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Naturalistic Decision-Making Processes of Multidisciplinary Teams that
Facilitate Community-Living Options for Adults with Intellectual Disabilities

By

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Abstract

In Ireland, multidisciplinary teams (MDTs) such as those comprising healthcare and social care professionals, as well as senior managers, are tasked with the implementation of the national deinstitutionalisation programme for people with disabilities in Ireland. The main aim of this study was to explore the decision-making processes of MDTs who were involved in transferring adults with an intellectual disability (ID) to dispersed housing in the community. The objectives of the study were as follows: (1) to determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community; and (2) to determine the factors that MDTs considered in their discussions when transferring an adult with an ID to dispersed housing in the community.

This study adopted an exploratory multiple-case study research design. Twenty-eight MDT members from various service providers took part in five different focus group discussions and five senior managers from each of the service providers were interviewed.

Findings indicated that four of the five MDTs in focus groups used all six decision-making task processes when considering transferring an adult with an ID to community housing. The sequential pattern of the decision-making task processes of *describing*, *recommending* and *planning* were the most frequently used, followed by *predicting* and *explaining*. The least used decision-making task process was *constructing hypothesis*. MDTs considered a myriad of factors when making decisions to move adults with an ID from campus-based to community-based settings. Five overarching themes emerged namely, *client profile*, *deinstitutionalisation*, *resources*, *person-centredness* and *ethos*.

The present study has contributed to the body of knowledge by identifying the Naturalistic Decision-Making (NDM) framework as a suitable framework that could be used by MDTs for exploring the task decision-making processes. The present study also highlighted theoretical and practical implications applicable to MDTs' decision-making process within the ID field, as well as implications for policy in the deinstitutionalisation process within the Irish context.

Author's Declaration

I, **Precious Jenga** certify that this doctoral thesis is my own work and that I have not used this work in the course of another degree, either at the Institute of Public Administration/University College Dublin or elsewhere. I declare that I took reasonable care in ensuring the originality of the work and, to the best of my knowledge, it does not breach copyright law.

Signed:

A handwritten signature in black ink, appearing to read 'Precious Jenga', written in a cursive style.

Student number: 13208801

Date: 22.03.2021

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To my dear friend and colleague Roisin Kinahan, your willingness to partake in the coding process of this study was highly appreciated. As a second coder your extensive experience in intellectual disability was invaluable. Thank you for being there for me during this journey.

I am extremely grateful to all participants from the National Federation of Voluntary Bodies and the HSE who took part in this study. Many thanks also to those who assisted in distributing invitation letters, consent forms, information sheets and booking rooms for focus group discussions and Interviews.

On a personal note, I would like to dedicate this thesis to my late husband, Jeffrey Sikhumbuzo Mnguni. I would not have started this journey had it not been for your encouragement and reassurance. Thank you for believing in me. I am sad that you are not around to see my final results.

List of Abbreviations

Abbreviation	Explanation
AAC	Augmentative Alternative Communication
AAIDD	American Association on Intellectual and Developmental Disabilities
ABS-RC	Adaptive Behaviour Scale-Residential and Community
AON	Assessment of Need
CIPFA	Chartered Institute of Public Finance and Accountancy
CTC	Community Transition Coordinator
CTM	Community Transfer Model
EASPD	European Association of Service Providers for Persons with Disabilities
EBT	Evidence-Based Treatment
EU	European Union
FG	Focus Group
UN	United Nations
HIQA	Health Information and Quality Authority
HRB	Health Research Board
HSE	Health Service Executive
ID	Intellectual Disability
INT	Interviewee
IT	Information Technology
JSNA	Joint Strategic Needs Assessment
MHC	Mental Health Commission
MDT	Multidisciplinary Team
NDA	National Disability Authority
NASET	

	National Association of Special Education Teachers
NDM	Naturalistic Decision-Making
NFVB	National Federation of Voluntary Bodies
NIDD	National Intellectual Disability Database
OECD	Organisation for Economic Co-operation and Development
OT	Occupational Therapist
PCP	Person-Centred Plan/Planning
RPD	Recognition-Primed Decision
SA	Situational Awareness
SIS	Support Intensive Scale
SLT	Speech and Language Therapist
SRV	Social Role Valorisation Model of Support
VFM	Value for Money: Value for Money and Policy Review of Disability Services in Ireland. Report produced by Department of Health (2012)
UK	United Kingdom
USA	United States of America

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1 CHAPTER ONE: INTRODUCTION

1.1 Introduction to the Background of the Problem

Social inclusion and community participation are considered rights under the United Nations (UN) Convention on the Rights of Persons with Disabilities. Specifically, Article 19 of the Convention recognises the right of all people with disabilities to live in community settings (UN, 2006). The UN, therefore, requires governments to take appropriate measures in facilitating people with disabilities to move from institutions to community-based settings (Mansell, Knapp, Beadle-Brown & Beecham, 2007; McConkey, Bunting, Ferry, Garcia-Iriarte & Stevens, 2013; Tatlow-Golden et al., 2014). In Ireland, the policy environment within the disability sector is changing, as evidenced by the development of a number of reports. Recent reports aimed at facilitating deinstitutionalisation include *Value for Money and Policy Review of Disability Services in Ireland* (Department of Health, 2012) and *Time to Move on from Congregated Settings: A Strategy for Community Inclusion* (Health Service Executive (HSE) (2011). The latter report is the subject of this study. It is known in the vernacular as the *Congregated Settings Report* of 2011 or *De-congregation* and is referred to as the former throughout the current study.

Professionals tasked with the implementation of the *Congregated Settings Report* of 2011 include multidisciplinary teams (MDTs), namely, healthcare, social care and administrative/management professionals on a team, with complementary skills, working together with a service user (person with an intellectual disability (ID)) and families to make effective decisions as a team, to ensure holistic care for the service user (MHC, 2006). Because MDTs make decisions on whether or not to transfer people to the community, it is pivotal to explore how these decisions are made. The problem is that in Ireland, the decision-making processes used by MDTs to move adults with an ID from congregated settings to the community-based settings have not yet been explored within the academic framework. Different theoretical frameworks are available that assist people in making decisions. Such frameworks include the naturalistic decision-making (NDM) framework, which describes how professionals make decisions in their natural environment (Klein, Orasanu, Calderwood & Zsombok, 1993).

Within that natural environment, it is important to look at contextual factors that may influence MDTs in their decision-making. This can be explored by examining the actual content of their captured discussions. The four main areas of literature reviewed for this study comprised policy, MDTs' decision-making processes, the NDM framework and contextual factors that impact on the decision-making of MDTs. Relevant aspects pertaining to these areas are presented throughout the present study.

This introductory chapter starts by defining an institution, deinstitutionalisation and community-based settings (1.2). It then moves on to define ID, provides a rationale for focusing on this type of a disability, and gives the reader an overview of international policy on deinstitutionalisation (1.3). The chapter highlights the two main Irish policies on deinstitutionalisation (1.4). This is followed by the introduction of Health Information and Quality Authority (HIQA) as a statutory body in Ireland and its role as a driving force to deinstitutionalisation (1.5). It then discusses Irish studies examining progress in deinstitutionalisation, quality-of-life outcomes and the cost associated with moving people to community-living options (1.6); it introduces the MDTs' decision-making processes (1.7); and gives an introduction to the theoretical framework of the NDM and the rationale (1.8). The chapter then states the purpose of the study and the Research Questions; (1.9; 1.10); specifies the relevance of the study and the expected contribution to the body of knowledge (1.11). Finally, it presents a summary (1.12) and concludes by giving a preview of the remaining chapters of the present study (1.13).

1.2 Definition of Institution, Deinstitutionalisation and Community-Based Settings

The European Association of Service Providers for Persons with Disabilities (EASPD) (2013) defines an institution as any place in which people with disabilities are isolated from the broader community and/or compelled to live together. Individuals are not allowed to exercise control over their lives and over decisions which affect them (EASPD, 2013; Mansell & Beadle-Brown, 2010). Deinstitutionalisation is a process of slowly abandoning large residential institutions and replacing them with small-scale services that enable people with an ID to live successfully in community-based settings (Mansell & Beadle-Brown, 2010).

Community-based settings are variously defined, according to Mansell and Beadle-Brown (2010). These settings include dispersed housing in the community, which may

be apartments and houses that are the same as those in which the majority of the population live, and located in different places in the community.

The two main types of dispersed housing are group homes and independent or supported living. Group homes are the focus of this study. They are viewed as providing a better quality of life and are as cost-effective as congregated settings (Mansell & Beadle-Brown, 2009, 2010). In group homes, typically three to eight people with an ID (including those with complex needs) live in a house in the community with staff supports. Typically, group homes are properties owned by service providers/organisations (Mansell & Beadle-Brown, 2009, 2010).

In the independent or supported living setting, people with disabilities rent or own their home and typically receive social care support from family or disability providers. Independent living affords independence and autonomy. The residents may share their home with people they choose, and have the same housing rights as other citizens (Mansell & Beadle-Brown, 2009, 2010).

Alternatives to dispersed housing are clustered housing, consisting of three types of model, as follows:

(1) Campus/congregated settings, which are often on the grounds of the institutions. They are not located in the community and typically serve people with higher support needs. In congregated settings, 10 or more people with a disability live together in a single living unit (HSE, 2011; HIQA, 2020). In most cases, people are grouped together and live in isolation, away from the community, family and friends. Many people in congregated settings may experience institutional living conditions, where they lack basic privacy and dignity (HSE, 2011; HIQA, 2020).

(2) Cluster housing or community clusters, which are generally located on a cul-de-sac in the community, where people with and without an ID live in small numbers in houses on the same site (Mansell & Beadle-Brown, 2009, 2010).

(3) Village/intentional communities, which are settings where individuals live in clustered housing in segregated settings away from the community. People with varying degrees of ID and other kinds of special needs live, work and share their lives with volunteer support workers, who work alongside qualified social care staff in communities such as the L'Arche and Camp Hill communities in Ireland (Kozma,

Mansell & Beadle-Brown, 2009; Linehan, et al., 2015; Mansell & Beadle-Brown, 2009, 2010).

Community living, by definition, does not equate with deinstitutionalisation. Some community options afford better outcomes, most notably dispersed community housing in the local communities (Mansell & Beadle-Brown, 2010). However, Abbot and McConkey (cited by Beadle-Brown, Mansel & Kozma, 2007) identify barriers to social inclusion for some people with an ID who lived in supported living or shared group homes in Northern Ireland. These barriers include personal abilities and skills, staff management of inclusion (for example, allowing and supporting people to go out), the location of the house within the community, and access to transport and community attitudes, as well as facilities available in the community.

Proponents of grouping people with an ID in separate communities argue that it is possible to achieve at least the same benefits as in dispersed housing (Mansell & Beadle-Brown, 2009). They propose three advantages of grouping people together, as follows:

(1) People living in clustered settings will have a richer social life.

(2) People will be safer. The authors point to exploitation and abuse in dispersed housing as evidence that quality of life will not necessarily be better among the general population.

(3) Overall costs will be lower because of economies of scale, that is, the cost of providing a service to residents decreases as the capacity of the service increases (Mansell & Beadle-Brown, 2009). Although the view about economies of scale is commonly held by organisations, it only comes into play in much more personalised supports for people with high supports (Stancliffe, Hayden, Larson & Lakin, 2002). Below is an overview of international policy on deinstitutionalisation, as evidenced in the literature.

1.3 Definition of Intellectual Disability, Rationale for Current Study, and Overview of International Policy on Deinstitutionalisation

Article 1 of the UN Convention on the Rights of Persons with Disabilities refers to people with disabilities as those who have long-term physical, mental, intellectual or sensory impairments, whose interaction in society must be placed on an equal basis with others (UN, 2006). Such disabilities include ID, which is the focus of this study.

An ID refers to a group of disorders that occur from birth and are characterised by long-term limited mental capacity (with an IQ of 70-75 or below) and difficulty with adaptive behaviours such as self-care, communication skills, choice-making, involved lifestyle (Schalock et al., 2010). The rationale for focusing on people with an ID is that in Ireland, they are overly represented in campus-based settings (Beadle-Brown et al., 2007). Mansell et al. (2007) report that Irish data revealed a total of 9,369 individuals with disabilities availing of residential services nationwide, of whom 8,228 were adults. Most individuals, 8,073, were identified as having an ID.

In Ireland, the National Intellectual Disability Database (NIDD) in 2017 indicated that there were 19,579 people registered with various degrees of ID, who were over the age of 18. A total of 4,353 were living in community group homes and about 2,000 were identified as living in residential centres. Others lived at home or in independent settings (NIDD, 2017). The recent figures from the National Ability Supports System (NASS) showed that ID was the most frequently reported primary type of disability, recording 17,481 people (NASS Bulletin, 2019). A total of 5,419 people with disabilities recorded on the NASS lived in congregated settings and 26 were reported to be living in unstable accommodation, such as a B&B/guesthouse or a hotel/hostel (NASS, 2019). HIQA reported that, by the end of 2019, there were 2,368 residential places registered in congregated settings (HIQA, 2020).

Since the early 19th century, large residential institutions existed in most European countries and remain so in many, as a form of service provision for people with disabilities (Mansell et al., 2007; Townsley, Ward, Abbott & William, 2010). More than one million children and adults are living in institutions across Europe (Fuente, Santiago, Roman, Dumitrache & Casasanto, 2014). Institutional care is the preferred model for a number of reasons in some jurisdictions, where, for example, there is lack of appropriate services in the community to support disabled people. Many families find it difficult or socially embarrassing to live with their disabled relative in the community (Mansel et al., 2007; Townsley et al., 2010).

The move from campus-based/congregation settings to community-living has intensified internationally in the last three decades (Mansell et al., 2007; McConkey et al., 2013; Tatlow-Golden et al., 2014). The argument for community living is that people with an ID are entitled to live in age-appropriate settings, similar to people

without an ID, and to have a good quality of life, participating fully in community activities (Mansell & Beadle-Brown, 2010). The move is more advanced in Scandinavia, the USA, Canada, the UK and Australia (Kozma et al., 2009). In the 1960s, the movement towards deinstitutionalisation had intensified to the extent that not only were people with mild disabilities moving to the community but also those with severe disabilities (Mansell et al., 2007). In Sweden, four Acts of Parliament (1954, 1967, 1985 and 1993) have gradually introduced community-based services, at the same time dissolving institutional-based services.

In the USA, beds in institutions decreased from 194,650 in 1967 to 48,496 by 1999 (Taylor, 2001). According to Emerson (2004), institutional beds in England decreased from more than 51,000 in 1976 to fewer than 4,000 in 2002. A similar trend was noted in Australia (Young, Ashman & Sigafos, 2001). By the 1980s, the development of community services reached an acceptable level, and the closure of more institutions was evident (Mansell & Ericsson, 1996).

This was evident in Ontario, Canada, where the government made a commitment in 1987 to close 16 residential institutions for adults with developmental disabilities within 25 years. In 2004, the government reported that 7,000 people had been transferred to community settings and all institutions were closed by March 2009 (Davidson, 2015; Moeschler & Shevell, 2014). By 2009, nine states had closed all state-operated institutions that accommodated 16 or more residents with intellectual or developmental disabilities (Bagenstos, 2012; Prouty, Lakin & Coucouvanis, 2007).

Tabatabainia (2003) believes that Australia is a latecomer to deinstitutionalisation, compared to the USA and Europe. A report published by the Australian Institute of Health & Welfare (2015), for example, indicated that during 2013-2014, a total of 321,531 people with disabilities were still living in residential settings, such as supported accommodation facilities and residential aged care facilities. There were people also living in short-term crisis, emergency or transitional accommodation facilities.

1.4 Irish Policies on Deinstitutionalisation

Tatlow-Golden et al. (2014) purport that Ireland's nationwide deinstitutionalisation programme was progressing slowly compared to many European counterparts.

Slow progress in deinstitutionalisation was not due to lack of policies, but rather due to a history of inadequate records of financial accountability and service delivery in some disability organisations (Linehan et al., 2015; Department of Health, 2012).

In Ireland, it is envisaged that the closure of congregated settings and the development of more personalised community-based settings are likely to occur in the next decade (Linehan et al., 2015). The development of numerous disability policies is shaping this reform. Recent reports outlining a move away from traditional congregated settings to more personalised social services and supports in the community for people with disabilities include: The Value for Money and Policy Review of Disability Services in Ireland (Department of Health, 2012) and the Time to Move on from Congregated Settings-A Strategy for Community Inclusion (HSE, 2011). As indicated previously, the latter is known as the *Congregated Settings Report* of 2011 and is referred as such throughout this study.

1.4.1 Value for Money and Policy Review of Disability Services in Ireland

Ireland, as part of the EU and OECD, has been exposed to reform ideas and has been put under pressure to adopt private sector practices and develop policies to reform the public sector (Foley, 2009; Ward, 2010). These private sector practices include accountability, performance management, decision-making processes, evaluation, policy review and value for money to name just a few (Foley, 2009; OECD, 2002; Ward, 2010). These practices are viewed as essential for good governance and the success of any new public management is depended on an integration of same (Barrett, 2007; Bovaid & Loffler, 2003; Bridgeman, 2007; CIPFA, 2004; Solomon, 2007).

However, some may argue that putting new public management ethos of profit and efficiency on health services is a regressive step. The Swedish healthcare system for example, introduced the new public management systems where public health centres and public hospital were to function as private firms in the healthcare market (Dahlgren, 2014). The main argument was that competition and privatisation will increase efficiency and patients will get the same care for less money. The market-oriented healthcare reforms were noted to be inefficient in for example, reducing geographical and social inequalities in health and health services (Dahlgren, 2014).

A meta-study where 317 articles were reviewed by Hollingworth (2008), for example, concluded that non-profit healthcare providers were as cost-effective if not more than for profit providers.

In Ireland, the *Value for Money and Policy Review of Disability Services in Ireland (VFM Policy Review)* was conducted by the Department of Health and the HSE, under the auspices of the government's programme of VFM reviews for 2009-2011. The HSE is a statutory body responsible for management and delivery of health and social services in Ireland. A Steering Group was established, consisting of an independent chairperson and members drawn from the disability sector, Department of Health, Department of Public Expenditure and Reform and the HSE. As part of the Review, an Expert Reference Group comprised of the Department of Health and chaired by the Policy Advisor to the Office for Disability and Mental Health, was established to examine the existing disability policy and assess whether it needed to be changed to better meet the expectations of people with disabilities.

The purpose of the Review was to assess current efficiency and effectiveness of the HSE-funded statutory and non-statutory disability services in Ireland. The Review made a range of recommendations about how these services should be structured in order to provide more affordable services that fit the purpose and better meet the needs of service users within existing resources. These recommendations are classified under seven thematic headings: 1. programme objectives and policy; 2. economy; 3. efficiency and effectiveness; 4. governance and accountability; 5. information framework; 6. funding framework and re-articulation of objectives; 7. future policy development (Department of Health, 2012). The transfer to individualised supports in community based-living is expected to take place within the existing constraints and within the context of the prevailing economic climate. Therefore, a sustainable approach is necessary in order to realise the goal and objectives of the policy (Department of Health, 2012). Hence the VFM is viewed as a sustainable mechanism which is likely to result in compliance of policy implementation (Department of Health, 2012).

1.4.2 Congregated Settings Report of 2011

HSE (2011) refers to congregated settings as residential settings where ten or more people with a disability share a single living unit or where the living arrangements are

campus-based. The key driver of the *Congregated Settings Report* of 2011 was the UN Convention on the Rights of People with Disabilities (UN, 2006) and Ireland's obligation under this treaty which was signed in 2007 (Linehan et al., 2015). The HSE in 2007 set up a Working Group on Congregated Settings.

This group was given the task of developing a report, outlining a national plan and change programme, for transferring people with disabilities from congregated settings to community-based living over a seven-year period. There were over 4,000 people living in these congregated settings, with slightly more males (52%) than females. The majority were people with an ID, 3,800 residents had a primary diagnosis of ID and 300 had either a physical or sensory disability. A high proportion of residents had severe or profound ID and considerable levels of behaviours that challenge (HSE, 2011).

The Working Group surveyed 72 sites and conducted a series of visits to congregated settings. Additionally, an international review of the cost, benefits and outcomes of deinstitutionalisation and community living was conducted. The experience of other countries that have undertaken deinstitutionalisation programmes was gathered through study visits to England, Wales, and Sweden as well as through a dialogue with experts from Norway and the USA (HSE, 2011). The Working Group also reported that 693 people had been transferred out of the settings surveyed between 1999 and 2008. Of the 72 sites surveyed, 46 had made arrangements for service users to be transferred from congregated settings to the community (HSE, 2011).

The Report outlined 31 recommendations and proposed a new model of moving people from congregated settings to dispersed forms of housing in the community, provided mainly by the housing authority (HSE, 2011). The key recommendation from the *Congregated Settings Report* of 2011 is for dispersed housing where no more than four persons with a disability live in the same house. The *Congregated Settings Report* of 2011 is used as the agreed national policy for a new model for residential support in the mainstream community (HSE, 2016). Its main objective is to move over 4,000 people with disabilities nationally into the community within a seven-year period, 2012-2019 (HSE, 2016) and to progressively close residential institutions (HSE, 2011).

The Transforming Lives Programme of 2014 oversaw the implementation of the *Congregated Settings Report* of 2011 and the *VFM Policy Review* (HSE, 2016).

The data suggest that there is still significant work to be completed. What has already been achieved in the implementation of the *Congregated Settings Report* of 2011 is that 145 people had moved to the community, but 2,725 people remained in the identified congregated settings at the end of 2015 (HSE, 2016).

1.5 The Role of Health Information and Quality Authority on Deinstitutionalisation

One of the recommendations made by Mansell et al. (2007), in their study of deinstitutionalisation process, outcomes and costs in Europe, was that there should be inspections to evaluate the living conditions of people with disabilities and their quality of life. In Ireland, inspections of residences for people with disabilities are a remit of HIQA – the statutory body established under the Health Act of 2007. Its aim is to promote continuous improvement in quality and safety of short- and long-term residential services provided to children and adults in Ireland. HIQA's role is fourfold:

1. It sets person-centred standards for health and social care services based on the following themes: individual supports and care; effective services; safe services; health and development; leadership, governance and management; use of resources; responsive workforce; and the use of information.
2. It is responsible for registering and inspecting all designated centres.
3. It monitors the quality and safety of health and personal social care services and investigates, as necessary.
4. It evaluates the clinical and cost-effectiveness of drugs, equipment and diagnostic techniques, to ensure the best outcomes for people availing of health services (HIQA, 2013).

HIQA's standards support the transition process to different settings where people with disabilities may live (HIQA, 2013). Residential services are monitored against their standards, which are outcome-based (18 outcomes), that is, each standard provides a specific outcome for the service to comply with (HIQA, 2013). HIQA's standard 2, for example, states that "Each person has a personal plan which details their needs and outlines the supports required to maximise their personal development and quality of life, in accordance with their wishes" (HIQA, 2013).

HIQA inspectors assess an individual's living arrangements and make recommendations, where necessary. HIQA is relevant to the current study, as MDTs'

decision-making may be referenced to HIQA's recommendations. Additionally, HIQA may be one of the factors considered in the input of the decision-making process by MDTs who are tasked with the transfer of adults to community-based settings.

1.6 Irish Studies on Deinstitutionalisation

Recent studies in Ireland examining the progress towards deinstitutionalisation include those conducted by McConkey et al. (2013), the Moving Ahead Project by Linehan et al. (2015), and the Next Steps Project conducted by the National Federation of Voluntary Bodies (NFVB) (Harnett, 2014). Each study is discussed below.

1.6.1 McConkey Studies

In their study of within-country variations to deinstitutionalisation in Ireland, McConkey, Kelly, Craig and Mannan (2013) used the NIDD to assess the number of individuals with an intellectual disability who have moved into the community. The NIDD is an HSE database that provides a comprehensive and accurate information base for decision-making with regard to the planning of services for people with and ID. The database registers the number of people in receipt of services, those without services but requiring same, those who live at home, those in receipt of full-time residential services, and those availing of MDT support services. People with a diagnosis of a mild ID are excluded from the NIDD (Doyle & Carew, 2015). The Health Research Board (HRB) manages the database on behalf of the HSE. McConkey et al. (2013) examined NIDD data from eight geographical regions from which health services were commissioned and delivered from 1999 to 2009.

By 2009, these data revealed 4,120 adults living in congregated settings, as compared to 3,838 living in the community. Additionally, there was a national increase of 45% of adults aged 20 years and older living in the community versus an 11% decrease in congregated settings. Despite the increases, there were variations nationally in the number of people moving to community living. For example, of the eight regions, three (North-Eastern, Mid-Western and Southern) were observed to have small increases of 2-6% in those supported in congregated settings. There was an increase of 24% in the Western region, as opposed to 80% noted in the Midlands region. The Southern region experienced an increase 8% of people moving to the community and 11% in the Eastern region, in contrast with 34% in the South-Eastern region.

The authors' analysis indicated significant progress in deinstitutionalisation from 1999 to 2009, even though there was considerable variation in this progress regionally.

In their report of 2013, McConkey, Bunting, Ferry, Garcia-Iriarte and Stevens gave an overview of the findings from an evaluation of 23 projects funded by Genio, in 2010 and 2011, to facilitate personalised housing and support arrangements for people with IDs, mental health difficulties and physical disabilities. Genio is an independent, non-profit organisation in Ireland that is supported by government and Atlantic Philanthropies to develop cost-effective ways of supporting disadvantaged people (McConkey, et al., 2013). In all, 13 projects served people with an ID. A total of 197 people participated, of whom 121 had an ID. The projects either achieved their goals in relocating people or were close to doing so. The quality-of-life indicators (for example, developing relationships and the use of ordinary services) that were examined with participants in the personalised and family groups generally reported better outcomes than for those in congregated settings. Personalised options were found to be less costly for some people than when they resided in congregated settings. However, there were a few instances of these arrangements being more costly (McConkey, et al., 2013). The evaluation also indicated that older people were found mainly in congregated settings. Those with mental health difficulties were more likely to move to a personalised arrangement, compared to people with an ID, who moved to community group homes (McConkey, et al., 2013).

1.6.2 Moving Ahead Project

In their study, McConkey et al. (2013) showed that there were variations in deinstitutionalisation rates in all regions. The Moving Ahead Project investigated two of the regions in which disparities occurred, to explore why such differences occur. Linehan et al. (2015) used multiple methodologies in the study, namely, a review of archived data (including data from the HSE National Service Plans and NIDD, to look at trends in community living in the preceding years), qualitative interviews, focus groups, and surveys. These data were gathered from four agencies in each region, which included an HSE institution, and a large and a small not-for-profit provider.

Part of the project explored trends in residential options. Data from 2011 indicated that regional disparities still existed, largely due to the use of seven-day residential centres in one region. While the demographic profile of people supported in the two regions

was comparable, the manner in which people were supported in the two regions was different.

The authors concluded that other factors seemed to be responsible for the disparities in service provision beyond the support needs of service users. These factors included, but were not limited to: a lack of standardised approach to the implementation of the policy; accessible/inaccessible decision-making systems; prepared/ill-prepared staff in the transition process; crisis referrals that contributed to a rushed move to the community; and those with high support needs (that is, low level of ability, those with complex medical needs, behaviours that challenge and dementia) being less likely to be transferred to the community and more likely to transfer back to a congregated setting when difficulties arose. The findings revealed that implementation varied among organisations, with staff readiness being a particular problem (Linehan et al., 2015).

1.6.3 Study by McCarron et al. (2018)

The purpose of this study was to systematically review evidence from 36 studies on the quality-of-life outcomes and costs associated with moving from congregated settings to community-living options for people with an ID within the Irish context. These studies included qualitative, quantitative, and mixed methods design studies. The review was requested by the Department of Health to inform the deinstitutionalisation process in Ireland (McCarron et al., 2018). The authors were of the view that Ireland was making an effort to reduce the reliance on congregated settings as residential arrangements (institutions with 10 or more residents) for people with an ID to community living arrangements (where each unit contains not more than four residents) (McCarron et al., 2018).

The authors concluded that the review supported evidence that moving from an institutional residential setting to a community residential setting improved the quality of life of adults with an ID. Some findings suggested that people with severe or profound IDs in particular either experienced a generally improved quality of life or experienced a lack of improvement, but not a deterioration in quality of life after moving to the community (McCarron et al., 2018). Additionally, the authors believed that there was no clear evidence of the cost effects of the move to the community. Furthermore, few conclusions could be drawn about the cost effects for people with highly

specialised support needs (McCarron et al., 2018). The authors suggested longitudinal studies to examine adequately representative samples of people with an ID, where there was a potential to gather baseline data (pre-move), follow people at different time points, examine their health status and participation in the community, and control for the effects of changing health and independence needs (McCarron et al., 2018).

1.6.4 National Federation of Voluntary Bodies Project

The NFVB is an umbrella organisation for ID service providers. In all, 60 organisations of the NFVB support people with an IDs nationally and provide residential, day, and respite services to more than 22,000 people across four HSE regions (NFVB, 2017). The NFVB works with its member organisations to implement national policy, such as the *Congregated Settings Report* of 2011. In 2011, the NFVB established the Next Steps Project. In all, 23 organisations participated in the project, which was recognised by the UN as one of 39 “innovative practices” in supporting people with an ID (Hartnett, 2014).

Organisations participating in the Next Steps Project are conducting ongoing case studies, working with one or more individuals developing new service options for moving to individualised supports in accordance with, for example, the *Congregated Settings Report* of 2011 and sharing their experiences with the NFVB membership. The aim of the project is to identify facilitators and barriers experienced by organisations when developing individualised supports (Harnett, 2014). Each of the 23 organisations present a case study and the project looks at what has worked, and the difficulties experienced by organisations when implementing *Congregated Settings Report* of 2011. So far, case studies have revealed that continued community involvement is achievable when the person has valued roles and can make a contribution to the community.

Some organisations have used assistive technology to help people with an ID in choosing self-directed support when transferring to the community (Harnett, 2014). Although positive outcomes were indicated, case studies have their limitations, as information is difficult to cross-check, generalisation is not always possible, and there are concerns about selective reporting (Bell, 2010; Bowling, 2009).

Some organisations reported that when making a decision to move people to the community, a team holds many meetings and works through a transition plan with the

service users and family to teach them skills they will require to live independently. A team typically consists of the service user, key worker, team leader for the decongregation project, and the organisation's representative on the Next Step Project (Hartnett, 2014).

1.7 Multidisciplinary Teams' Decision-Making Processes

This study aimed to explore the decision-making processes of MDTs, when considering a move to the community for adults with an ID. Theoretical framework of decision-making are presented in the next section. According to Robbins, De Cenzo and Moon (2005), decision-making is a process that allows one to choose the best alternative from a selection of alternatives. Decisions within the disability sector, such as the provision of clinical support services, are commonly made by MDTs (Choi & Pak, 2007; D'Amour, Ferrada-Videla, Rodriguez & Beaulieu, 2005; Légaré et al., 2011; Maye, 2016). As described by Maye (2016), a variety of opinions results in more holistic decision-making processes. The use of processes (strategies, actions, steps, procedures) in decision-making is recommended to enhance team effectiveness (Cordes, 2016; Maruping & Agarwal, 2004; West & Lyubovnikova, 2013). These processes include interpersonal and task decision-making processes. The former involves conflict management, motivation and confidence building, affect management, maintaining group collaboration, and evaluating the team decision-making process (Bartolo, Dockrell & Lunt, 2001; Maruping & Agarwal, 2004; Killumets, D'Innocenzo; Maynard & Mathieu, 2015). The latter are action processes where teams perform task directly related to the organisation's goal. Teams monitor and evaluate their progress, make recommendations, and plan for the future (Bartolo et al., 2001; Cordes, 2016).

Bartolo et al. (2001) identified six task processes involved in decision-making, namely, *describing, explaining, predicting, constructing hypothesis, recommending, and planning*. The interpersonal and task processes are equally important and are intertwined (Bartolo et al., 2001), with interpersonal processes laying the foundation of other processes (Maruping & Agarwal, 2004). Task processes are crucial, as they indicate how the team accomplishes its tasks (Cordes, 2016; Killumets et al., 2015). It is for this reason that the current study focused on the task processes, particularly those outlined by Bartolo et al., (2001), to explore the type of decision-making task processes used by MDTs when transferring people to dispersed housing in the

community. Team decision-making and the relevant processes involved are further discussed in Chapter Two.

1.8 Introduction to the Theoretical Framework

The current study focused on decision-making processes of MDTs when considering transferring adults with an ID from congregated settings to community-based settings. One of the available theoretical frameworks of decision-making is the NDM framework, which is briefly discussed below.

1.8.1 Naturalistic Decision-Making Framework and Rationale for Its Use in This Study

The NDM framework is the study of how professionals use their experience to make decisions in their natural environments (Klein, 1993; Zsombok & Klein, 1997). The framework is known as an expert-based decision-making process. Klein (2015) defines an expert as a professional who knows what needs to be achieved, based on past experience of the situation, who has sophisticated mental models of how things work, and who has the resilience to adapt to complex and dynamic situations. These professionals rely on patterns experienced that enable them to rapidly assess situations and make quick decisions without having to compare options (Klein, 2015).

The NDM framework focuses on the actual cognitive processes that professionals engage in when making decisions, and how they assess the environment/situation and take appropriate actions (Bryant, Webb & McCann, 2003; Meso, Troutt & Rudnicka, 2002). These cognitive processes include decision-making, sense-making, coordination, planning, and managing uncertainty and risk, as they occur in natural settings (Klein, Ross, Moon, Klein, Hoffman & Hollnagel, 2003; Nemeth & Klein 2010). The cognitive processes are crucial aspects of decision-making (Meso et al., 2002). Hence, the NDM offers a variety of explanations on how decisions are made (Falzer, 2004). The NDM framework aims at describing, in detail, how professionals (individually or in groups) make decisions in difficult situations.

The rationale for choosing the NDM framework of Klein et al. (1993) for this study was that this theoretical framework describes how professionals in their natural settings make decisions under conditions of time pressure, dynamic goals, uncertain cues and high risk (Klein & Calderwood, 1991; Klein et al., 1993; Zsombok & Klein, 1997; 2009). The study argues that MDTs operate in similar circumstances to those outlined above,

as they implement the *Congregated Settings Report* of 2011. The current study explored the various factors that may impact directly or indirectly MDTs' decision-making process. Details of factors considered in decision-making and NDM are further discussed in Chapter Two.

1.9 Aim and Objectives of the Study

The main aim of this study was to explore the decision-making processes of MDTs involved in transferring adults with an ID to dispersed housing in the community. There were two main objectives: firstly, to determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community; and secondly, to determine the factors that MDTs considered in their discussions when transferring an adult with an ID to dispersed housing in the community. These objectives were addressed with two linked research questions using separate methodologies.

The process of decision-making was examined in keeping with Bartolo et al.'s (2001) framework of decision-making task processes, namely, *describing, explaining, predicting, constructing hypothesis, recommending, and planning*. The factors considered were analysed in accordance with thematic analysis, in order to highlight the trend of common emerging themes captured from the discussions. Hence, the Research Questions were as follows:

1.10 Research Questions

- ***What decision-making processes are used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community?***
- ***What are the factors that MDTs considered in their discussion when transferring an adult with an ID to dispersed housing in the community?***

1.11 Relevance of the Study and Expected Contribution to the Body of Knowledge

This topic may be of interest to service providers/organisations in Ireland who are in the process of transferring adults from congregated settings to dispersed housing in the community. It was hoped that by representing their views, this might reflect on the larger ID population in Ireland. The findings may inform future decision-making and may facilitate more successful implementation of the *Congregated Settings Report* of

2011. This is an under-researched area. Therefore, it was hoped that the current study might expose and bring to light portions of knowledge that have previously not existed. The objective of the current study was to determine the types of decision-making task processes that could be made available to organisations tasked with facilitating the transfer of adults with an ID to community settings, and thus making the findings useful to organisations tasked with the implementation of the *Congregated Settings Report* of 2011. The use of these decision-making task processes may allow for a holistic consideration of the decision at hand. Knowing which task processes have been frequently used may allow MDTs to use these processes to inform and implement the *Congregated Settings Report* of 2011 within a realistic time frame, and more fluidly.

Another objective of the present study was to contribute to the understanding of factors considered by MDTs in their decision-making, when engaged in moving people from congregated settings to dispersed houses in the community. An awareness of factors that influence decision-making could enable MDTs to consider factors pertinent to the successful implementation of the *Congregated Settings Report* of 2011, in order to realise its objectives. Furthermore, a consideration of the influential factors may enable MDTs to formulate their prioritisation process of moving adults with an ID into the community.

1.12 Summary of the Chapter

This chapter has provided a background to deinstitutionalisation and highlighted different living options for people with an ID. It has also presented an overview of international policy on deinstitutionalisation and the argument for community living for people with an ID in different jurisdictions. It has discussed the recent two main policies in Ireland that facilitate the transfer of people with an ID from congregated settings to the community, namely, the *VFM Policy Review* and the *Congregated Settings Report* of 2011. The latter's key recommendation was that no more than four adults with a disability should live in the same dispersed house in the community. The chapter has also discussed Irish studies in relation to progress and variations to deinstitutionalisation and presented HIQA as a driving force for moving adults from congregated settings to the community. It also introduced team decision-making processes, as the study aimed to explore decision-making processes of MDTs when transferring adults with an ID to the community housing. Finally, it has given an introduction to the NDM framework on decision-making, outlined the rationale for this

theoretical framework, and described how professionals make decisions in difficult situations.

The decision-making processes used by MDTs to move adults with an ID to dispersed housing in the community have not yet been explored within the academic framework. Hence, the objective of the current study was to determine the types of decision-making task processes used by MDTs within the Irish context, when facilitating the transfer of adults with an ID to community housing. Additionally, the study's objective was to determine factors that MDTs consider in their decision-making, when engaged in moving adults with an ID to houses in the community, in order to bring to light factors that have not hitherto been examined.

1.13 Preview of the Chapters

Chapter Two reviews the literature pertaining to factors considered and decision-making processes, with regard to deinstitutionalisation. It considers possible theoretical frameworks that influence decision-making and discusses some standardised assessment tools and approaches used to inform decision-making when moving people with an ID into the community. It also provides a detailed background and description of the NDM framework, as well as critiquing it, and then gives a summary of the literature review and identifies a gap in the decision-making process within the Irish context when moving adults with an ID from congregated settings to the community.

Chapter Three identifies the research formulated questions and raises two research questions. The chapter begins with a justification of the research paradigm and methodology used, including the use of a case study design, the data collection, and a pilot case study. It outlines the data analyses suitable for this study and the rationale and includes the criteria for judging the quality of a case study design. It also addresses ethical considerations, the challenges in the methodology used, and a summary of the chapter. It ends with feedback from the participants on their experiences in this study.

Chapter Four presents an overview of the data garnered from MDTs in focus groups and senior managers in face-to-face, semi-structured interviews across the five case studies. It also highlights the research findings in keeping with two research questions. Furthermore, it identifies the type of decision-making task processes captured in focus

group discussions, related to Research Question One, as well as synthesising and mapping them onto Bartolo et al.'s (2001) framework. The chapter presents emerging themes generated from focus group participants and interviewees, addressing Research Question Two, and highlights patterns of similarities and differences between themes across the five case studies. Finally, it gives an outline of the analysis of the research questions, followed by a summary of findings.

Chapter Five presents a discussion and conclusion of the study. The discussion indicates the interpretation of the results from the research questions. The chapter shows how the results are related to literature, policy, and practice.

The chapter provides the implications of these findings and indicates the strengths and limitations of the study, highlighting future research that could be built on the study by broadening the context to a wider group within the Irish ID sector. Finally, it presents a set of concluding statements based on the research findings, as well as the author's reflective statement.

2 CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The main aim of this study was to explore the decision-making processes of MDTs involved in transferring adults with an ID to dispersed housing in the community. The objectives of this study were two-fold: (1) to determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community; and (2) to determine the factors that MDTs considered in their discussions when transferring an adult with an ID to dispersed housing in the community. Chapter One addressed the contextual overview of the study. This chapter presents the literature reviewed. It starts with an overview of literature on MDT decision-making and provides a definition and overview of team decision-making, including different team processes and criteria for the effectiveness of MDT (2.2). It proceeds to highlight assessment tools used internationally as key to the decision-making process and the approaches used in Ireland to facilitate the transfer of people to the community (2.3). This is followed by a summary of theories on decision-making, namely, normative vs intuitive theories (2.4). This leads to an example of the intuitive theory, namely, the NDM framework, which is the subject of this study (2.5). The chapter then presents an overview of NDM research (2.6), followed by a critical analysis exploring NDM empirical studies (2.7) and criticisms levelled against the NDM framework (2.8). The chapter then gives an overview of factors relevant to the decision-making processes of MDTs, in accordance with the ecology systems of Bronfenbrenner (1977) and Hogg's (1997) models (2.9). It ends with a summary of the literature review and an identified gap in the Irish context (2.10). Appendix 1 presents the research strategy.

2.2 Overview of Literature on MDT Decision-Making

The literature indicates that decision-making by a group/team of professionals is the essence of any management in health and educational organisation (Chen, Lawson, Gordon & McIntosh, 1996; Robbins, De Cenzo & Moon, 2005; Schwartz, 1994). Team decision-making allows managers and organisations to plan, organise, lead, and control situations. In addition, the literature identifies different types of decision-making, which form the basis of different models (Borrill, West, Shapiro & Rees, 2000; Fay, Borrill, Amir, Haward & West, 2006; Fleissig, Jenkins, Catt, & Fallowfield, 2006;

Harrison, 1993; Klein et al., 1993; Stoner, Yetton, Craig & Johnston, 1994; Simon, 1977).

Some of these models are based on principles that guide decision-making, to ensure consistency in the process (Bryant et al., 2003). Below are definitions and an overview of team decision-making.

2.2.1 Definitions and Overview of MDT Decision-Making

A wide range of terms is used to describe team/collaborative working arrangements between professionals (Nancarrow et al., 2013). Terms such as interdisciplinary, inter-professional, multi-professional and multidisciplinary are often used interchangeably in the literature. However, there are notable differences between them. Inter-professional/multi-professional are considered narrow terms (Nancarrow et al., 2013). They refer exclusively to teams of professionals from different disciplines, although they may include other non-professional staff (Nancarrow et al., 2013).

