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**Evidence about Best Practice in
Supported Accommodation
Services: What Needs to be in
Place?**

**A literature review for the NDIS
Quality and Safeguards
Commission**

Professor Christine Bigby

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ENQUIRIES

Christine Bigby. c.bigby@latrobe.edu.au
Director Living with Disability Research Centre
La Trobe University
Victoria 3086

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Executive Summary

Provision of supported accommodation services for people with disabilities are in a state of flux as new ways of funding and delivering services are implemented as part of National Disability Insurance Scheme. There is increasing separation of housing and support, and diversity of support providers involved in the lives of people with disabilities who live in supported accommodation. The focus of this review is group homes and people with intellectual disabilities who are the biggest group of people using these services. Group homes are defined as *accommodation shared by 2-6 unrelated people with disabilities who live under one roof or on one site and for whom twenty-four-hour staff support is available*.

The aim is to identify models of best practice the NDIS Quality and Safeguards Commission might consider in its capacity building work with providers and the development of relevant practice standards and quality indicators. The study builds on a realist review of the literature published in 2018 that identified and reviewed the strength of evidence about the variables that influence quality of life outcomes for people in group homes. The method was a rapid focussed narrative review of the peer reviewed published between 2015-2022 .

A best practice model for group homes has distinct components. First, foundation components which are universal and relevant to all people living in all group homes. These are the responsibility of staff working in group homes and the organisations that manage them. These components are the primary focus of the review. Second, are specialist components which are interventions or additional supports that should be available to an individual living in a group home if and when they are needed. These are provided by staff or professionals who are not based in a group home and may not necessarily be employed by the organisation managing the group home.

A third component is collaboration and coordination between staff and services involved with a person in a group home, and planning and decision making support with every individual in a group home. These components underpin effective use of individualised funding schemes and optimise holistic and consistent support for people with disabilities, but there is very little research about these in the context of group homes.

There is substantial evidence about some foundation components of best practice that make a difference to the QoL of people with intellectual disabilities in group homes. There remain gaps in knowledge particularly around embedding strategies to support healthy lifestyles and collaborative practices between the day-to-day practice by staff teams in group homes and specialist interventions or additional supports delivered by external professionals or inhouse professionals not based in a particular group home.

The following section provides a brief summary of the proposed elements of a best practice framework, the evidence about each of these and advice to the NDIS Quality and Safeguards Commission.

Components of a best practice framework

1. Staff practice of Active Support

What makes a difference: Good Active Support staff practice that supports engagement of people with intellectual disabilities in meaningful activities and social interactions, choice and control, communication, community inclusion, learning and development. Active Support is also a proactive strategy for supporting people with behaviours of concern and underpins many behaviour support plans.

Evidence: Active Support is an evidence informed practice. There is strong evidence that staff use of Active Support positively influences the quality of life (QoL) for all people in group homes, across the domains of personal development, emotional wellbeing, autonomy, interpersonal person relationships, and social inclusion. As an evidence informed practice that can be learned by front line staff, Active Support integrates the application of rights-based values and a range of support skills, including communication, support for choice, task analysis and adjusting support to the needs of the person.

Advice: Active Support should be a key component of a best practice framework for group homes that support people with intellectual disabilities. As a specific person-centred, evidence informed practice it should be explicitly named and included the NDIS Quality and Safeguards Commission practice standards and the NDIS Workforce Capability Framework rather than being subsumed under the generic nomenclature of person-centred practice.

2. Staff practice that supports healthy lifestyles and access health care

What makes a difference: Staff practice that promotes healthy lifestyles and supports people to get the health care that they need, identify early signs of health problems, supports communication with health professionals, and supports action on the health professionals' advice.

Evidence: There is strong evidence about the roles that staff in group homes play in supporting people to lead healthy lifestyles and supporting access to the health care they need, and the significance of this support to QoL. There is no overarching evidence informed support model that encompasses the health-related tasks, which articulates the roles of group home staff in meeting healthy lifestyle and health care needs, that sets out how these roles fit together, how staff should work in collaboration with external experts, or identifies the skills group home staff require to fulfil health related roles.

Advice: The absence of an overarching evidence informed model to support healthy lifestyles and access to health care that could be embedded into group home staff practice is a major gap in knowledge. Research is required to develop and test a holistic best practice model of support for health of people in group homes.

3. Staff practice with families

What makes a difference: Staff who acknowledge the role of families of people in group homes and collaborate with them where appropriate.

Evidence: There is minimal evidence about the practice of group home staff working collaboratively with family members of adults in group homes or the QoL benefits of this. However, this is an important component raised by families. There is some research about the benefits of a key worker role work in this regard but very little evidence about their roles in the current context. Group home cultures that are cohesive, respectful, enabling, and motivating are likely to be more open and collaborative with family members.

Advice: There is scant evidence about the benefits of collaboration between staff and families for the QoL of people in group homes or about the practice necessary to do this well. Research in this area would fill an important gap in practice knowledge.

4. Gaining the perspectives of people who live in group homes

What makes a difference: Having control over one's own life, relationships with staff, continuity of staff and staff knowledge about the people they support.

Evidence: : There is very little evidence that the perspectives of people who live in group homes have either been sought or are collectively taken into account in the design and delivery of services. The limited literature suggests their perspectives reflect to some extent those of families, the intent of disability policy and the aims of some elements of best practice.

Advice: The Commission should support research about the perspectives of people who live in group homes about their services and effective strategies for including their perspectives in the design and delivery of group home services.

5. Positive staff culture

What makes a difference: Staff culture that is cohesive, respectful, enabling and motivating, where staff perceive there is strong leadership and staff practice is attentive, responsive, flexible and pays attention to the dignity and comfort of the people they support as well as their inclusion and engagement needs.

Evidence: There is strong evidence that group homes which have a culture that is cohesive, respectful, enabling and motivating have better QoL outcomes. There is emerging evidence that

these types of culture are associated with good Active Support practice and strong Frontline Practice Leadership.

Advice: The Commission support ongoing research about the association between culture, good Active Support practice and QoL outcomes in group homes and support the further development of measures of culture as indicators of quality in group homes.

6. Staff who are competent and satisfied with their work

What makes a difference: Staff trained in Active Support, who have confidence in management and who are satisfied with their work and more likely to remain in their role.

Evidence: There is strong evidence that if group homes have staff who are trained in Active Support and who are confident in their management there is more likely to be good Active Support, which is indicative of good QoL outcomes. There is strong evidence that Active Support training should include a theory and hands on component. There is some evidence that staff who experience strong Frontline Practice Leadership and practice good Active Support are more satisfied with their work and more likely to remain in their role. There is some evidence that staff turnover is associated with poorer QoL for people in group homes.

Advice: Training in Active Support should be included in the NDIS Workforce Capability Framework and requirements for Active Support training included in practice standards for staff working in group homes with people with intellectual disabilities.

7. Staff practice enabled by Frontline Practice Leadership

What makes a difference: Frontline managerial practices that support front line staff to focus on quality of life of the people they support, work as a team, organise support on each shift, regularly observe and provide feedback to staff about their practice, coach staff, model good practice, and supervise staff.

Evidence: There is evidence that the five tasks of Frontline Practice Leadership encapsulate these frontline managerial practices. There is robust evidence that strong Frontline Practice Leadership positively influences the quality of Active Support practice by staff and QoL in group homes.

Advice: There should be more explicit reference in the NDIS Workforce Capability Framework to the evidence informed competences of Frontline Practice Leadership to assist in strengthening understanding of this enabling component of best practice. Specific and targeted training in the five tasks of Frontline Practice Leadership should be included in practice standards for frontline managers of group homes.

8. Senior organisational leaders who value direct staff practice and implement structures and processes to support and maintain it.

What makes a difference: Senior organisational staff who value and understand practice and put in place structures to support and maintain Active Support, Frontline Practice Leadership, train all staff in Active Support and monitor practice using observational techniques.

Evidence: There is strong evidence that the values held by senior organisational leaders about practice, and their actions are predictors of good Active Support practice and QoL in group homes. There is most evidence about the significance, at the organisational level, of providing overarching support for practice, embedding staff training in Active Support, (both the theory and practical application) in organisational processes, and structuring Frontline Practice Leadership so it is close to direct support staff and there is sufficient time for frontline managers to carry out all 5 tasks. There is growing evidence that paperwork is an increasing burden on front line staff and managers that detracts from providing good direct support. Not all paperwork of equal value and in particular, evidence indicates that paperwork such as policies, procedures and staff self-reports are not good indicators of the quality of practice in group homes and that observation of practice is a more robust approach to measuring or monitoring quality. A simple observational tool based on a complex research measure has been developed for *Observing Staff Practice* which yields a score about quality of staff practice and could be incorporated into external audit requirements as well as being used internally for quality assurance.

Advice: Expectations about the training in Active Support for all direct support staff, the tasks and structuring of Frontline Practice Leadership, should be included in practice standards for organisations providing group home services. The Commission should review the volume and type of paperwork it requires from group home staff, front line managers and organisations and in particular consider alternative strategies for collecting evidence about practice. This may be the inclusion of observational tools in audits for reaching judgements about the quality of practice and establishing a practice standard for observed practice quality.

9. Managerial practices that support access to specialist interventions and other forms of additional support.

What makes a difference: Managerial practices that supports access to specialist interventions, and additional supports as and when they are needed by individuals and which are provided by specialists either internal or external to the organisation.

Evidence: This study did not review the strength of evidence about specialist interventions for people in group homes but noted these were mediated by individual characteristics such as life course stage, health, behaviour and availability of informal support. It also noted the limited evidence about the implementation of specialist interventions in the context of group homes, and

that additional support from staff outside group homes is increasingly important in the context of the NDIS where the responsibility of group home staff vis other services is more diffuse.

Advice: It may be useful for the Quality and Safeguard Commission to review the evidence about the effectiveness of specialist interventions and additional support that complement the support from group home staff in order to understand the extent to which these improve or detract from an individual's QoL. This may be particularly important in the area of behaviour support which is a common specialist intervention provided by external professionals.

10. Managerial practices that support staff collaboration, service coordination, involvement in planning and support for decision making.

What makes a difference: Staff and managerial practices that support effective collaboration between group home staff and others involved in supporting an individual, that supports the coordination of services around an individual, that ensures an individual's involvement in all planning processes about their support and their receipt of good supported decision making.

Evidence: There are gaps in evidence about the type of practice that best supports collaboration between group home and external staff, the coordination of services, individual planning and supported decision making for people in a group home context. However, practice wisdom suggests they underpin effective use of individualised funding schemes and optimise holistic and consistent support for people with disabilities. Evidence does suggest that group homes with a cohesive culture which is open to outsiders and where there is strong Frontline Practice Leadership are all likely to facilitate collaboration between internal and external staff and thus the implementation of specialist interventions.

Advice: There is a need for research that addresses knowledge gaps about collaboration between group home and external staff, and effective planning and coordination of services and models for provision for supported decision making for individuals in group homes.

11. Design of group homes which support good QoL practice

What makes a difference: Group home designs where there are six or less people, the staff resources reflect the support needs of the people supported and people living together are compatible, and have similar levels of support needs in term of their adaptive behaviour

Evidence: There is strong evidence about the first two of these factors, small size and staff resources commensurate to the support needs of the people supported. There are gaps in evidence about assessing or ensuring the compatibility of people living together in a group home, other than evidence about the negative impact of grouping together people with behaviours of concern or people with very different levels of ability.

Advice: No more than six people living together under one roof or on one site should be reflected in service design standards. Research should be undertaken to further understanding about

determinants of compatibility of people living together in group homes and tools to facilitate choice of compatible house mates.

Evidence about Best Practice in Supported Accommodation Services

What Needs to be in Place?

1. Introduction

This review forms part of the NDIS Quality and Safeguards Commission Inquiry into Aspects of Supported Accommodation in the National Disability Insurance Scheme. Its aim is to identify ‘models of best practice for the delivery of supported accommodation that might be appropriate for consideration by the NDIS Commission in its capacity building work with providers and in the context of development of any future amendments to relevant practice standards and quality indicators’.

Models or frameworks of best practice vary in the way they are constructed. One approach combines, values, theory, the evidence base and processes together into a Framework (Gore et al., 2013). Another approach embeds a Practice Framework, more narrowly conceived as practices expected from staff, within a program theory or logic model that sets out the values, outcomes, processes and practices that underpin a service. For example, the Practice Framework is one component of the program theory of Welcome Support Services, while the components that enable its implementation, such as “ongoing management attention (practice leadership, orientation to each shift, observation)” are set out separately (Clement & Bigby, 2011, p 4).

All approaches to best practice frameworks bring together evidence about what is sought in terms of outcomes for people supported, what components must be in place to achieve outcomes in terms of the evidence informed direct practices and enablers such as managerial practices and organisational processes that operationalise and sustain these. Importantly best practice frameworks have multiple components that work together to produce outcomes and they are not a menu of options from which to pick and choose (Gore et al., 2013). In the Australian context the human rights values that underpin best practice frameworks are well articulated in the NDIS and other national disability policies and are not included in this review. Accordingly, this review briefly reviews quality of life (QoL) as the all-encompassing outcome sought for people living in supported accommodation, and identifies, from the peer reviewed literature, the most significant components that influence QoL of people living in supported accommodation which should be incorporated into a best practice framework.

In contrast to generic frameworks which point to broad components such as staff practice or culture that influence outcomes in supported accommodation, this review describes more precisely the nature of those components (i.e., the nature of staff practice or type of culture), the direction of influence and the relative strength of evidence. The review also identifies gaps in the literature where evidence is missing about components that practice wisdom suggests are important to

outcomes or about the contemporary context and models for organising supported accommodation services in Australia. Reflecting changing paradigms, the review includes research about the perspectives of people living in supported accommodation and their families about what makes a difference to their QoL. These perspectives have not figured prominently in the literature. Finally, the review synthesises evidence about the most significant factors influencing QoL and proposes a best practice framework for supported accommodation.

The key questions for the review were:

- what are the most important components that influence the QoL of adults living in supported accommodation?
- what obstructs or facilitates the presence of the components that positively influence QoL in supported accommodation?
- what do adults living in supported accommodation and their families consider necessary for a good QoL?
- what should be included in a best practice framework based on evidence about components that influence QoL in supported accommodation?
- what evidence is missing that should inform a best practice framework?

2. Background - Supported Accommodation Services

2.1 Definition and significance

Supported accommodation services encompass a diverse range of designs. Included under this generic label for example are, care homes and specialist services in the UK which cater for 4-20 people, group homes in Germany which may support up to 20 people in 3 or 4 subunits and group homes in Norway and Sweden which accommodate up to six people in separate apartments with some common spaces. In Victoria, prior to the National Disability Insurance Scheme (NDIS), shared supported accommodation services for people with disabilities were known as community residential units and more generally in other states as group homes. These services commonly accommodated 4-6 adults in one house but sometimes comprised smaller separate but adjacent units on the same site.

The organisation of supported accommodation services changed with the introduction of the NDIS and accelerated the trend of separating everyday support from other roles such as housing management, tenancy issues or service coordination. Under the new arrangements, the support provider, known as the ‘Supported Independent Living’ (SIL) provider, is more clearly distinguished, than in the past from the housing provider. The situation in respect of housing providers is complex; most new housing for people with disability built since the NDIS is known as ‘Specialist Disability Accommodation’ (SDA) and is owned privately or by non-government

organisations, older housing may be owned by non- government organisations or State or Territory governments. Guidelines require an agreement between SIL and SDA providers about the way they will work together and set out minimum expectations for such agreements (National Disability Insurance Scheme, 2018). Currently, much of the housing for supported accommodation services is owned by State or Territory governments but over time this is expected to change as more new SDA is financed and built by private or non-government providers.

This review uses the term *group homes* to refer to supported accommodation and defines group homes as *accommodation shared by 2-6 unrelated people with disabilities who live under one roof or on one site and for whom twenty-four-hour staff support is available* (Bigby et al., 2020). This review does not include services that provide drop in rather than 24-hour support, which in the literature are generally known as supported living services (Bigby et al., 2017). Best practice support for people living in this type of service is similar in some respects to that for group homes but also has some unique elements.

As has been the case historically, the cost of supporting people in group homes accounts for a significant amount of the overall expenditure on disability services. National Disability Insurance Agency (NDIA) figures indicate for example, that approximately, 5.2% of NDIS participants had SIL supports, yet these represented 26% of the costs of committed supports in NDIS plans as of 31 December, 2021 (NDIA, 2021¹). The average annual cost per participant for SIL supports in 2021 was \$256,300, and total average costs of all supports for these individuals was \$324,600 (NDIA, 2021). There have been upward trends in the number of people using SIL support and costs since 2018. However, this may represent the transition of state managed services into the NDIS, and the NDIA has noted there are issues calculating the exact number of participants using SIL supports.

2.2 Characteristics of people supported in group homes

Since deinstitutionalisation began in the mid 1970s, group homes have been the dominant form of accommodation available to people with disabilities in Australia, who were unable to live in their parental home. At the end of 2021, 25,954 adults received SIL supports across Australia (NDIA, 2021, p.627) and the majority were likely to be living in group homes. Their ages range from 15 to more than 65 years with most (86%) aged between 25 to 64 years (NDIA, 2021). The largest group are adults with intellectual disabilities, many of whom also have physical or sensory disabilities as well as autism, mental or physical health conditions. This population has diverse

¹ Note, these figures are for December 2021 and taken from the second NDIA quarterly report for 2021-2022. They are only approximate as people living in individualised SDA housing are also in receipt of SIL services. The figures for the type of housing where SIL recipients live are not available, but as an indication in June 2021, of the 1950 new SDA dwellings 875 were individual apartments (Douglas et al., 2022, p. 3)

characteristics, but finely grained data are not easily available from the NDIA. The most detailed data are from a longitudinal study conducted by the Living with Disability Research Centre, that in 2019 included 11 organisations across most Australian states. Table 1 summaries the characteristics of a representative sample of 294 people with intellectual disabilities living in 78 group homes from these organisations.

Table 1. Characteristics of a representative sample of 294 residents with intellectual disabilities living in 78 group homes from 11 organisations

Characteristic	Percentage, average or range
Average age	49 yrs. (21-82)
Average adaptive behaviour	154 (22-270)
Gender	48% male
Do not use speech to communicate	25%
Social impairment	62%
Autism	21%
Hearing impairment	7%
Vision impairment	17%
Mental illness	34%
Physical impairment	27%
More than five behaviours on Aberrant Behaviour Checklist rated as severe	14%

(source: unpublished data, Living with Disability Research Centre)

As these data indicate among the adults living in group homes there are a wide range of support needs. Some people have mild intellectual disabilities and relatively low supports needs (adaptive behaviour score 151 or above). This means they may only require prompting or guidance to engage in self-care, other activities, planning and problem solving. They are likely to be able to spend time alone safely and purposefully without support. Others have more severe or profound intellectual disabilities (adaptive behaviour score less than 151). They often have high, multiple and complex support needs, meaning they require support to initiate engagement in most activities and are unlikely to be safe if left on their own. This latter group, in particular, are only likely to complain or raise concerns about the quality of their support with assistance from significant others outside of the service. The group of people living in group homes which has received most attention from regulatory systems is the minority with behaviours of concerns who are most at risk of self-harm or harming others and being subjected to practices that restrict their rights.

The profile of people supported in group homes suggests that a sizable minority could live more independently and do not need 24 hour staff support. For example, a small study found that 30-35% of people living in group homes had similar support needs to those living more independently with drop-in support, and there was a greater range of severity of disability among people living in

group homes compared to those with drop-in support (Bigby et al., 2018). This raises questions about whether some people in group homes receive more support than they need at some points in their lives and could be supported to live more independently. Past initiatives, which have successfully assisted some people to move out of group homes to more independent living arrangements may be worthy of reinvigoration in the new individualised funding environment of the NDIS. Housing affordability is likely to be a major obstacle as well as ensuring skilled support to enable social inclusion, as many people currently in group homes are without social connections beyond staff. Research suggests such support has not been done well for people either in group homes or who live more independently resulting in loneliness and isolation (Bigby et al., 2017; Bigby et al., 2015a; Harrison, 2021). Alternatively, consideration could be given to the repurposing of some group home housing and reconfiguring support into more independent living arrangements.

The relatively small numbers of people without intellectual disabilities who live in group homes have acquired disabilities, chronic health conditions, mental health conditions or physical disabilities. Very little research has considered this group, although this may change as their numbers increase, particularly in new designs, such as co-located apartments with 24 hour shared on call staffing funded as new build Specialist Disability Accommodation by the NDIS (see for example Douglas et al., 2022).

