabilities, not just those who are more able. There are examples in the literature where formal programs have successfully facilitated the development of social relationships for people with more severe intellectual disabilities (Wightman 2009). Accounts demonstrate the intensive and lengthy processes involved that require planning, commitment, resources and a positive outlook. Such programs are usually supplementary rather than integral to group home programs and are of a very different nature to the employment of a one-to-one support worker whose role is often simply to support a person to participate in community activities or accompany them to community facilities such as coffee shop.

This study adds one more piece of evidence to the continuing debate in some jurisdictions about the benefits of small group living for people with intellectual disabilities compared with large and more congregated settings. The Making Life Good in the Community research leaves no doubt about the increased quality of life for people with intellectual disabilities that results from living in small group homes in the community compared to large institutions but suggests there is considerably more unrealised potential for their social inclusion. The research suggests multiple strategies will be needed if more than community presence is to be achieved. Attention must be given to the implementation of group home programs to ensure their day-to-day operations maximise opportunities for residents to develop their social connections in the community, as well as to exercise choice and engagement in meaningful activity through the use of person-centred active support. How these latter aspects might occur is discussed in detail elsewhere and the recommendations from the qualitative study are reproduced in Appendix 1 (Clement & Bigby 2008a, 2009). But, given the numerous and competing demands on group home management and staff, it may also be necessary to establish additional programs with a more explicit focus on developing community participation for residents to complement and support the work of group home staff. Such programs will act as champions of community participation and through demonstration of its diversity help to convince staff of the possibilities for all people with an intellectual disability regardless of their level of impairment. If the aspirations of current disability policy are going to be realised, and more than community presence be achieved, it is necessary to spell out much more clearly what is meant by community participation and its possible manifestations for people with an intellectual disability, as well as develop and refine the practices and technologies to support its development. This will only occur by paying attention to the more differentiated and targeted programs and policy implementation strategies for the very different groups that comprise people with a disability.

Introduction

Melbourne's Kew Residential Services (KRS), formerly known as Kew Cottages, was the oldest and largest institution for people with intellectual disabilities in Australia. Since the 1960s resident numbers declined slowly from a high of 950 to 330 in January 2005. The downsizing and the final commitment to close KRS, made in 2000, reflects the shift in government policy from the congregation and segregation of people with an intellectual disability to deinstitutionalisation and its embedded visions of equal rights and social inclusion.

The Bracks Labor Government that came to power in 2000 emphasised community development as a means to combat social exclusion (Government of Victoria 2005). It took a bold policy step in creating the whole-of-government *State disability plan* with the vision that:

By 2012, Victoria will be a stronger and more inclusive community – a place where diversity is embraced and celebrated, and where everyone has the same opportunities to participate in the life of the community, and the same responsibilities towards society as all other citizens of Victoria (Department of Human Services 2002).

The plan's focus was broader than disability services, regarding it as a whole-of-government responsibility to create inclusive communities for people with disabilities. Its three major aims were: to reorient disability supports to be more responsive to individual needs; to strengthen communities so that people with a disability have the same opportunities to participate in the social, economic, cultural, political and spiritual life of the community; and to take the lead in improving the accessibility and responsiveness of public services. A central implementation strategy was the closure of KRS. Despite significant debate in the media about replacing KRS with a centre of disability excellence or a cluster village, and controversy about the sale and future use of the land, the institution closed in April 2008.

Most of the KRS residents were relocated to small group homes (also called community residential units, or 'CRUs') in the community across metropolitan Melbourne and rural Victoria between 2004 and 2007. In April 2008 the remaining 100 residents moved to small group homes in the new housing development being built on the 27-hectare former KRS site, which had been sold to a commercial developer. The 20 group homes on the old site were 'to be integrated into the new suburb on site' (not clustered) and the '50–100 residents will integrate into a new residential subdivision on the site: living in community houses "a part of" not "apart from" their community' (u.d. Department of Human Services).

Background

Making Life Good in the Community

In 2004, as part of the redevelopment of KRS, the Victorian Department of Human Services released a tender to evaluate quality of life outcomes for residents moving from KRS into purpose-built group homes (Department of Human Services 2004). Professor Christine Bigby, from the School of Social Work and Social Policy at La Trobe University, and Dr Kelley Johnson, from the School of Social Science and Planning at RMIT University, were the successful applicants, leading a project that came to be known as Making Life Good in the Community. Following Kelley's departure to Ireland early in 2006, the project was led by Professor Christine Bigby.

The project had two major strands. The first was a large-scale outcome survey measuring changes in a range of quality of life domains for 100 residents. The longer than expected time scale for relocating residents meant the final data collection, a year after residents moved to the community, could not occur before April 2008, which delayed the completion of this part of the study. The outcomes survey was led by Professor Bigby, with significant support with the design and statistical analysis from Dr Brian Cooper from Monash University and Dr Kate Reid from La Trobe University; Ms Pam Salmon undertook the data collection.

The second and qualitative strand of research was a number of interlinked projects that primarily employed ethnographic and action research methodologies in five of the new group homes in the wider Melbourne metropolis, together with two research projects that investigated the concept of 'homeliness' and the role of a group home's manager, the house supervisor. Professor Bigby, Dr Tim Clement, Mr Alan Robertson and Dr Patsie Frawley worked on this research. Alan's presence on the research team reflects an important trend in investigating issues related to intellectual disability: the inclusion, as researchers, of people with this 'label' who have direct experience of receiving services. Dr Frawley supported Mr Robertson to undertake the 'homeliness' project and an account of including him in the research team was published in the *Journal of Intellectual and Developmental Disability* (Bigby & Frawley 2010).

A book based in the qualitative research, *Group homes for people with intellectual disabilities: Encouraging inclusion and participation* was published by the British publisher Jessica Kingsley in early 2010 (Clement & Bigby 2010a), as well as several refereed journal articles (Bigby et al. 2009c; Clement & Bigby 2009). In addition a series of reports on particular aspects were published by the Department of Human Services during the course of the study, and a synthesis final report, *As good as it gets*, was published in September 2008.²

The survey study reported here included a much larger and more diverse group of former KRS residents than were involved in the qualitative research. Notably, included in the survey were the residents who moved to the group homes built as part of the new residential sub-division on the KRS site. We have used the term 'known locality' group homes to characterise this group, as despite moving to new houses built as part of a new commercial housing development both residents and staff remained in a familiar locality with which some already had ties. A significantly larger proportion of residents in this group had mild or moderate levels of intellectual impairment compared with the residents who had moved to the other group homes spread across Melbourne. We have use the term 'new locality' to refer to this latter group, as although they moved to older and more established neighbourhoods, these localities were new and unknown to both residents and staff.

2 See (Clement & Bigby, 2007, 2008a, 2008b 2008c; Clement et al. 2006; Clement et al. 2008) available on <http://www.dhs.vic.gov.au/about-the-department/documents-and-resources/research,-data-and-statistics/making-life-good-in-the-community> or <http://www.latrobe.edu.au/health/about/staff/profile?uname=CBigby>

Background to this report

This study is situated in a substantial body of research that has examined processes of deinstitutionalisation for people with an intellectual disability, and compared the outcomes of moving from institutions to the community or between different less institutionalised models of accommodation support. A recent systematic review of this body of research confirmed the consistent pattern of evidence that has been emerging since the early studies in the 1970s that:

People in small-scale community-based residences or in semi independent or supported living arrangements have a better objective quality of life than do people in large, congregate settings. Particularly, they have more choice-making opportunities; larger social networks and more friends; access more mainstream facilities, and participate more in community life; have more chances to acquire new skills and develop or maintain existing skills; and are more satisfied with their living arrangements (Kozma et al. 2009, p. 210).

But positive outcomes are not the inevitable result of moving to the community for all people with an intellectual disability (Emerson & Hatton 1996; Kozma et al. 2009). Although demonstration programs have shown the potential for engagement in meaningful activity and social inclusion even for people with the most severe intellectual impairments or challenging behaviour, research has consistently shown significant variability in outcomes. As Mansell shows there remains an overlap between the quality of life for residents in the best institutions and the worse group homes (Mansell et al. 2007). For example, the proportion of time that staff engaged with residents in British community residences was found to vary between five and 31 per cent by Emerson and Hatton (1996), who go on to suggest:

On all measures of outcome the variation within community-based services was substantial. This suggests that for a significant minority of people, life in 'the community' would appear to be relatively indistinguishable, on these measures of outcome at least, from life in hospital (1996, p. 30).

Outcomes for residents of the best institutions, however, fall far short of the best community living programs. The evidence suggests the problem lies in 'weak implementation' rather than the small-scale group home model. The focus of research has begun to shift to a more finely grained examination of group home program implementation, the obstacles to good practice and the multi-layered factors that account for resident outcomes. Research on organisations, implementation of active support, staffing and the culture of group homes is beginning to provide some understanding about these complex processes. The Making Life Good in the Community reports have added to this knowledge, as has an ARC-funded project called Realising an 'Ordinary Life' for People with Intellectual Disabilities. Developing a theoretical framework for group home outcomes aims to develop a theoretical understanding of how such programs operate (Bigby et al. 2009b).

Finally, questions such as 'Is it good enough?' and 'How comparable is the quality of life of people with intellectual disabilities with that of the general population rather than previous institutional experiences?' have emerged from this body of research. Though there is a dearth of comparable indicators, the evidence does suggest that despite 30 years of deinstitutionalisation people with an intellectual disability remain one of society's most disadvantaged and socially excluded groups (Bigby 2004; Kozma et al. 2009).

The study reported here aimed to provide statistical indications of the changes to the quality of life of KRS residents who moved to group homes in the community. Though its methodology and its findings are similar to much previous overseas research, there are relatively few studies of this nature in Australia. For example, a 1998 systematic review (Young et al. 1998) identified only eight Australian published studies of outcomes from the closure of institutions. Kozma et al. (2009), who updated this review to 2007, identified only three more (McGilliray & McCabe 2005; Stancliffe & Keane 2001; Young 2006) and another was published the following year (Bigby 2008). Debate continues in some jurisdictions about the benefits of small group living for people with intellectual disabilities compared with large and more congregated settings, which supports the value of continuing to build evidence about outcomes of the comparative advantages of different accommodation models (Kozma et al. 2009). Continuing to collect up-to-date data also facilitates more easily normative comparison between the quality of life of people with an intellectual disability and the general adult population, and will help ensure this group is not excluded from the government's social inclusion agenda.

Method

Sample

The people in this study were all adults with an intellectual disability who were former residents of KRS. Potential participants were randomly selected from a sampling frame of the 330 residents who remained at KRS in January 2005. One hundred of this group were to remain on the KRS redeveloped site in group homes located in the commercial housing estate development, and 230 were to move to small group homes located across Victoria. Though all the residents were living at KRS in Time 1 the sample was stratified by future service location (new locality group homes or known locality group homes). Recruitment continued until each group comprised 50 residents. Due to the death of some residents and missing data, at the time of the 12-month follow-up (Time 2) a full dataset was completed for 47 residents in the new locality sample and 44 in the known locality sample, resulting in a total of 91. This was with the exception of the social network measures, which had another missing set of data and therefore only included 43 in the known locality sample.

In some instances more than one resident in a group home participated in the study, which meant a total of 42 group homes were included in the study. All the group homes were managed by the Department of Human Services through the relevant regional office for their location. Given the known locality group homes were all built as part of the new housing development in Kew, a disproportionate number of group homes in the study were managed by the department's Eastern Metropolitan Region, as shown in Table 1a.

Table 1a: Number of houses with survey participants managed by each departmental regional office

Region responsible	Known locality group homes	New locality group homes	Total	
			n	%
Eastern Metropolitan	18	6	24	57
Southern Metropolitan		5	5	12
North and West Metropolitan		11	11	27
Barwon-South Western		1	1	2
Gippsland		1	1	2
Total	18	24	42	100

Characteristics of the residents

Across the combined sample, the majority of residents were male (72 per cent) and typically aged in their mid to late forties. On average, residents had lived in KRS for close to 40 years. Table 1b shows the majority of residents had a severe/profound level of intellectual disability (60.4 per cent overall), with those relocated to new locality group homes significantly more likely to have a severe/profound disability compared with known locality residents (73.5 per cent versus 46.8 per cent).

Table 1b: Characteristics of residents at Time 1

	New locality (n = 50)	Known locality (n = 50)	Combined (n = 100)
Gender	%	%	%
Male	70.0	74.0	72.0
Female	30.0	26.0	28.0
Age in years			
Mean	46.10	49.54	47.82
SD	7.67	7.91	7.66
Level of disability	%	%	%
Mild/moderate	26.5	53.2	39.6
Severe/ profound	73.5	46.8	60.4
Years at KRS			
Mean	36.05	39.67	37.82
SD	8.04	7.80	8.09

SD = standard deviation

Over half of the known locality residents (53.2 per cent) had a mild/moderate level of intellectual disability compared with just over a quarter (26.5 per cent) of new locality group home residents. This differentiation of characteristics between the two groups was not a deliberate strategy by KRS management but is likely to have been an outcome of the criteria used to determine decisions about where residents would live. One of these criteria was attachment to the Kew locality, which may have been more common among residents with milder impairments who, while living at KRS had independently walked to the local shops and used other facilities in the neighbourhood.

