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The role of practice leadership in active support: impact of practice leaders' presence in supported accommodation services

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Objectives: Research shows practice leadership to be a factor in the successful implementation of active support. The aim of the study was to explore differences in staff practice, associated with the presence of a practice leader in a shared supported accommodation service.

Methods: Quality of support and engagement for 189 service users with intellectual disability from 58 services were collected during a 2 h observation using the EMAC-R and ASM. The practice leader was present in 19 services ($n = 59$) and absent in 39 ($n = 111$). An Observed Measure of Practice Leadership was administered during a second visit to each service.

Results: When the practice leader was present, levels of engagement and active support were statistically higher ($p < 0.01$). Although measured at a different time, observed practice leadership was also higher in services where the practice leader was present during the first observation.

Conclusion: The level of observed practice leadership and presence of the practice leader appear to be associated with better quality of support. This finding provides further evidence of the importance of systems for supporting, monitoring, modeling, and improving staff practice for effective implementation of active support.

Keywords: implementation, engagement, active support, practice leadership, supported accommodation

Active support, a person-centered approach, is a way in which staff or other caregiver enable people with intellectual disabilities to engage in meaningful activities and relationships (Mansell and Beadle-Brown 2012). Successful implementation of active support has been found to increase levels of engagement and improve skills, reduce challenging behavior, increase people's involvement in their own home and the community, increase choice and control, and improve mental health (for reviews see Mansell and Beadle-Brown 2012, chapter 3; Mansell *et al.* 2013; Stancliffe *et al.* 2008). However, in shared supported accommodation services (24 h staff support provided in group homes) implementation and maintenance of active support have been found to be neither easy nor straightforward (Mansell and Beadle-Brown 2012; Mansell *et al.* 2008).

One of the factors suggested to strengthen the implementation of active support is staff training, in particular combining classroom-based teaching of principles with *in situ* hands on coaching to put theory learned in the classroom into practice (Jones *et al.* 2001a, 2001b). However, training on its own has been shown to be insufficient

to bring about or maintain change in staff practice over time (Mansell and Beadle-Brown 2012). On the basis of previous research and experience of working with organizations, Mansell and Beadle-Brown (2012) went on to propose that support at the organizational level for ongoing staff development as well as the provision of a motivational context for active support is also needed. One element of this motivational context that has been explored in the active support research literature is practice leadership, a term used to refer to the individual who has direct front-line responsibility for leading the practice of staff on a day-to-day basis; this role may be combined with other responsibilities across one or more services. Practice leadership was defined by Mansell *et al.* (2004) as the implementation of practices by the front-line manager (practice leader) of a staff team within a shared supported accommodation service to develop and maintain good staff support for service users (i.e. accommodation residents). These practices were operationalized by Mansell *et al.* (2004) according to five domains: that is, leaders (a) focusing on staff supporting the quality of life of service users, (b) allocating and organizing staff support to meet service users' needs and wants, (c) coaching staff through feedback and modeling of good practice, (d) regularly reviewing individual staff practices, and (e) reviewing

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in team meetings how well staff teams enable the active engagement in meaningful activities and relationships of service users. This conceptualization draws on both general human services literature (e.g. Anderson 2013; Cherniss, 1980; Werner and DeSimone 2006) as well as literature more specific to intellectual disabilities (Deveau and McGill 2015; Schalock *et al.* 2008). Deveau and McGill (2015) emphasized the importance of practice leaders directly observing and monitoring staff practice, noting the inadequacies of relying on paperwork-based quality assurance mechanisms. Certainly, research has shown that sustaining good staff practice requires good quality management and leadership (Beadle-Brown *et al.* 2012; Clement and Bigby 2007, 2012; Hewitt *et al.* 2004; Reid and Parsons 2002). Although the wider literature (i.e. not specific to intellectual disability) does not directly address the importance of managers just being present in services, Peters and Waterman (1982) referred to the importance of ‘management by walking about’ (p. 122) as an important management monitoring strategy.

Beadle-Brown *et al.* (2014) found that practice leadership was a contributing factor in change in the implementation of active support over time, but, generally, only within the context of good management. Their study relied on staff-rated measures of practice leadership which the authors argued are problematic as staff perceptions are limited by their experience and expectations of managers, and can be biased due to social desirability and different interpretations of questions. This led to the development of the Observed Measures of Practice Leadership (Beadle-Brown *et al.* 2015) which is demonstrated as a more reliable measure of practice leadership (Bould, Beadle-Brown, Bigby, Iacono *in press*). This measure includes an interview with the front-line manager and observations of their practice, and a review of paperwork. Significant positive relationships were found between the level of active support and practice leadership scores, both overall and on all five domains, for 58 disability services in Australia.

