



# An Evaluation of the Use of Focus Groups in Services for Adults with Congenital Deafblindness

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## Abstract

This practice report is based on three practice-based projects which structured video analysis sessions using a focus group model. The aim of the projects was to improve the quality of services for adults with congenital deafblindness by supporting partner competence. The focus groups were composed of the partners of adults with deafblindness. The video analyses were guided by a consultant-moderator and based on two intervention models and a set of theoretical concepts described by Nafstad and Rødbroe in *Communicative Relations* (2015). The results of the semi-structured interviews and questionnaires indicated that the focus group members experienced more partner competence and that the group home became an environment where discussions on content were prioritized. Stable, positive, long-term effects could be achieved by systematic, ongoing implementation of the focus group model by qualified moderators and group home leaders. The positive effect of working with focus groups, where shared understanding and shared intervention goals are co-created in a continuous process, improved the quality of the services.

## Key Words

Congenital deafblindness, adult services, focus group, video analysis, planned intervention, partner competence, quality of services, theoretical framework, structured collaboration.

## Introduction

Three projects were conducted in group homes for adults with congenital deafblindness at MoGård in Sweden, at the Center for Deafblindness and Hearing Loss in Denmark and at the Deafblind Center at Signo Andebu in Norway. These projects targeted planning communicative interventions on the basis of analysing videos of adults with congenital deafblindness in social network groups. A network group consists of social partners from all the life arenas of the person with deafblindness, including professional social partners such as caregivers and social workers in group homes, and personal social partners such as parents and siblings. The Swedish project was conducted from 2000 to 2002 (Nyling, 2003), the Danish project from 2004 to 2006 (The Center for Deafblindness and Hearing Loss, 2007), and the Norwegian project from 2011 to 2013 (Rødbrøe et al., 2014). Of the three projects, the Norwegian one was performed the most systematically, as a result of the experiences and outcomes of the previous projects in Sweden and Denmark.

This report will first describe the development of the ‘focus group model’, then the method of working with focus groups and our results, with an emphasis on the Norwegian Project. It will then discuss the results in relation to different projects, differences in theoretical background, important qualitative outcomes and several limitations. Finally it closes with a clear conclusion.

### Developing the Network Model in a Focus Group Model

The method of working in social networks applied here, ‘the network model’, was developed in collaboration between the Regional Center for the Deafblind and the School for the Deafblind at Skådalen in Oslo and was later adapted to the adult area in the Swedish and Danish projects.

When the Norwegian project was conducted, the organization of the video analysis sessions was progressively disciplined by the principles which inform focus groups (Markova, Linell, Grossen, Orvig, 2007) as described in *Communicative Relations* (Nafstad & Rødbrøe, 2015). The point in focus groups is to develop shared knowledge about something relevant to the here-and-now. In this case, videos of adults with deafblindness interacting with their seeing/hearing partners are the topic of relevance.

### Theoretical Models and Concepts

The theoretical models and concepts described in *Co-creating Communication* (Nafstad & Rødbrøe, 1999) and in *Communicative Relations* (Nafstad & Rødbrøe, 2015) were more systematically applied in the Norwegian project than in the previous projects in Sweden and Denmark. Nafstad and Rødbrøe (2015) describe how video analysis can be guided by two intervention models and a set of relevant theoretical concepts. The first model, *the Diamond*,

defines the basic relationships as prioritized target areas in planned intervention; and the second model, *the Cue Model*, illustrates each of these target areas from a developmental perspective. For example the main cues in social interactive play are 'attunement', 'contact', 'turn-taking' and 'joint attention about an object' and in conversations 'proto-conversations based on emotional expressions' is the first cue and 'real conversations based on conventional signs' are the last one.

Analysing videos based on clear theoretical models complies with official Nordic requirements for institutions offering services to people with disabilities. These requirements are known as evidence-based practice. In the deafblind field we understand evidence-based practice as a practice inspired and informed by theory. In the case of congenital deafblindness the theories must be applicable to all possible variations of the condition, including those also affecting the bodily-tactile senses.