2.3 Outcomes sought and significance of support in group homes

Research about people with intellectual disabilities generally, and group homes in particular, has most commonly conceptualised sought-after outcomes in terms of QoL using Schalock et al.,’s (2002) eight domains. These are; emotional wellbeing, physical wellbeing, material wellbeing, personal development, interpersonal relations, social inclusion, self-determination and rights. Table 2 describes these domains, and the indicators and staff practices for each that are particularly relevant to people with more severe intellectual disabilities.

Table 2

Quality of Life domains, indicators of outcomes and associated staff practices relevant for people with severe or profound intellectual disability

Quality of Life Domain	Indicators
Emotional well-being Demeanour at ease Absence of challenging and self-stimulatory behaviour	<ul style="list-style-type: none"> • People appear content with their environment, their activities and their support, they smile and/or take part relatively willingly in a range of activities (including interactions) when given the right support to do so • People appear at ease with staff presence and support • People appear comfortable in their environment including with the level of arousal. • People appear pleased when they succeed in activities, do something new or experience interaction with new people in their environment • People do not show challenging behaviour or spend long periods in self-stimulatory behaviour
Interpersonal relations Positive family relationships (where relevant) Positively regarded by staff Breadth of social relationships	<ul style="list-style-type: none"> • Staff are proactive and people are supported to have positive contact with their family on a regular basis. Family can visit whenever they want to. • People experience positive and respectful interactions with staff and others in their social network including co residents • People are positively regarded by staff, they are seen as essentially human ‘like us’ and differences related to impairment or health are attended to from a value neutral perspective. • People have members in their social network other than paid staff and immediate family – and are supported to meet new people with similar interests both with and without disabilities, and to make and maintain friendships with people outside of their home as well as those within their home • From most of these contacts, people experience affection and warmth.
Material wellbeing	<ul style="list-style-type: none"> • People have a home to live in that is adapted to their needs in terms of location, design, size and décor within the constraints of what is culturally and economically appropriate • People have their own possessions which can be seen around their home. • People have enough money to afford the essentials and at least some non-essentials (e.g., holiday, participation in preferred activities in the community) • People are supported to manage their financial situation so they can access their funds, use them in accordance with their preferences, (preferences are sought and included in decisions about holidays, furniture or the household budget) • People have access to some form of transport in order to access the community

Personal development Engaged Participation in meaningful activities and interactions	<ul style="list-style-type: none"> • People are supported to engage in a range of meaningful activities and social interactions that span a range of areas of life (meaning full occupation or employment, household, gardening, leisure, education, social) • People are supported to try new things, have new experiences with just enough help and support to experience success and thus to develop their skills. • People are supported to demonstrate what they can do (their competence) and experience self-esteem.
Physical wellbeing General health Access to acute and preventative health care Healthy lifestyle	<ul style="list-style-type: none"> • People are supported to be safe and well in their own home and in the community (without staff being risk averse) • Personalised and respectful support with personal care is provided well and promptly –all aspects of personal care reflect individual preferences as well as specific needs in respect of things such as swallowing are provided • The environment is safe and healthy (e.g., environment not too warm or cold, no uneven or dangerous floors), people can move around their environment safely, • People are supported to live healthy lifestyles at least most of the time – good diet, some exercise etc. • Pain or illness are recognised and responded to quickly • People are supported to access healthcare promptly when ill and preventative care such as regular health checks appropriate to age and severity of disability – are not over or under weight – specific health issues are managed.
Self-determination Day to day decision making Autonomy Support with decision making Personalisation	<ul style="list-style-type: none"> • People are offered and supported to express preferences and make choices about day-to-day aspects of their lives which means people's own agendas and preferences guide what staff do rather those of staff • Staff use appropriate communication to support choice and respect people's decisions • People are supported to understand and predict what their day will be like, based on their own preferences and agendas • People are supported to be part of person-centred planning and other decision-making processes as much as possible and to have someone who knows them well and who can help others to understand their desires and wishes, such as an advocate or members of circle of support • People lead individualised lives rather than being regarded as part of a group of residents
Social Inclusion Community presence Community participation	<ul style="list-style-type: none"> • People live in an ordinary house in an ordinary street in which other people without disabilities live • People are supported to have a presence in the local community – access community facilities (shops, swimming pool, pub, café) and are recognised, acknowledged or known by their name to some community members • People are supported to take part in activities in the community not just with other people with disabilities. They actually do part of the shopping, for example. • People are supported to have a valued role, to be known or accepted in the community – membership of clubs, taking collection in church, are viewed respectfully by people in the community (e.g., shopkeeper/bus driver/neighbours make eye contact with them and call them by name), people are helped to be well presented in public, staff speak about people respectfully and introduce people by their name

Rights	<ul style="list-style-type: none"> • People are treated with dignity and respect in all their interactions and have privacy. • People have access to all communal areas in their own home and garden, and are supported to come and go from their home as and when they appear to want to. • People have someone external to the service system who can advocate for their interests • People can physically access transport and community facilities that they would like to or need to access. • People are supported to take part in activities of civic responsibility – e.g., voting, representing people with disabilities on forums, telling their story as part of lobbying for change etc. • People and staff are aware of and respect the arrangements in place for substitute decision making about finances or other life area (guardianship, administration)
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Source Bigby et al., (2014)

Some research on group homes has used engagement as a proxy indicator for QoL given that engagement is observable and can be measured objectively (Mansell & Beadle-Brown, 2012; Mansell, 2011). Observing engagement also captures the experience of people with more severe and profound intellectual disabilities who cannot self-report. As Table 2 suggests, engagement is a necessary precursor of most QoL domains. For example, if people with intellectual disabilities are not engaged it is impossible for them to exercise any choice or control over their lives, whereas their engagement in meaningful activity leads to increased competence, independence, choice and control as well as indirectly to more respectful and positive attitudes from staff (Mansell & Beadle-Brown, 2012).

Day-to-day support by group home staff contributes to achieving all of the eight domains of QoL. Support from group home staff occurs both in the home and in the community, as staff are responsible for supporting connections with family members, the use community or commercial facilities or engagement with activities or other services outside the home. The support they provide is much more than attendant care or a narrow focus on physical wellbeing. Group home staff also provide support with exercise of choice and decision making as many people in group homes will find it difficult to direct their own support in the way that people without cognitive disabilities may. Support from group home staff is complemented by informal support from family and friends, external specialist services and interventions, advocacy or peer support.

The significance of support from group home staff to a person's QoL vis a vis support from other sources has not been explored by research. Since the establishment of early group homes however, attempts have been made to avoid relying on one service provider to support all aspects of a person's life. Primary this has been achieved by dividing support by type - day and accommodation with the accommodation provider taking the lead in service coordination. In Victoria, in particular, this led to a typical pattern of life for people in group homes which meant spending weekdays from 9-4 away from home at a day or employment program and the rest of the day, evenings and weekends at home or in the community supported by group home staff. There is a paucity of research on the quality of day programs, but the little there is points to remarkable variability, meaning that assumptions cannot be made that people are fully occupied or engaged during the day in meaningful activities (Clement et al., 2007; Bigby, 2005).

The typical pattern of life for people in group homes is changing as the NDIS makes it more likely that people will receive more varied and individualised supports during the day or in the evenings. The recency of the NDIS however means there is no research about its

impact on patterns of life for people in group homes or the additional and externally sourced services they receive, although data about the latter could be extracted from NDIA records.

The contribution of group homes and their staff to QoL are moderated by many factors such as the proportion of the day spent in the group home, the number and quality of relationships a person has with people outside the group home, the additional support received from other services and types of activities engaged in outside the home. It will also depend on an individual's characteristics such as health, age, stamina and preferences. For example, as people get older, they are likely to spend more time at home and support from group home staff will become more significant. Also, the significant group of people living in group homes who do not have strong social connections with family or others beyond the group home are particularly dependent for most aspects of their lives on support from group home staff (Bigby, 2008; Harrison et al., 2021).

In summary QoL and engagement whilst at home and in the community have been used to measure outcomes for people living in group homes. The relative significance to QoL of support from group home staff vis a vis external services varies for each individual and changes across their life course. The contribution of group home staff is likely to be substantial for many people without social or community connections but will continue to change as the NDIS matures. This topic is worthy of further research.

2.4 QoL in group homes vis other models

On average people in group homes experience a higher QoL compared to those living in institutions or clustered living arrangements (Kozma et al, 2009; Mansell & Beadle Brown, 2009). Research on more independent models of drop-in support is relatively limited and few studies have compared QoL in group homes with drop-in support services. The available evidence suggests that overall outcomes are similar with both models offering a mediocre QoL (Bigby et al., 2018). However, drop-in support services are consistently found to deliver better on the domain of choice and control, and group homes on domains of physical well-being and interpersonal relations (Bigby et al., 2018; Stancliffe et al., 2000; Stainton et al., 2011; Oliver et al., 2020). Notably, Oliver et al., conclude that availability of informal support is a key contributor to good outcomes in more individualised drop-in services. However, in terms of the presence of abuse, violence and neglect no one service type stands out. Research has found incidents of abuse in all models of accommodation (Cambridge, 1999; Collins & Murphy; 2021).

2.5 Variable QoL in group homes

A distinctive feature of group homes is the extent to which the average QoL of people varies between homes within the same organisation, between organisations and between homes with similar levels of funding. Studies consistently demonstrate significant variability between group homes in terms of the quality of staff support and QoL of the people supported even when differing support needs are taken into account (Mansell et al., 2013; Bigby et al., 2019; Bigby & Beadle Brown, 2018). This research also shows consistently that people with higher support needs receive poorer quality of support and have a lower QoL of life compared to those with lower support needs.

This variability in QoL outcomes between group homes and for people with differing support needs is particularly significant in thinking about best practice models. It indicates that it is how staff resources are organised, the skills of staff and the quality of their support that makes the difference rather than resources or the model itself. For example, an Australian study found average engagement of people in group homes ranged from 38% to 66% of the time (23 to 40 minutes in an hour) and average scores for the quality of support ranged from 21% to 90% (Mansell et al., 2013; more detailed and recent unpublished data on variability is available from the Living with Disability Research centre).

The quality of support overall in group homes remains low and a recent UK study found that on average people in group homes spent at least 75% of their time with no contact from staff, friends, family or other residents – literally doing nothing (Beadle-Brown et al., 2021). This UK study also found no significant differences between the costs of services where people had higher or lower levels of engagement; strongly suggesting that supporting a better QoL does not require more staff resources and entails costs comparable to delivering a lower QoL.

In summary, the variability between group homes in terms of QoL makes it critically important to understand what influences outcomes and makes most difference to the quality of the staff support if QoL is to be raised and be more consistent across all homes. Data from the large body of research that has investigated the quality of support and QoL in group homes provide the background for this review. These data highlight that it is possible for people in group homes, including those with severe intellectual disabilities, to be supported to have a good QoL.

3. Method

The primary method was a rapid focussed narrative review of the peer reviewed literature (Bryne, 2016). The review covered the period from January 2015 to February 2022. These dates were chosen as a very substantial realist review² of the international literature on group homes was published in 2018 which included research published before 2015. The realist review exposed the many propositions about the variables influencing QoL in group homes and reviewed the strength of supporting evidence for these, identifying their relative influence (Bigby & Beadle Brown, 2018). Table 3 summarises the findings from that review.

Table 3. Summary of propositions with the strongest or most promising evidence about what makes a difference to the QoL outcomes for people in supported accommodation

Proposition – what makes a difference to QoL outcome in supported accommodation
Staff practice reflects Active Support
Staff practice compensates, as far as possible, for inherently disadvantageous characteristics of service users, particularly severity of disability and challenging behaviour.
Front-line management uses all aspects of practice leadership
Service culture is coherent, enabling, motivating and respectful
There are strong organisational policies and practice in the area of HR (that support front line leaders and recruitment of staff with the right values)
There are processes to assist staff to focus their practice on engagement of service users
Staff are trained in Active Support, and training has both classroom and hands on components
There are adequate resources for sufficient staff with the right skills to enable people to participate in meaningful activity and relationships but not too many that they obstruct participation.
Settings are small (1-6 people), dispersed, homelike

Adapted from Bigby & Beadle-Brown, 2018

² A realist review engages with the literature through a process of exploration, aiming to unpack the black box of interacting variables in a complex intervention (in this case a group home) to pick up, track and evaluate underlying theories that influence outcomes (Pawson et al. 2005). First a long list inherent theories is compiled from across different types of literature, journal articles, books, government and other reports. Documents are analysed to identify the theory or propositions they contain, and the value of particular variables and direction of effect, or, as appropriate, theory about why this variable was important, in what circumstances, for whom and why. Key data about propositions and outcomes are extracted from each document and compiled into a 'long list' of propositions about outcomes. In this case 60 propositions about 53 outcomes. Schalock et al.'s (2002) quality-of-life framework was used to collapse the initial 53 outcomes into eight quality-of-life domains. An initial schema clustered propositions using the consistent form, 'quality of life outcomes for services users of supported accommodation are better when. . .'. The initial clusters were refined by purposeful literature reviews to identify and extract the evidence for and against each proposition. In this case the Web of Science databases were searched over several occasions from 2010 to 2014 to ensure that the evidence for each proposition was as comprehensive as possible. Identified papers were analysed, and data extracted and compiled into a spreadsheet of evidence for each proposition and its various subparts.

Our knowledge of the literature suggested we were unlikely to find many studies that directly addressed ‘models of best practice’ in supported accommodation as most research has focussed on specific aspects of practice rather than an overarching model. Thus we were likely to find relevant literature that would inform a model of best practice in various more specific bodies of research. For this reason, we ran a number of separate data base searches using different terms as the primary focus as well as one that combined some of these. Appendix A includes a list of all the terms used for the various searches.

In summary we searched the five main databases that include research on services for people with disabilities (ERIC, Medline, CINAHL, PsycINFO, AMED, Embase (Ovid). As well as terms relevant to people with disability and supported accommodation we included in the various searches, terms such as, models of practice, Active Support, practice leadership, practice frameworks, influences on quality of life, perceptions of family, perceptions of people with disability, positive behaviour support, and autism. The search was limited to the years 2015 to February 2022 and peer review journal articles in English. We included empirical studies or commentary on empirical studies that addressed any aspect of the research questions, best practice or factors influencing QoL outcomes in group homes or perspectives of people supported in group homes or their families. All titles and abstracts were read before deciding on retrieval of a paper and then the full paper was read before making a final decision about inclusion.

Key journals in the field of disability and supported accommodation were also hand searched to ensure inclusion of early view online-only records. These were, Journal of Policy and Practice in Intellectual Disabilities, Journal of Intellectual and Developmental Disability, Journal of Intellectual Disability Research, International Journal of Developmental Disabilities, Journal of Intellectual Disabilities, Tizard Learning Disability Review, Journal of Applied Research in Intellectual Disability, International Journal of Positive Behaviour Support. We also hand searched the references of included papers for relevant papers not already identified. In total we identified 38 relevant papers through the data base searches and a further 26 from the hand searches bringing the total included papers to 64. Table 4 summarises the results from the various searches. Key data were extracted from each included paper, and Table A 4 in the appendix summaries the aim, methods, and findings from each of the 64 included papers.

Table 4. Summary of search results and number of included papers

Search focus	Total	Included after review of abstract and full paper
Combined terms (see Appendix)	106	12
Active Support and group homes	161	19
Practice Leadership and group homes	117	24
Positive Behaviour Support and group homes	6	1
People with autism and group homes	266	12
Family and individual perceptions of group homes	234	4
Total included after removal of duplicates		38
Addition from hand searches for papers, in press, in reference lists of included papers and journals poorly indexed		26
Total included papers		64

All the papers were read and key findings synthesised about the factors relevant to the key research questions. In presenting the findings from this body of literature we also include reference to some of the earlier literature on which more recent work builds. Also, particularly in respect of healthy lifestyles given the relative dearth of literature about the role of staff group homes we drew on a PhD study conducted in Australia and some of the current grey literature.

Findings

First is a consideration of the nature of the literature about group homes and then each section focuses on evidence about the key factors that influence staff practice and QoL outcomes for people supported to live in group homes.

4. Landscape of the Literature

4.1 Programs of research about group homes

Research about group homes has focussed predominantly on the quality of support by front line staff, management practices, culture, staff training, and organisational processes (Beadle-Brown et al., 2021; Bigby et al., 2020a). As already indicated this research has measured various aspects of QoL and some has used engagement as a proxy for QoL. Many studies have used observational techniques as these more reliably capture outcomes for people with more severe intellectual disability than staff or self-report (Mansell, 2011). The

most rigorous studies have used structured momentary time sampling techniques to measure levels of engagement, frequency of contact and assistance from staff and the quality of staff support. Other types of measures such as questionnaires have been used to consider emotional wellbeing, contact with friends and community inclusion of people living in group homes (Beadle Brown et al., 2021; Bould et al., 2019).

Two research programs feature prominently in the literature from 2015. These are associated with the Tizard Centre at the University of Kent in England, and the Living with Disability Research Centre at La Trobe University, in Australia. The new knowledge created by these research programs has strengthened evidence that was only emerging in 2014, about the efficacy and predictors of good staff practice mainly Person Centred Active Support (Active Support), the nature and significance of group home culture, Frontline Practice Leadership and senior organisational leadership (Beadle Brown et al., 2015, 2016, 2021; Bigby et al., 2015b, 2016, 2020a, 2020b, 2020c; Bradshaw et al. 2018; Bould et al., 2019; Deveau & McGill, 2016a, 2016b, 2019, Humphreys et al., 2019, 2020, 2021).

Complementing these two research programs, other studies published from 2015 have looked at the impact of staff training in Active Support on staff turnover and satisfaction (Baker et al., 2017; Rhodes & Toogood, 2016) and the implementation of Active Support in the US context (Qian et al., 2017; 2019). There is also a growing literature on interventions to support healthy lifestyles, such as diet, exercise, and preventative health care for people in group homes (Dixon-Ibarra et al., 2017, 2018 Chadwick, 2017; Chadwick et al, 2018; Janson et al, 2021; Lesser et al., 2018; O’Leary et al., 2018; Vlot-van Anrooij et al., 2020).

Further bodies of research have studied specialist interventions relevant to specific sub-groups of people in group homes such as people who are aging (Kahlin et al., 2016), or who display behaviours of concern (McGill et al., 2018; Mahon et al., 2021). These studies seldom focus solely on people in group homes. Similarly, there is research about support or programs relevant to many people in group homes but not specifically targeted at people in group homes. This latter research includes studies of effective programs to support social and economic participation, access to health or mainstream services, practices such as supported decision making or risk management. Notably, there is no curated collection of research about evidence informed programs or practices that support aspects of QoL of people with intellectual disabilities. This makes it difficult for providers to draw on best practice and keep their knowledge up to date.

4.2 Components of best practice in group homes

The landscape of the literature suggests distinct types of components should be incorporated into a best practice model.

1) *Foundation or universal components*. These are relevant to all people in group homes and should be present at all times in all group homes. These components are the responsibility of staff working directly in a group home, and or organisations that manage group home staff. Foundation components include for example, direct staff practices that support people to be engaged, exercise choice, have social interactions and social connections, be socially included in communities, or have healthy lifestyles. Foundational components also include enablers of staff practice, i.e., the organisational and managerial practices, structures or processes that create, reinforce and support expectations about the nature and quality of direct staff practice.

2) *Specialist components*. These are specialist interventions or additional support that build on foundation components and should be available if and when necessary to individuals. As Mansell et al. (2004) suggested more intensive or specialist interventions may be needed in addition to the foundation support provided by group home staff. The nature of these specialist components depend on individual characteristics such as age, life course stage, availability of informal supports, behaviour, or health related needs. Specialist components are often but not always provided by external professional staff who are not based in a group home and who may be employed by external disability support or advocacy organisations or be sole practitioners.

3) *Collaboration, coordination, planning and decision support* are potentially a third component of a best practice framework in group homes. Practice wisdom suggests that collaboration and coordination between group home staff or managers providing foundation support and external professionals are one of the keys to success of implementing specialist components such as behaviour support interventions. Holistic planning, support for decision making and coordination of services around each individual living in a group home are also likely to be important to QoL. Where responsibility for collaboration, coordination, planning and decision support lies differs according to the nature of service systems and funding models. No recent research has explored this specifically in regard to people living in group homes in Australia. In the new individualised funding context these components are becoming more significant and an area where further research is required. However,

consideration of these issues should not detract from the significance of day-to-day support received by people living in group homes.