Procedures

Senior program staff at KRS provided a de-identified list of residents and forwarded letters on behalf of the research team inviting them to participate. Consent was sought directly from residents or, where applicable, from their next of kin or formal guardian.

Data were collected prior to relocation (Time 1) and 12 months after their move to a group home (Time 2). At each of the two data collection points a face-to-face interview was conducted, with a caregiver nominated as a key staff informant. A key informant was defined as the caregiver who was most familiar with the resident on an ongoing basis. In the vast majority of cases, the informant was a different person at each time point. The interviews, however, were conducted by the same research assistant at both Time 1 and Time 2.

A number of staff acted as informants for more than one resident. In these circumstances, staff were interviewed separately about each resident. Time 1 data was collected between August and October 2005. Time 2 data was collected one year after a resident had moved, which meant this occurred progressively from September 2006 to May 2007 for the new locality group. For the residents in the known locality who moved during April 2008 this occurred between April and June 2009. The study was approved by the Human Research Ethics committees of La Trobe University and the Department of Human Services.

Measures

These measures were selected to ensure results would be comparable with a large British study of different models of accommodation (Emerson et al. 2000; Emerson et al. 2001; Robertson et al. 2001). The Architectural features scale (Thompson et al. 1990) was used to collect data on aspects of the 'homeliness' of the physical residential environment. *The Group Home Management Interview* (GHMI) (Pratt et al. 1980) was used to measure the extent to which the 'feel' of the residential setting had elements of a 'total institution', meaning block treatment, depersonalisation, rigidity of routines and social distance. Part I of the *Adaptive behaviour scale* (Nihira et al. 1993) was used to collect data on the adaptive skills of the resident (using the three commonly used factors of self-sufficiency, community utilisation and personal/social responsibility). Part II of the *Adaptive behaviour scale* (Nihira et al. 1993) was used to collect information on the maladaptive (or challenging) behaviour of the residents. A modified form of the *Index of community involvement* (Raynes et al. 1987, 1994) was used to collect data on the resident's involvement in 13 recreational/community activities over the preceding month. A modified version of the *Social Network Map* (Tracy & Whittaker 1990; Tracy & Abell 1994) was used to collect information about the resident's social networks and support available to them. The *Choice* scale (Hatton et al. 2000) was used to measure the extent to which the resident could exercise choice and control over key aspects of their life.

All the aforementioned measures have been assessed for evidence of reliability and validity in previous studies. Internal consistency (Cronbach's alpha) coefficients were all above 0.70 in the present study, indicating acceptable reliability. At Time 2, in addition to these validated instruments, an open-ended questionnaire called Staff member views sought staff views on aspects of their role, the support they provided and the meaning of outcomes such as choice, community inclusion and participation for the resident about whom they had completed other measures. The questionnaire had 13 items and was completed during the interview with staff. Its questions were based on the findings that were emerging from the qualitative strand of the

study about the lack of clarity about outcomes sought for residents, the meaning of social inclusion and the pivotal role of house supervisors.

Aside from the Architectural Features Scale (which was completed by the interviewer as an observer), the remaining measures were completed in a structured interview (lasting on average two hours) with the nominated key staff informant. A full set of measurements used in the study are included in Appendix 2.

Analysis

Descriptive and inferential statistics (paired sample t-tests and mixed within-between analyses of variance) were used to analyse the quantitative outcome measures. Results are reported for the combined sample, as well as for new locality group home and known locality residents separately. However, it was not the aim of the present study to directly compare the outcomes for new locality group home and known locality residents because they do not form discrete service models. Eta-squared (η^2) is reported as a measure of standardised effect size. Eta-squared ranges from 0 to 1 and provides a means of evaluating the magnitude of an intervention's effect. Larger values of eta-squared indicate stronger effects.

Content analysis was used to analyse the staff survey. The open-ended comments were transcribed and answers for each question were read, re-read, and then a first-cycle coding strategy was used to identify categories from the data. Sometimes referred to as the identification of 'themes', this type of analysis enables data to be categorised into implicit topics that organise a group of repeating ideas (Saldana 2009, p. 139). This was essentially 'meaning condensation'. Further or second-level coding that might have woven these initial categories together for meaning interpretation to uncover deeper meaning was not undertaken due to the lack of depth of this data. The number of useable records for the open-ended survey were greater than for the other measures used, which meant no records were omitted due to missing data and the total number of the sample was 93, which was all the residents who remained alive at Time 2.

Results

Resident outcomes

Choice

Table 2 presents means and standard deviations for degree of choice measures at Time 1 and Time 2. As shown, a paired sample t-test revealed that, across the combined sample, residents increased their degree of choice from Time 1 to Time 2. Interestingly, however, residents in new locality group homes showed no evidence of increased choice over time. This finding could be related to the greater level of intellectual disability among the new locality group home residents. However, a mixed between-within subjects ANOVA between time and level of intellectual disability (mild/moderate versus severe/profound) revealed no statistically significant interaction between time and level of disability. Calculating comparable figures showed that in Emerson et al.'s (2001) study the mean score on the choice scale for residents in group homes with three to six residents was 2.57, slightly higher than our sample estimates at both Time 1 and Time 2.

Table 2: Means and standard deviations for choice measures at Time 1 and Time 2

Total mean choice	Time 1		Time 2		t	η^2
	M	SD	M	SD		
New locality	1.96	0.38	2.02	0.31	0.95	.02
Known locality	2.32	0.48	2.89	0.56	8.87*	.67
Combined sample	2.12	0.46	2.42	0.62	5.53*	.26

Note: Possible range of scores: 1 (low choice) to 4 (high choice)

* $p < .05$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

Residential environment

Table 3 presents means and standard deviations for measures of the 'homeliness' of the physical residential setting at Time 1 and Time 2. A paired sample t-test revealed that across the combined sample there was a statistically significant increase from Time 1 to Time 2 in the rated homeliness of the residential setting. These increases were observed for both new locality group home and known locality residents.

Table 3: Means and standard deviations for measures of homeliness of the setting at Time 1 and Time 2

Homeliness	Time 1		Time 2		t	η^2
	M	SD	M	SD		
New locality homes		0.75	3.38	0.51	5.34*	.38
Known locality		0.85	3.84	0.47	6.37*	.49
Combined sample		0.80	3.60	0.54	8.28*	.43

Note: Possible range of scores: 1 (not at all homelike) to 5 (very homelike)

* $p < .05$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

Table 4 presents means and standard deviations for measures of the residential climate (as measured by the GHMI) at Time 1 and Time 2 for new locality group home and known locality residents (results for the combined sample are shown in Table 5). Paired sample t-tests revealed that across the combined sample there were statistically significant decreases from Time 1 to Time 2 in the extent to which settings were ‘institutionalised’ on all measures of residential climate. These decreases were evident for both new locality group home and known locality residents in block treatment, depersonalisation and social distance. However, a statistically significant decrease in rigidity of regimes was found for new locality group home residents but not for known locality residents. In interpreting these findings, we note there was a relatively high level of missing data for the GHMI measures. Caregivers reported difficulties in responding to the GHMI due to the subjective nature of many items in the instrument.

Table 4: Means and standard deviations for residential climate measures at Time 1 and Time 2 – new locality group home and known locality residents

	Time 1		Time 2		t	η^2
	M	SD	M	SD		
New locality						
Rigidity routines	8.03	2.86	5.29	1.66	-4.12*	.36
Depersonalisation	14.41	1.64	12.17	1.47	-6.05*	.57
Block treatment	8.11	0.88	6.21	0.98	-5.86*	.66
Social distance	9.17	1.88	6.20	1.82	-8.18*	.63
Known locality						
Rigidity routines	5.30	3.20	4.13	3.35	-1.39	.08
Depersonalisation	12.24	4.22	9.15	3.89	-7.05*	.61
Block treatment	6.68	1.91	4.05	1.84	-6.72*	.68
Social distance	8.22	3.55	4.12	2.56	-9.34*	.69

* $p < .05$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

Table 5: Means and standard deviations for residential climate measures at Time 1 and Time 2 – combined sample

	Time 1		Time 2		t	η^2
	M	SD	M	SD		
Combined sample						
Rigidity routines	6.87	3.27	4.80	2.56	-3.91*	.22
Depersonalisation	13.26	3.43	10.56	3.35	-9.19*	.58
Block treatment	7.34	1.67	5.05	1.84	-8.75*	.66
Social distance	8.70	2.86	5.16	2.44	-12.20*	.65

* $p < .05$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

Adaptive and challenging behaviour

Table 6 presents means and standard deviations for *Adaptive behaviour scale* (ABS Part I) scores at Time 1 and Time 2 for new locality group home and known locality residents (Table 7 shows the combined sample scores). As shown in Table 7, paired sample t-tests showed statistically significant increases from Time 1 to Time 2 in community utilisation and personal/social responsibility scores for the combined sample. These increases were found for both new locality group home and known locality residents. In contrast, personal self-sufficiency scores showed a statistically significant decrease across the combined sample. However, there was no evidence of change in personal self-sufficiency scores for new locality group home residents.

A paired sample t-test revealed no statistically significant change in total adaptive behaviour scores across the combined sample or for known locality residents. However, a paired sample t-test did reveal an increase in total adaptive behaviour scores for the new locality group home residents that just reached statistical significance at the 95 per cent level of confidence ($t = 2.00$, $p = .051$, $\eta^2 = .08$). A series of mixed between-within subjects ANOVA between time and level of intellectual disability (mild/moderate versus severe/profound) revealed no statistically significant interactions between time and level of disability on any of the *Adaptive behaviour scale* scores.

Table 6: Means and standard deviations for ABS adaptive behaviour scores at Time 1 and Time 2 – new locality group home and known locality residents

	Time 1		Time 2		t	η^2
	M	SD	M	SD		
New locality						
Total adaptive	60.00	38.69	66.00	43.20	2.00	.08
Self-sufficiency	39.72	22.59	39.53	21.53	-0.11	.00
Community	11.09	10.21	14.06	12.76	2.71*	.14
Personal/social	9.19	9.68	12.40	12.83	2.25*	.10
Known locality						
Total adaptive	119.95	78.02	121.16	82.47	0.26	.00
Self-sufficiency	57.05	23.66	50.73	26.69	-2.91*	.16
Community	35.84	37.05	39.48	38.28	1.54*	.05
Personal/social responsibility	27.07	23.39	30.95	23.07	2.42*	.12

* $p < .05$ *M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared***Table 7: Means and standard deviations for ABS adaptive behaviour scores at Time 1 and Time 2 – combined sample**

	Time 1		Time 2		t	η^2
	M	SD	M	SD		
Combined sample						
Total adaptive	88.99	67.68	92.67	70.51	1.36	.02
Self-sufficiency	48.10	24.58	44.95	24.67	-2.21*	.05
Community	23.05	29.40	26.35	30.76	2.60*	.07
Personal/social	17.84	19.75	21.37	20.62	3.32*	.11

* $p < .05$ *M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared*

Table 8 presents means and standard deviations for maladaptive (challenging) behaviour scores (ABS Part II) at Time 1 and Time 2. A paired sample t-test found a statistically significant reduction in maladaptive behaviour from Time 1 to Time 2 for the combined sample. These decreases were observed for known locality residents but not for new locality group home residents. A mixed between-within subjects ANOVA between time and level of intellectual disability (mild/moderate versus severe/profound) revealed no statistically significant interaction between time and level of disability on *malAdaptive behaviour scale* scores.

It is of interest to note the mean levels of maladaptive behaviour at Time 1 and Time 2 for both new locality group home and known locality residents were similar to those reported by Young (2006) in her Australian study of adults with moderate and severe intellectual disabilities who were relocated from an institution into either new locality group homes or cluster housing. However, the study by Young found no evidence of change in level of maladaptive behaviour compared with levels in the institution.

Table 8: Means and standard deviations for ABS maladaptive behaviour scores at Time 1 and Time 2

Total maladaptive	Time 1		Time 2		t	η^2
	M	SD	M	SD		
New locality homes	68.72	35.23	66.09	34.59	-0.46	.00
Known locality	66.95	41.36	46.32	44.19	-3.41*	.21
Combined sample	67.87	38.11	56.53	40.53	-2.68*	.07

* $p < .05$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

Community presence, activity and occupation

Table 9 presents means and standard deviations for the number of recreational/community activities (over the preceding four weeks) at Time 1 and Time 2. A paired sample t-test revealed a statistically significant increase from Time 1 to Time 2 in the number of recreational/community activities for the combined sample. These increases were observed for both new locality group home and known locality residents.

As shown in Table 9, the increase in the number of recreational/community activities in the last four weeks was greater for known locality residents (mean increase = 8.76 activities) than for new locality group home residents (mean increase = 2.40). Interestingly, further analysis showed that much of the increase in the activity engaged in by known locality residents was largely associated with greater use of cafés and shopping activities in the nearby Kew Junction shopping strip.