The interview transcripts and field notes from Beadle-Brown *et al.* (2015) were full of examples of practice leader uncertainty about what happened when they were not physically present in the service, and whether staff continued to use active support as consistently as they did when the practice leader was present. In the absence of published research related to the impact of the practice leaders’ presence in services, these field notes provided examples of the issues raised by practice leaders and observers. The field notes recorded, for example, that one practice leader had said that staff will work in the appropriate ways when he is working with them or doing observations, but felt ‘it is only a put on when I’m there’ and that when he is not there ‘they turn around and go back to the old ways [and some staff] take short cuts all the time by, for example, making residents toast and cups of tea’ (unpublished field note, Beadle-Brown *et al.* 2015). Another practice leader said that although staff provided

good support when he was on shift with them, feedback from service users made him aware of inappropriate staff support when he was absent from the house. This practice leader said, for example, that ‘One staff member bribes residents with food and lollies in order that he has a good shift and everyone is quiet’ (unpublished field note, Beadle-Brown *et al.* 2015). In contrast, some practice leaders felt staff did work in a consistent manner irrespective of their presence. Their judgments were based on observations of the service users’ behavior and well-being. One practice leader said, for example, ‘We don’t have behaviours. You’d have behaviours if staff are not being consistent because these people play staff against staff’ (unpublished field note, Beadle-Brown *et al.* 2015).

These qualitative data, collected during the process of rating practice leadership on the observed measure reported by Beadle-Brown *et al.* (2015) provide some indications that the way some staff work may be dependent on the presence of their line manager, thereby indicating staff reliance on external motivation and failure to internalize the values implicit in active support. Further, the qualitative data pointed to reliance on practice leadership presence as an indicator of poor practice leadership. If leadership were effective, then one would expect a culture of good practice to be embedded within a staff team and thus occurring at all times, regardless of the leaderships presence or absence. We drew on a subset of data from one year of an ongoing longitudinal study being conducted by the research team and colleagues (Beadle-Brown *et al.* 2015; Mansell *et al.* 2013) to test this premise. In this study, data are being collected on the quality of support, levels of service user engagement and observed levels of practice leadership. These data were used to address the aim of the current study: to investigate whether better support and outcomes are observed when practice leaders (front-line managers) are present than when they are absent. The research questions were: (a) is the quality of practice leadership associated with better staff practice? And (b) are the quality of active support and levels of service user engagement higher when a practice leader is present in the service?

Method

Participants and settings

The data were drawn from the longitudinal study of a cohort of supported accommodation services managed by nine organizations across three states in Australia. One organization was a regional branch of a government department and the others were not-for-profit agencies. Reported in this study are findings at the overall level across all nine organizations from one year of data collection (2013). Data were available for 187 service users from 58 services supporting from one to nine service users with intellectual disability. Further information on the characteristics of the people involved in the study is reported in the results section below. Approval for the longitudinal study from which the data were drawn was obtained from La Trobe University Human Ethics Committee.

Measures

Service user needs and characteristics

A measure of user needs and characteristics was obtained by questionnaires completed by a key worker or another member of staff who knew the individual well. Questionnaires included the short form of the Adaptive Behavior Scale (SABS) Part 1 (Hatton *et al.* 2001) and the Aberrant Behavior Checklist (ABC) (Aman *et al.* 1995). There were additional questions, such as gender, date of birth, and other disabilities present. The reliability and validity of the Adaptive Behavior Scale (from which the SABS was drawn), and ABC have been studied and reported as acceptable by their authors. A full-scale score for Part 1 of the Adaptive Behavior Scale can be estimated from the SABS using the formula provided by Hatton *et al.* (2001). This estimated full-scale score is presented in the current study. For some analyses, participants were grouped according to having an ABS score of below 151 or 151 and above. Although providing an arbitrary demarcation for severe versus less severe disabilities, this means for categorizing service users has been used in previous studies in which differences across the groups in levels of active support provided have been found (Beadle-Brown *et al.* 2015; Mansell *et al.* 2013).

Engagement in meaningful activity and quality of active support

A momentary time-sampling measure of engagement in meaningful activities and relationships (EMAC-R) (Mansell and Beadle-Brown 2005) was used to measure levels of engagement. Observations were conducted in each house, usually over a 2 h period from 1600 to 1800 h. A 1-min interval was used and each consenting service user present at the time of the observation was observed for 5 min in rotation. The Active Support Measure (ASM) (Mansell and Elliott 1996; Mansell *et al.* 2005) was used as an index of the quality of active support provided by staff, and was completed at the end of the 2 h observation period for each service user observed. The ASM includes 15 items focusing on the opportunities for involvement and the skills with which staff provided and supported those opportunities. Each item is rated on a scale of 0 (poor, inconsistent support/performance) to 3 (good, consistent support/performance). The maximum possible score was 45. For the current paper, we reanalyzed observational data collected by the three observers from the same 58 services reported by Beadle-Brown *et al.* (2015), in which inter-rater reliability was found to be 0.81. Full details of these measures, their administration, and observer training have also been described previously (Beadle-Brown *et al.* 2012; Mansell *et al.* 2013).