### **Services for Adults with Congenital Deafblindness**

Services for adults with congenital deafblindness differ in many ways from services for children with deafblindness. In most countries services for adults are provided fewer resources than services for children. Fewer resources result in fewer opportunities for one-to-one communication, which most people with deafblindness need. Children with deafblindness have a right to be educated on the basis of individual plans focusing on developing communication. The same right does not exist for adults with congenital deafblindness. However, most adults with congenital deafblindness have the potential to develop communication further. Moreover, adults who have already developed their communicative competence need competent communication partners every day to experience quality in their lives.

The tradition in adult services is to focus on care and independence. Focusing on the development of communication is not always a natural part of daily practice.

The standard training for carers for adults with deafblindness is less extensive than that required for children's services in most Nordic countries. Consultant services are available in all Nordic countries, but they are not always provided by local authorities or prioritized by staff or management at group homes.

A Danish survey conducted from 2002 to 2004 (The Danish Resource Center on Congenital Deafblindness, 2004) found an increase in the number of adults with congenital deafblindness. The adult group (aged 18 and over) increased by 39 people or 70.9% during the survey. It is therefore to be expected that a considerable number of adults with congenital deafblindness received services planned for other disability groups as they grew up. Most of the newly identified adults in the Danish survey were in services for people with intellectual disabilities.

### **Specific Challenges for the Partners of Adults with Congenital Deafblindness**

When Nafstad and Rødbroe (1999) developed *the Diamond* and *the Cue* models in the late 1980s and the 1990s the focus was on targeting communication interventions for children with congenital deafblindness. As the intervention focus of the models is to establish, stabilize and develop the basic processes in communicative relationships, it seemed more relevant and natural to apply the models to deafblind children than to adults. However, staff experienced that a group of deafblind adults suffered from long-term deprivation of access to basic environmental relations in the domain of face-to-face interaction (Nyling, 2003, Ehrlich, 2007). Many adults with deafblindness had learned some communicative skills, e.g. a few conventional signs, which were most frequently used in imperative communication, i.e. to influence environmental events. They were rarely or never engaged in declarative communication, i.e. to show or share something of interest to themselves which could lead to engagement in conversational interactivity. As a consequence some professionals started to adapt the models and the theoretical framework from *Co-creating Communication* to the group of adults with congenital deafblindness.

### **Challenging behaviours**

It was often observed during video analysis sessions that many adults with deafblindness realized less cognitive potential in communicative relations than in moving around or engaging in non-social exploration. Because this gap was caused by a long-term lack of positive experiences from social contexts, negative transactional effects could be observed, such as self-stimulation, self-injury or extreme passivity. Such behaviours challenge the partners of people with deafblindness in many ways, especially in coping with the close bodily emotional contact needed in all social contexts.

### **Low readability**

Low readability is the major challenge partners of children with deafblindness encounter. Partners have to react and respond to behaviours which are different from what they are used to, and in ways which may seem to them unnatural. For adults with deafblindness the problem of readability increases for two reasons: 1) it is more difficult for adults to adapt to the fundamental social contexts of deafblindness because they have long passed the age where such social-relational contexts are naturally formed. 2) Often adults with deafblindness have an uneven developmental profile, characterized by very poor communication. Partners of adults therefore need to be able to plan interventions, focusing on developing basic communicative functions and at the same time addressing areas where functioning has developed to more advanced levels.

### **Limited in communicative relations**

The present group of deafblind adults reflects earlier pedagogical approaches from the 1960s to the 1990s, in that their learning focused less on establishing and developing fundamental social-relational contexts and communication processes as prerequisites for language development. A few children from this group did develop language, but the majority did not, and a large group continue to be very limited in their active communicative relations.

