

Culture in Better Group Homes for People With Intellectual Disability at Severe Levels

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Abstract

Building on cultural dimensions of underperforming group homes this study analyses culture in better performing services. In depth qualitative case studies were conducted in 3 better group homes using participant observation and interviews. The culture in these homes, reflected in patterns of staff practice and talk, as well as artefacts differed from that found in underperforming services. Formal power holders were undisputed leaders, their values aligned with those of other staff and the organization, responsibility for practice quality was shared enabling teamwork, staff perceived their purpose as “making the life each person wants it to be,” working practices were person centered, and new ideas and outsiders were embraced. The culture was characterized as coherent, respectful, “enabling” for residents, and “motivating” for staff. Though it is unclear whether good group homes have a similar culture to better ones the insights from this study provide knowledge to guide service development and evaluation.

Key Words: *group homes; culture; people with intellectual disability at severe levels; quality services*

Achieving more efficient and effective disability service systems has been a cornerstone of reforms, and the development of personalized and marketized systems such as the insurance based system recently introduced in Australia (Commonwealth of Australia 2011; National Disability Insurance Scheme, 2013), individual budgets in the United Kingdom (Boxall, Dowson, & Beresford, 2009), and contracting-out of services in Sweden (Tideman, 2015). Good-quality services do not necessarily cost more than poor ones, once a threshold of sufficient funding is reached (Beadle-Brown et al., 2012) and, in times of austerity and actuarial systems, greater attention is given to measuring costs and outcomes. This is already evident in the reform of regulations and external quality-monitoring processes, which are paying more attention to quality of service and staff practice, rather than organizational processes and paperwork systems (Behan, in press). To achieve choice and drive better quality services in market systems, consumers, or family members and advocates on behalf of people with intellectual disability at more severe levels need quality indicators and data about organizational performance, as do funders and regulators.

Since the 1980s, small group homes have been the most common alternative to institutional care in Australia, the United Kingdom, and the United States, for people with people intellectual disability who do not live with their families (Mansell & Beadle-Brown, 2012). A significant body of evidence demonstrates that shared supported accommodation can deliver quality support that leads to good quality-of-life outcomes for people with intellectual disability, but outcomes are varied and consistently poorest for people with intellectual disability at more severe levels (Kozma, Mansell, & Beadle-Brown, 2009; Mansell & Beadle-Brown, 2012; Walsh et al., 2010). This evidence presents a significant challenge. People with more severe intellectual disability are likely to form a more significant proportion of group home residents as options expand, and evidence grows about comparable outcomes in less intensive models for people with similar support needs to some existing group home residents (Stancliffe & Keene, 2000).

Delivering consistent high-quality support, that leads to good quality of life outcomes, particularly for people with intellectual disability at more severe levels, has proved to be difficult. For

example, studies of implementing Active Support, an evidence-based practice that increases engagement in meaningful activities and social relationships, illustrate the difficulties in maintaining a threshold of good support across services even in organizations with a strong commitment to this practice (Mansell & Beadle-Brown, 2012; Mansell, Beadle-Brown, & Bigby, 2013).

Various frameworks have identified the bewildering array of interacting variables that impact on service quality (Felce, Lowe, & Jones, 2002; Hastings, Remington, & Hatton, 1995; Mansell, McGill, & Emerson, 1994). A realist review (Bigby & Beadle-Brown, in press) grouped propositions about variables into five clusters; staff and managerial working practices; organizational characteristics, processes, and leadership; resources and settings; culture; and external environment. They suggest overall there is a lack of research, and the strongest evidence relates to the positive effects of small, dispersed, and community-based setting, and staff and managerial working practices that reflect organizational values and policies, the principles of active support, and aim to compensate, as far as possible, for inherently disadvantageous characteristics of service users. As part of this latter cluster, they identified an emerging evidence base related to the importance of practice leadership (Beadle-Brown et al., 2014, 2015).

The effect of culture on service quality is a variable that has been consistently highlighted, but, about which there is little research. (Stancliffe, Emerson, & Lakin, 2004; Walsh et al., 2010). Culture is a slippery concept, most easily understood as “the way we do things around here.” The negative impact of culture figured in early studies of institutions (King, Raynes, & Tizard, 1971). Parallels are often drawn between culture in shared supported accommodation and institutions and blamed for abuse (Hutchinson & Stenferd Kroese, 2015). However, Bigby, Knox, Beadle-Brown, Clement, and Mansell (2012) found culture in group homes that did not support a good quality of life for residents (underperforming homes) was only similar to that of institutions on one of four domains; social distance between staff and residents.

Culture is a strong thread in organizational and managerial research generally (Alvesson, 2013; Trice & Beyer, 1993) and has been investigated in other fields, such as health (West, Topakas, & Dawson, 2014). Several authors have applied concepts from these broader studies of culture to

group homes. For example, Hasting et al. (1995) propose the applicability to group homes of Martin’s (2002, p. 15) “strong cultural thesis”—the positive effect of alignment of cultural values across all parts of an organization. Hatton et al. (1999) used generic measures to investigate cultural styles and dimensions. The study by Gillet and Stenferd-Kroese (2003) is one of the few to investigate the association between culture and quality. Using a generic measure of culture they found that the service with the more positive organizational culture, also scored higher in terms of quality of life.