5. Foundation Components of Best Practice - Staff Practice of Active Support

The realist review which reviewed the literature up to 2014, found that the strongest evidence about what made a difference to QoL in groups homes was staff practice of Active Support (Bigby & Beadle-Brown, 2018). At that time evidence about Active Support had spanned four decades, involved at least 1400 people, and used different methodologies in different countries. Since 2014 the evidence has grown substantially about the impact and factors necessary to embed Active Support within group homes.

5.1 Defining Active Support

Active Support was developed, in the late 1970s, by UK researchers who recognised the significance of engagement to QoL but observed that people with intellectual disabilities spent large proportions of their day disengaged waiting for short periods of activity. Their research demonstrated that by changing staff practice, people's levels of engagement could be increased. Mansell et al., (1982, p. 603) proposed that,

...instead of doing all the housework as effectively as possible, and then attempting to occupy clients for long periods of each day with toys, staff could perhaps be organized to spend most of the day doing housework with clients, arranging each activity to maximize the opportunities for clients with different levels of activity to participate.

Core to Active Support is the provision of enabling and empowering support that assists individuals to be engaged and participate successfully in meaningful activities and relationships. It has been described as,

an enabling relationship by which staff and other carers provide graded assistance to ensure success - assistance that is tailored to the needs, pace and preferences of the individual is delivered in a person-centred, warm and respectful way and making the most of all the opportunities available at home, in school, in the community and at work (Beadle-Brown et al., 2021, p.43)

The quality of Active Support is measured using two components, the way staff provide support and the way they interact with the people they support. These are summarised in Figure 1.

Way staff provide support <ul style="list-style-type: none"> • Offering real activities • Offering choice • Creating opportunities to be engaged • Giving the right type and amount of assistance • Ensuring the message is clear about what is being offered 	Interacting with the person <ul style="list-style-type: none"> • Noticing and responding to communication • Respecting the person in all interactions • Creating opportunities for friendly interactions
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Figure 1. Components of Active Support

Active Support is a precisely defined ‘person centred practice’ specifically focussed on support for people with intellectual disabilities. It uniquely brings together into one clear and understandable approach a set of values and skills which are underpinned by theory and empirical evidence. Active Support effectively translates complex knowledge into a very specific person-centred practice and skills that are easily taught to frontline workers without tertiary education. Active Support makes the abstract concept of person-centred practice more specific and concrete for staff to learn.

The most recent versions of the Active Support training materials reduced the emphasis on paper-based activity or opportunity plans to avoid the focus shifting from practice to paperwork and box ticking, which had been observed as a tendency in some services. Training developed by the Tizard centre translates the theories that underpin Active Support into ‘the four essentials’ of practice taught to frontline staff (Beadle-Brown, Murphy, & Bradshaw, 2017) and Australian training follows a similar approach (<https://www.activesupportresource.net.au>). The four essentials of Active Support are represented in Figure 2.



Figure 2. Four essentials of Active Support

- **Every Moment has Potential** for people to be engaged - wherever and whenever people and staff interact.
- **Graded Assistance to Ensure Success** – there is no hierarchy of different types of assistance, the focus is on finding right type of assistance for each individual.
- **Maximising Choice and Control** – respecting preferences and choices of the person being supported.
- **Little and Often** – some people need frequent opportunities to experience new things, and short periods of engagement rather than lengthy continuous periods

5.2 The impact of Active Support

Staff practice of Active Support impacts positively on various QoL domains. The strongest evidence is that Active Support increases assistance from staff which *increases peoples' engagement in meaningful activity and social interactions in household or community-based activities*. As already discussed, engagement is a key indicator of QoL, and without Active Support people with more severe intellectual disabilities are unlikely to be engaged. There is also evidence that staff use of Active Support improves individuals' skills, personal development, adaptive behaviour, choice, self- determination and autonomy, and reduces occurrence of behaviours of concern and mental health issues such as depression. Table 5 gives an overview of the evidence and its original sources.

Table 5. Summary of research evidence and sources about impact of Active Support

Impact of Active Support on people with intellectual disabilities	Main sources (For overviews see realist review Bigby & Beadle-Brown, 2018 and systematic review Flynn et al., 2018)
Increased engagement in meaningful activity or social interaction including participation in household and community-based activities	Baker, et al., 2017; Beadle-Brown et al., 2021; Bradshaw et al., 2004; Felce et al., 2000; Jones et al., 2001a; Jones et al., 2001b; Beadle-Brown et al., 2008; Beadle- Brown et al., 2012; Koritsas et al., 2008; Mansell et al., 2002; Mansell et al., 2008; Riches et al., 2011; Rhodes & Hamilton, 2006; Stancliffe at al., 2007; Stancliffe et al., 2010; Toogood, 2008; Totsika et al, 2010; No change Chou et al., 2010; Qian et al. 2019
Improvements in skills and personal development or adaptive behavior	Chou et al., 2011; Stancliffe et al., 2010 Beadle- Brown et al., 2012 No change - Koritsas et al., 2008; Stancliffe et al. 2007
Improvements in choice, self-determination and autonomy	Beadle- Brown et al., 2008; Beadle-Brown, et al., 2012; Koritsas et al., 2008; Shipton & Lashewicz, 2017; Chou et al., 2011 No change - Riches et al., 2011; Stancliffe, 2007;
Reduction in behaviours of concern	Positive – Jones et al., 2001b; Koritsas et al., 2008; Rhodes & Hamilton, 2006; Riches et al., 2011; Stancliffe et al., 2007; Stancliffe et al., 2010; Totskia et al., 2010; Beadle-Brown et al., 2012 No change over time or increase – Bradshaw et al., 2004; Chou et al., 2011; Toogood et al., 2009
Reduction in mental health issues such as depression	Riches et al. 2011; Stancliffe et al., 2010. No change - Chou et al. 2011; Stancliffe et al., 2007
Staff assistance increased	Baker et al., 2017; Beadle-Brown, 2012; Jones 2001b; Stancliffe et al., 2007; Stancliffe et al., 2008; Totsika et al. 2010; Toogood, 2008; Toogood, 2016.

Staff use of Active Support is also associated with staffs' satisfaction with their work (Rhodes & Toogood, 2016; Riches at al., 2011; Rhodes & Hamilton, 2006). For example, Rhodes and Toogood (2016) found that staff using Active Support were more satisfied with their own level of skill and the time they spent with the people they supported. This is an important finding as intrinsic work satisfaction is important to support workers (Hutchinson & Kroese, 2016). In the current Australian context of disability workforce shortages, staff satisfaction and retention are important issues for disability support organisations.

5.3 Active Support as the foundation for other person-centred approaches or specialist interventions

Staff practice of Active Support is relevant for all people with intellectual disabilities in all group homes, as well as in other community settings. It should not be regarded as an optional extra practice to be used by staff if they have time after they have completed other tasks nor as something that is only done for set periods of time (Mansell & Beadle-Brown, 2012).

When staff use Active Support they are also more likely to use other person-centred practices and provide good support for communication (Beadle-Brown et al., 2016). However, there is limited evidence about the effectiveness of the person-centred approaches which complement Active Support, such as the SPELL framework and person-centred thinking or planning (Bigby & Beadle- Brown, 2018).

It is suggested that Active Support and person-centred planning are interrelated, as knowledge about a person's preferences gained by staff using Active Support can inform the types of broad goals included person-centred plans. In turn, goals in person-centred plans can inform the opportunities and experiences offered by staff using Active Support on a daily basis (Beadle- Brown et al., 2017).

Several studies suggest synergies between Active Support and Positive Behaviour Support (PBS), in that Active Support provides the foundation for PBS and acts as a proactive intervention for people who display behaviours of concern (Jones et al., 2013; Mansell, 2007 & 2014). Active Support and PBS rely on similar strategies such as supporting communication (whether directly or through adjustments to the environment) and supporting engagement in meaningful activities and social interactions. The in-depth functional assessments carried out with people with behaviours of concern as part of PBS may increase the effectiveness of Active Support by facilitating more targeted and precise support strategies (Ockendon et al., 2015; Jones et al., 2013). Thus, Active Support is often included among strategies set out in behaviour support plans. However, not all people in group homes display behaviours of concern or require the level of intensity of a PBS intervention. Hence PBS should be regarded as a specialist intervention for a sub-group of people in group homes that is additional and complementary to Active Support rather than interchangeable with Active Support. Notably, there is much less evidence about the effectiveness or implementation of PBS in group homes than about Active Support (Simler et al., 2019)

5.4 Implementation of Active Support

Research in both the UK and Australia demonstrates it has been difficult for some organisations to sustain good Active Support practice (Bigby et al., 2019; Mansell et al., 2013; Mansell & Beadle-Brown, 2012). This raises concerns about claims made by organisations about staff use of Active Support practice without substantiating evidence. It has also prompted a body of research about the implementation of Active Support and the factors necessary to embed it within organisations.

Research has benchmarked good quality Active Support as a score of 66% or above on the Active Support Measure, mixed quality Active Support as 65%- 34%, and poor Active Support as 33% or less (Mansell & Beadle-Brown, 2012). The Australian longitudinal study of Active Support and Frontline Practice Leadership (longitudinal study) demonstrated trajectories of increasing quality of Active Support in some organisations. For example, over time the percentage of people in group homes receiving good Active Support increased in five of six organisations, with an increase from 30% to 50% of people in receipt of good Active Support. The study also demonstrated the fragile nature of good Active Support when for example in one organisation average scores dropped from 89% to 52% over a four-year period (Bigby, Bould & Beadle-Brown, 2019).

Early research demonstrated the significance of staff training (Jones et al., 2000) to embedding Active Support. As well as training, the realist review (Bigby & Beadle-Brown, 2018) identified propositions about other factors such as Frontline Practice Leadership, Senior Leadership, organisational coherence and documentation of expectations. However, prior to 2015 either no research had been conducted about these factors or research did not support the propositions. In the case of Frontline Practice Leadership there was only weak evidence of its significance to QoL and its association with good Active Support due to small sample sizes (Beadle Brown et al., 2014, 2015; Bigby & Beadle- Brown 2018).

Since 2015 larger studies have demonstrated stronger and more nuanced understandings of the managerial and organisational factors necessary to implement and sustain good Active Support in group homes. In 2018, the longitudinal study included 461 people, 134 group homes and 14 organisations and used multi-level modelling techniques. It provides the strongest and most rigorous evidence to date about the predictors of good Active Support practice, i.e., what needs to be present in an organisation for a consistently good level of Active Support (Bould et al., 2019; Bigby et al., 2020a, 2020b, 2020c). Figure 3 summarises the predictors of good Active Support.

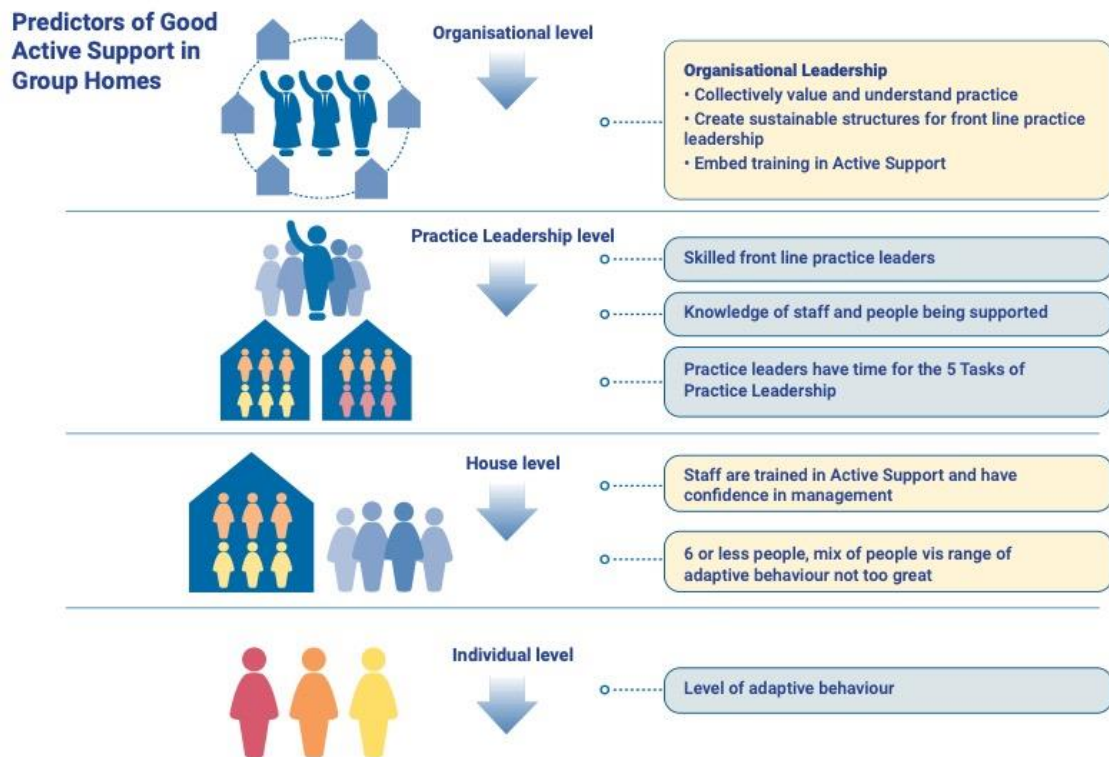


Figure 3. Predictors of good Active Support

In summary the predictors of good Active Support are:

- Staff trained in Active Support
- Staff confidence in the management of the organisation
- Services supporting people with relatively homogenous support needs but who do not all have behaviours of concern.
- Service design that has no more than six people under one roof.
- Strong Frontline Practice Leadership of support workers and staff teams through front line managers carrying out the five tasks of practice leadership; regular coaching, observation and feedback about their practice, discussion of Active Support in team meetings and individual supervision, shift planning, and support to maintain staffs' focus on the QoL of the people they support as core to everything they do.
- Frontline Practice Leadership structured such that leaders are close to every-day practice, and their tasks are not split across different positions.
- Senior leaders with shared understanding of Active Support and who recognise, value and support high quality practice.

The final predictor of good Active Support is the level of adaptive behaviour; people with lower support needs consistently receive better Active Support. Arguably, this is the only predictor of Active Support that cannot be directly influenced by staff or organisational practice (although good Active Support can lead to skill development, the quality of support should not rely on an individual's ability). The consistently poorer quality of support given to people with higher support needs is likely due to staff difficulties in applying Active Support principles and tailoring support to this group. This may be because they do not know a person sufficiently well, they find it difficult to adjust support to the differing needs of a diverse group of people they are supporting, or training has not focussed on people with high support needs. This highlights the need for a stronger focus in staff training on tailoring Active Support to people with high support needs and for organisations to direct greater attention to the engagement-related support needs of this group who often go unnoticed due to their passivity. Later sections in this review consider the other predictors of good Active Support in more detail (see sections 7, 8, 9 & 10).

Most research on Active Support has been with people with intellectual disabilities. Notably, however, a small Australian study explored the feasibility of implementing Active Support in supported accommodation services for people with neuro trauma, and found positive support for its principles from staff, families and the people supported (Bigby, Douglas & Bould, 2018). Given these findings and participants' appreciation of support that was more than simply attendant care, the application of Active Support to other groups of people with cognitive disabilities is worthy of further exploration.

5.5 Summary

In summary, staff use of Active Support positively influences the QoL for all people in group homes, across domains including, personal development, emotional wellbeing, autonomy, interpersonal relationships, and social inclusion. Active Support integrates into an evidence informed practice the application of rights-based values through a range of support skills, including communication, support for choice, task analysis and adjusting support to the needs of the person, that can be learned and applied by front line staff. Too often values are taught to staff without the skills necessary to enact them, or skills are disaggregated and taught separately, leaving staff ill prepared to integrate or apply them. Accordingly, Active Support should be a key component of a best practice framework for group homes which support people with intellectual disabilities. It is a specific person-centred, evidence informed practice which should be explicitly named and included the NDIS Quality and Safeguards

Commission's practice standards and worker capability framework rather than being subsumed under the generic nomenclature of person centred practice.

6. Foundation Components of Best Practice - Skilled Support for a Healthy Lifestyle and Access to Health Care

There is unequivocal endorsement in the literature that skilled support for a healthy lifestyle and to access health care services positively influence QoL of people in group homes and should be included in a best practice model. Despite practice wisdom about what needs to be done there is little evidence about how this type of support should be organised and delivered - what a model of skilled support for a healthy lifestyle and access to health care services looks like and how it can be embedded in group homes.

In view of the dearth of literature about delivery of health support in group homes I drew on an early empirical unpublished PhD study (Phillips, 2009). Phillips' study, conducted in group homes in Victoria, identified variation of support worker practice in group homes around health issues, the inadequacy of policies to guide their practice, the failure to clearly articulate their role or recognise the difficulties of people with intellectual disabilities in self managing their health, and the limited training, preparation or organisational support for group home staff in carrying out health-related roles. More recent international literature identifies similar features as obstacles to good health support in group homes (Dixon- Ibarra et al., 2017; 2018'; Vlot-van Anrooij et al., 2020). O'Leary, Taggart, & Cousins, (2018) found promotion of healthy lifestyles was not normalised or valued by organisations managing group homes with a consequent lack of capacity among staff, and that staff were more likely to be reactive rather proactive about health issues. Vlot-van Anrooij et al. (2020) identified a lack of clarity about staff roles in relation to health and unenforceable policies. Lesser et al. (2018) found that staff feared violating the rights of people with disabilities by overriding lifestyle choices that might be damaging to their health.

Some evidence-informed programs have been developed to assist group home staff in supporting aspects of healthy lifestyles, such as regular physical activity (Dixon- Ibarra et al., 2017; 2018), good diet (Janson et al., 2021), oral health (Chadwick et al., 2018) and dysphagia (Chadwick, 2017). A program of note is the US *Health Messages Program* which, although not designed specifically for people in group homes, included some participants in this type of accommodation (Marks et al., 2019). The *Health Messages Program* trained peer health educators and staff as mentors, who in turn trained their peers about key health matters. The 12- week program successfully fostered change in the knowledge and behaviour

of peer health educators and peers about hydration, diet and exercise, though did not lead to reductions in participant consumption of coffee or soda.

Although time limited pilots have been successful, programs to support aspects of healthy lifestyles have proved difficult to embed into ongoing staff practice (Dixon- Ibarra et al, 2017, 2018). Primary reasons for this are staff perceptions that programs are too complex or they themselves are too busy to implement them. This was evident in Dixon-Ibarra's Menu Choice program that aimed to assist staff to promote physical activity. Despite this program being designed to take account of identified factors that obstructed sustainability it was barely implemented by group homes staff.

Phillips (2009) and others identify the potentially enabling role of group home staff in ensuring healthy lifestyles and their influence on health-related decisions. Specific tasks identified for group home staff include;

- leading health promotion activities,
- monitoring or coordinating health care needs by recognising need for medical attention,
- facilitating access to primary health care,
- ensuring annual health checks and preventative health tests,
- supporting effective interactions with health professionals
- advocating for access to health service and quality treatment (Phillips, 2009; O'Leary et al. 2017; Naaldenberg et al., 2015; Vlot-van Anrooji, 2020).

Reflecting the skills and conditions these kinds of tasks require, the recent National Roadmap for Increasing the Health of People with Intellectual Disability (Roadmap) (Commonwealth of Australia, 2021), recommended that disability providers and the disability workforce should have better health literacy so they could better support people with intellectual disabilities to access health care. It also recommended the need for better linkages and more effective communication and coordination between health care professionals and disability support providers.

As the Roadmap hints, the success of group home staff in carrying out health-related issues depends on clarity about their tasks and their health literacy as well as professionals in the health sector having reciprocal skills for working with people with intellectual disability. In a similar vein a Cochrane review identified strategies researchers had found to be necessary to address health inequalities of all people with intellectual disabilities (Cantrell et al., 2020). These were, long-term relationships with supporters, adequate training for

supporters to identify health needs, effective communication within and between services, accurate record keeping, communication skills of all those in contact with people with intellectual disabilities, appropriate use of accessible resources including pain recognition and communication tools, and time to communicate and work effectively.