Interdisciplinary/multidisciplinary are broad terms. They are inclusive of all members of the healthcare team, both professional and non-professional, with the majority being from professional groups (Nancarrow et al., 2013; Fay et al., 2006). Similarly, the HSE (HSE, 2016) defines multidisciplinary teams (MDTs) as different healthcare and social care professional groups in a team, who have complementary experience, qualifications, skills, and expertise. Members of the team provide different services for people in a coordinated and collaborative way (HSE, 2018). In the disability sector, for example, members of the MDTs may include service users, family members, service management representatives, doctors, nurses, psychologists, psychotherapists, psychiatrists, speech and language therapists, social workers, social care staff, dieticians, community transition coordinators, physiotherapists, occupational therapists (OTs), art therapists, music therapists, behavioural therapists, pharmacists, and advocates (MHC, 2006; HSE, 2016, 2018). Team decision-making offers the potential for robustness. Teams are thought of as being more cautious, creative, informed, and accurate than individuals (Fay et al., 2006; MHC, 2006; Kimura & Moehlis, 2012).

Furthermore, teams bring a diversity of experience and perspective to the decision process and this, in turn, increases the legitimacy and acceptance of the solution (Maye, 2016). Also, teamwork results in better communication between the

professionals, leading to a coordinated decision-making process and team effectiveness (Cook, Gerrish & Clarke, 2001; MHC, 2006). Moreover, team members develop their knowledge and skills for future use (Stoner et al., 1994). MDTs are known for being able to deal with complex tasks and depend on each other both for individual and team task completion (West & Lyubovnikova (2013).

Just as there are advantages to team decision-making, there are reported disadvantages. It is time-consuming; it may hinder the decision-making process; there is pressure to conform in groups; there is ambiguous responsibility; a minority may dominate the discussions, leading to a deterioration of a group member's mental efficiency; and tensions between professionals may easily give rise to conflicts between them (Cook et al., 2001; MHC, 2006; Robbins et al., 2005; Stoner et al., 1994).

The current study examined the decision-making processes used by different MDTs in disability organisations in the transfer of adults with an ID from congregated to dispersed housing in the community. In the current study, the term MDT was used to include different healthcare and social care professionals, as well as senior management representatives on a team, with complementary skills working together with service users (people with disabilities) and families to make effective decisions as a team, in order to ensure holistic care for the service user (HSE, 2018; MHC, 2006). The following are examples of proposed models of team decision-making processes used by MDTs in different settings.

2.2.2 Team Decision-Making Processes and Criteria for Effectiveness of MDTs

As indicated previously, there are different types of team processes, namely, task and interpersonal team decision-making processes. Fay et al. (2006) and Sidhom and Poulse (2006) postulate that the effectiveness of teams depends on the quality of team processes. Below are examples of commonly utilised interpersonal team processes in the healthcare sector and private organisations. In the healthcare industry, the theoretical papers of Borrill et al. (2000) and West and Lyubovnikova (2013) considered the following interpersonal team processes as contributing to the effectiveness of MDTs: leadership, clarity of objectives, task orientation, information sharing, flexibility, shared influence over decision-making, and conflict management.

MDTs are said to be more innovative and efficient once they have in place good team processes, such as those mentioned above (Fay et al., 2006). Fleissig et al. (2006) are in agreement with Borrill et al. (2000) and highlight the following criteria as crucial: real leadership, positive team dynamics, adequate administrative support, sufficient staff, communication, workload, and funding. They claim that of the criteria listed above, good leadership is a prerequisite for effective teamwork, because MDTs need a leader to encourage full participation of team members and to give feedback on achievements and failures (Fleissig et al., 2006).

An example of a model of a task decision-making process at an organisational level, is that of Stoner et al. (1994). This model identifies the six steps of the decision-making process. The process begins with the identification of the problem to be solved in Step 1 and the prioritisation of the problem in Step 2. Steps 3 and 4 are linked, in that when decision-makers consider different alternatives to solve the problem (Step 3), they also focus on (Step 4) implementation issues, so that there is a clear connection between the process and the outcome components. In Step 5, the alternatives or goals have been clearly identified. In Step 6, attention is given to the plans of action outlining what specifically needs to take place. Once a decision is made and implemented, it is essential to monitor the outcome. Without regular feedback, it is impossible to determine the overall effectiveness of the decision made by the team (Stoner et al., 1994).

Bartolo et al.'s (2001) framework of the task decision-making processes was chosen in this study over Stoner et al.'s (1994) model for application, as the latter monitored the outcome of the decisions and the current study does not. Bartolo et al. (2001) explored task decision-making processes of MDTs used in the education and health settings. In their research, they highlighted six task processes, as follows: *describing* the problem; *explaining* the problem; *predicting* the future manifestation of the problem; *constructing hypothesis* with regard to reasons for the referral; *recommending* strategies for managing the problem; and *planning* for the implementation of the recommendations. Bartolo et al.'s (2001) study emphasises both interpersonal and task team decision-making processes. The current study focused only on Bartolo et al.'s (2001) team task decision-making processes. The rationale for this was that they indicate how team members accomplish a particular task (Cordes, 2016; Killumets et al., 2015). In the current study, MDTs are tasked with

the implementation of the *Congregated Settings Report* of 2011, whose objective is to move adults with disabilities from campus-based to community-based housing within a seven-year period.

2.3 Decision to Move People from Congregated Settings to the Community

2.3.1 Assessments as a Key Part of the Decision-Making Process

An assessment is defined as a process that involves collecting information about an individual for the purpose of making decisions (NASET, 2007). There are standardised and non-standardised assessment tools and approaches that can be used by MDTs as part of the decision-making process to move an adult with an intellectual disability from congregated settings to the community. The assessment process is crucial to the determination of the decisions related to evaluation, diagnosis, eligibility, planning and placement (NASET, 2007).

Fisher, Orkin, Green, Chinchili and Bhattacharya (2009) state that the process of how best to elicit the wishes and determine what constitutes an optimal environment for people with an ID is difficult. The process involves assessments and judgements about what matters most, which can be a challenge, especially when one does not know the individual's preferences, goals and wishes (Fisher et al., 2009; Freedman, 2001). Additionally, the process may also be a challenge for some individuals with an ID (especially those with a severe to a profound ID), who may not have sufficient capacity to make decisions about their care and needs (Fisher et al., 2009). Below are assessment tools and approaches that MDTs can use when making decisions to move people to the community.

Standardised Tools

Some standardised needs assessment and resource allocation tools exist that are used in deinstitutionalisation evaluation before service users take up residence in the community (Lerman, Apgar & Jordan, 2003). In the USA, for example, the support intensity scale (SIS), developed by Thompson et al. (2004) and published by the American Association on Intellectual and Developmental Disabilities (AAIDD) is used globally. This test determines person-centred needs for those with an ID and may be used to allocate funds by needs and goals rather than on what stakeholders choose to provide (Thompson et al., 2004; Weber & Stern, 2008). The SIS can be used in any situation, including deinstitutionalisation to evaluate the following support needs:

home living activities; community living activities; lifelong learning activities; employment activities; social activities; health and safety activities; protection and advocacy activities; and medical and behavioural support needs (Thompson et al., 2004).

In England, a joint strategic needs assessment (JSNA) is used to determine the eligibility of services and associated costs (Department of Health, UK, 2012). The parties involved in this process include the National Health Service, local government and the health and well-being boards. Collectively, the parties focus on assessing needs and priorities so that individuals can live healthier lives and have a better experience in the community. Additionally, the JSNA is used to inform present and future health and care needs for people within a local authority area (Department of Health, UK, 2012).

In the USA and England, the adaptive behaviour scale-residential and community second edition (ABS-RC: 2) developed by Nihira, Leland and Lambert (1993), is a commonly used tool in some research studies, including those of Young and Ashman (2004) and Broadhurst and Mansell (2007). The ABS-RC: 2 has established reliability and validity in determining behaviours of adults with an ID (Young & Ashman, 2004). It is used to assess the behaviour of institutionalised people with an ID and those in community settings (Young & Ashman, 2004). It assesses adaptive behaviours and gauges how people cope with nature and social demands of their environments. It measures coping skills and eight behaviours, which relate to manifestations of personality and behaviour disorders (Nihira et al., 1993). This information may be useful for the MDTs to consider, when making decisions to transfer people to the community.

Within the Irish context, the assessment of need (AON) is commonly used. The AON is a statutory right for children from 0-18 years, under the Disability Act of 2005. However, it is also used to assess the needs of adults with an ID, which is why it was introduced in this study. The AON is a simple tool that summarises the medical, physical, psychological, environmental, communicational and social needs and goals of the person with an ID. Members of the MDT complete the AON in conjunction with the service user and their advocate and/or some family members. In some

organisations, the AON informs management of where, in the community, to transfer service users to, and with whom. It also enables the prioritisation of transfers.

The use of the AON for people with an ID meets the requirements of the *Congregated Settings Report*, Regulation 5 (1) of the Health Act of 2007, and the HIQA standard 2.1. This regulation emphasises that an appropriate healthcare professional must conduct a comprehensive assessment for each resident before being admitted to a new place of residence (Department of Health, 2007). In Ireland, the AON can inform the person-centred planning (PCP) goals of the service user.

Approaches

Approaches such PCP have been used in making decisions about how a person wants to live and what is required to make that possible (National Disability Authority (NDA), 2005; 2015; Ritchie, Sanderson, Kilbane & Routledge, 2003; Robertson et al., 2007). In addition, the services of an advocate are frequently required to help represent the wishes of the person about his/her health, social needs and living arrangements (Llewellyn & Northway, 2008). Some organisations in Ireland use an advocate and/or PCP (NDA, 2015) to facilitate the transfer of adults with an ID from a congregated setting to community housing. Each of these approaches is discussed below.

(a) Person-Centred Planning

PCP was developed in the USA more than 30 years ago as an approach to organising assistance for people, including those with an ID (Mansell & Beadle-Brown, 2004). It has its roots in the normalisation principle (Ericsson, 2000) and its use has gained momentum in the UK and in Ireland (Thompson, Kilbane & Sanderson, 2008).

In England, the practice of PCP has become mandatory (Department of Health UK, 2002; Schwartz, Jacobson & Holburn, 2000). Here, PCP is an essential component of providing social care to all adults and is central to delivering the government's four principles: rights, independence, choice and inclusion (Department of Health (UK), 2005, as cited by Robertson et al., 2007; Scottish Human Services Trust, 2004), which have led to improvements in lifestyle-related outcomes for people with an ID (O'Brien & O'Brien, 2000, 2001; Robertson et al., 2007). However, in spite of the importance afforded to PCP both at policy and practice levels, few attempts have been made to formally evaluate its efficacy (Robertson et al., 2007).

Hence, in the UK, Robertson et al. (2007) conducted a longitudinal study investigating the efficacy and the cost of introducing PCP for 93 people with an ID, over a two-year period, across four localities in England. The results indicated that before the introduction of PCP, little change was evident in people's lives. However, after the introduction of PCP positive changes were noted in the following areas: social networks; contact with family; contact with friends; community-based activities; and scheduled day activities and choice (Robertson et al., 2007).

In Ireland, a national framework for PCP commissioned by the NDA and the HSE was developed in 2018, as a response to the identified need for a consistent approach to PCP. The framework serves as a guidance for organisations providing a service for people with disabilities including day, residential, home and community services (Gadd & Cronin, 2018). As a result, PCP goals of service users inform, for example, the transfer of people to the community as per the *Congregated Settings Report* of 2011.

New Directions, an HSE policy document that sets out policy in day services for people with disabilities (Gadd & Cronin, 2018) identifies the role of PCP goals to inform supports needed in day services. Each person's PCP covers the 12 areas of need that are required to be addressed under the New Directions policy to facilitate people being supported in their day service/community. These areas include support for making choices and plans; accessing education and formal learning; making transitions and progressions; and having a meaningful social role (Gadd & Cronin, 2018).

In Ireland, there is growing evidence that PCP has a very a beneficial impact on people with disabilities, with regard to alerting them to the options available to them and supporting them in moving towards their preferred choices (NDA, 2015). However, Ritchie et al. (2003) believe that PCP on its own is no guarantee of a better life. Many positive changes for people with disabilities could be achieved without using PCP. Much of the effectiveness of PCP would seem to lie in the way it is conducted (Ritchie et al., 2003).

(b) Advocacy

Advocacy is acknowledged as the “way forward” for people with an ID in their aim to gain respect and to have the same chances as others to lead full and satisfying lives in their environments (Department of Health (UK), 2002; Llewellyn & Northway, 2008; Stuntzner & Hartley, 2015). The role of the advocate is to represent the service user’s views (Llewellyn & Northway, 2008). People with an ID should have access to advocacy services concerning their health, social, and living arrangements (Llewellyn & Northway, 2008). There are different types of advocacy. These include, self-advocacy (people speaking out for themselves to express their needs and representing their interest); citizen advocacy (volunteers ensuring that their partner’s interest are represented); peer advocacy (speaking for others); professional advocacy (paid professionals such as health workers, who are involved with the person); independent advocacy (paid professionals dealing with specific issues on a one-to-one basis); and group advocacy (people coming together to represent shared interests) (Sandwell, 2017). Of all these types, self-advocacy has been the most influential type of advocacy for people with learning disabilities (Lishman; 2005; Swain, French & Cameron, 2003).

Self-advocacy is about speaking up for oneself or others, regarding rights and entitlements (Gray & Jackson, 2002). Self-advocacy is considered an invaluable life skill that is used by people with an ID to indicate their needs (Gray & Jackson, 2002). It empowers the individual to learn the following skills: having an accurate understanding of one’s ability; understanding the importance of standing up for one’s needs; communicating effectively the services needed; knowing one’s strengths and limitations; being aware of services or accommodation required (Stuntzner & Hartly, 2015). In Ireland, an independent advocate can assist a service user in making decisions (NDA, 2015) concerning their health, finances, and personal well-being, as per the Capacity Act of 2015.

2.4 Overview of Theories on Decision-Making

There is no single universally endorsed theory of decision-making (Cole, 2015). As evidenced in the literature, theories of decision-making are categorised into major groups. The following are examples of theories that are task orientated, namely, classical/normative theories and naturalistic/intuitive theories (Bryant et al., 2003;

Cole, 2015; Orasanu & Connolly, 1993). The classical/normative theories provide prescriptive guidelines on how people ought to make decisions. They focus on strategies of rational decision-making. In particular, they use information in an optimal manner, to make choices that are logically sound. Hence, rational and optimal concepts are synonymous with classical/normative theories (Falzer, 2004). These theories assume that decision-makers are objective, have the necessary information, and consider all possible alternatives and their consequences before selecting the optimal choice (Falzer, 2004; Falzer & Garman, 2012). The decisions are based on expected outcomes. There is an attempt to select a course of action that will bring the optimal outcome (Klein, 2015). Examples of the classical/normative theories are the classical/rational decision-making model and the bounded rationality model, as discussed below.

Classical/Rational Decision-Making Model

The classical/rational decision-making model (Simon, 1977) focuses on how decisions ought to be made. Hence, it is prescriptive and provides four steps to follow when making decisions. The decision-maker must: (1) define the problem and make a choice between competing alternatives; (2) focus on which alternatives are preferred (satisficing-acceptable level); (3) utilise a pragmatic process to evaluate alternatives and select the best one; and (4) make a formal decision based on a rational choice, implement, and monitor his/her choice.

Bounded Rationality Model

In contrast to the classic/rational model, the bounded rationality model is regarded as the oldest model to describe how decisions are made in a variety of organisations (Simon, 1977). This model is known as the administrative man model, which stipulates that decision-making involves achieving organisational goals, such as reaching specified targets at a given time. Therefore, decision-makers should understand the alternative courses of action for reaching these goals (Simon, 1977). A fundamental assumption of this model is that decision-makers aspire to make optimal choices but are hampered by the following two boundaries to rationality: (1) all possible information about the problem and alternative courses of action may not be known within a given period; and (2) a decision may be based on criteria other than the rational and logical evaluation of information, such as consideration of members' preferences and

coalitions in the organisation. As a consequence of the cognitive constraints of not being able to gather and process all the possible information, decision-makers “satisfy” rather than “optimise”, by selecting the alternative that appears good enough to solve the problem. Decision-making proceeds sequentially: options are examined one at a time, and the first satisfactory alternative that is found is selected (Simon, 1977).

Criticism of Normative Theories

The criticism levelled against the normative theories is that they are not applicable in a variety of settings (Klein & Klinger, 1991). They lack the flexibility for dealing with rapidly changing conditions, as they have been developed using inexperienced research subjects, such as college students. They are generic and require careful consideration and deliberation of data. As a result, they are time-consuming and are thus difficult to apply in complex situations where there are time constraints (Cole, 2015; Orasanu & Connolly, 1993; Zsombok & Klein, 1997; Klein & Calderwood, 1991). Lipshitz, Klein, Orasanu and Salas (2001) and Harrison (1993) are of the view that when presented with a real-world crisis involving a high level of uncertainty, individuals often find themselves lacking time to examine every possible alternative, which in turn prohibits the consistent use of the most pragmatic and rational choice.

By contrast, the naturalistic paradigms place decision-makers at the centre of the problem and seek to understand how professionals make decisions in complex uncertain situations where time and other resources are limited (Zsombok & Klein, 1997).

Naturalistic/Intuitive Theories

Alternative approaches to the classical/normative theories emerged half a century ago. In the last 25 years, these approaches have joined together and become known as naturalistic/intuitive theories, developing as a response to the limitations of the classical/normative theories. The latter were seen as inadequate in describing, evaluating, and assisting people with making decisions in difficult situations (Falzer, 2004; Falzer & Garman, 2012; Gore, Flin, Stanton & Wong, 2015).

In contrast, naturalistic/intuitive theories describe how people make decisions in uncertain contexts (Bryant et al., 2003; Klein & Calderwood, 1991). Unlike the classical/normative theories, naturalistic/intuitive theories rely on the assumption that

people use intuition to make decisions, that is, large numbers of patterns gained through experience, resulting in different forms of explicit knowledge (Klein et al., 1993). Similarly, Klein (2015) defines intuition as an expression of experience that people build up and which enables them to rapidly assess the situation and make decisions without having to compare options. Examples of naturalistic/intuitive theories include the NDM framework, the organisational decision-making model (Bryant et al., 2003; Roberts & Cole, 2018), and Patel's naturalistic theory (Falzer, 2004). The organisational decision-making model and Patel's naturalistic theory were excluded for application in the present study, because the former seeks and selects a solution that will create value for stakeholders in the organisation (Roberts & Cole, 2018). The latter examines the relationship between physicians and organisational decisions, as well as patient-physician interactions (Falzer, 2004). The current study focuses on the NDM as the emphasis is on MDT decision-making within the ID sector.

2.5 Background to the NDM Framework

NDM is a by-product of classical/traditional decision-making research (Lipshitz et al., 2001). The term was conceived in 1989 during a conference sponsored by the U.S. Army Research Institute. The conference was organised for 30 behavioural researchers who had stepped outside of the traditional decision research paradigms to discuss issues of real-world problem-solving (Beach, Chi, Klein, Smith & Vicente, 1997; Lipshitz et al., 2001).

The U.S. Army Research Institute became interested in naturalistic decision-making following the 1988 shooting incident in which a U.S. Navy Aegis cruiser destroyed an Iranian commercial airline in error. The army and the navy wanted to assist their employees in making high-stake decisions under extreme time pressure and under dynamic and uncertain conditions (Klein, 2008).

During the conference, the researchers discovered that the type of decisions they made shared three common themes that were difficult to replicate in laboratories and which needed to be understood (Orasanu & Connolly, 1993). The first theme related to the importance of time pressure, uncertainty, ill-defined goals, high personal stakes, and other complexities that characterised decision-making in real-life situations. The second theme was the importance of studying people who had some degree of expertise, rather than novices. The third theme was the way professionals weighed

situations that seemed more critical, rather than selecting courses of actions (Klein et al., 1993). The ideas generated from the conference were subsequently transformed into a theoretical concept and the first volume of NDM was published in 1993 by Gary Klein, Judith Orasanu, Roberta Calderwood and Caroline Zsombok. Several NDM conferences have taken place between the USA and Europe. Looking at the latest contributions made to the NDM research in the 14th conference in 2019, the core areas covered to date have been in the areas of education and training, healthcare, security, military, government and law, transport, engineering, the arts, firefighting, crisis response, nuclear and petrochemical power plant operations, information technology, and aviation. It would seem that there has been no paper presented or published that addresses the current topic of decision-making in deinstitutionalisation.

2.5.1 Definition and Description of the NDM Framework

The original definition of NDM was proposed by Orasanu and Connolly (1993) as “the study of how experienced people, working as individuals or groups in dynamic, uncertain and often fast-paced environments, identify and assess their situation, make decisions and take actions whose consequences are meaningful to them and to the larger organisation in which they operate” (Zsombok & Klein, 1997, p. 5). Following the second conference in 1996, an alternative definition had emerged: that NDM is a way in which people use their experience to make decisions in different naturalistic settings (Zsombok & Klein, 1997; 2009).

Proponents of NDM state that decision-makers in natural settings rely heavily on intuition (Klein et al., 1993; Klein, 2008, 2015; Patterson, Pierce, Boydstun, Ramsey & Shannan, 2013). Hence, it is regarded as the non-standard approach of decision-making (Connolly & Koput, 1997 cited in Gore, 2006).

NDM views decision-making as a process, rather than a one-time, point-specific event. Furthermore, it explores methods used by experts working as individuals or in groups, to identify and assess their situations, and make decisions (Gordon & Gill, 1997; Klein et al., 1993; Zsombok & Klein, 2009).

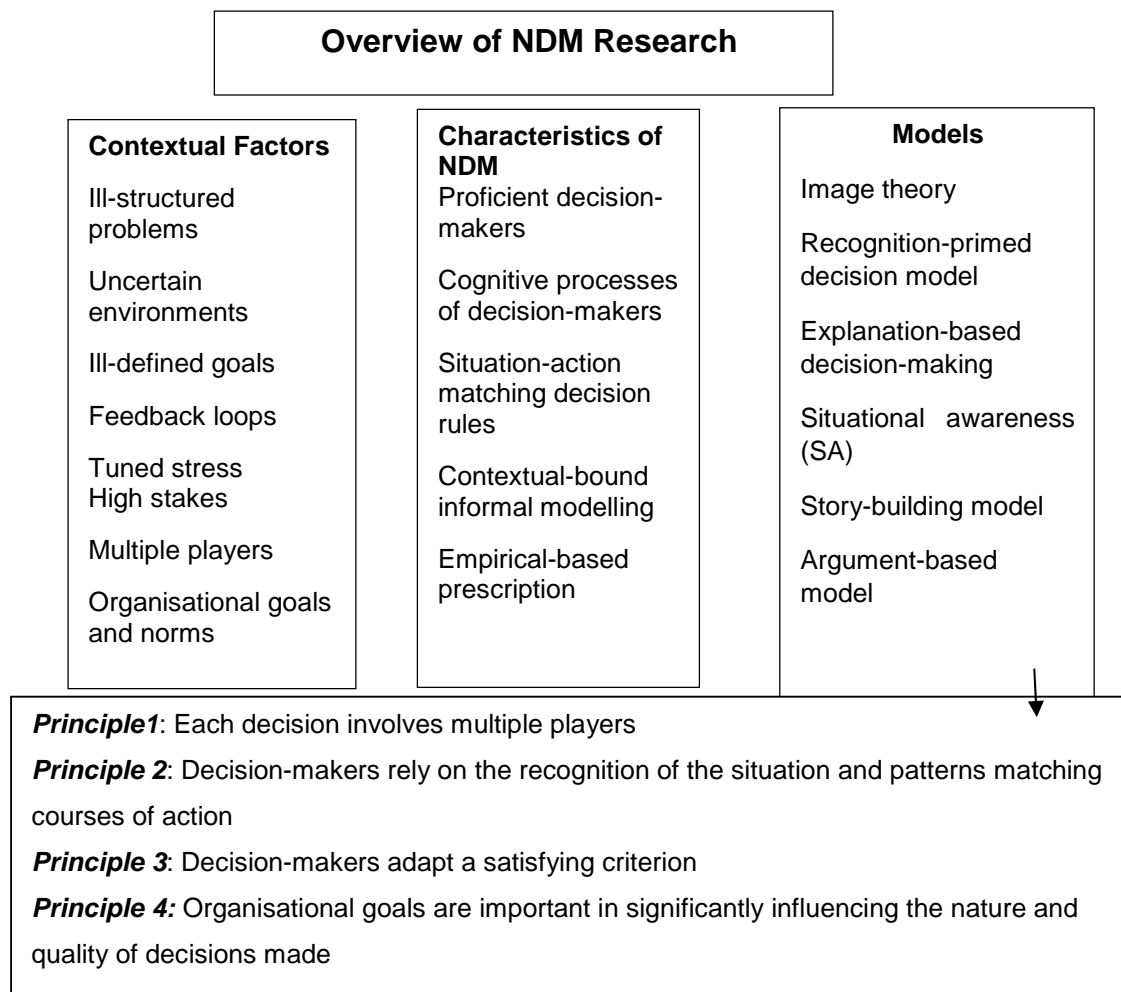
NDM differs from the classical decision-making theories in that it places emphasis on four criteria: (1) the use of experts or professionals as decision-makers; (2) the environment, which is usually characterised by time pressure, dynamic goals, uncertain and ambiguous conditions and high stakes; (3) describing strategies that

professionals use to make decisions; and (4) being aware of a situation (Gore, 2006; Gore et al., 2015; Klein, 2008; Lipshitz, 2006). Additional contributions to the NDM research are illustrated in Table 2.1 below.

2.6 Overview of NDM Research

From the literature, it seems evident that concepts (the contextual factors and characteristics of a naturalistic decision-maker), models (Klein et al., 1993; Orasanu & Connolly, 1993) and principles (Bryant et al., 2003) have emerged from NDM research. An overview of these concepts, models and principles, as applied in NDM research, is illustrated in Table 2.1

Table 2. 1 Overview of NDM Research



Adapted from Bryant et al. (2003) and Orasanu and Connolly (1993).

Table 2.1 illustrated an overview of NDM research; concepts and models relevant to the current study which are discussed below.

2.6.1 Contextual Factors of NDM and Characteristics of Naturalistic Decision-Makers

Klein et al. (1993) and Orasanu and Connolly (1993) identify eight key contextual factors that challenge the way in which professionals make decisions in real-life situations. These factors relate to problems that professionals experience when making decisions. Problems most commonly addressed by professionals are viewed as ill-structured in nature, juxtaposed in uncertain and dynamic environments, usually risky, requiring action/feedback loops, placing immense time and pressure on decision-makers, tending to be highly complex, and involving multiple players to collaborate. The above-mentioned characteristics indicate that experienced decision-makers consider organisational goals and norms as opposed to decision-making in a vacuum (Klein et al., 1993; Orasanu & Connolly, 1993; Gore, et al., 2015; 2006).

The current study argues that the above contextual factors are evident in the ID sector in Ireland. The environment in which MDTs make decisions could be under time pressure. HIQA's recommendation, for example, is typically to move an adult to community living within a stated time frame. On occasion, organisations may not be in a position to comply, due to a number of factors outside their control, such as identifying suitable accommodation. Dynamic goals are evident in organisations, because they have been tasked with moving adults with an ID from congregated settings to the community by 2019. The HIQA directive may impose ongoing changes to the goals for each adult with an ID. There could be a case, for example, where HIQA has stated that an individual should move to community housing. The organisation may be uncertain as to whether they will meet this directive, due to financial constraints and a lack of appropriate accommodation in the community.

Furthermore, the organisation may not predict how people with an ID would adapt to their new environment in the community, and how the immediate community would receive the individual. In relation to high stakes, an adult with an ID moving to the community setting may present with behaviours that are unpredictable and challenging, which may result in injurious behaviour to self and-or to others in the community. Hence, it could be argued that in the Irish context, MDTs may be influenced by a myriad of factors in their decision-making process when transferring

people to community settings. These factors have not been explored formally as a framework for decision-making by MDTs.

The aforementioned normative theories (classical and bounded rationality models) are viewed as failing to address the contextual factors mentioned above because they were formulated for straightforward tasks (Klein & Calderwood, 1991; Klein, 1993). They were not intended for situations where time was limited, where goals were vague and shifting, and where data were questionable. Therefore, these models are not seen as useful in helping people to make decisions in dynamic settings (Klein & Calderwood, 1991; Klein, 1993).

In an attempt to understand how people make decisions in real-life contexts, Lipshitz et al. (2001) specify five characteristics that define the NDM framework. The NDM places emphasis on the following:

- 1) Proficient decision-makers. These are people with relevant experience or knowledge in the decision-making situation and who rely on their experience.
- 2) An orientation towards cognitive processes of the decision-makers, not just the outcome. The intuitive theories, in particular NDM theorists, emphasise the outcome as secondary to the cognitive processes and consequently examine cognitive processes involved in decision-making (Gore et al., 2006; Klein, 2008; Lipshitz, 2006; Zsombok & Klein, 1997). The cognitive processes examined in NDM include planning, sense-making, coordination, and managing uncertainty and risk (Klein et al., 2003) to decide on a particular action to take (Klein et al., 1993). The NDM models describe what information decision-makers look for, how they interpret information, and which decision rules they use.
- 3) The development of situation-action matching decision rules allows people to make decisions by using various forms of matching, rather than by concurrent choice. That is, they evaluate options sequentially, one at a time, and select or reject options based on their compatibility with the situation. Matching can be analytic or done informally (Pennington & Hastie, 1993).
- 4) NDM focuses on the context-bound informal modelling of decisions. Proficient decision-makers rely on their experience and are sensitive to semantic and

syntactic content. Decision-makers use their cognitive processes (Klein et al., 2003) to solve specific problems, by taking concrete actions (Klein et al., 1993).

- 5) NDM puts emphasis on improving possible options for decision-makers, rather than replacing them altogether (Lipshitz et al., 2001).

In addition to the above-mentioned contextual factors, various models of decision-making have emerged out of NDM's body of research. Some of these are discussed below.

2.6.2 Models of NDM

As indicated in Figure 2.1, there are six NDM models. According to Bryant et al. (2003), the NDM framework is underpinned by the following four common principles, which apply to all models of the NDM:

1. Decisions are made by multiple players.
2. Decision-makers rely primarily on the recognition of a situation to generate potential courses of action and compare them to past experiences.
3. Decision-makers adapt a satisfying criterion, stopping the search once an acceptable course of action has been identified (Bryant et al., 2003; Klein, 1993).
4. The fourth principle is outlined by Schmitt (1997, cited in Gore, 2006 and in Meso et al., 2002) and states that organisational norms and goals are important and significantly influence the nature and quality of decisions made.

In a study examining which NDM models were applicable to 98 forensic team leaders, Helsloot and Groenendaal (2011) concluded that of the six NDM models, three were found to be commonly used: namely, the recognition-primed decision (RPD) model (Klein, 1993); the image theory (Beach, 1993) and the explanation-based decision-making model (Pennington & Hastie, 1993). These models are further discussed in the analysis of NDM below. The main similarity between all three models is that they focus on the recognition of the situation.

The difference is that in the explanation-based decision-making model, a story is constructed to assist in the decision-making, while image theory takes into account the decision-makers' values. According to Klein (2002), an advantage of the RPD model is that plans based on this model are found to be better adapted to situation

demands than other plans. However, one disadvantage is that the model has little recognition (Klein, 2002).

The current study discounted these models in favour of the situational awareness (SA) model for the following reasons: (1) The two Ecology Systems of Bronfenbrenner (1977) and Hogg (1997) that are discussed further below, emphasise the importance of considering the person's contexts when making decisions. (2) Claims made by the NDM framework are that decision-making consists of two aspects: assessing the situation and selecting a course of action (COA) and once the situation is understood, the COA decision is usually obvious. (3) One of the criteria of the NDM theories that distinguish them from classical decision-making theories is being aware of the situation (Gore, 2006; Gore et al., 2015; Klein, 1997; 2008; Lipshitz, 2006). (4) The SA model was used in Bartolo et al.'s (2001) study and SA is considered a precursor to effective decision-making (Endsley, 2000; 2009).

Situational Awareness Model

The SA model has been applied in various theories of the NDM, such as the cognitive continuum theory (Standing, 2008). This theory states that decision-making in naturalistic settings can range from intuitive thinking (Gore et al., 2015; Klein, et al., 1993) to analytic thinking (Ramiah & Banks, 2015). The terms "situational awareness", "situational assessment" and "situational measurement" appear to be used interchangeably in the literature (Endsley, 1995). The term was coined by Endsley in 1988 and developed further in the 1990s (Endsley, 2009). For consistency, the term "situational awareness" (SA) is adopted in this study. Endsley (1995) defined SA as the process of perception that is followed by the understanding and forming of judgments. In simple terms, SA is being aware of what is going on around you (Endsley, 2000; Stubbings, Chaboyer & McMurray, 2012). The SA model recognises that, in order to make informed decisions, decision-makers must first be aware of, and understand, the situation, integrating the meaning of what they perceive in accordance with the goals, and projecting future needs, thus preventing critical situations from happening (Endsley, 1995). SA is therefore a precursor to decision-making and performance (Endsley, 2009; Stubbings et al., 2012; Patterson et al., 2013). The SA model identifies three levels of SA associated with decision-making in naturalistic settings (Endsley, 1995; 2000), as outlined below.

Level 1: Perception of the Current Situation (Gathering Data)

This is the lowest level of SA and is associated with the professional's perception of information (Endsley, 1995; 2009). It involves perceiving critical factors in the environment and understanding the situation (Endsley, 2009). No interpretation of the data is performed at this stage. This level is intended to represent the initial receipt of information in its raw form. Sources of information may be tactile, visual and auditory stimulation within the work environment and tasks in which the person is engaged (Endsley, 1995; 2009).

Level 2: Comprehension of the Current Situation

In this level, not only are multiple pieces of information are collected, but they are also interpreted, stored, retained and analysed or categorised, in order to produce an understanding of the relevance of the tasks (Endsley, 2009). These multiple pieces of information are understood within a particular context (Endsley, 2009).

This process is facilitated by the use of mental models, that is, patterns of thought or behaviour that are instantly recognisable and understood by the decision-maker, and which effectively simplify the decision-making process (Endsley, 2009).

Level 3: Prediction of the Future Status

This is the highest level of SA and is associated with the ability to project the future states of the environment (Endsley, 1995; 2009), that is, the ability to forecast what is likely to happen in the future, and the associated implications (Endsley, 2009). Endsley (2009) advises that paying more attention to level 3 is crucial, as it allows for timely decision-making. She describes this level as a mark of a skilled expert. According to Endsley (2009), when all three levels are used, people are more likely to make effective decisions in many environments.

In their study, Bartolo et al. (2001) constructed a framework consisting of six decision-making task processes, four of which were derived from the SA model, namely: (1) *describing* the problem; (2) *explaining* the problem; (3) *predicting* the future manifestation of the problem; (4) *constructing hypothesis* with regard to reasons for the referral; (5) *recommending* strategies for managing the problem; and (6) *planning* the implementation of the recommendations.

The first four task processes were identified as SA processes and the last two were solution processes (Bartolo et al., 2001).

Bartolo et al. (2001) adopted an exploratory, purposive multiple-case research design, to capture sequential decision-making task processes used by multi-professional teams in a transdisciplinary assessment of children with disabilities, within the NDM paradigm. In this transdisciplinary approach, professionals from multiple disciplines assess the child simultaneously, using both standardised measures and informal methods. One person assumes the role of facilitator, one or two interact with the child, while others observe (Myers, McBride and Peterson, 1996). In Bartolo et al.'s (2001) study, two multi-professional teams comprising three people each used the transdisciplinary approach to assess, simultaneously, four preschool children (2½-5 years) who were suspected of having autistic spectrum disorder, in order to ascertain how decisions were made when using this approach. The two multi-professional teams had varied experience and conducted the transdisciplinary assessments at two different sites. The medical site was based in a neuro-disability centre in London and consisted of a paediatric senior registrar, a clinical psychologist and a speech therapist. The education site was based in a school psychological service also in London and consisted of an educational psychologist, a psychotherapist, and the deputy head of a special school.

During the assessments, group discussions took place involving a parent interview, a referral meeting among professionals, planning of assessment activity, behind-the-scene comments, the evaluation meeting among professionals, final conference with parents, and post-conference reflection. Post-assessment, semi-structured interviews with each participant and the families were conducted. All group discussions and interviews were audio recorded. Verbal protocol analysis was conducted to capture task processes at three hierarchical levels of decision-making, namely, main-goal episodes, sub-goal episodes and single statements. Four content categories were constructed to represent the type of information obtained in discussions, namely, behaviour and emotional aspects of the child's functioning, medical and contextual aspects, and group interaction aspects. The results indicated that all six decision-making task processes were applied in the decision-making processes of the multi-professionals at both sites. However, the multi-professionals differed with regard to the content to which the processes were applied, especially to the medical aspects.

Multi-professionals in the medical site, for example, obtained information on a number of medical aspects, as compared to the multi-professionals in the educational site, who ignored the medical aspects.

The study also indicated that there was a sequential trend in the application of six task processes influenced by professionals addressing problems, in a series of three cycles (use of all six task processes per cycle) of decision-making. *Constructing hypothesis* was found to be a major task process used by professionals in the medical and educational settings in all different content categories. In both settings, hypotheses were explicitly constructed first by eliciting more relevant and elaborate description of the child's difficulties from the referral. Additionally, hypotheses were raised in post-assessment interviews and discussions. Hence, the results were derived from retrospective think-aloud protocols. Describing and explaining were also major task processes at both sites, followed by predicting, recommending, and planning.

2.7 Critical Analysis Exploring NDM Empirical Studies

Due to a dearth of literature in the disability field, a search for empirical studies on NDM was expanded to include other disciplines. A search for empirical studies was conducted from 2001 to 2018. As previously mentioned, in the 14th NDM conference hosted in 2019, there were no papers presented or published that addressed the current topic. The study of Bartolo et al. (2001) was included, as it focused on MDTs in the disability sector, hence its relevance to the present study. Studies reviewed from various domains included the following: the military (Militello, Sushereba, Branlat, Bean & Finomore, 2015); healthcare (Baker-Ericzén, Jenkins, Park & Garland, 2015; Cioffi, 2012; Mackintosh, Berridge, & Freeth, 2009; Phipps & Parker 2014; Reiter-Palmon, Kennel, Allen Jones & Skinner, 2015; Taylor, Sims & Haines, 2014; Tower & Chaboyer, 2013); disability sector (Bartolo et al., 2001); labour disputes (Ramiah & Banks, 2015); interaction design (Hassard, 2009); forensic science (Helsloot & Groenendaal, 2011); simulated real-world environments (Patterson et al., 2013); and outdoor backpacking expeditions (Boyes & Potter, 2015). The results of the search are presented in accordance with the following themes: research design and methodology, NDM models of decision-making, types of NDM decision-making, limitations and conclusions.

Research Design and Methodology

Of the 14 NDM studies reviewed, eleven were qualitative research as compared to three that were quantitative. One of the criticisms levelled against NDM is that there is a scarcity of experimental, quantitative studies (Ericsson, 2005). Of the five qualitative approaches outlined by Creswell (2007), ethnography (Mackintosh et al., 2009; Taylor et al., 2014) and case study design (Bartolo et al., 2001; Militello et al., 2015; Cioffi, 2012) were the preferred approaches.

Only three publications reviewed for the current study applied NDM in team decision-making. First, Bartolo et al. (2001) used multi-professional teams to capture sequential decision-making task processes, as indicated previously. Second, Mackintosh et al. (2009) described key mechanisms, as well as supplementary supports for team SA, which were critical in-patient safety in delivery suites in four UK hospitals. These supports facilitated the work and coordination of MDTs consisting of midwives, doctors, social workers, interpreters, patients, coordinators and other professionals in the community and hospital settings. Ethnographic observations took place in two stages, which were 11 months apart. The following were observed: safety culture, non-technical skills, and teamwork and decision-making. Furthermore, focus group discussions took place with teams in the delivery suites. Inductive analysis was conducted. The authors concluded that key supports such as whiteboard, handover, and the role of the delivery suit coordinator served as formal methods of securing and maintaining team SA. The whiteboard, in particular, acted as an important viewing lens for doctors, while midwives took greater ownership of selecting and updating information. The supplementary supports included the role of the ward clerk, ad hoc communication, and written notices. The conclusion was that supplementary supports can augment key supports by either compensating when a key support is compromised or by contributing to a specific work culture (Mackintosh et al., 2009).

Third, in Baker-Ericzén et al.'s (2015) quasi-experimental study, clinicians were divided into those with and without training in evidence-based treatment (EBT) in community mental health. The team comprised psychologists, social workers and marriage and family therapists. The clinicians (48 in total) were individually presented with four different standardised written case vignettes, one at the time. The case vignettes consisted of clinical information about a child with disruptive behavioural

problems. The think-aloud technique was used. Clinicians were asked to verbalise out loud their thoughts about the case and make a decision about the treatment plan.

Verbalisations were digitally and video recorded and transcribed verbatim into verbal protocols. The authors concluded that evidence-trained clinicians demonstrated decision-making skills that were more consistent with the predictions of the NDM theory. They used forward reasoning, for example, by using the relevant clinical information provided and by asking focused questions (for example about symptoms) to gather additional information. They also asked half as many questions compared to those not trained in EBT.

Of all the 14 retrieved NDM empirical studies, there were no recommended years of work experience of professionals. The experience of the participants varied from 1 and 10 years in Bartolo et al. (2001) and 3 to 28 years (Militello et al., 2015). In Helsloot and Groenendaal, 11 years was the mean range of experience and 15 years in Ramiah and Banks (2015), whereas, in Boyes and Potter (2015), the average years of experience were 25 years. In the theoretical papers by Klein (1997; 2015), cognitive skills, such as the ability to assess the context/situation and use of experience to determine a possible course of action, were key determinant of professionals' decision-making processes, and not years of experience.

Another common element of the publications is that all studies used purposive sampling as a recruitment method, with the exception of Taylor et al. (2014), who used convenience sampling. Data collection was undertaken by focus group discussions, as recommended by NDM scholars, in order to understand the phenomenon of interest. This was the case in Helsloot and Groenendaal (2011); Militello et al. (2015); Mackintosh et al. (2009) and Taylor et al. (2014). Assessment discussions about the children took place in Bartolo et al. (2001).

Not only were focus group discussions and observations (Mackintosh et al., 2009; Militello et al., 2015; Phipps & Parker, 2014; Tower & Chaboyer, 2013 and Taylor et al., 2014) used in these studies, but also semi-structured interviews. The latter were conducted in Phipps and Parker (2014); Tower and Chaboyer (2013); Hassard (2009); Militello et al. (2015). However, in two studies, those of Boyes and Potter (2015) and Cioffi (2012), retrospective interviews were conducted. That is, participants were asked to recall memorable incidents in which their skills and experiences were applied.

In both studies, SA was the key feature for making appropriate decisions in naturalistic settings.