A mixed between-within subjects ANOVA between time and level of intellectual disability (mild/moderate versus severe/profound) revealed a statistical interaction whereby the increase in recreational/community activities was greater for residents with a mild/moderate degree of intellectual disability than those with a severe/profound disability.

Table 9: Means and standard deviations for recreational/community activity measures at Time 1 and Time 2

No. of activities	Time 1		Time 2		t	η^2
	M	SD	M	SD		
New locality	7.30	4.42	9.70	5.55	2.63*	.13
Known locality	12.39	7.69	21.15	13.46	5.25*	.41
Combined sample	9.67	6.63	15.03	11.51	5.51*	.26

* $p < .05$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

Table 10 shows the type of recreational and community activities residents had attended in the preceding four-week period at Time 1 and Time 2. At Time 2 a higher proportion of residents had had friends or family around for a meal, or been to a social club, pub, hairdresser, concert or play.

Table 10: Percentages for recreational/community activity measures at Time 1 and Time 2

No. of activities	Time 1			Time 2		
	New locality	Known locality	Combined	New locality	Known locality	Combined
Had guests to stay	0.0	0.0	0.0	0.0	0.0	0.0
Had family/friends around for meal	8.0	19.1	13.4	23.4	52.3	37.4
Been to a social club	6.0	21.3	13.4	12.8	65.9	38.5
Stayed overnight with family/friends	4.0	17.0	10.3	2.1	13.6	7.7
Had trips out with family or friends	36.0	53.2	44.3	42.6	54.5	48.4
Been to a café	94.0	95.7	94.8	93.6	95.5	96.7
Been to a pub	6.0	17.0	11.3	12.8	38.6	25.3
Been to a hairdresser	52.0	44.7	48.5	89.4	86.4	87.9
Been shopping	78.0	87.2	82.5	76.6	95.5	85.7
Been to place of religious worship	4.0	2.1	3.1	6.4	2.3	4.4
Been to a sports event	6.0	25.5	15.5	0.0	38.6	18.7
Been to a cinema	50.0	55.3	52.6	27.7	52.3	39.6
Been to a concert or play	2.0	21.3	11.3	40.4	52.3	46.2
Been to their bank	0.0	4.3	2.1	0.0	0.0	0.0

A small proportion of residents were employed on a full- or part-time basis in disability business services (previously known as sheltered workshops), and a high proportion attended a centre-based disability day program on a full- or part-time basis. It is important to note, however, that residents would be involved in off-site community-based activities as part of their program at a day centre, which was not captured by the measures used in this study. Table 11 shows the engagement of residents in the workforce or their primary day occupation for the new locality and known locality group.

Table 11: Employment or day occupation of residents

Occupation	New locality %	Known locality %	Combined sample %
Membership of workforce (full or part time)	15	2	8
Full-time centre-based day activity program	61	83	72
Part-time centre or flexible home-based program	22	13	17
No regular day activity	2	2	3

Informal social networks

The term social network is used to refer to the people with whom the resident had been in contact over the previous year in other than a fleeting manner (such as saying hello to a person on a bus). Informal network contacts included: (a) family; (b) friends, neighbours and acquaintances from organisations or clubs without an intellectual disability; and (c) friends and acquaintances with an intellectual disability (excluding co-residents). Paid staff were not included as members of informal social networks. This data was based on reports from staff and their interpretation of the meaning of friendship. Some of the data on residents' social contacts were collapsed together because the numbers in some categories (such as neighbours and organisational contacts) were very small.

Size of social networks

The change in the average size of residents' informal networks from Time 1 to Time 2 for individuals from the known locality and new locality sites is shown in Table 12. Overall, there was a small gain in the size of the informal network. However, the new locality group had a significant decrease in informal network size from Time 1 to Time 2, whereas the known locality evidenced a significant increase in informal networks over time.

Table 12: Means and standard deviations of informal network size at Time 1 and Time 2

	Time 1			Time 2			t	η^2
	M	SD	Range	M	SD	Range		
New locality	1.64	0.67	1–3	1.13	0.71	0–3	-3.68**	.23
Known locality	1.40	1.05	0–4	2.65	1.48	0–6	5.23**	.39
Combined sample	1.52	0.88	0–4	1.86	1.37	0–6	2.03*	.04

* $p < .05$, ** $p < .01$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

As Table 12 shows, the network size of residents living in group homes on the known locality increased significantly from Time 1 to Time 2, from a mean of 1.40 informal contacts at Time 1 (range 0–4), to a mean of 2.65 informal contacts at Time 2 (range 0–6). In contrast, the mean network size for the residents in new locality group homes decreased significantly over this time period, from a mean of 1.64 informal contacts at Time 1 (range 1–3) to a mean of 1.13 informal contacts at Time 2 (range 0–3).

Table 12 provides further detail of this change in network size, and shows that for the entire sample at Time 1 only two (2.2 per cent) residents had four or more people in their network, compared with 14 (15.6 per cent) at Time 2. As Table 14 shows the increase in network size is accounted for solely by change among residents on the known locality. At Time 2, 14 (32.6 per cent) residents on the known locality had four or more people in their network, whereas no residents in new locality group homes had a network this size. The number of residents with a network of zero or one member remained at 44 (48.7 per cent) over time. However, hidden in this figure is an increase from 22 (46 per cent) to 34 (72.3 per cent) of residents with zero or one network members among the new locality group and a decrease from 22 (51.2 per cent) to 10 (33 per cent) among residents in the known locality.

Table 13: Size of informal network for known locality and new locality residents at Time 1 and Time 2

Network size	Time 1						Time 2					
	New locality		Known locality		Combined		New locality		Known locality		Combined	
	n	%	n	%	n	%	n	%	n	%	n	%
0	10	23.3	-	-	10	11.1	3	7.0	8	17.0	11	12.2
1	12	27.9	22	46.8	34	37.8	7	16.3	26	55.3	33	36.7
2	17	39.5	20	42.6	37	41.1	11	25.6	12	25.5	23	25.6
3	2	4.7	5	10.6	7	7.8	8	18.6	1	2.1	9	10.0
4	2	4.7			2	2.2	10	23.3			10	11.1
5							3	7.0			3	3.3
6							1	2.3			1	1.1
Total	43	100	47	100	90	100	43	100	47	100	90	100.0

Composition of social networks

Table 14 summarises the mean change that occurred in the number of each type of informal network member. Paired sample t-tests indicates that family network size decreased overall from Time 1 to Time 2 ($t(89) = -3.08, p < .01, \eta^2 = .10$). However, this decrease was restricted to the new locality group ($t(46) = -3.52, p < .001, \eta^2 = .21$), and was not evident for the known locality group ($t(42) = 1.05, p = .299$). The small numbers for the other types of network member (other ID – intellectual disability – and other non-ID) mean tests of significance could not be undertaken.

Table 14: Means and standard deviations of family, other ID, and other non-ID in social network at Time 1 and Time 2

	Time 1			Time 2		
	M	SD	Range	M	SD	Range
New locality						
Family	1.62	0.64	1–3	1.13	0.71	0–3
Other ID	–	–	–	–	–	–
Other non-ID	0.02	0.15	0–1	–	–	–
Known locality						
Family	1.28	1.01	0–4	1.09	0.84	0–4
Other ID	–	–	–	1.19	1.31	0–4
Other non-ID	0.12	0.39	0–2	0.28	0.55	0–2
Combined sample						
Family	1.46	0.85	0–4	1.11	0.77	0–4
Other ID	–	–	–	0.57	1.08	0–4
Other non-ID	0.07	0.29	0–2	0.13	0.40	0–2

M = mean; SD = standard deviation

Other non-ID contacts included neighbours, however, no social contact with neighbours without an intellectual disability was recorded for either group. Similarly, the number of others without intellectual disability (for example, from clubs or organisations in resident networks) was low. Only five residents from the entire sample recorded contacts of this nature at Time 1 (one from the new locality group and four from the known locality group, with one person in this group reporting two such contacts). At Time 2 the number of residents with this type of social contact had increased but only among the known locality group. No residents from the new locality group had contacts with others without an intellectual disability; however, eight known locality residents had one contact and two had two contacts without an intellectual disability from a club or organisation.

At Time 1 no-one had a person with intellectual disability in their network who was not a co-resident. At Time 2, the situation had changed, particularly for the residents in the known locality group for whom the mean number of network members with an intellectual disability had increased from nil to 1.19 (range 0–4). In contrast, at Time 2 no residents in the new locality group recorded contact with a network member with an intellectual disability.

Nature and frequency of contact with social network members

Table 15a shows the frequency of contact between residents and the family member they see most often. These figures show the percentage of people with no family contact increased from 13.6 per cent to 21.4 per cent. There was little change overall in the percentage of residents having contact with family on a weekly basis or more often (15.9 per cent at Time 1 and 19.0 per cent at Time 2). Tables 15b and 15c show the frequency of contact between residents and friends with and without an intellectual disability. In the known locality 53 per cent of residents saw a friend with an intellectual disability who did not live with them on a daily basis, compared with none of the residents in the new locality group having any contact with such friends. Table 15c shows that 5.6 per cent of residents had weekly contact with a friend or acquaintance without an intellectual disability. Overall, 24 (28.2 per cent) residents had at least weekly contact with a family member, friend or acquaintance outside their home.

Table 16 sets out the median ratings for the nature of support provided by family members in contact. Overall, few differences in median ratings were identified. Wilcoxon signed-rank tests were used to compare support ratings over time. Information/advice ratings increased significantly for the known locality residents ($z = -3.67, p < .05$). Table 17 provides further data about the nature of family relationships, suggesting contact is initiated by the family members who generally feel quite close to their relative with an intellectual disability. This suggests that staff do not often play a role in supporting residents to initiate contact with family members. Closeness ratings increased significantly over time for both the new locality ($z = -1.99, p < .05$), and known locality groups ($z = -2.93, p < .05$).

Table 15a: Percentage frequency of contact of residents with family members at Time 1 and Time 2

Family	Time 1			Time 2			Combined					
	New locality	Known locality	Combined	New locality	Known locality	Combined	New locality	Known locality	Combined			
Contact frequency	n	%	n	%	n	%	n	%	n	%		
None			12	27.9%	12	13.6%	8	19.0%	10	23.8%	18	21.4%
Few times/ year	27	60.0%	10	23.3%	37	42.0%	16	38.1%	11	26.2%	27	32.1%
Monthly	13	28.9%	12	27.9%	25	28.4%	8	19.0%	15	35.7%	23	27.4%
Weekly	5	11.1%	9	20.9%	14	15.9%	10	23.8%	6	14.3%	16	19.0%
Daily		-	-									
Total	45	100%	43	100%	88	100%	42	100%	42	100%	84	100%
Weekly or more	5	11.1%	9	20.9%	14	15.9%	10	23.8%	6	14.3%	16	19.0%

Note: Frequency of family contact is based on the highest rating given by a resident to a family member.

Table 15b: Percentage frequency of contact of residents with friends with an ID at Time 1 and Time 2

Other non-ID	Time 1			Time 2			Combined					
	New locality	Known locality	Combined	New locality	Known locality	Combined	New locality	Known locality	Combined			
Contact frequency	n	%	n	%	n	%	n	%	n	%		
None	47	100%	43	100%	90	100.0%	47	100%	20	46.5%	67	74.4%
Few times/year												
Monthly							15	34.9%	15	16.7%	27	27.4%
Weekly							5	11.6%	5	5.6%	10	10.0%
Daily							3	7.0%	3	3.3%	6	6.0%
Total	47	100%	43	100%	90	100%	47	100%	43	100%	90	100%
Weekly or more	0	0%	0	0%	0	0%	47	100%	8	18.6%	55	58.9%

Table 15c: Percentage frequency of contact of residents with others without an intellectual disability at Time 1 and Time 2

	Time 1			Time 2			Combined						
	New locality	Known locality	Combined	New locality	Known locality	Combined	New locality	Known locality	Combined				
Contact frequency	n	%	n	%	n	%	n	%	n	%			
None	46	97.9%	39	90.7%	85	94.4%	47	100.0%	33	76.7%	80	88.9%	
Few times/year													
Monthly	1	2.1%	4	9.3%	5	5.6%	5	11.6%	5	11.6%	5	5.6%	27.4%
Weekly													19.0%
Daily													
Total	47	100%	43	100%	90	100%	47	100%	43	100%	90	100%	
Weekly or more	0	0%	0	0%	0	0%	0	0%	5	11.6%	5	5.6%	
All informal contacts													
Weekly or more													
Contact	5	11.1%	9	20.9%	14	15.9%	10	23.8%	14	32.6%	24	28.2%	

Note: Frequency of contact is based on the highest rating given by a resident to a friend.