The essence of the role and tasks of group home staff in respect of health of the people they support was captured in a recent submission to the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability,

The disability support system [has a major role] in relation to supporting people to get the health care that they need, identifying early signs of health problems, promoting healthy lifestyles, supporting communication with the health professionals, supporting action on the health care professionals' advice (Simpson, 2020)

In this respect, there is a major gap in the literature and the absence of an evidence informed support model that encompasses the breadth of health-related tasks that need to be incorporated into the role of group home staff. There is no overarching model that articulates the role of group home staff in meeting healthy lifestyle and health care needs, sets out how these roles fit together, how staff should work in collaboration with external experts, or identifies the skills group home staff require to fulfil health related roles. There is however, ample knowledge and practice wisdom about the roles that should be incorporated into a best practice model, which are summarised in the quote from Simpson above. This is a major gap, that requires further research to develop and test a holistic best practice model of support for health of people in group homes.

The NDIS Quality and Safeguards Commission instigated specific health related practice standards and committed to a longer-term educational strategy to increase awareness and capability of disability support providers about health-related issues (NDIS Commission, 2019). This followed recommendations of a scoping review on the causes of death of people with disability in Australia (Salamon & Trollor, 2019). However, many of the proposed strategies are broad, targeting the entire disability sector, and pitched at high levels of abstraction rather than specifically at group home staff. In addition, some of the Commission's strategies are narrowly focussed on specific health conditions which risk promoting a piecemeal rather than holistic approach to support for people with multiple complex needs living in group homes who rely on a team of staff to meet their health needs. For example, mandating specific stand-alone plans for discrete conditions fragments support

for an individual into separate plans that staff must be aware of and implement. Having multiple plans may be less effective than having one holistic plan for an individual, as where there are multiple plans the chances increase of one being overlooked or that plans contain contradictory information or instructions.

7. Enabling Components of Best Practice - Strong Frontline Practice Leadership

The influence of frontline managers on the quality of staff practice has figured in the disability literature for a long time (King, Raynes & Tizard, 1971; Burchard et al., 1990; Hewitt & Larson, 2005). Research in the early 2000's identified the wide span of tasks expected of frontline managers in group homes and the breadth of competencies they needed to fulfill these (see Hewitt et al., 2004; Larson et al., 2007; Clement & Bigby, 2007; 2012). It also showed that support workers were often promoted to frontline managers with little or no training for the role. At that time, in Australia, the work of frontline managers was dominated by administrative tasks and direct support, with only a small fraction of time concerned with leading staff practice (Clement & Bigby, 2007). Based on their UK research, Mansell et al. (2004) argued a particular style of frontline of management, which led rather than managed practice, was needed to improve staff practice in group homes,. They defined Frontline Practice Leadership as having 5 domains which are now known as tasks and are illustrated in Figure 4.



Figure 4. Five tasks of Frontline Practice Leadership

The tasks of Frontline Practice Leadership are defined as;

- Focusing staff attention on the overall quality of life of the people supported
- Allocating and organising staff to provide the support people need when they need it to maximise their quality of life
- Observing, giving feedback, coaching, modelling to shape up the quality of staff support
- Supervising the practice of each staff member individually
- Facilitating teamwork and team meetings to share information, ensure consistency and teamwork.

These five tasks are broader than coaching or individual supervision, which tend to be perceived as the default functions of a front-line practice leader. Rather Frontline Practice Leadership extends beyond this to ensuring the optimal focus of staff on QoL, use of staff resources and team work on each shift, regular observation of and feedback to every staff member, and leading teamwork across the staff group.

The longitudinal study identified strong Frontline Practice Leadership as a predictor of good Active Support practice and a significant influence on QoL in group homes (Bould et al., 2019; Bigby et al., 2020a, 2020b, 2020c). Several other strands of research also point to the impact of strong Frontline Practice Leadership on QoL and its importance in generating good practice in group homes. Qualitative studies show that the culture in better group homes is characterised by staff perceptions of strong leadership characterised by tasks such as setting expectations for staff, leading by example, giving feedback to staff about practice, facilitating teamwork and generating a common sense of purpose among staff aligned with the values of the organisation (Bigby et.al., 2015; 2016). A more recent quantitative study, using the Group Home Culture Scale, similarly found that where staff felt there was a culture of effective team leadership and their leaders' values aligned with those of the organisation there were better outcomes for service users (Humphreys et al, 2020). These findings about a culture of strong leadership in better group homes contrast sharply to the culture of weak leadership in underperforming homes where power is held by staff factions whose values do not always reflect those of the organisation (Bigby et al., 2012).

From another perspective, several qualitative studies report on the importance frontline managers of group homes attach to the tasks of Frontline Practice Leadership in achieving QoL for the people they support. For example, in a UK study, managers talked about using tasks of practice leadership to directly influence staff practice (Deveau & McGill, 2016b) and

supervisors in a study of Swedish group homes talked about being present as a leader to provide support and instant feedback to their staff about their practice (Berlin Hallrup et al., 2019). These supervisors regarded themselves as role models and interacted on a daily basis with staff to carry out the tasks that elsewhere are labelled as Frontline Practice Leadership such as observing their practice and giving instant feedback. Importantly, there are also some indications that being in receipt of strong Frontline Practice Leadership has a positive effect on staff satisfaction and levels of staff stress in group homes (Deveau & McGill, 2016b; Berlin Hallrup et al. 2018)

7.1 Impact of weak frontline management or weak practice leadership

Various studies identify the negative impact, on both staff and the people supported of weak frontline management in group homes and the absence of Frontline Practice Leadership tasks being undertaken. For example, inadequate or inconsistent leadership and support for frontline staff and lack of monitoring are associated with the culture in underperforming group homes (Bigby et al., 20212), organisational risks for abuse, (Collins & Murphy, 2021 Marsland et al., 2007), staff mistrust and uncertainty about management (Hutchison & Kroese, 2016) and obstacles to implementing Active Support (Qian et al., 2017).

Frontline managers themselves are also reported to perceive the negative impact of weak frontline leadership. For example, participants in a Delphi study of managers identified poor leadership as the primary obstacle to building and sustaining effective teams and providing high-quality services (Gomes & McVilly, 2019).

7.2 Summary

In summary, there is now robust evidence that strong Frontline Practice Leadership positively influences the quality of Active Support and QoL in group homes. Notably, the NDIS Workforce Capability Framework does not name or differentiate tasks of Frontline Practice Leadership in group homes from more generic descriptions of managing, supervising and coaching staff. More explicit reference in the Framework to the evidence based competences of Frontline Practice Leadership would assist in strengthening understanding of this enabling component of best practice, and the value of the specific and targeted training that is available that the Commission funded (<https://www.practiceleadershipresource.com.au>). The following section considers evidence about optimal ways of structuring Frontline Practice Leadership, i.e., models rather than the tasks and skills of its practice.

8. Enabling Components of Best Practice - Senior Leadership that Values Practice and Organisational Structures and Processes that Support Practice

Despite propositions about the significance of coherence and communication of organisations' mission, policy and procedures, the realist review identified limited research about their influence on QoL in group homes (Bigby & Beadle-Brown, 2018). There is also no research about whether the inclusion of people with disabilities on Boards of disability services impacts on service quality. However, research in other fields points to the importance of partnering with people who use services in advisory roles but does not tackle the challenges this presents in meaningfully including people with intellectual disabilities in such roles and avoiding tokenism (Farmer et al., 2018).

The realist review (Bigby & Beadle-Brown, 2018) noted however, that organisational processes such as recruitment, induction of staff, rostering practices that ensured shadow shifts and the translation of abstract concepts about practice into clear behavioural expectations of staff were generative factors of culture in better group homes (Bigby et al., 2015b).

8.1 Senior leadership and organisational support for practice

The longitudinal study added new knowledge about organisational factors that influence sustaining good Active Support practice over time and thus QoL. Distinguishing features of organisations with predominantly good practice (71% or more of their services have good Active Support) were senior leaders who prioritised practice, understood Active Support, and strongly supported Frontline Practice Leadership. It was these characteristics of senior leaders rather than other factors such as size of an organisation, its scope or the quality of paperwork that predicted good Active Support (Bigby et al., 2020b, 2020c).

Reflecting these findings, a UK qualitative study of frontline managers found that managers saw organisational support important to carrying out their role (Deveau & McGill, 2016b). Conversely, in a Swedish study, group home managers identified a lack of support from their organisation and its leaders, the absence of a clear vision and conflicting organisational priorities as frustrating their work (Berlin-Hallrup, 2018). In a similar vein, in the US Qian et al, (2017) found the absence of organisational endorsement and poor leadership was an obstacle to the implementation of Active Support.

Also important in predicting good Active Support is the way organisations structure Frontline Practice Leadership. The traditional group home model of one group home one

supervisor is being reformed, as administrative tasks are centralised, and the span of control broadened from one to two or more group homes. There is no one formula or ratio of group homes to front line managers and the optimal organisation of the tasks of Frontline Practice Leadership depends on both the experience and skills of frontline staff and the complexity of the needs of the people they support. Nevertheless, findings from the longitudinal study indicated that the 5 tasks of Frontline Practice Leadership should be consolidated into one position and this should be located close to frontline staff. The person responsible for the 5 tasks should know the staff they are responsible for and the people they support and have sufficient time to carry out these tasks in addition to any others involved in their position (Bigby et al., 2020c). This means the roles of frontline managers or staff positions responsible for the 5 tasks of Frontline Practice Leadership differ between organisations and carry different titles. For this reason, the recent training program described the five tasks of Frontline Practice Leadership and associated skills rather than equating these tasks to a specific position (<https://www.practiceleadershipresource.com.au>).

8.2 Organisation and availability of staff training

The realist review (Bigby & Beadle-Brown, 2018) identified the impact of staff training in Active Support on QoL in group homes which was confirmed in the longitudinal study. Effective Active Support training requires two elements; theoretical content on the values, rationale, principles and essential elements of Active Support, and practical application, a ‘hands on’ practice component conducted by a skilled practitioner/trainer (Baker et al., 2017; Jones 2001a, 2001b; Totskis et al., 2008). The longitudinal study suggests that Active Support training should be embedded in induction programs so that all staff are trained in Active Support. If this does not happen the proportion of staff with training declines over time. High quality evidence-based training packages are available in the UK and Australia (<https://www.activesupportresource.net.au>). A new free online evidence based Active Support training package funded by the Commission will be completed by the end of 2022.

The realist review concluded there was little evidence about the impact of training in practice skills other than Active Support (Bigby & Beadle-Brown, 2018). Concerns about effectiveness of staff training were echoed by a recent systematic review of training across the disability sector which suggested reliance on individualised training packages, rather than empirically supported training models might explain the theory-practice gap (Gormley et al., 2020). Recent studies have shown for example, the limited or variable impact of PBS training that included group home staff. A randomised control trial found for example, that a six-day

staff training program in PBS principles and plans had no impact on the people supported, and on the quality of behaviour support plans which were rated as weak irrespective of whether or not staff had completed training (Hassiotisi et al., 2018).

8.3 Paperwork as a facilitator, indicator or potential obstacle of good practice

Paperwork used by staff in group homes is both paper based and electronic. It serves various purposes including; guiding daily practice, such as organisational policies or support plans; quality assurance and providing evidence about quality, such as daily reports or progress notes written by staff; and managing risks, such as risk assessment procedures (Quilliam et al., 2015). The longitudinal study of group homes examined policies and procedures for guiding practice such as job descriptions, policies or procedures and did not find any association between the coherence or quality of these documents and the level of Active Support in organisations (Bigby et al., 2020b; 2020c).

Several smaller qualitative studies have explored the use of paperwork by staff for quality assurance and providing evidence about practice. Quilliam et al., (2018) found that staff ‘managed’ the paperwork they were expected to complete, often prioritising other tasks they thought more important to the QoL of the people they supported. Other studies have identified differences between expectations and the actual practice of completing paperwork (Dahm et al., (2017), the failure of staff to complete paperwork such as incident reports (Parliament of Victoria, 2016) or records of activities (Dixon- Ibarra et al., 2017) or else inaccurate completion of paperwork by staff, misrepresenting what has happened (Quilliam, et al., 2018).

These studies point not only to the inaccuracy of some paperwork completed by staff but also the perception by staff that paperwork is burdensome and detracts from rather than adds to the quality of their support. A qualitative UK study found, for example, that frontline managers thought completing paperwork, which was often about compliance or internal quality assurance, interfered with their capacity to do their jobs well and deliver a good QoL (Deveau & McGill, 2016b). Despite such concerns, the volume of paperwork to be read or completed by staff in group homes has increased significantly over time. Quilliam et al.’s (2015) analysis showed for example an increase of 80% from 1988 to 2009.

Paperwork is the dominant way that the quality of group homes is judged internally by organisations and externally by regulators. For example, McEwen et al., (2014) found that 81% of the 387 indicators in the Victorian Disability Standards relied on written information, such as policies, support plans or client file notes, and only 19% required observations of

staff practice or interviews with service users and staff. Furthermore, they identified that audit formulas meant the proportion of services users interviewed could be as small as 4 for a service with 200 users. They also suggested that short interviews with strangers were likely to be ineffective in gaining feedback from service users and excluded people without good communication skills. A later study of quality systems in disability services internationally found a similar bias in favour of paperwork and procedures as a means judging quality and QoL outcomes (McEwen et al., 2020).

Researchers have cautioned the high degree of reliance on paperwork completed by staff in quality assurance and compliance systems. The main concerns are about the accuracy of paperwork in portraying events and its reliability as an indicator of the quality of support or QoL outcomes (Mansell, 2011; Beadle-Brown et al., 2008; Finlay et al., 2008; Bigby et al; 2014; 2020c; McEwen et al., 2014). In group homes particularly, researchers argue the value of direct observation of staff practice as the most effective way of judging quality. These arguments are supported by a UK study that clearly illustrated major discrepancies between conclusions about service quality using judgments based on paperwork and those based on direct observation of staff practice and QoL (Beadle-Brown et al., 2008). Problems with reliance of paperwork are also illustrated by examples both in the UK and Australia where significant abuse and appalling practice has been found in supported accommodation services which have been audited in accordance with regulations and deemed to have met quality standards (Collins & Murphy, 2022; Plomin, 2013; Parliament of Victoria, 2016).

A simple tool for observing and assessing the quality of staff practice in group homes, that aligns with the more complex Active Support Measure used by researchers, is currently in the final stages of development. The *Observing Staff Support* tool will provide an important means of measuring quality of practice, and ensuring experiences of people with more severe and profound intellectual disabilities are captured in judgements about quality of support. A tool of this nature could be incorporated into external audit requirements as well as being used internally for quality assurance. It would also be feasible for Commission practice standards to include minimum quality of practice scored on a reliable tool such as this.

8.4 Staff satisfaction and turnover

The realist review identified propositions about the impact of staff stability on QoL in group homes but found only a very few small studies and conflicting findings (Bigby & Beadle-Brown, 2018). Since then, a US study found some evidence about the positive impact of staff stability in group homes on QoL; fewer changes in direct support worker positions

were a predictor of levels of social engagement of people group homes (Qian et al., 2019). Staff stability is influenced by external labour force conditions but also conditions created by managers such as staff satisfaction. For example, staff satisfaction is associated with the use of Active Support (Rhodes & Toogood, (2017), receipt of strong Frontline Practice Leadership (Deveau & McGill, 2016b; Berlin Hallrup et al. 2018) and staff confidence in management in management is a predictor of Active Support (Bould et al., 2019).

8.5 Summary

In summary research suggests that values held by senior leaders about practice, and their actions influence QoL in group homes. There is most evidence about significance of providing overarching support for practice, embedding staff training in Active Support, and structuring Frontline Practice Leadership so it is close to direct support staff and there is sufficient time for frontline managers to carry out all 5 tasks. It would be feasible to incorporate expectations about the tasks and structuring of Frontline Practice Leadership, and staff training in Active Support in the Commission's practice standards for organisations delivering group home services. A growing literature suggests the increasing burden on staff of paperwork detracts from good practice in group homes, and that paperwork is often neither an accurate reflection of what actually happens nor a good indicator of quality in group homes. Further research about the amount and impact of paperwork on group home practice and finding ways to address these issues in the new context of the NDIS would be useful. The critique of paperwork as an indicator of quality suggests the greater use of observational tools in audits for reaching judgements about the quality of practice and associated potential for establishing a practice standard for observed practice quality.

9. Enabling Components of Best Practice - Enabling, Motivating, Respectful and Cohesive Group Home Culture

The realist review concluded that culture was widely perceived as influential in group homes, but evidence about types of culture associated with good QoL was only just emerging (Bigby & Beadle-Brown, 2018). Since then, qualitative and quantitative research has identified the characteristics of culture in group homes associated with better QoL outcomes (Bigby et al, 2015; 2016; Humphreys et al., 2020).

Group home culture represents collective staff assumptions about what is expected of them, the purpose of their work, and how they should regard the people they support, managers, the organisation and funding bodies. Very simply culture is seen as 'the way we do things around here' that is implicitly conveyed to and adopted by incoming staff (Schein,

2010). Culture is not taught in the same way as skills and is rarely explicitly visible. Culture is not the same as practice but influences and is influenced by practice. For example, strong Frontline Practice Leadership is set of observable tasks carried out by a frontline manager, whereas a culture of effective team leadership is staffs' perceptions of the leadership in the group home where they work. A culture of effective team leadership might be inferred by observing the practice leader interacting with staff . Generally, culture is best understood by watching what staff do, how they talk about their work, and their use of objects in the workplace.

A large qualitative study characterised the culture in group homes where there was a better QoL, as cohesive, respectful, enabling for the people supported and motivating for staff (Bigby et al., 2015b, 2016). Figure 5 illustrates the stark comparison between the type of culture in better and underperforming group homes.

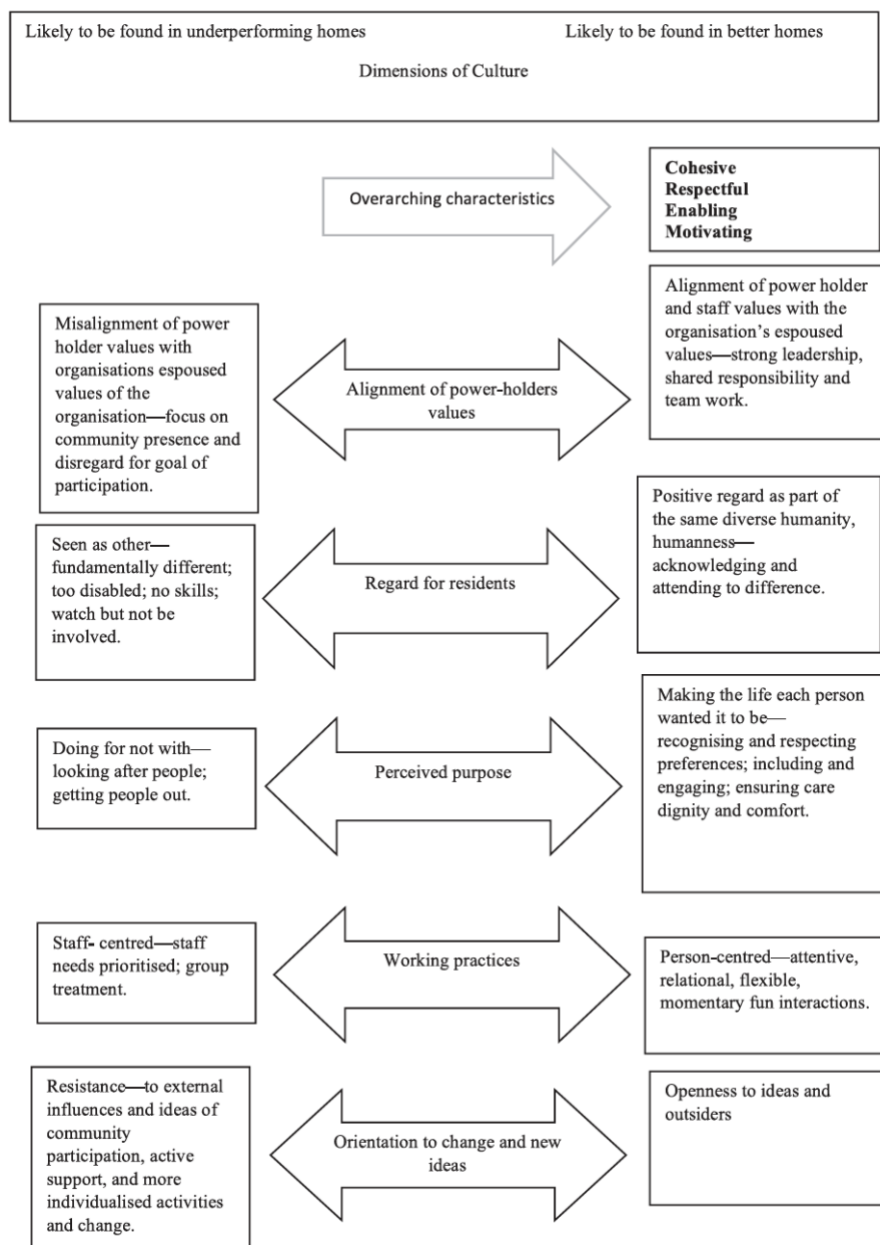


Figure 5. Dimensions of culture in better and underperforming group homes (Bigby & Beadle Brown, 2016)

Culture in better group homes prioritises choice, inclusion, engagement, health and care - support is relational, attentive and flexible as staff pay attention to the dignity and comfort of the people they support as well as their inclusion and engagement. Leadership in this type of culture is strong and undisputed but power is dispersed among staff who share responsibility for the quality of support. In this type of culture some staff are guided by the platinum rule, thinking about ‘what the person they support would want’ rather than the more common golden rule, ‘what staff themselves would want if they were the person they supported’.