An Australian study used ethnographic methods to describe culture in underperforming group homes, for people with severe and profound intellectual disability (Bigby et al. 2012). Table 1 summarizes the five dimensions of culture identified and thought to be common to all group homes, and describes the negative end of each and the hypothesized descriptors for the more positive ends. A follow-up study of group homes that had better quality-of-life outcomes for residents (higher performing) described one of these dimensions “regard for residents” (Bigby, Knox, Beadle-Brown, & Clement, 2015, p. 284). In contrast to underperforming homes the culture in the better homes positively regarded residents, seeing them as “like us.” Staff attributed humanness to the residents, differences were not devalued but rather acknowledged through adaption of support to compensate for impairments and poor health. Organizational processes and policies about things such as language, recruitment, orientation and support for practice leaders were identified as contributory factors to this positive aspect of culture.

Descriptions of culture in group homes for people with severe or profound intellectual disabilities, and empirical study of the impact of different types of cultures on service quality help in understanding how to influence culture. Such understanding is critical to developing strategies to promote better quality services and outcomes for people with intellectual disability. From a workforce perspective, too, it is important for organizations to know how to create and maintain positive culture and staff experience. These factors improve staff retention and motivation, reduce costs associated with poor morale, increasing cost effectiveness.

This article describes the more positive end of four of the five dimensions of culture in higher

Table 1
Dimensions of Group Home Culture Adapted from Bigby et al. (2012)

Dimension	Negative End (Hypothesised Positive End)	Descriptor
Alignment of power-holders vales	Misalignment of power holder values with organisation’s espoused values (alignment) <ul style="list-style-type: none"> • Power not aligned with formal positions, e.g. power dispersed among staff or held by a small cliques rather than resting with the house supervisor • Values of those who exercise power does not reflect those of the organisation; e.g., staff disregard goal of building inclusive communities and focus on community presence but not community participation 	“We’re not going to do it that way”
Regard for residents	Otherness (the same as other citizens) <ul style="list-style-type: none"> • Residents seen as fundamentally different from staff, e.g., as childlike, able to watch activities but too disabled to participate, having no skills, or worries • Residents referred to in derogatory terms, e.g., “grabbers or shitters” 	“Not like us”
Perceived purpose	Doing for (doing with) <ul style="list-style-type: none"> • Staff see their purpose to look after residents, attend to personal care, and get them out into the community • Disconnection of staff work from resident engagement, sequential and hierarchical view of purpose, where completing domestic chores takes priority over and is seen as separate from involving residents in these activities. 	“We look after them”
Working practices	Staff-centred (client centred) <ul style="list-style-type: none"> • Task focussed and structured into high and low intensity periods to allow breaks • Staff needs, fair allocation of work, and staff preferences prioritised in things such as composition of rosters and choice of activities • Regular routines tend to support residents as a group rather than individuals 	“Get it done so we can sit down”
Orientation to change and ideas	Resistance (openness) <ul style="list-style-type: none"> • Sense of distance from the wider organisation and senior managerial staff • Strategies to preserve the status quo and resist external influences seeking change to practice 	“Yes, but”

performing group homes for people with severe and profound intellectual disabilities and contrasts these with underperforming homes. It draws on a subset of the data from the Ordinary life study, which was described in the earlier paper that considered the fifth dimension of culture “regard for residents” (Bigby et al., 2015).

Methodology

An interpretative methodological paradigm was used, drawing on qualitative ethnographic methods to collect data (Adler & Adler, 1987). The theoretical foundation was Schein’s (1992, p. 12) understanding of culture as

A pattern of shared basic assumptions . . . that has worked well enough to be considered valid and, therefore, to be taught to new members as the correct way to perceive, think, and feel in relation to those problems.

In keeping with this definition and a case study approach (Yin, 2014), in depth data were collected about a wide range of contextual variables and from multiple perspectives: supervisors, direct support staff, and residents. We acknowledge that the direct voices of the residents are not included; but as they are people with severe and profound intellectual disability, their thoughts, feelings, and other inner mental states cannot be directly accessed, and reliance must be placed making inferences and interpreting individuals' behaviors (Kellett & Nind, 2001). The residents were not absent from our data, as the observational methods captured their some of their behaviors and responses to their life in group homes.

Recruitment

Advertisements and newsletter articles were used to invite stakeholder groups to nominate group homes that they perceived to be the “best of their kind” to be invited to participate in the study. Four group homes from three organizations were identified and agreed to participate. Data were collected in these homes using the methods described below. To test the proposition that these were good group homes, we rated them on eight quality of life domains, comparing them to each other and three underperforming homes in a previous study. A 4-point scale was created to quantify the qualitative data and rate each group home on each domain as follows: 0 = outcome was not present for any residents; 1 = mixed outcome, partial or strong outcomes for some residents some of the time, 2 = partially good outcome for all residents most of the time, and 3 = strong outcome for all residents most of the time. The scale reflected the proportion of people in the home who were achieving each quality of life domain and how consistent this was. The “unit of analysis” was the group home, scores of 2 and 3 required that all residents in a setting were achieving the quality-of-life domain at least to some extent, a good group home should produce good outcomes for all its residents not just some (see Bigby, Knox, Beadle-Brown, & Boud, 2014, for a full description of this process). The scores of 22,

18, and 14 out of a maximum possible score of 24 suggested that the four homes were not uniformly *good* but were considerably *better* than the underperforming homes, which scored, 8, 7, and 6. Data from the three highest performing homes, which are referred to as *better* group homes, were analysed and are reported in this article.