Table 16: Median ratings for nature of family contacts for known locality and new locality residents at Time 1 and Time 2

	Time 1			Time 2				
	Concrete support	Emotional support	Information/ advice	Critical	Concrete support	Emotional support	Information/ advice	Critical
New locality	2.0	2.0	2.0	1.0	2.0	2.0	1.0	1.0
Known locality	2.0	3.0	2.0	1.0	3.0	3.0	3.0	1.0

a All items are measured on the scale 1 = Hardly ever, 2 = Sometimes, 3 = Almost always

Table 17: Median ratings for family contacts for known locality and new locality residents at Time 1 and Time 2

	Time 1				Time 2			
	Direction of help ^a	Closeness ^b	How often seen ^c	How long known ^d	Direction of help	Closeness	How often seen	How long known
New locality	2.0	2.0	1.0	3.0	2.0	3.0	1.5	3.0
Known locality	2.0	3.0	1.5	3.0	2.0	3.0	2.0	3.0

a 1 = Goes both ways, 2 = Person listed to resident, 3 = Resident to person listed

b 1 = Not very close, 2 = Quite close, 3 = Very close

c 1 = Few times/year, 2 = Monthly, 3 = Weekly, 4 = Daily

d 1 = Less than 1 year, 2 = From 1 – 5 years, 3 = 5 years or more

Understanding changes in social networks

Several factors may explain the increased network size and increased number of network members with an intellectual disability among the known locality group. At Time 1, residents were living in a large institution and had a high number of co-resident friends; however, co-resident friends were not included as network members and thus not represented in network size. At Time 2, residents may have remained in contact with the same friends with an intellectual disability with whom they had previously lived, but as they were now living in a separate group home in the known locality these people were no longer a co-resident friend and therefore included among social network members and in the calculation of network size. The data tends to support this assertion. As shown in Table 18 the average number of co-resident friends decreased from Time 1 to Time 2, with both the new locality and known locality evidencing a decrease while, as Table 14 shows, friends with an intellectual disability who were not co-residents increased.

Table 18: Means and standard deviations of co-resident friends with an ID at Time 1 and Time 2

No of co-resident friends	Time 1			Time 2			t	η^2
	M	SD	Range	M	SD	Range		
New locality	5.74	1.54	2–11	3.64	0.74	3–5	-9.32*	.65
Known locality	5.63	1.63	0–8	4.05	0.74	3–7	-5.96*	.47
Combined sample	5.69	1.58	0–11	3.83	0.76	3–7	-8.46*	.45

* $p < .01$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

As well as the existence of friendships among people who had previously lived together, two other factors may have increased the likelihood that staff in the known locality houses would support contact between residents living in different group homes in that locality. Though not forming a separate cluster in the housing development, all the known locality houses were within walking distance of each other. They were built at the same time and occupied simultaneously over one weekend. This meant that staff and residents were very aware of the both the existence and location of the other group homes in their locality. In contrast the new locality group homes were established over a period of several years, in locations where no other group homes were within easy walking distance and staff would not necessarily know of any other group homes in that locality .

A further factor is the significantly higher number of people with mild or moderate intellectual disability in the known locality group, which at Time 1 was 53.2 per cent compared with 26.5 per cent for the new locality group, and at Time 2 (due to the reduced sample size) was 66 per cent for the known locality group and 34 per cent for the new locality group. As Table 19 shows there was a relationship between informal network size and level of intellectual disability.

Paired sample t-tests indicated that, overall, informal network size increased from Time 1 to Time 2 for those with a mild or moderate intellectual disability but did not change for those with a severe or profound intellectual disability.

For residents in the known locality group, the size of their informal networks from Time 1 to Time 2 increased significantly for both residents with a mild or moderate level of intellectual disability, and residents with a severe or profound intellectual disability. However, in the new locality group informal network size decreased significantly for all residents. A mixed between-within subjects ANOVA between time and level of intellectual disability (mild/moderate versus severe/profound) revealed that, overall, residents with a mild or moderate disability had larger informal networks than residents with a severe or profound disability. A statistically significant interaction between time and level of disability was also evident: at Time 1 informal network size did not differ according to level of intellectual disability; at Time 2, residents with a mild or moderate intellectual disability had larger informal networks than those with a severe or profound intellectual disability.

Table 19: Means and standard deviations of informal network size for residents with a mild or severe intellectual disability at Time 1 and Time 2

	Time 1			Time 2			t	η^2
	M	SD	Range	M	SD	Range		
New locality								
Mild/moderate	1.91	0.70	1–3	1.36	0.50	1–2	-3.46**	.50
Severe/ profound	1.54	0.66	1–3	1.03	0.75	0–3	-2.85**	.19
Known locality								
Mild/moderate	1.23	0.92	0–3	2.95	1.40	0–5	6.50**	.67
Severe/ profound	1.50	1.10	0–4	2.39	1.54	0–6	2.01*	.19
Combined Sample								
Mild/moderate (n = 33)	1.54	0.90	0–3	2.42	1.39	0–5	3.69**	.30
Severe/ profound (n = 53)	1.52	0.82	0–4	1.49	1.25	0–6	-0.18	.00

** $p < .01$

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

Additionally, as the data on community activities shows (see Table 9), residents living in the known locality increased their use of cafés and shopping facilities in the Kew Junction shopping strip, with which many were already familiar before the move. We hypothesise they may have continued long-term habits of going to these facilities with friends with an intellectual disability who had previously been co-resident but who were now living in separate group homes but still in the locality.

Staff perceptions

The open-ended questions sought the views of staff in respect of each particular resident about whom they had completed the standardised measures. Although the staff from KRS who chose to continue their employment as direct care workers or supervisors had been relocated to the group homes, it is likely that during the course of the 12 months since the initial move some staff turnover would have occurred or additional staff without the prior experience of working at KRS would have been employed. The content of open-ended questions were coded into categories, which meant that in many instances a response fell into more than one category.

Staff perceptions of the advantages and disadvantages of the move to group homes are set out in Table 20.

Table 20: Staff perceptions of the advantages and disadvantages of relocation to small group homes

Advantages of relocation	New locality (n = 49)		Redeveloped (n = 44)		Combined (n = 93)	
Improved, less stressful environment	40	81.6%	35	79.5%	75	80.6%
Greater individualised support possible	18	36.7%	8	18.2%	26	28.0%
More contact with friends and family	8	16.3%	2	4.5%	10	10.8%
Greater choice and control	7	14.3%	5	11.4%	12	12.9%
Better quality day program	6	12.2%		0.0%	6	6.5%
Better resident health	5	10.2%	5	11.4%	10	10.8%
Fewer challenging behaviours	5	10.2%	4	9.1%	9	9.7%
More domestic and community activities	2	4.1%	4	9.1%	6	6.5%
More consistent staff	-	0.0%	3	6.8%	3	3.2%
Disadvantages of relocation						
None	7	14.3%	16	36.4%	23	24.7%
Reduced access to specialist health care	16	32.7%	4	9.1%	20	21.5%
Less freedom of movement	9	18.4%	9	20.5%	18	19.4%
No shared support or backup	4	8.2%	5	11.4%	9	9.7%
Residents miss familiar staff	4	8.2%		0.0%	4	4.3%
Residents miss friends	4	8.2%		0.0%	4	4.3%
Residents miss a busy environment	4	8.2%	6	13.6%	10	10.8%

For both groups of residents a majority of staff perceived the most significant advantage to be an improved and less stressful home environment. Staff mentioned factors such as less noise, bustle and potential for abuse from other residents, as well as a much improved physical fabric of the home. Their perceptions are reflected in the data presented in Table 3, which shows a significant increase in the way interviewers rated the homeliness of the new group homes compared with KRS. In contrast the view of 16.3 per cent of staff in the new locality group homes that an advantage of relocation was that residents would have more contact with their family and friends was not supported by the survey data. Rather, as Table 12 shows there was a significant decrease in size of residents' networks among this group.

Only about a quarter of all staff perceived there had been no disadvantages as a result of the move for the resident they were speaking about. The most common disadvantages they identified were reduced access to specialist health care facilities, less freedom of movement and the loss of flexibility in providing support because staff no longer had backup from a large pool of staff working in close proximity. Significant variation in the frequency of staff comments are analysed using chi square tests only in those instances where the total number of comments exceeded 20. The new locality group staff were more likely to comment that no specialist health care was a disadvantage of relocation ($p < .01$), but there was no other variation in comment frequency for the advantages and disadvantages of relocation. Notably, 10 per cent of staff commented that residents were disadvantaged by the loss of a busy environment, where activity could be observed and opportunity for fleeting interaction with a large number of people was greater than in small group homes.

No variation was found between views of staff from the new locality and known locality groups about the meaning of community inclusion, choice or participation for the resident. As Table 21 shows just over 50 per cent of staff from both groups perceived community inclusion for the resident they were speaking about to be the use of community-based public or commercial facilities such as dentists, doctors, libraries, cafés or cinemas, or doing activities in the community such as going swimming, to a class or on another outing. Many saw it as a combination of these things, while a much smaller proportion (10.8 per cent) saw social inclusion in terms of social interaction with people in the community. These perceptions were reflected in staff responses to a question about the meaning of participation for the resident they were talking about.

Table 21: Staff perceptions of community inclusion for residents

Meaning of community inclusion for this resident	New locality (n = 49)		Redeveloped (n = 44)		Combined (n = 93)	
Use of community facilities	28	57.1%	23	52.3%	51	54.8%
Doing activities in the community	25	51.0%	25	56.8%	50	53.8%
Social interaction with community members	5	10.2%	5	11.4%	10	10.8%
Occurs at day program	9	18.4%	9	20.5%	16	17.2%
Unable to say or has little meaning	5	10.2%	4	9.0%	9	9.7%
Exercising choice	3	6.1%	5	11.4%	8	8.6%

As Table 22 shows staff perceived participation to be about activity either in the home or the community but did not refer to it in terms of social interaction. A much higher proportion of staff from new locality group homes saw community participation as problematic for the resident they were talking about, on the basis that they did not like crowds or busy places.

Table 22: Staff perceptions of the meaning of participation

Meaning of participation for this resident	New locality (n = 49)		Redeveloped (n = 44)		Combined (n = 93)	
Activities out of home	16	32.7%	16	36.4%	32	34.4%
Going out with co-residents	2	4.1%	16	36.4%	18	19.4%
Problematic as dislikes people and busy places	15	30.6%	2	4.5%	17	18.3%
Exercising choice	6	12.2%	10	22.7%	16	17.2%
Doing domestic chores at home	7	14.3%	7	15.9%	14	15.1%
Going out with others (not co-residents)	2	4.1%	7	15.9%	9	9.7%
Very limited	3	6.1%	4	9.1%	7	7.5%

As Table 23 shows over half of staff perceived choice as being exercised in relation to food or other day-to-day things such as activity. None mentioned choice in respect of options that were likely to have a longer lasting impact on the person's life, such as where they lived, or whether they attended a day program or employment service. A large proportion of staff from both the new locality and known locality group referred to the limited, risk or complex nature of choice for the resident.

Table 23: Staff perception of the meaning of choice for the particular resident

Meaning of choice for this resident	New locality (n = 49)		Redeveloped (n = 44)		Combined (n = 93)	
Choosing food	29	59.2%	19	43.2%	48	51.6%
Choosing other day-to-day to day things such as activity	19	38.8%	29	65.9%	48	51.6%
Very limited possibilities	29	59.2%	20	45.5%	49	52.7%
Very risky	4	8.2%	3	6.8%	7	7.5%
Very complex	1	2.0%	2	4.5%	3	3.2%

As Table 24 shows staff from the new locality group were more likely to identify staff competence as a factor supporting individualised support, whereas staff from the known locality were more likely to identify knowledge of the resident and good planning as a factor ($p < .05$).

Table 24: Staff perceptions of factors that support provision of individualised support

Factors that support individualised support	New locality (n = 49)		Redeveloped (n = 44)		Combined (n = 93)	
Staff competence	28	57.1%	13	29.5%	41	44.1%
Staff knowledge of the resident and good planning	7	14.3%	26	59.1%	33	35.5%
Number of staff	11	22.4%	3	6.8%	14	15.1%
Knowledge of external resources	9	18.4%	2	4.5%	11	11.8%
Availability of family and friends	4	8.2%		0.0%	4	4.3%

Following each of the questions about social inclusion, participation, choice and individualised support, staff were asked to comment on the difficulties or obstacles of supporting residents to achieve these outcomes. The content of answers to all four questions was very similar and therefore similar codes were used for each of these outcomes. As Table 25 shows a large majority of staff thought that the resident characteristics, such as degree of impairment, challenging behaviours, dislike of crowded places and limited life experiences were the major obstacles to supporting them to achieve inclusion, participation and choice.

Table 25: Staff perception of the obstacles to providing support

Nature of obstacle	Area of support			
	Inclusion %	Participation %	Choice %	Individualised support %
Resident characteristics	76.3	69.9	80	21.5
Meaningfulness for resident	–	–	64.5	–
Staff skills	12.9	5.4	4.3	15.1
Staff availability	16.1	16.1	3.2	48.4
Community attitudes and physical barriers	3.2	3.3	–	–

Discussion

The findings from this part of the Making Life Good in the Community study broadly tell the same story as the qualitative research but in a different, less nuanced manner.