### **Use of the bodily-tactile approach**

The complexity of communicative relations and the limitations of their reduced distal senses obviously mean that communicative interventions with people with congenital deafblindness should always be based primarily on the use of the bodily-tactile senses. The Nordic countries have focused on and developed the bodily-tactile approach in recent decades. Mastering the bodily-tactile approach

## **Methods**

### **Focus Groups in Group Homes for Adults with Congenital Deafblindness**

Working with focus group was chosen as a method to improve quality in services for adults with deafblindness by supporting partner competence. The three days of staff development in the Norwegian project started by implementing the three different focus group models in two group homes for adults with congenital deafblindness at Andebu Deafblind Center. The staff training started with presentations addressing how different theoretical frameworks have informed how communication development is supported in services for people with congenital deafblindness, from the early start in the late 1980s down to the present day. One of the presentations focused on dialogical theory and how this thinking has enriched and changed daily practice. The objective was for the external consultant who performed the staff training to implement the focus group method, and that after three focus group meetings, four consultants at Andebu Center would adopt the role of focus group moderator. The moderators worked in pairs, two for each group home, and were supervised by the external consultant.

Inspired by the experience gathered from the Swedish and Danish projects, it was decided to run focus group meetings for three hours every third month. First, the external consultant acted as and modelled the role of moderator, supported by the consultants. All the social partners involved with the relevant adult with deafblindness were invited as focus group members, including the families.

Some of the parents and one of the sisters who joined the first focus group meetings subsequently decided only to receive reports of later meetings. Needing to travel long distances influenced these decisions.

The daily leaders of the two group homes were included as permanent focus groups members to support them in fulfilling their role as the people responsible for the quality of the services.

### **Introduction to the focus group model**

An introduction was presented by the external consultant at the first meeting of each of the three focus groups. The main purpose of this introduction was to explain how the 'focus group model' works and why it is a useful model for structuring video analysis sessions.

Another issue was to clarify the roles of the various members of the focus groups, e.g. what is expected from each of the participants, and what the participants could expect to gain from being focus group members.

This introduction emphasized that the main purpose was to identify relevant intervention targets and to reach agreement on these intervention targets. Working in focus groups creates awareness that adults with deafblindness usually have many different people fulfilling the partner role. As the communicative development of each adult with deafblindness has to be planned in detail and the partner role differs from how partners would intuitively act in their relations with other people, intervention goals are at risk of not being coordinated. If this happens the risk is that the partners would not have an unambiguous understanding and thus a sufficiently similar way of relating to the deafblind person. A shared understanding of the intervention goals with as many partners as possible ensures that the communicative functions focused on can become strong and stable, which is a prerequisite for further development.

It is therefore important that all the partners of an adult with deafblindness join the focus group in their own role, e.g. as partners, consultants and group leaders, to ensure that as much information as possible is made explicit during the video analysis and during the discussion of the video at the meeting. The result of the shared knowledge emerging from all the different perspectives and experiences will exceed the sum of all the contributions, as during the discussion each participant tends to be inspired by the contributions of others.

It was highlighted that the outcome of the session depends on the participants' willingness to share their opinions, knowledge and experiences, and their willingness to take on the role of listening and acknowledging people. It was underlined that all the partners had to pursue and attempt the intervention goals agreed on at the meeting.

The presentations on dialogical theory focused on trust in the partner and the experience of feeling worth being listened to as preconditions for people with deafblindness to feel free to express themselves in their own voices (Nafstad, 2015).

It was not difficult for the participants to compare this knowledge to collaboration in a focus group. Reflections on how too much agency from one participant or from the group leader might silence the rest of the group were addressed and discussed in the group.

### **Discussing and analysing the video clip**

A video was presented by one of the social workers after the presentation and discussion at the first meeting. The video clip presented a well-functioning interaction or communication sequence between the adults with deafblindness and one of the partners present at the meeting.

The moderator tried to model the principles for picking out a small sequence for detailed analysis using the first quality criteria, described in *Communicative relations*: a sequence where the person with deafblindness was more active than in the rest of the video.

Basic principles for shifting the analytic focus were used for the detailed analysis, including questions such as What does the person with deafblindness focus his/her attention on? What does the partner focus his/her attention on? Do the partners share attention or is each occupied with his/her own project? When the person with deafblindness is active, does the partner respond in a way which is perceived by the person with deafblindness?

In making their suggestions, the participants were asked to try to point to the observational cue on which they based their interpretation. The discussion was thus disciplined by differentiating observational cues and interpretations. Joint attention can be paid to observational cues while interpretations can differ and be discussed.