Settings and Participants

The three better group homes were managed by two nongovernment organizations, which were funded and regulated by the state of Victoria, Australia. The homes were staffed 24 hours a day, and all had operated for more than 10 years. Two had active night staff, the other a sleep-over staff. Two homes had six residents, and one home five. Staff gave their own consent to participate; and, in accordance with ethical guidelines, consent was sought from the guardians or close family members of the 17 residents who were people with intellectual disability at more severe levels and were judged not to have the capacity to consent for themselves. The study was approved by La Trobe University human research ethics committee.

Measures

Resident characteristics. Data on resident characteristics were collected using the *Adaptive Behaviour Scale (ABS)* (Hatton et al., 2001; Nihira, Leland, & Lambert, 1993); the *Aberrant Behaviour Checklist (ABC)* (Aman, Burrow, & Wolford, 1995) and an item on “quality of social interaction,” originally from the *Schedule of Handicaps, Behaviour and Skills* (Wing & Gould, 1978). For each resident the measures were completed by a staff member who knew the person well. As Table 2 shows, all except one resident had an ABS scores below 151 (i.e., in the bottom half of the total possible ABS score), indicating more severe disabilities. Table 2 illustrates the severity and complexity of needs of the sample overall as rated by staff.

Participant observation. The primary method of data collection was participant observation. An average of 22 visits of 3-hr duration were made to each house over a period of 9–12 months during 2011–2012. Visits were made, over all days of the week, at different times, between 06.00 until 02.00. As far as possible a strategy of “non-interventionism” was employed (Adler & Adler, 1987), but some time on each visit was spent interacting with

Table 2
Overview of the Residents and Settings

	Hesta Ave.	Tiger St.	Bee Lane
Sector	Non-government	Non-government	Non-government
Type of House	Purpose-built	Purpose-built	Adapted ordinary house
Approximate years home had been open at the start of the project	11	11	20
Night staffing	Active night	Active night	Sleep-over
No. of residents	6	6	5
Men/women	2/4	3/3	1/4
Mean age (range)	36.0 (30–46)	43.4 (39–48)	30.2 (21–39)
Mean estimated Part 1 ABS score (range)	80.6 (43.2–165.9)	67.2 (47.9–99.9)	68.2 (26.7–123.5)
Percentage socially impaired	50.0%	50.0%	60%
Percentage with a physical impairment	83.3%	83.3%	100%
Percentage nonverbal	66.7%	100%	40%

Note. ABS = Adaptive Behaviour Scale.

the residents in order to get to know them. Observations focussed on staff day to day practices whilst on shift in the house, in staff meetings, and out in the community. Detailed field notes were written after each visit. Additionally, 34 semi-structured interviews were conducted with staff, including the supervisor for each home, to find out how they thought about their work. All the data were collected by a research fellow who left the team during the final stages of data analysis.

Data Analysis

The interviews were recorded and transcribed. The interview transcripts and field notes were loaded into NVIVO 9, qualitative data analysis software, which was used to support the analysis and manage the large volume of data. Using a template analytic approach (King, 1998), some codes (the template) were defined, based on the coding from earlier studies (Bigby et al., 2012; Bigby et al., 2015), prior to undertaking an in-depth analysis. This is similar to the notion of sensitizing concepts in Charmaz's (2014) constructive grounded theory approach. Reflecting Schein's definition of culture attention was given to artefacts, espoused values and basic underlying assumptions. Artefacts included physical environment, rituals, staff and service users clothing; espoused values, included ideas, values, aspirations explicitly articulated in talk, and; basic underlying assumptions, the taken for granted values or assumptions that determine behavior, were interpreted from actions.

Coding was done for each home followed by a cross case analysis. Additional codes were added to the template during the analysis as it became evident that some of those flagged in the original hypotheses about the positive end of dimensions (see Table 1) were not reflected in the data. This most commonly occurred for the two dimensions, "alignment of power holder's values" and "perceived purpose." For example, the hypothesized positive end of perceived purpose had been "doing with" rather than for residents. New codes such as, "trying new things," "making judgements about preferences," "prioritizing choice," "choice in household chores," were developed to reflect the importance staff accorded to residents having the lifestyle they preferred rather than one prescribed by others. These were collapsed together to become the sub category "recognizing and respecting preferences" and, together with other new subcategories of "including and engaging" and "ensuring dignity and comfort," were brought together as the new descriptor "making the life each person wanted it to be" as the positive polar end of perceived purpose. As the findings show, although new codes were added, they were accommodated within the existing five dimensions of culture.

Rigor was ensured through thick descriptions, constant comparison of data across the three houses, and regular meetings of the first author with other members of the research team to discuss the coding process and make revisions to the template as the analysis preceded. For example,

inserting new emergent codes, merging or changing the scope of codes that had been too narrowly or broadly defined.

The source of data extracts presented in the findings is indicated by data source, “I” stands for Interview and “F” for Field note an identifier of setting (HA, TS, or BL) and either “S” for staff and “HS” for house supervisor. Names and identifiers have been changed to provide anonymity.

Findings

Table 3 and the following sections describe the culture at the more positive end of the four dimensions, using excerpts from field notes and interviews illustrating artefacts, staff talk and actions. For completeness Table 3 includes the fifth dimension from the earlier paper. As described above the additional codes added to the template during analysis changed some of the descriptors flagged in the original hypotheses (see Table 1). The coherence and mutual reinforcement of the different parts of the culture were striking, and as the excerpts show one comment or moment of practice often embodied multiple parts of the culture operating simultaneously.

