Received: 29 November 2019 | Revised: 6 August 2020 | Accepted: 12 August 2020

DOI: 10.1111/jar.12797

ORIGINAL ARTICLE

JARID Journal of Applied Research in Intellectual Disabilities bild WILEY

A multiple case study investigating changes in organizations serving residents with intellectual disabilities and challenging behaviours

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Funding information
Institutional: CCE receives financial support of the Dutch government.

Abstract

Background: the present authors examined changes made in disability service organizations supporting residents with intellectual disabilities and challenging behaviours, because these changes may influence residents' support and subsequently their challenging behaviours.

Method: In this multiple case study, the present authors collected and qualitatively analysed data (organizational documents, meetings records and focus group reports) on organizational changes made in two specialized Dutch disability service organizations, using ecological theory as a sensitizing framework and the constant comparative method.

Results: Themes describing organizational changes in this context were as follows: a messy start to the transition; staff, professionals and managers remain at a distance; staff members' ability to change; clear boundaries between formal and informal caregivers; and staff's feelings of being unheard.

Conclusions: Organizational changes can enhance, but also limit, the quality of residential support services provided to people with intellectual disabilities and challenging behaviours. The change process and impact of organizational changes on residents must be examined closely.

KEYWORDS

challenging behaviour, challenging behaviour management, disability service organization, ecological theory, intellectual disabilities, organizational change

1 | INTRODUCTION

Residential service organizations for people with intellectual disabilities and challenging behaviours are dynamic and often change their organizational models (Bigby & Beadle-Brown, 2018; Hulgin, 2004; Tossebro et al., 2012). Organizational changes are associated with various positive resident outcomes, such as shifts to person-centred support services that can reduce challenging behaviour incidents (Walker, 2012). Through staff members' attitudes, a coherent and supportive organizational culture helps to enhance residents'

quality of life and decrease their challenging behaviours (Bigby & Beadle-Brown, 2018; Bigby, Knox, Beadle-Brown, & Clement, 2015; Hastings et al., 2013). Changes in service organizations that aim to improve resident outcomes are vital for people with intellectual disabilities and challenging behaviours. These residents often rely on long-term professional support, but risk receiving lower quality support services than residents without challenging behaviours (Beadle-Brown et al., 2016; Hamlin & Oakes, 2008; Hastings et al., 2013; Hensel, Lunsky, & Dewa, 2014 Hulgin, 2004; White, Holland, Marsland, & Oakes, 2003).

Changes in residential disability service organizations for people with intellectual disabilities and challenging behaviours include various aspects which influence each other (Walker, 2012). Ecological theory provides a sensitizing framework to aid understanding of these changes. According to this theory, each residents' environment (ontosystem) consists of different ecological systems: the microsystem (e.g. resident–staff interactions), mesosystem (e.g. staff–family interactions), exosystem (e.g. influence of higher management on daily staff practices) and macrosystem (e.g. national policies and budgets; Bronfenbrenner, 1979, 1994; Tudge, Mokrova, Hatfield, & Karnik, 2009). Changes in the resident and the people, objects or symbols in his or her environment comprise the chronosystem (Bronfenbrenner, 1979, 1994; Tudge et al., 2009). Chronosystem aspects include major life transitions (ontosystem), changes in treatment methods (micro- and mesosystems), organizational mergers (exosystem) and changes in national budgets (macrosystem). Ecological theory also states that residents and their environment interact continuously and reciprocally (Bronfenbrenner, 1979, 1994; Tudge et al., 2009). For example, organizational aspects (e.g. vision and leadership) may impact support service aspects (e.g. team climate and staff working methods), in turn affecting resident–staff interactions via staff members' beliefs about residents' behaviours (Deveau & McGill, 2019; Olivier-Pijpers, Cramm, Buntinx, & Nieboer, 2018; Olivier-Pijpers, Cramm, & Nieboer, 2019). However, few studies examine residential service organizational changes from an ecological perspective (Bigby & Beadle-Brown, 2018; Olivier-Pijpers et al., 2018).