Only two studies reviewed, those by Taylor et al. (2014) and Bartolo et al. (2001), reported on how they achieved methodological rigour in their studies. Taylor et al. (2014) achieved rigour by applying the triangulation strategy, where two methods of collecting data were used to ensure credibility and conformability of the study, namely, focus groups and observations. Data collection continued until data saturation was reached with the third focus group. A total of 18 participants took part in the three focus groups. The study used a checklist, the consolidated criteria for reporting qualitative research, which supported the triangulation of focus groups and observational data. Additionally, co-authors checked the credibility of the first author's coding and categories and verified emergent themes.

In Bartolo et al.'s (2001) study, the triangulation strategy was also used, where post-assessment semi-structured interviews and group discussions were employed to collect data, in order to obtain complete perceptions of the participants. Lack of reporting on rigour may be in keeping with some proponents of NDM, who state that rigour is not an important feature of NDM research, which is conducted in natural settings and not in laboratories (Lipshitz et al., 2001).

NDM Models of Decision-Making

The 14 studies included in this review revealed that different types of models were used in various domains. Phipps and Parker (2014) for example, used both the RPD model and the image theory in their study. However, Boyes and Potter (2015), Hassard (2009) and Militello et al. (2015) utilised only the RPD model.

Commonly used NDM models in the professionals' daily practices, as well as contextual factors that might influence their decisions, were identified by Helsloot and Groenendaal (2011). In their study, 98 forensic team leaders were examined making decisions with regard to criminal charges in real-life situations. Two focus groups were each presented with three different cases (fire in a retail store, a family murder, and a murder) and each case consisted of two versions. Three contextual biases (gossip, the presence of a highly emotional context, and the difference in the amount of forensic information involved) were included in either version. Participants were asked to discuss the cases for 30 minutes and make their decision on whether or not the person

was guilty, based on the forensic information. The results indicated that participants generated examples representing the following models: the RPD model in a fire in a retail store case; image theory in the murder case, and the explanation-based decision-making model in the family murder case. In addition, decisions of the participants were influenced by contextual factors. For example, providing the participants with a greater amount of information resulted in further information gathering; participants were likely to spend more time on emotionally charged cases; and participants used not only forensic evidence, but also tactical unverified information (gossip) regarding the policy inquiry.

Phipps and Parker (2014) used the recognition-primed decision model and image theory of the NDM to examine how anaesthetists use the rules governing their practice. Over a six-month period, 23 consultant anaesthetists were observed carrying out their duties in two hospitals for a total of 170 hours. During observations and interviews, use of the following rules emerged: “doing the right thing”, as in conducting preoperative visits and equipment checks; “doing what works in the circumstances”, for example, going ahead with the procedure even if the patient had not fully fasted; and using one’s skills and expertise, such as determining the correct time for the procedure.

Of the 14 studies reviewed, three studies documented specifically how SA was a precursor to effective decision-making, as reported by Endsley (2000; 2009). The first example was that of Bartolo et al. (2001), indicated previously. Second, is a qualitative study by Tower and Chaboyer (2013), which used Endsley’s (2000) three-level model to describe SA as a precursor to decision-making in a naturalistic setting during documentation. Registered nurses (17) were asked to verbalise their thoughts and record what they were thinking, as they documented in-patients’ progress notes. Following the think-aloud data collection, recorded semi-structured interviews were conducted to further explore what they thought, as they documented information. Data were transcribed verbatim and individually analysed for evidence of cues informed by the three levels. The study concluded that registered nurses’ complex mental model for decision-making was drawing on all three levels of SA.

Third, unlike Tower and Chaboyer's (2013) study, Mackintosh et al. (2009) described mechanisms supporting shared SA between team members and supplement patterns of support, as indicated previously.

Types of NDM Decision-Making

NDM has been successful in describing intuitive decision-making by professionals in complex situations, where boundaries were unclear, time and resources were limited and tasks were often unexpected (Gore et al., 2015), as was the case in 12 of the studies. However, less is known about how professionals make decisions, when thinking analytically following a system (Standing, 2008). Such a study has been conducted by Ramiah and Banks (2015), who examined how analytic naturalistic decisions are made. They contrasted 50 experts and novices, while resolving labour disputes. Verbal protocols were analysed, using Toulman's argument model. The results revealed that when constraints of the arguments were clarified, labour officers were faster at resolving disputes, and expert decision-makers made more accurate reasoned justifications (warrants) than novices.

The only study that examined both intuitive and analytic thinking based on Standing's Cognitive continuum theory (2008) was conducted by Taylor et al. (2014). In their study, intuitive and analytic categories at the opposite ends of the continuum were used to analyse decision-making processes of care staff in four nursing homes, when providing mobility care. Care staff members were observed making decisions during mobility care provided in nursing homes, in accordance with the nine cognitive practice modes, ranging from intuitive judgement to experimental research. The observed events during a six-month period included transferring residents in and out of wheelchairs and chairs, as well as walking in the facilities. Additionally, focus group interviews with 18 nurses were conducted. Thematic analysis was used for these focus groups and content analysis for observations. The results indicated that care staff may make decisions either intuitively (by means of reflective and intuitive practice) or analytically aided by systems such as care plans (system-aided judgement) or guided by peers or residents (peer/resident-aided judgement).

Limitations

Although the results of the above studies on decision-making supported the NDM theory and models, these studies were not without limitations. In Bartolo et al. (2001),

for example, task and not interpersonal processes (maintaining group collaboration, eliciting referral concerns, and evaluating the group decision-making process) were analysed. Furthermore, this study was limited to two multi-professional teams assessing four children with a disability. Mackintosh et al. (2009) noted that the assessment of SA is challenging due to its complexity. Ramaiah and Banks (2015) were concerned about the use of verbal protocols and commented that asking participants to think aloud could influence their thought processes.

In Reiter-Palmon et al.'s (2015) study, the limitation was that healthcare professionals supporting patients who had fallen were on different shift teams and only came together for a limited time and dispersed again to resume their duties. Additionally, as the falls were infrequent and unpredictable, there was a need to document the falls promptly with different staff participating.

All the studies alluded to the fact that sample sizes were small and thus could not be generalised to other populations. However, Gore et al. (2015) argues that NDM research provides rich and meaningful insights that helps us to understand the complexities of decision-making. Therefore, larger sample sizes may not result in a contextual understanding of decision-making processes.

Conclusion of Literature Review

This review concludes that NDM has been researched in a wide variety of fields, using a diversity of theoretical frameworks, research designs, methods, and analyses. As a result, there is no proposed use of specific models, research design or methodology. It would seem that research in this area depends on the field of the researcher. The present study was guided by what has been researched previously, thus extracting relevant aspects of theoretical frameworks, models, research design and methodology. These studies were published in an array of journals, illustrating the heterogeneous nature of the field. Although studies within healthcare were evident, very few published studies were within the disability field. Indeed, no study was found addressing a similar topic to the present one, in the last 16 years.

2.8 General Criticisms of the NDM Framework

Field observations, drawing on methods from anthropology, ethnography, cognitive science, and discourse analysis, are critical to NDM research for examining phenomena in their natural context (Gore et al., 2006; Lipshitz et al., 2001).

Simulations (for example aircraft cockpits) and laboratory techniques have also been used. However, some researchers argue that the use of simulations and laboratory experimentation are not suitable for NDM research as they imply giving up some contextual features that define the phenomena in real-life settings (Lipshitz et al., 2001).

In addition, NDM researchers forgo the type of rigour that guides laboratory studies (Lipshitz et al., 2001). Consequently, NDM methodology has been criticised as being soft, as researchers do not adhere to the methods and standards appropriate for laboratory-based experiments (Gore et al., 2006; LeBoeuf & Shafir, 2001; Lipshitz et al., 2001). However, proponents of NDM have indicated that it is not applicable to research conducted in a laboratory (Klein et al., 1993, Klein, 2008).

Lipshitz et al. (2001) conclude that there are three challenges facing the NDM paradigm. The first challenge is that the NDM paradigm needs more empirical studies applying appropriate rigorous methodology. The above authors suggest using complementary routes; that is, balancing the results from qualitative field research with findings from traditional experimental work; developing simulation methods that allow observations of complex decision processes under controlled conditions; and developing a better understanding of, and methods for, rigorous observations of decision-making in naturalistic settings. The second challenge is the development of more comprehensive models and theories and well-defined boundary conditions for what NDM is and what it is not. The final challenge is to start the process of consolidating the applications of NDM, conducting careful evaluations to better demonstrate the efficacy of the NDM applications (Lipshitz et al., 2001).

Rather than the methodological issues raised above, Meso et al. (2002) are critical of the notion of expert-based decision-making. The authors point out that NDM puts emphasis on experts making decisions in organisations, though expertise is hard to define in organisational settings. This is because the outcomes of most decisions have multiple causes and effects, most of which are unknown or misunderstood by individuals involved in the decision-making process. Professionals may not have routinised or well-defined scenarios for dealing with the diverse decision-making situations they encounter (Meso et al., 2002). Some problems can present in contexts not previously faced by decision-makers. Furthermore, cognitive skills and

background experience (which are key determinants of professionals' decision-making within the NDM framework) used in one context do not necessarily transfer to other settings. Moreover, background experience may be limited or non-existent in other contexts, thus requiring decision-makers to be creative (Lipshitz et al., 2001).

The models of the intuitive theories are said to be formulated vaguely. They require detailed modelling of specific cognitive functioning and accurate decision-making settings (Bryant et al., 2003). Some authors are of the view that there is a role for prescriptive models, as purely descriptive models tend to overlook the intrinsic nature of certain decision-making. In medical practice, for example, descriptive models will result in unsatisfactory responses in the medical field, which is driven by standards of health, quality of care and expertise (Falzer, 2004).

Despite the above criticisms, Klein (2008) is of the view that NDM cognitive field research methods have proven to be useful for generating insights into decision-making. Hence, these methods are being used to study other macrocognitive functions such as SA, making sense, planning and re-planning, and the ways they are linked. Therefore, macrocognition, the study of cognitive adaptations to complexity, may reflect the next step in the evolution of NDM. The above empirical studies have indicated that in the NDM models, context factors might influence decision-makers.

The objective of the current study was to determine not only the decision-making processes, but also the knowledge brought to bear on those decisions made by professionals. To explore this knowledge, a theoretical framework was selected that identifies the key environmental/situation factors impacting on an individual with an ID. Below is a summer of ecology systems that are different from the NDM framework, which takes into account environmental/situation factors when making decisions.

2.9 Ecology Systems Relevant to the Decision-Making Process

The objective of the *Congregated Settings Report* (2011) is to transfer people with an ID from congregated settings to the community. As no decision is made in isolation (Klein et al., 1993), it would seem that it is important to acknowledge the context within which decision-making occurs. One way of looking at environmental/situation factors to assist MDTs in their decision-making process is to use the ecology systems of Bronfenbrenner (1977) and Hogg (1997). These approaches indicate that there could

be a wide variety of stakeholders involved, and a number of factors to consider, when moving people to the community. The two approaches are discussed below:

2.9.1 Bronfenbrenner Ecology Systems Theory

The ecology systems theory of Bronfenbrenner (1977) is a theoretical framework that looks at how different levels of the environment interact with the individual and how environments may have an impact on a person either directly or indirectly. The theory holds that the development of a person does not occur in a vacuum, but rather in the context of systems of relationships that form his/her environment (Bronfenbrenner (1977)).

Hence, Bronfenbrenner (1977) places emphasis on studying a person in the context of his/her multiple environments, known as ecology systems, in an attempt to understand his/her individual development. Bronfenbrenner (1977) outlines four main complex levels of environmental factors, each having an effect on the development of a person. The first level is the *microsystem*, which is the smallest and most immediate environment in which the individual lives. This comprises the person's immediate family (parents and siblings), home, school or day-care centre, peer group or community. Interactions within the *microsystem* typically involve personal relationships with family members, classmates, teachers, and caregivers, in which influences go back and forth. How these groups or individuals interact will have an impact on the development of a person. Similarly, how the person reacts to people in his/her *microsystem* will also influence how they treat the individual in return (Bronfenbrenner, 1977).

The second level of the environment is the *mesosystem*. This encompasses the interaction of different *microsystems* in which the developing person finds himself/herself. It is, in essence, a system of *microsystem* that involves linkages and processes between, for example, home and school, between peer group and family, or between family and church. The person's development is affected positively where harmony exists in the *microsystem* (Bronfenbrenner, 1977).

The ecosystem is the third level which contains connections between *micro* and *meso-systems* that influence the environment in which a person lives. That is, this level defines the larger social system in which the person does not function directly. It comprises the people and settings which the person may not directly interact with, but

which may still have an effect on the individual. Such settings and people may include workplaces, the larger neighbourhood, and extended family members. In this setting, the person is not an active participant in decision-making, but the decisions made still affect the individual (Bronfenbrenner, 1977).

The fourth level of the ecology system theory is the *macrosystem*. This level encompasses the environments (*microsystem*, *mesosystem* and *exosystem*) in which the person lives, as well as other systems that affect him/her. It comprises cultural values, customs, economic, educational, political, and legal systems. The effects of larger principles defined by the *macrosystem* influence the interactions of all other levels (Bronfenbrenner, 1977).

Bronfenbrenner's (1977) model of ecology systems has various versions, for example, the person-process-context model (Bronfenbrenner & Crouter, 1983) and the bioecological model (Bronfenbrenner & Morris, 1998). It has been used to examine factors associated with parenting success for caregivers of children with disabilities, as in Algood, Harris and Sung Hong's (2013) study. It has also been adapted and used by different researchers to analyse situations in different fields. Hogg (1997), for example, applied this approach to older people with an ID.

2.9.2 Hogg's Model of Ecology System of Older People with Intellectual Disabilities

Another model that acknowledges the importance of the context within which decision-making occurs, particularly among adults with an ID, is that of Hogg's model of ecology system (1997). This model analyses situations and other factors impacting on older people with an ID. It looks, for example, at the impact of cultural influences on family, carers, and service provision. The model emphasises that, as the person with an ID gets older, there will be changes in his/her life and changes in their family situation and environment. Hogg states that this model is not static but rather, changes over time, with all elements subject to changes individually and in interaction (Hogg, 1997). He identifies eight levels and, in the same way as in Bronfenbrenner's model, these levels interact with each other. At the centre of the system are: (1) the older person with an ID; (2) his/her immediate family; (3) close community of neighbours, friends, and others with whom they interact; (4) specific service provisions, for example day services; (5) organisations that provide services; (6) the wide range of legislation bearing on service provision and the rights of people with an ID; (7) philosophical

considerations of the service, and society's values and ideologies; and (8) cultural values and influences.

Both models highlight the need to look at all levels and to consider the role they play in the lives of individuals with an ID. They contribute to the body of knowledge, in that they provide a theoretical context within which to consider how individuals, with or without an ID, interact in different contexts. The above ecology systems are relevant to the current study, in that they may provide MDTs (tasked with implementing the *Congregated Settings Report* of 2011) with a framework that could assist them in determining what kind of environmental/situation factors to consider at different levels of the ecology systems that could facilitate the transfer of adults with an ID to dispersed housing in the community.

The current study has noted the similarities and differences between the ecology system models. It adapted both models and constructed a model relevant to adults with an ID, namely, a model of ecology systems of adults with an ID (Figure 2.1). In this model, the four levels of the ecology system are as follows: *microsystem*, *mesosystem*, *exosystem* and *macrosystem*.

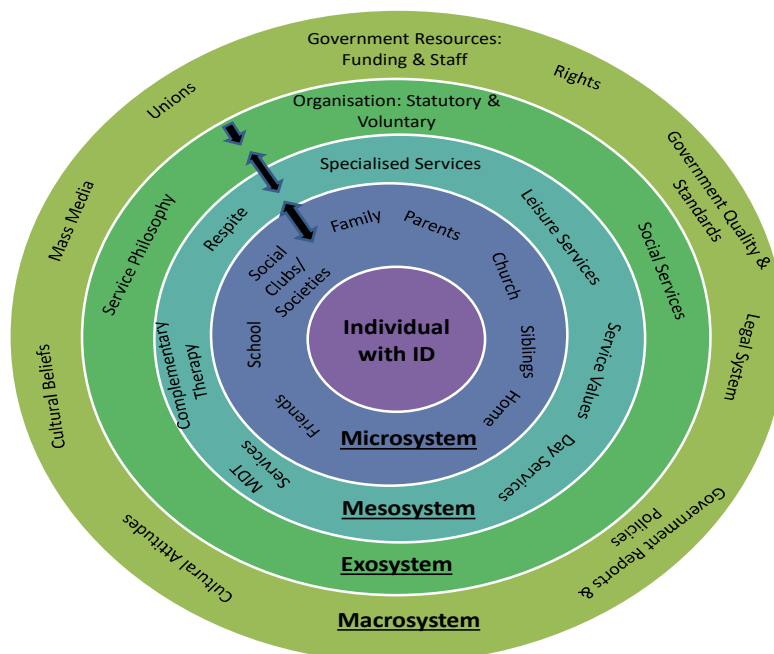


Figure 2. 1 Model of Ecology Systems of Adults with an Intellectual Disability: Adapted from Bronfenbrenner's (1977) Ecology Systems Theory and Hogg's (1997) Model of Ecology Systems of Older People with Intellectual Disabilities

The previously mentioned ecology systems bring to light the importance of environmental information that needs to be considered when MDTs make decisions. With regard to the current study, in the above model, the *microsystem* represents an adult with an ID, who is in the centre, surrounded by his/her family, community and service settings.

The *mesosystem* includes information about the family interaction with community services, such as day services, respite, MDT services, advocacy, and leisure services. The *exosystem* includes details about the organisations (for-profit or not-for profit) that provide a service and their service philosophy. The *macrosystem* includes information about legislation, for example, government policies such as the *Congregated Settings Report* of 2011, standards and guidelines for service delivery (HIQA, advocacy, PCP) and resources (MDTs), rights (to live in the community as per article 19 of UN Convention) and cultural beliefs.

2.10 Summary of Literature Review and Identified Gap in the Irish Context

This literature review has presented two major contrasting theories of decision-making, namely, classical/normative theories, which are prescriptive, and naturalistic/intuitive theories, which are descriptive in nature. The literature review has also highlighted individual and team decision-making processes that support the NDM theory and the SA model, in particular, in different fields of study. The current study considered the tools used by MDTs when formulating a decision to changing living arrangements for adults with an ID. These tools included formal (SIS, JSN, ABS-RC: 2) and informal tools (AON), as well as approaches, such as PCP and advocacy.

A critical analysis of some of the NDM empirical studies revealed similarities and differences with regard to the design research, methods, and analysis, providing guidance for the methodological approach of the current study. The literature reviews also revealed that the NDM framework faces challenges with regard to methodology, empirical work and conducting careful evaluations to better demonstrate the efficacy of its applications (Ericsson, 2005; Lipshitz et al., 2001), as well as the issue of using experts rather than novices in the decision-making process (Meso et al., 2002).

Two ecology approaches provided a theoretical framework to examine how different levels of the environment interact with the individual, and how situational information may have an impact on a person—either directly or indirectly.

The two ecology approaches are the ecology systems theory of Bronfenbrenner (1977) and Hogg's (1997) model of ecology system of older people with intellectual disabilities. These approaches were adapted to construct a model suitable for adults with an ID. The ecology systems highlighted the importance of environmental/situational information that needs to be considered when MDTs make decisions.

The gaps identified in the current study are the lack of available empirical research exploring decision-making processes used within the current Irish context, as well as factors influencing MDTs' decision-making when transferring adults with an ID from congregated settings to dispersed housing in the community. Consequently, the objective of the present study was to determine the decision-making processes of MDTs who are involved in transferring an adult with an ID to dispersed housing in the community. Another objective of the study was to determine factors that MDTs consider in their discussions when transferring an adult with an ID to dispersed housing in the community.

3 CHAPTER THREE: RESEARCH METHODOLOGY

3.1 Introduction

The previous chapter reviewed the literature on decision-making, including processes, models and theoretical contextual frameworks that can assist MDTs in making effective decisions. The search has indicated that there is no empirical research on how MDTs make decisions in the Irish context when transferring adults with an ID from congregated settings to dispersed community-living options. The main aim of this study was to explore the decision-making processes of MDTs who were involved in transferring adults with an ID to community-living options. Therefore, the objectives of this study were:

- (1) To determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community. The process of decision-making was examined in keeping with Bartolo et al.'s (2001) framework of decision-making task processes, namely, *describing, explaining, predicting, constructing hypothesis, recommending and planning*.
- (2) To determine the factors that MDTs considered in their discussions when transferring an adult with an ID to dispersed housing in the community. The factors considered were analysed in accordance with thematic analysis, in order to highlight the trend of common emerging themes captured from the discussions.

This chapter describes the case study methodology used for investigating the research problem and the research questions developed as a result of the literature review. The chapter starts with the justification of the research paradigm and case study methodology (3.2). It then highlights the criteria for judging the quality of a case study design (3.3). The chapter then moves on to identify the research problem and questions (3.4). This is followed by the sampling strategy used to identify the relevant participants (3.5). It then highlights the data collection, in particular focus groups and face-to-face, semi-structured interviews, and the rationale for their use (3.6). It presents an outline of the qualitative approaches considered (3.7), followed by different data analyses used to address the research questions. The chapter also includes the rationale for data analyses, as well as the process involved (3.8; 3.9).

It illustrates cross-case analysis, indicating similarities and differences across all service providers (3.10) and presents communication sequences and ethical considerations (3.11). Furthermore, it presents a pilot study of the methods used (3.12), together with a summary of the methodology used in the study (3.13). Finally, the chapter concludes with feedback from the participants (3.14).

3.2 Justification of the Research Paradigm and Case Study Strategy

Patton (2002) suggests that the best way to choose a research paradigm is to think about the intended purpose of the study, as well as the target audience. This study aims to explore factors influencing decision-making and the decision-making processes of MDTs in different service providers that facilitate the transfer of adults with an ID from congregated settings to dispersed houses in the community. Therefore, it was considered that an explorative qualitative approach, rather than a quantitative approach, would be best suited for this study, for the following reasons:

- (1) The qualitative approach was commonly used in NDM research, as noted in 11 of the 14 empirical publications reviewed for this study.
- (2) The nature of the research questions (How? or What?) posed for this study were consistent with qualitative research, as they described the phenomena (factors considered in decision-making and decision-making processes of MDTs).
- (3) This phenomenon needed to be explored in “depth and detail”, to determine personal experiences of the participants.
- (4) This experience was studied in the participants’ naturalistic environments.

This exploratory study offered insight into experiential phenomena (decision-making processes of MDTs and factors considered in their decision-making) to determine, “What? or How?” The most suitable method for answering these questions was deemed to be the case study (Creswell, 2007).

A case study is “an empirical inquiry that investigates a contemporary phenomenon (the ‘case’) in depth and within its real-life context especially when the boundaries between phenomenon and context are not clearly evident” (Yin, 2014, p.16). A case is a bounded entity: person, people, organisations, events, programs, processes, decisions, critical incidents, or communities (Yin, 2012; 2014).

In the current study, a case was one of five service providers/organisations tasked with the implementation of the *Congregated Settings Report 2011*.

The following reasons endorsed the selection of a case study as the research strategy. Firstly, a case study can add value to the research, when the aim is to provide practitioners with tools to perform their work (Gummesson 2000; Yin, 2009) – in this case, factors influencing decision-making and, more specifically, the types of decision-making task processes that can be used by MDTs when transferring people to the community.

Secondly, case study methodology allows for an in-depth investigation and aims at describing the real-world experiences of a single case, in order to shed light on a larger population (Gilham, 2001) – in this case, organisations tasked with the implementation of the *Congregated Settings Report of 2011*.

Thirdly, case studies enlighten researchers about situations studied and evaluated, when they have no clear set of outcomes (Collis & Hussey, 2009; Zikmund, 2003) – in this case, decision-making processes used and factors influencing MDTs to facilitate the move to the community may vary from organisation to organisation.

Fourthly, the research issue is related to contemporary rather than historical events (Yin, 2009; 2012) – in this case, the contemporary events were the decision-making processes of MDTs in organisations tasked with the implementation of the *Congregated Settings Report of 2011* and the assessment of factors considered, in order to take appropriate action.

Previous research on decision-making processes, and NDM in particular, has adopted an exploratory approach, case study research design, for example, Bartolo et al. (2001), Cioffi (2012) and Militello et al. (2015). In keeping with NDM research, the current study used a multiple case study to describe phenomena for the following reasons:

(1) The logic of multiple case studies researching the same phenomena is deemed to make the overall study more robust (Yin, 2012). In this study, five case studies were conducted in five different service providers, where MDTs have shared in the decision-making experience of transferring people from congregated settings to the community.

The MDTs were decision-makers working within a bounded system of various organisations (Yin, 2012, 2014).

(2) Multiple cases were studied to understand the differences and the similarities between and across cases (Baxter & Jack, 2008; Eisenhardt & Graebner, 2007; Yin, 2012). As a result, the five case studies provided an opportunity to observe and analyse phenomena that had not previously been studied within the Irish context.

(3) Data derived from a multiple case study are considered reliable (Baxter & Jack, 2008), allowing for wider exploring of research questions and explanation of theories (Eisenhardt & Graebner, 2007).

(4) As suggested by Yin (2014), a variety of sources was used to gather data and to avoid any bias by getting information from different stakeholders.

3.3 Criteria for Judging the Quality of a Case Study Design

The current study used construct validity, external validity, and reliability for assessing rigour. These strategies are relevant to the type of case study design used (Cepeda & Martin, 2005; Houghton et al., 2013). Methodological rigour in the present study was modelled on NDM studies, particularly those of Bartolo et al. (2001) and Taylor et al. (2014). Consequently, the triangulation strategy was used to increase construct validity, where two sources of evidence were used, namely:

(1) Focus group discussions of a standard hypothetical case vignette, which replaced a service user, were undertaken to examine the decision-making processes, when moving people from congregated settings to the community, and the factors considered, in order to take appropriate action.

(2) Face-to-face semi-structured interviews with senior management were undertaken, to provide additional information on factors impacting the organisations' decisions when transferring adults with an ID to dispersed housing in the community. The benefit of using both data sets is that triangulation occurs, thus enhancing the level of validity (Cepeda & Martin, 2005; Houghton et al., 2013).

To increase external validity, MDTs from different backgrounds and different service providers discussed the same hypothetical case vignette, in order to identify the types of task process employed and the factors taken into account when making decisions. This required the researcher to provide sufficient details to allow participants to

determine the degree of similarities and differences between future studies (Merten, 2010).

The hypothetical case vignette was validated by five MDT members who participated in a pilot focus group and a senior manager validated the interview questions. All MDT members were from the same disability organisation, as suggested by Baker-Ericzén et al. (2015) and were tasked with moving people into community-living options.

3.4 Research Problem and Questions

The available data indicated that there was no empirical evidence on the factors considered and the type of decision-making processes used by MDTs within the Irish context when transferring adults with an ID from congregated settings to dispersed community-living options. Therefore, the objectives of the study were: (1) to determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community; and (2) to determine the factors that MDTs consider in their discussions when transferring an adult with an ID to dispersed housing in the community.

In keeping with this case study design, the descriptive “What” questions were used, as recommended by Yin (2012). In keeping with Braun and Clarke’s (2006) formulation of research questions, the first question was formulated in line with the NDM research of Bartolo et al. (2001). This question was applicable to MDT members (healthcare professionals only) who participated in focus group discussions. The second question was not based on pre-existing theory, but rather on inductive data, to determine a trend in common themes, if any, that emerged from analysing the content of the discussions. This question was applicable to all MDT members, including those attending focus groups, senior healthcare, and social care professionals, and senior management representatives who were interviewed. The latter were included to determine any additional organisational information they might consider when moving people to community-based living. Consequently, the following two research questions were addressed:

Research Questions:

- *What decision-making processes are used by MDTs when transferring an adult with an ID to dispersed housing in the community?*
- *What are the factors that MDTs considered in their discussion when transferring an adult with an ID to dispersed housing in the community?*

3.5 Qualitative Sampling Strategy

Purposive sampling is a preferred strategy in a case study design, as it provides an opportunity to purposefully select cases that could inform an understanding of a phenomenon and show different perspectives on an issue (Bowling, 2009; Bryman, 2008, Creswell, 2007). Purposeful sampling was applied in the current study.

Participant Level:

In case study research, not more than five cases in a single study are recommended. This is to allow ample opportunity to identify themes of the cases, as well as conducting cross-case analysis (Creswell, 2007). In line with the above, the MDTs of five organisations were invited to take part in the study. The use of the MDT approach in decision-making in this study was similar to that of NDM studies cited previously, namely, Bartolo et al. (2001), Mackintosh et al. (2009), and Baker-Ericzén et al. (2015).

Participant Profile:

In total, 33 MDT members participated in this study; 28 senior healthcare and social care professionals participated in the focus group discussions; and five senior managers from each of the organisations took part in individual interviews. All participants were over the age of 18 and the majority were females (31), with two males. Participants had a wide range of experience from 3 to 30 years, across a range of disciplines. Participants in the focus groups comprised senior speech & language therapists, occupational therapists, psychologists, behavioural support staff, physiotherapists, social workers, social care leaders, psychotherapists, community transition coordinator and nurses. In order to gain further insight into factors influencing the decision-making at a managerial level, one senior management representative (CEO/service manager/director of service/administrator) from each of the selected service providers took part in a face-to-face, semi-structured interview. All participants were required to have at least three years' experience in their current role.

This criterion reflected the HSE stipulation threshold of three or more years to progress to a senior post (HSE, 2017). Table 3.1 below illustrated a profile of the participants, with regard the type of service providers, number of participants and their gender, years of experience, and disciplines.

Table 3. 1 Profile of Participants

Service Provider	Number of Focus Group & Interviewees	Number of Participants & Gender	Range of Years' Experience	Discipline
NFVB	Focus Group 1	5 Females	10-20	SLT, Physio, Psych, OT, S.W.
	Interviewee 1	Female	20	Administrator
NFVB	Focus Group 2	4 Females 1 Male	15-30	S.W, S.W, BSS, Psych, SLT
	Interviewee 2	Female	22	Service Manager
NFVB	Focus Group 3	5 Females	3-15	OT, Nurse, S.W, SLT, SCL
	Interviewee 3	Female	10	Service Manager
NFVB	Focus Group 4	4 Females 1 Male	5-20	SLT, OT, SW, Nurse, SCL.
	Interviewee 4	Male	15	Director of Services
HSE Run	Focus Group 5	8 Females	10-25	PsychT, OT, S.W, Psych, Nurse, Physio, BSS, CTC.
	Interviewee 5	Female	18	Director of Services

Key: NFVB – National Federation of Voluntary Bodies; HSE – Health Service Executive; SLT – Speech & Language Therapist; OT – Occupational Therapist; SW – Social Worker; SCL – Social Care Leader; Physio – Physiotherapist; Psych – Psychologist; PsychT – Psychotherapist; BSS – Behaviour Support Staff; CTC– Community Transition Coordinator

Site Level:

In order to recruit five organisations, a total of 15 were approached to participate in the study. These organisations were purposefully selected from a pool of 60, all of which were members of the NFVB in Ireland, and therefore tasked with implementing the *Congregated Settings Report* of 2011. Four organisations agreed to participate in the current study and seven declined, citing a lack of MDTs. Four organisations failed to respond to the invitation at all. Hence, it was necessary to widen the scope of recruiting and to include HSE disability services. Four HSE disability services were invited and one agreed to participate in the study.

Site Profile:

The five organisations recruited provided a mix of residential and community services for adults with an ID. Four service providers were run by religious orders and one was run directly by the HSE. The five service providers represented were from the HSE regions of Southern, South Eastern, West, Dublin North, and Dublin South. Service provider 2 was small, supporting fewer than 60 people and indicated that it did not envisage having the people it support moved to the community by the 2019 deadline. Service providers 1 and 5 were medium, supporting fewer than 100 people. Service provider 1 aspired to have everyone it supported moved in the next five years, while service provider 5 aspired to meet the deadline of 2019. The large service providers were 3 and 4, supporting approximately 100 residents. The former indicated that it would be three years before the remaining residents moved and the latter stated that it would have less than one-third of residents moved to the community by the end of 2019.

3.6 Data Collection

Yin (2014) states that case study research should aim to use a variety of evidence types, so that all sources can be reviewed and analysed together, to understand the phenomenon better. The use of multiple sources is said to rate more highly with regard to the quality of the study, as compared to the use of a single source of evidence (Yin, 2014). In line with case study research recommendations, multiple sources of data collection in the current study comprised focus group discussions and face-to-face, semi-structured interviews, each of which is discussed below:

3.6.1 Focus Groups

Collecting verbal protocol data via focus groups has become a common feature in healthcare and has been successfully used in healthcare research (Carlsen & Glenton, 2011; Fryer et al., 2016; Kreuger, Colletti, Bogner, Barg, & Stineman, 2017; Perreira & Berta, 2016) to evaluate health services and to elicit views of key stakeholders (Kitzinger, 1995; Kreuger et al., 2017; Powell & Single, 1996; Twohig & Putnam, 2002; Halcomb et al., 2007). Focus groups are carefully planned series of discussions with participants that possess certain common characteristics gathered together to help understand a topic of interest (Morgan, 1997; Breen, 2006; Kreuger & Casey, 2009). They are considered to be an effective instrument of collecting data (Creswell, 2015; Mertens, 2010; Morgan, Kreuger & King, 1997; Kreuger et al., 2017; Perreira, & Berta, 2016).

Focus groups are used to gain an insight into a topic, so that decision-makers can make more informed choices. Furthermore, they are viewed as a quick and reliable method of gathering broad impressions about experiences and opinions on products or services (Kreuger & Casey, 2009). Focus groups are seen as safe discussions in which to explore sensitive subjects that might be difficult to talk about during face-to-face interviews (Bowling, 2009; Kreuger & Casey, 2009). Participants may often argue and challenge each other about their experiences of a topic, thus allowing the researcher to have a more realistic account of what participants think and how they express their thoughts (Bryman, 2008).

Rationale for Focus Groups

In the current study, little was known about decision-making processes used by MDTs and the factors they consider when transferring adults with an ID to dispersed housing in the community. Therefore, focus group discussions were deemed to provide an opportunity for MDTs' opinions to be heard, and an effective way of exploring their descriptions of the phenomena (decision-making processes and factors considered), as well as their perceptions and feelings about the topic (Fryer et al., 2016; Belzile & Oberg, 2012; Morgan, 1997; Ryan, Gandha, Culbertson & Carlson, 2014), that is, the implementation of the *Congregated Settings Report* of 2011. Type A focus groups were conducted as suggested by Ryan et al. (2014). Here, the moderator uses a standardised protocol with a prompt directive along the lines of: "Please read through

the case and verbalise your decision as a group and rationale for same.” In contrast, Type B focus groups use loosely structured protocols that allow the participants to take over the focus group process (Ryan et al., 2014). Although there are no specific guidelines as to the number of focus groups to conduct in a given study, many researchers aim for 4-6 (Morgan, 1997; Carlsen & Glenton, 2011; Kitzinger, 1995) or 4-20, depending on the aims of the research and the availability of the resources (Bowling, 2009; Kitzinger, 1995; Powell & Single, 1996). The size of a focus group can vary from 4-12 participants (Breen, 2006; Carlsen & Glenton, 2011; Kitzinger, 1995; Kreuger & Casey, 2009). However, focus groups of not more than 9 participants in a group are recommended, to allow participants to talk freely, especially when the topic is controversial or complex (Mertens, 2010).

In this study, a total of five focus groups was hosted, each with five to eight MDT participants from five different organisations. The duration of the focus group discussions was typically 60 minutes, as suggested by Goss (1998), Krueger (2009), Kitzinger (1995) and Mertens (2010). With the consent of the participating service providers, focus groups and interviews with senior management were conducted on the same day, at the participants’ organisations. The organisations were thought of as the most convenient location for participants in order to minimise disturbances to their schedules (Boyce & Associates, 2006; Breen, 2006; Powell & Single, 1996). As part of signing a consent form, MDT members indicated the title of their profession and the number of years of experience they had in the disability field. All data were gathered in 2018.

Material and Procedure

One hypothetical, uniformly written, case vignette, which replaced a service user, was devised explicitly for the present study, following from Baker-Ericzén et al. (2015). This hypothetical case vignette was presented to all five MDTs (healthcare and social care professionals) for discussion, in order to determine the type of decision-making task processes used. The hypothetical case vignette contained clinical information that is typically available to MDTs at initial assessment/contact, such as diagnosis, current concerns reported, reason for referral and demographic information, as cited by Baker-Ericzén et al. (2015). The participants were given opportunities to ask the moderator/facilitator questions about the profile of the hypothetical case, Rose.

The hypothetical case vignette (See Table 3.2 and Appendix 2) was developed by the researcher and validated in a pilot focus group by five MDT members from different disciplines, who have been working in the disability field, as suggested by Baker-Ericzén et al. (2015). Using the Type, A focus group approach, participants were asked to read through the hypothetical case vignette and verbalise their team decision and the rationale for same (See Table 3.2), following from Baker-Ericzén et al. (2015). The duration of the discussions was up to 60 minutes and data were digitally recorded and transcribed verbatim, following from Baker-Ericzén et al. (2015); Ramiah and Banks (2015) and Helsloot and Groenendaal (2011).

Table 3. 2 Instructions and Description of a Hypothetical Case Vignette

“Imagine that you are presented with this case, representing a service user in your organisation. Discuss how you would approach this case. The decision you are being asked to make is around moving the service user to a dispersed house in the community. Please verbalise your decision as a team, including your rationale for the decision.”

Rose is a 32-year-old woman who has a diagnosis of a moderate ID, with co-occurring health issues of epilepsy and bipolar and is at risk of choking due to PICA (persistent craving and eating of non-food substances), as she ingests stones. She has been living in a unit on the grounds of the congregated setting managed by her support agency for 16 years. There are seven other women in this unit. She shares a room with another woman with an ID who is non-verbal. Rose can speak, although unfamiliar people find it difficult to understand her. She uses pictures and LAMH signs. Rose presents with self-injurious behaviours. She lives more than 80 miles from her family home, where her elderly parents reside. Her two younger sisters live abroad. She goes home fortnightly, staying for the weekend. She is a church attender at her local church, where she helps by distributing the parish newsletter at Mass. Rose reports that she is very happy in her residence and, according to staff, she gets on reasonably well with others in the unit. HIQA has recommended that Rose move to dispersed housing in the community.

3.6.2 Face-to-Face, Semi-Structured Interviews

Interviews are considered a common source of collecting evidence in case studies, as they offer richer and more extensive information than, for example, surveys (Collis & Hussey 2009; Yin, 2012; Zikmund, 2003). The use of interviews assists in gathering valid and reliable data that are relevant to research questions and objectives (Saunders, Lewis & Thornhill, 2009). In particular, semi-structured interviews in a case study design are likely to be used not only to reveal the understanding of “What or How”, but also explore the “Why” (Saunders et al., 2009).

Face-to-face, semi-structured interviews with open-ended questions were conducted (Collis & Hussey 2009; Zikmund, 2003) to allow the study to have greater freedom in the sequencing of questions, as well as providing the exact wording and the amount of time given to a particular topic (Robson, 1993). Interviews were digitally recorded, and transcribed verbatim, following the guidelines stipulated by Bowling (2009), Bryman (2008) and Creswell (2007; 2015). The duration of the interviews was up to 60 minutes. The study adhered to the code of conduct, as outlined by the UCD Research Ethics Committee (2016), when collecting, documenting, and storing data.

Rationale for Face-to-Face, Semi-Structured Interviews

In the current study, other members of the MDTs, that is, senior management representatives (CEOs/service managers/directors of services/administrators) of each organisation were interviewed. Senior management were included in the study, because it was anticipated that their contribution might be at organisational and policy levels, so factors that impact on their decision-making might differ from those of the MDTs in focus groups who work at the level of the individuals they support. In combination, the contributions from all, as opposed to some MDTs, was deemed to provide sufficient information about factors that impact on the decision to transfer adults with an ID to dispersed housing in the community. An interview schedule was devised in line with Mertens (2010) and Robson’s (1993) guidelines (See Appendix 3). Table 3.3 below illustrated the types of question asked during the interviews.

Table 3. 3 Table Interview Questions

1.	What is the ethos of your organisation?
1a	Is your Organisation involved in the implementation of the <i>Congregated Settings Report</i> of 2011?
1b	How does the ethos of your organisation influence the implementation of the <i>Congregated Settings Report</i> of 2011?
2	How many people with an ID is your organisation currently supporting?
2a	In the last five years in your organisation, how many adults with ID have been transferred to dispersed houses in the community?
2b	How many are waiting to be transferred?
3	How do you gather the information to transfer adults with an ID from the organisation's congregated setting to dispersed houses in the community?
3a	What criteria inform your decision to move people from congregated settings to dispersed houses in the community?
3b	In your organisation, what information influences your decision to transfer adults with an ID from congregated settings to dispersed houses in the community?
4	What are the goals of your organisation with regard to the <i>Congregated Settings Report</i> of 2011?
4a	How do the goals influence the decision-making processes concerning the transfer of adults with an ID from a congregated setting to dispersed houses in the community?
4b	How far along is your organisation in meeting the 2019 deadline set by the HSE?
5	What difficulties do you perceive in managing the transfer from congregated settings to dispersed houses in the community?

3.7 Outline of the Qualitative Approaches Considered for the Data Analysis

Literature suggests seven main types of qualitative data analysis, namely, content, discourse, narrative, interpretative, grounded theory, thematic analysis, and case study, in particular cross-case analysis (Braun & Clarke, 2006; Creswell, 2007, Clandinnin & Connelly, 2000; Kuckartz, 2014; Wilkinson, 2000). Of the seven approaches, five were not applicable to the current study for the following reasons:

- (1) Content Analysis:** this approach to analysis was not chosen for the present study as it tends to examine who said what, to whom, and with what effect (Bloor & Wood, 2006). It also focuses on frequently used words and phrases as the unit of analysis, which can be quantified in a qualitative study (Bloor & Wood, 2006; Kuckartz, 2014; Powers & Knapp, 2010; Ryan & Bernard, 2000; Wilkinson, 2000). In the current study, emerging themes were not quantified. Rather, it looked at qualitative themes of the views of MDT members who were required to make decisions as a team. The purpose of content analysis is to describe the characteristics of the document's content by examining discourse analysis. This type of analysis focuses on how language is used in everyday situations, for example, in semiotics (how sign language is created and communicated) (Burman & Parker, 1993; Willig, 2013). This study did not analyse how language was used, and as a result, the analysis was deemed not suitable for it.
- (2) Discourse Analysis:** This type of analysis focuses on how language is used in everyday situations, for example, in semiotics (how sign language is created and communicated) (Burman & Parker, 1993; Willig, 2003; Brown & Yule, 1983). This study is not analysing how language is used; as a result, the analysis was not suitable for the current study.
- (3) Narrative Analysis:** narrative discourse was not an option, because it uses stories, journals, field notes, photographs and autobiographies as a unit of analysis to create the meaning of people's lives (Clandinin & Connelly, 2000). The current study sought to determine how healthcare and management professionals make decisions as a team, in their naturalistic environments. It did not seek to document life stories.
- (4) Interpretative Analysis:** this approach describes personal experiences in detail, in order to gain an understanding of "what" happened and "how" the phenomenon was experienced (Creswell, 2007). The current study focused on determining the type of decision-making task processes used by MDT members and factors they consider when moving adults with an ID to dispersed housing in the community, not how MDTs look at how the experience happened.
- (5) Grounded Theory:** this was not applicable to the analysis of this study, as it involves discovering an emergent theory via the analysis of data from the

“bottom up” (Holloway & Todres, 2003; Thornberg, 2012). In the current study, the analyses were both data and theory driven, as indicated below. In the former, themes derived from data were not linked to a particular theory, but rather to data themselves, in order to determine common emerging themes captured from the discussion of the MDTs. Additionally, the study was based on the already existing theory, the NDM theory, in particular, that of the type of decision-making task processes employed in Bartolo et al.’s (2001) framework of decision-making task processes.