Alignment of Power Holder Values— “Vision and mission are exactly what we live to”

This dimension was characterized by strong leadership and team work, which had been absent in the underperforming houses. As hypothesized, the values of the formal power holder, who in these homes were the supervisors, were aligned with the espoused values of the organization. Power was not only held by strong and respected leaders but also shared among staff and consistently exercised by the whole team to translate espoused organizational values into practice.

As the supervisor of Hestia Ave. said, “The organisation’s vision and mission is exactly what we live to, ordinary people living ordinary lives . . . that’s what we aim for” (I, HA, HS). Expectations that staff adhere to the organizations’ values echoed throughout the data and were diffused through all dimensions of the culture. As the comment from one staff member illustrated, deviation was not tolerated:

We all share the same work ethic. . . . If you’re a hard worker and you’re good at your job you go well here, if you’re not a good hard worker,

Table 3
More Positive End of the Dimensions of Group Home Culture Found in Better Group Homes

Dimension	More Positive End	Descriptor
Alignment of power-holders values	Alignment of power holder and staff values <ul style="list-style-type: none"> • Strong leadership • Shared responsibility and teamwork 	“Vision and mission are exactly what we live to”
Regard for residents	Positive regard as part of the same diverse humanity <ul style="list-style-type: none"> • Humanness • Acknowledging and attending to difference 	“Like us” (from Bigby et al., 2015)
Perceived purpose	Making the life each person wanted it to be <ul style="list-style-type: none"> • Recognising and respecting preferences • Including and engaging • Ensuring care, dignity and comfort 	“It’s her choice”
Working practices	Person-centred <ul style="list-style-type: none"> • Attentive • Relationships • Flexible • Momentary fun interactions 	“The guys come first no matter what”
Orientation to change and ideas	Openness to ideas and outsiders	“Let’s face it everyone can improve”

if you want to sit around and slack-off, this is not the house to do it and you don't last long. (I, BL, S)

Strong leadership. Little room was left for doubt, because supervisors took responsibility for leading staff practice, setting expectations and giving feedback. As one said, "I manage them, very well, to be honest, although we haven't had any issues, and I think they do listen to me when I need to [say], 'This is how it is' (I, HA, HS). Supervisors' leadership was undisputed, without the opposing cliques that had been evident in underperforming houses. As a staff member in Hestia Avenue said about her supervisor,

There's a standard she expects from everyone that works here and if you're not doing it, believe me! But she treats everyone the same. . . . [How do you know you are doing a good job?] "Madge would tell us if we weren't" . . . and she does embarrass me sometimes in praise."

These field notes illustrate leadership in action:

Seth back in the living area has been making quite a lot of sounds whilst Madge [supervisor] has been feeding Niki. She says to Pearl [staff] who is passing through, "Seth is wanting quite a bit of attention if you are free." (F, HA)

The style was leading by example, "walking the talk." As one supervisor said, "I wouldn't expect my staff to do anything that I wouldn't do" (I, HA, HS). Supervisors worked alongside staff, modelling, monitoring and correcting their practice. This conscious strategy gave them respect and credibility with staff, meaning their power stemmed from both their position and personal standing. The perspective of leaders was reflected in that of staff:

I'm constantly having supervision, constantly, every time I walk in that door. I'm talking to staff . . . I get more out of staff that way. . . . The whole shift we're just constantly talking (I, TS, HS).

She's there with you, she's not in her office . . . she's on the frontline so to speak. . . . She's in the house with you, and she doesn't isolate herself, as, "I'm the manager and I don't do that sort of stuff." She will just do everything that we do. Everything she asks of us, she'll do

it, and that gains respect amongst the staff (I, HA, S).

Teamwork and shared responsibility. Supervisors facilitated the strong sense of team work, whereby staff shared common values and purpose, and everyone's contribution was valued. The way power was shared with staff, for example, meant responsibility for quality of support rested with everyone. As the Tiger Street's supervisor said, "I like to empower the team, give them responsibilities, to skill them up. I know that I can leave. . . . They know what's required." Echoing this one of her team said, "managers are not always around and you have to step up to the occasion and lead the way for new people coming in."

As the following excerpts illustrate, staff talk was reflected in their practice, through monitoring each other and using various forms of communication to correct or draw attention to issues.

Henry [staff] directs Karma [staff] to ask Pete whether he wants lemonade or juice to drink. Karma steps the two metres and bends down and asks "Do you want lemon or juice?" Karma reports back that Peter wants lemon and Henry pours a large glass of lemonade, which is then given to Pete, which he drinks through a straw. . . . Henry gives Karma some more guidance about how to cut up Pete's food and how to feed him. (F, BL).

The quality of support was not affected by the absence of the supervisor, as one staff member pointed out in her reply to the question what staff would do when the supervisor went on leave,

"It'll be fine, because we have no secrets here, everybody knows about everything," which we have to do, because we've all got to hand over, and you've got to know all the information. No, I don't think anything will change, all that much. She's [supervisor] always on the end of the phone anyway, not that she will be in an official capacity, but everyone's quite used to just picking each other's brains and finding out information, and sharing it, so we're be fine (I, BL, S).