Culture in better group homes is also characterised by openness to ideas and outsiders. Features such as this, and strong leadership are likely to contribute to the ease and quality of collaboration between group home staff (who provide foundation day to day support) and professional providing more intensive interventions, treatments or support.

The Group Home Culture Scale (GHCS) developed from the qualitative research discussed above now provides a valid and reliable measure of dimensions of culture in group homes (Humphreys et al., 2019) illustrated in Table 6.

Table 6. Dimensions of culture - Group Home Culture Scale

	Subscale	Description	Score Interpretation
1.	Supporting Well-Being	The extent to which staff members' shared ways of working are directed towards enhancing the well-being of each resident.	A higher score indicates that shared norms, patterns of behaviour, and ways of working are directed towards supporting the residents' well-being.
2.	Social Distance from Residents	The extent to which there is social distance between staff and residents, where staff regard the residents to be fundamentally different from themselves.	A lower score indicates social distance between staff and residents. Conversely, a higher score indicates the absence of social distance between staff and residents.
3.	Valuing Residents and Relationships	The extent to which staff value the residents and the relationships they have with them.	A higher score indicates that staff value the residents and the relationships they have with them.
4.	Collaboration within the Organisation	The extent to which staff have a positive perception of organisational support and priorities.	A higher score indicates that staff have a positive perception of organisational support and priorities.
5.	Alignment of Staff with Organisational Values	The extent to which staff members' values align with the espoused values of the organisation.	A higher score indicates greater alignment between staff members' shared values and the organisation's espoused values.
6.	Factional	The extent to which there are divisions within the staff team that have a detrimental influence on team dynamics.	A higher score indicates an absence of divisions within the staff team that have a detrimental influence on team dynamics. Conversely, a lower score indicates divisions within the staff team that have a detrimental influence on team dynamics.
7.	Effective Team Leadership	The extent to which the frontline supervisor engages in leadership practices that transmits and embeds the culture.	A higher score indicates that the frontline supervisor transmits and embeds a positive team culture.

The largest study of group home culture in Australia included, 86 staff from 23 group homes managed by 5 organisations. It found that higher scores on dimensions of Effective Team Leadership and Alignment of Staff with Organisational Values predicted higher engagement of the people supported, higher scores on the Supporting Wellbeing subscale and more community involvement (Humphreys et al., 2020). A later study showed significant

variations in culture between group homes even within the same organisation (Humphreys et al., 2021).

As well as generating data that demonstrates relationships between culture and QoL, the GHCS scale enables organisations to analyse culture in each group home, identifying where improvements are required. The 2022 data collection for the longitudinal study will collect data on group home culture and QoL in a large sample, and potentially these data will provide robust indications of the association between culture and QoL in group homes, as well as patterns of culture that predict QoL.

Research on the cohesive, respectful, enabling and motivating group home culture associated with better QoL resonates with the expectations and values inherent in NDIS and other disability policies, particularly those about dignity, respect, choice and inclusion. This type of culture demonstrates reciprocity between practices and culture, and reflects the evidence informed direct support and managerial practices that positively influence group home QoL, such as Active Support and Frontline Practice Leadership. There is limited evidence however, about broader organisational features that generate cohesive, respectful, enabling and motivating cultures in group homes, and whether these are similar to those predictive of Active Support (senior leaders that value practice, and the organisation and structuring of training and Frontline Practice Leadership discussed in an earlier section).

The type of group home culture associated with good QoL is the antithesis of cultures where there is high risk of abuse. A recent review of the literature identified that services where there was a high risk of abuse were characterised by poor management (lack of support for front-line staff, and negative relationships between staff and senior management), limited staff training, resistance to change, and lack of team meetings or reflective practice (Collins & Murphy, 2022).

In summary, there is now more evidence about the types of culture associated with QoL in group homes and efficient and effective ways of measuring culture in group homes. Although the generative factors remain unclear, some of these appear to be the types of staff and managerial practices that are predictors of good QoL. Although practice and culture are different concepts, it is clear that staff use of Active Support and strong Frontline Practice Leadership are indicative of the type of culture associated with good QoL.

10. Enabling Components of Best Practice - Size, Adequate Resources and Compatibility

The realist review found the strongest evidence about design and its impact on QoL of group homes was small size (6 or less people), housing of a similar type to that of the surrounding area, home likeness features and homes that were dispersed rather than clustered (Bigby & Beadle-Brown, 2018). The only more recent research about design is from the longitudinal study, which confirmed the significance of small size (6 or less) as one of the predictors of Active Support (Bould et al., 2019).

The realist review found that staff resources should reflect the support needs of the people living a group home, and that QoL was better where there were enough staff to meet needs but not too many that they interacted with each other or did all the household tasks for people (Bigby & Beadle-Brown, 2018). A recent UK study confirmed earlier findings that once resources reach a threshold of adequacy they do not impact on QoL (Beadle- Brown et al., 2017; 2021). These studies found that good support did not require significantly more staff time, and there was no evidence of higher total costs for those receiving good support. Australian research has not measured costs but, as indicated earlier, found variability between QoL and support in group homes which had similar funding.

The evidence strongly suggests it is staff skills and the way staff resources are organised that make a difference to QoL in group homes rather than the volume of resources. These findings beg the question of what constitutes adequate resources to achieve QoL in a group home. This is not formulaic and depends on the support needs of the people supported in the home and its location. However, from another perspective, key drivers of cost should be those of delivering the components of a best practice framework, such as staff trained in Active Support and frontline management positions organised close to direct support staff and with sufficient time to carry out all 5 tasks of Frontline Practice Leadership.

There is little evidence about the compatibility or mix of people living in group homes. The realist review found some evidence to support propositions that QoL outcomes are better when people in a group home are not grouped together by ability level or additional support needs such as behaviors of concern (Bigby & Beadle-Brown, 2018). In terms of ability level, the longitudinal study added a more nuanced perspective, suggesting the disadvantage of mixing together people with very dissimilar support needs. It found that a mix of people with relatively similar levels of ability, was more likely to be predictive of good Active Support than groupings of people who had very different abilities. This aligns with the reasoning that

staff find it difficult to switch between applying the principles of Active Support to supporting people with severe or profound intellectual disability and those with milder disabilities, with the resultant poorer support to the former group.

No research has looked at the compatibility of people who live together in group homes other than issues relating to ability and behaviours of concern. Yet there is considerable anecdotal evidence about the impact of poor compatibility on QoL. The mix of people living together in group homes is largely the result of earlier policy regimes where access to vacancies was often dependant on crisis rather than careful matching of interests, personalities, or ages. Or else it was based on resources which meant people with similar high levels of behaviours of concern were grouped together. Practice wisdom suggests that compatibility is important to QoL of people living in group homes and that involvement in selection, and collective decisions of people living in a group home about new residents might be an important strategy in achieving this. This is an area worthy of future research.

11. Perspectives of People Living in Group Homes and their Families

11.1 Perspectives of people living in group homes

Views about group homes from people who use these services are largely absent from the literature. The four studies identified that included perspectives of adults in group homes also included those living in a range of other community settings, and two of the four only included people with behaviours of concern (Evans & Gore, 2016; Clark et al., 2019). One reason for the scant literature may be that a high proportion of people living in groups homes have more severe and profound intellectual disabilities and thus researchers have used observational methods to ensure inclusion of their experiences, rather than self- report surveys or interviews, which would exclude this group (Mansell, 2011).

The identified studies suggest a common perspective among people with intellectual disabilities about controlling their own lives rather than being controlled by staff (Evans & Gore, 2016; Clarke et al., 2019; Giesbers et al., 2018; Shipton & Lashewicz, 2016). This desire was echoed by people who had moved from group homes to more independent living, who reflected on their appreciation of having greater choice and control since they had moved (Bigby et al., 2017). Other issues raised by people in group homes were the importance of relationships with staff, particularly for those with few other types of relationships, staff continuity and staff knowledge about them as a person (Giesbers et al., 2018; Evans & Gore, 2016).

11.2 Perspectives of Family Members

Similarly, there is very little research specifically exploring the perspectives of family members of people in group homes. Rather they are more often included in studies of families of people from a wide range of living situations. There are however, some common themes. Families want to be acknowledged as partners in caring for their relative with disability and value good relationships with staff or managers (McKenzie, et al., 2018; Jensen et al., 2018; Koelewijn et al. 2021; Bright et al., 2018). For example, a small qualitative study found that families wanted staff to recognise the family context of the people they supported, but that this was hampered as families had to have relationships with multiple staff members (Bright et al., 2018). Families in that study would have preferred to build a relationship with one key staff member. This preference resonates with the practice of having a *key worker* whereby each person supported in group home has a nominated worker who leads aspects of their support such as access to external services, relationships with family and the development and implementation of support planning. This practice was researched in some depth by Clement and Bigby (2008) but has seldom appeared in the literature since and may be worth further research in the current context and revisiting as part of a best practice model

Continuity of support was important to families, which they thought was achieved through staff knowing and understanding their family member (Shipton & Lashewitz, 2016; Koelewijna et al., 2021). The views of families reflected the principles of the NDIS and they valued many of the components that positively influence QoL identified in this review. For example, families valued people with disabilities being treated with dignity and respect, and being supported to be engaged and exercise self-determination (Koelewijn et al., 2021; Mckenzie et. al., 2018). For the families in Brights' study it was often the 'little things' that reflected the quality of support for their family member, such as whether they were wearing their own or other people's clothes or were missing regular activities because of changes in staff.

There is little direct evidence about the contribution of family involvement to the QoL of people living in group homes. However, some research does identify the roles that families play, the importance of the strength of social networks to wellbeing and the often protective and empowering roles that social connections outside the home play for people with intellectual disabilities. For example, the early evaluative research on the NDIS demonstrated the advantages of having strong advocates outside the service system to gaining funding (Mavromaras et al., 2017) and literature points to the preventative role in terms of abuse that

families and others outside the service system play for people with intellectual disabilities (Collins & Murphy, 2022).

In summary, both people living in group homes and their family members value the types of staff and managerial practices identified in this review as positively influencing the QoL in group homes. This further strengthens the rationale, based on research evidence for including these factors as part of a best practice framework. There is little evidence about the influence of staff continuity (or the opposite turnover) nor the significance of staff respecting the role of families. However, relational support and openness to outsiders were characteristics of the culture in better group homes. The longitudinal study will include qualitative interviews with people with lower support needs in the 2022 data collection, giving an opportunity to explore how observational measures of QoL in group homes align with more subjective perspectives of lived experiences. This will help both in understanding the perspectives of people who use group homes service about what makes a difference to their QoL, but also in canvassing their choices about alternatives to group homes or reasons for preferring to remain. We will also include families of people with higher support needs living in group homes, as the experience of the Making Life Good study illustrated it can be very hard for self-advocates with lower support needs to represent the views of those with more severe disabilities (Bigby & Frawley, 2010b).

12. Specialist Components of Best Practice

12.1 Specialist interventions or additional support

As discussed in section 4.2 the second part of a best practice framework for group homes are the specialist components such as interventions or additional support from staff or professionals whose work base is outside the group home. It was not within the scope of this study to review the literature about what constitutes best practice for this wide range of specialist interventions or additional support as these cross many different bodies of research. These components are nevertheless, crucial adjuncts to support from group home staff. The extent to which specialist components use evidence informed practice and conform to best practice clearly depends on their nature, practitioner's knowledge, and degree to which they are subject to professional registration or accreditation. Some of these services are delivered by highly professionalised staff such as allied health practitioners and others by a less regulated workforce such as workers that support community inclusion or support coordinators. The quality of these specialist components mediates their contribution to the QoL of people in group homes and should be within the purview of the Commission.

Specialist components are diverse and for many there is little research about effective interventions or practice. Nor is there finely grained evidence about how practice or specific interventions should be adapted and applied to people in group homes or how practice should interface with the foundation support provided by staff in group home. This means a practice framework might more appropriately include overarching principles to guide the provision of specialist components rather than pointing to the types of evidence informed practices included for foundation components.

For an individual, specialist components complement the foundation day to day support from staff in a group home, and informal support. Staff who deliver specialist components may be employed by the SIL provider, working with multiple people living in group homes in the organisation or may be employed by external organisations or be independent professional practitioners. For example, behavioural support or health specialists employed by the organisation may work directly with people in the organisations' group homes or provide expert advice and guidance as necessary to staff or frontline managers of group homes. Alternatively, specialist components may be provided by independent professionals external to the organisation.

Specialist components are likely to be funded as part of an individuals' NDIS plan or mainstream services. These components will be different for each individual, reflecting their characteristics and needs. They cover a wide spectrum of types of support ranging from, interventions about behaviours of concern to specialist assessment, advice and support with for example, communication, physical activity, positioning, meal-time support, changing support needs, or support to identify, access and participate in regular community activities, volunteer or build social connections.

12.2. Coordination, planning and supported decision making

Another set of additional specialist components to be considered in a best practice framework are associated with coordination, planning and supported decision making. These will be particularly important to the many people living in groups who do not have strong family or other sources of informal support. They have become more pivotal in the individualised funding context of the NDIS where opportunities for choice and control, options and potential combinations of different types and providers of services have expanded.

There is a strong rights position that components of this nature should be provided by organisations or professionals independent of SIL providers, although there is little empirical

research in this area. Notably, however, research does indicate that good practice for these additional components are characterised by the person with disability being known well, consistent supporters over time and long-term trusting relationships between the person with disability and practitioners (Bigby & Frawley, 2010a; Bigby et al; 2007; Douglas & Bigby, 2018). In thinking about practice guidance, it may be worth considering that for some people these types of relationships already exist with group home staff.

12.3 Collaboration between specialist, other additional components and foundation components of best practice

Specialist interventions and other additional specialist components such as service coordination, planning or support for decision making that are delivered by staff or professionals external to group homes are diverse and informed by evidence of varying strengths. Nevertheless, there are common issues about access to and the provision of these which should be included as components of a best practice framework.

First, people in group homes should be able to access the types of specialist interventions and additional supports as and when the need them. Accordingly, a component of a best practice model for group homes should be that people in group homes are supported to identify needs and access specialist interventions or additional specialist components when necessary. Second, as well as access and quality, the way that these specialist components are coordinated and the degree of collaboration between providers external to the group home and group home staff will significantly impact their effectiveness and the QoL of people in group homes. There is very limited evidence about this type of collaboration. Extrapolation from other evidence suggests that some foundation components of best practice can facilitate collaboration. For example, the type of culture found in better group homes, such as cohesiveness, openness to outsiders and effective leadership, as well as features of organisational enablers such as Frontline Practice Leadership are all likely to facilitate staff collaboration and thus implementation of specialist components. This proposition is supported by research about synergies between some specialist and foundation components of best practice in group homes. For example, commentators and researchers assert the significance of Active Support as a core element for implementing PBS with people who need behavioural support, (Jones, 2021; McGill et al., 2020, 2018). Additionally, the most comprehensive examination of implementing PBS in group homes demonstrates the significance of practice that incorporates Active Support and Frontline Practice Leadership to successful implementation and QoL outcomes (McGill, et. al., 2018)

13. Components of a Best Practice Framework

A best practice model for group homes has distinct components. First, foundation components which are universal and relevant to all people living in all group homes. These are the responsibility of staff working in group homes and the organisations that manage them. These components are the primary focus of the review. Second, are specialist components which are interventions or additional supports that should be available to an individual living in a group home if and when they are needed. These are provided by staff or professionals who are not based in a group home and may not necessarily be employed by the organisation managing the group home.

A third component is collaboration and coordination between staff and services involved with a person in a group home, and planning and decision making support with every individual in a group home. These components underpin effective use of individualised funding schemes and optimise holistic and consistent support for people with disabilities, but there is very little research about these in the context of group homes.

There is substantial evidence about some foundation components of best practice that make a difference to the QoL of people with intellectual disabilities in group homes. There remain gaps in knowledge particularly around embedding strategies to support healthy lifestyles and collaborative practices between the day-to-day practice by staff teams in group homes and specialist interventions or additional supports delivered by external professionals or inhouse professionals not based in a particular group home.

The following section provides a brief summary of the proposed elements of a best practice framework, the evidence about each of these and advice to the NDIS Quality and Safeguards Commission.

13.1 Staff practice of Active Support

What makes a difference: Good Active Support staff practice that supports engagement of people with intellectual disabilities in meaningful activities and social interactions, choice and control, communication, community inclusion, learning and development. Active Support is also a proactive strategy for supporting people with behaviours of concern and underpins many behaviour support plans.

Evidence: Active Support is an evidence informed practice. There is strong evidence that staff use of Active Support positively influences the quality of life (QoL) for all people in group homes, across the domains of personal development, emotional wellbeing, autonomy, interpersonal person relationships, and social inclusion. As an evidence informed practice

that can be learned by front line staff, Active Support integrates the application of rights-based values and a range of support skills, including communication, support for choice, task analysis and adjusting support to the needs of the person.

Advice: Active Support should be a key component of a best practice framework for group homes that support people with intellectual disabilities. As a specific person-centred, evidence informed practice it should be explicitly named and included the NDIS Quality and Safeguards Commission practice standards and the NDIS Workforce Capability Framework rather than being subsumed under the generic nomenclature of person-centred practice.

13.2 Staff practice that supports healthy lifestyles and access health care

What makes a difference: Staff practice that promotes healthy lifestyles and supports people to get the health care that they need, identify early signs of health problems, supports communication with health professionals, and supports action on the health professionals' advice.

Evidence: There is strong evidence about the roles that staff in group homes play in supporting people to lead healthy lifestyles and supporting access to the health care they need, and the significance of this support to QoL. There is no overarching evidence informed support model that encompasses the health-related tasks, which articulates the roles of group home staff in meeting healthy lifestyle and health care needs, that sets out how these roles fit together, how staff should work in collaboration with external experts, or identifies the skills group home staff require to fulfil health related roles.

Advice: The absence of an overarching evidence informed model to support healthy lifestyles and access to health care that could be embedded into group home staff practice is a major gap in knowledge. Research is required to develop and test a holistic best practice model of support for health of people in group homes.

13.3 Staff practice with families

What makes a difference: Staff who acknowledge the role of families of people in group homes and collaborate with them where appropriate.

Evidence: There is minimal evidence about the practice of group home staff working collaboratively with family members of adults in group homes or the QoL benefits of this. However, this is an important component raised by families. There is some research about the benefits of a key worker role work in this regard but very little evidence about their roles in the current context. Group home cultures that are cohesive, respectful, enabling, and motivating are likely to be more open and collaborative with family members.

Advice: There is scant evidence about the benefits of collaboration between staff and families for the QoL of people in group homes or about the practice necessary to do this well. Research in this area would fill an important gap in practice knowledge.

13.3 Gaining the perspectives of people who live in group homes

What makes a difference: Having control over one's own life, relationships with staff, continuity of staff and staff knowledge about the people they support.

Evidence: : There is very little evidence that the perspectives of people who live in group homes have either been sought or are collectively taken into account in the design and delivery of services. The limited literature suggests their perspectives reflect to some extent those of families, the intent of disability policy and the aims of some elements of best practice.

Advice: The Commission should support research about the perspectives of people who live in group homes about their services and effective strategies for including their perspectives in the design and delivery of group home services.

13.4 Positive staff culture

What makes a difference: Staff culture that is cohesive, respectful, enabling and motivating, where staff perceive there is strong leadership and staff practice is attentive, responsive, flexible and pays attention to the dignity and comfort of the people they support as well as their inclusion and engagement needs.

Evidence: There is strong evidence that group homes which have a culture that is cohesive, respectful, enabling and motivating have better QoL outcomes. There is emerging evidence that these types of culture are associated with good Active Support practice and strong Frontline Practice Leadership.