The process of changing the organizational environment to yield positive resident outcomes and improve management of challenging behaviours is complex and often long (Hulgin, 2004; Walker, 2012). Supplementary organizational changes can be implemented to improve support services, such as closing group homes and transferring residents to smaller community settings. This is typically performed over a number of years and impacts residents' daily lives, which in turn may affect their behaviour. However, resident relocation is insufficient for preventing challenging behaviour. Instead, supplementary changes, such as those in the organization's vision with respect to resident participation (e.g. increasing control for residents and representatives in support services), are required to further manage challenging behaviours (Hamlin & Oakes, 2008; Walker, 2012). The process of supplementary organizational change is complex, because each change takes place over time and is multifaceted, influenced by organizations' members and circumstances (Hulgin, 2004). Insight into relevant aspects of organizational change processes may help further improve residential support services.

Some organizational changes negatively affect support quality and residents' challenging behaviours (Bigby & Beadle-Brown, 2018; Olivier-Pijpers et al., 2019; Tossebro et al., 2012). For example, media attention that only focuses on what is considered to be bad practice or restrictions in financial resources can result in organizations exerting more control over their employees, which negatively influences challenging behaviour management (Olivier-Pijpers et al., 2019; Tossebro et al., 2012). A better understanding of organizational change may help to prevent these negative consequences.

Focusing on organizational change in residential services may increase understanding of residents' challenging behaviours and how they can best be managed (Hulgin, 2004; McGill et al., 2018; Walker, 2012). Thus, this study aimed to qualitatively explore changes made in two Dutch residential disability service organizations that provide support to people with intellectual disabilities and challenging behaviours.

2 | METHOD

2.1 | Study design and setting

A multiple case study design was used to explore the complex social phenomena of changes made in two service organizations for residents with intellectual disabilities and challenging behaviours (Forrest-Lawrence, 2019; Rodgers et al., 2016; Yin, 2018). We selected this approach to inform other residential disability service organizations about organizational changes made by higher management and how these changes relate to support for people with intellectual disabilities and challenging behaviours (Forrest-Lawrence, 2019; Yin, 2018).

Two large service organizations in different regions in the Netherlands were studied. Each organization supports around 2,000 residents, with more than 2,000 employees within large-scale institutions (around 50 years old) and some small-scale community group homes and cluster housing. This paper describes a longitudinal data series of changes within these organizations. Table 1 shows a timeline of major organizational changes and data collection over three phases.

In both organizations, typically three to five residents per year display severe and persistent challenging behaviours which support staff are unable to prevent or manage. These residents are often restricted in their activities and social interactions, and may experience frequent restraints. Their complex care needs necessitate several staff members and professionals to provide support services, and such efforts have not generally yielded positive resident outcomes. In such cases, the organizations request support from the Centre for Consultation and Expertise (CCE). The researchers were CCE employees and conducted this study during consultations for 13 residents. The residents had mild to severe intellectual disabilities and diagnoses of attachment disorder, depression, panic attacks and autism spectrum disorder. They

TABLE 1 Timeline of major organizational changes in both disability service organizations and data collection phases

	2008–2012	2013	2015	2016	2017	2018
Organization A	Merger of intellectual disability service organizations	From a rather controlling, hierarchical system to a supportive managerial approach	Implementation of self-organizing staff teams Increased involvement of residents and representatives in decision-making processes Vision change in order to minimize restraint measures	Insufficient organizational budgets and high absenteeism, limiting support by self-organizing staff teams	Implementation of a new electronic health record system with a portal for representatives Interim director appointed Limiting of budgets	New CEO and CFO appointed
Organization B	Persistent financial problems	Reorganization with several years of employee relocations	Reorganizations	New CEO appointed New organizational philosophy with a focus on resident–staff member–representative relationships and work quality	From a controlling to a more supportive management style with less-bureaucratic work models New housing for residents Employee training	Implementation of self-organizing staff teams
Data collection				Phase 1 Collecting meeting records Phase-one focus groups and start of phase-two focus groups	Phase 2 Collecting meeting records Phase-two focus groups	Phase 3 Collecting organizational documents Phase-three focus groups

displayed severe physical and verbal aggression, persistent self-injurious behaviours, and extreme anxiety or apathy.