As this excerpt also illustrates, good communication played a big role in their team work, as one staff member said, "That's why we have all these

notes and communication things going on, so that it's passed on, handed over" (I, BL,S). Shared decision making helped staff to be involved in the overall picture of what was happening. For example, one house supervisor talked about her deliberate strategy of involving staff in decisions to help them feel valued. She said,

I don't make a decision, I'm talking about any big decisions, obviously at the end of the day it's my responsibility, but if there's an issue with the residents we all discuss it, we talk about it, we even ring each other up at home and say, "Look, I've been thinking about such-and-such," so there's no "big boss" as such. . . . I try to make people feel valued. I want their input (I, BL, HS).

Other examples of actions to facilitate teamwork included active monitoring of staff dynamics, and using staff meetings for discussion and acknowledgement of contributions, as these examples illustrate:

If there's any difficulties between staff, Faith [supervisor] wants to know about it. She likes to keep her finger on the pulse. If there's any unhappiness, she wants to know about it. She'll generally make an effort to fix it. . . . We work as a team –like everything's discussed. . . . Something as simple as what time does someone put their pyjamas on, we've had lots of discussion (I, BL, S).

[at the staff meeting] Madge gives Jewel an award for solving the problem with the snails in the post box, which involved a small stick to get some light into the box. People clap. Jenn receives a note pad and pen (F, HA).

Perceived Purpose—"It's her choice"

Though primarily illustrated through staff practices, this dimension, the perceived purpose of the group home, focused on the *why* rather than *what* of the staffs' work, as intent can only be accessed through interpretation of words and actions. The more positive end of this dimension was not quite the same as "doing things with rather than for people" that had been hypothesized. An overarching perceived purpose hinged on supporting each person to lead the type of life they wanted. It had three elements: staff recognizing and respecting

preferences in all aspects of their work and in residents' lives; including and engaging residents, and; ensuring dignity, care and comfort. As one staff member said:

So it's being able to speak on their behalf, and understand them, what they like and what they don't like. If I'm making their life what they want it to be, as best as I can, from what I know of them (I, TS, S).

Recognizing and respecting preferences.

Strategies to expand experiences, elicit preferences, respect and act on these were the embodiment of making the life each resident wanted. As illustrated previously, in writing about the cultural dimension of positive regard, staff adapted their practice to accommodate differences in cognitive capacity, in many instances relying on their interpretations of preferences rather than direct communication of choice (Bigby et al., 2015). One supervisor captured the importance of expanding an individual's repertoire of activities to broaden possible options to choose from, when she said, "We just keep trying things and if she's smiling we figure she must be having a good time." The Tiger Street supervisor illustrated how options had increased for one resident, saying,

For many years, she was never taken to shopping centres, she was never taken to stage shows. We then started taking her to more low-key, high school concerts, or performances like local performances. She liked the musical but she didn't like the crowd. Once she was more comfortable in the crowds, we started taking it further and further, and now she will actually attend a live show, in the city, at the Arts Centre, or theatres (I, TS, HS).

Respecting preferences wasn't simply about activities but permeated all aspects of residents' lives and the work of staff. As the examples illustrate, this might involve questioning choices made for residents' by others or increasing time staff took to complete tasks:

Jake's family wanted Christianity pictures put up in Jake's bedroom, because they are Christians, and I said no, because Jake's been to a Christian youth group, and each time he's been there he's hated it, absolutely hated it. . . .

So it was about they didn't like certain pictures, okay, we took the pictures down . . . so we put up nice pictures of beaches and stuff, because Jake loves water and he loves the beach, so we compromised in that way. . . . We put pictures up that we thought Jake may like, yes (I, TS, HS).

Bruno leads a conversation about where Seth wants to go. It is worked out that they will go to City Mall, where Seth will get a haircut, get something to eat, and have a head massage. Bruno tells me that although the mall is further than some of the local shopping centres it is one that Seth prefers (F, HA).

Including and engaging. Inclusion and engagement in household activities, the community, and social relationships with staff, family, and community members were perceived as a core purpose. Rather than generic or abstract, activities and relationships had to be on residents' own terms. As well as more traditional forms of facilitating inclusion, through contact with neighbours, and community organizations, staff created warm and inclusive atmospheres through light-hearted banter, music, and chat. They perceived such atmospheres as enabling residents' inclusion in the milieu, despite their limited cognitive and communicative capacity.

Both Seth and Bruno scream as we drive away. On the journey, Bruno includes Seth in the conversation: "I'm having to pull into the inside lane. I've got some speedster on my tail. . . ." and after a "1-2-3" they both holler (F, HA).

At times staff weighed residents' preferences about engagement in more concrete activities again inclusion in the general milieu, as the examples below illustrate,

You try and involve them but a lot of the time they don't want to. Like Edie I did have her involved in baking the cake but she'll prefer to be interactive with you, clapping or whatever than baking. . . . We find that Niki likes to sit at that table with us. . . . She seems to prefer to sit right at the table listening to all the conversation, and being part of whatever's going on at the table (I, HA, S).

Artefacts, particularly photographs of residents' families and activities, illustrated the importance accorded to being included and engaged. For example, in Tiger Street the field notes recorded, "There were photographs of Cain washing and drying dishes and making a smoothie."

Ensuring dignity, care, and comfort. To keep people with high support needs—and often complex health issues—well, personal care occupied a significant proportion of staffs' time. But, as one staff member, emphasized, the central thread of recognizing and respecting preferences carried over into this domain,

I think it's still about choice . . . Anthony's always given a choice, of who will attend to him, and I think that makes, gives him a little bit of dignity back, too (I, HA, HS).