During the analysis the moderator tried to relate the various practical contributions from the participants to some of the theoretical principles, the concepts and the two intervention models described in *Communicative Relations*.

### **Agreeing on intervention goals**

Many participants were active and some listened with interest during the analysis. Many ideas for improving the quality of the relations were suggested. They were written down and at the end of the analysis the participants were asked to agree on two or three of the suggestions for future intervention targets.

After identifying the intervention targets, examples of how they might be applied in daily practice in the different life arenas and in different activities were discussed.

The intervention targets for a woman with deafblindness as agreed on by the focus group members after the first focus group meeting included that:

- Partners should try to comment on what happens here-and-now in shared activities
- Partners should try to be tactile in all togetherness using hands and body

The video from the analysis was used to point to moments where a comment could be added. The bodily-tactile approach was tried out by the participants in practical examples.

Written intervention targets were distributed to all the participants after the meeting.

### **Following up the agreements**

The intervention goals were tried out in practice by the participants in all the life arenas of the person with deafblindness in the run-up to the next focus group meeting. Video recordings of these trials were to be discussed at team meetings. Logbooks focusing on written examples from the trials were introduced. One or two videos from the trials were analysed at the next focus group meeting to evaluate the intervention targets and form the basis for intervention targets for the next trial period. The consultants from the centre were available if the team needed support during the trial period.

### **Evaluation in a semi-structured interview**

After the first meeting which introduced the focus groups, each meeting started with an 'evaluation round-up'. The participants were asked briefly to share their experiences from the trial and from applying the focus group model. This round-up served two purposes:

- The participants experienced the roles of speaker and listener (Nafstad, 2015).
- The round-up gathered statements which could be used as feedback for the consultants to develop the focus group model further.

Once the group was functioning as a safe place where everybody felt free to speak, the round-up was replaced by a brief introduction about the trials and a short report from the logbooks.

### **The Data Collection**

Various data was gathered to evaluate whether working in focus groups improves the quality of services for adults with deafblindness, through semi-structured interviews from the focus group meetings and written questionnaires with additional comments from the social workers, the group home leadership and the consultants. The data was mainly qualitatively analysed in four themes:

- 1) The overall impact of the project
- 2) Change in the professional environment at the group home
- 3) Quality of the relations between the partner and the deafblind person
- 4) Self-awareness of competence.

### **Long-Term Effect Evaluation**

According to the project plan, the questionnaires and the interviews should have been administered immediately after the external consultant stopped attending. However, owing



to various organizational changes this process was postponed until two years after the start of the focus groups. A fortunate effect of the delay was that the final results included information about the long-term effect.

## Results

### Results from the Norwegian Project

The results of the questionnaires are based on answers from 23 social workers. Most questionnaires were completed at focus group meetings two years after the start of the group. The results are presented in Table 1.

**Table 1**

*Data Focus Groups Norwegian Project.*

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<b>Data Category</b>	<b>The overall effect of the project</b>	<b>Participant</b>
Semi-questionnaire	<i>'I am so grateful to experience how so many people try to do the best for my child'. 'I am happy to experience that we can share the positive as well as the difficult moments'.</i>	Family member
Interview	22 out of 22 understand the intervention goals.	Social worker
Interview	23 out of 23 feel responsible for following the intervention goals.	Social worker
Additional comments	<i>'When we collaborate in a focus group we become much more aware of how we are together – how we discuss and inspire each other'.</i>	Social worker
Additional comments	<i>'I find collaboration in focus groups efficient and valuable'.</i>	Group home leader

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<b>Data Category</b>	<b>Change in the professional environment in the group home</b>	<b>Participant</b>
Semi-questionnaire	<i>'I experience more professional awareness and more discussion on the content in my group home'.</i>	Group home leader

Semi-questionnaire	<i>'I experience more professionalism in the group homes'.</i>	Consultants
Written Interview	The staff need regular support from consultants	Group home leader
Additional comments	<i>'My leader acknowledges me and I experience my deafblind partner's "happiness".'</i>	Social worker
Additional comments	<i>'One of the reasons why I enjoy my work is the strong network that exists around each deafblind person and the staff member.'</i>	Social worker