2.2 | Data collection

Study data comprised information on changes in both service organizations and were collected in three phases, as organizational change processes can take place over several years. In phases 1 and 2, written meeting records were examined and focus groups were held (n = 6 and 7, respectively). In phase 3, eight organizational documents were examined and four focus groups were held. Experts in focus groups and change management supervised the creation of meeting records and focus group action plans (Appendix 1).

2.2.1 | Meeting records

Meeting records were reports on multidisciplinary team meetings and meetings with resident representatives, staff and professionals held as part of CCE consultations. A standard method was used to create these records, and Bronfenbrenner's ecological system levels were employed as sensitizing concepts. The staff member or psychologist on the multidisciplinary team the longest involved was asked to create each record, providing information on professionals' daily practices during organizational changes. Records were studied and discussed with other staff, professionals and managers in focus groups during phases 1 and 2.

2.2.2 | Organizational documents

Organizational documents provided insight into organizational changes from higher management's perspective. All annual organizational reports from 2016 to 2019 and two quality reports by higher management from this period were collected.

2.2.3 | Focus group reports

Focus groups (2–3 hr each) were held between 2016 and 2019 to provide insight into changes made in the organizations and support services, using Bronfenbrenner's ecological system levels as sensitizing concepts in the action plans. Groups were led by two trained and experienced CCE members and attended by the first author. The moderators and researchers (authors of this study) had no direct relationships with the organizations. Each focus group included at least one staff member, psychologist, manager and CCE coordinator or expert, to gain multiple perspectives on organizational changes. The moderators ensured that all participants had equal opportunities to express their views. The first author audio-recorded the sessions, with all participants' permission, transcribed the recordings and checked the transcript accuracy with all participants (Farnsworth

TABLE 2 Characteristics of focus group participants

Number of participants per focus group	5–10
Sex	18% male
	85% female
Employment duration	A few months to > 20 years
Professions	23 direct staff members
	13 psychologists
	2 physicians
	13 managers
	11 CCE experts
	9 CCE case coordinators
Education	51%, four years of secondary vocational education
	49%, university degree in the social sciences
	All had extra training in managing challenging behaviour.

& Boon, 2010; Freeman, 2006; Onwuegbuzi, Dickinson, Leech, & Zoran, 2009). Focus group data were collected from organizational employees and CCE members who worked with residents with severe and frequent challenging behaviours (see Table 2).

2.3 | Data analysis

The first and third authors coded the data by reading the records, reports and documents several times and applying open codes to each sentence or paragraph. Ecological system levels were used to avoid bias related to preconceptions about organizational changes, as these levels provide a sense of how to arrange data without prescriptive instructions. The constant comparative method was used to search for and analyse themes and their boundaries and relationships in the data, with the authors conferring with each other during every step in the process to ensure agreement (Bowen, 2006; Onwuegbuzi et al., 2009). To enhance the external validity, data were analysed using Atlas.ti software (version 7; Scientific Software Development, Berlin, Germany). This allowed for enhanced transparency in theme construction until theoretical saturation occurred (Boeije, 2002; Bowen, 2006; Dunne, 2011; Onwuegbuzi et al., 2009). The quotations presented with the themes were translated from Dutch to English by a professional translator and checked by the first author after translation.

3 | RESULTS

Data from both organizations provided similar themes regarding organizational changes for residents with intellectual disabilities and challenging behaviours. The quotations below are anonymized and from members of both organizations.

3.1 | A messy start to the transition

Annual reports from higher management and focus group reports (by organization and CCE members) indicated that organizational changes initially felt "messy" to staff. Over a few weeks during a transition to self-organizing staff teams, staff members became solely responsible for drafting residents' new personal care plans and contacting other professionals, instead of receiving frequent support from psychologists or managers on residents' challenging behaviours. After a few weeks, psychologists provided new treatment plans to supplement the care plans, providing better guidelines for daily management of challenging behaviours. In a focus group, a psychologist explained this messy start:

Staff became responsible for contacting other professionals. Regularly messy. Where do you have to go for that? Do I have to decide on my own? How do you find …? How do you reach this or that person? Also, the amount of responsibility you have depends on the individual care manager. A lot of support and facilitation [from the manager] only at the staff's request. Personal care plans are drawn up without other professionals. In addition to transitioning from the old care plan to the new, now a treatment plan must be drawn up [by the psychologist]. [The change] is implemented at high speed, and there are no clear guidelines.