Cain has taken some of the coffee but will not finish it. "That's so unlike Cain," says Effie [staff]. She takes his hands and signs and speaks, "Will you finish your coffee?" Hetty comes and offers her advice. She tests the temperature of the coffee with her little finger and thinks it may be a little cold. "You've got to have some fluids. Let's make another one, and if he doesn't want it we'll try cordial" (F, TS).

Working Practice—"The guys come first, no matter what"

Working practices were person centred as hypothesized and characterized by attentiveness, relationships, flexibility, and momentary fun interactions. Talking about their practice staff implicitly contrasted their person-centred ways of working to the staff-centred practices found in underperforming homes. As excerpts in previous sections have already illustrated supporting residents took priority over completing household tasks. One staff said for example, "If you focus on the residents then the other things 'fall into place.' You can always do jobs like washing and cooking later" (I, BL, S). Expanding this sentiment, and emphasizing that residents came before both tasks and staff needs the supervisor at Hestia Ave said,

I know I have staff on shift and they have lots of stuff they have to do and be there for the people we support, but it's not about making it easy for the shift, so that so-and-so needs to go

to bed because I've got to leave and then someone else might have to do it. It's not about that (I, HA, HS).

Attentive. As examples have illustrated, staff practice was characterized by being attentive to the spectrum of each residents' preferences and needs. Sometimes this required immediate interpretations of the preferences encoded in body language, vocalizations and evidence of emotions. But at other times, as illustrated below, being attentive all required forethought and planning. Being attentive also meant interpreting and responding to each resident in the context of broader knowledge about their health issues, prior preferences, or personal story,

Stephanie [staff] feels Hank's legs to make sure that he is not getting too warm. He is wearing black sweat pants which "absorb the heat." "You love the warmth," she says. She notices that Hank needs adjusting in his chair and calls out Daisy to help her move him upward (F, HA).

[the house supervisor said] When Jake's had to go to hospital, I've been there, and I've said to the staff: "Oh, he's about to have a seizure," and they'll say: "How do you know that?" I explained it's just because I know them (I, TS, HS).

Ivan's sister is having a baby, due any time soon. Zadie [staff] wants to be notified when the baby is born, so that she can come in and take Ivan down to see his new niece or nephew (F, TS).

Relational. A relationship with each resident was fundamental to staff, in contrast to underperforming homes where this had barely figured. The centrality of relationships was illustrated by one staff member who said, "I don't know how you can do your job and not become attached?" Relationships were warm, caring and committed, and sometimes blurring the boundaries between work and personal time or resources. For example,

I've built up a relationship with Hank, so I regard him as my friend, and so I just try and do things that I would do, to certain extent, with my mates (I, HA, S).

The staff paid for Vera to have her hair and make-up professionally done for the party (F, BL).

Flexible. Staff used their time flexibly without rigid adherence to a daily routine. For example, the supervisor at Hestia Ave said,

The guys will tell us when they're ready to go to bed. That's why I don't actually have a stiff routine. . . . "It's usually around this time that Sarah might look tired and may want to go to bed," but Sarah will walk into her bedroom if that's the case. If not, she'll walk up and go into the tele room and she could sit there until one or two o'clock until she's ready to go to sleep and that's her choice and that has to be respected (I, HA, HS).

Staff organized their time around the needs of residents rather than completion of tasks or their own needs. Flexibility was facilitated by the culture of shared responsibility and teamwork that enabled staff to rely on each other to complete tasks, as the following examples illustrate:

If the residents are not ready the bus has to wait says Hetty: "We don't care," she adds, suggesting that supporting the residents is more important. (F, TS).

Venus tells me that you are entitled to a half-hour break for a six-hour shift. She says that you have to be very flexible. On some shifts you miss your break. She does not direct staff where or when to take their break. (I, TS, HS).

Momentary fun interactions. Short intensive bursts of fun like interactions were diffused across all aspect of their practice and were evident in the way staff supported inclusion in social milieu. This type of interaction vividly illustrated a commitment to adapting to people's differences and engaging directly with people who were often more attuned to sensory forms of engagement than words. For example,

Pearl takes the pills and some chocolate mousse down to Edie's bedroom, where Edie is lying in her bed. She knocks on the door, goes in, nudges Edie, and speaks to her. Edie opens her eyes and wants to hold Pearl's hands (F, HS).

Kitty brushes Reba's lips with the loaded spoon. Reba seems reluctant to eat. Kitty puts down the spoon and sings, "Let do the time warp," and rubs her chest (F, BL).

Orientation to Change and Ideas—"Let's face it, everyone can improve"

Although in the underperforming homes there was a sense of defensiveness and an overt oppositional stance toward external influence, these homes were open to outsiders and new ideas. Interaction was embraced with outsiders, such as families of residents, staff from other parts of the organization, local communities, and communities of interest around disability issues. The benefits of interactions were acknowledged and included opportunities for residents' to be socially included or make a contribution. Examples included minding a neighbour's cat, being filmed for a new training program, and inviting volunteers into the home to learn more about people with severe disabilities.

Openness to outsiders, such as researchers and staff from other organizations, also meant the staff team contributed to the wider community of disability professionals and services. For example, staff in one home had been mentoring some from another organization. Being open also meant embracing new ideas and a willingness to try different approaches to practice, despite practical difficulties. For instance, several staff talked about efforts to introduce active support, which, despite the practical difficulties they had not dismissed as "unrealistic."