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<b>Data Category</b>	<b>Quality of the relations between the partner and the deafblind person</b>	<b>Participant</b>
Semi-questionnaire	<i>'I like to see the theoretical concepts played out in practice'.</i>	Social worker
Semi-questionnaire	<i>'I experience now that my deafblind partner contributes more and I now see his contributions as meaningful'.</i>	Social worker
Semi-questionnaire	<i>'I have experienced that relations function better when I am more tactile'.</i>	Social worker
Written Interview	<i>'I experience more professional focus on each deafblind individual'.</i>	Consultant
Additional comments	<i>'My deafblind partner has become more interested in me as a partner, which means that I have become more interested in him'.</i>	Social worker

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<b>Data Category</b>	<b>Self-awareness of competence</b>	<b>Participant</b>
Semi-questionnaire	<i>'It is easier to be a leader responsible for the content when you know what is being focused on just now and why this focus is necessary'.</i>	Group home leader
Semi-questionnaire	<i>'Supervising in a focus group model makes it more fun and more challenging to be a consultant'.</i>	Consultants
Written Interview	We need specific deafblind courses and collaboration with leaders from the field to be able to support the staff.	Group home leaders
Written Interview	The requirements for consultants working as leaders of focus groups demand a lot of knowledge and specific competences.	Consultants
Written Interview	<i>'I experience that the staff is more open for developing as competent partners and more aware of the role they play in the</i>	Consultant

*relation*'.

Written Interview	We need formal deafblind-specific education, collaboration with colleagues, time for literature studies and external supervision.	Consultants
Interview	23 experience themselves and their deafblind partner as more competent now.	Social worker
Interview	Aware of being a competent partner 12 often – 9 sometimes – 0 never	Social worker
Interview	Aware why you are a competent partner 0 very rare – 10 to some degree – 11 very often.	Social worker
Additional comments	<i>'I am inspired by thinking before acting'</i>	Social worker

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Agreements and disagreements in the four main themes are analysed and described in the following sections.

### **The overall effect of the project**

Families, social workers and leaders agreed that sharing and collaborating in focus groups is efficient and valuable. The families were grateful for the focus on their child and the social workers felt responsible for following the agreed intervention targets.

### **Change in the professional climate in the group home**

The leaders of the group homes and the consultants notice that the group home has changed into an environment where content is focused on and discussed.

The social workers appreciate acknowledgment from their leaders and enjoy working in a team.

### **Quality of the relations between the partner and the deafblind person**

Consultants indicate that they experience more focus on the person with deafblindness. One social worker is able to recognize theoretical concepts in practice and more social workers are aware of how their own contribution affects the quality of their relation with the person with deafblindness. The social workers are more aware of the competence of the person with deafblindness.

### **Awareness of competence of self**

The answers show that the leaders, the consultants and the social workers need specific education, support and collaboration with peers to feel competent in their role. In the questionnaire all the social workers answer that they feel competent but only half of them are aware of why they feel more competent.

### **Additional Results from the Danish and Swedish Projects**

In oral interviews at the end of the Swedish and Danish projects, the staff and the leaders expressed that more specific deafblind knowledge had developed in the focus groups during the two-year project period. More focused intervention targets had improved the quality of the daily practice, which could be observed in the communicative relations between partners and the deafblind person in focus. In two cases the challenging behaviour of the deafblind person decreased considerably (Nyling, P., 2003, *The Center for Deafblindness and Hearing Loss*, 2007).

The participants in the Danish network groups expressed that they found it difficult to share the knowledge they gained during the focus group meetings with colleagues who did not participate in the focus groups. The project did not lead to an overall change in the professional climate of the group homes.

Experiences from both projects showed that the structured way of working with video analysis gradually disappeared when the project ended and the guided video analysis sessions ceased.

## **Discussion**

The three projects considered the effect of video analysis in focus groups as having a positive effect on partner competence and thereby on the quality of services. Only the Norwegian project was systematically evaluated and showed a long-term effect, including improvements in the professional environment in the group home.