In the first few weeks during periods in which entirely new staff teams were constructed to provide more efficient support, these teams had insufficient information to handle residents' behaviours, and incidents involving challenging behaviours increased. Staff felt judged by managers and psychologists for these increased incidents, as explained in a focus group by a group home staff member:

I wanted to prevent the daycare team from being judged because things went wrong during daytime activities, as if they would have caused this mess. It was a whole new staff; there had been a reorganisation. They had little knowledge and expertise about this resident; it was not a matter of not working, it was ambiguous work without consistent supervision. There were many escalations; the team couldn't do anything about them. They weren't familiar with [the residents] and were thrown into the deep end.

3.2 | Staff, professionals and managers remain at a distance

Another theme identified in the meetings and focus group reports by all organization and CCE members was the increased distance between staff, other professionals and managers during employee and resident relocations. Staff, other professionals and managers argued that relocations improved residents' quality of life by offering a more suitable environment and more efficient daily support. However, they stated that the long relocation period for managers and psychologists, along with several changes in managerial functions, affected resident–staff bonding. Without proper working relationships, the staff found it difficult to focus on residents' needs. In a focus group, a staff member, manager and psychologist recalled the timeline of this period, starting in 2013 with relocations, followed

with managerial changes (which expanded managers' control) in 2015. In this context, increasing distrust in working relationships among staff and other organization members and less resident–staff bonding affected management of challenging behaviours:

Staff member: There were no target group managers anymore, and many relocations of managers and psychologists. That caused a somewhat unsafe feeling in daily work practices and in group homes. Residents could not bond with professionals or staff, and staff found it difficult to trust anyone in the organisation.

Manager: Were there no target group managers anymore? Three years ago, they were still there; didn't they just stop two years ago?

Staff member: They were still there, but the change had been announced. And two years ago, that change was indeed implemented. Several changes—from team leader, to target group manager, to care manager. The atmosphere in the group homes around those changes was uncertainty. In 2015, a new organisational philosophy was clearly being developed, and was actually initiated in 2016.

Psychologist: Relocations, position changes among managers, and also relocations among psychologists. It started in 2013 and lasted a few years. Co-operation among various disciplines was not optimal, partly due to all the relocations. There was uncertainty; people remained at a distance.

After implementing self-organizing teams, staff and other professionals had less informal and formal contact. A coach and staff member stated in a focus group that coaches remained hesitant to assist staff, because they must wait for staff members to signal for help, according to the organizational vision. Staff members were hesitant to ask for help, as they were supposed to be self-organizing teams, resulting in heavy workloads during periods of increased incidents with challenging behaviours:

Coach: the present authors, too, are still learning. Should the present authors be close to the staff, or rather aim for a staff team who feels 'the present authors have the freedom; don't take everything away from us'?

Staff member: the present authors have a very independent team, which the present authorsnt well for a while until major issues arose. A lot of work ends up on few shoulders, and it is no longer bearable. Asking a question [to a coach for help] is still difficult.

3.3 | Staff members' ability to change

According to focus group participants and organizational reports, not all staff members were able (or willing) to change. Individual staff members' attitudes and routines seemed to limit higher management's ability to implement a new vision for managing challenging behaviours via minimizing restraint measures. A 2017 quality report indicated that staff needed more awareness and knowledge to positively change how they managed challenging behaviours. Proper staff behaviours were stimulated by discussing organizational views on support and upcoming legislative changes:

In 2017, many actions were taken to reduce restraint measures. As a result, the number of restraint measures has fallen sharply. However, there is still room for improvement at the individual level. This mainly concerns raising awareness (what are restraint measures) and consciously applying them (why is it inappropriate). Too often, the present authors still work on the basis of routine: 'that's how the present authors always do it'. the present authors used the developments surrounding the Care and Compulsion Act (WZD) as an extra reason to bring the restraint measures and extension of freedom back to [staff's] attention and to share knowledge about 'what is and is not allowed'. Additionally, teams are encouraged to reason from a resident's perspective.