As we got more and more busy, with only the two staff on, things like that [active support] went by the wayside, we're now hoping that with the extra staff that sort of thing will be reintroduced, but then again it's a matter of teaching the new staff . . . and Kloe loves being in the kitchen, helping, actually physically helping with the cooking, not just sitting there watching (I, TS, S).

Beth checks the mail, she would always check the letterbox . . . and I think Hank started doing it, and there was, someone else watered the garden. . . sort of things like that, that never really worked, unfortunately, and maybe we didn't stick at it long enough? (I, HA, HS).

Families were welcomed to the houses, to be part of planning and for regular or special activities. At Tiger St., Fawn's mother, for instance, visited

regularly at weekends and helped to maintain the garden. There was a sense of staff's being in partnership with families, whom they consulted regularly. Families' concerns were taken seriously by staff who, as illustrated earlier, did not always agree with their preferences, but felt they had the right to have input.

There was a perception that families undoubtedly had the interests of residents at heart and were essential to accountability and the protection of rights. The following excerpt about the reasons staff agreed to participate in the research illustrates this point, further pointing to the perceived benefits of openness and scrutiny from outsiders in terms of motivation, feedback, and accountability for service quality,

I think we all need to be, looked at about what we're doing. . . . I want to know that we're doing a good thing, and we, you will tell us, maybe? . . . It would be nice to hear, where we can improve, because let's face it, everyone can improve, definitely, and where, maybe we've gone a bit off track, or just got used to doing that way and are not often thinking about it anymore, we're just, you know, habitually doing something, I think that's a good thing, and why not, we've got nothing to hide (I, HA, HS).

Discussion

The starting point of this analysis was four of the five dimensions of culture identified in underperforming group homes from Bigby et al. (2012). By including, the fifth dimension reported in Bigby et al. (2015), these findings put a descriptive "value" to the culture in group homes and clearly illustrate differences in culture between services of differing quality, for the first time using empirical investigation rather than generic tools. As Figure 1 shows, the more positive end of each cultural dimension was described as alignment of power holder and staff values, positive regard for residents, perceived purpose to make the life each person wants it to be, person-centred working practices and openness to change and new ideas.

Drawing the dimensions together, the overall culture in better group homes can be characterized as cohesive, respectful, enabling, and motivating. Cohesiveness was evident in the interrelationship of the various elements that reinforced each other. For example, respect for humanness and attention