In summary, none of the qualitative analysis options outlined above were deemed appropriate for the present study. However, two types of analyses deemed suitable were thematic analysis and cross-case analysis. Each is discussed below, together with its rationale and the processes involved. Additionally, each analysis is discussed in relation to the research questions.

3.8 Analysing Research Question One: Deductive Coding Using the Bartolo et al. (2001) Framework of Decision-Making Task Processes

3.8.1 Thematic Analysis and Rationale

The benefit of using thematic analysis is that it is flexible and can be applied across a range of theoretical and epistemological approaches (Braun & Clarke, 2006). The current study used thematic analysis for a number of reasons, as follows. Firstly, thematic analysis is a method used to identify, categorise, analyse, and report common themes within qualitative data (Braun & Clarke, 2006). Secondly, it comprises three types of analysis (Percy et al., 2015) to develop and select themes for analysis, namely, deductive and inductive thematic analysis (Gale et al., 2013; Elo & Kyngäs, 2007, Roberts et al.2019), as well as thematic analysis, with constant comparison (Percy et al., 2015). The current study focused only on deductive and inductive thematic analyses. The former is theory driven, that is, codes and themes are pre-selected based on the pre-existing theoretical assumptions or specific research questions. The latter is data driven (DeCuir-Gunby et al., 2011; Gale et al., 2013; Percy et al., 2015), whereby codes are generated from the raw data, refined and organised into specific themes (Braun & Clarke, 2006; DeCuir-Gunby et al., 2011; Elo & Kyngäs, 2007; Gale et al., 2013; Percy et al., 2015; Roberts et al., 2019).

The combined approach of using deductive and inductive thematic analysis is not only applicable when looking at specific issues, but also appropriate when considering the way participants assign meaning to a phenomenon (Gale et al., 2013). The present study employed a deductive approach to address Research Question One and an inductive approach to address Research Question Two.

As with all methodologies, there are advantages and disadvantages to thematic analysis. The main disadvantage is that because of its flexibility, it may be difficult for researchers to decide what aspects of the data corpus to focus on, leading to inconsistency and a lack of cohesion when developing themes (Braun & Clarke, 2006; Holloway & Todres, 2003). Furthermore, if thematic analysis is not used within the existing theoretical framework, it may be limited to the description, rather than the interpretation, of data (Braun & Clarke, 2006). Additionally, a lack of substantial literature may cause inexperienced researchers to be unsure of how to conduct thematic analysis rigorously (Holloway & Todres, 2003). In this study, as indicated previously, construct validity, external validity and reliability were assessed for the data corpus, to enhance the level of rigour.

In addition to the abovementioned deductive and inductive analyses conducted in each of the five case studies, a further analysis was undertaken, which aimed to compare and contrast each of the five case studies. This analysis is discussed later in the chapter.

3.8.2 The Process of Thematic Analysis in the Current Study

In the present study, thematic analysis was selected as an appropriate analysis for identifying, categorising and reporting on common themes. Thematic analysis employs a six multi-stage process of categorising and coding, so that the researcher can analyse data that can be integrated into a model to explain the processes studied (Braun & Clarke, 2006; Kuckartz, 2014). The best-known stages of Braun and Clarke (2006) include familiarising oneself with the data; initial coding; generating themes; reviewing themes; defining and naming themes; and interpreting and reporting the findings. The current study was influenced by Braun and Clarke's (2006) model in linking theme emergence to the decision-making process of MDTs, in order to comprehensively draw truths out of what emerged from the data corpus. Hence the data analyses were applied in the following manner:

The **first stage** of thematic analysis involved deductive coding (extracting words/sentences within the data, labelling them and assigning units of meaning) of the transcripts from five focus groups, to identify the six decision-making task processes, namely: *describing, explaining, predicting, constructing hypothesis, recommending, and planning*. These decision-making task processes addressed Research Question One, which examined the type of decision-making task processes used during the discussions by MDT members in focus groups.

Friese et al. (2018) state that the purposes of coding differ from research to research and from phase to phase. Hence, a decision to code in a certain way lies with the researcher. In the current study, the coding process involved organising data into thematic categories, as per the six decision-making task processes. This involved the reading and rereading of the transcribed text five times by the researcher and a second coder to highlight and identify the decision-making task processes in each focus group's transcription.

To validate the description and coding (Jonsen & Jehn, 2009) for the six task processes, consensus was reached by the two coders who were involved in the coding process, as suggested by Belotto (2018). The second coder was a healthcare professional of similar background to the researcher, with over 25 years' experience in ID. One additional coder was deemed sufficient for the study, as "the use of one or more independent coders is supported in the literature by multiple authors" (Belotto, 2018, p 2625).

Focus group transcripts were manually categorised and analysed into different colour schemes representing the captured decision-making task processes. Within this process of analysis, the codes were moved around, as some data required fine-tuning before being coded to specific task processes. Although it is recommended that text segments should be assigned a single code (Creswell, 2015), it may be necessary for the codes to overlap, especially when data is viewed from different perspectives (Elliot, 2018).

Furthermore, according to Richard (2015), one statement may be coded multiple times because it is about different aspects of the study. As a result, in the current study, some text segments from the transcripts were double coded, as they showed different task processes applied in a passage, each of which needed to be referenced.

For example, the following extract was coded for the task processes of *describing* and *predicting*: “*She presents with PICA. There is a high possibility of her choking especially in the community. Is there a plan around this?*”

Double coding was undertaken on three task processes, namely, *describing*, *predicting* and *planning*, which were derived from six statements from four focus groups. The total number of task processes from these four focus groups was 534. The reliability was established at 98%, using Miles and Huberman’s (1994) calculation. As a rule of thumb, a minimum of 75% demonstrates an adequate level of agreement in small data with a high number of variables (Roberts et al., 2019).

The difficulty in the first stage was analysing and assigning the correct decision-making task process to the collected data.

The **second stage** of thematic analysis was the representation of the six decision-making task processes considered by the five participating MDTs, when transferring people to the community from congregated settings. This entailed counting the pieces of texts and identifying the most-to the least-used decision-making task process employed by the five MDTs. Below is an explanation of each decision-making task process as it applied to the current study.

3.8.3 Explanation of Each Decision-Making Task Process

In order to help with the interpretation of analysis of text coded within the six different decision-making task processes, explanations are provided below as to what type of information would be coded to each. Task processes are said to help teams to identify choices, recognise types of information to collect, engage in interdependent actions, and adapt to changing conditions (Cordes, 2016). Below are examples of the types of information coded to each decision-making task process.

- 1) **Describing**: in the current study, commentary which was classified as “describing” entailed anything related to a description of Rose’s cognitive and linguistic functioning, her medical condition, her move to the community and her existing environment.
- 2) **Explaining**: commentary that was classified as “explaining” captured text that explained external pressures resulting in a referral being considered, including

compliance with the *Congregated Settings Report* of 2011 and HIQA's recommendations to move Rose to suitable accommodation in the community.

- 3) **Predicting future manifestation:** commentary that was classified as "predicting" explored anything to do with predicting the expected adaptation to the new home in the community and supports required to ensure adequate community inclusion.
- 4) **Constructing hypothesis:** commentary that captured text which explained reasons why Rose herself was considered for a move. This entailed anything related to MDTs' discussion about constructing reasons for transfer, for example, Rose's age, her existing inappropriate placement, and behaviours that challenge.
- 5) **Recommending strategies:** this entailed any general comments on suitable existing supports and those that would be required in the community.
- 6) **Planning the implementation of the recommendations:** this included any action required with regard to implementing the specific supports needed, for example, specific training, up-skilling of frontline staff, and individual care plans to support Rose.

3.9 Analysing Research Question Two: Inductive Coding and Generation of Themes

The *third stage* entailed listening to and transcribing the audio recordings and reading and rereading a total of 10 transcripts from five focus groups and five individual interviews. The process also entailed selecting important text passages to highlight on flip charts, inductive thematic coding, and generating and ranking of relevant themes. Some commentary may have been lost during transcription, due to intelligibility difficulties, when all focus group members spoke at the same time.

After rereading all data, line-by-line inductive thematic coding commenced to create codes. This process distinctly addressed Research Question Two, which sought to identify factors that MDTs considered while reviewing Rose's suitability for community living and the people with an ID in general. In this process, codes referred to labelling of words/phrases into units of meaning connected to specific contexts, to create a codebook as a tool to assist in analysing large data (DeCuir-Gunby et al., 2011; Belotto, 2018; Maguire & Delahunt, 2017; Ranney et al., 2015; Roberts et al., 2019).

As indicated previously, a decision to code in a certain way lies with the researcher (Friese et al., 2018). In addition, the number of codes to use in analysing data varies in the literature from 20 to 300, as highlighted by Elliot (2018) and Saldaña (2016). However, Creswell's (2015) suggestion is to reduce the codes to 20 and then collapse them into five to seven major themes.

To offset biases and validate the codes and themes generated in the study (Jonsen & Jehn, 2009), two coders, as indicated previously, were involved in the coding process. The second coder was invited to carry out peer briefing on the interpretation of codes and themes on the codebook, following Belotto (2018). The reliability of the coding is presented later in the chapter.

Some transcripts were double coded, that is, more than one code was assigned to a section of a text, as it had different meanings. The text "*Now we have to move again because the house is not suitable due to mobility issues*", for example, was assigned separate codes, "suitable housing" and "diagnosis". These codes were logged into a codebook. A codebook serves as a guide for the coder tasked with coding data in a consistent and reliable manner (Ranney et al., 2015). This process allows for a consensus-based development of themes during the coding process (DeCuir-Gunby et al., 2011; Belotto, 2018; Ranney et al., 2015; Roberts et al., 2019). The codebook used in the present study (See Appendix 4) included codes, their definitions, and examples of each code, as well as themes based on the context of the study (Belotto, 2018; Ranney et al., 2015).

In the present study, one codebook was created for both the focus group participants and interviewees, as they had the same task to complete (Belotto, 2018), that is, implementing the *Congregated Settings Report* of 2011. Focus group discussions and the corresponding interviewee transcripts were coded for content in a manner akin to grounded theory, whereby the text was coded as it emerged from the data. The coding process of all transcripts followed the steps recommended by Belotto (2018). The first step involved reducing the raw data of each focus group and interview by coding at the level of meaning: that is, identifying and labelling similar concepts from the texts related to the Research Question Two from different participants of each case study, generating data-driven codes.

The Microsoft Word review functions “Highlighted text”, “Track changes” and “Comments” were used to assign codes in the margin of the transcripts, as per Belotto (2018). The coders went through transcripts from Focus Group 1 and Interview 1 to generate an initial set of codes and themes. They then proceeded to read through each of the transcripts of the focus groups and interviews (from 2-5), engaging in a constant comparison method, to see if any new codes and themes emerged, and to add them, as needed.

This whole process of reading transcripts from focus groups and interviews (from 1-5) was carried out three times, to introduce additional codes and themes that may have been previously missed. In summary, each transcript was double coded and reviewed three times by the coders.

The first iteration of codes resulted in a total of 56 codes from five focus groups and five interviews generated by the MAXQDA software, as indicated in Appendix 5 and Appendix 6. These codes were refined, and the number of codes was reduced to 35. Seven codes were debated disagreements, namely: “best practice”, “diagnosis/client profile”, “medical/changing health needs”, “informed consent/choice”, “importance of relationships/compatibility”, “social role/socialisation”, and “core values and principles”. For the first iteration, the reliability of the codes was established at 80%. Reliability was calculated using Miles and Huberman’s (1994) calculation, that is, the total number of agreements (35) divide by the total number of agreements + disagreements (7).

The second iteration involved clustering codes with similar meaning. There were more than five different codes, for example, that referred to communication: “LÁMH signing, picture communication systems (PECS), verbal, non-verbal communication and communicative behaviours”. These were condensed to one code, “Communication Status”. This reduced the codes from 35 to a total of 31. Seven codes were debated disagreements, namely: “best practice”, “diagnosis/client profile”, “medical/changing health needs”, “informed consent/choice”, “importance of relationships/compatibility”, “social role/socialisation”, and “core values and principles”. For the second iteration, the reliability of the codes was established at 77%.

Following the rereading of the transcripts by both coders, an agreement was reached on these disagreements. It was agreed, for example, that the code “medical/changing

health needs” would be a standalone code, rather than being incorporated into the code “diagnosis”, because extracts from the transcript indicated that there may be future health needs not currently diagnosed, such as mobility issues. In the second iteration, as indicated previously, the reliability of codes was established at 77%.

Following the identification of the clustered codes, the content of the transcripts was analysed again, in the third iteration, to examine emerging patterns that were relevant to the research question (Maguire & Delahunt, 2017). In this third iteration, codes were further condensed, as suggested by Creswell (2015), from 31 to 25, of which five were debated disagreements. These included: “best practice”, “diagnosis/client profile”, “medical/changing health needs”, “informed consent/choice”, and “core values and principles”. It was agreed to omit the codes of “importance of relationships” and “social role/socialisation”, as they were not deemed relevant to the research focus (Becker et al., 2012; Ryan & Bernard, 2003). Only relevant codes were logged into the codebook. The reliability of the codes was established at 80% in the third iteration.

In each process of iteration, themes were identified by looking at direct quotes from the data, identifying items of data that corresponded to specific patterns, and clustering related patterns into themes (Maguire & Delahunt, 2017; Percy et al., 2015). These themes were formed from the analysis of codes (Elliot, 2018, Saldaña, 2016). In the first iteration, 14 themes were identified. These themes were refined and, after consensus with the second coder, they were condensed to 11 in the second iteration and further reduced to five overarching themes in third iteration, in keeping with Creswell (2015) and Saldaña’s (2016) suggestion. The five overarching themes are indicated below in Table 3.4.

Table 3. 4 Generating Overarching Themes in Focus Groups and Interviews

First Iteration of themes	Second Iteration of Themes	Third Iteration: Overarching Themes
Client Profile	Client Profile	Client Profile
Diagnoses	Resources	Resources
Resources	Deinstitutionalisation	Deinstitutionalisation
Deinstitutionalisation	Challenges	Ethos
Dispersed Housing	Socialisation	Person-Centredness
HSE Funding	Environment	
Socialisation	Family Support	
Environment	Community Services	
Family Support	Ethos	
Community Services	Person-Centredness	
Ethos	Future Planning	
Person-Centredness		
Challenges		
Future Planning		

The rationale for prioritising these five overarching themes was based on the following aspects: (1) themes captured aspects of the data that were interesting (Braun & Clarke, 2006); (2) themes showed how MDT members placed different levels of emphasis on them; (3) themes were identified by the high regularity of their occurrence in the corpus of data (Ryan & Bernard, 2003) and consisted of codes that were relevant to the research focus (Becker et al., 2012; Ryan & Bernard, 2003).

The validity of the themes was determined by reviewing the direct quotes and ensuring that they accurately reflected the meanings, as per the quotes, and that they were coherent and distinct from each other (Braun & Clarke, 2006). The five overarching themes of *client profile*, *resources*, *deinstitutionalisation*, *person-centredness*, and *ethos* were logged into the codebook (See Appendix 4). Direct participants' quotes were extrapolated from the transcript, in order to support the rationale for the emerging themes (Belotto, 2018) and are presented in Appendix 4.

3.10 Cross-Case Analysis

The **fourth stage** of thematic analysis concentrated on cross-case analysis of focus group and interviewee transcripts from the five service providers. The rationale for using this type of analysis is that it allows patterns to be identified from multiple sources of information, to provide construct validity, thus making the overall study robust (Yin, 2003). Yin (2003), Creswell (2007) and Cousins and Bourgeois (2014) advocate the use of the cross-case analysis when studying two or more cases using a uniform framework. In addition, this type of analysis permits the researcher to look for similarities and differences between the cases and allows for generalisations from which others can learn (Creswell, 2007; Cruzes et al., 2011). In the present study, a cross-case analysis technique, namely, pattern matching, was used to look for within-group similarities and inter-group differences of the five cases (Baxter & Jack, 2008; Eisenhardt & Graebner, 2007; Yin, 2014).

The final stage of thematic analysis was writing up Chapters Three and Four of the study.

3.11 Communication Sequences and Ethical Considerations

A number of legal and ethical considerations were taken into account during the undertaking of this research, as follows:

- The legal basis for processing information relevant to this study was in line with Article 6(1) (a) “consent” and Article 9(2) (j) “scientific research” of the Data Protection Act of May 2018.
- Full review ethics was applied for and approval was granted in 2017 and 2018 (See Appendix 7) by University College Dublin before the study commencing, as advised by UCD’s Human Research Ethics Committee (2016).
- The study adhered to ethical guidelines, as stipulated by the UCD Human Research Ethics Committee (2008, 2016).
- As per ethical approval, the University’s letterhead was used to dispatch invitation letters, information sheets, and consent forms to different HSE-run organisations and organisations that were identified as members of the NFVB, all of whom were asked to participate in the research.
- An agreed protocol was applied in contacting organisations. In total, 15 invitation letters were written to CEOs/service managers/directors of

services/administrators (See Appendix 8 with the corresponding information sheet and consent form), outlining the objectives of the investigation. Five organisations agreed to participate in the study. As a result, these organisations were requested to nominate one person to assist the researcher. The nominated person circulated the invitation letters to MDT members (See Appendix 9 with corresponding information sheet and consent form) and senior management (See Appendix 10 with information sheet and consent form). The nominated person informed the researcher about how many MDT members were interested in participating in the study. Once the researcher had a list of names from each of the five organisations, they contacted the participants and arranged suitable dates for focus group discussions and interviews. The researcher collected the written consent forms on the day of the visit to conduct the focus group and interview in each organisation. The researcher had a debriefing protocol (See Appendix 11) in place for dealing with participants who might become distressed during discussions, as suggested by Draucker, Martsof and Poole (2009). In this way, the methodology of the study protected the anonymity of participants until they had provided consent.

- Data were pseudonymised and all identifiable information was redacted. Numeric coding was used to protect the anonymity of individuals and the organisation.
- Data were stored in a computer that was password protected and backed up weekly. Only the researcher and their supervisors had access to the data. Consent forms were securely locked and kept separately from the digital recorder. Physical data were stored under lock and key in the researcher's office in the HSE-funded premises, with a 24-hour monitored security system.
- In accordance with the Data Protection Act of 2018, participants were informed, before data collection commenced, that electronic data would be stored on the encrypted computer with authorised access only by the researcher and supervisors. In accordance with the ethical approval obtained for this study, data will be destroyed after the research degree has been granted.
- Participants were informed that they could opt out of the study up to the data analysis stage. They were assured of the above in writing, as well as verbally,

before the focus groups and interviews commenced. Upon completion, participants were given a summary of the research project.

3.12 Pilot Study

A pilot study is the collective term used to describe small-scale, exploratory research techniques that use sampling (Zikmund 2003), in preparation for data collection (Yin, 2014). Pilot testing assisted the study in determining if there were flaws, limitations, or other weaknesses (Breen, 2006) within the hypothetical case vignette discussions or within the face-to-face, semi-structured interview design. This allowed the researcher to make the necessary revisions before implementation and helped her, as a moderator, to learn about her effectiveness, and to obtain comments on how the discussion or questions come across for participants (Breen, 2006).

A pilot test should be conducted with participants that have similar interests to those who will participate in the actual study (Bryman, 2008; Creswell, 2007; Yin, 2014). Therefore, the hypothetical case vignette was piloted in one focus group consisting of five MDT members from different disciplines, who were tasked with moving people into community-living options. Also, one senior manager from the same organisation (Baker-Ericzén et al., 2015) was interviewed. This organisation was a member of NFVB but was not selected to participate in the actual study.

In this pilot study, the participants asked questions about the distance between Rose's residence and her family home, as this was not clear in the hypothetical case vignette presented. This allowed the researcher to clarify, in the final draft of the hypothetical case vignette, that Rose's current residence was 80 miles away from her family home. Additionally, the pilot test allowed the researcher an opportunity to practise being a moderator, answering questions and keeping the participants focused.

3.13 Summary of the Methodology

This chapter has described the research methodology that was employed in this study. Based on the qualitative nature of the data, the study used multiple case studies to answer the questions posed. Data collection was based on focus groups discussions and interviews. Data were digitally audio recorded, transcribed verbatim, and colour coded. Deductive and inductive thematic analyses were used to address Research Questions One and Two, respectively.

Cross-case analysis was used to identify patterns of similarities and differences between the multiple cases. Construct validity, external validity, and reliability tests were used to achieve rigorous standards and to remove the study's bias. Ethical issues were considered. Changes and lessons learned from conducting a pilot test were highlighted.

3.14 Feedback from the Participants

With their consent, MDTs gave the following feedback about the study. All participants were of the view that the study was relevant, given the *Congregated Settings Report* of 2011. MDT members in focus groups reported that Rose was typical of service users they dealt with in their current positions. They also indicated that the researcher acted as if she knew Rose well and was able to answer questions that helped them to make decisions about moving her into the community.

All the interviewees stated that adults with an ID should move to the community, because they will experience a better quality of life. They believed that funding was a challenge and impeded the progress of implementing the *Congregated Settings Report* of 2011. However, they were not concerned about the deadline for de-congregation, as they felt they had made significant progress, given the limitations of both funding and suitable staff.

4 CHAPTER FOUR: DATA ANALYSIS AND PRESENTATION OF RESEARCH FINDINGS

4.1 Introduction

The main aim of the current study was to explore the decision-making processes of MDTs who were involved in transferring adults with an ID to community-living options. There were two main objectives: (1) to determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community; and (2) to determine the factors that MDTs consider in their discussion when transferring an adult with an ID to dispersed housing in the community. Chapter Three described how the research design and methodology were developed. It also looked at how data were collected and the rationale for that approach. This chapter presents the study's findings, which centre on two Research Questions:

Research Question One: the type of decision-making task processes identified among MDT members who participated only in focus groups. Themes that emerged from the MDT members' discussions in focus groups were analysed using Bartolo et al.'s (2001) framework of decision-making task processes, namely: *describing, explaining, predicting, constructing hypothesis, recommending, and planning*. Similarities and differences in themes generated from different focus groups were also presented.

Research Question Two: the emerging themes from all MDT members in both focus groups and interviews (healthcare and social care professionals as well as senior managers respectively). This research question focused on the content within these discussions. Similarities and differences between the themes generated from different focus groups and interviews were also presented.

4.2 Findings

Findings from the qualitative analysis undertaken in this study were presented in accordance with the two research questions, as follows: (1) findings of the MDTs decision-making task processes, as well as commentary on the similarities and differences between the task processes used across focus groups; (2) findings of emerging themes identified across focus group and interview participants from the five service providers, with commentary on similarities and differences; (3) the chapter

ends with a summary of analysis of the research questions and an indication of the most notable findings.

4.2.1 Findings from Research Question One: Types of MDT Decision-Making Task Processes from Five Focus Groups

The present study first looked at the findings of the captured task processes, in keeping with Bartolo et al.'s (2001) framework of decision-making task processes. These task processes were generated from deductive analysis. Recall that the first objective of this study was to determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community. Hence, Research Question One: ***What decision-making processes are used by MDTs when transferring an adult with an ID to dispersed housing in the community?*** This question aimed to determine the type of decision-making task processes currently used by MDTs within the Irish context, when moving adults with an ID from congregated settings to dispersed housing in the community. The qualitative analysis of the transcripts from MDTs' discussions during focus groups revealed two findings. Firstly, participants were set with the task of deciding whether Rose, a hypothetical woman with an ID, should move from a congregated setting to dispersed housing in the community. The participants in general were in favour of such a move.

Secondly, MDTs' discussions during the focus groups ascertained that all six task processes identified by Bartolo et al. (2001) were employed by most, that is, four of the five MDTs in their decision to move Rose to the community. Figure 4.1 below showed the frequency of usage of these types of decision-making task processes captured in the commentary by MDTs in focus groups (FG) from five different service providers.

The rationale for using frequency counts/numerical data to indicate the usage of the types of decision-making task processes was as follows: (1) exploratory research design commenced with qualitative data collection and analysis which build up to quantitative analysis (Guetterman et al., 2015; Neale et al., 2014); (2) the use of numbers assisted in assessing and presenting the amount of evidence from the data and gave precision to statements about frequency, dominance, common, more, often and less than (Guetterman et al., 2015; Maxwell, 2010; Neale et al., 2014); (3) numerical data allowed patterns in the data to emerge with greater clarity and

increased the meaning of key findings (Neale et al., 2014); and (4) numerical data contributed to the generalisation within the study, establishing that the themes identified were characteristic of participants under review (Maxwell, 2010). Numerical data were included in this study but no conclusions should be drawn about the frequency of the types of decision-making task processes used beyond this study.

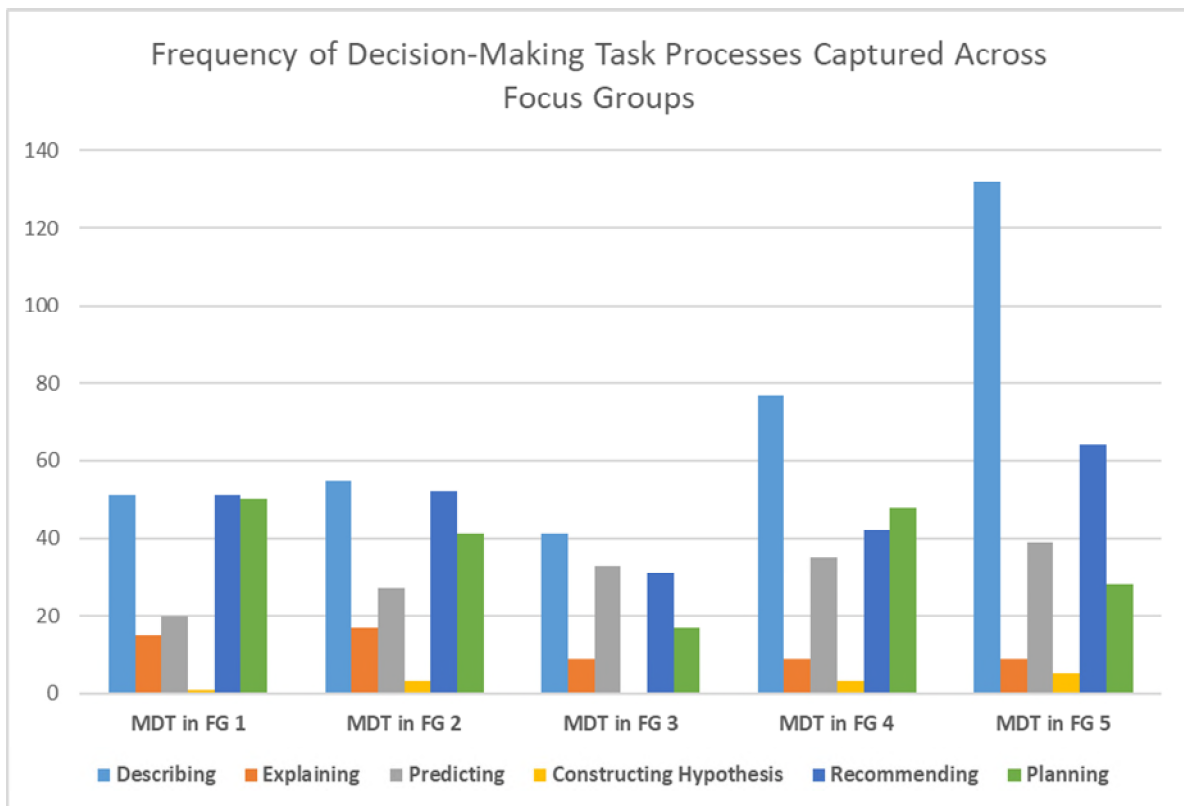


Figure 4. 1 Types of Decision-Making Task Processes Captured in the Commentary by MDTs in the Focus Groups of Five Service Providers

(a) Frequency and Analysis of Decision-Making Task Processes

Figure 4.1 above clearly showed that four of the five MDTs in focus groups used the six task processes ascertained by Bartolo et al. (2001) in their decision-making process. In contrast with Bartolo et al.'s (2001) study, there was one layer to the analysis of the six task processes in the current study. The analysis looked at what processes were used most often by MDTs. In general, and in keeping with Bartolo et al.'s (2001) study, there was a sequential pattern of decision-making task processes used by MDT members from different service providers in their discussions to transfer Rose to dispersed housing in the community. The most dominant decision-making task processes were *describing*, *recommending*, and *planning*. The next most

commonly used task processes were *predicting* and *explaining*. The least used decision-making task process was *constructing hypothesis*. The above sequential pattern of decision-making task processes contributed to the decision to move Rose, albeit at different levels of frequency.

(b) Explanation and Examples of Decision-Making Task Processes

This section presented a brief overview of the commentary generated during the focus groups. It used relevant quotations to demonstrate each of these task processes. It indicated code co-occurrence or text that was double coded (multiple codes) and provided an explanation thereof. In addition, it provided an interpretation of these codes.

As noted previously, *describing* pertained to descriptions of Rose's move to the community, including descriptions of her cognitive and linguistic functioning, her medical condition, and her environment, for example, FG3: NO4: "*This is a lady with moderate ID. She is capable of doing so many things independently. She can do well in the community. There are so many people similar to her who are striving in the community.*" FG1 NO2: "*So she is verbal, and she uses PECS.*" FG5 NO5: "*She lives in a place where she's more likely to hurt herself or eat things she should not eat.*" FG4 NO2: "*She is presently placed very far from her family, isn't she?*" FG5 NO6 "*An opportunity to move closer to home should also be pursued as an alternative.*" FG1 NO4: "*I suppose just one thing, and probably it does not apply that much in this scenario, because it does not say anything about her physical needs, but there is a possibility of her losing her mobility [so] at some stage the new house will need to have a ramp.*"

Describing was the most used task process by all focus groups. The de-congregation process and advantages of same for Rose were described in focus group discussions. According to the hypothetical case vignette, Rose was sharing a room in a unit with seven other residents in a congregated setting. MDTs in focus groups indicated that, in the community, Rose will share a house with four people, for example, FG3: NO1: "*If she were to share, she would be sharing the house in the community with 4 people.*" FG4 NO2: "*Remember, she cannot share a room, according to HIQA.*"

One explanation for the high frequency of the use of *describing*, may be suggestive of the following:

(1) MDT members spent time describing Rose's condition and her environment, and asked questions to gather more information about Rose. This may imply that MDTs need more time to discuss before making a decision to transfer an adult with an ID to dispersed housing in the community.

(2) In their discussions, they gathered information from different contexts, in order to understand Rose's situation. This may have resulted in some text segments double coded, that is, the meaning of the same quotation was applicable and referenced in another task process. The following texts, for example, illustrated the presence of multiple coding for different task processes: FG5 NO6: "*An opportunity to move closer to home should also be pursued as an alternative.*" FG1 NO4: "*I suppose just one thing, and probably it does not apply that much in this scenario, because it does not say anything about her physical needs, but there is a possibility of her losing her mobility [so] at some stage the new house will need to have a ramp.*"

The above texts not only described Rose's living environment and medical needs, but also encompassed future environmental planning, thus embedding the task processes of *describing*, *planning*, and *predicting*. The initial interpretation of the evidence of double coding was that it may be in keeping with the NDM characteristics of the types of problem experienced by professionals when making decisions, that is, problems were often complex, requiring further investigation by the professionals, in order to attain ample information to inform the decision-making process. Furthermore, the use of different task processes to make decisions may be consistent with criteria for NDM theories, which place emphasis on describing strategies used by professionals to make decisions.

(3) Another interpretation of the overlap of the task processes may be that the nature of thematic analysis was such that each text may not be coded to one theme, as participants often addressed multiple aspects of a complex issue, thus leading their commentary to be assigned multiple coding of task processes.

(4) Evidence of overlapping codes may reflect that MDTs understood Rose's current situation and drew ample information from the case vignette to make a decision to move her to dispersed housing in the community, in keeping with Levels 1 and 2 of the SA model.

According to Bartolo et al. (2001), *describing* was one of the four SA processes that take into account an individual's situation when making decisions. The quotes classified in this study as *describing* indicated that MDTs spent time discussing an array of conditions that would impede or facilitate Rose's move to the community. As with Bartolo et al. s' (2001) study, the extracts not only described Rose's medical conditions but also described the context in which she lived, and her level of cognitive and linguistic functioning.

The next most commonly used decision-making task process was *recommending*, which entailed any reference to comments on suitable supports, current and future, to support Rose in dispersed housing in the community, for example, FG5 NO2: "*Has she been told through social stories that she's moving?*" FG2 NO3: "*Is the psychiatrist recommending that the medication be changed?*" FG3 NO5: "So, this is the time to be creating the communication passport." FG3 NO1: "*I would recommend that she continue to use her iPhone and progress to an iPad and use that to communicate more.*"

Recommending was one of two solution processes identified by Bartolo et al. (2001), along with *planning*. Strategies on how to support Rose in dispersed housing in the community were evident in the transcripts of the current study. Extracts such as FG1 NO5: "*We are all recommending that the house must have grass or wooden patio due to PICA, to reduce chances of her ingesting stones*" suggested how the house in the community should look, in order to address Rose's needs. *Recommending* extracts within transcripts included the need for staff to communicate clearly with Rose through social stories regarding her move to the community, as well as identifying the importance of a communication passport to hold personal information about Rose and her presentation.

Overall, the transcripts demonstrated an awareness of MDT members in providing suitable supports necessary for Rose to transition and live successfully in dispersed housing in the community. The findings suggested that MDT members not only described Rose's condition but were also interested in offering solutions that might ensure a successful transfer to dispersed housing in the community. This data may be in keeping with Level 2 of the SA model, where MDT members discuss and suggest supports necessary for the move to be successful for Rose.

Planning included any discussion of planned action required to provide specific supports needed for Rose's transfer to the community, such as a transition period to trial the new residence, the upskilling of front-line staff, and the generation of individual care plans. FG5 NO7: "A process needs to be in place, the equivalent of a CTC, formalised transition process that will look at all her needs and who needs to support her." The following extracts depicted an overlap with the task process of describing: FG3 NO4: "A transition period needs to be well planned in advance, so as to ease the move and reduce the anxiety." FG2 NO2: "She has a risk of choking, so a choking protocol would be needed and staff trained in FEDS."

These were other examples of double coding where two task processes were applied (*describing* and *planning*), whereby the MDTs considered both explicit issues outlined in the case vignette (risk of choking), in addition to implicit issues (completion of the choking protocol and staff FEDS training), indicative of thematic analysis. Furthermore, the above extracts were in keeping with Level 2 of the SA model, one's current and future needs and supports to ensure a successful move to community living.

Similar to Bartolo et al.'s (2001) study, extracts in the present study highlighted plans and programmes that would need to be implemented in order to support Rose in the community. Participants were of the view that *planning* for such supports was essential in order for Rose's transfer to be successful, for example, FG1 NO4: "She will need nursing support in relation to her epilepsy." FG5 NO5: "Staff needs to know about the plans and programmes and know what to do in order to support her." FG4 NO4: "That's going to be challenging, going to a new community setting, so we normally look at the risks of the new environment as well, and discuss those and try to plan for those."

The *planning* quotes also highlighted the awareness of MDT members of the need to ascertain Rose's wishes and future goals. FG2 NO3: "I wonder, has something being done with Rose about vision setting, about her dream life? What are the things that she really likes? What she likes to do in the future?" FG2 NO2: "To figure out what would she likes to do, in case something happens in the future, an advocate might set up a circle of support." MDT members were of the view that consistent implementation of Rose's support plans and intervention programmes, once she moved to the

community, would maximise her meaningful participation in the community and promote successful inclusion.

Predicting explored anything to do with predicting how Rose would adapt to her new home in the community, for example, FG4 NO1: “*She may need a bedroom downstairs due to epilepsy.*” FG1 NO5: “*They will have to adapt the new house to suit her needs, like removing possible things that she can ingest.*” In addition, predicting explored supports required by Rose to ensure adequate community inclusion: FG4 NO3: “*I suppose it is about her exposure in the community to learn the new skills.*” FG3 NO1: “*There is a chance of her learning more independent skills if she is in the community.*”

Predicting was the second of four SA processes outlined by Bartolo et al. (2001), where future manifestations of the problem were predicted, for example, FG1 NO4: “*I suppose just one thing and probably it does not apply that much in this scenario, because it does not say anything about her physical needs, but there is a possibility of her losing her mobility [so] at some stage the new house will need to have a ramp.*” The following extract also predicted a future problem for Rose, thus leading to a decision for her to have a room downstairs, when she moves to the community. FG1 NO5: “*She has epilepsy and there is that risk of possible seizures, probably going down the stairs would be an issue, so a room downstairs would be better.*”

The above extracts demonstrated the ability of MDT members to predict possible challenges and to generate solutions to these challenges, to reduce the risk of Rose experiencing a failure in the community. Evidence of double coding in texts may reflect difficulties that professionals encounter when making decisions, as problems were not as straightforward to resolve according to the NDM framework. Furthermore, the interpretation of the data was that MDTs may be able to predict potential challenges for Rose, in keeping with Level 3 of the SA model.

Explaining captured commentary that explained external pressures that resulted in a referral being considered, such as compliance with the *Congregated Settings Report* of 2011 and HIQA’s recommendations to move Rose to suitable accommodation in the community. This was explained by the participants, as follows. FG1 NO5: “*So we need to know, Rose needs to know that her unit is closing down, it must be explained to her that she is moving out and how she feels about this.*” FG2 NO2: “*Do they not all have to move anyway, because of HIQA?*” FG3: NO2: “*Is it not that everyone is*

moving anyway, as part of de-congregation?” FG5 NO7: “Looks like the inspection is the cause of the move. Do her parents know?”

The third of Bartolo et al.’s (2001) SA process, *explaining* the reason for the move, was discussed, as indicated in the following extract: FG1 NO3: *“She has to move out, because HIQA will not register the place.”* As the recommendation to move Rose to a dispersed house in the community came from HIQA, as per the hypothetical case vignette, further explanation for the rationale behind the move may not have been deemed necessary by participants. The following extracts, for example, illustrated the emphasis that MDT members placed on communicating to Rose and significant others, including her family, the reasons for the move and the benefits of same. FG4 NO1: *“I know the family might be a little bit worried, because they may feel that HIQA are saying things have to change, so we need to explain to them why people have to move.”*

Out of the discussion of MDTs, it would appear that it was HIQA recommendations, registration and de-congregation that were important to MDTs in explaining the reason for the move. These were in keeping with Level 1 of the SA model, that is, gathering information pertaining to the context surrounding the move.

The least-used decision-making task process, *constructing hypothesis*, comprised any communication in MDTs’ discussions that constructed reasons for Rose’s transfer to the community, for example, Rose’s age, current inappropriate placement, and behaviours that challenge. FG1 NO3: *“She is still young. She deserves to experience life outside a campus-based home. She is a good candidate for community living.”* FG2 NO3: *“It is not a great building, so it is a building issue, rather than a service issue.”* FG2: NO4: *“She has bipolar and PICA.”*

Constructing hypothesis was the fourth of Bartolo et al.’s (2001) SA processes. Quotations highlighted the reasons considered by MDT members regarding why the move was taking place and why Rose, in particular, was selected for a transfer to the community. For example, FG4 NO1: *“Has Rose displayed any indications that she herself would like to move?”* FG5 NO8: *“Without labelling her as somebody with challenging behaviour, she is better off moving, so that she can have a better life.”*

Constructing hypothesis was used the least in the decision-making process of MDT members and, in fact, was not present at all in Focus Group 3. One explanation could

be that since a decision to move Rose had already been inferred by HIQA, MDT members did not further hypothesise about the reasons for the move. This may suggest that MDTs worked only with the data presented in the vignette and the perception of Rose's situation depicted therein, as per Level 1 of the SA model.

In general, the sequential pattern of the types of decision-making task process was similar across MDTs in each service provider, in their discussion of Rose. In all organisations there were three dominant decision-making task processes commonly used, namely: *describing*, *recommending* and *planning*. *Predicting* and *explaining* were next. The least used, or not at all used, decision-making task process was *constructing hypothesis*. Quotations were coded to all of the six task processes used, to make a decision to move Rose to dispersed housing in the community. However, there was evidence of an overlap of task processes of *describing*, *planning* and *predicting*.

4.2.2 Commentary on Similarities and Differences between the Decision-Making Task Processes across Five Focus Groups

Having identified the usage of different types of decision-making task processes in the focus groups, the researcher then analysed the pattern of similarities and differences between these task processes across the five participating organisations. Table 4.1 illustrated the frequency of different types of decision-making task processes used by MDTs in five focus groups. The usage of different task decision-making processes was discussed in terms of similarities and differences across the five service providers.

As indicated previously, the rationale for using the frequency counts/numerical data to indicate the usage of the types of decision-making task processes was to allow patterns in the data to emerge with greater clarity and to increase the meaning of key findings (Neale et al., 2014). However, no conclusions should be drawn about the frequency of the types of decision-making task processes used beyond this study.

Table 4. 1 Frequency of the six Types of Decision-Making Task Processes as Used by MDTs in Each of the Five Participating Focus Groups

MDT in FGs	D	E	PR	CH	R	PL	T
MDT in FG 1	51 27%	15 8%	20 11%	1 1%	51 27%	50 26%	188
MDT in FG 2	55 28%	17 9%	27 14%	3 1%	52 27%	41 21%	195
MDT in FG 3	41 31%	9 7%	33 25%	0 0%	31 24%	17 13%	131
MDT in FG 4	77 36%	9 4%	35 16%	3 1%	42 20%	48 22%	214
MDT in FG 5	132 48%	9 3%	39 14%	5 2%	64 23%	28 10%	277

Key: D-Describing; E-Explaining; PR-Predicting; CH-Constructing Hypothesis; R-Recommendng; PL-Planning; T-Totals

Table 4.1 reported on the frequency of each decision-making task process used in each focus group, as well as the total occurrences of all task processes across all focus groups. The frequency of the usage of task processes was mutually exclusive. The trends of the use of these task processes in different organisations is discussed below.