With this effort to minimize restraint measures and the lack of staff competence in supporting residents with moderate intellectual disabilities, more severe incidents with challenging behaviours occurred. Expensive temporary workers were then hired, as stated in a 2017 quality report:

Partly due to the reduction of restraint measures, the number of aggression incidents in several groups for residents with moderate intellectual disabilities increased. This group was relatively new to our organisation, and staff were not sufficiently equipped to support them. As an alternative, the present authors opted to use temporary employment agencies that specialised in supporting such groups. In the second half of the year, there was more focus on reducing the use of temporary workers.

After receiving training in positive attitudes and use of fewer restraint measures, some staff members showed increased abilities to redirect challenging behaviours. One staff member explained in a focus group how her attitude change after receiving training in 2018 affected her support of a resident; the resident was no longer restrained by staff when he displayed challenging behaviours:

There are still a few times when the resident walks away, but he often returns on time. We're not angry when he comes back, but the present authors're glad he is honest. We talk openly about it. Initially, he was afraid the present authors would get angry and restrain him, which made him angry again. He now knows that the present authors'll welcome him positively, and the present authors will keep supporting him. Tomorrow, the present authors'll have new opportunities. He wants to talk about it the next day. The relationship is mutual trust and welcoming him anew.

3.4 | Clear boundaries between formal and informal caregivers

According to focus group participants and organizational reports, the roles of residents' representatives and professionals were initially blurred during organizational changes meant to allow representatives more say regarding support services. These changes eventually led to acknowledging representatives' unique input on specific topics regarding complex support services provided to their family members. A staff member explained in a focus group how staff limited the topics in which a resident's mother had a say (e.g. regarding activities and goals), resulting in clearer boundaries between roles of the mother and professionals:

What belongs to the mother and what belongs to the professionals? That's been separated. Mother and aunt, as well as curator and psychologist, were all at the table the moment the mother tried to discuss topics

for the professionals. The mother must discuss her topics with the curator. The mother used to be intertwined with the professional system.

A staff member in another focus group explained how a new electronic health record system helped create a transparent working relationship between staff and a resident's ex-husband. Inquiring with the ex-husband helped the staff understand the resident's personal history, and reading daily reports in the health record allowed the ex-husband to stay informed about the support provided to the resident without arguing with the staff:

Relationships with the family are different, based on the new information on causes for resident's challenging behaviour [with help from the ex-husband]. The family can now let go a bit more, being able to read daily reports [by staff] from home. The [electronic health record] pilot was January 2017. Since May 2017, the present authors've started with her and her family. The staff is no longer questioned on what her day was like, because her ex-husband can already read in her record, and he thinks about when it would be best for him to come to the group home.

3.5 | Staff's feelings of being unheard

Implementing changes over several years (e.g. budget cuts, self-organising staff teams) led to changes within staff teams and how they functioned, as indicated in the focus groups and meeting records. Some focus group participants shared frustrations about higher management not listening to them regarding how organizational changes impacted their daily practices. Staff then focused less on interacting with residents and managing challenging behaviours and more on how little influence they had within the organization. A CCE expert and a middle manager explained this in a focus group:

Expert: So, the present authors made an inventory [with the multidisciplinary team]. And they said, 'That's really nice, but that's been done a lot and nothing ever happens. So...' And there's the bit about the CCE's influence. They said: 'Those reports have been made often about who this resident is and what she needs. And the conditions [needed for her support] have repeatedly been identified, but nothing is happening and staff has been waiting for years.' So, these comments went around several times from different [staff members]. the present authors let them display their frustration, and gave them our attention.

Manager: All this is 'office politics': energy that you can no longer use for 'How do you deal with your residents and how do you organise support'? I've said on a number of occasions I think that's so unfortunate, and I think you'll end up doing yourself and the residents a disservice.