### **The Overall Effect in Different Projects**

The aim of the projects was to evaluate whether working in focus groups improves the quality of services for congenitally deafblind adults. Data and experiences show that the model has proved effective in planning, trying out and evaluating intervention goals based on video analysis sessions, and proved in all three projects to support the development of competent partners in the short term.

The focus group model and the use of video analysis did not have a long-term effect in the Swedish and Danish projects. The focus groups in the Norwegian project continued to

function after two years, as qualified consultants still guided the sessions. The use of an external consultant in the three projects served two purposes at the same time: to develop and to model a strategy for running focus groups in adult services. However the consultants all stressed the need for more knowledge. Working in pairs, as in the Norwegian project, was experienced as a big advantage by all four consultants.

### **Qualification of the consultant- moderator**

It appeared crucial that the consultants who implemented the focus group model in the meetings were appropriately trained. The training for moderators used in the Norwegian project proved useful. They received a three-day course (18 hours) on the content of '*Communicative Relations*' (Nafstad & Rødbrøe, 2015), more specifically on the *Diamond Model* and the *Cue Model* and on different theoretical concepts of dialogical theory, such as trust, partner perspectives, roles and perspectives in the different relations, and primary, secondary and tertiary intersubjectivity. They were also trained in how to conduct a focus group and clarify the roles of the different group members. Support was offered by an experienced external consultant, who not only modelled the first three focus group meetings, but also supervised the consultant-moderators during the whole two-year project period.

### **Differences in the theoretical framework and in the performance of the three projects**

A common knowledge platform was presented in the three projects during three days of staff development focusing on the theoretical framework that the projects were based on. In the Norwegian project the sessions were inspired and informed by dialogical theory in the analysis, in developing the group process, and in clarifying the roles of all the participants, as described in the previous section.

The different roles were not explicit in the Swedish and Danish projects. Nor did the induction address the need for an environment where all members feel free to speak and ready to listen to foster a creative group process. The theoretical framework was different in these earlier projects, as was the role of the group leader. The group leader played a more active role, which influenced the group process negatively. It was more difficult to establish a climate of trust. Competition among partners was experienced as one of the reasons for the focus groups ceasing to function.

### **The role of the moderator**

The consultants and the group home leaders emphasized that the role of the focus group moderator is essential and demanding, as it has to balance between being a facilitator of the knowledge-creation process in the group and the expert responsible for the quality of the analysis.

When groups function well, the role of the moderator gradually changes, as could be observed in some of the groups. The participants became more active and the moderator less active in running the video analyses. One important aspect in this process is that the participants gradually started to be able to single out the short video clips where the person with deafblindness displays his/her best performance and could thereby point to emerging new functions or identify the Zone of Proximal Development (ZPD).

### **Change in the professional environment and the role of the leader in the group home**

The evaluations, the feedback at focus group meetings and the data in the three projects showed that sharing knowledge and working systematically with agreed intervention targets form a basis for developing a professional environment where theoretical and practical issues are shared and discussed openly and where staff members experience trust and acknowledgement.

In addition, it showed that the development of a climate of professionalism and trust depends on how the group home leaders fulfil their roles. In a semi-structured interview, one of the group leaders expressed that a leader needs to have enough knowledge about the content to be able to be responsible for the quality of the service. Such responsibility includes being able to set priorities e.g. scheduling time for video analysis, time for discussions on the content and time for continuous staff development.

The leader's engagement, presence in the group home and ability to balance between establishing clear objectives for the staff to follow and the ability to acknowledge and support the staff influence both knowledge-sharing, creativity and the quality of services. It was experienced in the projects that the sustainability of the focus group was dependent on how the leader prioritized and valued this working model.

### **The quality of the relations between the partner and the person with deafblindness**

When quality of services improved, staff were able to observe increasing engagement by the person with deafblindness in communicative relations. One partner explained that she

had noticed that her partner with deafblindness was happier and more active, another that she experienced that her partner with deafblindness took greater interest in her. Both reports indicate that the social partners are more aware of the competences of the adults with deafblindness in question. During the analysis, examples of videos illustrating how already established skills began to function in new and more relational ways as the basic communicative functions were established, re-established or strengthened. In these cases the adults with deafblindness developed more quickly than expected. In other cases, basic communicative functions such as co-creating reciprocity required continuous and often increasingly detailed focus on the intervention goals.