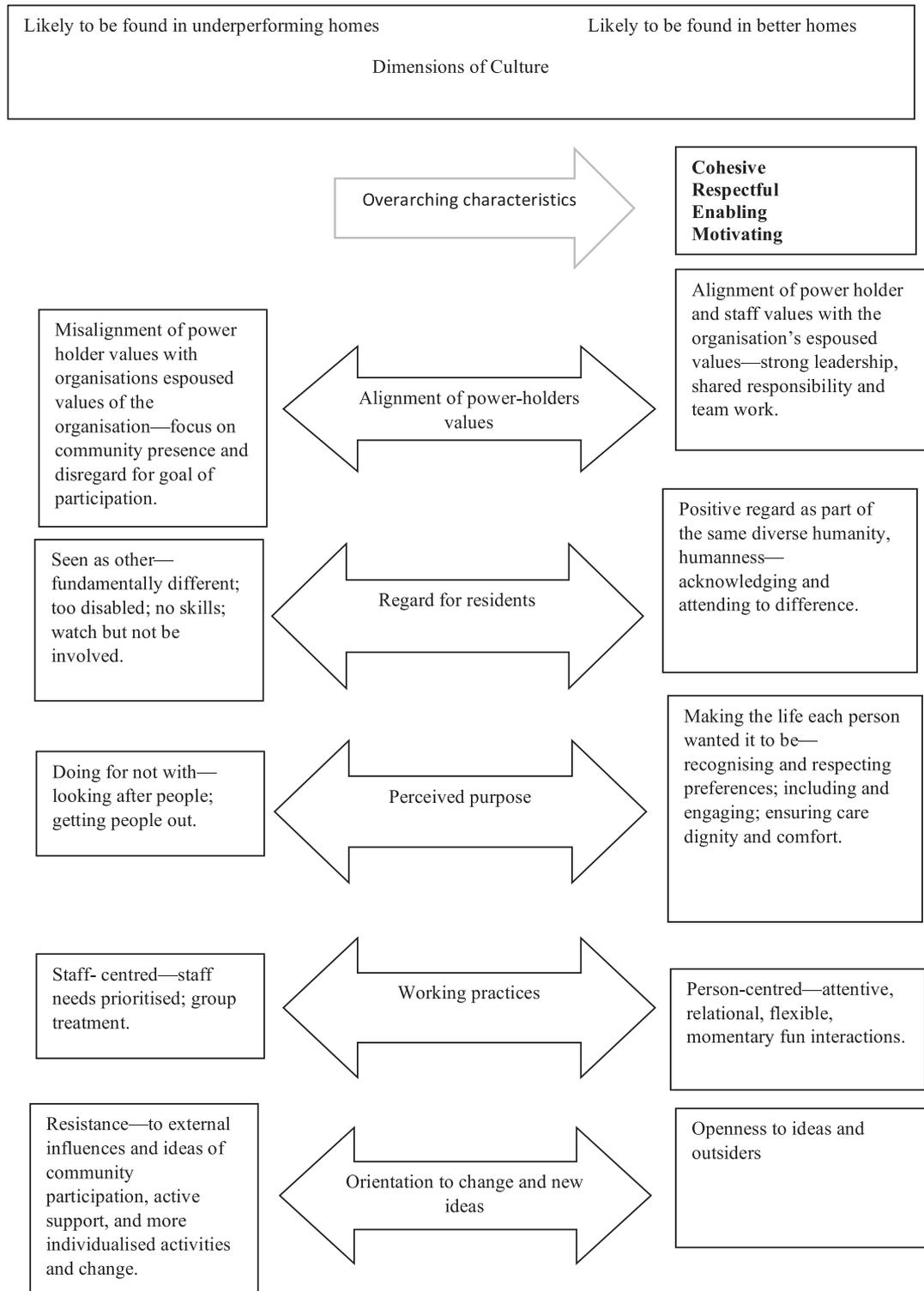


Figure 1. Culture in underperforming and better group homes.

to difference were reflected in the perceived purpose that avoided normative assumptions about preferred lifestyle but also prioritized elements (physical care, good health, inclusion, engagement, and choice) associated with a good quality of life; attentive working practices took account of differences in communication; strong leadership supported teamwork and all staff's taking responsibility for monitoring the quality of support for people whose different means of communication meant they would have difficulty exercising consumer rights to walk away from poor services. This type of culture and its embedded values and staff practices meant staff provided support that enabled residents to have a better quality of life than in underperforming services. The strong leadership, unequivocal expectations, shared power, good communication and team work are all reflective of factors that motivate staff to perform well (West et al., 2014). The underpinning values of positive regard for humanness meant this was a respectful culture, but as the data illustrates it was also based on a wide range of skills in supporting and caring for people with high and often complex needs.

The underlying intent and the skills evident in staff working practices in this type of culture are not new, although not commonly seen together. There are bodies of knowledge about, for example, adapting communication with people who don't use words and use of tacit knowledge to interpret preferences (Reinders, 2010), the role of attachment in professional care giving (Schuengel, Kef, Damen, & Worm, 2010); use of momentary fun or intensive interactions inactions to engage or include people with little expressive or receptive language (Johnson, Douglas, Bigby, & Iacono, 2012a), processes that support formation of relationships between people with severe intellectual disability (Johnson, Douglas, Bigby, & Iacono, 2012b), strategies for supporting inclusion in community places (Bigby & Wiesel, 2015), and using active support a facilitative relationship to support engagement and inclusion (Mansell & Beadle-Brown, 2012). This study identifies how these practices, often conceived of separately, coalesce in working practices associated with better quality services. It provides a starting point to develop an overarching practice framework encompassing all aspects of supporting people with severe and profound intellectual disabilities.

These findings supports evidence emerging from quantitative studies about the significance of

practice leadership to better quality of life outcomes (Beadle-Brown et al., 2014, 2015). The leadership and teamwork described in the present paper resembles the items included in the Measure of Observed Practice Leadership, highlighting the importance of modelling, coaching, monitoring, supervision and communication among team members focussed on supporting a good quality of life of people being supported. Generative factors of the dimension positive regard for residents such as, recruitment practices focussed on staff values, orientation to practice separated from induction to procedures, translation of organizational values into grounded expectations of staff, identified in an earlier article (Bigby et al., 2015), appear to be also relevant to the other dimensions described in this article. The culture of strong leadership and teamwork in these better homes suggests organizational structures and processes that support this type of front-line managerial practices might be a particularly important influence.

The sample of "better" rather than "good" group homes was a limitation of this study, which raises the question whether culture is different in "good" homes. These homes were cast as "better" because none provided consistently good support for all residents in domains of personal development or interpersonal relationships (see Bigby et al., 2014) but were rating as leading to better quality-of-life outcomes than the underperforming homes, which were drawn from the same service system and similar funding arrangements (see Bigby et al., 2012). The data showed, for instance, that although residents had positive family relationships (where applicable) and were positively regarded by staff, most did not have a breadth of relationships. It could be hypothesized that in these homes, the sense of commitment by staff and their warm close relationships with residents overshadowed the need to support development of other relationships with perhaps less reliable or committed community members. In terms of personal development, although residents' engagement in social interactions and inclusive milieu was high, they spent little time engaged in the type of meaningful activities that the more effective implementation of active support might enable. These forms of engagement are not always mutually exclusive, and there is potentially no reason residents could not experience higher levels of engagement in activities without detracting from their social interac-

tions or inclusion in the milieu. This would, however, require a shift in working practices.

Conclusions

The study has added to the limited body of evidence about factors that affect the quality of group homes services in Australia and the effective implementation of visionary policies about social inclusion of people with intellectual disability. It has for the first time described the nature of culture associated with group homes that have better quality-of-life outcomes. This knowledge has the potential to inform quality assessment frameworks, staff training and the organizational structures and processes of disability service organizations. Understanding the nature of this culture provides, for example, a set of descriptors that could be used to develop information and observational tools for consumers, funders and regulators to support judgements and comparison of group home services. Potentially the findings can also be used to develop a measure of group home culture that is more attuned to its nuances than the more generic measures used previously (Gillett & Stenfert-Kroese, 2003; Hastings et al., 1999) that could be used in research and service evaluation.

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