4 | DISCUSSION

In this study, multiple perspectives provided insight into organizational changes at the exosystem level (e.g. self-organising staff teams, personnel relocations and new visions), support service changes at the mesosystem level (e.g. staff's feelings and working relationships with representatives) and changes in staff–resident interactions at the microsystem level (e.g. bonding and incidents) in service organizations for residents with intellectual disabilities and challenging behaviours (ontosystem). This study is among the first to explore changes in residential service organizations for people with intellectual disabilities and challenging behaviours from an ecological system perspective.

First, during initial exosystem-level transitions, staff members lacked support from psychologists and managers and information on residents' behaviours at the meso- and microsystem levels. This created a "messy" situation that negatively impacted management of challenging behaviour. Research indicates support from managers and psychologists through practice leadership, with frequent formal and informal staff contact, is vital for improving management of challenging behaviours and building a coherent team culture, leading to staff receiving and sharing guidance on how to provide support in line with residents' behaviours (Deveau & McGill, 2019; Deveau, Gore, & McGill, 2020; Olivier-Pijpers, et al., 2018; Olivier-Pijpers et al., 2019; Tournier, Hendriks, Jahoda, Hastings, & Embregts, 2020).

Second, during years of employee and resident relocations, or transitioning to self-organising staff teams, organization members remained at a distance from each other at the mesosystem level, affecting resident–staff bonding at the onto- and microsystem levels, which in turn limited management of challenging behaviour. To bond with residents and act positively towards them during incidents with challenging behaviours, staff members need consistent, positive working relationships with managers and psychologists, based on clear organizational values and team culture (Olivier-Pijpers, Cramm, & Nieboer, 2019; Ravoux, Baker, & Brown, 2012; Tournier et al., 2020).

Third, while aiming to minimize restraint measures, incidents initially increased, and not all staff members were able or willing to change at the microsystem level. Discussions about impending legislation at the macrosystem level and providing staff training improved some staff members' attitudes and abilities. These findings are partly in line with Schippers (2019), who concluded that organizational changes meant to minimize restraint measure use in behavioural management must be accompanied by interventions at the support service (specialized multidisciplinary team formation and training) and resident (changes in care plans) levels. Bridging the gap between a new vision and daily practices is difficult, and staff members' skills and motivation to change may increase through situational leadership to encourage staff, reviews of interventions to enforce new actions and information on new actions to monitor changes (Deveau & Leitch, 2020; Ravoux, et al., 2012; Tournier et al., 2020). Furthermore, a stable and well-informed multidisciplinary team is the base for continual staff education and required for successful long-term changes made to prevent challenging behaviours (Walker, 2012).

Fourth, in the context of a new exosystem-level vision for improving interactions between representatives and staff and implementing electronic health record systems, representatives' input in support services for their family members became more valued by staff, and clarity in boundaries between staff and representatives

improved at the mesosystem level. Transparency should be emphasized in these working relationships, as it is foundational for residential support services and positive resident outcomes (Doody, 2011; Griffith, Hutchinson, & Hastings, 2013; Olivier-Pijpers, Cramm, & Nieboer, 2020).

Fifth, managers and psychologists neglecting staff while implementing exosystem-level organizational changes over several years ultimately resulted in staff and other professionals feeling ignored at the mesosystem level, which could increase challenging behaviours at the microsystem level. White and colleagues (2003) stated that such feelings can restrict the influence of other professionals, possibly leading to abusive staff practices when managing challenging behaviours. Our findings are partly in line with Philips and Rose (2010), who concluded that factors such as insufficient staff resources and staff feeling unheard can impair support services, thus manifesting as less-frequent and less-appropriate staff–resident interactions and an overworked staff unable to proactively manage challenging behaviours. Combined with poor administrative systems and/or insufficient information about organizational changes, which reinforces staff feelings of helplessness, this can lead to the breakdown of support services and poor resident outcomes (Philips & Rose, 2010). Thus, organizational changes are able to increase the quality of support services for residents with intellectual disabilities and challenging behaviours, but can decrease the quality as well, thereby affecting resident outcomes.