### **Self-awareness of competence**

The data showed that all the groups stressed the need for different forms of staff development, including formal education, collaboration and supervision, to be able to fulfil their roles. Professionals commonly want more knowledge when they find that new knowledge makes their work more interesting and fun.

It is remarkable that all the social workers responded that they felt competent, but only half were aware of why they were competent. Feeling competent may be more related to external acknowledgment from leaders, consultants, family members and colleagues, whereas awareness of confidence concerns a strong inner sense of being competent, or as Buelund describes it in her research (Buelund, 2015), having a strong inner I-position. Buelund concludes that a strong I-position is essential to being able to transfer knowledge learned at courses into action in daily practice. The results from the data in the Norwegian project indicate that external acknowledgment is important for developing awareness of being competent. Moreover, the data indicate that this need must be complemented by more theoretical knowledge to give partners the inner sense of being confident in their role as partners.

### **Collaborating with families**

In focus groups for children with congenital deafblindness the role of family members is important and natural. From the very beginning, they are included in their child's communicative development. In addition, most of them take part in sessions with video analysis together with professionals. In the Nordic project this way of collaborating was new for most of the families. It was obvious that both the families and the staff members found their new roles in this collaboration challenging. That is probably one of the reasons why

parents chose to leave the focus groups. The children here were adults. Parents of adult children cannot be expected to continue to take on the role of advocates for the quality of services for their children if they are not directly involved in the services. The management of the adult services therefore have an important role as advocates for the quality of the services for each adult with deafblindness.

### **Documentation**

The authorities currently require increasingly large volumes of documentation for each individual person with deafblindness receiving services. The focus group model structure provides material for producing ongoing video documentation of the development of an individual, supplemented by notes describing the intervention goals and trials in logbooks. Such ongoing documentation can be used in future longitudinal studies of deafblind communication which could add to the knowledge of communicative development under difficult circumstances.

### **Staff ratio**

The staff ratio in the Swedish project was high, with frequent options for engaging in one-to-one communicative relations during most of day. In the Danish project the staff ratio was lower. Staff members were often responsible for two or three adults with deafblindness at the same time. In the Norwegian project the staff ratio was one-to-one for most of the day. However, there are no clear indications that a high staff ratio automatically leads to a higher quality of services. This statement is based on observations of the quality of the services at the start of the three projects and the experiences from other services for adults with deafblindness. However, it is obvious that a high staff ratio has a positive effect on how focused the trial was. The evaluation of each trial is presented in the video documentation which forms the basis for evaluation and future intervention planning. The availability of the consultants during the Swedish and Norwegian projects proved essential for maintaining the focus on the intervention goals. The staff ratio thereby influenced the quality of the services for the adults involved in the projects.

### **Limitation of the results of the projects**

The material gathered for this practice report is limited by the small number of participants, namely the numbers of leaders and consultants. The Swedish and Danish results are limited because no relevant data from the evaluations are available. The



documentation of these projects (Nyling, 2003), (The Center for Deafblindness and Hearing Loss, 2007) describe and illustrate the communicative development of three deafblind adults but do not address the working model. However, the differences between the projects in the theoretical framework, the models for organizing video analysis sessions and the short-term and long-term effects have provided relevant information for this report.

## **Conclusion**

It can be concluded that working with video analysis in focus groups is an effective way of structuring sessions focusing on developing a goal-directed practice with reflective, creative and curious staff members who share and collaborate. The success and the sustainability of a focus group is dependent on qualified consultant-moderators and competent group home leadership.

Increasingly many institutions offering services for people with disabilities are having to prioritize how resources are used. The result of these projects indicate that priority should be accorded to training the consultants who run focus groups and the group home leaders, as they are the ones deploying knowledge and competence directly to the people with deafblindness.

Focus group sessions are part of the ongoing staff development programme which families and all professional groups need, to secure quality in the services they provide. The advantage of this form of staff development is that all the partners develop together and thereby share a common and explicit theoretical framework which makes it easier to create an environment where open discussions on content is a part of the culture.

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