Similarities and Differences between the Five Focus Groups in Relation to the Decision-Making Task Processes Used

The trend in Table 4.1 above suggested that *describing* was the most frequently used task decision-making process by all five focus groups, followed by *recommending* then *planning*. However, cumulatively, the task decision-making processes of *recommending* and *planning* exceeded that of *describing* in four of the five focus groups, that is, in all the groups bar Focus Group 5.

The findings may suggest that Focus Groups 1 to 4 were more focused on the solution processes of *recommending* and *planning* than on *describing* alone, when making a decision to transfer Rose to dispersed housing in the community. Subsequently, the findings may imply that MDTs in Focus Groups 1 to 4 were more focused on solution-based task processes (*recommending* and *planning*) than the SA processes (*describing, explaining, predicting, and constructing hypothesis*).

This pattern was in contrast to Bartolo et al.'s (2001) study, where the converse was apparent. The interpretation of this contrast may be related to the task that MDTs in the current study were required to complete, that is, implementing the *Congregated Settings Report* of 2011. Consequently, in their discussions they generated more solutions-based task processes. Furthermore, MDTs may have been focusing on finding appropriate solutions, while adhering to the same principles of best practice of their professions. Hence, they considered similar factors that impact on their decision-making.

In the context of the SA process of *describing*, in individual organisations, MDTs spent most time outlining Rose's situation. All focus groups were in agreement that Rose should move to dispersed community housing, as her current residence was not conducive, due to her age, as she was the youngest in her residence. Additionally, she was sharing a room and her residence was none compliant with HIQA standards. However, participants in Focus Group 3 were concerned about the proximity of the proposed house in the community to Rose's family home and the impact that this may have on her access to, and frequency of, home visits. FG3 NO4: "*How far is the proposed house where she would be moving to? How far away is it from her parents, because at the moment, her home is XXX miles?*" FG3 NO2: "*Can she still visit her*

parents every second week and travel by bus, like before? Because, travelling to XXX by bus for XXX is not bad."

When discussing who should move with Rose to the community, Focus Group 3 focused on compatibility with peers with regard to age. FG3 NO 5: *"She should move with peers who of are a similar age."* FG3 NO1: *"Will all her new mates in the house be of the same age?"* FG3 NO2: *"The same age group should move together, definitely."*

In contrast, Focus Group 1 focused on cognitive ability and gender. FG1 NO2: *"She needs to move with women of similar or higher cognitive ability, because in order to fulfil her full potential socially, that needs to happen, so that she does not regress."* FG1 NO3: *"Yes, preferably ladies with [a] higher level of functioning, because she has lived with the others all her life really."* The comparison suggested that some groups were aware that for Rose to thrive in the community, she should be in a house with peers who were compatible with her, so that she would not regress cognitively.

Two groups highlighted the need for Rose's medication to be reviewed before she moved to the community. Focus Group 2 suggested a review around her medication for her bipolar diagnosis, for example, FG2 NO 5: *"I am thinking about her meds for bipolar: they need to be reviewed before she moves."* FG2 NO2: *"Has the psychiatrist reviewed her medications? She should consult her psychiatrist about her medication sooner rather than later."* Focus Group 1 recommended that her epilepsy status be re-evaluated before the move. FG1 NO4: *"This is a lady who suffers from epilepsy. A review around her epilepsy may be necessary before she transfers over to the community."* The two groups were of the view that her medication status may or may not change in the community, therefore it was advisable to establish a base line before she moved.

In the context of solution-based task processes, *recommending* and *planning*, Focus Group 3 recommended access to a nurse in the community, in case Rose should require medication for epilepsy in the future. FG3 NO5: *"Will she have access to a nurse in community housing? It may be no harm to start looking for one, because she may require medication in the future."* A similar recommendation was stated in Focus Groups 1 and 5. However, participants in Focus Group 2 were of the view that there was no need for a nurse in the community, as long as social care staff could be trained

in epilepsy management. FG2 NO5: *“You do not necessarily need nursing staff going out to the community.”*

Compared to other groups, Focus Group 5 was the only service provider with a dedicated post responsible for transferring people to the community, that is, the community transition coordinator (CTC). This group spent time discussing the role and remit of the CTC in the process of transitioning Rose to dispersed housing in the community, for example, FG5 NO2: *“I am just wondering, given that the parents are so elderly, and the change ahead is so big, is there consideration for a CTC who can very much mind the person's interests?”* The participants recommended training options for the CTC person and also recommended that Rose be viewed within the social role valorisation model of support (SRV), where for example, FG5 NO3 says: *“Rose's interests, assets and conditions for success can be explored.”*

These findings may explain the difference between this focus group and Focus Groups 1 to 4, that is, why the use of the *describing* decision-making task process was higher than those of *recommending* and *planning* cumulatively. The MDTs were more concerned with *describing*, as there was a designated CTC in this specific organisation whose remit was the *recommending* and *planning* decision-making task processes.

In *planning* for Rose's future needs, for example, Focus Group 3 recommended the continued use of IT to support Rose's independent skills, as she was able to use her iPhone, for example, and the apps on her iPhone. FG3 NO2: *“She can use her phone. Maybe a few apps that might help support and make her more independent can be uploaded, so that she can communicate effectively.”* FG3 NO4: *“She should continue to use her iPhone and progress to an iPad and use these to communicate more. Her SLT will be able to help her with that progression.”* This group gave more consideration to IT support. Perhaps this group's range of experience from 3-15 years was more immersed in the culture and reliance on IT, in comparison to the other focus groups, which comprised MDTs with an average experience ranging from 3-30 years.

In comparison to the other groups, the decision-making task process *predicting* was the second highest in Focus Group 4. This may be due to the fact that participants discussed challenges and possible risks that Rose might encounter in the community. FG4 NO1: *“Because she has a tendency to ingest things in her mouth, there is a risk of her choking.”* FG4 NO4: *“There is a risk of her tripping over and hurting herself, as*

you said that happened before.” The MDTs emphasised the development of, for example, a communication passport to educate staff about Rose’s needs and wants, thus minimising the risk of her becoming distressed in the new environment.

Compared to other groups, the decision-making task process *explaining* was the highest in Focus Group 2. This group spent time discussing whether the reason for the move had been explained to Rose, how she had been informed, and whether the benefits of community living had been explained not only to Rose but also to her family. FG2 NO1: *“Has staff explained to Rose why she has to move? Did she understand the reasons?”* FG2: NO3: *“I would imagine that an AAC device like Table Mat was used to explain HIQA’s recommendations, pros of moving, and to at least reduce her stress levels.”* FG2 NO4: *“Are the parents aware of the HIQA report?”*

The only MDT members to use *constructing hypothesis* more than the others were in Focus Group 5. This may have been due to the higher number of participants (eight in this group), thus generating more discussion, as compared to five participants in the other focus groups. Another explanation may be the fact that this group had more experience in *constructing hypothesis*, when engaged in transferring people to the community. Recall that this group was from a medium-sized HSE-run organisation that supported fewer than 100 people in a congregated setting and in the community. This service provider aspired to meet the deadline of 2019.

Furthermore, Focus Groups 5 and 1 considered the possibility of the transition for Rose into the community not working out, hence their use of *constructing hypothesis*. FG5 NO6: *“If it does not work out for her in the community, do they have a policy of the person being transitioned back into the congregated setting?”* FG1 NO1: *“Things may not work out for her in the community. She should have an option of coming back.”* Focus Group 1 used *constructing hypothesis* minimally and was from a medium-sized voluntary organisation that supported fewer than 100 on campus and in the community. But it would be five years before everyone they supported moved to dispersed housing in the community.

In contrast, *constructing hypothesis* was not used at all in Focus Group 3. Given that *constructing hypothesis* entailed constructing reasons for the referral, and the reason for Rose’s potential move was stated in the vignette, participants in this group may not have seen the need to discuss this further. Another explanation may be that this group

has had little if any experience in transferring people to the community. This voluntary service provider was large in size, supporting approximately 100 people in a congregated setting and in the community. With this service provider, it would take three years before the remaining residents moved to the community. In comparison to Focus Groups 4 and 2, which used the *constructing hypothesis* with equal frequency. These focus groups differed in their experience of transferring people to the community. Focus Group 4 had experience in transferring people to the community. Its voluntary organisation was large in size, supporting approximately 100 people, and it would have moved less than one-third of its residents to the community by the end of 2019. Focus Group 2, on the other hand, was from a small voluntary organisation supporting fewer than 60 people but did not envisage meeting the 2019 deadline.

It would appear that the pattern of classification for the types of decision-making task processes was quite similar across all groups, with minor differences in the actual frequencies observed for specific groups. This may indicate that MDTs working within organisations were more focused on the solution-based task processes (*recommending* and *planning*) than the SA processes (*describing*, *explaining*, *predicting* and *constructing hypothesis*). The results may reflect the fact that MDT members used similar standards across disciplines and adhered to the same principles of best practice of their professions. Hence, they considered similar factors that impacted their decision-making.

4.3 Findings from Research Question Two: Emerging Themes from Focus Groups and Interviews from Five Service Providers

Recall that the second objective of current study was to determine the factors that MDTs consider in their discussion when transferring an adult with an ID to dispersed housing in the community. Hence, Research Question Two: ***What are the factors that MDTs considered in their discussion when transferring an adult with an ID to dispersed housing in the community?*** This question was applicable to all MDT members: healthcare and social care professionals who participated in focus groups and senior managers who took part in the interviews.

This section presented the findings of focus groups and their corresponding interviewees from the five different service providers. These findings were presented in two parts (a) thematic analysis of focus group participants and interviewees; and (b)

commentary on similarities and differences between emerging themes in focus group participants and interviewees of the five service providers.

(a) Thematic Analysis of Focus Group Participants and Interviewees

In total, five overarching themes emerged in participants' discussions to move Rose in particular and people with an ID in general, from a congregated setting to dispersed housing in the community. The emerging themes were: *client profile*; *resources*; *deinstitutionalisation*; *person-centredness* and *ethos*. The number of these themes is in keeping with recommendations from Creswell (2015) and Saldaña (2016).

The rationale for including these overarching themes was as follows: (1) the themes captured interesting data (Braun & Clarke, 2006); (2) the themes highlighted how MDT members placed different levels of emphasis on them; and (3) the prioritisation of these themes was in keeping with Ryan and Bernard (2003) and related to the frequency with which they appeared in the body of data, as well as being consistent with codes that were relevant to the research focus (Becker et al., 2012; Ryan & Bernard, 2003). Due to the weighting of the five themes in the current study, some emerged as dominant and some as less dominant, depending on the frequency of their occurrence. Figure 4.1 depicted the five themes captured both from the focus groups and interviewees from five different service providers.

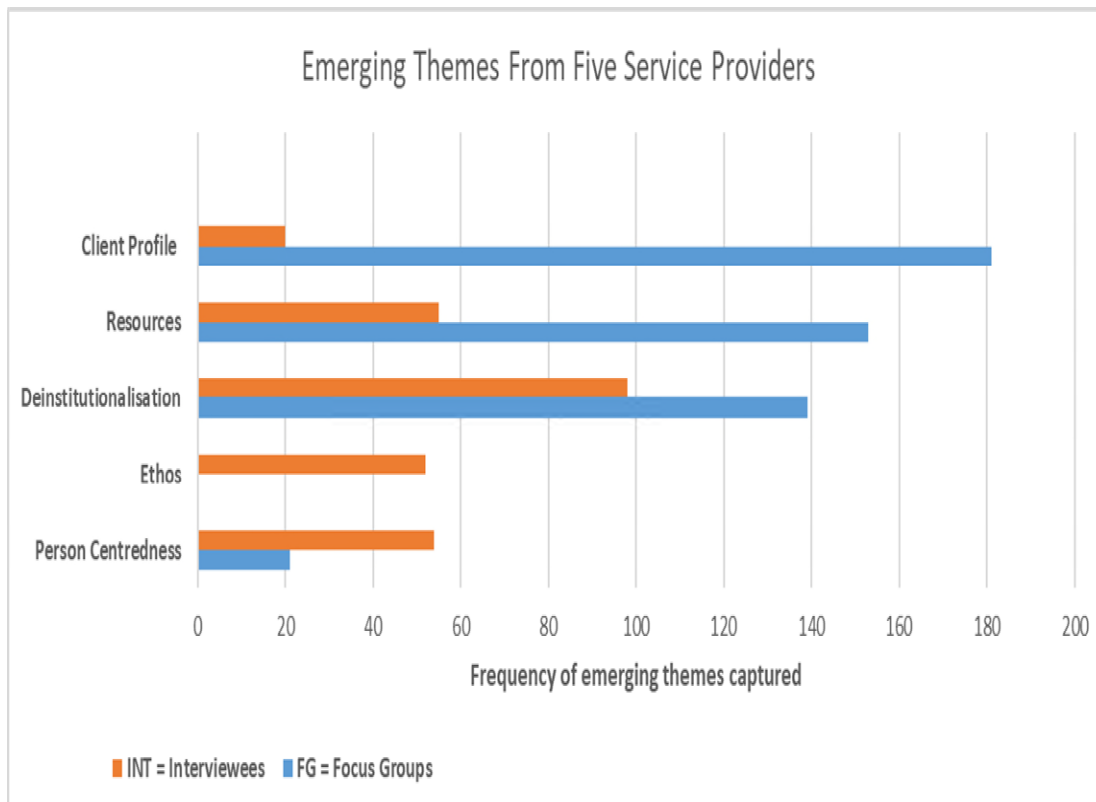


Figure 4. 2 Emerging Themes from Five Service Providers

Figure 4.2 above illustrated the five overarching emerging themes from focus groups and interviews across five service providers. The frequency of emerging themes by interviewees and focus groups was indicated in the figure above. As mentioned previously, the rationale for using the frequency counts/numerical data to indicate the frequency of emerging themes was to allow patterns in the data to emerge with greater clarity and to increase the meaning of key findings (Neale et al., 2014). There were three dominant themes: *deinstitutionalisation* and *resources*, followed by *client profile* (from highest to lowest frequency). The least dominant themes were *person-centredness* and *ethos*, respectively. Details of the themes and the corresponding codes are contained in the Codebook in Appendix 4. Each of the five themes is outlined below, along with a selection of quotations extracted from the combined data sets. Also included are statements that constituted overlapping meanings, resulting in double coding.

Explanation and Examples of Each Theme

The theme of *deinstitutionalisation* highlighted the process of slowly abandoning large residential settings and replacing them with small community-based settings. This theme was generated from codes such as the ‘*Congregated Settings Report of 2011, informed consent, choice, HSE, dispersed housing in the community, and HIQA’s recommendations*’. The theme of *deinstitutionalisation* was the most dominant in both focus groups and interviews, and was mentioned 139 and 98 times, respectively. One explanation for the high frequency of this theme may be that all MDTs were in favour of adults with an ID transferring to dispersed housing in the community. Focus group participants discussed HIQA as the driving force for the move into the community setting. The participants were of the view that the move should be informed by an individual’s choice, as illustrated in the following texts. FG2 NO3: “*So, HIQA are making the recommendation for the house as part of the de-congregation.*” FG5 NO4: “*She will have her own space in her new house in the community, in line with de-congregation?*”

In contrast, the content of discussion by interviewees revealed that their main focus of this theme was whether organisations were compliant with the *Congregated Settings Report of 2011* and the barriers to its successful implementation. Interviewee 2: “*We are in line with the Congregated Settings Report. We are ahead of it, but we need more houses in the community.*” Interviewee 3: “*We have to wait for at least another 2-3 years before people can move to the community, because, as I said, staffing is a major issue and funding from the HSE.*”

As illustrated in the above extract, another explanation for the high frequency of this theme may be an indication of statements that were applicable to two different themes. The following extract indicates the themes of *deinstitutionalisation* and *resources*. Interviewee 3: “*We have to wait for at least another 2-3 years before people can move to the community, because, as I said, staffing is a major issue and funding from the HSE.*” Interviewee 2: “*We are in line with the Congregated Settings Report. We are ahead of it, but we need more houses in the community*”.

In general, the analysed commentary demonstrated that MDTs in focus groups and interviewees alike considered this theme to be one of the key factors that influenced their decision to transfer people to dispersed housing in the community. The analysis

also suggested that MDTs were familiar with the contents of the *Congregated Settings Report* and used it to guide their decision-making process.

The theme *resources* represented the requirements needed for the person with an ID to live successfully in dispersed housing in the community. This theme emerged from combining codes of 'MDT support, recruitment of staff, funding, staff training needs, suitable housing in the community, assessment tools, care plan, best practice and advocates who can speak on behalf of an adult with an ID'. The theme of *resources* was the second most dominant in both data sets (it occurred 55 times in interviews and 153 times in focus groups) but had a different emphasis for those reporting in focus groups than for those reporting in interviews.

Focus group participants, for example, emphasised staff training, albeit addressing different needs that would be necessary to support an individual with an ID living in the community. These participants discussed the configuration of staff/MDTs required to support Rose in the community; training required by staff; assessment tools to be carried out before the transfer to the community; and care plans to support her needs. These issues were apparent in the following quotes: FG1 NO1: "*The AON must be completed prior to the move, to ensure that the identified house is suitable.*" FG1 NO5: "*Staff need to know about the plans and programmes and know what to do in order to support her.*" FG3 NO3: "*Will there be Speech & Language Therapy involvement in the community?*" FG4 NO5: "*Through the AON, MDTs need to look at potential risk in the community. A risk assessment must be completed, so that people are aware of the risk, so that they can minimise that risk in the community.*"

For the interviewees, the theme of *resources* reflected mainly the importance of funding for staff and the availability of suitable housing for people with an ID. The interviewees also cited challenges linked to resources that had an impact on moving people to the community. These challenges included acquiring HSE funding for staffing, the involvement of unions with regard to the redeployment of staff in the community, getting landlords to agree to modifications, and getting 10-year leases from landlords. Interviewee 2, for example, stated: "*If we had properties in the morning that were suitable, we would be moving all of them. We are involved with the HSE in securing property as part of the overall strategic plan.*" Interviewee 5 identified another resource challenge: "*Our main challenge was with the unions in negotiating hours and*

moving staff around.” Other interviewees viewed MDT members and community connector staff as influencing the move to the community. Interviewee 3, for example, stated: *Through the PCP process, our MDT professionals play a significant role in identifying who needs to move first and why, depending on resources, staffing, and funding from the HSE of course.*” Other interviewee viewed the outcome of the assessment as influencing the move to the community. Interviewee 4, for example, stated: *“From the AON, we look at what they will need, what staff will be needed in the community, and look at whether the houses will meet their needs in the community otherwise, they cannot move.”*

In general, extracts clearly indicated that *resources*, as one of the factors pertinent to moving people to the community, had a different emphasis for focus group participants and interviewees. Focus group participants were more concerned with staff training and the ability of staff to implement programmes, whereas, interviewees were more concerned with the recruitment and redeployment of staff, HSE funding and the availability of suitable housing. Interviewees were more likely than MDTs in focus groups to discuss the challenges associated with a lack of resources. One explanation may be that MDTs in focus groups were not necessarily concerned with budgetary constraints and limitations in resources but were more focused on making clinical recommendations based on best practice.

The theme *client profile* represented content related to the presentation of people with an ID. This included content regarding ‘diagnoses, communication status, medical/changing health needs, compatibility, independent skills, behaviours that challenge (of concern) and potential risk’. This theme occurred most frequently in focus group discussions (181 times), while MDT members were discussing the move to the community for Rose. The following quotes were indicative of text classified to the theme of *client profile*: FG1 NO3: *“She needs to move into a house with ladies of similar abilities, so that her cognitive and verbal needs can be fulfilled, and her abilities maintained.”* FG4 NO5: *“She peels her skin off, and from what you are saying she has been doing this for about two years. Maybe she is not happy. What triggers this behaviour? Do you know?”* FG2 NO1: *“She has epilepsy, bipolar, PIC.”* FG4 NO1: *“She can speak but people find it difficult to understand her.”*

For the interviewees, this theme was mentioned 20 times and highlighted those that needed to be prioritised for the move to the community. Interviewee 3, for example, stated: *“Those that have been reported to have challenging behaviour move first.”* Interviewee 4 stated: *“For example, some of our service users engage in self-injurious behaviour, you know, of banging their heads on walls, those are prioritised first.”* Interviewee 5: *“We have a transition process and see if people are compatible.”* Interviewee 5 also stated that in their organisation, the decision to move individuals was influenced by three factors, that is, risk, restrictive practices, and safeguarding issues.

These findings demonstrated that the theme *client profile* was a relevant, albeit less dominant, factor considered by both focus groups and their corresponding interviewees. The findings revealed that the person’s diagnosis and behavioural presentation were factors taken into account predominantly by MDTs in their decision-making. This finding may be in keeping with some researchers who believe that people with behaviours that challenge should be prioritised for community living.

Person-centredness related to the codes ‘person-centred planning, wishes and choice’. *Person-centredness* is an approach used by service providers supporting people with an ID, to ensure that they are equal partners in planning and developing their care, and to make sure that their needs, desires and goals are met. In focus groups, this theme occurred 21 times and was discussed in the context of choices. FG2 NO4: *“The other question I would have, I suppose is her preferences. Has she expressed any preference about who she wants to move with?”* FG3 NO5: *“Is that what she wants?”* FG5 NO8: *“If this is her choice, then the organisation must carry out her wishes.”*

Person-centredness was dominant when discussed by interviewees (mentioned 54 times), and the theme was linked to *ethos*. Therefore, high frequency of this theme among interviewees may be due to the connection between *person-centredness* and *ethos*. This link may have resulted in overlapping themes, where the same texts were applicable to both themes. The following quotes are indicative of text classified to both themes: Interviewee 3 stated: *“Our ethos is about our values as an organisation, doing all we can to preserve the dignity of people. It is about person-centredness, doing all we can to respect their wishes.”* Interviewee 2 regarded their ethos as follows: *“It is*

about what the organisation stands for, it is about person centredness.” Interviewees 4 and 5 spoke about the person’s choices and wishes. Interviewee 5, for example, regarded *ethos* as being *“about our attitudes towards servery delivery, delivering good standards of care and exploring who the person is, his/her wishes, needs and wants”*.

The above extracts were yet more examples of double coding, which may be indicative of the type of analysis used, where each text did not necessarily fit into one theme. The overlap of themes may be due to the fact that professionals often addressed more than one topic when discussing and making decisions about complex issues. The findings may also suggest that the connection between the themes of *person-centredness* and *ethos* may lead to unexpected findings, which was the overlapping themes in this study.

The data analysis undertaken to generate this theme indicated the awareness of focus group members to the importance of the individual’s choice with regard to Rose’s living environment, goals and wishes. In addition, the theme of *person-centredness* indicated an awareness by senior managers in considering the needs and wants of service users themselves, as opposed to what they may deem best for the service user, or what the service can offer. The service user’s own desires and wishes were key factors for consideration by all MDTs in their decision-making process regarding moving to community housing. The findings may also suggest that when making-decisions, senior managers adapt a holistic approach, taking on board the key principles of PCP.

The theme *ethos* pertained to codes of ‘core values and principles that the service providers aspired to, as well as the standard of care they adhered to’, when they provide services to people with an ID. *Ethos* was a theme unique to interviewees: it did not arise for participants in the focus groups, despite the fact that the hypothetical case vignette was open and there was an opportunity for focus group participants to discuss issues they considered pertinent, without prompting from the moderator. The following extracts comprised text that classified the theme *ethos*: Interviewee 1, for example, indicated: *Our ethos is based on the six core principles of respect, service, collaboration, justice, excellence and creativity.*” Interviewee 5: *“The ethos really is to support each person as an individual within their own right to have the best life*

possible.” Interviewee 4: “*I suppose the general ethos is valuing and treating every person we look after as individuals, providing the highest standard of care.*”

Interviewees considered each of their organisation’s core values when engaging in the decision-making process. The extracts above indicated that interviewees were influenced by the *ethos* of their organisations when making decisions pertaining to the transfer of people to community housing.

In general, the dominant common themes that were considered to be pertinent in the decision-making process of moving people to the community were *deinstitutionalisation* and *resources*, followed by *client profile* in both focus groups and interviewees, albeit at different levels of frequency. The high regularity of their occurrence was in keeping with the fact that all participants were in agreement with the *Congregated Settings Report* of 2011. However, participants were cognisant of the fact that adequate resources were crucial for the successful implementation of this report. Challenges linked to resources were explicitly discussed by interviewees only. The reason may be that senior managers were aware of budgetary constraints that were unfamiliar to MDTs. Under the theme of *client profile*, the move to dispersed housing in the community was influenced, for example, by the person’s diagnosis and behavioural presentation, albeit at levels of frequency in both focus groups and interviewees.

The theme *person-centredness* was dominant in interviewees but less dominant in focus groups, perhaps given that the focus group participants concentrated mainly on clinical needs. *Ethos* was unique to interviewees. One explanation may be that senior managers need to look at the overall context, when considering an individual with an ID moving to the community setting. MDTs in focus groups may be of the view that they did not necessarily have to consider, for example, issues of ethos and funding, but instead adhered to their professional standards and clinical judgment, when making decisions about moving people to a community setting.

(b). Commentary on Similarities and Differences between Themes Emerging from Focus Groups and Interview Participants of the Five Service Providers

The analysed data in this section was presented in two parts. The first part, indicated in Table. 4.2, showed the frequency of themes in focus groups and their corresponding interviewees across five service providers.

The second part presented a comparison of the five themes among participants representing five different organisations. The five themes presented in this section were: *client profile*, *resources*, *deinstitutionalisation*, *person-centredness*, and *ethos*.

Frequency of Themes in Focus Groups and Their Corresponding Interviewees across Five Service Providers

Table 4. 2 Frequency of Themes that Emerged in Focus Groups and Interviewees across Five Service Providers

MDTs in SP	Client Profile		Resources		Deinstitutionalisation		Person-Centredness		Ethos		Total
	INT	FG	INT	FG	INT	FG	INT	FG	INT	FG	
MDT in SP1	8	38	12	31	35	53	14	3	12	0	206
	22%		33%		43%		8%		6%		
MDT in SP2	5	35	12	46	28	26	10	4	10	0	176
	23%		33%		31%		8%		6%		
MDT in SP3	2	23	10	10	14	20	10	2	10	0	101
	25%		20%		34%		12%		10%		
MDT in SP4	2	45	11	20	11	20	10	10	10	0	139
	34%		22%		22%		14%		7%		
MDT in SP5	3	40	10	46	10	20	10	2	10	0	151
	28%		37%		20%		8%		7%		
TOTAL	20	181	55	153	98	139	54	21	52	0	773

Key: MDT-Multidisciplinary Team; SP-Service Provider; INT- Interviewee; FG-Focus Group

Table 4.2 above illustrated that MDTs considered some themes more frequently than others. Hence, the frequency of use of these themes was high in some organisations and low in others. A pattern of the trend was such that the themes of *deinstitutionalisation*, *resources* and *client profile* were considered most frequently by MDTs of service providers. The next most frequently considered themes were *person-centredness* and *ethos*.

Comparison of Themes across Focus Group and Interview Participants of the Five Service Providers

This section presented a comparison of themes that emerged across MDTs of the five organisations. The comparison was made in the following themes: *deinstitutionalisation*; *resources*; *client profile*; *person-centredness* and *ethos*.

A similar pattern emerged among all the MDTs from the five service providers, in relation to all codes associated with *deinstitutionalisation*. All focus groups and their corresponding interviewees were in favour of the move to dispersed housing in the community, as per the *Congregated Settings Report* of 2011. Therefore, the extracts from all MDT participants suggested that the theme of *deinstitutionalisation* may have been the driving force for the move to the dispersed housing in the community from congregated settings.

MDTs in focus groups were of the view that Rose should have her own room in community housing, in order to protect her privacy and maintain her dignity. The discussions about *deinstitutionalisation* were in keeping with HIQA standards and requirements: according to HIQA, each service user must have their own bedroom. Furthermore, MDT participants, while aware of the objective of implementing the *Congregated Settings Report* of 2011, acknowledged that not all service users were suitable candidates for community living. Hence, two groups (Focus Groups 1 and 5) were unique, in that the members wanted a plan to be put in place for a return to a congregated setting, in case community living be unsuccessful. FG5 NO6: "*If it does not work out for her in the community, do they have a policy of the person being transitioned back into the congregated setting?*" FG1 NO1: "*Things may not work out for her in the community. She should have an option of coming back.*" FG5 NO8: "*You are right XXX, what if things do not go according to plan in the new house and she wants to come back? I think she should be allowed back.*"

The organisations were at various stages of meeting the deadline of 2019 for the implementation of the *Congregated Settings Report* of 2011. Only one of the four voluntary organisations aspired to move less than one-third of its residents to the community by the end of 2018 (Service Provider 4). The other three organisations indicated that they either would not be able to meet the deadline of 2019 (Service Provider 2) or it would take three (Service Provider 3) to five years (Service Provider 1) to move all their residents to the community. The HSE-run organisation aspired to have all its residents moved to the community by the middle of 2019 (Service Provider 5). All interviewees reported that their organisations were subject to periodic HIQA inspections.

Under the theme *resources*, discussions revealed a trend associated with different codes for both focus group participants and interviewees. Focus group participants focused on resources in relation to 'MDT support, staff training needs and assessments tools' and interviewees were concerned about challenges linked to 'recruitment and deployment of staff, funding, and availability of suitable housing'.

In Focus Groups 1 and 5, the participants suggested that to ease Rose's transfer to the community, she should have familiar staff. FG1 NO4: *"I would imagine she is moving with her own staff, staff that she knows."* FG5 NO6: *"Is she transferring over with staff that is familiar with her needs?"* Focus Group 5 not only suggested moving with familiar staff but staff of similar age. FG5 NO7: *"It would be really healthy and positive to have staff that are of a similar age."*

Three focus groups proposed three completely different needs for training in IT, staff development and assessment. In Focus Group 3, for example, IT was a higher priority. The group discussed staff training, specifically in IT, to develop Rose's independent skills for communication, as indicated in the following examples, FG3 NO1: *"We have been recommending that she continues to use the iPhone and iPad and more apps to be installed. We should also recommend staff training in the use of these AAC devices, otherwise staff will not know how to communicate with her."* FG3 NO5: *"So, training in IT should come first."* However, staff training/support in Focus Group 4 centred on strategies that staff would need to support Rose in the community, for example, FG4 NO5: *"Staff need to be trained in her behaviour management plan, epilepsy management plan and around strategies to reduce the risk of choking. These*

strategies are very important.” FG4 NO3: “Do staff know what they need to do in order to support Rose?”

In contrast, staff training in Focus Group 5 was specifically focused on the staff use of the community transfer model (CTM) and support intensive scale (SIS) assessment tools to assist in Rose’s transition, as illustrated in the following examples: FG5 NO3: *“We recommend that the organisation have one dedicated staff, if they do not have a CTC in place, so that one staff [member] would be her key worker.”* FG5 NO1: *“We recommend the training of the CTC person; [and] we also recommend that Rose be viewed within the SRV model.”* Focus Group 5 was unique in that it was the only group that cited the SIS, CTM and CTC as contributing factors when deciding to transfer people to the community.

In comparison to the other MDTs, who used tools such as AON and the PCP process to inform their decision-making, MDTs of Service Provider 5 used the SIS assessment tool to assist in identifying supports that Rose would need in the community, and the CTM assessment that would indicate Rose’s likes and dislikes. FG5 NO7: *“We use the SIS where we outline everything the service proposes to put in place for the lady when she goes to the community. Everything from what she likes and does not like, to who she’ll live with and what her nursing hours will be if there is nursing input.”*

Interviewee 5: *“The SIS was used to assess the entire residential population in 2012 to 2013. We have the CTC and we use a process called conditions for success process to determine people’s compatibility and to transition them to the community.”*

In addition to assessments used to inform their decision-making, interviewees highlighted specific challenges they encountered in moving people to community housing. Interviewee 1 stated: *“We could move more tomorrow, but we do not have any funding at the moment. We need funding from the HSE, so that we can recruit staff and secure suitable houses.”*

In summary, while the operationalisation of relocating individuals in other organisations involved using a mix of informal tools such as the AON and the PCP process, MDTs in Service Provider 5 were unique in that they used a standardised assessment tool, the SIS, to inform the move to the community.

In addition, the above extract showed considerable differences across the service providers, indicating that study participants were of the belief that individuals with an ID can be supported in varying ways, as they move to the community. What drove this variation may have been the differing cultures within these organisations.

The above extracts clearly indicated that interviewees were more likely than MDTs in focus groups to discuss the challenges associated with a lack of resources. One explanation may be that MDTs in focus groups were not necessarily concerned with budgetary constraints and limitations in resources but were more focused on making clinical recommendations based on best practice.

In discussions pertaining to *client profile*, the comparison of the themes related to the codes of diagnoses, compatibility, behaviours that challenge and identified risk, which were key factors influencing a transfer to the community. MDT members in Focus Group 2 asked more questions than those in Focus Group 1 about Rose and her needs. They asked specific questions around her capacity to make decisions: FG2 NO4: *“Does anyone question her ability to make decisions?”* Focus Group 2 specifically recommended a review around Rose’s medication for her bipolar diagnosis, as she would soon be moving to the community. Focus Group 1 focused only on her epilepsy. Of note was the fact that the participants of this group had predominantly behavioural mental health backgrounds, thus possibly explaining their emphasis on consent and the need for psychiatric and psychological inputs. Therefore, the extracts could be deemed as biased.

Similarly, the overlying trend of Rose’s diagnosis was also discussed in Focus Groups 1, 3 and 5. The participants wanted some nursing hours allocated to Rose, given her diagnosis. FG5 NO3: *“I am just looking from a bipolar/epilepsy/PICA perspective that there may be some nursing hours that would be proposed for this lady also.”* In contrast, participants in Focus Group 2 were of the view that Rose did not need a nurse in the community. FG2 NO5: *“You do not necessarily need nursing staff going out to the community.”*

Focus Group 1 was unique in that it was the only group to include the need for Rose to move to a house with both the key characteristics of people of the same sex and of similar cognitive abilities. Focus Group 3 was in agreement with regard to compatibility according to the same age but did not consider cognitive abilities. Instead, it

considered similar age group. FG1 NO3: *“She needs to move into a house with ladies of similar abilities, so that her cognitive and verbal needs can be fulfilled, and her abilities maintained.”* FG3 NO 5: *“Are they of similar age?”* Focus Group 4 discussed Rose’s communication skills. FG4 NO1: *“She can speak but people find it difficult to understand her.”*

In contrast, *client profile* was less dominant in the discussions of interviewees. The discussions were related to the codes ‘behaviours that challenge and potential risks’. The criteria to move people to the community, for example, were influenced by the reported behaviours that challenge, risk, and restrictive and safeguarding practices. Interviewee 5, for example, considered the following: *“I suppose the biggest driving force behind who gets priority to go, one of the things is safeguarding. It is probably up there. The other is risk and restrictive practices. So, we’re very conscious of those three things.”* Interviewee 3’s criteria to move people were determined by those with behaviours that challenge and those who indicated that they wanted to move via PCP goals. *“We look at those that have been reported to have challenging behaviours: they move first and those [who] have been requesting to move for a long time, as per their PCP.”* Interviewee 2 mentioned: *“We had a couple of service users with autism, who had huge challenging behaviours and there were XXX safeguarding issues related to assaulting staff. They moved first, after their families agreed to [them] moving to a particular house in the community.”*

The above extracts showed that under the theme of *client profile*, the code of compatibility dominated the discussions among focus group participants. However, conflicting emphasis was placed on medical needs and diagnoses, and whether or not nursing staff were required in the community. On the whole, the interviewees took into account *client profile*, when deciding to move people to the community, along with safeguarding and risk issues.

Focus Group 4 gave more emphasis to the theme of *person-centredness*. This group advocated for Rose to be involved in the decision-making and planning around her future wishes and needs, and encouraged her to identify her own goals and compile a plan to achieve them. The group also suggested an advocate to be involved to assist Rose in setting her goals. For example, FG4 NO3 stated: *“I am assuming that Rose was part of her PCP and [that] she identified her goals, and [that] staff will help her*

achieve those goals.” FG4 NO1: “I think it would be better if an advocate is invited to her PCP, so that she can ensure that Rose’s voice is being heard.” FG4: NO5: “Are her wishes and goals also documented in her care plan? Staff can work from that plan.”

MDT members in focus groups used the PCP process to ensure that Rose’s rights were met (the right to have a choice). The PCP approach allowed for service users to shape their own future and plan accordingly with adequate resources, as identified by MDTs. Their discussion showed that PCP as an approach could influence the decision-making process.

Person-centredness was a dominant theme among interviewees. As in the focus groups, the wishes and choices of people were highly considered for the move to the community, to ensure that their needs, desires, and goals were met. The following extracts also indicated that the organisations used the principles of *person-centredness*, when conducting the AON to prioritise the needs of individuals. Interviewee 1: *“We completed the AON together with the residents, in terms of obtaining what their wishes and choices were, who they would like to live with.”*

Commentary both from the focus groups and the interviewees suggested the individual’s wishes and choices as key factors to be considered in their decision-making process, although at different levels of frequency. The MDTs’ views about *person-centredness* alluded to the fact that the principles of PCP were inherent in their decision-making process.

The last theme, *ethos*, was exclusive to the interviewees. They commented on the core values and principles (codes) governing their organisations. In their commentary, this theme was related to *person-centredness*. Interviewee 3, for example, stated: *“Our ethos is about person centredness, doing all we can to respect their wishes and to de-congregate people to the community.”*

Interviewee 5 stated: *“So, the ethos is about exploring who the person is and what the person wants – their needs and wants and moving towards – what everyone else in society has, which is equality really. That’s really the essence of it.”*

In general, none of the focus groups considered *ethos* as significant factor that influenced a move to the community. Recall that the focus groups were presented with

a hypothetical case vignette and, although they were allowed to openly discuss issues, they did not consider ethos worthy of same. One possible explanation may be that MDT participants focused on Rose's needs and the support required in the community, in order for *deinstitutionalisation* to be successful, rather than discussing content that was not in their remit. Another reason may be that MDT participants were more influenced by their professional standards and codes of ethics, rather than what may be perceived as an organisational influence. Furthermore, MDT participants made recommendations based on what the service user required in an ideal world. They were not bound by budgets and financial constraints, as these were within the remit of the senior management in an organisation.

4.4 Summary of Analysis of Research Questions and Notable Findings

Research Question One: ***What decision-making processes are used by MDTs when transferring an adult with an ID to dispersed housing in the community?***

The findings were that across all focus groups, dominant and less dominant sequential decision-making task processes were employed. In general, it was evident that *describing*, *recommending*, and *planning* were commonly used decision-making task processes among MDTs in focus groups. In contrast, *predicting* and *explaining* were less frequently used by most groups and *constructing hypothesis* was the least-used task process. There were examples of the same texts that were applicable to more than one task process.

Collectively, Focus Groups 1-4 applied solution-based task processes (*recommending* and *planning*) more than the SA task processes (*describing*, *explaining*, *predicting* and *constructing hypothesis*) to transfer an adult to dispersed housing in the community. MDTs in Focus Group 5 used *constructing hypothesis* more than the other groups. One explanation may be that this group had experience in using *constructing hypothesis*, when transferring people to the community. This group came from an HSE-run organisation that supported fewer than 100 people in congregated settings and in the community and aspired to moving all its residents to the community by the middle of 2019, thus meeting the set deadline.

Research Question Two: ***What are the factors that MDTs considered in their discussion when transferring an adult with an ID to dispersed housing in the community?***

The pattern of five overarching themes emerged across the five different service providers. The themes differed in emphasis in both the focus group participants and the interviewees. The themes included *client profile*, *resources*, *deinstitutionalisation*, *person-centredness* and *ethos*. Some themes were dominant and some less dominant. The themes of *deinstitutionalisation*, *resources* and *client profile* were dominant among the focus groups and the interviewees, although at levels of frequency. The next common themes were *person-centredness* and *ethos*. *Ethos* was unique to interviewees and did not feature in focus groups. These two themes were closely associated when considered by interviewees, as they may have been perceived as being connected.

Overall, common themes that were significant factors in the decision-making process across all five service providers were *deinstitutionalisation* and *resources*. Both focus group participants and interviewees were in favour of *deinstitutionalisation*. However, they were cognisant of the fact that adequate resources were vital for the process to succeed. Interviewees, in particular, identified the challenges associated with *resources* that impacted on the implementation of the *Congregated Settings Report* of 2011, namely, HSE funding, recruitment and redeployment of staff, and the availability of suitable houses in the community.

5 CHAPTER FIVE: DISCUSSION OF FINDINGS AND CONCLUSION

5.1 Introduction

The current study aimed to address a gap in current knowledge with regard to exploring the decision-making processes of MDTs who were involved in transferring adults with an ID to community-living options. There were two main objectives: (1) to determine what decision-making processes were used by MDTs when transferring an adult with an ID from congregated settings to dispersed housing in the community; and (2) to determine the factors that MDTs considered in their discussion when transferring an adult with an ID to dispersed housing in the community. The previous chapter looked at how data collection methods were applied and how the findings were analysed and presented to answer two research questions, namely:

- ***What decision-making processes are used by MDTs when transferring an adult with an ID to dispersed housing in the community?***
- ***What are factors that MDTs considered in their discussion when transferring an adult with an ID to dispersed housing in the community?***

This section discussed the meaning of the findings outlined in Chapter Four in relation to the above two research questions. The chapter began with a summary of the findings of the research questions and proceeded with a discussion and interpretation of the findings, and their relationship to previous literature. The chapter proceeded to highlight the study's contribution to the body of knowledge. It also included the implications of the findings in terms of theory, practice, and policy. This chapter contained a discussion on the strengths and limitations of the present study, as well as highlighting commendations for future research. The chapter ended with conclusions drawn from the current study.

5.2 Summary of Findings Related to the Research Questions

5.2.1 Summary of Findings Related to Research Question One

The results of the current study provided tentative answers to Research Question One, ***What decision-making processes are used by MDTs when transferring an adult with an ID to dispersed housing in the community?*** Firstly, a decision was made by all MDT members (healthcare and social care professionals) from five different focus groups to transfer Rose from a congregated setting to a dispersed house in the community. Secondly, the findings indicated that all six task decision-making

processes were used by four of five MDT members in their discussions to move Rose to the community, namely: *describing, recommending, planning, predicting, explaining* and *constructing hypothesis*. Thirdly, the sequential pattern of the types of decision-making task processes were similar in each service provider regarding their discussion of Rose. In all organisations, there were three dominant decision-making task processes commonly used, namely: *describing, recommending, and planning*. *Predicting* and *explaining* were the next most commonly used decision-making task process. The least-used decision-making task process was *constructing hypothesis*. Some text segments were applicable to more than one task process.