These findings are similar to Australian and international studies that have used survey methods to consider quality of life outcomes for people with an intellectual disability who have moved from an institution to the community. Unequivocally the people who left KRS to live in small group homes have experienced an increased quality of life. Significant positive changes have occurred in: the homeliness of their place residence; the degree of choice they exercise; their adaptive behaviour; their use of community facilities for leisure purposes and other activities; and the size of their social networks. They have less maladaptive behaviour and experience less depersonalisation and block treatment. As other studies have found too, there are variations in outcomes across the sample, and less progress has been made in expanding social networks and community participation than other dimensions of quality of life. As with the wider Making Life Good in the Community study the focus was on social inclusion and engagement in meaningful activity, which meant data were not collected on all quality of life dimensions, most notably health.

This report adds another source of Australian evidence about the relative advantages of small group community living for people with an intellectual disability. It is worth noting, however, that the context of this study is different from that of earlier research that examined the downsizing and institutional closures in Australia and overseas from the mid 1970s to mid 1990s. Bradley (1994) refers to that period as the era of deinstitutionalisation when disability policy was based on a developmental model with a single focus on specialist disability services. Policy was less ambitious, less multifaceted and not embedded in broader social policies with similar goals. In contrast the 2008 closure of KRS, and the move to community living for its residents, occurred at a time when the dominant paradigm had shifted to one of community membership for people with intellectual disabilities that emphasised both social inclusion and human rights (see, for example, United Nations Convention on the Rights of Persons with Disabilities 2008; Department of Health 2001, 2009; Department of Human Services 2002). Significantly, disability policy was paralleled by broader social policy directions. For example, Gleeson (2004, p 315) suggested Australian social and urban policies in the 1990s were characterised by 'the new social yearning: the desire for a secure place in social networks based on reciprocity, trust and mutual respect'.

The closure of KRS was one strategy within a whole-of-government *State disability plan*, which aimed to further the social inclusion of people with disabilities in Victoria. The plan was three-pronged, aiming not only to provide individualised support services for people with disabilities, but also to build a more inclusive Victorian community and increase access to public facilities and services. Though the data for this report were collected between 2006 and 2009, just four years into the *State disability plan*, one might have expected to find its influence reflected in the community living experience of KRS residents. Yet, despite this different context, resident outcomes were very similar to earlier research conducted in a different era.

Although not an explicit goal of the study, our findings provided the opportunity to contrast two slightly different models of supported accommodation: new locality small group homes in established suburbs that were new to residents and staff, and group homes in relatively close proximity to each other located in a private housing development in a new suburb being built in a locality well known to residents and staff. Though in the first stage of the private development most of the group homes are fairly near each other, this cannot be construed as a cluster development. Each group home is self-contained and managed as an individual unit from the relevant departmental regional administration and there are no shared facilities. As Figure 1 illustrates group homes are located on ordinary streets alongside other dwellings and, in the future, they will be more dispersed throughout the development, as some residents will relocate to other parts of the new suburb as building is completed.

Figure 1: KRS redevelopment site map³

Concept Plan: Indicative option for lot layout



- Transitional community houses
- Permanent community houses

The group homes in the known locality are therefore different from Mansell and Beadle-Brown's (2009, p.314) definition of clustered housing as 'a number of living units forming a separate community from the surrounding population'. They do not conform to any of the types of cluster housing they identify because they are not:

- village communities where support workers, who are often unsalaried, and their families live communally with people with an intellectual disability to facilitate close personal relationships, and provide them with a social and cultural framework for work, community service, worship and education
- residential campuses, developed in the United Kingdom (UK) as part of the program of closure of institutions, built on institution sites and run by health service providers with paid staff and usually serving people with higher support needs, and operating as self-contained places with day provision and other services on site
- cluster housing, which typically has a relatively small number of houses on the same site and forming a cul-de-sac in housing for the wider community.

Although these two settings had similar staffing and management arrangements, that is, single group homes, each with its own house supervisor and managed by the Department of Human Services from the relevant regional office, statistically significant differences in resident outcome were found between the two models. The differing composition of the two groups explains some of these findings. The known locality group had a greater proportion of residents with a mild to moderate level of intellectual impairment, and the average scores of this group were higher than the other group on measures of choice, adaptive behaviour and community activities prior to the move. Research has consistently demonstrated that people with milder intellectual disability have better outcomes compared with people with more severe impairments (Kozma et al. 2009; Mansell et al. 2008). Caution must also be applied to using and interpreting statistical tests based on small numbers and the tests of difference described earlier, which suggest the differences in outcomes between the two groups were a function of the service setting rather than the residents' level of disability.

Other than level of impairment, it is only possible to speculate what may account for these differences. It may have been the proximity of dwellings on the known locality for residents who have previously known each other and a location with which both staff and residents had a pre-existing familiarity that account for some of these differences in outcomes. Also of note is that all the group homes on the known locality were managed by the department's Eastern Metropolitan Region, which had oversight of the redevelopment and a very strong commitment to the success of the relocation process, while the new locality houses were managed by various regions across the state depending on their location. Additionally, the move to houses on the known locality occurred in many instances several years after the move for the new locality group.

During this period the KRS redevelopment team and the Eastern Metropolitan Region continually adapted the training and preparation provided to staff moving from work in the institution to the new group homes based both on their experience and the earlier qualitative strands of the Making Life Good in the Community study. For example, a community inclusion officer worked directly with staff in all 20 of the known locality group homes to support practices such as person-centred active support and inclusion, and a 'lessons learnt' working group was created to identify areas that needed refining and strategies and processes to implement any changes. There can be little doubt that staff in the group homes in the known locality benefited from managerial learnings about staff training and other aspects of the relocation process.

Homeliness

Overall the data suggests that residents' quality of life increased with the move to small group homes. In particular, for both groups the quality of their material surroundings improved, their homes were more homely and their social and physical environment less institutionalised. These findings were reflected in the qualitative study of homeliness conducted in five of the new locality group homes (Robertson et al. 2001). However, this and the other Making Life Good in the Community reports drew attention to the subjective nature of homeliness, which can mean very different things to different people. Attention was also drawn to the features, such as wide corridors, specialist equipment and staff bathroom facilities, that detracted from homeliness and the tension that arises when a person's home is also someone's workplace, which requires constant negotiation. This was summed up by a comment from one of the house supervisors, who said:

I find it really difficult to explain to some staff, 'When you're on duty you can walk in the house, when you're not on duty you have to ring the doorbell. When you're in the house, even if you're on shift, I don't really like you taking over the kitchen and making full gourmet meals for yourself, even if it's your meal break. It's your meal break but it's their home, you've got to respect that'. That's the difference between the personal and professional. Yes it is a home, and therefore you've got a good kitchen, and it is your meal break, but it's not your home (Clement & Bigby, 2007, p80).

Choice and engagement

The degree of choice residents exercised increased overall and the level of choice was similar to the 500 people in Emerson et al.'s 2001 study. The survey of staff perceptions suggested, however, that staff most commonly applied ideas of choice to everyday concrete options about food or activities rather than options with a more overarching or longer term impact on people's lives such as where and with whom they lived. The open-ended questions also suggested that over half of all staff struggled to see how to make choice meaningful for the resident they supported, and some also found it difficult to balance issues of dignity of risk with the imperative of protection.

Similar issues were found in a study by Jingree and Finlay (2008), which suggested that staff relied on the discourse of practicalities to explain the difficulty of supporting resident autonomy. They used for example a notion of empowerment that bounded choice and restricted it to simple everyday issues, and continually compared the tensions between facilitating choice and managing risk. This was a theme that ran through the entire Making Life Good in the Community project, which provided some vivid illustrations of the difficult issues staff confront in managing these tensions. The qualitative work also suggested that few staff knew residents sufficiently well to identify their particular interests or preferences regarding activities in the community. Together these findings suggest that greater emphasis should be placed on processes, such as reflective practice and person-centred active support, which are designed to enable multiple perspectives on resident preferences and to facilitate staff practices that will maximise residents' potential to exercise choice or preferences. A recent study of people with severe challenging behaviour has some good practice examples of how facilitation of choice can be tailored to take account of a resident's level and type of impairment and when it might be appropriate to interfere and limit people's choices (Clement & Bigby 2010b). For example, the belief that Frank, Freddie and Paul's choices had to be constrained was expressed by the direct support staff:

You can't say 'Go and do anything you like'. Some of the people in our care are autistic, so too many choices would lead to chaos. With Paul [you ask], 'Do you want your coffee black or white?' or 'Do you want tea or coffee?' It's not, 'Which of these fifty drinks would you like?' You need to limit it so he understands what you're saying. That's within his experience, so he knows what it is that you are offering.

If you offer him something you give him two choices. [In] people with autism, if you give them too many choices they get confused, so you give them, say, two choices. 'Would you like to go for a drive and then go for a walk round the lake, Paul, or would you like to do some digging?' But if you said. 'Paul, do you want to go gardening, or do you want to listen to music, or do you want to go for a drive and go for a walk around the lake, or do you want to have lunch with Rachel at [the church hall] or do you want to whatever?', it'd be too much.

In the mornings Frank can create stress levels for himself and staff. An example is, if his cupboard is open he will take all the clothes out, but still not know what he wants to wear. Once you start picking stuff for him, then he'll refuse to put it on. So what I traditionally do is ... lay out two shirts, so that's his choice, not ten shirts ... 'Which one will I wear today, this one or this one?' This one, okay. The other one goes back in the cupboard. The choice is done, this is what you're wearing, and you seem to be happy about it (Clement & Bigby, 2010b, p. 68-69).

The degree of change in residents' adaptive behaviour scores was less than has been found in comparable studies, and of particular note is the static nature of scores on the self-sufficiency subscale for the new locality group and the decline for residents on the known locality. One possible reason for this may be the complex health issues of some residents, which was certainly the case in one of the houses in the qualitative study.

These findings reinforce the difficulties identified in the qualitative study of shifting staff and organisational practices from a hotel model where staff do everything for residents towards an Active Support model where residents participate to the fullest extent in tasks of everyday living and household chores. For example, the Action Research Project in one of the houses illustrated the complexity of factors involved in both implementing and sustaining a rational evidence-based model of person-centred active support in the context of a group home, where some staff had poor literacy skills, little formal supervision occurred and few opportunities existed for reflection on practice (Clement & Bigby 2008c).

Both prior to and after the establishment of the group homes in this study the Department of Human Services invested in Active Support training for staff, but these findings suggest Active Support has not become embedded in the operation of group homes and further attention must be paid to its longer term implementation. The department's Eastern Metropolitan Region is currently undertaking a partner a project with La Trobe University, the Tizard Centre and several non-government organisations, which is examining these questions. This project is also partly funded by the Office of the Senior Practitioner (Bigby et al. 2009a).

Social inclusion

Following O'Brien (O'Brien & Lyle 1987), but also reflecting more recent conceptualisations (Australian Social Inclusion Board 2009) that list the nature of an individual's social relationships as an indicator of social inclusion, two distinct elements of social inclusion were defined in this and the other Making Life Good in the Community reports. The first was 'community presence', the sharing of ordinary places that define community life. The frequency that people left their home and the nature and type of activities undertaken outside the home were used as the indicators of community presence. The second dimension was 'community participation', which O'Brien and Lyle (1987) defines as the experience of being part of a growing network of personal relationships that includes people other than co-residents, paid staff and immediate family. The nature of personal social networks such as size, relationships and frequency of contact were used as indicators of community participation.

The findings show significant increases in community presence across the combined sample. This increase was markedly higher for residents on the known locality, which we have hypothesised is due to both their milder level of impairment and pre-existing familiarity among both residents and staff with the locale. The indicators of community presence are very limited, as is the case with much of the extant research in this field (Bigby 2010). They tell little about the processes by which decisions are made about the type of community activities residents do, thus whether residents have exercised choice or if activities are meaningful to them. Nor do they indicate who or how many others accompanied a person in the activity, whether the person consistently went to the same venue or activity, or the nature of the social interaction if any that occurred during its course. These findings do suggest, however, that, similar to the qualitative study, the most frequent destinations in the community were relatively anonymous public places, such as cafés or shopping centres. Such activities are unlikely to lead to the formation of new friendships or even acquaintances with other community members. Nevertheless it was clear from the qualitative data that residents went out more often, in smaller groups, and to a greater variety of places than they had done when they lived in the institution. This is a significant positive change for residents.

The findings about the nature of residents' social networks from a UK study of 500 people with an intellectual disability using different models of residential support Robertson et al. (2001) are compared with those from the present study in Table 21. Included in this table is Robertson et al.'s full sample of 500 people, the sub-sample of 281 residents living in community-based accommodation and findings from a previous longitudinal Victorian study of a group of KRS residents relocated to small group homes in the community (Bigby 2008).