Organizational changes can be limited when staff perceives a gap between such changes with their daily support practices due to distance from other organization members, feeling unheard or receiving insufficient guidance. Organizational changes trigger negative organization members' responses and may affect their daily practices (Greenhalgh, Robert, MacFarlane, Bate, & Kyriakidou, 2004). As Rogers (1995) stated, these responses consider whether changes benefit those involved, are compatible with staff norms and values, are observable and not too complex, and allow for experimentation (Nieboer, Pijpers, & Strating, 2011). Furthermore, long-standing organizational changes in daily practices are influenced by informal and formal staff social networks in the organization (Greenhalgh et al., 2004). Thus, desired changes and outcomes for staff and residents should be examined before any changes are made, as organizational changes should improve outcomes for and decrease challenging behaviours in residents.

Many organizational changes, including those examined in this study, are executed over multiple years and hindered by the complex transformational process, which is initially messy and then consists of assimilation and routinization (cf. Finlay, 2000; Greenhalgh et al., 2004). This process is also difficult because supporting staff and managing challenging behaviours cannot be encompassed by universal procedures or rules, and organizational visions and values must be continually translated into daily staff practices to form transparent working relationships among organization members and representatives (Bigby, Knox, Beadle-Brown, & Clement, 2015; Finlay, 2000; Tournier et al., 2020). Walker (2012) stated that organizational changes entail comprehensive cultural changes across an organization, including strategies generating commitment to organizational values, authentic actions according to the organizational vision, shifts in power and control, and cultivation of staff engagement (Finlay, 2000; Walker, 2012). Organizations have the responsibility to improve resident outcomes by identifying intervening environmental factors and aligning support strategies with these factors, disability policy goals and residents' rights, human functioning and quality of life (Schalock, Luckasson, & Shogren, 2020; Shogren et al., 2018; Shogren et al., 2020). Accordingly, research should not only focus on changes in residents but also the continuous, complex process of change in service organizations.

This study has value for researchers and practitioners, as the ecological perspective provides insight into recent studies on implementing and maintaining active support in various services, which have concluded that hands-on training and managerial leadership seem to be crucial organizational aspects (Beadle-Brown, Bigby, & Bould, 2015; Bigby & Beadle-Brown, 2018; Bigby, Bould, Iacono, Kavanagh, & Beadle-Brown, 2019; Deveau & McGill, 2016a, 2016b, 2019). As Bould, Beadle-Brown, Bigby, and Iacono (2016) stated, implementing a new vision or support service is often supported by training and practice leadership, as well as performed through generally good management and proper working relationships. In practice, organizations' long-term commitment to change, translated into managers' and psychologists' practice leadership, with guidelines and information for staff and a focus on transparency in working relationships, is important for managing challenging behaviours (Deveau and McGill, 2019; Deveau, Gore, & McGill, 2020; Olivier-Pijpers, et al., 2018; Schippers, 2019; Tournier et al., 2020; Walker, 2012). During organizational changes, continuous discussions on aligning staff attitudes with the organizational vision, staff training in positive attitudes and reduced restraint use, and sufficient information about residents' needs to enhance resident–staff bonding are also necessary (Olivier-Pijpers, Cramm, & Nieboer, 2019; Philips & Rose, 2010; Walker, 2012). Future studies should seek to determine how organizational changes can enhance management of challenging behaviours without a "messy" transitional process and negative consequences for staff and residents.

4.1 | Limitations

This study has several limitations. First, it was conducted with only two Dutch disability service organizations, which might limit the findings' generalizability. Analytic generalization, however, remains possible; other cases can be examined to identify similarities and differences, with reflection on these with respect to organizational changes (Forrest-Lawrence, 2019; Rodgers et al., 2016; Yin, 2018). Residents and their representatives were not invited to the focus groups, as the research topic was "organizational changes," into which organization employees are likely to have the most insight. Their perspectives should be considered in future research. Additionally, focus groups have limitations, which we tried to manage by providing clear action plans, using independent and