In their decision to transfer an adult to dispersed housing in the community, four focus groups applied solution-based task processes (*recommending* and *planning*) more so than the SA task processes (*describing, explaining, predicting* and *constructing hypothesis*). MDTs in Focus Group 5 were the only group to use *constructing hypothesis* more than the other groups. One explanation may be that this group had experience in using *constructing hypothesis* when transferring people to the community.

5.2.2 Summary of Findings Related to Research Question Two

Research Question Two, ***What are factors that MDTs considered in their discussion when transferring an adult with an ID to dispersed housing in the community?*** An array of influential factors across the five service providers were noted as significant in the decision-making process of MDT members, both healthcare, social care professionals and senior managers. The findings identify five overarching themes as influential factors including: *deinstitutionalisation, resources, client profile, person-centredness* and *ethos*. Some themes were dominant and some less dominant. The findings showed that the themes of *deinstitutionalisation* and *resources* were dominant and overlapped in both focus groups and interviewees. *Ethos* was unique to interviewees and did not feature in focus groups. Interviewees considered the themes of *person-centredness* and *ethos*. These two themes may have been considered synonymous by interviewees.

5.3 Interpretation of the Findings and their Relationship to the Literature: Research Question One

This section presented a discussion on the following aspects: (1) The relationship between Bartolo et al.'s (2001) study and the current study, in relation to the similarities

and differences of both. (2) The relationship of the findings regarding the NDM framework and (3) the NDM model, namely, the SA model. (4). The findings were related to the principles of the NDM framework. (5) The type of methodology and analysis used in this study.

Similarities and Differences between Bartolo et al.'s (2001) Study and the Current Study

As indicated previously, the current findings from Research Question One were in agreement with Bartolo et al.'s (2001) study, which used a purposive multiple-case research design to capture sequential decision-making task processes used by multi-professional teams in a transdisciplinary assessment of children with disabilities. Similarities with the present study were reported with regard to the following areas: (1) MDT members were decision-makers in both studies. (2) MDTs from different organisations (four in the current study) applied all six task processes in their decision-making in both studies. (3) There was a sequential pattern of processes evident in the discussions. (4) Some descriptions of task processes in both studies were similar in content, except they were applied in different contexts. For example, in Bartolo et al.'s (2001) study, *recommending* referred to remedial action required to manage/teach the child and recommended solutions such as educational/placement or medical treatment. In the current study, the same task was interpreted as any commentary that entailed suitable supports (both current and potential) to support Rose in dispersed housing in the community.

The above similarities suggested that MDTs within the Irish context may apply Bartolo et al.'s (2001) six task processes when engaged in decision-making with regard transferring people with an ID to dispersed housing in the community. The findings suggested that MDTs might use these available task processes as a framework for decision-making when engaged in the implementation of the *Congregated Settings Report* of 2011.

Four major differences were evident between Bartolo et al.'s (2001) study and the present study. The first major difference related to the frequency of usage of the task process of *constructing hypothesis*, which was the least-used decision-making process in the current study. In contrast, *constructing hypothesis* was the dominant task process used by MDTs in both the medical (neuro-disability centre) and

educational (special school) settings in Bartolo et al.'s (2001) study. The interpretation of this contrast was that in Bartolo et al.'s (2001) study, MDTs had constructed hypotheses about reasons for a referral in three separate discussions (post-assessment, interviews and discussions), as compared to just one discussion in the current study. Because the reason for moving to the community was indicated in the hypothetical case vignette in the current study, that is, it was a requirement by HIQA, some MDTs may not have deemed it necessary to discuss it further. Another interesting finding that was different from the current study was that *describing* and *explaining* were also major task processes used in Bartolo et al.'s (2001), study followed by *predicting*, *recommending*, and *planning*, all occurring in one cycle.

Another explanation for the frequency of usage of task process of *constructing hypothesis*, in Bartolo et al.'s (2001) study, may be related to the fact that SA task processes were applied in their decision-making, compared to solution-based task processes. However, MDTs applied more solution-based task processes in the current study. The explanation for this difference may be related to the task that MDTs were required to complete. In the current study, the task of the MDTs was to implement the *Congregated Settings Report* of 2011. Therefore, the findings may support Bartolo et al.'s (2001) conclusion that when MDTs' make decisions, their discussions reflect attempts to gather more information to understand the problem, while trying to solve the problem.

The second difference was that, in Bartolo et al.'s (2001) study, MDT members addressed problems in a series of three cycles of decision-making within each assessment, where a cycle was made up of the complete use of the six task processes. In contrast, in the current study, MDTs discussed a hypothetical case vignette, in order to capture the six task processes. It may be said that MDTs in Bartolo et al.'s (2001) study had ample opportunity to apply the task processes, compared to the current study. As a result, one task process, in particular, *constructing hypothesis*, was less used, as the MDT only had a case vignette to consider and discuss in the present study.

The third difference applied to how the two studies were analysed. In Bartolo et al.'s (2001) study, task processes were analysed at three levels of decision-making, namely, main-goal episodes, sub-goal episodes, and single statements.

This differed from the current study, where task processes were analysed at one level, discussing a hypothetical case vignette of Rose, to determine the usage of type of task processes.

Finally, the analysis of the task processes revealed an overlap in coding for some processes. Code-co-occurrence was not reported in the former study but was observed in the latter study, especially when coding for the task processes of *describing*, *planning*, and *predicting*. In Bartolo et al.'s (2001) study, statements were assigned one task process, even though the comments constituted different elements of an argument. This analysis is further discussed in the present chapter.

The Relationship of the Findings to the NDM Framework

This section discussed the variations between Bartolo et al.'s (2001) study and this study, in relation to an overlap of some task processes. This variation may be explained by the NDM theories' emphasis on the processes (strategies) involved in decision-making. These theories and their researchers had a much stronger interest in the processes of decision-making, rather than outcomes, hence the processes were the focus of these theories and studies (Klein et al., 1993; Klein, 1997; Gore et al., 2006; Klein, 1997; Lipshitz, 2006; Zsombok & Klein, 1997). It may be therefore said that, in the present study, the commentary from MDTs was consistent with the views of the NDM theories, as all the processes that were applied in the MDTs' comments were analysed and assigned not only to one process but also to other task processes, where applicable.

Furthermore, the variations between Bartolo et al.'s (2001) study and the present study regarding an overlap of some task processes may be explained by three factors, which may be consistent with the NDM framework. The first explanation for the evidence of an overlap of some task processes may be related to the NDM characteristics of the types of difficulties that professionals experience when making decisions. According to Orasanu and Connolly (1993), decisions were often complicated by several of the eight contextual factors. Three of these factors may apply to the current study, namely: (1) decisions were made by multiple team members; (2) problems were ill-structured; and (3) these problems were juxtaposed in uncertain and dynamic environments (Klein et al., 1993; Orasanu & Connolly, 1993).

The explanation of the overlap in relation to the first factor may be that, in the current study, a decision to move Rose to dispersed housing in the community was made by 28 MDT members with varied professional backgrounds from five different organisations. It can be argued that, because of the different views, MDT members may have perceived some aspects of one task process as applicable in another process, hence, *describing*, *planning*, and *predicting* overlapped. This was consistent with Elliot's (2018) view that multiple coding may be necessary if a study was designed to evaluate data from different perspectives.

The explanation of the overlap in relation to the second factor may be that according to the NDM framework, professionals often addressed ill-structured problems. That is, they usually had insufficient information at their disposal when making decisions and had to do significant work in defining the problem and developing appropriate response options (Klein et al., 1993; Orasanu & Connolly, 1993). In the current study, MDT members relied on information in the hypothetical case vignette and asked the facilitator/moderator for clarification, when in doubt. They spent ample time *describing* and discussing Rose's problems. As they were *describing* her conditions, they were also *planning* all the supports that she would need in the community, as well as *predicting* what would happen if these supports were not in place. It may be argued that, because of the task that MDT members were being asked to carry out, they might have viewed several courses of action as equally important. As a result, it may be said that their comments did not necessarily fit into only one task process, as stated by Elliot (2018) and Richard (2015).

With regard to the third factor, the explanation of the overlap may be related to the fact that professionals sometimes addressed problems that were ambiguous. As a result, MDTs gathered information by asking questions and clarified information about Rose's conditions, and her current and future environment, in order to make a decision for her to transfer to dispersed housing in the community. Their commentary had more than one interpretation of the problem (Klein et al., 1993; Orasanu & Connolly, 1993). As a result, the same texts were assigned to the overlapping task processes of *describing*, *planning*, and *predicting*.

Situation Awareness Model and use of Task Decision-Making Processes

Chapter Two indicated that of the 14 NDM studies reviewed, three detailed how SA was a precursor to effective decision-making, namely, those of Bartolo et al. (2001), Mackintosh et al. (2009), and Tower and Chaboyer (2013). What was common among these studies was that the decision-making was based on drawing on all three levels of the SA model. These levels included: the professionals' perception of the current situation and gathering of data (Level 1); the comprehension of the current situation by collecting and interpreting multiple pieces of information within a particular context (Level 2); and prediction of the future status and the associated implications (Level 3) (Endsley, 2000;2009).

Similar to the three NDM studies mentioned above, the SA model was evident in the current study, where MDT members extracted information from all three levels of the model, in order to make a decision to move Rose to dispersed housing in the community. While applying Bartolo et al.'s (2001) task processes in their discussion of a hypothetical case vignette, MDT members in focus groups asked questions about Rose, in order to understand her diagnosis, current environment, and presentation and behaviour, as well as determining the reason for the move. Gathering this type of information to understand the context was in keeping with Level 1 of the SA model. It would appear that in this level, MDTs used mainly two of the four SA processes, that is, *describing* and *explaining* (more so than *predicting* and *constructing hypothesis*) to make a decision to transfer Rose to the community.

In Level 2, the MDT members understood that their task was to make a decision about transferring Rose to dispersed housing in the community, as per HIQA's directive. At this level, they discussed the current supports for Rose and suggested other supports that would be needed in the community for the transfer to be successful. Examples of the SA process *describing*, as well as the solution processes *planning* and *recommending* task processes, were evident in the discussions at this level.

In Level 3, both SA and solution processes were used. MDT members were able to predict (SA process) possible challenges that Rose might encounter. Consequently, they made suggestions (solution process) to ensure her safety with regard to having a room downstairs rather than upstairs, to minimise the risk of falling, in view of her diagnosis of epilepsy.

These patterns revealed that the findings from the present study were in agreement with those from the existing literature, particularly in claims from the NDM theories that decision-making comprised assessing the situation and selecting a course of action, once the situation was understood (Gore, 2006; 2015; Klein, 1997; 2008; Lipshitz, 2006). Furthermore, the findings indicated that MDT members demonstrated decision-making skills that were consistent with NDM theory predictions (Gore, 2006; 2015), as was the case in Baker-Ericzén et al.'s (2015) study. MDT members used, for example, relevant clinical information provided in the case vignette and asked questions about Rose's condition and environment, in order to be able to make a decision to move her to dispersed housing in the community.

Principles of NDM

The SA model mentioned above was underpinned by four main principles of the NDM (Bryant et al., 2003), all of which were applicable to both data sets in the current study, namely:

1. Decisions are made by multiple team players. The importance of the involvement of MDTs in decision-making in healthcare was cited in previous literature (Choi & Pak, 2006; Fay et al., 2006; Kimura & Moehlis, 2012; Robbins et al., 2005; Schwartz, 1994). The importance of MDTs in decision-making was echoed in May's (2016) recommendation that diversity of disciplines and opinions result in a better course of action. As indicated previously, this diversity of disciplines and opinions was evident in the current study, as MDT members comprised senior psychotherapists, community transition coordinator, nurses, psychologists, behaviour support staff, social workers, social care leaders, physiotherapists, occupational therapists, speech and language therapist and service managers.

The composition of MDT members in the current study was broader than that of some of organisations involved in pivotal research on deinstitutionalisation in Ireland. Specifically, representation in this study was broader than that of organisations taking part in the Next Step Project conducted by the NFVB, the umbrella body for ID agencies in Ireland (Hartnett, 2014). MDT members in the NFVB study who were involved in decision-making on deinstitutionalisation typically comprised the service user, key worker, team leader for the de-congregation project, and the organisation's representative. In line with best practice (MHC, 2006), a service user should be

involved in the decision-making process which, in the case of the current study, was represented by the hypothetical case vignette of Rose.

2. Decision-makers rely on the recognition of a situation to generate potential courses of action and compare them to past experiences. In the current study, MDT members in two of the five focus groups recommended that provisions be made for Rose to come back to a congregated setting, if the placement in the community did not work out. These groups cited examples of people who had transferred to the community in the past but who came back to a congregated setting, as they could not cope for various reasons, including the development of complex medical needs. This was a clear example of decision-makers recognising the situation and drawing from their past experiences to generate a course of action.

The participants' decision to make provision for Rose to come back to a campus-based setting may be linked to some of the findings of the Moving Ahead Project, which investigated two regions in Ireland where disparities occurred regarding rates of deinstitutionalisation. The findings revealed that a number of factors caused the disparities, including the referral of those with high supports needs (low levels of ability, complex medical needs, behaviours that challenge), and who were less likely to be transferred to the community, but if moved, were more likely to come back to a congregated setting when difficulties arose (Linehan et al., 2015).

3. Decision-makers adapt a satisfying criterion. Varied criteria were adopted by MDTs to enhance decision-making on deinstitutionalisation in the current study. The criteria to move people to the community for the interviewees, for example, were based on a mix of information from MDT assessment results, adults who had consented to the move, those with behaviour that challenge, and those with safeguarding issues. Conversely, other MDT participants were influenced by the outcome of a globally used assessment tool such as the SIS, AON processes, PCP, and families' wishes to move an adult with an ID into the community.

HIQA's recommendation to move Rose to dispersed housing in the community was another satisfying criterion considered by MDTs, given that they were informed by the facilitator that Rose had to move to the community, as her current residence did not meet HIQA safety standards. The HIQA standards were a driver of the national programme of deinstitutionalisation (HIQA, 2013), whereby a threat of closure on non-

compliance placed significant pressures on disability organisations to move to community options.

4. Organisational goals are important and influence decisions. The findings of the current study indicated that all MDTs were in favour of *deinstitutionalisation*. They were committed to achieving their organisation's goal of moving people to dispersed housing in the community. However, all organisations were at different stages of implementing the *Congregated Settings Report* of 2011, the document outlining Ireland's strategy for *deinstitutionalisation*. It would seem that the process of *deinstitutionalisation* will take longer than seven years to accomplish. The seven-year period was over at the end of 2019. As indicated previously by Linehan et al. (2015), the closure of congregated settings in Ireland will not occur in this timeframe: it was more likely to happen in the next decade.

Methodology and Thematic Analysis

As indicated previously, the current study and that of Bartolo et al. (2001) were similar, as both adopted an exploratory, purposive multiple-case research design, to capture sequential decision-making task processes used by MDTs within the NDM framework. However, the studies differed in the specific methodology used and in data analysis.

With regard to methodology, recall that in order to ascertain how professionals made decisions, Bartolo et al. (2001) had two MDT teams with three professionals per team in two different sites (a neuro-disability centre and a special school), who were asked to simultaneously assess four preschool children (two in each team) suspected of having autistic spectrum disorder. In the current study, a total of 28 MDT members participated in five different focus groups (five to eight per group) from five different organisations and were required to make a decision about moving a hypothetical 32-year-old woman who was being considered for a transfer to dispersed housing in the community.

During the assessments in Bartolo et al.'s (2001) study, group discussions revolved around information from a number of sources, including, parental interviews, a referral meeting among professionals, professionals' planning of assessment activity, behind-the-scene comments, an evaluation meeting among professionals, a final conference with parents, and a post-conference reflection. Post-assessment, semi-structured interviews were conducted with each participant and the families.

Group discussions and interviews were audio recorded. In contrast, the present study's discussions in focus groups revolved around a small quantum of information from one source, that is, information on a hypothetical case vignette with a short profile of the case, Rose, and opportunities to question the facilitator/moderator.

As highlighted in Chapter Two, only two studies of those reviewed, those by Taylor et al. (2014) and Bartolo et al. (2001), reported on how methodological rigour was achieved. In the former, the study achieved rigour by applying triangulation, whereby two methods of collecting data were used to ensure credibility and conformability of the study, namely, focus groups and observations. Additionally, co-authors checked the credibility of the first author's coding and categories and verified emergent themes. In the latter, the triangulation strategy was also used, whereby post-assessment semi-structured interviews and group discussions were used to collect data, in order to obtain complete perceptions of the participants. As previously mentioned, a lack of reporting on rigour may be in keeping with some proponents of NDM, who stated that rigour was not an important feature of NDM research, which was conducted in natural settings and not in laboratories (Lipshitz et al., 2001).

The current study took on board proposals from Bartolo et al. (2001) and Taylor et al. (2014) on how to achieve methodological rigour. Consequently, the triangulation strategy used two methods of data collection, namely, focus group discussions and individual interviews, to ensure the credibility of the study. In contrast to the above studies, in the current study, both data sets were analysed in combination, to allow a fuller understanding of the data and to enable truths to emerge, as suggested by Cepede and Martin (2005). In addition, a second coder, as recommended by Belotto (2018), was used to verify coding and the emerging themes. Furthermore, a hypothetical case vignette was developed by the researcher, in accordance with Baker-Ericzén et al.'s (2015) suggestions and was validated by a focus group consisting of five MDT members. The interview questions were validated by a senior manager. The focus group and the senior manager were from a similar organisation to those participating in the study. Furthermore, the focus group and interview transcripts were preserved for verification.

Previously, the overlapping of coding for task processes was explained in relation to the NDM framework.

In this section, the overlap is explained in relation to the analysis used. Bartolo et al. (2001) used verbal protocol analysis to analyse data, as opposed to the thematic analysis of coding for task processes and themes in the current study. As indicated previously, a second coder was used to verify coding and the emerging themes. But there were segments of data that resulted in an overlap when coding for some task processes.

Some researchers stipulated that there was no clear response in the literature with regard to whether codes should overlap or be exclusive to one category (Creswell, 2015; Elliot, 2018; Friese et al., 2018; Richard, 2015). According to Creswell (2015), the answer may depend on whether codes were pre-existing or emerging, but even with these, there may be text segments with multiple coding (Elliot, 2018). Although single coding was recommended (Creswell, 2015), Elliot (2018) was of the view that multiple coding may be necessary if the research was designed to analyse data from different perspectives. As a result, it may be said that MDT members' comments might not necessarily have fitted into a single task process, as stated by Elliot (2018) and Richard (2015).

Given the above varied views, it may be argued that the double coding of task processes in the current study was unavoidable, as data from the MDTs in five different focus groups was analysed to identify Bartolo et al.'s (2001) six task processes, thus capturing different points of view. Double coding was evident mainly in texts assigned to *describing*, which were also applicable to other processes such as *planning* and *predicting* and vice versa. The following example illustrated text segments that encompassed the task processes of *describing* and *planning*. FG5 NO6: "*An opportunity to move closer to home should also be pursued as an alternative.*" *Describing* and *predicting* task processes were reflected in this quotation: FG1 NO4: "*I suppose just one thing, and probably it does not apply that much in this scenario, because it does not say anything about her physical needs, but there is a possibility of her losing her mobility [so] at some stage, the new house will need to have a ramp.*"

Arguably, evidence of such an overlap may be consistent with Creswell's (2015) assertion above, which indicated that multiple coding may occur even in pre-assigned codes such as those of Bartolo et al. (2001). Furthermore, the presence of code co-occurrence in the current study may support Elliot's (2018) comment that when

analysing data from different points of views, double coding may be necessary. Additionally, evidence of the overlapping task processes of MDTs' commentary may reflect the nature of thematic analysis, where text segments may not be coded to one theme, as participants often address multiple aspects of a complex issue. This may result in data being assigned multiple coding (Elliot, 2018; Freise et al., 2018; Richard, 2015), as was the case in some text segments of the participants' discussions in the current study.

Overall, the findings of Research Question One were compatible with NDM theories. Just as they were similarities between the current study and Bartolo et al.'s (2001) study in particular, there were also differences. The main differences related to the methodology and analysis used.

5.4 Interpretation of the Findings and their Relationship to the Literature: Research Question Two

The results from the current study addressing Research Question Two identified five overarching themes impacting on the decision-making process of MDTs when transferring an adult with an ID from a congregated setting to a dispersed house in the community. The following themes were part of the discussion to move to the community, namely: *client profile*; *resources*; *deinstitutionalisation*; *person centredness* and *ethos*. The literature has highlighted that no decision was made in isolation, as there were contextual factors that were likely to help professionals decide on a course of action (Klein et al., 1993; Orasanu & Connolly, 1993; Gore et al., 2006; Zsombok & Klein, 1997), based on their experience (Lipshitz et al., 2001).

The current study was interested in exploring additional frameworks that could facilitate an examination of the impact of contextual factors in the decision-making process. From the theoretical literature review, an appropriate framework was identified, namely the ecology systems of adults with an intellectual disability, which was adapted from Bronfenbrenner (1977) and Hogg (1997). The next section gave an overview of the five overarching themes that emerged from Research Question Two and their relationship to these ecology systems.

Overarching Themes and their Relationship with Ecology Systems

The current findings were broadly in line with the ecology systems of adults with an ID. In keeping with the ecology systems, it was evident that there was a wide variety

of stakeholders involved (Bronfenbrenner, 1977; Hogg, 1997) and that the process involved considering many levels of environmental information to decide on the appropriate course of action to achieve organisational goals. Recall that the ecology system comprised four layers/levels of *microsystem*, *mesosystem*, *exosystem*, and *macrosystem*.

Within the present study, the *microsystem* (inner layer/level of the ecology system) represented an adult with an ID, in this instance Rose, who was located in the centre of the system, surrounded by her family, community and service settings. In the current study, under the theme of *client profile*, MDTs in focus groups took into account information pertaining to Rose's medical conditions, cognitive abilities, environment, communication skills, and behaviours that challenge. Similarly, among the interviewees, moves to the community were influenced by, for example, the person's diagnosis and behavioural presentation. These findings suggested that the focus groups and their corresponding interviewees reflected on information at the *microsystem* level in order to facilitate a move to the community. This study expected that the *microsystem* would be an area of attention for MDT members in focus groups, because they were skilled in gathering information when developing a *client profile*. However, this study has revealed that senior managers also compiled a *client profile* when making decisions more generally to move people to the community and were therefore also working at the *microsystem* level during the decision-making process.

The discussion on *resources* pertinent to the move to the community suggested that information at the *mesosystem* (inner layer/level of the ecology system) was also utilised during the decision-making processes. The theme of *resources* had a different emphasis for MDT members, whereby focus group members emphasised staff training, MDT support, and assessment tools. In contrast, interviewees focused on the right to live in the community, funding for suitable housing in the community, and issues pertaining to recruiting and redeployment of staff.

Ethos was unique among interviewees and indicated that senior managers were influenced by their organisation's core values and principles in their decision-making process. Commentary suggested that interviewees were influenced by information at the *exosystem* (outer layer of the ecology system), when making decisions to move people to dispersed housing in the community. Recall that this layer of the ecology

system represented the service provider's *ethos* and the service they provided, which was the remit of the interviewees. Interestingly, this level was not considered by those involved in the focus groups, suggesting that the organisation's *ethos* did not have the same level of priority for this group as for senior managers.

Finally, information considered by the interviewees was most often associated with the outer layer ecology system, namely, the *macrosystem* than for focus group members. This layer represented information about the organisation, government policies (*Congregated Settings Report* of 2011), standards and guidelines (HIQA, advocacy, PCP) and human rights. It was expected that interviewees would take into account information at the *macrosystem* level, as the goal of the organisations was the overall implementation of the *Congregated Settings Report* of 2011.

In summary, a relationship between the themes that emerged, and all the levels of the ecology systems of Bronfenbrenner (1977) and Hogg (1997) was evident in the present study. This relationship indicated that the ecology system could be a useful framework in which to consider an array of issues that affected individuals directly or indirectly when moving to dispersed housing in the community.

5.5 Contribution to the Body of Knowledge

The current study has made six contributions to the body of knowledge on the decision-making processes of MDTs when transferring an individual with an ID from a congregated setting to dispersed housing in the community within the Irish context.

Firstly, this study has identified the NDM framework as a suitable framework for exploring the task decision-making processes used by MDTs when implementing the *Congregated Settings Report* of 2011 in Ireland.

Secondly, the present study has identified which specific task decision-making processes were dominant and which were seldom used during participants' deliberations. MDT members (healthcare and social care professionals) sought to accomplish their organisation's goal of transferring an individual to dispersed housing in the community by applying three dominant sequential task processes in their decision-making, namely, *describing*, *recommending*, and *planning*. However, cumulatively, the solution-based task processes of *recommending* and *planning* were used more frequently than the SA solution of *describing*.

Thirdly, the current study has contributed to the field by highlighting that there may be some overlap when coding for task processes such as *describing*, *planning*, and *predicting*. Furthermore, some themes may have been considered synonymous by senior managers, namely, *person-centredness* and *ethos*.

Fourthly, the literature has indicated that decision-makers were influenced by contextual factors in their decision-making process (Klein et al., 1993; Orasanu & Connolly, 1993; Gore et al., 2006; Zsombok & Klein, 1997; Lipshitz et al., 2001). The contribution to the literature was that the current study outlined five overarching themes that were influential factors considered by MDT members when transferring an individual with an ID from a congregated setting to dispersed housing in the community. The themes comprised: *client profile*, *resources*, *deinstitutionalisation*, *person-centredness*, and *ethos*. The present study established that the abovementioned themes closely aligned with the ecology systems of Bronfenbrenner (1977) and Hogg (1997), namely, *microsystem*, *mesosystem*, *exosystem*, and *macrosystem*.

The fifth contribution to the body of knowledge was the finding that, while some disability organisations work through a transition plan to move an adult with an ID to dispersed housing in the community (Harnett, 2014), the present study has highlighted other mechanisms of planning, such as the SIS, PCP and AON.

The final contribution to the literature was that the statutory body, HIQA, established under the Health Act of 2007 in Ireland, was effective in evaluating the living conditions of people with disabilities (Mansell et al., 2007). It could be argued that the *Congregated Settings Report* of 2011 may have a better chance of being implemented if the recommendation came from HIQA, and if there was a threat of non-compliance or closure.

5.6 Practice and Policy Implications

The implications of the findings related to theory have been highlighted above. This section presented the implications of the findings of the current study in relation to policy and practice.

1) Practice Implications

As discussed previously, the importance of involving MDT members in the decision-making process in healthcare was widely cited in the literature (Choi & Pak, 2006; Fay et al., 2006; Kimura & Moehlis, 2012; Robbins et al., 2005; Schwartz, 1994). This implied that Irish service providers in the ID field should continue to involve not only senior managers but also MDTs in decision-making, with regard to the implementation of the *Congregated Settings Report* of 2011.

Additionally, the present study has highlighted different assessment tools and approaches that both MDT members and senior managers used to make a decision to transfer an adult with an ID to the community. This implied that MDT members could use both formal (SIS) and informal (AON) assessments, as well as approaches such as PCP, to make decisions that will facilitate the transfer of an adult from a congregated setting to a house in the community.

The present study has illustrated how individuals involved in making these key decisions use information available at multiple layers, from information related to the individual and the support systems required (*microsystem* and *mesosystem*) through to information regarding the organisational ethos (*exosystem*), and information on standards and policies (*macrosystem*). It was therefore important that organisations equip their staff with accurate and timely information on the individuals they support, the available resources, and the broader ethos of their organisation. In this way, decision-making will be made on the basis of well-informed staff.

2) Policy Implications

The organisations that participated in the current study were at different stages in the implementation of the *Congregated Settings Report* of 2011. This may be reflective of inadequate resources (funding for staffing, suitable houses in the community) available to them to complete the deinstitutionalisation process. Therefore, the deadline of 2019 for moving all people to dispersed housing in the community may not be realised. It was envisaged that in Ireland, the process of deinstitutionalisation may take another decade to complete (Linehan et al., 2015).

Implications for policy in deinstitutionalisation may include the need for greater consensus at national and local level as to what information was required by staff when

making decisions that impacted on the lives of people with an ID. This study has revealed a somewhat ad hoc manner of assessing the suitability of a particular individual to move to the community. A more standardised approach, whether using consistent assessments or PPC, would provide greater transparency and equity for making these decisions.

5.7 Strengths and Limitations of the Study and Recommendations for Future Research

The strengths of the current study, as previously indicated, lied mainly within the following areas. (1) This was an important study, in that it was timely and took place during the implementation of *Congregated Settings Report* of 2011, the blueprint for the national deinstitutionalisation programme of people with disabilities in Ireland. (2) The study looked at the unique glimpse into decision-making in the context of deinstitutionalisation. (3) It employed a good recruitment strategy with five organisations represented, from not-for-profit to HSE-run organisations. (4) There was good representation of 28 professionals in MDTs and five senior managers. (5) The hypothetical case vignette of Rose was validated by a focus group that comprised five MDT members, and the interview questions were validated by a senior manager. In this study, methodological rigour was achieved by using the triangulation strategy and both data sets were analysed in combination. Additionally, a second coder verified coding and the emergent themes.

The limitation of the study was that the sample size used was small and within the Irish context, and though it cannot be generalised, it reflected well against other studies exploring decision-making within the health and social services fields, including those of Bartolo et al. (2001); Baker-Ericzén et al. (2015); Mackintosh et al. (2009); Taylor et al. (2014) and Tower and Chaboyer (2013). The current study was designed to try maximise validity and reliability, in order to achieve methodological rigour.

Despite efforts to ensure compatibility across groups, one group had a different composition of expertise and led to some members being more dominant than others. Two social workers represented in this group. This may have caused bias with regard to the analysis of the extracts depicted in this group, which in turn might have affected the findings. The recommendation was that MDT members should include representatives of many disciplines. However, given the lack of resources, this may

prove difficult in the ID sector, where there may be a lack of MDT members and a lack of varied disciplines.

This study recognised that MDTs do not routinely make decisions to move people to the community. The study looked at varied MDTs as decision-makers in organisations that provided a mix of congregated settings and community housing for 60-100 adults with an ID. It was possible that smaller service providers, where there may be lack of MDTs, decisions to move people to community housing could fall within the remit of senior managers only. Future studies should examine smaller service providers, to determine who made the decisions to transfer people to the community.

Another limitation of this study was the inclusion of a recommendation by HIQA, in the hypothetical case vignette, that the current living conditions were inappropriate. This recommendation may have limited the scope of MDTs constructing the reasons for a referral, as reflected in the minimal use of the task process of *constructing hypothesis*. It was possible that other groups may have viewed the recommendation from HIQA as mandatory, thus requiring no further discussion. Future studies should take this limitation on board, when constructing a hypothetical case vignette.

Recommendations for future research include a quasi-experimental study, using multiple case vignettes to determine the decision-making process of professionals, which will allow for greater data analysis and potentially generalisability. The data could be analysed quantitatively following from Baker-Ericzén et al. (2015), given the criticism of a lack of quantitative studies in NDM research.

In this study, views of service users, their families and keyworkers were reflected in the SIS, PCP goals and the AON. Therefore, their views were considered in the decision to move people to the community. However, future research should consider MDTs interviewing individual service users, their families, and the keyworkers, to determine their views on the move to the community.

In the current study, the results indicated the frequency counts of the types of decision-making processes used by MDTs. It should be noted that these frequency counts were used as a proxy for what the researcher thought was happening, and the weight given to each type of the decision-making process. The frequency counts were not formally measured. Therefore, conclusions could not be drawn about the frequency of the types of decision-making task processes used beyond this study. *Describing*, for example,

was the most used decision-making task process among all the focus groups. Statements such as FG4 NO2: “*Remember she cannot share a room, according to HIQA*” may have carried more weight in the discussions and resulted in MDTs deciding to move Rose to the community.

Another limitation of the study was that the researcher was a member of an MDT and may have brought personal bias to the analysis of data. Measures to address this potential bias included a structured review of literature to guide the study and the use of a second coder.

Finally, the limitation of the current study was related to the challenges in the methodology. These issues and how they were addressed are indicated below.

Challenges in Methodology Implementation

The main challenge in undertaking case studies was that the information was difficult to cross-check, generalisation was not always possible, and there were concerns about selective reporting (Bell, 2010; Bowling, 2009; Breen, 2006). Additionally, studying more than one case may dilute the overall analysis (Creswell, 2007; Yin, 2014). However, the current study addressed the above issues by setting boundaries with regard to time and events of the research. That is, MDT members discussed the same hypothetical case vignette in five different organisations and senior managers answered the same questions when interviewed.

Case studies were difficult to conduct, due to operational and logistical issues (Breen, 2006; Kreuger & Casey, 2009). In the current study, it was difficult to schedule suitable times for all participants and not all organisations sampled agreed to participate in the study. Senior management of some organisations that responded declined the researcher’s invitation to participate, citing lack of MDT to facilitate same. Others did not respond to the invitation. Others cited data protection issues, as they wanted to retained consent forms, rather than this being the responsibility of the researcher.

An additional methodological issue was that when participants provided a rationale for their decision, this act removed them from the process of problem-solving, causing them to think about what they were doing rather than simply doing it, resulting in changes in their performance (Trickett & Trafton, 2009). Furthermore, there was a potential for subjective interpretation of verbal protocol data, from interpreting

incomplete utterances to assigning those utterances a code. The danger was that a researcher may think he/she “knows” what a participant intended to say or meant by some utterance, and thus inadvertently misrepresent the verbal protocol (Trickett & Trafton, 2009). In the current study, there were some utterances that were unintelligible; as a result, they were not coded for analysis.

Finally, focus groups were time-consuming and data obtained was context-specific, and hence difficult to generalise. Responses from the focus groups may be difficult to analyse and results may be shaped by the participants (Breen, 2006 Kreuger & Casey, 2009) and their professional background and position within their organisation. Furthermore, the nature of focus groups was such that neither confidentiality nor anonymity could be guaranteed, as the researcher had no control of participants’ actions during the discussions (UCD Human Research Ethics Committee, 2008). However, it was important to note that both confidentiality and anonymity was assured by the researcher in the reporting of the discussions.

5.8 Conclusions from the Current Study

The following conclusion can be drawn from exploring the two research questions in this study. With regard to Research Question One, the current study has demonstrated that the findings were consistent with Bartolo et al.’s (2001) study in capturing six task decision-making processes. The main differences were that the task process of *constructing hypothesis* was dominant in Bartolo et al.’s (2001) study but not in the current study. Furthermore, the methodology and the analysis used differed between Bartolo et al.’s (2001) study and the present study.

In addition, this study’s findings were in agreement with existing literature, in particular, one of the NDM models, SA. In the current study, MDT members extracted information from all three levels of SA, in order to make a decision to move Rose to the community. Furthermore, their discussions illustrated that the four principles of the NDM framework were applicable to data gathered in the current study. In general, the findings of Research Question One were compatible with the NDM theories.

With regard to Research Question Two, the present study has illustrated a relationship between the five overarching themes that emerged and the four levels of ecology systems of Bronfenbrenner (1977) and Hogg (1997). The study has served to illustrate how these themes could be applied within the ecology systems, in order to understand

an individual's situation/environment and issues directly and indirectly affecting the people with an ID. Furthermore, the conclusion of the present study was that it was necessary to include both senior managers and MDT members in the decision-making process, to ensure that all four levels of the ecology system were examined. It was envisaged that the involvement of senior managers and MDT members would result in a more realistic achievement of the *Congregated Settings Report* of 2011, in addition to the formulation of a prioritisation process.

In Ireland, a variety of assessment tools and approaches were used by MDT members to facilitate the transfer of adults with an ID to the community. Additionally, this study has highlighted the need for adequate resources to allow organisations to complete the deinstitutionalisation process. The study has revealed that organisations differ in term of their progress with regard to the implementation of the *Congregated Settings Report* of 2011. Access to appropriate assessment tools may facilitate implementation.

The present study has not only made six contributions to the body of knowledge but has also highlighted theoretical, practical and policy implications applicable to the decision-making process of MDTs within the ID field. Furthermore, this study has served to identify its strengths and limitations. Notwithstanding its limitations, it was hoped that the strengths of this study were sufficient to deem it making a positive contribution to the field.

5.9 Author's Reflective Statement

I am a proponent of MDTs, including healthcare, social care professionals and senior managers, as decision-makers in deinstitutionalisation. I believe that as a member of an MDT in a larger organisation that provides a mix of congregated settings and community housing to over 100 adults with an ID, it is crucial for important decisions such as moving people to the community to be robust and not be left to a select few people. As a result, I have often wondered how MDTs of other organisations make decisions to move people to the community, hence this study. In my 10 years' experience as a speech and language therapist, involved in transferring adults with an ID to the community, I have seen MDTs engage in best practice and I have also seen how this practice is not always possible, due to a lack of MDT members.

It is my experience that meetings are held to discuss moving people to the community, following discussions with the service users and families, as was the case in the

current study. However, it is not always possible to have varied disciplines represented in these meetings. It is usually the core disciplines that are represented, in the form of speech and language therapists, social workers, psychologists, physiotherapists, occupational therapists, nurses and representatives from management. In some instances, the core team members may not be available, and the organisation makes a decision based on a quorum of three MDT members from different disciplines. In this case, it is the organisation that is dictating who should be involved in the decision-making process.

Being a long-standing member of an MDT, I may have brought personal bias to the analysis of this data. To address this potential bias, I approached this research in an open-minded manner. I included a structured review of literature to guide this study. In addition, I used a second coder to eliminate the risk of researcher bias.

During my literature review, it transpired that some service providers did not have MDT members involved in the decision-making process, as was the case in the Next Step Project (Hartnett, 2014).

I was reassured when the focus groups consisted of five to eight members of the MDT from different disciplines volunteered to participate in this study. This reaffirmed my belief that different disciplines are involved in decision-making, as best practice dictates. But the composition of one focus group in this study, where two social workers, behavioural support staff, and a psychologist were represented also proved that varied disciplines may not always be available to take part in the discussions. This was a difficult focus group to moderate, as the members asked many questions focused on mental health and psychological well-being and took longer to make a decision. This may have resulted in bias when analysing the extracts which, in turn, may have affected the findings. Despite the composition, this group was the most experienced. Although the literature advocates for MDT members to be decision-makers in deinstitutionalisation, it does not specify which disciplines should be involved. The involvement of varied disciplines may not always be possible, given the lack of MDT members in some organisations.

During this study, a new role has emerged in my organisation that of a transforming lives project leader (TLPL). This role is similar to the community transition coordinator (CTC) that was unique to Focus Group 5. The TLPL acts as a key worker for service

users and looks after their interests. Additionally, the TLPL oversees the transition plans, monitors and records progress with regards to deinstitutionalisation. The TLPL advocates for the service users and their families, gathers the relevant information, coordinates MDTs, and facilitates meetings. By the time the MDTs deliberate, they have all the relevant information to hand. Since the introduction of this role, the process of deinstitutionalisation has accelerated and has assisted the organisation in the implementation of the *Congregated Settings Report* of 2011. This role has resulted in more service users being considered for the transfer to dispersed housing in the community, compared to previous attempts made by other MDT members.

The current lack of MDT members in some organisations may continue to be a reality in the future. I had difficulty collecting data in some organisations, due to a lack of MDT members, which resulted in the data collection being delayed by six months. It is possible that in these organisations, the process of deinstitutionalisation continues without the involvement of MDT.

Apart from the frustration I experienced with the delay in collecting data, due to lack of MDTs in these organisations, I enjoyed the journey involved in completing this research. My curiosity is fulfilled, having researched the area of MDTs involved in deinstitutionalisation. It would seem that in organisations where MDT members are well represented, the process of deinstitutionalisation is progressing, albeit slowly. It would be interesting to see how smaller organisations fare in completing this complex process.

REFERENCES:

- Algood, C. L., Harris, C., & Hong, J. S. (2013). Parenting success and challenges for families of children with disabilities: An ecological systems analysis. *Journal of Human Behavior in the social environment*, 23(2), 126-136.
- Australian Institute of Health and Wellbeing (2015). *Australian Welfare*. No 12, Cat. No AUS 189. Canberra.
- Bagenstos, S. R. (2012). The past and future of deinstitutionalization litigation. *Cardozo L. Rev.*, 34, 1.
- Baker-Ericzén, M. J., Jenkins, M. M., Park, S., & Garland, A. F. (2015, February). Clinical decision-making in community children's mental health: Using innovative methods to compare clinicians with and without training in evidence-based treatment. In *Child & youth care forum* (Vol. 44, No. 1, pp. 133-157). Springer US.
- Barrett, P. (2007). A Matter of Record: Document Management as Part of Good Corporate Governance, Risk Management and Decision-Making. *Australian Accounting Review*, 17(41), 88-95.
- Bartolo, P. A., Dockrell, J., & Lunt, I. (2001). Naturalistic decision-making task processes in multiprofessional assessment of disability. *Journal of School Psychology*, 39(6), 499-519.
- Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report*, 13(4), 544-559.
- Beach, L. R. (1993). Image theory: An alternative to normative decision theory. *ACR North American Advances*.
- Beach, L, Chi, M., Klein, G., Smith, P., and Vicente, K. (1997). *Naturalistic Decision Making and Related Research Lines*. In Zsombok, C and Klein, G. (Eds). Lawrence Erlbaum Associates, Mahwah, New Jersey.
- Beadle-Brown, J., Mansell, J., & Kozma, A. (2007). Deinstitutionalization in intellectual disabilities. *Current Opinion in Psychiatry*, 20(5), 437-442.
- Becker, S., Bryman, A., & Ferguson, H. (Eds.). (2012). *Understanding Research for Social Policy and Social Work 2E: Themes, Methods and Approaches*. Policy press.
- Bell, J. (2010). *Doing Your Research Project* [electronic resource]. EBL. <https://ezp.lib.unimelb.edu.au/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=cat00006a&AN=melb.b4139977&scope=site\nhttp://www.unimelb.eblib.com.au.ezp.lib.unimelb.edu.au/patron/FullRecord.aspx?p=771407>
- Belotto, M. J. (2018). Data analysis methods for qualitative research: Managing the challenges of coding, interrater reliability, and thematic analysis. *The Qualitative Report*, 23(11), 2622-2633.
- Belzile, J. A., & Öberg, G. (2012). Where to begin? Grappling with how to use participant interaction in focus group design. *Qualitative Research*, 12(4), 459-472.