Advice: The Commission support ongoing research about the association between culture, good Active Support practice and QoL outcomes in group homes and support the further development of measures of culture as indicators of quality in group homes.

13.5 Staff who are competent and satisfied with their work

What makes a difference: Staff trained in Active Support, who have confidence in management and who are satisfied with their work and more likely to remain in their role.

Evidence: There is strong evidence that if group homes have staff who are trained in Active Support and who are confident in their management there is more likely to be good Active Support, which is indicative of good QoL outcomes. There is strong evidence that Active

Support training should include a theory and hands on component. There is some evidence that staff who experience strong Frontline Practice Leadership and practice good Active Support are more satisfied with their work and more likely to remain in their role. There is some evidence that staff turnover is associated with poorer QoL for people in group homes.

Advice: Training in Active Support should be included in the NDIS Workforce Capability Framework and requirements for Active Support training included in practice standards for staff working in group homes with people with intellectual disabilities.

13.6 Staff practice enabled by Frontline Practice Leadership

What makes a difference: Frontline managerial practices that support front line staff to focus on quality of life of the people they support, work as a team, organise support on each shift, regularly observe and provide feedback to staff about their practice, coach staff, model good practice, and supervise staff.

Evidence: There is evidence that the five tasks of Frontline Practice Leadership encapsulate these frontline managerial practices. There is robust evidence that strong Frontline Practice Leadership positively influences the quality of Active Support practice by staff and QoL in group homes.

Advice: There should be more explicit reference in the NDIS Workforce Capability Framework to the evidence informed competences of Frontline Practice Leadership to assist in strengthening understanding of this enabling component of best practice. Specific and targeted training in the five tasks of Frontline Practice Leadership should be included in practice standards for frontline managers of group homes.

13.7 Senior organisational leaders who value direct staff practice and implement structures and processes to support and maintain it.

What makes a difference: Senior organisational staff who value and understand practice and put in place structures to support and maintain Active Support, Frontline Practice Leadership, train all staff in Active Support and monitor practice using observational techniques.

Evidence: There is strong evidence that the values held by senior organisational leaders about practice, and their actions are predictors of good Active Support practice and QoL in group homes. There is most evidence about the significance, at the organisational level, of providing overarching support for practice, embedding staff training in Active Support, (both the theory and practical application) in organisational processes, and structuring Frontline Practice Leadership so it is close to direct support staff and there is sufficient time for frontline managers to carry out all 5 tasks. There is growing evidence that paperwork is an

increasing burden on front line staff and managers that detracts from providing good direct support. Not all paperwork of equal value and in particular, evidence indicates that paperwork such as policies, procedures and staff self-reports are not good indicators of the quality of practice in group homes and that observation of practice is a more robust approach to measuring or monitoring quality. A simple observational tool based on a complex research measure has been developed for *Observing Staff Practice* which yields a score about quality of staff practice and could be incorporated into external audit requirements as well as being used internally for quality assurance.

Advice: Expectations about the training in Active Support for all direct support staff, the tasks and structuring of Frontline Practice Leadership, should be included in practice standards for organisations providing group home services. The Commission should review the volume and type of paperwork it requires from group home staff, front line managers and organisations and in particular consider alternative strategies for collecting evidence about practice. This may be the inclusion of observational tools in audits for reaching judgements about the quality of practice and establishing a practice standard for observed practice quality.

13.8 Managerial practices that support access to specialist interventions and other forms of additional support.

What makes a difference: Managerial practices that supports access to specialist interventions, and additional supports as and when they are needed by individuals and which are provided by specialists either internal or external to the organisation.

Evidence: This study did not review the strength of evidence about specialist interventions for people in group homes but noted these were mediated by individual characteristics such as life course stage, health, behaviour and availability of informal support. It also noted the limited evidence about the implementation of specialist interventions in the context of group homes, and that additional support from staff outside group homes is increasingly important in the context of the NDIS where the responsibility of group home staff vis other services is more diffuse.

Advice: It may be useful for the Quality and Safeguard Commission to review the evidence about the effectiveness of specialist interventions and additional support that complement the support from group home staff in order to understand the extent to which these improve or detract from an individual's QoL. This may be particularly important in the area of behaviour support which is a common specialist intervention provided by external professionals.

13.10 Managerial practices that support staff collaboration, service coordination, involvement in planning and support for decision making.

What makes a difference: Staff and managerial practices that support effective collaboration between group home staff and others involved in supporting an individual, that supports the coordination of services around an individual, that ensures an individual's involvement in all planning processes about their support and their receipt of good supported decision making.

Evidence: There are gaps in evidence about the type of practice that best supports collaboration between group home and external staff, the coordination of services, individual planning and supported decision making for people in a group home context. However, practice wisdom suggests they underpin effective use of individualised funding schemes and optimise holistic and consistent support for people with disabilities. Evidence does suggest that group homes with a cohesive culture which is open to outsiders and where there is strong Frontline Practice Leadership are all likely to facilitate collaboration between internal and external staff and thus the implementation of specialist interventions.

Advice: There is a need for research that addresses knowledge gaps about collaboration between group home and external staff, and effective planning and coordination of services and models for provision for supported decision making for individuals in group homes.

13.11 Design of group homes which support good QoL practice

What makes a difference: Group home designs where there are six or less people, the staff resources reflect the support needs of the people supported and people living together are compatible, and have similar levels of support needs in term of their adaptive behaviour

Evidence: There is strong evidence about the first two of these factors, small size and staff resources commensurate to the support needs of the people supported. There are gaps in evidence about assessing or ensuring the compatibility of people living together in a group home, other than evidence about the negative impact of grouping together people with behaviours of concern or people with very different levels of ability.

Advice: No more than six people living together under one roof or on one site should be reflected in service design standards. Research should be undertaken to further understanding about determinants of compatibility of people living together in group homes and tools to facilitate choice of compatible house mates.

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Appendix A

Table A 4. Summary of included papers

Category	Author/s (Year)	Title	Place	Aims and Research Questions	Method	Findings
<u>Impact of Active Support</u>	Baker, Appleton, & Williams (2017)	An examination of the addition of video informed reflective practice to the Active Support toolkit	Wales	To evaluate an Active Support training package with additional video informed reflective practice and its effects on the quality of interactions between staff and service users, service user's level of engagement in meaningful activities, and staff practice.	Participants included 25 service users of four group homes, 54 staff who were included in the training and 2 managers who were responsible for managing the four homes. Observation was used to collect data.	Service user engagement, staff assistance and positive interactions between staff and user increased significantly post-training. Negative interactions decreased significantly.
	Beadle-Brown, Beecham, Leigh, Whelton, & Richardson (2021)	Outcomes and costs of skilled support for people with severe or profound intellectual disability and complex needs	England	To evaluate the impact of Active Support on the quality of life of people with severe and profound intellectual disabilities and complex needs, identify which domains of quality of life are affected, and explore implications in terms of the costs of support.	Participants included 110 service users across 35 supported accommodation services. Data were collected using direct observation, interviews and questionnaires.	People who received consistently good Active Support were significantly more engaged in meaningful activities and relationships overall and also in social activity, compared to those who received mixed, weak or no Active Support. Additionally, there was no evidence of higher costs for the people who received good Active Support.
	Beadle-Brown, Leigh, Whelton, Richardson, Beecham, Baumker, & Bradshaw (2016)	Quality of life and quality of support for people with severe intellectual disability and complex needs	England	To explore the quality of life and quality of support for people with severe intellectual disabilities and complex needs.	Participants comprised 110 people with severe and profound disabilities and complex needs in supported accommodation services. Structured observations and staff questionnaires were used to measure quality of life and quality of support.	Only one-third of the whole sample were receiving consistently good active support and on average people were still spending at least three-quarters of their time with no contact from anyone. Active Support was associated with other measures of quality of support and was the strongest predictor of outcomes.
	Qian, Larson, Ticha, Stancliffe,	Active Support training, staff	USA	Does providing Active Support training to the staff of small group	Participants comprised 75 individuals with intellectual	Staff assistance not associated with the provision of Active

	& Pettingell (2019)	assistance, and engagement of individuals with intellectual and developmental disabilities in the United States: Randomised controlled trial		homes increase staff assistance provided to individuals with intellectual and developmental disability, and non-social engagement and social engagement by individuals with intellectual and developmental disabilities measured 3 and 12 months after the staff were trained?	and developmental disabilities living in groups homes, direct support staff and house supervisors. Survey and observational data were collected.	Support training. No significant difference found in observed levels of non-social engagement and social engagement across time or between individuals in the control (no Active Support training for staff) and experimental group (Active Support training for staff). However, a link between greater staff stability and better outcomes for people with intellectual and developmental disabilities was found.
	Rhodes & Toogood (2016)	Can Active Support improve job satisfaction?	England	To explore the relationship between Active Support and staff job satisfaction.	Participants comprised 38 direct care staff working in group homes for adults with intellectual disabilities. A single group repeated measures design was used. Job satisfaction was measured pre and post Active Support implementation. Pre and post observations of Active Support in the homes were also conducted.	Significant increase in reported job satisfaction following the implementation of Active Support. The most significant increases in satisfaction were in relation to skill level and amount of time spent with service users.
<u>Implementation of Active Support</u>	Bigby, Bould, & Beadle-Brown (2019)	Implementation of Active Support over time in Australia	Australia	To identify some of the implementation issues experienced in supported accommodation services.	Data were collected from six organisations providing supported accommodation services to people with disability, through staff questionnaires, observations and manager interviews for between two and four years.	Active Support improved over time for people with lower support needs. Weak positive correlation between Active Support and practice leadership, and Active Support and the percentage of staff reporting Active Support training.
	Bigby, Bould, Iacono, & Beadle-Brown (2020a)	Predicting good Active Support for people with intellectual disabilities in supported accommodation	Australia	To explore predictors of good Active Support, particularly organisational management features.	Cross-sectional design. Multilevel modelling with data from surveys, observations and interviews was used to identify predictors of Active Support at the levels of service	Positive staff perceptions of management, prioritisation of practice and Active Support by senior managers, strong management support for practice leadership, organisation

	services: Key messages for providers, consumers and regulators			users (n = 253), services (n = 71) and organisations (n = 14).	of practice leadership close to everyday service delivery, and concentration of practice leadership with frontline management were all significant predictors of good Active Support.
Bigby, Bould, Iacono, & Beadle-Brown (2020b)	Quality of practice in supported accommodation services for people with intellectual disabilities: What matters at the organisational level	Australia	To explore the relationship between differences in organisational leadership and structures and the quality of Active Support in supported accommodation services.	Fourteen organisations providing supported accommodation services to people with intellectual disability participated in this mixed methods study. Data sources were semi-structured interviews with senior organisational leaders, organisational documents, and structured observations of the support received by service users, which was used to complete the Active Support Measure.	Organisations where at least 71% of services delivered good Active Support prioritised practice, understood Active Support, and strongly supported practice leadership. The combination of shared prioritisation of practice and Active Support, strong support for practice leadership by senior managers, the organisation of practice leadership close to every-day service delivery and concentration in one position with frontline management are associated with good Active Support.
Bigby, Bould, Iacono, Kavanagh, & Beadle-Brown (2020c)	Factors that predict good Active Support in services for people with intellectual disabilities: A multilevel model	Australia	To identify factors associated with individuals, services and organizational variables that predict the quality of Active Support using multilevel modelling.	Repeated cross-sectional design in which data were collected from 2009 to 2017, at 7 time points. A total of 461 service users with intellectual disability from 134 group homes managed by 14 not-for-profit organizations participated in the study. Mixed methods were used to collect data including observations, interviews and questionnaires.	Good Active Support was predicted by a higher level of adaptive behaviour at service user level, strong practice leadership, training in Active Support and greater time since implementation. Greater heterogeneity of adaptive behaviour among service users, 6> people in a service and management of more services were associated with poorer quality Active Support.
Bould, Bigby, Iacono, & Beadle-Brown (2019)	Factors associated with increases over time in the quality of Active Support in	Australia	To investigate factors associated with increases over time in the quality of Active Support.	Repeated measures longitudinal design. The same data were collected at baseline and then intervals of 12–18	There was an increase in average Active Support Measure scores over time, with rate of change not differing

	supported accommodation services for people with intellectual disabilities: A multi-level model			months. Participants comprised of service users and staff from 51 services of 8 participating disability organisations. Questionnaires and observation methods were used to collect data.	significantly across service users according to support needs. Rate of change slower for services with greater baseline Active Support Measure scores. Greater levels of adaptive behaviour significantly associated with better Active Support. Strong practice leadership and more staff trained in Active Support were also significant predictors of higher levels of Active Support. Larger group homes s (7+ individuals) and greater heterogeneity among service users in terms of adaptive behaviour associated with lower quality of Active Support.
Iacono, Bould, Beadle-Brown, & Bigby (2019)	An exploration of communication within Active Support for adults with high and low support needs	Australia	To explore the relationship between quality of active support and communication support for people in group homes with high and low support needs.	Data were available for 182 of a total of 246 service users from 54 group homes of nine disability organisations. The measures were of quality of active support, engagement and staff contact.	Active Support and engagement levels were better when appropriate communication was used by staff. Good communication skills are an integral part of Active Support
Qian, Tichá, & Stancliffe (2017)	Contextual factors associated with implementing active support in community group homes in the United States: A qualitative investigation	USA	To increase the understanding of contextual factors at individual and organizational levels that are viewed as challenges for successful implementation of Active To support intervention by direct support professionals, their supervisors, managers, and trainers. To gain understanding of how staff consumers of Active Support (i.e., direct support professionals, supervisors, and managers) perceive the impacts of Active Support on staff and resident outcomes.	Participants were group home staff including 4 direct support professionals, 6 program directors and 6 managers, as well as 3 Active Support trainers. Interviews and focus groups were conducted to collect the qualitative data.	Participants reported increased participation and self-determination and reduced challenging behaviour in residents after Active Support implementation. Direct support professionals said they experienced positive change in mind-set and staff-resident interactions. The main challenges to Active Support implementation reported were high staff turnover, lack of commitment/buy-in from the organisation, and lack of effective leadership support.

<u>Review Papers</u> <u>(Active Support)</u>	Flynn, Totsika, Hastings, Hood, Toogood, & Felce (2018)	Effectiveness of Active Support for adults with intellectual disability in residential settings: Systematic review and meta-analysis	Mixed	To review evidence for the effectiveness of Active Support in residential settings and the views of adults with intellectual disability and/or of staff regarding Active Support training and implementation.	Systematic review and meta-analysis.	Significant increases in the amount of time residents spent engaged in all types of activities at home (total engagement) following implementation of Active Support. Active Support training and implementation were positively received by staff and residents. Staff experienced increased job satisfaction.
<u>Practice Leadership.</u>	Beadle-Brown, Bigby, & Bould (2015)	Observing practice leadership in intellectual and developmental disability services	Australia	To establish psychometric properties of an observational method of measuring practice leadership. To measure the extent of practice leadership and the relationships between practice leadership and quality of staff support and client outcomes.	Data were collected from 58 supported accommodation services across nine organisations supporting 241 people with intellectual disability, using questionnaires, observations and interviews.	The observational practice leadership measure had high internal consistency. Overall, practice leadership was poor. There were significant positive correlations between practice leadership scores and active support at the service-user level and service level. Significant positive correlations were found between the amount of time people received contact from staff and practice leadership at the service-user level and service level. Significant positive correlations were found between quality of practice leadership and time spent engaging in meaningful activity at the service-user level. Services where practice leadership was better provided better Active Support and had more engaged service-users.
	Berlin Hallrup, Kumlien, & Carlson (2018)	Service managers' experiences of how the participation of people with intellectual disabilities can be promoted in Swedish group homes	Sweden	To explore service managers' experiences of how the participation of adults with intellectual disabilities can be promoted in Swedish group homes.	Exploratory Qualitative Study. Data were collected from 14 service managers of groups homes for adults over the age of 20 with intellectual disability who had autism or a condition resembling autism.	Two main themes were identified; 1) creating preconditions for participation which involved facilitating a trusting relationship with service users and supporting staff to increase participation; 2)

				Individual interviews explored perceptions of what participation for adults with intellectual disabilities means and how participation for adults with intellectual disabilities in a group home is facilitated.	barriers for promotion of participation which included restrictions hindering participation (i.e. low staff turnover, attitudes of next of kin, physical restrictions in group homes) and managing while experiencing a lack of support. Being present as a leader providing support and instant feedback to the staff in their efforts to include service users' needs and perspectives was a prominent strategy described by informants. Another important strategy for supporting staff was supervision. Informants regarded themselves as role-models and interacted in day-to-day practice by observing and providing supervision to staff, indicating the importance of supporting staff in enabling service-user participation.
Bould, Beadle-Brown, Bigby, & Iacono (2018a)	Measuring practice leadership in supported accommodation services for people with intellectual disability: Comparing staff-rated and observational measures	Australia	To compare an observational method of measuring practice leadership with staff ratings of practice leadership.	Data were collected from 29 front-line managers working across 36 services (seven worked across two services). Each service was at different stages of implementing active support. An expanded staff-rated practice leadership index was adapted from the SESQ and administered to staff members who knew the front-line managers well. Service user engagement, practice leadership, service user needs and characteristics and quality of support were also measured.	The staff-rated index and the observational measure of practice leadership shared no significant correlation. Staff rated their managers as having high practice leadership in the domains of allocating staff (69%), team meetings (97%) and overall practice leadership (90%), whereas the observed measure of practice leadership found managers had high practice leadership in the domains of coaching (62%) and supervision (62%). Overall observed practice leadership predicted Active Support.