trained group moderators, and working to create a safe and open setting. the present authors also used other data sources (meeting records and organizational documents); however, the large amount of data was difficult to manage, which was complicated by the lack of clear rules on how to extract themes. Finally, the present authors used ecological theory as a sensitising framework, which helped us to unravel aspects of supplementary changes at multiple levels, but can also pose limitations. Models of organizational change (cf. Finlay, 2000) may help all multiple phases in change processes to be examined, and the use of such models may have allowed us to better unravel these phases of organization change. Further, a multidimensional contextual paradigm, instead of the person–environment paradigm of ecological theory, may provide supplementary insight for multiple levels, factors and interactions that facilitate or hinder changes in residents' support and lives (Schalock et al., 2020; Shogren et al., 2018, 2020).

4.2 | Conclusions

Organizational changes can enhance support services and, in turn, positively influence residents' behaviours; however, they can also limit support services. Thus, organizational changes made in the context of providing support services to residents with intellectual disabilities and challenging behaviours should be made with great thoughtfulness and long-term organizational commitment, and prioritize support service quality and improving management of challenging behaviours.

CONFLICT OF INTEREST

No conflict of interest has been declared.

ETHICAL APPROVAL

The Dutch Central Committee on Research Involving Human Subjects confirmed that this research did not fall under the scope of the Medical Research Involving Human Subjects Act. Participants gave their consent prior to the study.

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How to cite this article: Olivier-Pijpers VC, Cramm JM, Landman W, Nieboer AP. A multiple case study investigating changes in organizations serving residents with intellectual disabilities and challenging behaviours. *J Appl Res Intellect Disabil*. 2021;34:190–199. https://doi.org/10.1111/jar.12797

APPENDIX 1

Standard method for creating meeting records

Detailed written records were created after meetings related to Centre for Consultation and Expertise (CCE) consultation, according to the following instructions:

1. Provide written information on the characteristics (e.g. intellectual disabilities, challenging behaviours) and history of the resident for whom the CCE consultation is being conducted (Bronfenbrenner's chrono-, onto-, micro- and mesosystem levels)
2. Provide written information on staff members' and other care professionals' difficulties in support services, and the reasons for and people involved in the CCE consultation (at the chrono-, meso- and exosystem levels)
3. Recollect and provide information about a meeting during the CCE consultation that exemplifies how care professionals (e.g. staff members, psychologists, physicians), managers and representatives are working together in providing support services and managing the resident's challenging behaviour (at the meso- and exosystem levels)
4. Record what you saw, heard and felt during the meeting without interpretation

Focus group action plans

Action plan for phase-one and phase-two focus groups

These focus groups were held to discuss organizational changes made during CCE consultations and were held in data collection phases one and two. They were conducted using the following action plan:

1. Read information provided by staff members and psychologists on the characteristics (e.g. intellectual disabilities, challenging behaviours) of residents for whom CCE consultations had been started during the relevant period, and on staff members' and other care professionals' difficulties with the support services (Bronfenbrenner's onto-, micro- and mesosystems)
2. Discuss detailed written records of meetings held with multidisciplinary teams, representatives and/or professionals regarding CCE consultations conducted during the relevant period (meso- and exosystems)
3. Discuss contemporaneous organizational aspects and changes in the context of residents (chrono-, meso-, exo- and macrosystems)
4. Discuss possible relationships among these aspects and changes in the context of residents with intellectual disabilities and challenging behaviours and the staff members responsible for them (chrono-, micro-, meso- and exosystems)

Action plan for phase-three focus groups

These focus groups were held to discuss organizational changes made during CCE consultations in data collection phase three. They were conducted using the following action plan:

1. Construct a timeline of participants' involvement with the organization, their residents and CCE consultations to determine the period of interest
2. Discuss key moments in that period in which organizational aspects and changes positively affected professionals' work in the context of residents for whom CCE consultations had been conducted (and other residents in the group home or with similar care needs; Bronfenbrenner's chrono-, micro-, meso-, exo- and macrosystems)
3. Extract and discuss key elements of organizational aspects and changes based on these key moments (chrono-, micro-, meso-, exo- and macrosystems)