Table 26: Comparison key network dimensions with other studies

Network dimensions	KRS (current study) (n = 91) %	Robertson et al. 2001, total sample (n = 500) %	Robertson et al. 2001, community (n = 281) %	KRS residents relocated in 1999, Bigby 2008 (n = 24) %
Percentage with no family contact	26.6	18	19	16
Percentage in contact with one or fewer family members	48	25	–	–
Percentage in contact with three or fewer family members	84	–	25	–
Percentage in contact with five or fewer family members	96	75	–	–
Percentage in contact with six or fewer family members	100	–	75	–
Mean size of network and range	1.86 0–6	2 0–13	3 0–6	1.92 0–13
Percentage of sample with a network member who was not a family member of person with an ID	10.8	30	44	13
Mean size of family in network			1.9	–
Mild/moderate ID	1.16	–	–	–
Severe/profound ID	1.09	–	–	–

Although the varied way in which findings are reported makes comparison between studies difficult, and it is not possible to control for differences in the population characteristics such as level of intellectual disability, between these studies these figures suggest that the residents in this study compare unfavourably to earlier studies on all social networks dimensions, with the possible exception of the mean size of social networks for people with mild to moderate levels of impairment. An indicative comparison of residents' social network characteristics with data on the general population illustrates more starkly their social disadvantage. For example, the 2006 General Household Survey (ABS 2006) found that in the week preceding the survey 96 per cent of Australian adults had been in contact with a family member or friend outside their own household. Data from the present study suggests this was only the case for approximately 28.2 per cent of residents with an intellectual disability. The General Household Survey also found that 37 per cent of the general population had one or two family members outside their household in whom they could confide, and 53 per cent had a similar relationship with three or more friends outside their household. In comparison the present study suggests that only 17.8 per cent of residents with an intellectual disability had contact with a family member on a weekly basis, 56.6 per cent had either no or very limited contact with a family member, and only 25.6 per cent had three or more family members or friends whom they saw at least once a year.

On another common measure of social inclusion – participation in the workforce – residents also fared badly compared with the general population. Only eight per cent of the residents in this study were members of the workforce compared with available figures for all people with an intellectual disability (43 per cent) between the ages of 15 and 65 and the general population (81 per cent⁴) (Australian Institute of Health and Welfare 2008).

The findings about the nature of residents' social networks are consistent with the suggestion that the nature of activities and increased community presence was unlikely to lead to new social relationships. Minimal changes occurred to residents' social networks following their move to the community, and there was little indication that residents had formed new relationships with community members without an intellectual disability, or even nodding acquaintanceships with their neighbours.

Importantly, however, the findings suggest that residents in the known locality had maintained relationships with previous co-residents in the institution, but this had not occurred for residents in the new locality houses. There was some evidence from the qualitative study that staff did take groups of residents on outings with staff and residents from other group homes, or visits occurred to other group homes. This data, however, supports the hypothesis that one of the drivers for visits had been maintenance of relationships between staff rather than between residents. Overall this data strongly supports the findings from the qualitative data that residents continued to live in a distinct social space made up of family, staff and other people with an intellectual disability. After a year of living in the community only 10 residents had a person without an intellectual disability who was not a family member or paid staff person in their social network, and just over half the sample had one or fewer people in their social network.

4 Note the figures are slightly incomparable as KRS figures include a small number of people over the age of 64.

Understanding outcomes

The data in both the qualitative and outcomes study suggest some explanations for the minimal change in community participation, which was one of the key expected outcomes of the move to the community.

Unclear and doubtful staff expectations

The key policy documents that guide practice in group homes are fairly vague and unspecific about the expected nature of social inclusion for people with an intellectual disability. This was not clarified at the several sessions of staff training observed as part of the qualitative study or in any more detailed documents available to staff such as the Residential services practice manual (Department of Human Services 2007). As a result staff did not receive strong clear messages about the meaning of social inclusion for the residents they worked with, nor were they given indicators with which to measure success. Not surprisingly there was little consistency in the way staff and house supervisors in the five houses involved in the qualitative component of study understood social inclusion. The data on staff perceptions suggests a particular interpretation of social inclusion that equates social inclusion with activities in public places or groups rather than also being about more personal or individual relationships. These views aligned with the survey findings (see Tables 9 and 12), which show residents had a significant increase in their use of community facilities but no significant increase in relationships with people without an intellectual disability. Across all parts of the study staff more commonly understood inclusion as a residents' capacity to conform to social norms, visit public facilities or use commercial outlets such as shops and restaurants, reflecting an interpretation based on community presence rather than community participation.

Staff understanding of social inclusion aligned with the type of activities they supported residents to undertake, such as shopping and other trips into the community, and helps to explain the low proportion of activities in the qualitative study, such as regular attendance at a community group or activity associated with a person's interest that might have led to new acquaintances or friendships.

When staff were confronted with more explicit definitions of community participation in one of the action research projects, it was apparent that some were sceptical about its feasibility for the residents with whom they worked. Some staff saw their residents with severe and profound intellectual disability as 'too different' from the rest of the community to either form relationships with other community members or for these to be meaningful. Though some staff thought a policy objective such as community participation might be a good idea in general, their view was it would not work for the men they worked with. This perception was not confined to direct care staff but sometimes also shared by supervisors and the few family members involved in the study.

A separate survey of 144 staff from both day and residential services for people with an intellectual disability unconnected to the closure of KRS confirmed the hypothesis that emerged from the qualitative data that, while staff accepted community participation in principle, they did not see it as feasible for people with more severe intellectual disabilities (Bigby et al. 2009b). Similarly, in the present study, the vast majority of staff in the open-ended staff survey thought the residents' characteristics were a primary obstacle to providing support for their social inclusion and participation. This suggests many staff still understand their work from an individual perspective of disability, seeing impairment rather than social

or environmental process and structures as needing to be the focus of change. For example, over 50 per cent of staff thought the meaningfulness of choice for the resident was an obstacle to providing support. The availability of staff and, to a less extent, their skills were perceived as the primary obstacles to providing individualised support. In terms of these factors several staff referred to the need for specialist knowledge or external expertise about the local community and the opportunities it presented for social inclusion. Many also referred to the necessity for one-to-one support and the difficulties they encountered in taking a number of residents in wheelchairs out together.

These findings reinforce the need for the disability service system to more clearly illustrate the diverse manifestations that community participation and choice might take and devise strategies to convince staff that building social connections is possible for all people with an intellectual disability (Bigby 2010). This was achieved in the UK closure programs through demonstration programs that modelled good practice and documented its outcomes for people with the most severe impairments (Mansell et al. 2001).

Organisational issues and public attitudes

An analysis of some aspects of the organisations that managed the group homes in the qualitative study suggested that not only was there no consensus among staff about the mission of community inclusion but some parts of the organisation obstructed rather than supported staff practices to support community participation (Clement & Bigby 2008a, 2008b). An obvious example was when all houses were provided with large multi-seater buses. Given some staff found the buses difficult to park, this made ease of parking a priority in choosing locations for group outings rather than more resident-related issues dominating choices about activities. It was evident, too, that the organisation did not have a strong culture of supervising or monitoring staff day-to-day practices, and had few mechanisms in place to enforce its policies about supervision of frontline staff. This was compounded by rostering practices that meant house supervisors did not regularly work alongside all staff, which led to an absence of opportunities for house supervisors to exercise the various guises of practice leadership (Clement & Bigby 2007). For much of the time front-line staff were left to implement their own understanding of inclusion in their day-to-day practice, with very little guidance in the form of coaching, role modelling, monitoring or active supervision.

Staff in the five houses in the qualitative part of Making Life Good in the Community identified significant obstacles to community participation in the external environment, most notably negative public attitudes towards people with an intellectual disability. They talked about people staring or moving away from residents in public places, and the need to educate the general public about people with an intellectual disability. These views were not reflected by staff in the survey, although this may have been due to the absence of an explicit definition of community participation for staff to comment on.

Possible problems stemming from dedifferentiated policy

Despite relocation to the community occurring within a policy context with a much stronger emphasis on social inclusion, the outcomes for the residents in the Making Life Good in the Community studies are very similar to those found in previous decades when relocation occurred within a much narrower policy paradigm of ‘deinstitutionalisation’ where people with an intellectual disability continue to be present in local communities but not participating members. These findings raise questions about the nature and effectiveness of the current policy. The dedifferentiated disability policy found in Victoria lacks clearly specified indicators of outcomes for broad aims such as inclusion. It relies on dispersed staff to deliver individualised support in, for example, group home programs, and multiple communities or organisations to become more inclusive. This type of policy does not measure well against the conditions that policy implementation theories suggest are necessary for effective implementation, which include clarity, minimal ambiguity, jurisdiction to achieve goals, simple workable models, involvement of limited ‘players’ and a clear chain of accountability (Bridgman & Davis 2004; Sabatier & Mazmanian 1979).

For example, Lipsky’s (1980) work on policy implementation illustrated the potential for ambiguous policies to be diverted from original intentions through reinterpretation by street-level bureaucrats: ‘the routines they [street-level bureaucrats] establish and the devices they invent to cope with uncertainties and work pressures, effectively become the public policies they carry out’. This resonates with the findings where, in the absence of clear guidance from policy or supervisors, many staff construct their own interpretation of social inclusion or decide its feasibility selectively, which clearly influences outcomes both sought and achieved for residents. Frontline staff working in organisations without effective supervisory structure left free to impose their own (mis)interpretations and priorities are shaping the policy aim of inclusion for residents to be one of community presence rather than both presence and participation. While these findings provide evidence of this occurring in group homes, the absence of policy guidance about inclusion for specific groups indicates the potential for policy intention to be undermined in other program areas such as day support.

The nature of social participation, the support required to foster it, and the obstacles likely to be encountered differ not only with an individual’s social circumstances and characteristics but more generally by severity and type of impairment. For some people with a disability, community presence, achieved through provision of equipment, accessible transport or buildings, may be sufficient to create self-directed opportunities to pursue interests and interactions that lead to community participation. For others, particularly those with a more severe intellectual disability who will always require paid or informal support to take advantage of opportunities for social interaction, more intensive strategies that stretch far beyond access or presence may be needed if they are to achieve community participation. This suggests a need for dedifferentiated disability policy to be supported by strong mid-level policies or guidance about the nature of social inclusion and its applicability to each of the diverse subgroups that now fall under the umbrella of people with disabilities. Differentiated implementation strategies are more able to take account of the differing pathways and support that may be required to achieve community participation, and reinforce participation as an aim that is equally applicable to all people with disabilities, not just those who are more able.

At the more micro level of policy implementation through group home programs, our findings highlight the need for significant work to achieve greater organisational coherence and translation of broad policy aims into much clearer guidance for staff backed up by much stronger frontline management. How this might occur is discussed in detail elsewhere and the recommendations from the qualitative study are reproduced in the Appendix 1 (Clement & Bigby 2008a, 2009). These findings also raise questions about the breadth of expectations placed on group home programs, the consequent multiple roles to be played by staff and diverse skill sets thus required. Almost sole responsibility lies with house staff to: provide day-to-day personal care; monitor health; administer finances; manage the household; assess, formulate and implement short and long-term plans around issues such as skill development, pursuit of interests, community presence/participation, domestic participation, and longer term issues such as retirement; provide support and nurture relationships between residents and families; and support residents to exercise choice and protect their human rights. House staff are expected to be housekeepers, attendant carers, case managers, social workers, advocates and community developers. All these are complex roles and at times contradictory. Yet most staff have no tertiary qualifications. Where demands on staff time exceed resources and tensions exist between different roles, staff attention is most likely to be held by those tasks they feel most comfortable with or that are most immediately obvious if left undone and will pose most risk in the short term, such as attendant care, household management and supporting community presence.

The question is then about how importance and time can be accorded to community participation for residents of group homes who are increasingly likely to be those with a more severe intellectual disability, even if a greater consensus is reached about its meaning and applicability. It seems that the group home program is regarded as the sole strategy to implement community participation for residents rather than being one of multiple strategies as envisaged by the new policy paradigm. Perhaps, in line with the multifaceted community membership paradigm, additional strategies to complement group home programs should be devised to develop participation for residents. These may be the type of small-scale local programs or voluntary parent-run initiatives discussed below that are found both in Australia and overseas that have as their sole mandate the creation of social relationships for people with an intellectual disability who require significant support. Currently, however, such programs seldom include residents in group homes or those without strong family advocacy support.

Our findings provide some indication of the likelihood that, like staff, some community members are sceptical about possibilities of community participation for people with more severe intellectual disabilities. Strategies such as community development or education are not individualised, and primarily work at the meso level with organisations, communities and local institutions. There was no evidence in our studies of the impact of these broader policy implementation strategies, such as the MetroAccess program or the work of the Office of Disability, that seek to change social structures or processes and make local communities more inclusive for people with disabilities, among whom are the residents of group homes. It may be that the dedifferentiated nature of policy and the absence of clarity about specific outcomes is hampering the effective implementation of this type of social change strategy at the local level. For example, Ryan (1999) suggests that where, as is the case in Victoria, reliance is placed on partnerships with other organisations such as local government or clubs and sporting associations to implement policy, the focus should be on ways to measure and monitor outcomes, that is, what actually happens for people, rather than specifying inputs or processes

by which these will be achieved. Similarly, Rogers' (1995) diffusion of innovation theory suggests the importance of policy having 'observability' –clearly expected or measureable outcomes to be achieved. As already discussed this is not the case for disability policy in Victoria.