- Bloor, M., & Wood, F. (2006). *Keywords in qualitative methods: A vocabulary of research concepts*. Sage.
- Borrill, C., West, M., Shapiro, D., & Rees, A. (2000). Team working and effectiveness in health care. *British Journal of Healthcare Management*, 6(8), 364-371.
- Bovaird, T., & Löffler, E. (2003). Evaluating the quality of public governance: indicators, models and methodologies. *International review of administrative sciences*, 69(3), 313-328.
- Bowling, A. (2009). *Research Methods in Health: Investigating Health and Health Services*. Maidenhead, Berkshire, England: McGraw Hill/Open University Press.
- Boyes, M., & Potter, T. (2015). The application of recognition-primed decision theory to decisions made in an outdoor education context. *Journal of Outdoor and Environmental Education*, 18(1), 2-15.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, 3(2), 77-101.
- Breen, R. L. (2006). A practical guide to focus-group research. *Journal of Geography in Higher Education*, 30(3), 463-475.
- Bridgman, P. (2007, April). Performance, Conformance and Good Governance in the Public Sector. *Keeping Good Companies*, 149–157. <http://old.cognitive-edge.com/wp-content/uploads/2007/06/55-KGC-April-risk-mgmt.pdf>
- Bronfenbrenner, U., & Morris, P. A. (1998). *The Ecology of Development Processes*. In Damon, W and Lerner, R.M (Eds). *Handbook of Child Psychology, Vol 1: Theoretical Models of Human Development*. (Fifth Ed). New York: John Wiley and Sons Inc.
- Broadhurst, S., & Mansell, J. (2007). Organizational and individual factors associated with breakdown of residential placements for people with intellectual disabilities. *Journal of Intellectual Disability Research*, 51(4), 293-301.
- Bronfenbrenner, U. (1977). Toward an experimental ecology of human development. *American psychologist*, 32(7), 513.
- Bronfenbrenner, U., & Crouter, A. C. (1983). *The Evolution of Environmental Research*. In Mussen, P.H and Kessen, W (Eds). *Handbook of Child Psychology, Vol 1: History, Theory, Methods*. (Fourth Ed). New York: Wiley.
- Bryant, D. J., Webb, R. D., & McCann, C. (2003). Synthesizing two approaches to decision making in command and control.
- Bryman, A. (2008). *Social Research Methods (Third Ed)*. New York: Oxford University Press.
- Burman, E., & Parker, I. (1993). Introduction—discourse analysis: the turn to the text. *Discourse analytic research: Repertoires and readings of texts in action*, 1-13.

- Carlsen, B., & Glenton, C. (2011). What about N? A methodological study of sample-size reporting in focus group studies. *BMC medical research methodology*, 11(1), 1-10.
- Cepeda, G., & Martin, D. (2005). A review of case studies publishing in *Management Decision* 2003-2004. *Management Decision*.
- (CIPFA) Chartered Institute of Public Finance and Accountancy. (2004). *The Good Governance Standard for Public Services*. OPM and CIPFA.
- Chen, Z., Lawson, R. B., Gordon, L. R., & McIntosh, B. (1996). Groupthink: Deciding with the leader and the devil. *The Psychological Record*, 46(4), 581-590.
- Choi, B. C., & Pak, A. W. (2007). Multidisciplinary, interdisciplinary, and transdisciplinary in health research, services, education and policy: 2. Promotors, barriers, and strategies of enhancement. *Clinical and Investigative Medicine*, E224-E232.
- Cioffi, J. (2012). Expanding the scope of decision-making research for nursing and midwifery practice. *International Journal of Nursing Studies*, 49(4), 481-489.
- Clandinin, D. J., & Connelly, F. M. (2000). *Narrative inquiry: Experience and story in qualitative research*. San Francisco: Jossey-Bass.
- Collis, J., & Hussey, R. (2009). Understanding Research. In *Business Research. A Practical Guide for Undergraduate and Postgraduate Students* (p. 358).
- Cook, Kate Gerrish, Charlotte Clarke, G. (2001). Decision-making in teams: issues arising from two UK evaluations. *Journal of interprofessional Care*, 15(2), 141-151.
- Cordes, S. (2016). Do not even think: virtual team process for flexible decision making. *Journal of Organizational Psychology*, 16(1).
- Cousins, J. B., & Bourgeois, I. (2014). Cross-case analysis and implications for research, theory, and practice. *New Directions for Evaluation*, 2014(141), 101-119.
- Creswell, J. W. (2015). *A Concise Introduction to Mixed Methods Research*. California: SAGE Publications, INC.
- Creswell, J. (2015). *30 essential skills for the qualitative researcher*. Los Angeles, CA: SAGE.
- Creswell, J. W. (2007). *Qualitative Inquiry and Research Design: Choosing Among Five Approaches*. Book (Vol. 2nd ed).
- Cruzes, D. S., Dyba, T., Runeson, P., & Host, M. (2011, September). Case studies synthesis: Brief experience and challenges for the future. In *2011 International Symposium on Empirical Software Engineering and Measurement* (pp. 343-346). IEEE.
- D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M. D. (2005). The conceptual basis for interprofessional collaboration: core concepts and theoretical frameworks. *Journal of interprofessional care*, 19(sup1), 116-131.

Dahlgren, G. (2014). Why public health services? Experiences from profit-driven health care reforms in Sweden. *International Journal of Health Services*, 44(3), 507-524.

Data Protection Act. (2018). Irishstatutebook.ie. <http://www.irishstatutebook.ie/eli/2018/act/7/enacted/en/html>

Davidson, A. L. (2015). A collaborative action research about making self-advocacy videos with people with intellectual disabilities. *Social Inclusion*, 3(6), 16-28.

DeCuir-Gunby, J. T., Marshall, P. L., & McCulloch, A. W. (2011). Developing and using a codebook for the analysis of interview data: An example from a professional development research project. *Field methods*, 23(2), 136-155.

Department of Health (UK). (2012). *Statutory Guidance on Joint Strategic Needs Assessments and Joint Health Wellbeing Strategies*.

Department of Health, 2007. Health Act 2007 (Care and Support of Residents in Designated Centres for Persons (Children and Adults with Disabilities) Regulations 2013, Pub. L. No. 367/2013 (2007). Ireland. <https://www.higa.ie/system/files/Disability-Care-and-Support-Regulations-2013.pdf>

Department of Health. (2012). *Value for Money and Policy Review of Disability Services in Ireland*. Department of Health. Dublin. <http://healthupdate.gov.ie/wp-content/uploads/2012/07/VFM-of-Disability-Services-Programme-July-2012.pdf>

Department of Health, (2012). *New Directions Review of HSE Day Services and Implementation Plan 2012-2016* Health Service Executive.

Doyle, A., & Carew, A. (2015). *Annual Report of the National Intellectual Disability Database Committee, Main Findings Series 30*. Dublin.

Draucker, C. B., Martsof, D. S., & Poole, C. (2009). Developing distress protocols for research on sensitive topics. *Archives of psychiatric nursing*, 23(5), 343-350.

Eisenhardt, K. M., & Graebner, M. E. (2007). Theory building from cases: Opportunities and challenges. *Academy of management journal*, 50(1), 25-32.

Elo, S., Kääriäinen, M., Kanste, O., Pölkki, T., Utriainen, K., & Kyngäs, H. (2014). Qualitative content analysis: A focus on trustworthiness. *SAGE open*, 4(1), 2158244014522633.

Endsley, M. R. (1995). Measurement of situation awareness in dynamic systems. *Human factors*, 37(1), 65-84.

Endsley, M. R. (2000). Theoretical Underpinnings of Situation Awareness: A Critical Review. In *Situation Awareness Analysis and Measurement* (Endsley, M & Garland, D eds). Lawrence Erlbaum Associates, Mahwah, New Jersey.

Endsley, M. R. (2009). The Role of Situation Awareness in Naturalistic Decision Making. In Zsombok, C. E and Klein, G. (Ed.), *Naturalistic Decision Making*. New Jersey: Routledge, Taylor & Francis Group.

Ericsson, K. (2000). Deinstitutionalization and Community Living for Persons with an Intellectual Disability in Sweden: Policy, Organizational Change and Personal Consequences. In Disability Conference (pp. 1–12).

European Association of Service Providers for Persons with Disabilities (EASPD). (2013). Making Community-Based Services a Reality: Roadmap on Deinstitutionalisation. Brussels.

Falzer, P. R., & Garman, D. M. (2012). Image Theory's counting rule in clinical decision making: Does it describe how clinicians make patient-specific forecasts? *Judgment & Decision Making*, 7(3).

Falzer, P. R. (2004). Cognitive schema and naturalistic decision making in evidence-based practices. *Journal of biomedical informatics*, 37(2), 86-98.

Fay, D., Borrill, C., Amir, Z., Haward, R., & West, M. A. (2006). Getting the most out of multidisciplinary teams: A multi-sample study of team innovation in health care. *Journal of Occupational and Organizational Psychology*, 79(4), 553-567.

Fisher, K. M., Orkin, F. K., Green, M. J., Chinchilli, V. M., & Bhattacharya, A. (2009). Proxy healthcare decision-making for persons with intellectual disability: perspectives of residential-agency directors. *American journal on intellectual and developmental disabilities*, 114(6), 401-410.

Fleissig, A., Jenkins, V., Catt, S., & Fallowfield, L. (2006). Multidisciplinary teams in cancer care: are they effective in the UK? *The lancet oncology*, 7(11), 935-943.

Foley, A. (2009). The size, cost and efficiency of the public service. *Administration Journal Editions*. Administration, Vol 57, NO1.

Freedman, R. I. (2001). Ethical challenges in the conduct of research involving persons with mental retardation. *Mental retardation*, 39(2), 130-141.

Friese, S. (2014). *Qualitative Data Analysis with ATLAS.ti*. 2. Ed. London: Sage.

Fryer, S., Bellamy, G., Morgan, T., & Gott, M. (2016). "Sometimes I've gone home feeling that my voice hasn't been heard": a focus group study exploring the views and experiences of health care assistants when caring for dying residents. *BMC Palliative Care*, 15(1), 1-9.

Fuente, J. D., La, Santiago, J., Román, A., Dumitrache, C., & Casasanto, D. (2014). Common European Guidelines on the Transition from Institutional to Community-Based Care. *Psychological Science* (Vol. 25).

Gadd, T., and Cronin, S. (2018). A National Framework for Person Centred Planning in Services for Persons with a Disability Summary Version. Report commissioned by HSE on behalf of the National New Directions Implementation Group, and produced by ACE communication Ireland.
<http://13.94.105.41/eng/services/list/4/disability/newdirections/person-centred%20planning%20framework%20summary%20report.pdf>.

Gale, N. K., Heath, G., Cameron, E., Rashid, S., & Redwood, S. (2013). Using the framework method for the analysis of qualitative data in multi-disciplinary health research. *BMC medical research methodology*, 13(1), 1-8.

Gillham, B. (2001). *Case Study Research Methods*. London: Continuum Books.

Gordon, E.G., & Gill, R. T. (1997). *Cognitive Task Analysis*. In Zsombok, C and Klein, G. (Eds). *Naturalistic Decision Making*. Lawrence Erlbaum Associates Inc. Mahwah, New Jersey.

Gore, J., Banks, A., Millward, L., & Kyriakidou, O. (2006). Naturalistic decision making and organizations: Reviewing pragmatic science. *Organization studies*, 27(7), 925-942.

Gore, J., Flin, R., Stanton, N., & Wong, B. (2015). Applications for Naturalistic Decision Making. *Journal of Occupational and Organisational Psychology*, 88(2), 223–230.

Goss, G. L. (1998). Focus group interviews: a methodology for socially sensitive research. *Clinical excellence for nurse practitioners: the international journal of NPACE*, 2(1), 30-34.

Gray, B., & Jackson, R. (2002). *Advocacy and Learning Disability*. London: Jessica Kingsley Publishers.

Gummesson, E. (2000). *Qualitative Methods in Management Research*. Sage Publication.

Guetterman, T. C., Fetters, M. D., & Creswell, J. W. (2015). Integrating quantitative and qualitative results in health science mixed methods research through joint displays. *The Annals of Family Medicine*, 13(6), 554-561.

Halcomb, E. J., Gholizadeh, L., DiGiacomo, M., Phillips, J., & Davidson, P. M. (2007). Literature review: considerations in undertaking focus group research with culturally and linguistically diverse groups. *Journal of clinical nursing*, 16(6), 1000-1011.

Hartnett, A. (2014). *National Federation of Voluntary Bodies. Immersion Transformation Project: An Evaluation Report*.

Harrison, E. F. (1993). Interdisciplinary models of decision making. *Management Decision*.

Hassard, S. T. (2009, June). The variations of recognition primed decision-making and how it informs design decision-making. In 9th Bi-annual International Conference on Naturalistic Decision Making (NDM9) 9 (pp. 339-346).

Helsloot, I., & Groenendaal, J. (2011). Naturalistic decision making in forensic science: toward a better understanding of decision making by forensic team leaders. *Journal of forensic sciences*, 56(4), 890-897.

HIQA. (2013). Home | HIQA. [Hiqa.ie](https://www.hiqa.ie/). Retrieved 25 May 2017, <https://www.hiqa.ie/>

HIQA (2013). *National Standards for Residential Services for Children and Adults with Disabilities*. George's Court, George's Lane Dublin 7.

- HIQA (2020). Annual overview report on the inspection and regulation of disability services in 2019. George's Court, George's Lane Dublin 7.
- Hogg, J. (1997). Intellectual Disability and Ageing: Ecological Perspectives from Recent Research. *Journal of Intellectual Disability Research*, 41(2), 136–143.
- Hollingworth, B. (2008). The measurement of efficiency and productivity of health care delivery. *Health Econ*, 17 (10), 1107-1128.
- Holloway, I., & Todres, L. (2003). The status of method: flexibility, consistency and coherence. *Qualitative research*, 3(3), 345-357.
- Houghton, C., Casey, D., Shaw, D., & Murphy, K. (2013). Rigour in qualitative case-study research. *Nurse researcher*, 20(4).
- HSE. (2018). Multidisciplinary Team. <https://www.hse.ie/eng/services/list/4/mental-health-services/dsc/communityservices/proffesionalsandteams.html>
- HSE. (2017). Eligibility Criteria. <http://www.hse.ie/eng/staff/Jobs/EligibilityCriteria/Speech-and-Language-Therapist-Senior-March-2017.pdf>
- HSE (2017). “Guidelines on terms and Conditions of Employment”. Corporate Employee Relations Services, HR Division. 64-64 Adelaide Rd, Dublin.
- HSE (2017). Time to Move On from Congregated Settings Retrieved 22 May 2017 <http://www.hse.ie/timetomoveon/>
- HSE. (2016). Transforming Lives Programme of 2014 (1st ed). Dublin: HSE. <http://www.hse.ie/eng/services/list/4/disability/congregatedsettings/BulletinJul16.pdf>
- HSE. (2011). Time to Move on from Congregated Settings A Strategy for Community Inclusion. Dublin.
- Irish Statute Book. (2017). Irishstatutebook.ie. Retrieved 22 May 2017, <http://www.irishstatuebook.ie>
- Jonsen, K., & Jehn, K. A. (2009). Using triangulation to validate themes in qualitative studies. *Qualitative Research in Organizations and Management: An International Journal*.
- Khan, S., & VanWynsberghe, R. (2008, January). Cultivating the under-mined: Cross-case analysis as knowledge mobilization. In *Forum qualitative Sozialforschung/forum: Qualitative social research* (Vol. 9, No. 1).
- Kimura, M., & Moehlis, J. (2012). Group decision-making models for sequential tasks. *SIAM Review*, 54(1), 121-138.
- Killumets, E., D’Innocenzo, L., Maynard, M.T., & Mathieu, J. (2015). A Multilevel Examination of the Impact of Team Interpersonal Processes. *Small Group Research*, 46(2), 227–259.
- Kitzinger, J. (1995). Qualitative research: introducing focus groups. *Bmj*, 311(7000), 299-302.

- Klein, G. A., & Calderwood, R. (1991). Decision Models: Some Lessons from the Field. *IEEE Transactions on Systems, Man, and Cybernetics*, 21(5), 1018–1026.
- Klein, G., Zsombok, C., & Thordsen, M. (1993). Team Decision Training: Five Myths and a Model. *Military Review*, 36–42.
- Klein, G. (2015). A Naturalistic Decision Making Perspective on Studying Intuitive Decision Making. *Journal of Applied Research in Memory and Cognition*, 4(3), 164–168.
- Klein, G. (2015). Reflections on Applications of Naturalistic Decision Making. *Journal of Occupational and Organizational Psychology*.
- Klein, G. (2008). Naturalistic Decision Making. *Human Factors*, 50(3), 456–460.
- Klein, G. (1993). A Recognition-Primed Decision (RPD) Model of Rapid Decision Making. *Decision Making in Action: Models and Methods*, 138–147.
- Klein, G., & Klinger, D. (1991). Naturalistic Decision Making. *Human Systems IAC Gateway*, 50(3).
- Klein, G., Ross, K. G., Moon, B. M., Klein, D. E., Hoffman, R. R., & Hollnagel, E. (2003). *Macrocognition*. IEEE Computer Society, (May/June).
- Klein, G. (2002). *Why Developing Your Gut Instincts Will Make You Better At What You Do: Intuition at Work*. New York: Doubleday.
- Klein, G., Orasanu, J., Calderwood, R., and Zsombok, C. E. (Ed.). (1993). *Decision Making in Action: Models and Methods*. Norwood, CT: Ablex.
- Klein, G. (1997). An Overview of Naturalistic Decision Making Application. In Zsombok, C and Klein, G (Eds). *New Jersey: Erlbaum Associates Inc, Mahwah*.
- Kozma, A., Mansell, J., & Beadle-Brown, J. (2009). Outcomes in different residential settings for people with intellectual disability: A systematic review. *American journal on intellectual and developmental disabilities*, 114(3), 193-222.
- Krueger, A. B., Colletti, P., Bogner, H. R., Barg, F. K., & Stineman, M. G. (2017). Conducting focus groups in *Second Life* on health-related topics. *J Alternative Med Res*, 9(2), 357.
- Krueger, A. R., & Casey, M.A., (2009). *Focus Groups: A Practical Guide for Applied Research*. 4th Edition. Sage Publications Inc. California.
- Kuckartz, U. (2014). *Qualitative text analysis: A guide to methods, practice and using software*. Sage.
- LeBoeuf, R. A., & Shafir, E. (2001). Problems and Methods in Naturalistic Decision-Making Research. *Journal of Behavioral Decision Making*, 14(5), 373–375.
- Légaré, F., Stacey, D., Pouliot, S., Gauvin, F. P., Desroches, S., Kryworuchko, J., Graham, I. D. (2011). Interprofessionalism and Shared Decision-Making in Primary Care: A Stepwise Approach towards a New Model. *Journal of Interprofessional Care*, 25(1), 18–25.

- Lemay, R. A. (2009). Deinstitutionalization of People with Developmental Disabilities: A Review of the Literature. *Canadian Journal of Community Mental Health*, 28(1), 181–194.
- Lerman, P., Apgar, D. H., & Jordan, T. (2003). Deinstitutionalization and Mortality: Findings of a Controlled Research Design in New Jersey. *Mental Retardation*, 41(4), 225–36.
- Linehan, C., O'Doherty, S., Tatlow-Golden, M., Craig, S., Kerr, M., Lynch, C., & Staines, A. (2015). *Moving Ahead, Executive Summary*. Dublin: School of Social Work and Social Policy, Trinity College Dublin. Dublin: School of Social Work and Social Policy, Trinity College Dublin.
- Lipshitz, R. (2006). Introduction to the Special Issue. *Naturalistic Decision Making and Organizational Decision Making: Exploring the Intersections*. *Organization Studies*, 27, 917–923.
- Lipshitz, R., Klein, G., Orasanu, J., & Salas, E. (2001). Taking stock of naturalistic decision making. *Journal of Behavioral Decision Making*, 14(5), 331–352.
- Lishman, J. (2005). *Empowerment and Advocacy Cited in Handbook for Practice Learning in Social Work and Social Care: Knowledge and Theory*. (J. Lishman, Ed.). London: Jessica Kingsley Publishers Ltd.
- Llewellyn, P., & Northway, R. (2008). The Views and Experiences of People with Intellectual Disabilities Concerning Advocacy: A Focus Group Study. *Journal of Intellectual Disabilities: JOID*, 12, 213–228.
- Mackintosh, N., Berridge, E.J., & Freeth, D. (2009). Supporting Structures for Team Situation Awareness and Decision Making: Insights from Four Delivery Suites. *Journal of Evaluation in Clinical Practice*, 15, 46–54.
- Maguire, M., & Delahunt, B (2017): "Doing a Thematic Analysis: A Practical Step-by-Step Guide for Learning and Teaching Scholars. *All Ireland Journal of Higher Education*, Vol 9, NO3.
- Mansell, J., & Beadle-Brown, J. (2004). Person-Centred Planning or Person-Centred Action? Policy and Practice in Intellectual Disability Services. *Journal of Applied Research in Intellectual Disabilities*, 17(1), 1–9.
- Mansell, J., & Beadle-Brown, J. (2009). Dispersed or clustered housing for adults with intellectual disability: A systematic review. *Journal of intellectual and developmental disability*, 34(4), 313-323. <https://pubmed.ncbi.nlm.nih.gov/19860598/>
- Mansell, J., & Beadle-Brown, J. (2010). Deinstitutionalisation and Community Living: Position statement of the Comparative Policy and Practice Special Interest Research Group of the International Association for the Scientific Study of Intellectual Disabilities. *Journal of Intellectual Disability Research*, 54(2), 104–112.
- Mansell, J., & Ericsson, K. (1996). *Deinstitutionalisation and Community Living: Intellectual Disability Services in Britain, Scandinavia and the US*. London: Chapman & Hall.

- Mansell, J., Knapp, M., Beadle-Brown, J., & Beecham, J. (2007). *Deinstitutionalisation and Community Living – Outcomes and Costs: Report of a European Study. Volume 2: Main Report.* Canterbury.
- Maruping, M., & Agarwal, R. (2004). Managing Team Interpersonal Processes through Technology: A Task-Technology Fit Perspective. *Journal of Applied Psychology, 89*(6), 975–990.
- Maxwell, J. A. (2010). Using numbers in qualitative research. *Qualitative inquiry, 16*(6), 475-482.
- Maye, C. (2016). *Fuller Lives Safer Lives Policy for Restrictive Practices.* Cork.
- McCarron, M., Lombard-Vance, R., Murphy, E., O'Donovan, M. A., Webb, N., Sheaf, G., & May, P. (2018). Quality of life outcomes and costs associated with moving from congregated settings to community living arrangements for people with intellectual disability. Dublin: HRB.
- McConkey, R., Bunting, B., Ferry, F., Garcia-Iriarte, E., & Stevens, R. (2013). *An Evaluation of Personalised Supports to Individuals with Disabilities and Mental Health Difficulties.*
- McConkey, R., Kelly, F., Craig, S., & Mannan, H. (2013). A Longitudinal Study on the Intra-Country Variations in the Provision of Residential Care for Adult Persons with an Intellectual Disability. *Journal of Intellectual Disability Research, 57*(10), 969–979.
- Mental Health Commission (MHC) (2006). *Multidisciplinary Team Working: From Theory to Practice.* Mental Health Commission, 1–68.
- Mertens, D. M. (2010). *Research and Evaluation in Education and Psychology: Integrating Diversity with Quantitative, Qualitative and Mixed Methods.* London, EC1Y 1SP: SAGE Publications Ltd.
- Meso, P., Troutt, M. D., & Rudnicka, J. (2002). A review of naturalistic decision making research with some implications for knowledge management. *Journal of Knowledge Management.*
- Millitello, L. G., Sushereba, L.E., Branlat, M., Bean, R., & Finomore, V. (2015). Designing for Military Pararescue: Naturalistic Decision Making Perspective. *Journal of Occupational & Organisational Psychology, 88*(6).
- Morgan, D. L. (1997). *Focus Groups as Qualitative Research: Qualitative Research Methods.* Second Ed. SAGE, London.
- Morgan, D., Krueger, R., & King, J. (1997). *When to Use Focus Group and Why. Focus Group Kit, (First Edition).* Thousand Oaks, CA: SAGE Publications.
- Moeschler, J. B., & Shevell, M. (2014). Comprehensive Evaluation of the Child with Intellectual Disability or Global Developmental Delays. *Pediatrics, 134*(3), 903–918.
- Nancarrow, S. A., Booth, A., Ariss, S., Smith, T., Enderby, P., & Roots, A. (2013). Ten Principles of Good interdisciplinary Team Work. *Human Resources for Health, 11*(1), 19.

- NASET. (2007). National Association of Special Education Teachers: Teachers Teaching Exceptional Children. Naset.org. Retrieved 25 May 2017, <https://www.naset.org/>
- National Ability Support Service (NASS). (2019). Disability Service Use & Need. Retrieved from NASS Bulletin 2019 (hrb.ie)
- Neale, J., Miller, P., & West, R. (2014). Reporting quantitative information in qualitative research: Guidance for authors and reviewers [Editorial]. *Addiction*, 109(2), 175–176. <https://doi.org/10.1111/add.12408>
- Nemeth, C., & Klein, G. (2010). The Naturalistic Decision Making Perspective. *Wiley Encyclopaedia of Operations Research and Management Science*, 1–9.
- (NDA) National Disability Authority. (2015). About Us | The National Disability Authority. Nda.ie. Retrieved 25 May 2017, <http://nda.ie/About-Us/>
- NDA (2005). Guidelines on Person Centred Planning in the Provision of Services for People with Disabilities in Ireland.
- NDA (2005). Person Centred Planning for People in Ireland who Have Disabilities. Dublin.
- NDA (2015). Review of the Implementation of Regulations and Inspections in Residential Services for Adults and Children with Disabilities. Dublin.
- (NFVB) (2017). National Federation of Voluntary Bodies. Informingfamilies.ie. Retrieved 25 May 2017, <http://www.informingfamilies.ie/a-z-of-supports-and-information/national-federation-of-voluntary-bodies.305.html>
- (NFVB) Fedvol.ie. (2017). Member organisations of the NFVB. Fedvol.ie. Retrieved 25 May 2017, http://www.fedvol.ie/Our_Members/Default.748.html
- (NFVB) Fedvol.ie. (2017). Next Steps Project. www.fedvol.ie. Retrieved 25 May 2017, http://www.fedvol.ie/Next_Steps_Project/Default.1644.html
- (NIDD) National Intellectual Disability Database. (2017). Annual Tables and Figures of the National Intellectual Disability Database Committee. Health Research Board, Dublin.
- Nihira, K., Leland, H., & Lambert, N. (1993). Adaptive Behaviour Scale—Residential and Community: Second Edition. Washington, DC: American Association on Mental Retardation.
- O'Brien, C. L., & O'Brien, J. (2000). The Origins of Person-Centred Planning: A Community of Practice Perspective.
- O'Brien, J., & O'Brien, C. (2001). The Politics of Person Centred Planning. Atlanta: Responsive Systems Associates.
- OECD. (2002). The OECD Output Manual. Paris: OECD.

- Orasanu, J., & Connolly, T. (1993). The Reinvention of Decision Making. In *Decision Making in Action: Models and Methods* (pp. 3–20). Westport, CT, US: Ablex Publishing.
- Patterson, R.E., Pierce, B.J., Boydston, A.S., Ramsey, L.M., & Shannan, J. (2013). Training Intuitive Decision Making in a Simulated Real-World Environment. *Human Factors*, 55(2), 333–345.
- Patton, M. Q. (2002). *Qualitative Research and Evaluation Methods*. Qualitative Inquiry (Vol. 3rd).
- Pennington, N., & Hastie, R. (1993). A Theory of Explanation-Based Decision Making. In *Decision Making in Action: Models and Methods* (pp. 188–201). Westport, CT, US: Ablex Publishing.
- Pennington, N., & Hastie, R. (1993). Reasoning in Explanation-Based Decision Making. *Cognition*, 49(1-2), 123–163.
- Perreira, T., & Berta, W. (2016). Using Focus Groups to Modify the Workplace Affective Commitment Multidimensional Questionnaire for use in Health Care. *Journal of Health and Human Services Administration*, Vol 39, Iss.3, 407-424.
- Percy, W. H., Kostere, K., & Kostere, S. (2015). Generic qualitative research in psychology. *The Qualitative Report*, 20(2), 76-85.
- Phipps, D. L., & Parker, D. (2014). A Naturalistic Decision-Making Perspective on Anaesthetists Rule-Related Behaviour. *Cognition, Technology and Work*, 16(4), 519–529.
- Powell, R. A., & Single, M. (1996). Methodology Matters-V Focus Groups. *International Journal for Quality in Health Care*, 8(5), 499–504.
- Powers, B., & Knapp, T. (2010). “*Dictionary of Nursing Theory and Research*” (3rd ED). New York, Springer Publishing Company.
- Prouty, R., Lakin, K. C., & Coucouvanis, K. (2007). In 2006, Fewer Than 30% of Persons Receiving Out-of-Family Residential Supports Lived in Homes of More Than Six Residents. *Intellectual and Developmental Disabilities*, 45(4), 289–292.
- Ramiah, S. P., & Banks, A. P. (2015). Naturalistic Decision Making Through Argumentation: Resolving Labour Disputes. *Journal of Occupational and Organizational Psychology*, 88(2), 364–381.
- Ranney, M. L., Meisel, Z. F., Choo, E. K., Garro, A. C., Sasson, C., & Morrow Guthrie, K. (2015). Interview-based qualitative research in emergency care part II: Data collection, analysis and results reporting. *Academic Emergency Medicine*, 22(9), 1103-1112.
- Reiter-Palmon, R., Kennel, V., Allen, J. A., Jones, K.J., & Skinner, A. M. (2014). Naturalistic Decision Making in After-Action Review Meetings: The Implementation of and learning From Post-Fall Huddles. *Journal of Occupational and Organisation Psychology*, 88, 322–340.

- Richards, L. (2015). *Handling qualitative data: A practical guide* (3rd ed.). London, UK: SAGE.
- Ritchie, P., Sanderson, H., Kilbane, J., & Routledge, M. (2003). *People, Plans and Practicalities-Achieving Change through Person-Centred Planning*. Edinburgh.
- Robbins, S.P., De Cenzo, D.A., & Moon, H. (2005). *Fundamentals of Management: Essential Concepts and Applications* (Sixth ed.). Pearson Prentice Hall.
- Robertson, J., Emerson, E., Hatton, C., Elliott, J., McIntosh, B., Swift, P., & Joyce, T. (2007). Person-Centred Planning: Factors Associated with Successful Outcomes for People with Intellectual Disabilities. *Journal of Intellectual Disability Research: JIDR*, 51(Pt 3), 232–43.
- Roberts, K., Dowell, A., & Nie, J. B. (2019). Attempting rigour and replicability in thematic analysis of qualitative research data; a case study of codebook development. *BMC medical research methodology*, 19(1), 66.
- Roberts, A., & Cole, J. C. (2018). Naturalistic decision making: taking a (cognitive) step back to take two steps forward in understanding experience based decisions. *Journal of Applied Research in Memory and Cognition*, 7 (1), 70-81.
- Ryan, G. W., & Bernard, H. R. (2000). *Data management and analysis methods*.
- Ryan, K. E., Gandha, T., Culbertson, M. J., & Carlson, C. (2014). Focus group evidence: Implications for design and analysis. *American Journal of Evaluation*, 35(3), 328-345.
- Ryan, G.W. & Bernard, H.R. (2003). Techniques to identify themes. *Field Methods*, 15 (1), 85-1009.
- Saldaña, J. (2016). *The coding manual for qualitative researchers*. London, UK: SAGE.
- Sandwelladvocacy.org. (2017). Sandwell Advocacy. Sandwelladvocacy.org. Retrieved 25 May 2017, <http://www.sandwelladvocacy.org/>
- Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research Methods for Business Students* (Fifth). Pearson Education Limited, England.
- Schalock, R. L., Borthwick-Duffy, S. A., Bradley, V. J., Buntinx, W. H. E., Coulter, D. L., Craig, E. M. & Yeager, M. H. (2010). *Intellectual Disability: Definition, Classification, and Systems of Supports*. Eleventh Edition. American Association on Intellectual and Developmental Disabilities. <https://bookstore.aaidd.org/BookDetail.aspx?bid=97>
- Schwartz, A. E. (1994). Group Decision Making. *The CPA Journal*, 64(8), 60–63.
- Schwartz, A., Jacobson, J., & Holburn, S. (2000). Defining Person Centeredness: Results of Two Consensus Methods. *Education and Training in Mental Retardation and Developmental Disabilities*, 35, 235–249.
- Scottish Human Services Trust. (2004). *It is not just Person Centred Planning: Learning from the Family Futures 2 Project*. Glasgow.

- Sidhom, M. A., & Poulsen, M. G. (2006). Multidisciplinary Care in Oncology: Medicolegal Implications of Group decisions. *Lancet Oncology*, 7(11), 951–954.
- Simon, H. A. (1977). *The Logic of Heuristic Decision-Making*. In *Models of Discovery and Other Topics in the Methods of Science*. Springer Science & Business Media
- Simon, H. A. (1977). *The New Science of Management*. NJ: Englewood Cliffs, NJ: Prentice Hall.
- Solomon, J. (2007). *Corporate Governance and Accountability (Second Ed)*. Chichester, England: Wiley.
- Stoner, F.A., Yetton, W., Craig, F.J., & Johnston, D. (1994). *Management (Second Ed)*. Prentice Hall, Sydney.
- Stancliffe, R. J., Hayden, M. F., Larson, S. A., & Lakin, K. C. (2002). Longitudinal Study on the Adaptive and Challenging Behaviors of Deinstitutionalized Adults with Mental Retardation. *American Journal of Mental Retardation: AJMR*, 107(4), 302–320.
- Standing, M. (2008). Clinical Judgement and Decision Making in Nursing-Nine Modes of Practice in a Revised Cognitive Continuum. *Journal of Advanced Nursing*, 62(1), 124–134.
- Stubbings, L., Chaboyer, W., & McMurray, A. (2012). Nurses' Use of Situation Awareness in Decision-Making: An Integrative Review. *Journal of Advanced Nursing*, 68(7), 1443–1453.
- Stuntzner, S., & Hartley, M. T. (2015). Balancing Self-Compassion with Self-Advocacy: A New Approach for Persons with Disabilities. *Annals of Psychotherapy & Integrative Health*.
- Swain, J., French, S., & Cameron, C. (2003). *Controversial Issues in a Disability Society*. Buckingham: Open University Press.
- Tabatabainia, M. M. (2003). Listening to Families' Views Regarding Institutionalization and Deinstitutionalization. *Journal of Intellectual & Developmental Disability*, 28(3), 241–259.
- Tatlow-Golden, M., Linehan, C., O'Doherty, S., Craig, S., Kerr, M., Lynch, C., & Staines, A. (2014). *Living Arrangement Options for People with Intellectual Disability: A Scoping Review*. Dublin: School of Social Work and Social Policy, Trinity College Dublin.
- Taylor, S. J. (2001). The Continuum and Current Controversies in the USA. *Journal of Intellectual & Developmental Disability*, 26(1), 15–33.
- Taylor, S., Sims, J., & Haines, T. (2014). The Emergent Relevance of Care Staff Decision-Making and Situation Awareness to Mobility Care in Nursing Homes: An Ethnographic Study. *Journal of Advanced Nursing*, 70(12), 2767–2778.
- Thompson, J., Kilbane, J., & Sanderson, H. (2008). *Person Centred Practice for Professionals*. McGraw Hill/Open University Press.

- Thompson, J. R., Craig, E. M., Bryant, B. R., Campbell, M. E., Hughes, C., Rotholz, D. A., & Wehmeyer, M. L. (2004). Supports Intensity Scale. Washington DC: American Association on Intellectual and Developmental Disabilities (AAIDD).
- Thornberg, R. (2012). Informed grounded theory. *Scandinavian Journal of Educational Research*, 56(3), 243-259.
- Tøssebro, J., Bonfils, I. S., Teittinen, A., Tideman, M., Traustadóttir, R., & Vesala, H. T. (2012). Normalization Fifty Years Beyond-Current Trends in the Nordic Countries. *Journal of Policy and Practice in Intellectual Disabilities*, 9(2), 134–146.
- Tower, M., & Chaboyer, W. (2013). Situation Awareness and Documentation of Changes that Affect Patient Outcomes in Progress Notes. *Journal of Clinical Nursing*, 23, 1403–1410.
- Townsley, R., Ward, L., Abbott, D., & William, V. (2010). Implementation of Policies Supporting Independent Living for Disabled People in Europe: Synthesis Report. Bristol: Norah Fry Research Centre.
- Trickett, S. B., & Trafton, J. G. (2009). A primer on verbal protocol analysis. *The PSI handbook of virtual environments for training and education*, 1, 332-346.
- Twohig, P. L., & Putnam, W. (2002). Group interviews in primary care research: advancing the state of the art or ritualized research? *Family practice*, 19(3), 278-284.
- UCD. (2008). Further Exploration of Harm, Risk, Deception, Privacy and Confidentiality. Dublin.
- UCD. (2008). Research Ethics Appeals Procedure Policy. Dublin: UCD. <http://www.ucd.ie/t4cms/REC%20Appeals%20Procedure%20Policy%20260608.pdf>
- UCD. (2016). Code of Good Practice in Research. Dublin.
- UCD. (2016). Human Subjects Ethical Review Application Form. Dublin.
- UCD. (2016). Research Ethics UCD POLICY. Dublin: UCD. <http://www.ucd.ie/t4cms/Research%20Ethics%20Policy%20090216.pdf>
- United Nations. (2006). Convention on the Rights of Persons with Disabilities. Treaty Series, 2515, 3. <http://www.un.org/disabilities/>
- Watson, N., & Vehmas, S. (Eds.). (2019). *Routledge handbook of disability studies*. Routledge.
- Ward, T. (2010). Public Service Reform in Ireland: The Influence of International Hard and Soft Law Instruments and Trans-National Norms. *Administration*, 58(1), 1–27.
- Weber, L., & Stern, J. (2008). Washington’s Residential Resource Allocation Model.
- West, M.A., & Lyubovnikova, J. (2013). Illusions of Team Working in Health Care. *Journal of Health Organization*, 27(1), 134–142.
- Willig, C. (2013). *Introducing qualitative research in psychology*. McGraw-Hill Education (UK).

- Wilkinson, S. (2000). Women with breast cancer talking causes: Comparing content, biographical and discursive analyses. *Feminism & Psychology*, 10(4), 431-460.
- Yin, R. K. (2012). Case Study Research. Design and Methods. *Zeitschrift Für Personalforschung*, 26, 93–96.
- Yin, R. K. (2014). *Case Study Research: Design and Methods*. Sage Publications (Vol. 26).
- Yin, R. K. (2009). *Case Study Research: Design and Methods*. Applied Social Research Methods Series: 5.
- Young, L., Ashman, A., Sigafos, J., & Grevell, P. (2001). Closure of the Challinor Centre II: An extended report on 95 individuals after 12 months of community living 1. *Journal of Intellectual & Developmental Disability*, 26(1), 51–66.
- Young, L., & Ashman, A. F. (2004). Deinstitutionalization for Older Adults with Severe Mental Retardation: Results from Australia. *American Journal on Mental Retardation*, 109(5), 397–412.
- Zsombok, C. E., & Klein, G. (2009). *Naturalistic Decision Making*. New York, London: Routledge, Taylor & Francis Group.
- Zsombok, C. E., & Klein, G. (1997). *Naturalistic Decision Making*. Naturalistic decision making.
- Zikmund, W. G. (2003). Basic and Applied Research. *Business Research Methods*, 3(1), 7. <http://amzn.com/0030350840>

APPENDICES:

APPENDIX 1: RESEARCH STRATEGY

A review of existing literature both international and national on deinstitutionalisation was conducted to support the study undertaken in this dissertation. The literature review was based on studies conducted primarily in the U.S.A, Canada, Scandinavian countries, Britain, Australia, and Ireland. An electronic search of literature deemed to be important for this type of study was conducted using the following academic search engines: One search, Scopus (Elsevier), CINAHL PLUS, ERIC, Google Scholar and ABI/INFORM GLOBAL. The electronic searches with a combination of the following key terms were used: Deinstitutionalisation/Institutionalisation; HSE-Congregated Setting Report; intellectual disabilities; decision-making processes; ecology systems; multidisciplinary teams; group/team decision-making, decision-making models, naturalistic decision- making (NDM), intuitive and normative theories; assessment tools in intellectual disability.

A manual review of article bibliographies, seminar presentations, books, published projects, as well as a perusal of the following journals identified as important and relevant to the current study was carried out, For example: Advanced Journal of Nursing; Applied Research in Intellectual Disabilities, Learning Disability and Mental Retardation; British Journal of Learning Disabilities; Canadian Journal of Community Mental Health; Canadian Military Journal; British Medical Journal; American Journal on Mental Retardation; American Journal on Intellectual and Developmental Disabilities; Journal of Education and Teaching; Journal of Mental Health; Journal of Intellectual Disability Research; Journal of Intellectual and Developmental Disability; Journal of Knowledge & Management; Journal of School Psychology; Journal of International Review of Administrative Science; Journal of Forensic Science Journal of Interprofessional Care; Journal of Management; Journal of Occupational & Organisational Psychology; Journal of Behavioural Decision-Making; Journal of Cognitive Psychology & Work and Journal of Applied Research in Memory and Cognition. The search resulted in 195 journal articles which were potentially relevant. They were screened and selected on the basis of the following criteria: (1). Published either in print or electronically in the period 2001-2020; (2). Appeared in an English language journal; (3). Based on the original qualitative and/or quantitative research and contained information about the participants and the methodology used (4). The

research conducted was mainly from the previously listed countries. Based on this criterion, the following were relevant and used in the literature review: 139 Articles, 72 Books, 44 Reports/Acts/Conferences and 12 Websites. Other literature which emanated these articles/books/reports/websites were also read.

APPENDIX 2: DESCRIPTION OF A HYPOTHETICAL CASE VIGNETTE

“Hi, I am Precious Jenga, thank you for agreeing to take part in this focus group. I am a student of a DGov programme, offered jointly by UCD and IPA. The purpose of this focus group is to determine factors MDTs consider in their decision-making and identify decision-making processes they use when transferring adults with an intellectual disability from congregated settings to dispersed houses in the community. The research will help in identifying factors considered and the type of decision-making processes that MDTs use in Ireland when transferring people to the community. Numeric coding will be used to protect your anonymity and that of your organisation. Please be assured that everything you tell me will be treated as confidential. However, should you mention something that leads me to believe that you and/or someone else is at risk of serious physical and/or emotional harm, I will have to stop the focus group and inform my supervisors and the Health Service Executive (HSE). The focus group should take approximately one hour. You are free to withdraw your responses up to the data analysis stage (Dec 2018). Do you have any questions before we start? Is it OK to record the discussion? Before we start, can I please have the consent forms? The hypothetical case that I would like you to discuss as a group is as follows:

“Imagine that you are presented with this case in your organisation. Discuss how you would approach this case. The decision you are being asked to make is around moving the service user to a dispersed house in the community. Please verbalise your decision as a team including your rationale for the decision”.