Bould, Beadle-Brown, Bigby, & Iacono (2018b)	The role of practice leadership in Active Support: impact of practice leaders' presence in supported accommodation services	Australia	To investigate whether the presence of practice leaders is associated with better support and user outcomes.	Data were collected from 187 service users with intellectual disability from 58 services. User needs and characteristics, service user engagement and practice leadership were measured across two visits to the services.	Engagement levels and quality of support from staff were significantly better when a practice leader was present. For service users, time spent receiving assistance from staff and contact from staff were significantly higher in the presence of a practice leader. Overall, low levels of practice leadership were found across the services. Practice leadership was significantly higher in services where there was a practice leader present.
Bradshaw, Beadle-Brown, Richardson, Whelton, & Leigh (2018)	Managers' views of skilled support	England	To explore the views and experiences of managers of supported accommodation services around the aim of their service, their understanding of Active Support, and the challenges they face in fulfilling their role.	Semi-structured interviews were conducted with 35 service managers. Of the 35 services included in this study, 71% were classed as supported living and the rest were small group residential care services.	Managers had difficulties defining Active Support, often describing it as part of people's daily routines. They also discussed it in terms of treating people the same as others. For most managers, Active Support was seen as task focused with an emphasis on the person being engaged in doing something to achieve an end-result. Services varied in terms of how formal their approaches to implementation and monitoring were. Training was seen as useful but the classroom-based aspects were described as needing to be reinforced by practical support, including mentoring and on-the-job training. Cuts to funding posed the greatest challenges to service quality, as roles of

					frontline staff were reduced as a consequence of the cuts.
Deveau & McGill (2016b)	Impact of practice leadership management style on staff experience in services for people with intellectual disability and challenging behaviour: A further examination and partial replication	England	To examine additional staff experience factors with a different, larger sample and to partially replicate the findings of (Deveau & McGill, 2014).	This study was a survey of staff self-reported data collected as part of a larger study (Deveau & McGill, 2014).	Practice leadership was associated with staff experiences of lower stress and greater positive experiences in teamwork, job satisfaction and trust in manager. In this study, practice leadership was associated with staff being less likely to leave and in the earlier study no significant association was shown.
Deveau & McGill (2016b)	Practice leadership at the front line in supporting people with intellectual disabilities and challenging behaviour: A qualitative study of registered managers of community-based, staffed group homes	England	To examine the experiences of registered managers and explore how they seek to influence the behaviour of their staff (i.e. through practice leadership).	Data were collected using semi-structured interviews with 19 registered managers working in residential services for people with intellectual disability and challenging behaviour.	Five groups of themes emerged: Managers valued the importance of; (1) knowing what's going on and directly monitoring the support being provided to service users; (2) developing new practice and ways of working with service users; (3) their approach to developing and shaping staff performance; (4) the influence of employing and external organisations; (5) the influence of their personal feelings and 'value base'.
Deveau & McGill (2019)	Staff experiences working in community-based services for people with learning disabilities who show behaviour described as challenging: The role of management support	England	To investigate the self-reported experiences of staff working with people who may show behaviour described as challenging, and the impact on staff experiences of frequency of contact with service managers and of practice leadership.	A single point in time survey was conducted with a purposive sample of staff working with people with intellectual disabilities, who have exhibited behaviours described as challenging, living in group homes in the community. Senior managers of seven organisations providing residential services for people with learning	Staff experience of burnout, job satisfaction and likelihood to leave were greater with increased severity of challenging behaviour. Teamwork, trust in manager and recognition and incentives were not so related. The perceived severity of challenging behaviours was not significantly related to contact with service manager or with practice

				<p>disabilities were asked to select staff from group homes for people who may present challenging behaviours. A total of 420 questionnaires were distributed and 144 returned.</p>	<p>leadership. More frequent service manager contact was significantly associated with greater practice leadership. However, while more frequent contact with service managers was positively associated with greater practice leadership, reasonable levels of practice leadership were experienced at all levels of service manager contact, even by staff who reported contact as “rarely to none”. Overall, a practice leadership style of management has been shown to be associated with improved work experiences for staff working with people with intellectual disabilities.</p>
Gomes & McVilly (2019)	The characteristics of effective staff teams in disability services	Australia	To develop a consensus model of the characteristics of an effective staff team; addressing the question “what constitutes an effective staff team for the delivery of community-based disability services?”	<p>Participants comprised staff in the disability sector, including both government and community sector organisations, across a number of levels including direct-support staff and front-line managers. An online Delphi method was used, whereby disability support staff and their managers answered a series of surveys to build a consensus as to “what constitutes an effective team.” 29 participants completed the first round, 17 participants completed the second round, and 13 participants completed the third round.</p>	<p>The results indicate achieving client outcomes and observing positive respectful interaction among staff and clients (in the current study referred to as communication) have been found to be the most important measures of an effective disability support team. Recognising staff and rewarding them for good work (referred to here as leadership) is also important in building and sustaining an effective disability support team. Poor leadership was identified as the leading obstacle to building and sustaining an effective disability support team, and an obstacle to providing high-quality services.</p>

	Hume, Khan, & Reilly (2021)	Building capable environments using practice leadership	Scotland	To outline the development and piloting of a training intervention for social care staff that uses a capable environments framework to improve the quality of staff support. To evaluate changes in the quality of staff support and in levels of engagement and challenging behaviour for one of the individuals supported.	Single case study design. The participant was a young male with intellectual disability aged residing in a group home. Observations were conducted at baseline and again after the training programme.	The service user's level of engagement and staff interaction increased substantially following training. The service user also demonstrated a decrease in severity of challenging behaviour.
	Jones (2021)	Commentary on "Building capable environments using practice leadership"		To present a conceptual viewpoint highlighting the utility of active support in implementing capable environments and to extend this by presenting a three-tiered preventative model of positive behavioural support (PBS) in UK health and social care.	Provision of a commentary on "Building capable environments using practice leadership" by Hume, Khan and Reilly.	Training staff in Active Support and developing practice leadership help implement capable environments.
<u>Culture in group homes</u>	Bigby & Beadle-Brown (2016)	Culture in better group homes for people with intellectual disability at severe levels	Australia	To describe the culture of better performing group homes in terms of the five dimensions of culture.	Participants comprised staff and service users from three groups managed by 2 organisations. Resident characteristics and staff practices were measured using questionnaires, observation methods, and interviews.	Better group homes had supervisors with strong leadership who set expectations, provided feedback and lead by example. Supervisors worked with staff by modelling good practice and monitoring and correcting staff practice. Supervisors facilitated teamwork, ensuring common values and purpose among staff. Such values/purposes were recognising and respecting client preferences, engaging residents, and ensuring dignity, care and comfort. The responsibility for delivery of high quality support for service-users rested on all staff, and working practices were person-centred. The staff in better homes communicated effectively, and staff meetings

					involved discussion and acknowledgement of contributions. The managerial practices described are characteristic of practice leadership.
Bigby, Knox, Beadle-Brown, & Clement (2015)	"We just call them people": Positive regard as a dimension of culture in group homes for people with severe intellectual disability	Australia	To explore staff regard for residents in higher performing group homes.	Participants comprised staff and service users from three groups managed by 2 organisations. Resident characteristics and staff practices were measured using questionnaires, observation methods, and interviews.	Participants conveyed a strong sense of positive regard for residents who were seen as being 'like us'. It was generally apparent that staff attached little importance to the severity of the residents' intellectual disability in the way they went about their work and talked with residents. Aspects of the organizational structures and processes in houses such as recruitment, and induction of staff, rostering and practice leadership contributed to the production and reproduction of positive regard for residents.
Humphreys, Bigby, & Iacono (2020)	Dimensions of group home culture as predictors of quality of life outcomes	Australia	To examine dimensions of group home culture as predictors of quality of life outcomes.	This study used an exploratory, multivariate correlational research design. A cross-sectional survey was conducted of group homes for people with intellectual disabilities. Participants were 98 people with intellectual disabilities, 86 disability support workers and 21 front-line supervisors from 23 group homes managed by five participating organisations. The Group Home Culture Scale (GHCS) was used to measure staff perceptions of culture. QOL data were	Of the GHCS subscales, Effective Team Leadership and Alignment of Staff with Organizational Values significantly predicted residents' engagement in activities. Supporting Well-Being significantly predicted residents' community involvement. None of the GHCS subscales significantly predicted domestic participation and choice making. The findings suggest that strategies to improve Effective Team Leadership and Supporting Well-Being

				available from 98 people with intellectual disabilities.	dimensions of culture may contribute to enhancing certain QOL outcomes.	
	Humphreys, Bigby, Iacono, & Bould (2019)	Development and psychometric evaluation of the Group Home Culture Scale	Australia	To develop and evaluate the psychometric properties of an instrument to measure dimensions of organizational culture in group homes—named the Group Home Culture Scale (GHCS).	A mixed-methods sequential research design was used with the following stages (a) item development, (b) expert review, (c) cognitive interviews and (d) questionnaire administration. Data from 343 front-line staff were used for exploratory factor analysis.	The content and face validity of the GHCS were found to be acceptable. Exploratory factor analysis indicated that the GHCS measured seven dimensions of group home culture. Cronbach's alpha for the dimensions ranged from 0.81 to 0.92. The GHCS meets the recommended criteria for scale development (DeVellis, 2012; Wymer & Alves, 2013).
	Humphreys, Bigby, Iacono, Bould (2021)	Patterns of group home culture in organisations supporting people with intellectual disabilities: A cross-sectional study	Australia	To examine patterns of group home culture within disability organisations.	A cross-sectional survey was conducted of group homes for people with intellectual disabilities. A comparative, nonexperimental research design was used. The sample comprised 216 disability support workers and 44 frontline supervisors who worked across the 58 group homes. Staff perceptions of group home culture were measured.	In six of the organisations patterns were indicative of differentiated culture for one or more GHCS subscales. In three of the organisations patterns were indicative of integrated culture for one GHCS subscale. Examination of staff perceptions of culture suggested potential concerns in some group homes about perceived organisational support and priorities, as indicated by the relatively low scores on the subscale Collaboration within the Organisation.
<u>Measuring quality</u>	Hutchison & Kroese (2016)	Making sense of varying standards of care: The experiences of staff working in residential care environments for adults with learning disabilities.	England	To examine front-line staff experiences of working in residential care for people with intellectual disabilities.	Six care workers currently working in residential homes participated in the study. Semi-structured interviews were conducted with each participant.	Three overarching factors were consistently found to be important to the experiences of care workers: (1) the quality of their relationship experiences with colleagues, service users and managers; (2) the extent to which they experienced their role as being consistent or congruent with their underlying

					values and priorities, and the subsequent extent to which they were able to obtain intrinsic reward from their work; and (3) the impact of environmental and/or organisational constraints.
	McEwan, Bigby, & Douglas (2020)	Moving on from quality assurance: Exploring systems that measure both process and personal outcomes in disability services.		To identify quality systems that measure both processes and personal outcomes in disability services, and explore their content to determine any possible advantages and limitations that may be associated with using them.	An internationally accepted eight domain quality of life framework and a qualitative content analysis was used to map and evaluate the characteristics of three combined quality systems currently used in the disability sector.
	Quilliam, Bigby, & Douglas (2015)	Paperwork in group homes for people with intellectual disability.	Australia	To explore changes over time in the amount and types of paperwork in Victorian group homes.	A combination of enumerative and ethnographic content analysis techniques were used to examine paperwork described in two Victorian group home manuals, dated from 1988 and 2009.
<u>Broad Determinants of Quality in Group Homes</u>	Bigby, & Beadle-Brown, (2018)	Improving quality of life outcomes in supported accommodation for people with intellectual disability: What makes a difference?		To expose and synthesize the theories/ propositions about variables influencing service quality and quality-of-life outcomes for service users, and to review the strength of evidence	Realist literature review. A purposive sample of literature was selected via team meetings. An initial sample of 44 documents (academic and professional journal articles, evidence was strongest for the presence of staff practices (use of Active Support), front-line management practice (use of practice leadership), culture

		for these and identify their relative influence.	books, government and other reports and commentaries published between 1970 and 2010) was analysed to identify the theory/propositions they contained, and the value of particular variables and direction of effect. Evidence was reviewed for and against each of five clusters of propositions identified .	(enabling and motivating), human resources policies and practice (that support front-line leaders and recruitment of staff with the right values), adequate resources, and small, dispersed and homelike settings. The evidence informs policy and practice but in some clusters remains limited, warranting further research which measures outcomes on all QOL domains.
Collins, & Murphy (2022)	Detection and prevention of abuse of adults with intellectual and other developmental disabilities in care services: A systematic review.	To highlight the risk and protective factors for abuse of adults with intellectual and other developmental disabilities in such services. To identify any assessment tools or interventions to detect or to help to prevent abuse of adults with intellectual and other developmental disabilities in services.	Systematic review. Evidence related to how abuse is detected and prevented within services was reviewed. 48 articles were reviewed.	Several risk and protective factors were highlighted relating to victim characteristics (e.g., severity of learning disabilities and associated communication difficulties), perpetrator characteristics (e.g., low intrinsic motivation to work in care, limited ability to cope with increasing stress and perceptions of service-users as 'different' from them), and organisational factors (e.g., poor leadership, staff shortages and/or high staff turnover and lack of reflective practice). A key barrier to the detection of abuse was a lack of awareness and knowledge among staff regarding what constitutes abuse and when intervention is warranted. Recommendations for how abuse can be detected and prevented were made, including better staff training, supervision and monitoring of services.
Gormley, Healy, Doherty, O'Regan, & Grey (2020)	Staff training in intellectual disability and developmental disability settings: A scoping review	To investigate potential explanations for the limited dissemination of evidence-based practices to staff working in the	Scoping review. 156 studies published between the years 200 and 2018 were included in the review.	The studies reviewed provided staff training across a range of practices, however many empirically supported

			intellectual and developmental disability sector.		interventions were not utilized. The literature did not robustly evaluate effective protocols to disseminate these practices to frontline staff. There is a continued reliance on individualised training packages, rather than the implementation of empirically supported training models, and provides a possible explanation for the "theory-practice" gap. Only a relatively small number of included studies examined the impact of staff training on service user outcomes. Adult service users were underrepresented across all intervention categories, the majority of articles provided training to staff supporting children with intellectual or development disability.
Kahlin, Kjellberg, & Hagberg (2016)	Choice and control for people ageing with intellectual disability in group homes	Sweden	To explore how choice and control in the everyday life of people ageing with intellectual disability is expressed and performed in the group home's semi-private spaces.	45 staff members and 15 residents from four community-based group homes providing 24hr support for people with intellectual disability, and of having older residents, (i.e., aged 50 or older were selected to participate). A combination of participant observations and qualitative interviews were used to collect data.	The level of choice and control is continuously influenced by the physical, social, and cultural environment uniquely created in group homes. Findings showed that choice and control were restricted by the interplay between this environment and age-related physical and psychological functional decrease. Space and object, time and routines, privacy, and a person-centred approach were identified as central aspects influencing choice and control. Staff reported that it was harder to use person-centred approaches with older residents.

McGill, Bradshaw, Smyth, Hurman, & Roy (2020)	Capable environments	England	To outline the role played by different aspects of social, physical and organisation environments in preventing behaviour described as challenging in people with intellectual disabilities.	Conceptual elaboration drawing on research practice literature.	Community placements for people with intellectual disabilities should develop the characteristics of capable environments. Capable environments produce positive outcomes for individuals and their supporters such as enhanced quality of life, and prevent many instances of challenging behaviour. In many settings, there remain significant barriers to the provision or development of more capable environments. Most of these barriers reflect more general issues with bringing about organisational change.
Qian, Tichá, Larson, Stancliffe, & Wuorio. (2015)	The impact of individual and organisational factors on engagement of individuals with intellectual disability living in community group homes: A multilevel model.	USA	To examine how individual and organisational variables were associated with non-social and social engagement of individuals with intellectual disability.	Participants comprised 78 individuals with intellectual disability, 174 direct support professionals, and 21 supervisors from 21 US group homes. Direct observation and questionnaires were used to collect data.	Significantly lower levels of social engagement among individuals in group homes with severe to profound intellectual disability. Individuals with greater adaptive skills and who were supported by more competent staff showed significantly higher levels of social engagement. Individuals with less severe disability showed greater levels of non-social engagement however there was large variability between group homes that remained unexplained.

Worthington, Patterson, & Halder (2018)	Working with intellectually disabled autistic individuals – A qualitative study using repertory grids	England	To elucidate how care professionals/providers construe, understand and make sense of the characteristics that are important when providing care to adults with an intellectual disability and autism spectrum disorder (ASD), based on their experiences of working within their roles within a residential care setting.	Participants comprised of ten care professionals and providers, including team leaders, support workers, one member of the executive management team and one clinical member of staff, working at a community autism and intellectual disability service. Each participant was interviewed. A Repertory Grid Technique (RGT) was used to collect data in a constructivist approach.	Ten themes were identified for working effectively with people with autism and intellectual disabilities; making autism-specific adaptations, approachable, reflective/self-aware, strong understanding of their residents/empathetic, benevolent, empowering, follows plans consistently, confident in ability to support residents with autism, resilient, respectful. The “empowering” theme maps directly onto that taught in the Active Support training.
Quilliam, Bigby, & Douglas (2018)	How frontline staff manage paperwork in group homes for people with intellectual disability: Implications for practice.	Australia	To explore how frontline staff use paperwork in group homes for people with intellectual disability and identify implications for practice.	Constructivist grounded theory methodology. Participants comprised staff members and residents of group homes. Semi-structured interviews and participant observations were conducted to collect data.	Staff reported feeling overwhelmed at times with the prescriptive nature of the paperwork rules, and approached these rules from their own pragmatic standpoint. Staffs' paperwork practices varied between services, however they had two overarching approaches: trying to follow the rules and managing the rules. Paperwork was purposefully managed to enable staff to focus on their core responsibility of supporting residents.

<u><i>Views of people with disabilities</i></u>	Clarke, Dagnan, & Smith (2019)	How service-users with intellectual disabilities understand challenging behaviour and approaches to managing it	England & Ireland	To elicit detailed descriptions of how people with intellectual disabilities understand their own challenging behaviour, as well as their perceptions of the factors and processes that have shaped these understandings, and the impact of these understandings on their overall well-being.	Participants comprised of eight people with intellectual disability were users of the services of a National Health Services Trust in England and a private specialist learning disability service in Ireland and presented with varying forms of challenging behaviour. Data were collected through individual semi-structured interviews.	Three major themes emerged. 1) Challenging behaviour was understood as occurring due to either internal or external factors, with different understandings having different implications for how participants attempted to manage behaviour. 2) Positive relationships were viewed to have a more long-term beneficial relationship with challenging behaviour, acting as a buffer, whereas negative relationships could lead to challenging behaviour by creating triggering situations. 3) A greater ability to exert power and control in day-to-day life was perceived to promote long-term reductions in challenging behaviour.
	Evans & Gore (2016)	Staff behaviours valued by service users: Views of people whose behaviour challenges	England	To examine the perspectives of people with intellectual disabilities and behaviour that challenges on staff behaviour and qualities they thought make a good support worker.	Participants comprised of 17 people with mild to moderate intellectual disability and behaviour that challenges. Participants were receiving between 23 and 103 hours per week of one-to-one support from an organisation. All participants had previously experienced a range of service settings and had significant experience of staff support. Individual semi-structured interviews were conducted.	Among positive staff behaviours or characteristics that participants valued were being kind or nice, staff having a sense of humour or ability to make participants laugh, staff treating them 'in a good way', being 'caring', generous, 'honest', 'talkative' and having patience. Participants also valued being helped, staff understanding what was important to them, and staff making time for them. Staff behaviours that participants did not value included staff being too controlling, being too busy or not providing enough support, and being disrespectful in how they spoke to them.

Giesbers, Hendriks, Jahoda, Hastings, & Embregts (2018)	Living with support: Experiences of people with mild intellectual disability	Netherlands	To develop a better understanding of the unique experiences, challenges and needs of adults with mild intellectual disability with regard to their support.	Participants comprised of six individuals with mild intellectual disability, living in community-based settings. All participants received support within a clustered care setting and had set times for one-to-one support, but they were able to ask for additional support 24 hr a day. Staff were either based in the same or an adjacent building. Individual semi-structured interviews were conducted with each participant.	All participants valued staff being there for them, although this held various meanings for them. Relationships with staff played a more central role in the lives of participants when they had few other friendships or close relationships. Continuity of support was very important to participants. For example, a few participants reported a negative impact of high staff turnover; 3) The third theme concerned participants views of their disability and need for support and the impact this has on their sense of self and wider lives. For example, participants talked about their experiences of stigma related to the fact that they receive support. Participants also talked about their struggles with identity and accepting their disability, and their struggles accepting and receiving support from others.
Shipton & Lashewicz (2016)	Quality group home care for adults with developmental disabilities and/or mental health disorders: Yearning for understanding, security and freedom	Canada	To uncover and understand factors influencing quality of care received by adults with developmental disabilities and/or mental health disorders living in group homes.	This study is a secondary analysis of focus group data collected as part of a broader project funded by the Canadian Institutes of Health Research (CIHR), titled 'Aging well with pre-existing disabilities: Understanding and supporting sibling support'. There were data from 52 participants in nine focus group discussions, comprising adults with developmental disabilities and/or mental health disorders, and their family and paid caregivers.	Principles and practices of social inclusion and self-determination are central to the themes identified in participants' descriptions of what constitutes quality group home care. Family member participants described the importance of staff approaches that facilitate social inclusion and self-determination according to two main themes of supporting adults with developmental disabilities and/or mental health disorders in (i) being understood, and (ii)