The doctoral work of Fiona Reidy (2010) suggests that local governments (one of the key partners in broader community development strategies) have struggled with the generic nature of disability policy aims, finding these difficult to operationalise and thus to implement at the local level. There are other indications that broader dedifferentiated strategies about social inclusion have had little impact on people with an intellectual disability. For example, disability action plans now required under both state and federal legislation have been criticised as being vague and generic based on stereotypical views of people with disabilities using wheelchairs (Goggin & Newell 2005). People with an intellectual disability were not found to have the same clear benefits from disability discrimination legislation as people with physical and sensory disability (Productivity Commission 2004), and very few people with an intellectual disability are included on national, state or local advisory committees and when they are, are poorly supported (Frawley & Bigby, 2011).

There is no reason why more finely grained differentiated approaches directed at specific groups should not be used to effect broader social change under the umbrella of dedifferentiated policy. More targeted strategies, such as community education with the aim of equipping community members with ideas about interacting with people with an intellectual disability, or the establishment of community development targets, such as each local community organisation having at least one member with an intellectual disability, may be both easier to implement and more successful than broad dedifferentiated strategies that target all people with disabilities. Tensions about differentiation of strategies and clearer specification of goals or sub-goals need to be identified and debated if policy is to have an impact on people with more severe intellectual disabilities. Questions need to be asked about all proposed implementation strategies, such as: How will it improve participation for people with an intellectual disability? Does it take account of the obstacles they may encounter? And, if not, how can it be made to do so?

Finally, these findings about the apparent continuing failure to achieve community participation for people with an intellectual disability raises the question, posed by one of the senior departmental staff during the course of the study, 'Is it feasible for inclusion to be more than community presence for people with more severe intellectual disability?' We would argue it is and the current state and federal policies on social inclusion exclude no one.

Strategies to support community participation

Support for the position that community participation is possible for all people with an intellectual disability is underpinned by acknowledging its diverse forms and the need to tailor goals and support to reflect each individual's preferences. Case studies found in the academic and grey literature illustrate this diversity and recount successful examples of relationships being developed between ordinary community members and people with severe intellectual disabilities (O'Brien & Lyle O'Brien 2002; Taylor et al. 1995; Taylor & Bogdan 1989; Wightman 2009). Such case studies illustrate the work of programs that, while centred on an individual, also involve community organisations and other community members. One approach is deliberate network building, illustrated by the work of Planned Lifetime Advocacy Network (PLAN) (see <www.plan.ca>) in Canada, whose work has informed Planned Individual Networks (PIN) (see <www.pin.org.au>) in Australia and Equal Futures in Scotland (see <www.equalfutures.org.uk>). These are parent-run organisations that support the development of a 'personal network' around an individual with a disability. Using paid facilitation, they aim to build a web of relationships, not only between each member and the focus adult, but also between members, thus developing the network's collective identity and strength. The first phase involves an exploration of the person, their interests, aspirations and capacities, and seeks out possible connections and contacts in the local community. In the second phase members are recruited by the facilitator, goals, strategies and commitments are made, and the network is fashioned. In the final phase the facilitator supports regular meetings, ensuring follow through on commitments and adaptations to change are made. It is estimated that initial network formation takes up to 40 hours of facilitator time over an eight-month period, with ongoing support taking about three to four hours a month. Key elements of this type of network development are a vision of what is possible, the willingness to look beyond traditional social service systems and the ability to ask for support and involvement of others.

Other examples of formal programs that support the formation of relationships take as their starting point regular community presence, and are based on the premise that participation in community-based activities or acquisition of valued social roles are the means to building individual relationships. An example of this type of approach is the Community Membership Project in Indiana (Harlan-Simmons et al. 2001; Kultgen & Todd 2000). This program uses person-centred planning techniques to understand the person's strengths and preferences, and a paid 'community builder' to explore the local community for places where they may play a valued role. The community builder facilitates the introduction of the person to activities, and seeks out and support natural supports within them. The degree to which friendships develop depends on attentive listening, strategy, persistent support and sometimes luck.

Approaches such as these require significant investment of time, intensive in the exploratory stage and less so but often continuing in the long term. The nature of such programs is very different from employing a one-to-one support worker whose role is often simply to support a person to participate in community activities or accompany them to community facilities such as coffee shops. Descriptions of programs that seek to build and support informal relationships demonstrate the intensive and lengthy processes involved that requires planning, commitment, resources and a positive outlook. Although many such examples are drawn from small-scale initiatives often driven by resourceful and committed family members, there are also instances where human service programs, such as the recent Connecting People project conducted by the Foundation for People with Learning Disabilities have successfully

built new social relationships and fostered community participation for people with more severe intellectual disabilities (Wightman 2009). However, building social networks is likely to be a low-intensity task that stretches over a considerable period and programs do not easily fit into formal service system requirements like episodes of care. It is notable, however, that common features of programs such as these are often a small size and focus on clearly articulated aims.

Conclusions

The Making Life Good in the Community research leaves no doubt about the increased quality of life for people with an intellectual disabilities that results from living in small group homes in the community compared with large institutions but suggests there is considerably more unrealised potential for their social inclusion. The research suggests multiple strategies will be needed if more than community presence is to be achieved. Attention must be given to the implementation of group home programs to ensure their day-to-day operations maximise opportunities for residents to develop their social connections in the community, as well as to exercise choice and engagement in meaningful activity through the use of person-centred active support. But given the numerous and competing demands on group home management and staff, it may also be necessary to establish programs with a more explicit focus on developing community participation for residents that can complement and support the work of group home staff. Such programs will also act as champions of community participation and, through demonstration of its diversity, will help to convince staff of the possibilities for all people with an intellectual disability regardless of their level of impairment. If the aspirations of current disability policy are going to be realised and more than community presence be achieved, it is necessary, as Vinson (2009) suggests, to spell out much more clearly what is meant by social inclusion and its possible manifestations for people with an intellectual disability. This will support the implementation of more differentiated and targeted strategies for the very different groups that comprise people with a disability.

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Appendix 1: Recommendations from Qualitative Component of Making Life Good in the Community. (Clement & Bigby, 2008a, p 69)

Table 10: A synthesis of recommendations

DDSOs	<ul style="list-style-type: none"> • Prerequisite English literacy skills. • Knowledge about the role and responsibilities of a keyworker. • Knowledge about how to support people with severe and profound intellectual disabilities using an active support framework. • Strategies and skills to 'get to know' people with severe and profound intellectual disabilities. • Knowledge about how to communicate with people with severe and profound intellectual disabilities. • Strategies and skills for planning. • Strategies and skills to develop reflective practice. • A positive orientation towards 'useful' paperwork.
House supervisor and Team manager	<ul style="list-style-type: none"> • Implement and monitor organisational systems. • Keep recording systems fresh and relevant. • Analyse data regularly and give feedback. • Prioritise planned formal supervision meetings. • Enable the staff group to become reflective practitioners. • Plan for community participation. • Manage effective house meetings. • Observe DDSOs interact with residents. • Use the physical environment to promote the desired work culture. • Identify coaching and training needs.

Organisational level

- Ensure a stable and skilled workforce.
- Minimise the use of casual staff.
- Work to keep core processes and principles in focus during times of change.
- Recruit DDSOs with prerequisite skills.
- Provide an organisational response to manage incumbents without the capacity to develop prerequisite skills.
- Recruit house supervisors and team managers with prerequisite skills.
- Use the competency document to recruit house supervisors.
- Use the competency document to communicate to house supervisors what they are expected to do.
- Use the competency document to develop a self- and peer-assessment tool.
- Develop a more theorised understanding of practice leadership.
- Review and clarify the DDSO2 role.
- Review and clarify the team manager's role.
- Provide comprehensive job descriptions.
- Provide training/coaching to bridge competency gaps (e.g. running effective house meetings).
- Introduce comprehensive supervision and appraisal systems.
- Clarify and embed the Professional Development and Supervision Policy.
- Develop training that reflects the four modes of supervision.
- Ensure adequate and good use of resources, particularly in relation to flexible rosters, house meetings attended by all, planned formal supervision for all, and time for planned informal supervision.
- Provide practice guidance for working with people with severe and profound intellectual disabilities. Translate Departmental goals into practical guides for action. Acknowledge the personal restrictions of profound intellectual disability.
- Clarify what is meant by the goal of building inclusive communities and align related documentation and guidance with this goal.
- Enhance planning and assessment tools.
- Experiment with specific schemes to enhance community participation.
- Review and clarify the 'type' of relationships direct support staff can have with service-users.

Appendix 2: Data collection form

KRS Individual schedule

Code:

Date of Interview:

Interviewer:

Position of person completing
this form:

Length of time known client:

Length of Interview:

Background

1. What is the age of the person?

2. Gender of person

Male

Female

3. At what age did the person first enter residential care?

4. How long has the person been living at KRS?

Please enter approximate number of years

years

5. Level of intellectual disability

Mild/moderate

Severe/profound

6. What other disabilities (eg. physical/psychiatric), if any, does the person have?

7. Is the person involved in a day program?

Yes

No

8. What is the name of the day program? (specify full name)

9. How many hours per week does the person usually
go to a day program?

hours per week

10. How many hours usually per day?

hours per day

Resident choice

In what ways is the person supported in making choices with regard to the following areas of their life?

Rating scale:

1. No procedure/nothing mentioned
2. Some procedure(s) mentioned but unlikely to give person much real choice
3. Some procedure(s) mentioned through which person can express preferences but final say does not rest with person
4. Procedures in place for person to express preferences and these are the final say unless clearly inappropriate or dangerous.

The content of their evening meal	1	2	3	4
The timing of their evening meal	1	2	3	4
Where they eat their evening meal	1	2	3	4
The leisure activities they take part in indoors e.g. TV, radio	1	2	3	4
Going out eg pub, cinema	1	2	3	4
The time they go to bed in the evening	1	2	3	4
The clothes that they purchase	1	2	3	4
The clothes they wear each day	1	2	3	4
Household routines, eg. shopping for food, housework rotas	1	2	3	4
Keeping pets	1	2	3	4
Who they live with	1	2	3	4
Where they live	1	2	3	4
Recruitment of staff	1	2	3	4
Staff performance review	1	2	3	4
The firing of unsuitable staff	1	2	3	4
Involvement with girlfriends or boyfriends	1	2	3	4
Their haircut	1	2	3	4
Their day time activities	1	2	3	4
Holidays: where they go, who they go with and when they go	1	2	3	4
The time they spend in the bath or shower	1	2	3	4
Their employment	1	2	3	4
Access to a private area	1	2	3	4
Moving home in the future	1	2	3	4
The furnishings in their home	1	2	3	4
The furnishings in their bedroom	1	2	3	4
Personal possessions	1	2	3	4

Social networks

Social Network Map

Consider who, over the past month, has been important in this person's life and who has had *contact (face to face or otherwise)* with them. This can include people who have provided concrete or emotional support or have given them information or advice.

In the circle below, put the *initials* for each person you think of in the appropriate segment (we do not need to know who the initials stand for):

Formal Services: people who come into contact with the person as part of their job.

Household: people living with the person.

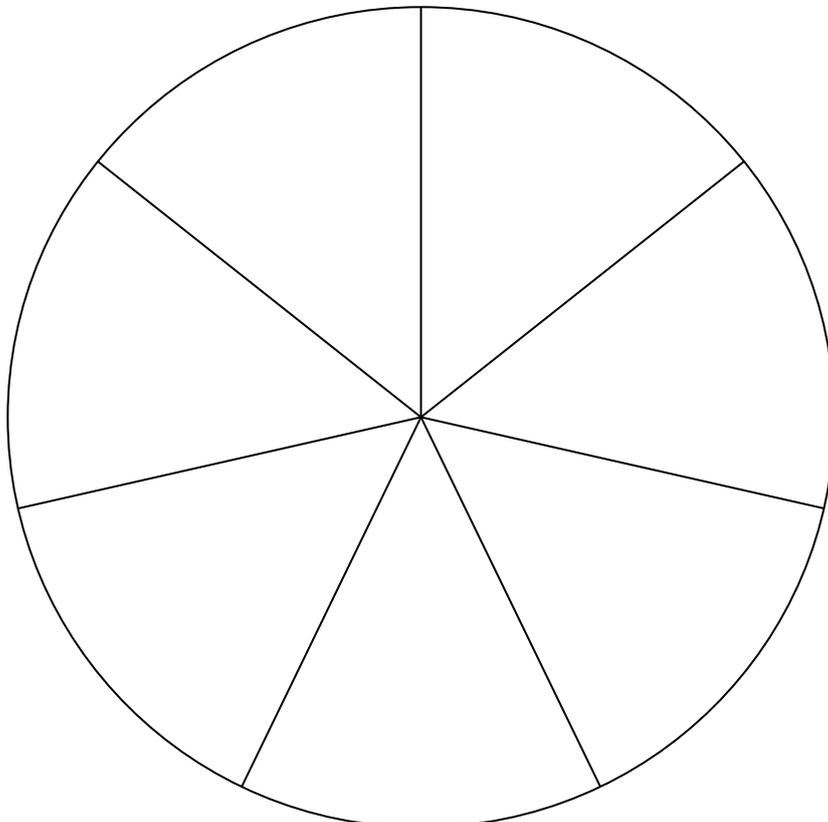
Family: family members with whom the person has contact.