Rose is a 32-year-old woman who has a diagnosis of a moderate intellectual disability, with co-occurring health issues of epilepsy and bi-polar and is at risk of choking due to PICA (persistent craving and eating of non-food substances), she ingests stones. She has been living in a unit on the grounds of the congregated setting managed by her support agency for 16 years. There are seven other women in this unit. She shares a room with another woman with an intellectual disability who is non-verbal. Rose can speak, however unfamiliar people find it difficult to understand her. She uses pictures and LAMH signs. Rose presents with self-injurious behaviours. She lives over 80 miles from her family home where her elderly parents live. Her two younger sisters live abroad. She goes home fortnightly staying for the weekend. She is a church attender at her local church, where she helps by distributing the parish newsletter at mass. Rose reports that she is very happy in her residence and according to staff; she gets on reasonably well with others in the unit. Health Information Quality Authority (HIQA) has recommended that Rose move dispersed housing in the community.

APPENDIX 3: INTERVIEW SCHEDULE & QUESTIONS

In order to establish rapport, the interview schedule will consist of a verbatim script of introductory remarks including indicating the purpose of the interview, the researcher's credentials, providing assurance of confidentiality, list of questions to ask, a set of associated prompts as well as closing comments by summarising what has been said and thanking the participants (Mertens, 2010; Robson, 1993).

Verbatim Script

"X, I am Precious Jenga, thank you for agreeing to take part in this interview. I am a student of a DGov programme, offered jointly by UCD and IPA. The purpose of this interview is to ask questions about your organisation and determine what environmental/situational information you consider when transferring adults with an intellectual disability from congregated settings to the dispersed houses in the community. The research will help in identifying a framework that MDTs use in Ireland when transferring people to the community. Please be assured that everything you tell me will be treated as confidential. However, should you mention something that leads me to believe that you and/or someone else is at risk of serious physical and/or emotional harm, I will have to inform my supervisors and the Health Service Executive (HSE). The interview should take approximately one hour. You are free to withdraw your responses up to the data analysis stage (Dec 2018). Do you have any questions before we start? Is it OK to record the interview? Can I please have your consent form? Questions that I would like to ask you are as follows:"

Interview Questions:

1.	What is the ethos of your organisation?
1a	Is your Organisation involved in the implementation of the Congregated Settings Report of 2011?
1b	How does the ethos of your organisation influence the implementation of the Congregated Settings Report of 2011?
2	How many people with an intellectual disability is your organisation currently supporting?
2a	In the last five years in your organisation, how many adults with an intellectual disability have been transferred to dispersed houses in the community?
2b	How many are waiting to be transferred?
3	How do you gather the information to transfer adults with an intellectual disability from the organisation's congregated setting to dispersed houses in the community?
3a	What criteria inform your decision to move people from congregated settings to dispersed houses in the community?
3b	In your organisation, what information influences your decision to transfer adults with an intellectual disability from congregated settings to dispersed houses in the community?
4	What are the goals of your organisation with regards to the Congregated Settings Report of 2011?
4a	How do the goals influence the decision-making processes concerning the transfer of adults with an intellectual disability from a congregated setting to dispersed houses in the community?
4b	How far along is your organisation in meeting the 2019 deadline set by the Health Service Executive (HSE)?
5	What do you perceive the difficulty to be in managing the transfer from congregated settings to dispersed houses in the community?

APPENDIX 4: CODEBOOK for MDT PARTICIPANTS in FOCUS GROUPS and INTERVIEWEES OF FIVE SERVICE PROVIDERS

CODE	DESCRIPTION	EXAMPLE	EMERGING THEMES
Communication status	Participants refers to how Rose is able to express herself and by what means	She uses Lámh signs and is well able to express her needs and communicate	Client Profile
Diagnoses	Rose's confirmed medical condition	<p>The reason being she has psychiatric issues, she is bipolar and she also has epilepsy. She has huge medical needs</p> <p>Now we have to move again because the house is not suitable due to mobility issues</p> <p>Did the Psychiatrist recommend that the medication be changed?</p>	
Medical/ changing health needs	Rose's need to support/maintain an adequate level of health, wellbeing and independence	<p>There is a possibility of her losing her mobility at some stage</p> <p>Would she know to close the bathroom door if she's using the toilet or shower or anything like that?</p>	
Independent skills	Basic activities that Rose has to engage in on a daily basis	She has good transferable skills. Is she making her bed? Showering herself?	

Assessment tools	Formal or informal instruments such as checklists, questionnaires, SIS, AON used to determine and plan for individuals' needs	<p>The team completes an assessment and a proposal, that's brought to senior management that signs it off. The team goes through it with a fine tooth comb</p> <p>I was trained up in Supports Intensity Scale. So over 2012-2013, I assessed the whole population, it was around XXXX at that time.</p>	Resources
Staff training needs	Training required by professionals supporting people with an intellectual disability in their residential setting	<p>That's the reason staff need to be equipped. It is not about nursing or social care</p> <p>We recommend staff training in IT skills so that staff can support Rose communicating with her sisters abroad using IPad and SKYPE</p> <p>Suddenly you had to look at the skills of staff and to see who is best to go to the community</p> <p>Recommending her to have her own room would be best practice</p>	
Best practice	Professional procedures that are acceptable as being the most effective or correct	Its' best practice that all care plans be transferred over to the new house	

Advocate	Someone who can promote and support Rose's needs	<p>Also the decision can be made by an advocate</p> <p>Would the advocate come in then after the MDT will formulate an opinion and the advocate will have to work with the MDT around that</p>	
Suitable housing in the community	<p>Surroundings that describe the house</p> <p>internally and externally for people with an intellectual disability</p>	<p>We are in line with the report, we are ahead of it but we need suitable houses in the community</p> <p>Now we have to move again because the house is not suitable due to mobility issues</p>	
Challenges	Barriers and difficulties that management experience when facilitating people to dispersed housing in the community	<p>The other challenge is our funding and staff ratio.</p> <p>Funding from the HSE is a major issue</p> <p>Recruitment and redeploying staff is a challenge</p> <p>The second issue was the unions. We have 4 unions in XXXX and there's been about XXX hours of negotiations with the unions to try and move this on because not only are we moving people we are also</p>	

		moving the staff that worked XXX to XXX years here	
<p>Congregated Settings Report of 2011/ De-congregation</p> <p>HSE</p> <p>Dispersed housing in Community</p>	<p>National HSE report whose objective is to move over 4000 adults with disabilities from a campus based setting community housing and to progressively close residential institutions within a seven-year period</p> <p>Health Service Executive, statutory body responsible for management and delivery of health and social services in Ireland</p> <p>Group homes where less than 5 people with disabilities</p>	<p>Yes, we are fully behind de-congregation we started in 2012</p> <p>We certainly have a focus of trying to move people from congregated settings here to houses in the community</p> <p>Everyone has a right to a home in the community</p> <p>She'll have her own space in her new house in the community in line with de-congregation</p> <p>Staffing is a major issue and funding from the HSE".</p> <p>It is an opportunity for her to live off campus and avail of new things in the community.</p>	<p>Deinstitutionalisation</p>

Choice	<p>(including those with complex needs) live in a house in the community with staff supports as per Congregated Settings Report of 2011</p> <p>Choosing between different options available to a person with an intellectual disability as his/her family</p>	<p>What about in the community, how much support does she need in the community house?</p> <p>She needs to have a choice in who she lives with, that's huge</p> <p>It is about giving people choices and obtaining their wishes in terms of what they want</p>	
Informed consent	<p>Informing Rose about the move and her giving consent</p> <p>Permission granted in full knowledge of possible risks and benefits in moving to community housing</p>	<p>Has Rose been informed about the move?</p> <p>How do her family feel?</p> <p>I suppose Rose needs to know that her unit is closing down, everybody needs to move.</p> <p>We need to know in terms of obtaining what their wishes and choices were</p>	
HIQA	<p>Health Information Quality Assurance statutory body that sets person-centred standards for</p>	<p>The house was inspected by HIQA and passed in 2015 before the move</p> <p>According to HIQA she should have her own room, isn't?</p>	

	health and social care services for people with intellectual disabilities in Ireland	HIQA would expect you to have meetings about the move to the community	
Core values and principles	Fundamental beliefs of the organisation that determine if they are fulfilling their goals in supporting people with an intellectual disability	Our ethos is based on respect and doing everything we can to meet the service users' needs. The ethos really is to support each person as an individual within their own right to have the best life possible	Ethos
Standard of care	Adherence to a standard of reasonable care while looking after people with an intellectual disability	We deliver the highest quality standards of care	
Person Centred Planning (PCP)	An approach that organises assistance for people with an intellectual disability and provide individualised plans and supports needed to stay healthy and safe The plan highlights the	To establish what they wanted and whether they wanted to move off campus or not. It is about person centredness, doing all we can to respect their wishes and de-congregate people to the community	Person Centredness

Wishes and choices	person's needs wants and choices and is based on the principles of rights, independence, choice and inclusion.	We're person centred, you know it is about the person, whatever the person requires; we would try and secure services around that for him or her.	
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APPENDIX 5: MAXQDA REPRESENTATION of all CODES and THEMES in FOCUS GROUPS

Focus Groups 1-5

Code System	FOCUS GROUP 1	FOCUS GROUP 2	FOCUS GROUP 3	FOCUS GROUP 4	FOCUS GROUP 5	SUM
Person centredness						0
> Person centred planning	4	1				5
Resources						0
> Care plan	10	9		2		21
> MDT support	17	22	9	7	31	86
> Advocate	3	5		1	3	12
> Best practice	1	2		2	1	6
> Staff training	1	6		5	5	17
> Best practice				1		1
> Assessment tools		4		1	1	6
Community Services						0
> Access to local/ day services	12	10	4	4	3	33
> Care plan				1	3	4
Environment						0
> Type of house setting	15	1	7	14	16	53
> Risk management	1	6	2	10	8	27
Challenges						0
> Staffing	4	5	1	19	9	38
> Suitable housing in the community		3				3
Family Support						0
> Family	8	8	4	9	13	42
Future Planning						0
> Transition period	12	10	14	18	24	78
Socialisation						0
> Importance of relationships	16	14	6	6	17	59
> Social role	6	2	3	6	11	28
Deinstitutionalisation						0
> Informed consent	8	2	3	1	1	15
> HIQA	4	7	4	4	1	20
> Dispersed housing in the communit	37	18	15	23	13	106
> Congegrated setting	7	6	4	10	8	35
> Choice	3	8	1	11	6	29
Client Profile						0
> Medical/ changing health needs	11	6	3	9	16	45
> Behaviours that challenge	5	9		4	10	28
> Compatibility	15	6	6	5	9	41
> Communication status	4	1	5	14	5	29
> Diagnoses	7	6	1	6	3	23
> Independent skills		10	8	8	4	30
SUM	211	187	100	201	221	920

APPENDIX 6: MAXQDA REPRESENTATION of all CODES and THEMES in INTERVIEWS

Interviews 1-5

Code System	Interview 5	Interview 4	Interview 3	Interview 2	Interview 1	SUM
▼ Ethos						0
> Core values and principles	2	1	1	2	7	13
> Standard of care					2	2
▼ Deinstitutionalisation						0
> Dispersed housing in community	8	10	7	11	16	52
> Choice		6	4	1	16	27
> Informed consent					1	1
> Congregrated setting	10	6	2	14	14	46
> HIQA	4	2			1	7
▼ Socialisation						0
> Importance of relationships			1		6	7
> Social role	2	2	1		1	6
▼ Challenges						0
> Staffing	9	4	6	6	1	26
> Unions				1		1
> Funding	4		4		8	16
> Suitable housing in the community	2		1		8	11
▼ Future planning						0
> Transition period	1	4	1	1	1	8
▼ Community services						0
> Access to local/ day services					2	2
▼ Family support						0
> Family	1	3	2	2	3	11
▼ Resources						0
> MDT support	7	2	3	4	4	20
> Best practice				1		1
> Assessment tools	1	2	3	1	6	13
▼ Environment						0
> Type of house setting	1	4			2	7
> Risk management	4					4
▼ Person centredness						0
> Person centred planning	1	1	1	2		5
▼ Client profile						0
> Behaviours that challenge			1		1	2
> Compatibility	3	2			5	10
> Access to local/day service	3					3
> Diagnoses					1	1
> Medical/ changing health needs			1	6		7
Σ SUM	63	49	39	52	106	309

APPENDIX 7: ETHICAL APPROVAL



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August 31st, 2017

Ms Precious Jenga c/o Dr Christine Linehan
UCD School of Social Policy, Social Work & Social Justice
Hanna Sheehy-Skeffington Building

Re: HS-17-26-Jenga-Linehan: Naturalistic Decision Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities

Dear Ms Jenga

Thank you for your response to the Human Research Ethics Committee – Humanities (31/08/17). The Decision of the Committee is that approval is granted for this application which is subject to the conditions set out below.

Please note that public liability insurance for this study has been confirmed in accordance with our guidelines.

Please note that approval is for the work and the time period specified in the above protocol and is subject to the following:

Any amendments or requests to extend the original approved study will need to be approved by the Committee. Therefore, you will need to submit by email the Request to Amend/Extend Form (HR4);

Any unexpected adverse events that occur during the conduct of your research should be notified to the Committee. Therefore, you will need to Submit, by email, an Unexpected Adverse Events Report (HR5);

You or your supervisor (if applicable) are required to submit a signed End of Study Report Form (HR6) to the Committee upon the completion of your study;

This approval is granted on condition that you ensure that, in compliance with the Data Protection Acts 1988 and 2003, all data will be managed in accordance with your application and that you will confirm this in your End of Study Report (HR6);

Please note that further new submissions from you may not be reviewed until any End of Study Reports due have been submitted to the Office of Research Ethics. That is, any earlier study that you received ethical approval for from the UCD HRECs;

You may require copies of submitted documentation relating to this approved application and therefore we advise that you retain copies for your own records;

Please note that the granting of this ethical approval is premised on the assumption that the research will be carried out within the limits of the law;

Please also note that approved applications and any subsequent amendments are subject to a Research Ethics Compliance Review.

The Committee wishes you well with your research and look forward to receiving your End of Study Report. All forms are available on the website www.ucd.ie/researchethics please ensure that you submit the latest version of the relevant form. If you have any queries regarding the above, please contact the Office of Research Ethics and please quote your reference in all correspondence.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Joan Tiernan', written in a cursive style.

Dr Joan Tiernan: Chair, Research Ethics Committee - Humanities



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August 16th, 2018

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UCD School of Social Policy, Social Work & Social Justice
Hanna Sheehy-Skeffington Building

Re: HS-17-26-Jenga-Linehan: Naturalistic Decision Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities

Dear Ms Jenga

Thank you for your recent Amendment/Extension Request Form to the Human Research Ethics Committee – Humanities (16/08/18). The Decision of the Committee is to grant approval for your request to extend this application which is subject to the following.

Please note that approval is for the work and the time period specified in the above protocol and is subject to the following:

The time period of the ethical approval for this study was extended and is valid until December 31st 2019;

If applicable, all permissions to access participants, whether internal (heads of Schools/Registrar) or external are obtained before the recruitment of the participants is commenced;

Any amendments or requests to extend the original approved study or subsequent approved amended revisions of that study will need to be approved by the Committee. Please submit by email the Request to Amend/Extend Form (HR4);

Any unexpected adverse events that occur during the conduct of your research should be notified to the Committee. Therefore, you will need to Submit, by email, an Unexpected Adverse Events Report (HR5);

You or your supervisor (if applicable) are required to submit a signed End of Study Report Form (HR6) to the Committee upon the completion of your study;

This approval is granted on condition that you ensure that, in compliance with the Data Protection Acts 1988 and 2003, all data will be managed in accordance with your application and that you will confirm this in your End of Study Report (HR6);

Please note that further new submissions from you may not be reviewed until any End of Study Reports due have been submitted to the Office of Research Ethics. That is, any earlier study that you received ethical approval for from the UCD HRECs;

You may require copies of submitted documentation relating to this approved application and therefore we advise that you retain copies for your own records;

Please note that the granting of this ethical approval is premised on the assumption that the research will be carried out within the limits of the law;

Please also note that approved applications and any subsequent amendments are subject to a Research Ethics Compliance Review.

All forms are available on the website www.ucd.ie/researchethics please ensure that you submit the latest version of the relevant form. If you have any queries regarding the above, please contact the Office of Research Ethics and please quote your reference in all correspondence.

Yours sincerely,

A handwritten signature in black ink, appearing to read 'Joan Tiernan', with a long horizontal flourish extending to the left.

Dr Joan Tiernan, Chair, Human Research Ethics Committee - Humanities

APPENDIX 8: INVITATION LETTER



UCD School of Psychology Scoil na Síceolaíochta
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Studies Ionad an Staideir ar
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www.ucd.ie/psychology

IPA/UCD DGov Programme

57- 61 Lansdowne Road

Dublin 4

24th January 2018

Dear CEO/Administrator, Service Manager/Director of Services,

Re: Participation in DGOV Research Project: Naturalistic Decision-Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities.

I am a Doctorate of Governance Student via the Institute of Public Administration Dublin/University College Dublin. As part of my postgraduate study under the supervision of Associate Professor Christine Linehan (UCD) and Dr Dearbhla Casey (IPA), I have chosen to undertake a research project. I am investigating the naturalistic decision-making processes used by multidisciplinary teams (MDTs) in organisations in deciding whether individuals will move from congregated settings to the community. The aim is to identify factors considered and describe the type of decision-making processes that are being used within the Irish context. The UCD Human Research

Ethics Committee (Ref No: HS-17-26-Jenga-Lineh) as well as XXX Ethics Committee have approved the study.

I am looking for your support in recruiting five to eight experienced healthcare professionals who sit on MDTs in your organisation. Namely, those healthcare professionals with three years' experience or more from any of the following health disciplines: Speech & Language Therapists, Psychologists, Psychotherapists, Physiotherapists, Occupational Therapists, Psychiatrists, Social Workers, Social Care Workers, Nurses and Behaviour Support Staff. I would like to invite the healthcare professionals to take part in a focus group to discuss a hypothetical case study of an adult with intellectual disability who is being considered for a move to community living. Furthermore, I wish to conduct an interview on the same topic with an experienced member of staff involved in the residential services of your organisation who is a member of the MDT. This individual should have five years or more experience in their current position. This person may be a CEO, Director, Service Manager, or Administrator within the organisation. Both the focus group and the interview should take no more than one hour each. In order to minimise any disruption, I would be most grateful if you would consider allowing me to host the focus group and interview on site in your organisation, as this may be most convenient for your staff.

I would appreciate if the focus group and the interview can take place during January to March 2018. I would also appreciate if one member of your organisation can be nominated to assist me. I would be willing to meet with the nominated person on site/or via email and ask that she/he distribute invitation letters, information sheets and consent forms to the members of the MDT including an experienced personnel representative. Interested members of the MDTs should contact me directly.

Once I know the numbers interested in taking part in the study, I will arrange the focus group and interview. Additionally, I will ask all those participating to sign the consent form on the day of the focus group and interview. Data will be digitally audio recorded. Numeric coding will be used to protect your anonymity and that of your organisation. It will also ensure confidentiality of responses. Members of the MDT can choose to withdraw from this research project up to the data analysis stage (Dec 2018).

Please note that should members of the MDT mention something that leads me to believe that they or someone else is at risk of serious physical and/or emotional harm, I will have to stop the focus group discussion or the interview and inform my supervisors. The Health Service Executive (HSE) designate officer in your organisation will also be notified, who will then be obliged to implement the HSE guidelines for safe guarding vulnerable adults. Should the participant experience distress for any reason, I will ask the participant to contact his/her GP and/or the employer assistance programme, which is a national independent 24-hour counselling

service offered to all HSE and the voluntary organisations employees free of charge. The service can be contacted at 015180356.

Upon completion of this research project and subsequent publication, you will be informed where a copy can be obtained. Should you require further information, please do not hesitate to contact me at precious.jenga@ucdconnect.ie or at telephone number 087 1344702.

Thanking you in anticipation for your co-operation in this research,

Yours Sincerely,

A handwritten signature in black ink, appearing to read 'Precious Jenga', written in a cursive style.

Precious Jenga: DGOV Student, IPA/UCD



UCD School of Psychology
UCD Centre for Disability Studies
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INFORMATION SHEET FOR PARTICIPANTS IN RESEARCH PROJECT- CEO/DIRECTOR OF SERVICES/SERVICE MANAGER/ADMINISTRATOR

This sheet contains important information about this project and what to expect should you decide to participate. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. Your participation is voluntary. Your decision will not affect your future relationship with the researcher or college.

Researcher's Name:

Precious Jenga

Name of Research School:

UCD School of Social Policy, Social Work and Social Justice, Hanna Sheehy-Skeffington Building, Belfield, Dublin and IPA/UCD DGov Programme, 57- 61 Lansdowne Road, Dublin 4

Title of Research Project:

Naturalistic Decision Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities

What is this research about?

The research project is about decision-making processes of multidisciplinary team members, namely, healthcare, social care and administrative professionals who are

involved in transferring adults from congregated settings to dispersed housing in the community.

Why I am doing this research?

I am conducting this research because to my knowledge, there is no available empirical research on how multidisciplinary teams make decisions in the Irish context when transferring adults with an intellectual disability from congregated settings to dispersed community-living options. I intend to conduct focus groups with healthcare professionals and interview administrative personnel to explore this issue.

Why has your organisation been invited to take part?

Your organisation has been invited to participate because your organisation is HSE run or a member of the National Federation of Voluntary Bodies, providing residential services on campus and in the community for adults with an intellectual disability and currently involved in the transfer of people from congregated settings to the community. Participating organisations are asked to identify and invite members of their multidisciplinary teams to attend a focus group and identify an experienced member of staff involved in residential services to attend a face to face interview with the researcher.

How will your data be used?'

Data will be gathered via anonymous recordings of focus groups and interviews, which will be transcribed verbatim for analysis. The researcher and academic supervisors will have access to these data, which will be analysed and reported for the purposes of obtaining a doctoral level qualification. The only identifiable data gathered are signed consent forms, which will be stored in a locked cabinet in a separate location to the tape recordings and transcripts.

What will happen if you decide to take part in this research study?

As CEO/Director/Service Manager/Administrator of your organisation, you or a nominated staff member will be asked to sign the attached consent form to record the agreement of your organisation to participate in this research. If you agree that your organisation will take part, you will be asked to identify members of your experienced multidisciplinary team (MDT) to participate in a focus group and identify an experienced member of staff who will partake in an interview. The topic of the focus group is to discuss a hypothetical case study of an adult with an intellectual disability being moved to the community. The topic of the interview is to discuss the broader context of the organisation regarding the implementation of community living options for adults with an intellectual disability. I would like to host the focus group and interview on the same day on the premises of your organisation in order to minimise

any disruption to your staff. During this visit, I can collect the attached consent form, which documents the agreement of your organisation to participate in this research. Additionally, I request the provision of a quiet area on the day of data collection in the event that a participant needs time out due to disclosure causing distress.

How will your privacy be protected?

No individuals or organisations will be named in any reporting of this research. During data analysis, numeric and colour coding will be used to protect your anonymity and that of your organisation. Any potentially identifiable information will be redacted in transcribed documents. Data will be kept for two years from the commencement of data collection, after that, it will be destroyed.

What are the benefits of taking part in this research study?

While there are no direct benefits to individuals' participation in this research, your organisation may benefit from the opportunity to reflect on their decision making process during the focus group and interviews. From an academic perspective, the input of the MDT members will contribute in the identification of the type of decision-making processes used by multidisciplinary teams in Ireland and knowledge about factors considered when transferring people to the community.

What are the risks of taking part in this research study?

The risks are that should any disclosure be made during focus groups or interviews that leads me to believe that MDT members, interviewees or someone discussed during these exercises is at risk of serious physical and/or emotional harm, I will have to stop the focus groups or interviews and inform my supervisors. The Health Service Executive (HSE) designate officer in your organisation will be notified, who will then be obliged to implement the HSE guidelines for safe guarding vulnerable adults. The topic for discussion is a sensitive one regarding the opportunity for individuals with an intellectual disability to transfer from a congregated setting to the community.

There is a risk that some participants may become distressed discussing this topic. Should a participant experience distress for any reason during the focus group or interview, I will ask the participant to contact his/her GP and/or the employer assistance programme, which is a national independent 24- hour counselling service offered to all HSE and the voluntary organisations employees free of charge. The service can be contacted at 015180356.

Can you change your mind at any stage and withdraw from the study?

Yes, you can change your mind and withdraw from the research project up to the data analysis stage, which is expected to be in Dec 2018.

How will you find out what happens with this project?

Upon completion of the research and subsequent publication, the research participants will be informed of same and where a copy can be accessed for their perusal.

Permission:

This study has UCD Human Research Ethics Committee approval.

Contact details for further information:

Should you require any further information, you can contact me at precious.jenga@ucdconnect.ie or 0871344702; Associate Professor Christine Linehan (UCD); christine.linehan@ucd.ie (017168678); Dr Dearbhla Casey (IPA); dcasey@ipa.ie (012403600)



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CONSENT FORM –CEO/DIRECTOR /SERVICE MANAGER/ADMINISTRATOR

I.....agree to MDT members including healthcare, social care professionals and a senior personnel representative to participate in Precious Jenga's research study as part of the Doctorate in Governance Programme delivered by IPA and UCD.

The purpose and nature of the study has been explained to me in writing.

I understand that multidisciplinary team (MDT) members including an experienced personnel representative will participate voluntarily and I understand that the focus group and interview will last approximately one hour.

I understand that MDT members can withdraw from the project up to the data analysis stage expected to take place in Dec 2018.

I understand that data will be confined to the researcher and supervisors, retained in a secured location and securely stored on password-protected computers.

I understand that all information provided for this study will be treated confidentially and that numeric coding will be used to protect the anonymity of MDT members of the organisation.

I understand that the signed consent form and recorded data will be destroyed in two years after commencement of the study.

I understand that if Precious Jenga is informed about someone at risk of harm, she may have to report this to her supervisors and the Health Service Executive (HSE), with or without my permission.

I understand that I am free to contact any of the people involved in the research to seek further clarification and information: Precious Jenga, precious.jenga@ucdconnect.ie, (0871344702); Associate Professor Christine

Linehan (UCD); christine.linehan@ucd.ie (017168678); Dr Dearbhla Casey (IPA); dcasey@ipa.ie (012403600).

Signed-----

Date-----

Discipline -----

Years of experience in current position: -----

APPENDIX 9: INVITATION LETTER-MDT MEMBER (HEALTHCARE and SOCIAL CARE PROFESSIONALS)



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IPA/UCD DGov Programme

57- 61 Lansdowne Road

Dublin 4

24th January 2018

Dear Multidisciplinary Healthcare Member,

Re: Participation in DGov Research Project: Naturalistic Decision-Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities

I am a Doctorate of Governance Student via the Institute of Public Administration Dublin / University College Dublin. As part of my postgraduate study under the supervision of Associate Professor Christine Linehan (UCD) and Dr Dearbhla Casey (IPA), I have chosen to undertake a research project. I am investigating the naturalistic decision making processes used by multidisciplinary teams (MDTs) in organisations in deciding whether individuals will move from congregated settings to the community. The aim is to identify and describe the type of decision-making processes that are being used within the Irish context. The UCD Human Research Ethics Committee (Ref No: HS-17-26-Jenga-Lineh) as well as XXX Research Ethics Committee have approved the study.

I would be most grateful if you could consider participating in a focus group for approximately one hour in your organisation to discuss a hypothetical case study of an adult with an intellectual disability who is being considered for a move to community living. Naturalistic decision-making has yet to be examined regarding dispersed housing in the community for people with intellectual disabilities and your experience and expertise would be invaluable in this research.

If you agree to participate, the focus group discussion will be digitally recorded and transcribed verbatim. All identifiable information will be removed. No individuals or organisations participating in this research will be identified in any reporting of this study.

Please note that should you disclose something that leads me to believe that you or someone else is at risk of serious physical and/or emotional harm, I will have to stop the focus group discussion and inform my supervisors. The Health Service Executive (HSE) designate officer in your organisation will be notified, who will then be obliged to implement the HSE guidelines for safe guarding vulnerable adults. Should you experience distress due for any reason, I will ask you to contact your GP and/or the employer assistance programme, which is a national independent 24-hour counselling service offered to all HSE and the voluntary organisations employees free of charge. The service can be contacted at 015180356.

If you would like to participate, please contact me directly. I will arrange a suitable time and venue for the focus group discussion. If you have any questions, you may contact me at precious.jenga@ucdconnect.ie or 0871344702.

Yours Sincerely,



Precious Jenga, DGOV Student, IPA/UCD



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INFORMATION SHEET FOR PARTICIPANTS IN RESEARCH PROJECT- MDT MEMBERS (HEALTHCARE PROFESSIONALS)

This sheet contains important information about this project and what to expect should you decide to participate. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. Your participation is voluntary. Your decision will not affect your future relationship with the researcher or college.

Researcher's Name:

Precious Jenga

Name of Research School:

UCD School of Social Policy, Social Work and Social Justice, Hanna Sheehy-Skeffington Building, Belfield, Dublin and IPA/UCD DGov Programme, 57- 61 Lansdowne Road, Dublin 4

Title of Research Project:

Naturalistic Decision-Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities

What is this research about?

The research project is about decision-making processes of multidisciplinary team members namely, healthcare, social care and administrative professionals who are involved in transferring adults from congregated settings to dispersed housing in the community.

Why I am doing this research?

I am conducting this research because to my knowledge, there is no available empirical research on how multidisciplinary teams (MDTs) make decisions in the Irish context when transferring adults with an intellectual disability from congregated settings to dispersed community-living options.

Why have you been invited to take part?

You have been invited because you are a member of a multidisciplinary team (MDT) in your organisation, making decisions on whether or not to transfer adults with an intellectual disability from congregated settings to the community.

How will your data be used?

Data will be gathered via anonymous recordings of a focus group, which will be transcribed verbatim for analysis. The researcher and the supervisors will have access to these data, which will be analysed and reported for the purposes of obtaining a doctoral level qualification. The only identifiable data gathered are signed consent forms, which will be stored in a locked cabinet in a separate location to the tape recordings and transcripts.

What will happen if you decide to take part in this research study?

You will be invited to attend a one-hour focus group where you and other participants will be asked to discuss a hypothetical case study of an adult with an intellectual disability who is being considered for a move to community dispersed housing living. The focus group will be digitally recorded and later transcribed. The focus group will take approximately one hour. At the beginning of the focus group, you will be asked to sign the attached consent form. This form will be securely stored in a locked cabinet.

How will your privacy be protected?

No individuals or organisations will be named in any reporting of this research. During data analysis, numeric and colour coding will be used to protect your anonymity and that of your organisation. Data will be kept for two years from the commencement of data collection, after that, it will be destroyed.

What are the limits of confidentiality in focus groups?

Please be assured that everything you tell me will be treated as confidential. However, confidentiality cannot be fully guaranteed. Therefore, you will be asked to respect each other's views and not share information outside the group and sign the consent form.

What are the benefits of taking part in this research study?

MDT members may benefit from the opportunity to reflect on their decision making process during the focus group discussions. From an academic perspective, the input of the MDT members will contribute in the identification of the type of decision-making processes used by multidisciplinary teams in Ireland and knowledge about factors considered when transferring people to the community.

What are the risks of taking part in this research study?

The risks are that should any disclosure be made during focus group discussions leading me to believe that you and/or someone else is at risk of serious physical and/or emotional harm, I will have to stop the focus group and inform my supervisors and the Health Service Executive (HSE). The HSE designate officer in your organisation will be notified, who will then be obliged to implement the HSE guidelines for safe guarding vulnerable adults. Should you experience distress for any reason during this study, I will ask you to contact your GP and/or the employer assistance programme, which is a national independent 24- hour counselling service offered to all HSE and the voluntary organisations employees free of charge. The service can be contacted at 015180356.

Can you change your mind at any stage and withdraw from the study?

Yes, you can change your mind and withdraw from the research project up to the data analysis stage, which is expected to be in Dec 2018

How will you find out what happens with this project?

Upon completion of the research and subsequent publication, the research participants will be informed of same and where a copy can be accessed for their perusal.

Permission:

This study has UCD Human Research Ethics Committee approval.

Contact details for further information: Should you require any further information, you can contact me at precious.jenga@ucdconnect.ie or 0871344702; Associate Professor Christine Linehan (UCD); christine.linehan@ucd.ie (017168678); Dr Dearbhla Casey (IPA); dcasey@ipa.ie (012403600)



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CONSENT FORM- MDT MEMBERS (HEALTHCARE CARE PROFESSIONALS)

I.....agree to participate in Precious Jenga's research study as part of the Doctorate in Governance Programme delivered by IPA and UCD.

The purpose and nature of the study has been explained to me in writing. I am participating voluntarily and I understand that the focus group will last approximately one hour.

I give permission for the focus group discussions to be digitally audio recorded.

I understand that I can withdraw from the project up to the data analysis stage expected to take place in Dec 2018.

I understand that data will be confined to the researcher and supervisors, retained in a secured location and securely stored on password protected computers.

I understand that all information I provide for this study will be treated confidentially and that I will respect other participants' views and not share information outside the focus group.

I understand that numeric coding will be used to protect my anonymity and that of my employer.

I understand that if I inform Precious Jenga that I or someone else is at risk of harm, she may have to report this to her supervisors and the Health Service Executive (HSE), with or without my permission.

I understand that disguised extracts of the focus group discussions may be quoted in Precious Jenga's dissertation.

I understand that the signed consent form and recorded data will be destroyed in two years after commencement of the study.

I understand that I am free to contact any of the people involved in the research to seek further clarification and information:

Precious Jenga, precious.jenga@ucdconnect.ie, (0871344702); Associate Professor
Christine Linehan (UCD); christine.linehan@ucd.ie (017168678); Dr Dearbhla Casey
(IPA); dcasey@ipa.ie (012403600).

I confirm I am over 18 years of age.

Signed-----

Date-----

Discipline: -----

Years of experience in current position: -----

**APPENDIX 10: INVITATION LETTER – MDT MEMBER –SENIOR PERSONNEL
REPRESENTATIVE**



UCD School of Psychology
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IPA/UCD DGov Programme
57-61 Lansdowne Road
Dublin 4
24th January 2018

Dear Senior Personnel Representative,

Re: Participation in DGOV Research Project: Naturalistic Decision-Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities

I am a Doctorate of Governance Student via the Institute of Public Administration Dublin / University College Dublin. As part of my postgraduate study under the supervision of Associate Professor Christine Linehan (UCD) and Dr Dearbhla Casey (IPA), I have to undertake a research project. I am investigating the naturalistic decision making processes used by multidisciplinary teams (MDTs) in organisations in deciding whether individuals will move from congregated settings to the community. The aim is to identify and describe the type of decision- making processes that are being used within the Irish context. The UCD Human Research Ethics Committee (Ref No: HS-17-26-Jenga-Lineh) as well as XXX Research Ethics Committee have approved the study.

I would be most grateful if you could consider participating in a face-to-face interview for approximately one hour in your organisation to answer questions about

environmental/situational information you consider when transferring adults with an intellectual disability from congregated settings to the dispersed houses in the community. Naturalistic decision-making has yet to be examined regarding dispersed housing in the community for people with intellectual disabilities and your experience and expertise would be invaluable in this research.

If you agree to participate, please be aware that the interview will be digitally recorded and transcribed verbatim. All identifiable information will be removed.

No individuals or organisations participating in this research will be identified in any reporting of this study.

Please note that should you disclose something that leads me to believe that you or someone else is at risk of serious physical and/or emotional harm, I will have to stop the interview and inform my supervisors. The Health Service Executive (HSE) designate officer in your organisation will be notified, who will then be obliged to implement the HSE guidelines for safe guarding vulnerable adults.

Should you experience distress for any reason, I will ask you to contact your GP and/or the employer assistance programme, which is a national independent 24-hour counselling service offered to all HSE and the voluntary organisations employees free of charge. The service can be contacted at 015180356.

If you would like to participate, please contact me directly. I will contact you to arrange a suitable time and venue for the interview. If you have any questions, you may contact me at precious.jenga@ucdconnect.ie or 0871344702

Yours Sincerely,



Precious Jenga, DGOV Student, IPA/UCD



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INFORMATION SHEET FOR PARTICIPANTS IN RESEARCH PROJECT- MDT MEMBER- SENIOR PERSONNEL REPRESENTATIVE

This sheet contains important information about this project and what to expect should you decide to participate. Please consider the information carefully. Feel free to ask questions before making your decision whether or not to participate. Your participation is voluntary. Your decision will not affect your future relationship with the researcher or college.

Researcher's Name:

Precious Jenga

Name of Research School:

UCD School of Social Policy, Social Work and Social Justice, Hanna Sheehy-Skeffington Building, Belfield, Dublin and IPA/UCD DGov Programme, 57- 61 Lansdowne Road, Dublin 4

Title of Research Project:

Naturalistic Decision-Making Processes of Multidisciplinary Teams that Facilitate Community-Living Options for Adults with Intellectual Disabilities

What is this research about?

The research project is about decision-making processes of multidisciplinary team (MDT) members namely, healthcare, social care and administrative professionals who are involved in transferring adults from congregated settings to dispersed housing in the community.

Why I am doing this research?

I am conducting this research because to my knowledge, there is no available empirical research on how multidisciplinary teams (MDTs) make decisions in the Irish context when transferring adults with an intellectual disability from congregated settings to dispersed community-living options.

Why have you been invited to take part?

You have been invited because you are a senior personnel representative and a member of a multidisciplinary team in your organisation, making decisions whether or not to move adults with an intellectual disability from congregated settings to the dispersed community-living options

How will your data be used?

Data will be gathered via anonymous recordings of interviews, which will be transcribed verbatim for analysis. The researcher and supervisors will have access to these data, which will be analysed and reported for the purposes of obtaining a doctoral level qualification. The only identifiable data gathered are signed consent forms, which will be stored in a locked cabinet in a separate location to the tape recordings and transcripts.

What will happen if you decide to take part in this research study?

You will be invited to attend a face-to-face interview to answer questions about environmental/situational information you consider when an adult with an intellectual disability is being considered for a move to dispersed housing in the community. The interview will be digitally recorded and later transcribed. The interview will take approximately one hour. At the beginning of the interview, you will be asked to sign the attached consent form. This form will be securely stored in a locked cabinet.

How will your privacy be protected?

No individuals or organisations will be named in any reporting of this research. During data analysis, numeric and colour coding will be used to protect your anonymity and that of your organisation. Data will be kept for two years from the commencement of data collection, after that, it will be destroyed

What are the benefits of taking part in this research study?

The experienced personnel may benefit from the opportunity to reflect on his/her decision-making process during the interview. From an academic perspective, the input of senior personnel will contribute to the body of knowledge factors considered when transferring people to the community in Ireland

What are the risks of taking part in this research study?

The risks are that should any disclosure be made during interview leading me to believe that you and/or someone else is at risk of serious physical and/or emotional harm, I will have to stop the interview and inform my supervisors and the Health Service Executive (HSE). The HSE designate officer in your organisation will be notified, who will then be obliged to implement the HSE guidelines for safe guarding vulnerable adults. Should the participant experience distress for any reason during this study, I will ask the participant to contact his/her GP and/or the employer assistance programme, which is a national independent 24- hour counselling service offered to all HSE and the voluntary organisations employees free of charge. The service can be contacted at 015180356.

Can you change your mind at any stage and withdraw from the study?

Yes, you can change your mind and withdraw from the research project up to the data analysis stage, which is expected to be in Dec 2018

How will you find out what happens with this project?

Upon completion of the research and subsequent publication, the research participants will be informed of same and where a copy can be accessed for their perusal.

Permission:

This study has UCD Human Research Ethics Committee approval.

Contact details for further information: Should you require any further information, you can contact me at precious.jenga@ucdconnect.ie or 0871344702; Associate Professor Christine Linehan (UCD); christine.linehan@ucd.ie (017168678); Dr Dearbhla Casey (IPA); dcasey@ipa.ie (012403600).



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Áras Newman

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www.ucd.ie/psychology

CONSENT FORM –MDT MEMBER- SENIOR PERSONNEL REPRESENTATIVE

I.....agree to participate in Precious Jenga's research study as part of the Doctorate in Governance Programme delivered by IPA and UCD.

The purpose and nature of the study has been explained to me in writing. I am participating voluntarily and I understand that the interview will last approximately one hour.

I give permission for the interview to be digitally audio recorded.

I understand that I can withdraw from the project up to the data analysis stage expected to take place in Dec 2018.

I understand that data will be confined to the researcher and supervisors, retained in a secured location and securely stored on password-protected computers.

I understand that the signed consent form and recorded data will be destroyed in two years after commencement of the study.

I understand that all information I provide for this study will be treated confidentially.

I understand that numeric coding will be used to protect my anonymity and that of my employer.

I understand that if I inform Precious Jenga that I or someone else is at risk of harm, she may have to report this to her supervisors and the Health Service Executive (HSE), with or without my permission.

I understand that disguised extracts of the interview may be quoted in Precious Jenga's dissertation.

I understand that I am free to contact any of the people involved in the research to seek further clarification and information: Precious Jenga, precious.jenga@ucdconnect.ie, (0871344702); Associate Professor Christine

Linehan (UCD); christine.linehan@ucd.ie (017168678); Dr Dearbhla Casey (IPA); dcasey@ipa.ie (012403600).

Signed-----

Date-----

Discipline: -----

Years of experience in current position: -----

APPENDIX 11: PROCEDURE FOR DEBRIEFING OF PARTICIPANTS

The researcher will implement the protocol suggested by Draucker et al. (2009) for dealing with a participant who may become distressed for any reason during discussions and interview. The protocol will be firstly to stop the discussion and offer immediate support by acknowledge the participant's distress. The researcher will invite the participant to take some time out and conduct a debriefing session with him/her, i.e. talking to the participant to determine whether he/she needs more time to gather his/her feelings, ask if he/she feel safe to resume the discussion or he/she wishes to leave the group. If the participant decides to continue with the group, the researcher will inform the other participants that the discussion will continue. The researcher will follow up after the group discussion (with the participant's consent), with a courtesy call. If the participant continues to feel anxiety and distress, the researcher will advise the participant to contact his/her GP and/or the employer assistance programme, which is a 24-hour counselling service offered to all employees of Health Service Executive (HSE) funded organisations free of charge. This service can be accessed at 015180356.