	Stewart, Bradshaw, & Beadle-Brown (2018)	Evaluating service users' experiences using Talking Mats®	England	To establish the effectiveness of Talking Mats® (TM) in evaluating service users' experiences, and explore their views of the implementation of Person-Centred Active Support.	Participants comprised 8 individuals with a moderate-severe learning disability and were sampled from a supported living provider. A mixed methods pre-post study was used. Qualitative interviews and observations were carried out prior to Person Centred Active Support training and, again, 6-12 months after the completion of training.	experiencing security and freedom in their living environment. Overall, results indicated inconsistent implementation of Active Support. The quality of service provided was variable both before and after the intervention, with “poor”, “mixed” and “good” support being provided to individuals supported within the same service. Participants reported dissatisfaction with aspects of staff behaviour related to interpersonal skills and it seems likely that staff who have poor rapport with service users may find it difficult to implement other aspects of Active Support, resulting in variable service quality.
<u><i>Views of family members of people with intellectual disability</i></u>	Bright, Hutchinson, Oakes, Marsland (2018)	Families' experiences of raising concerns in health care services: An interpretative phenomenological analysis	England	To increase understanding of the experiences of families of people with intellectual disabilities when noticing and raising concerns in services. A	Seven participants (all female) were recruited through local and national voluntary agencies; five were mothers of people with intellectual disabilities, one was the aunt and one the sister. Participants took part in semi-structured interviews centred on their experiences of noticing and raising concerns, these were recorded and transcribed. The data were analysed using interpretative phenomenological analysis.	There were three superordinate themes: the nature and importance of concerns, relationships between families and staff and the process of raising concerns. A key and surprising finding was the importance of “the little things.” This research highlights important implications for services such as the need to simplify the process of raising concerns, attend to the relationship with families and ensure advocacy services are identified for those without family.
	Jansen et al, (2018)	Do they agree? How parents and	Netherlands	To explore agreements in the way parents of a person with profound	An adapted version of the Dutch Measure of Processes of	In general, the parents and the professionals disagreed on

	professionals perceive the support provided to persons with profound intellectual and multiple disabilities		intellectual and multiple disabilities and professionals perceive the support in terms of its family-centredness in order to gain a better understanding of their collaboration.	Care was completed by 109 parents, and an adapted version of the Dutch Measure of Processes of Care for service providers was completed by 144 professionals. Agreements between parents and professionals were analysed using multilevel analysis.	occurrence and importance of both the Enabling and Partnership scale and the Respectful and Supportive Care scale. In order to deliver family-centred support, service providers should be aware that there are disagreements between the parents' perception of what is important in the support provided and the perception of the professional.
Koelewijn, Lemain, Honingh, & Sterkenburg (2021)	View of relatives on quality of care: Narratives on the care for people with visual and intellectual disabilities	Netherlands	To explore the views of relatives regarding the quality of care and support for people with visual and intellectual disabilities.	Qualitative exploratory design. Participants were relatives (parents, siblings, or in one case an uncle) of people with visual and intellectual disabilities having experience with multiple group-homes of specialised care organisations. All people lived in a central residential setting (i.e. one location with group-homes for people with a visual and intellectual disability receiving care on a 24 hour basis). 12 semi-structured interviews were conducted.	Relatives wish to be involved in the care that the person with disabilities needs and receives. They would like to be seen as partners of care professionals in providing the needed care and support and wish to be contacted if choices or decisions are made. It is important for people with a disability living in a group-home to be respected as a person by care professionals, to be able to learn new things, to receive structured care by familiar carers and to feel safe and at home in the group-home.
McKenzie, K., et al. (2018).	The views of carers about support for their family member with an intellectual disability: With a focus on positive behavioural approaches.	England	Explored the views of family carers about the support that their adult children with an intellectual disability had received in relation to their behaviour that challenged.	Semi-structured interviews with eight family carers, of people with intellectual disability, four of whom lived in supported accommodation. Data were analysed using inductive thematic analysis	Four key themes. Good support, of which PBS was an example, was seen as both having reduced behaviours that challenged and having a wider positive impact on the quality of life of the individual and their families. Key features highlighted were: technical knowledge and skill; a strong value base of warmth, acceptance and respect; a

Healthy Lifestyle	collaborative, consistent approach; open communication; and the extension of support to the family carer when needed. It was recognised that there is a need for broad systemic change and for the application of a workforce development model that takes account of the needs of staff, carers and those working in wider systems that have contact with people with an intellectual disability.					
	Chadwick (2017)	Dysphagia management for people with intellectual disabilities: Practitioner identified processes, barriers, and solutions	England	To identify: 1. The process of dysphagia management with adults with intellectual disability and those typically involved; 2. The barriers to dysphagia management for adults with intellectual disability as identified by the health professionals working in this field; 3. Current practices found to be successful in reducing these barriers; 4. Strategies that have been less successful in reducing barriers.	Exploratory Descriptive Study. A brief survey containing open-ended questions was completed by 38 practitioners working in dysphagia management (37 speech & language therapists, 1 dietician) about the way their service operates, the barriers they have faced in providing support around managing dysphagia, and the solutions and strategies they have found useful.	Dysphagia management typically involved referral and assessment, development of an intervention strategy, communication and negotiation, education and training in safe dysphagia management and monitoring, evaluation, and assessment. Numerous barriers to involvement, assessment, management implementation, ongoing adherence and organisational barriers were identified however, stakeholder beliefs, knowledge, and feelings underpinned many of them. Good communication and interaction between all involved appeared to underpin all strategies that were found to be effective in dysphagia management. Good dysphagia management was also underpinned by building relationships, person-centred practice and responsiveness, pragmatism and innovation in training, and disseminating

Chadwick, Chapman, & Davies (2018)	Factors affecting access to daily oral and dental care among adults with intellectual disabilities	England	To identify factors influencing engagement in day-to-day oral and dental health care for adults with intellectual disabilities.	The participants were people with intellectual disabilities and their family and paid caregivers (N=372). A majority of the participants lived in group homes and a smaller number were living with family. A dental epidemiological survey comprising open-ended questions was used to collect data regarding the lived experiences of daily oral care of people with intellectual disabilities and their carers. These survey questions administered via face-to-face or telephone interviews.	dysphagia management information.
Dixon-Ibarra, Driver, Nery-Hurwit, & VanVolkenburg (2018)	Qualitative evaluation of a physical activity health promotion programme for people with intellectual disabilities in a group home setting.	USA	To complete a process evaluation of the Menu-Choice Physical Activity programme to receive descriptive information about programme implementation and feedback for programme refinement.	Twelve interview participants were recruited from the group home agency that completed the Menu-Choice activity pilot intervention. Five residents with mild to moderate intellectual disability and 7 support staff participated in the semi-structured interviews.	A strong focus on personal characteristics as barriers was evident; in particular, the presence of behaviours considered obstructive to daily care, a dislike of oral care, pre-existence of oral health problems, problems remembering and understanding how to brush and problems coordinating and holding the toothbrush. Social and environmental factors were often seen as facilitators and included caregiver support, equipment and adaptations used and oral hygiene routine. The lack and inconsistencies of programme use were most apparent. The reluctance to change routines to implement a health promotion programme was a difficult barrier to overcome in this study. Future implementation should consider whether staff and agency providers are ready to implement a programme. Sites with the lowest programme use mostly provided barriers for its implementation such as negative attitudes about activity and programme implementation, insufficient coordinator training and only one staff implementing the programme. Residents felt unsupported and frustrated that they were not able to be active

					because of the barriers expressed by the staff (i.e., lack of time, shortage of staff, negative attitudes, staff programme burden, limitations). Sites that described more success with the programme provided facilitators that aided with implementation and felt positively about the programme materials.
Dixon-Ibarra, Driver, VanVolkenburg, & Humphries (2017)	Formative evaluation on a physical activity health promotion program for the group home setting	USA	To conduct a process evaluation to describe the preliminary outcomes and feasibility of using the Menu-Choice Physical Activity Program.	Fourteen program coordinators, 22 staff, and 18 group home residents with intellectual disability participated. Program coordinators trained the support staff within their group homes. Baseline assessments from staff and residents were obtained prior to implementation. Following baseline assessment, the group homes were instructed to use the program materials for 10 weeks. After the implementation period, post assessments of the program were conducted. Data were collected using surveys, qualitative feedback, completed program materials and measures of health outcomes.	General feedback from staff about the program training was positive. Fidelity scores of basic Menu-Choice components from the survey indicated low use of the program materials, particularly goal evaluation sheets, and the physical activity knowledge section. Resident's knowledge about physical activity did not change from baseline to post intervention. Data indicates that residents likely did not change their physical activity behaviour from pre to post pilot study. Resident body weight did not substantially change from baseline, post, to follow up. The review of the program indicated that staff and residents needed additional supports to implement the program more sufficiently.
Janson, Moen, & Aure (2021)	Introducing a nutritional app in supervised residences for independent living: Experiences of individuals with	Norway	To explore the feasibility of a tablet-based app about nutrition called APPetitus, among individuals with intellectual disability and their formal	Four full-time care staff, 2 managers, 1 professional development advisor and 5 people with intellectual disability living in supervised, independent residences	The residents showed more initiative in wanting to understand and participate in their nutritional care, while the carers were given an opportunity to engage in food-

	intellectual disabilities and their caregivers.		caregivers in supervised, independent residences.	participated in the study. Carers were responsible for introducing the APPetitus app to the residents and give follow-up support. Carers were first introduced to the app and its functionality by the researchers. Data was collected in semi-structured dyad interviews with care staff and residents before and after the trial period, and in focus group interviews with care staff and managers.	related conversations without challenging the residents' autonomy. In conversation about dietary behavioural changes, both parties can be active participants, thereby increasing the residents' opportunity to make choices, explain or reflect on choices, and participate in relevant conversations.
Leser, Pirie, Ferketich, Havercamp, & Wewers (2018)	The perceived role of direct support professionals in the health promotion efforts of adults with developmental disabilities receiving support services	USA	To explore how developmental disability community agency administrators, direct support professionals, family members, and adults with developmental disability define "health" for people with developmental disability, as well as how they perceive the role of direct support professionals in the health promotion efforts of the individuals they serve. Additionally, to understand the barriers to health promotion for people with developmental disability and the ways to overcome these barriers.	Participants comprised developmental disability agency administrators, direct support professionals, family members, and people with developmental disability. Six focus groups were conducted with a total of 48 participants.	There is no one single definition of health that is applicable to all people with developmental disability because of the individualized needs and differences within the population. Some participants thought that direct support professionals actively make choices for the person they support, while others thought that making healthy or unhealthy behavioural choices should be left to the person with disability. Barriers included fear of violating the rights and autonomy of people with developmental disability, limited income, limitations pertaining to specific disabilities, general lack of motivation/interest in helping people with disability practice to be healthy, high turnover rates in the field/lack of continuity of care, unenforceable policies, and lack of training on health promotion.

O' Leary, Taggart, & Cousins (2018)	Healthy lifestyle behaviours for people with intellectual disabilities: An exploration of organizational barriers and enablers	Ireland	To explore the organizational barriers and enablers to staff supporting people with intellectual disabilities to engage in regular physical activity and a healthy diet.	Participants comprised 21 staff (i.e., support/care workers and 11 managers from organisations providing supported living and residential services for people with intellectual disabilities. Four focus groups were conducted with the staff and 11 phone interviews were conducted with managers. Qualitative data were collected.	Findings demonstrated that the promotion of healthy lifestyles for people with intellectual disabilities was not normalized or valued within the organization cultures. Stronger values were attached to reacting to health issues as opposed to taking steps to promote healthy behaviours, thereby leading to a healthier population. Greater value was attributed to addressing administration tasks, daily routines and behavioural problems within the culture of the organization and role of the staff members. Staff within the organizations appeared to resist change, and identified resource barriers related to time and workload as challenging capacity to implement and sustain a health promotion change.
Marks et al. (2019)	Effectiveness of a Health Messages Peer-to-Peer Program for People With Intellectual and Developmental Disabilities	USA	To examine the effectiveness of a peer-led health promotion program for people with intellectual and developmental disability.	Single group, repeated measures design. Participants comprised of 3 groups: peer health coaches and peer participants with intellectual and developmental disability and staff mentors from community organisations. Participants with disability lived in a variety of settings ranging from group homes, supported living arrangements, and with their families. The <i>Health Messages Program</i> ran for 12-weeks. Data collection occurred at two time-points, before and immediately after participation in the program.	Following the program, the peer health coaches had significant improvement in physical activity and hydration knowledge, mentors had significant improvement in self-efficacy scores, and peer participants had significant improvement in physical activity and hydration knowledge, social supports, and total health behaviours.

					Self-efficacy, health advocacy, health knowledge, health behaviours, social support and process evaluation were measured.	
	Vlot-van Anrooij et al. (2020)	How can care settings for people with intellectual disabilities embed health promotion?	Netherlands	This study aimed to identify and prioritize ideas for physical activity and healthy nutrition in the living environment of people with intellectual disabilities from their own perspective.	Participants comprised people with moderate intellectual disabilities and family and care professionals of people with severe/profound intellectual disabilities (N=51). The people with intellectual disabilities lived in group homes or participated in day activities provided by an intellectual disability care provider. Group meetings were used to generate and rank ideas on assets supporting healthy nutrition and physical activity in Dutch intellectual disability care settings.	185 ideas were identified in the group meetings. These fell into three overarching themes: 1) People - the ideas focused on how the social network can support healthy living, the conditions for a stable network and dilemmas in providing support such as encourage support and having open conversations.; 2) Places - ideas related to tools, facilities, person-environment fit and accessibility such as healthy home environment, enabling environment and accessibility; 3) Preconditions - ideas related to health care and prevention, financial aspects and health-promoting organisation policies. Participants ranked the importance of clusters of ideas. Encouraging support and supportive network were ranked as most important, and an open conversation the least important.
<u>Impact and Implementation of Positive Behaviour Support</u>	Bosco et al. (2019)	Process evaluation of a randomised controlled trial of PBS-based staff training for challenging behaviour in adults with intellectual disability	England	To conduct a process evaluation of a national clinical trial investigating the impact of Positive Behaviour Support (PBS) based staff training on the level of challenging behaviour in adults with intellectual disability.	Semi-structured interviews with 62 stakeholders from the intervention arm (service users with mild/moderate intellectual disability, family and paid carers, service managers, staff who delivered the intervention and Positive Behaviour Support trainers), quantitative data from the	Overall results from the trial revealed that the Positive Behaviour Support-based staff training did not reduce challenging behaviour for people with intellectual disability compared to treatment as usual. Stakeholders reported an appreciation of Positive Behaviour Support and its

				study database and an external evaluation of the quality of the Positive Behaviour Support plans were used.	potential to impact quality of care and engagement with the participant. However, important challenges were also identified including managing Positive Behaviour Support-related caseloads, paid carer turnover and service commitment to the delivery of Positive Behaviour Support.
Hassiotis et al. (2018)	Clinical outcomes of staff training in positive behaviour support to reduce challenging behaviour in adults with intellectual disability: Cluster randomised controlled trial	England	To evaluate whether such training is clinically effective in reducing challenging behaviour during routine care.	Cluster randomised controlled trial. 23 community intellectual disability services in were randomly allocated to manual-assisted staff training in Positive Behaviour Support (n = 11) or treatment as usual (n = 12). Treatment as usual included any treatment approach that is available to community intellectual disability teams within the National Health Service. Data were collected from 246 participants with intellectual disability and challenging behaviour.	No significant reductions in carer-reported challenging behaviour in the intervention plus treatment as usual arm compared with the treatment as usual arm alone over 12 months. The findings suggest that training the community intellectual disability services staff in Positive Behaviour Support, as delivered in this study, was no more effective than treatment as usual in reducing challenging behaviour.
Hastings et al. (2018)	Who's Challenging Who training for staff empathy towards adults with challenging behaviour: Cluster randomised controlled trial	England	To evaluate the effectiveness of the Who's Challenging Who? training course on staff empathy for people with intellectual disability and challenging behaviour.	Cluster randomised controlled trial. A total of 118 residential settings were randomised to either the waiting list control group or the intervention training group. Residential settings supporting between one and 10 people with intellectual disability, and provided at least some 24h support were included. Two staff members from each residential setting participated (N=236). Twelve training	Increased staff empathy for people with challenging behaviour was reported among staff in the intervention group at 20 weeks post-randomisation, however this effect was small and not statistically significant. The study found insufficient evidence to suggest that the Who's Challenging Who? training was effective.

				<p>sessions were delivered by people with intellectual disability to staff, and supported by a trainer without intellectual disability. Outcome measures were collected at baseline (i.e., prior to randomisation), 6 weeks and 20 weeks post-randomisation. The primary outcome measure was staff self-reported empathy for people with challenging behaviour, measured at 20 weeks post-randomisation.</p>	
Mahon, Walsh, Holloway, & Lydon (2021)	A systematic review of training methods to increase staff's knowledge and implementation of positive behaviour support in residential and day settings for individuals with intellectual and developmental disabilities		To evaluate procedures used to train staff in positive behaviour support, on both knowledge of positive behaviour support and implementation of behaviour support plans among staff supporting individuals with intellectual and developmental disabilities in residential or day settings.	Systematic review. Evidence was evaluated from 18 studies measuring knowledge, implementation, or both.	Description, modelling, feedback and role-play were the most commonly used training components in different combinations across all the implementation studies. Description was the most commonly used training component, however when used in isolation did not consistently result in increasing staff knowledge of positive behaviour support.
McGill et al. (2018)	Reducing challenging behaviour of adults with intellectual disabilities in supported accommodation: A cluster randomized controlled trial of setting-wide positive behaviour support	England	To evaluate the implementation of setting-wide positive behaviour support in improving the quality of social care in supported accommodation settings.	Cluster randomised controlled trial. Quality of support, quality of life and challenging behaviour were measured at baseline and after intervention with challenging behaviour being additionally measured at long-term follow-up 12–18 months later. 24 residential settings each supporting 1-8 people with disability were randomly allocated to the intervention group or the	Social care practice and quality of support improved significantly in the experimental group. Ratings of challenging behaviour declined significantly more in the experimental group and the difference between groups was maintained at follow-up. Quality of life improved in experimental settings however this difference was not significant.

			control group. Settings in both groups had access to individualised positive behaviour support, however additionally within the experimental group, social care practice was reviewed and improvement programmes set going.	
Mc Gill & Breen (2020)	Can sensory integration have a role in multi-element behavioural intervention? An evaluation of factors associated with the management of challenging behaviour in community adult learning disability services	To evaluate whether sensory integration has a role in multi-element behavioural intervention in order to manage challenging behaviour and reduce the potential need for restrictive interventions in the community for adults with a learning disability.	Literature review. Seven intervention studies were included in the review. Participants in the studies resided in community supported living.	The use of restrictive intervention is still an issue in community practice. Services are slowly beginning to incorporate primary preventative strategies such as positive behaviour support to manage challenging behaviour for adults with an intellectual disability. Positive behaviour support and multi-element intervention were used within all the behavioural studies with positive results. Although Positive behaviour support involves functional analysis, it does not specifically focus on sensory risks as a potential contributing factor to challenging behaviour for adults with an intellectual disability.

Appendix B

Search terms used for each search.

Combined search

("intellectual disabilit*" OR "mental retardation" OR "down syndrome" OR "mental* handicap*" OR "intellectual* handicap*" OR "learning disabilit*" OR "cognitive disabilit*" OR "developmental disabilit*") AND ("intellectual disability service*" OR "shared supported accommodation" OR "support* accommodation service*" OR "group home*" OR "disability service*" OR "residential service*") AND adult* AND ("active support" OR "practice leadership" OR "positive behaviour support" OR "behaviour support plan") AND ("challenging behavio*" OR "behavio* of concern") AND ("staff practice*" OR practice* OR "restrictive practice*") OR (view* OR percept* OR experience* OR opinion* OR perspective*) AND ("service quality" OR regulat* OR quality) OR ("model of practice" OR "best practice" OR "quality of life influence")

People with autism and group homes

"developmental disabilit*" OR "autism spectrum disorder" OR autism OR autistic AND "intellectual disability service*" OR "shared supported accommodation" OR "day service*" OR "support service*" OR "support* accommodation service*" OR "group home*" OR "disability service*" OR "residential service*" OR "community service" AND adult*

Positive Behaviour Support in group homes

"intellectual disabilit*" OR "mental retardation" OR "down syndrome" OR "mental* handicap*" OR "intellectual* handicap*" OR "learning disabilit*" OR "cognitive disabilit*" OR "developmental disabilit*" OR "acquired brain injur*" AND "intellectual disability service*" OR "shared supported accommodation" OR "day service*" OR "support service*" OR "support* accommodation service*" OR "group home*" OR "disability service*" OR "residential service*" OR "community service" AND "positive behaviour support" OR "behaviour support plan" AND "challenging behavio*" OR "behavio* of concern" AND "staff practice" OR practices OR "restrictive practice"

Family and individual perceptions of support in group homes

"intellectual disabilit*" OR "mental retardation" OR "down syndrome" OR "mental* handicap*" OR "intellectual* handicap*" OR "learning disabilit*" OR "cognitive disabilit*" OR "developmental disabilit*" OR "acquired brain injur*" AND "intellectual disability service*" OR "shared supported accommodation" OR "day service*" OR "support service*" OR "support* accommodation service*" OR "group home*" OR "disability service*" OR "residential service*" OR "community service" AND View* OR percept* OR experience* OR opinion* OR perspective* AND "service quality" OR regulat* OR quality

Active Support and group homes

"intellectual disabilit*" OR "mental retardation" OR "down syndrome" OR "mental* handicap*" OR "intellectual* handicap*" OR "learning disabilit*" OR "cognitive disabilit*" OR "developmental disabilit*" AND "active support"

Practice Leadership and group homes

"intellectual disabilit*" OR "mental retardation" OR "down syndrome" OR "mental*
handicap*" OR "intellectual* handicap*" OR "learning disabilit*" OR "cognitive disabilit*"
OR "developmental disabilit*" AND "support service*" OR "supported accommodation
service*" OR "group home*" OR "disability service*" OR "residential service*" OR
"community service*" AND "practice leader*" OR leadership OR "frontline manage*" OR
"front line manage*" OR supervisor OR "house supervis*" OR management OR manager*
OR coaching