Work/Day Service: people the person knows from attending work or a day service.

Organisations/Clubs: people the person knows from organisations and clubs or church.

Neighbours: people living close by.

Other Friends: any other friends that the person has who are not included in any of the above.



Social networks

The following table asks for more detailed information in the person's social network.

First write the initials of these people in the first column. If more than 15 people are identified, please choose the "top 15".

Please note whether they have an intellectual disability and the Area of Life (eg if the first person listed is a member of the person's family, put "2" in the box for "Area of Life").

Note the extent to which the person can rely on each of the people listed to give the following types of support:

Concrete Support: helping the person in practical ways eg giving them a lift

Emotional Support: eg listening to them talk about their feeling, comforting them when upset, helping through stressful times.

Information/Advice: eg help to make decisions, tell them how to do something.

Fill in the remaining columns as follows:

Critical: note the extent to which each of the people is critical of the person in a way that may make them feel bad or inadequate

Direction of Help: note the direction of the help to or from each of the people listed - does help go both ways, just from the people listed to the person concerned, or just from the person concerned to the member of their social network listed?

Closeness: note how close each of the people listed is to the person.

Finally, note how often the person is in contact with each of the people listed and how long they have known them.

Initials	Does person have an intellectual disability?	Area of life	Concrete support	Emotional support	Information/Advice	Critical	Direction of help	Closeness	How often seen	How long known
	1. Yes 2. No	1. Household 2. Family 3. Work/day service 4. Neighbours 5. Formal services 6. Organizations/clubs 7. Other friends 8. Other	1. Hardly ever 2. Sometimes 3. Almost always	1. Goes both ways 2. Person listed to resident Resident to person listed	1. Not very close 2. Quite close 3. Very close	1. Few times/year 2. Monthly 3. Weekly 4. Daily	1. Less than 1 year 2. From 1-5 years 3. 5 years or more			
13										
14										
15										

How much contact has the person had with their family over the past 3 months?
(enter zero if none, blank if unsure)

Number of visits by family to person's home
Number of visits by the person to family home
Number of telephone calls (approximately)
Number of letters received by the person
Length of time known client:
Length of Interview:

Living environment schedule

Setting information

(enter zero if none, blank if unsure)

1. Size

How many long term places are there in this setting?

How many of these are currently occupied?

2. Groupings - gender

How many males live in this setting?

How many females live in this setting?

3. Groupings - age range

What age is the youngest resident?

What age is the oldest resident?

4. Groupings - how many residents have:

Profound or severe intellectual disability?

Moderate/mild intellectual disability?

5. Number of senior care staff usually present

6. Number of other direct care staff (day) usually present

7. Number of other direct car staff (night) usually present

8. Other staff (eg. domestic staff) usually present

Building design

(To be rated by the researcher)

Is the dining room	1	2	3	4	5
<p>Very home like Small dining area typical of family home, seat 8 or fewer Family style furnishings and dishes. Good material standard. Residents eat family style.</p>					
<p>Non-home like Large area, seats 25+. No subdivision of space. Complete meal brought to residents or cafeteria style serving. Furniture and dishes for large numbers. Barren.</p>					
Is the main living area	1	2	3	4	5
<p>Very home like Typical of family home. Furniture is comfortable and typical of private home. Good material standard and personal touches.</p>					
<p>Non-home like Large and poorly furnished. Furniture designed for use by large numbers. No/few personal touches.</p>					
Is the bathroom (if more than one rate typical)	1	2	3	4	5
<p>Very home like Typical of private home bath, sink, toilet, shower, cabinets, personal towels and toilet requirements. Personal touches, plants etc.</p>					
<p>Non-home like Large, to be used by several people at same time. No provision for privacy. No provision for personal storage of toothbrush, shampoo etc.</p>					
Is a typical bedroom	1	2	3	4	5
<p>Very home like No more than one adult per room. Private cupboards. Good material standard and personal touches. Carpeted or rugs. Evidence of activity other than sleeping eg books, desk, comfortable chair.</p>					
<p>Non-home like 4 or more residents per room. Minimal furnishings. Furniture designed for large groups. Crowded. No personal cupboards or just locker. No/few personal possessions. Room just used for sleeping.</p>					
Is the garden	1	2	3	4	5
<p>Very home like Well landscaped with flowers, shrubs, trees. Garden furniture/ equipment appropriate to age of residents available.</p>					
<p>Non-home like No landscaping, grass only. No outdoor furniture or equipment or is inappropriate to age of residents. Poorly maintained.</p>					

Group home management interview

The following questions are about daily activities as they happened yesterday (if previous day is a Saturday or Sunday, complete for previous Friday). Record ONE response only for each question with a fixed response.

1. What time did the residents get up yesterday?

First resident

Last resident

2. Do they always get up at this time?

All yes 2

Yes except on specified day 1

All no 0

Other

3. What time was breakfast?

Began

Ended

4. Is breakfast always at that time?

Always 2

Different on specified days 1

Different at weekends 0

5. What did residents do after breakfast?

6. 6a. How many residents went out to work or to a day service?

6b. What time did they leave?

First left

Last left

7. 7a. How did residents get to their work or day service? (record main transport)

Private bus 1

Public transport 2

Walk 3

Other (specify) 4

7. 7b. Do residents travel together?	
All in one group	2
Mixed pattern	1
No more than 3 in a group	0
8. What time did the residents return from their work or day service?	
First returned	
Last returned	
9. What happened after their return and before dinner?	
10. What time was dinner?	
Began	
Ended	
11. Is dinner always at that time?	
Always	2
Different on specified days	1
Different at weekends	0
12. What happened after dinner yesterday?	
13. How many residents had a bath yesterday?	
14. Are there set times when the residents have their baths?	
Yes, all scheduled	2
Some scheduled	1
Individual choice	0
15. What time did the residents go to bed last night?	
First resident	
Last resident	
16. Do they always go to bed at the same time?	
All yes	2
Yes except on specified days	1
All no	0
Other (specify)	

17. Are the residents wakened for toileting at night?	
All residents	2
Some residents	1
None	0
18. What rules are there about quiet times eg use of TV or stereos	
Strictly scheduled	2
Some time rules	1
At residents' own discretion	0
19. What is the curfew time for residents to be in the house at night?	
Curfew time	
No curfew time	0
20. Is this the same every night?	
Yes	2
Yes, except specified nights	1
None	0
21. Is the curfew time the same for all residents?	
Yes, all	2
Yes, except specified people	1
No, or none	0
22. 22a. Is the house door ever locked?	
Yes	1
No	2
22b. If yes, how many residents have their own keys?	
None	2
Some	1
All	0
23. 23a. When can relatives visit the residence?	
Certain days only	2
Any day but set times	1
Any time	0
23b. When can friends visit the residence?	
Certain days only	2
Any day but set times	1
Any time	0

24. What rules are there concerning dating?	
No dating allowed	2
Allowed under specified conditions or times	1
No restrictions	0
25. When may residents use their bedrooms?	
Only at bedtime or to change	2
Under specified conditions	1
Any time	0
26. When may residents use the kitchen?	
Not at all	2
Under supervision, specified times	1
Any time	0
27. Are there restrictions on the use of any other area of the residence?	
Certain areas restricted always	2
Certain areas restricted certain times	1
No restrictions	0
28. Where do residents keep their clothes?	
Communal storage	2
Shared storage	1
Private storage	0
Other (specify)	
29. How many of the residents have books, games, radios, TVs etc of their own?	
None	2
Some (give number)	1
All	0
30. What is done with these items?	
Kept but not allowed to use	2
Used but become communal	1
Used and shared at owner's discretion	0
Other (specify)	
31. How many of the residents have been clothes shopping in the last month?	

31. How many of the residents have been clothes shopping in the last month?

32. How are meals planned at the residence?

Staff only	2
Staff and certain residents	1
Residents only	0
Other (specify)	

33. Who does the shopping?

Staff only or delivery	2
Staff and certain residents	1
Residents only	0
Other (specify)	

34. Who shops for residents' clothing and personal articles?

Staff only	2
Staff and certain residents	1
Residents only	0
Other (specify)	

35. How many residents:

Have bank accounts	
Have more than one bank account	
Have been to the bank in the last month	

36. How is the banking handled?

Staff only for all	2
Staff and certain residents	1
Residents only	0

37. How are household chores allocated eg washing up, making beds?

Staff decide who will do	2
Staff and certain residents	1
Residents decide	0
Other (specify)	

38. How often are parties or social events held in the residence?

Please enter number of times approximately per year

39. Who organizes parties?	
Staff only	2
Staff and certain residents	1
Residents only	0
Other (specify)	
40. 40a. Do staff invite their friends and relatives to parties too?	
Yes	1
No	2
40b. How often do friends and relatives of staff visit?	
Rarely	2
Sometimes (once a month or so)	1
Often (once a week or more)	0
41. Do staff have a chance to eat with residents at meals?	
Seldom, usually supervise during meals	2
Some staff sit but don't eat	1
All staff frequently	0
42. Do the residents watch TV as a group in the evenings? Do staff sit and watch TV with them?	
Seldom, usually supervise only	2
Someone sometimes does	1
Someone usually does	0
43. How are birthdays celebrated?	
Joint parties or no recognition	2
Mixed pattern	1
Individual presents and parties	0
Other (specify)	
44. Can a resident have a pet?	
None allowed	2
Common only	1
Individual pets allowed	0
45. What hobbies or crafts do residents enjoy? Do the staff work on these with them sometimes?	
Rarely	2
Someone sometimes does	1
Someone usually does with at least some residents	0

46. How are the residents' medical needs usually met?

Doctor comes to residence for all	2
Residents all go to same doctor's office	1
Residents have own personal doctors	0

47. How are residents' dental needs met?

One dentist for all	2
Mixed pattern	1
Individual dentists	0

48. How many residents have been to stay with a relative for a night or longer during the past 3 months?

49. How many residents have been to a friend's house for a meal in the last month?

50. How many residents have had friends in for a meal in the last month?

51. Please note how many residents have taken part in the following activities in the last month. Also note whether they took part as an individual or as part of the whole group.

Activity	No. in last month (zero if none, blank if unsure)	No. in last month individual	No. in last month mixed	No. in last month whole group
Movie				
Restaurant				
Museum				
Church				
Concert				
Play				
Sports event				
Social/recreational club				
Continuing education				
Hairdresser				
Other (specify)				

53. How many of the residents have been on an outing with staff in the last three months?	
None	2
Some	1
All	0

54. How many residents went away on holiday in the past year?	

55. Did residents go on holiday individually or as a group?	
All went as a group	2
Mixed	1
Individual trips	0

Addendum. Re the staff member views. (Time 2 only)

1. What do you understand community inclusion means for this resident?
2. What are the difficulties you encounter in supporting community inclusion for this resident.
3. What do you understand choice to mean for this resident?
4. What areas of choice making are difficult to support for this resident.
5. What do you understand participation to mean for this resident?
6. What are the difficulties you encounter in supporting this resident to participate.
7. What obstacles do you encounter in providing individualised support for this resident?
8. What factors support the provision of individualised support?
9. In what way did the transition training help you to work in this house?
10. What other support or training would have been useful prior to or after the move?
11. In your view what are the advantages for this resident of moving from Kew?
12. In your view what are the disadvantages for this resident of moving from Kew?
13. What do you think are the three key tasks of the house supervisor?

Appendix 3: Means and standard deviations of family network size for residents with mild or severe intellectual disability at Time 1 and Time 2.

	Time 1			Time 2			t	η^2
	M	SD	Range	M	SD	Range		
New locality								
Mild/moderate	1.82	0.60	1–3	1.36	0.50	1–2	-2.89**	.46
Severe/ profound	1.54	0.66	1–3	1.03	0.75	0–3	-2.85**	.19
Known locality								
Mild/moderate	1.00	0.89	0–2	1.05	0.80	0–2	0.24	.00
Severe/ profound	1.50	1.10	0–4	1.22	0.94	0–4	-0.89	.04
Combined Sample								
Mild/moderate (n = 32)	1.28	0.89	0–3	1.16	0.72	0–2	-0.85	.02
Severe/ profound (n = 53)	1.53	0.82	0–4	1.09	0.81	0–4	-2.74**	.13

M = mean; SD = standard deviation; t = t-test; η^2 = eta-squared

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