Observed measure of practice leadership

The Observed Measure of Practice Leadership, including observer training has been described in detail by Beadle-Brown *et al.* (2015), who reported inter-rater reliability as

0.63. For the current paper, we reanalyzed data collected by four observers, from the same 46 front-line managers (10 of whom had responsibility for two services) reported by Beadle-Brown *et al.* (2015). This data collection involved an additional visit to the service, or one of the services, supervised by the practice leader (front-line manager), during which a short period of observation of 10 to 30 min was undertaken, followed by an interview with the practice leader (approximately 1 h) and a review of the paperwork associated with practice leadership, such as staff allocation and minutes of team meetings. All interviews were digitally recorded, and detailed field notes were written as soon as possible after each visit. After completion of the visit, the researcher scored the five domains (which were previously explained in the introduction) on the measure. The ratings were made on a five-point rating scale (with 1 being no or almost no evidence of the element being in place to 5 being excellent — could not really improve on this element). An overall mean score of above 4 represents strong practice leadership on most domains, a score between 2 and 4 represents mixed practice leadership, and a score below 2 represents consistently weak practice leadership.

Procedure

Once consent had been gained (from staff, practice leaders and service users), service user questionnaires were sent to each service with requests for a key worker or another member of staff who knew the individual well to complete and return directly to the research team using the prepaid envelopes provided. A researcher visited each service to conduct the EMAC-R observation at the end of which the ASM was completed for each person. The researcher also recorded whether the practice leader was present (i.e. working alongside other staff) or absent during this observation. A further observation to complete the Observed Measure of Practice Leadership was conducted on a different day to when the EMAC-R observation was conducted and by a different researcher. Thus, each service had two observational visits (the exception being when a front-line manager worked across more than one service, and the observation for the practice leadership measure was conducted in only one of those services), usually within two months of each other. The exceptions were four services in which circumstances resulted in a longer gap of three to four months.

Analyses

Analyses were primarily descriptive and presented at service user level. Although the EMAC-R and ASM were completed for each service user, the Observed Measure of Practice Leadership was completed at the service level. In situations in which more than one service user participated in the study (most services), the same practice leadership score was used for each person in that service. The sample was divided into two observational groups: (a) service users observed when the practice leader

was present during the 2 h EMAC-R observation, and (b) service users observed when the practice leader was absent. Depending on level of measurement and whether other parametric assumptions were met, differences were explored using *t*-tests, Mann-Whitney *U*, and Chi-Square for (a) the ratings on the Observed Measure of Practice Leadership; and (b) engagement and the quality of active support. In addition, differences in engagement and active support according to practice leaders' presence or absence at the time of the EMAC-R observation were also explored according to whether service users had more severe (ABS below 151) or less severe (ABS of 151+) disabilities. Significance of main effects is reported at $p < 0.05$ and Bonferoni adjustments were used for *post hoc* comparisons, with significance reported at $p < 0.01$.

Results

Description of participants and settings

Table 1 provides summaries of service user characteristics. Inspection of Table 1 indicates variability across the sample, but differences across the observational groups were not statistically significant. Across the 58 services, the average number of service users was 4.2 (range 1–9), and there was no significant difference in the number of service users who were observed according to whether a practice leader was present ($M = 4.2$, range 1–7) or not present ($M = 4.3$, range 1–9) during the observations ($t(142) = -0.636, p = .526$).

Quality of life – engagement

EMAC-R observational data were available for 59 service users (19 services) when the practice leader was present and 111 service users (39 services) when the practice leader was absent. There was a significant difference in the level of engagement of service users who were observed according to whether a practice leader was present ($M = 57%$) or not present ($M = 42%$) during the observations (Mann-Whitney $z = -2.792, p = 0.05$). Further analysis explored differences in engagement levels between the two groups for service users with severe and less severe disability. Results showed that the difference in engagement levels was accounted for by those with more severe disabilities (ABS below 151) (Mann-Whitney $z = -3.041, p = 0.002$); there were no differences in engagement levels between

Table 2 Quality of staff support for the two observational groups

		Practice leadership		Statistical comparisons
		Present (n = 59)	Absent (n = 111)	
ASM score	Mean	64%	42%	t 5.741 $p = 0.001$
	Range	7–97%	2–93%	
Time spent receiving assistance	Mean	5%	2%	z -2.754 $p = 0.006$
	Range	0–28%	0–26%	
Time spent receiving contact from staff	Mean	21%	15%	z -2.642 $p = 0.008$
	Range	0–58%	0–82%	

the two groups for service users with less severe disability (ABS 151+) (Mann-Whitney $z = -0.935, p = 0.35$).

Quality of support

For each service user, a percentage of the maximum possible score on the ASM (45) was calculated. This percentage score, reported as an average (and range) across groups, is presented in Table 2. Inspection of Table 2 shows that levels of active support were significantly higher when the practice leader was present. This pattern was found for both service users with more severe ($t(42) = 4.241, p = 0.001$) and less severe ($t(76) = 3.513, p = 0.001$) disability.

The quality of staff support is also reported according to the percentage of time during which service users received assistance (help that appeared to be intended to facilitate engagement in meaningful activity and relationships) or contact (any other contact that was not assistance, e.g. pushing someone's wheelchair, giving medication) from staff, as observed using the EMAC-R. The mean scores and the range are also shown in Table 2. Levels of assistance were significantly higher when the practice leader was present than when absent. Further analysis explored difference in levels of assistance between the two groups for service users with severe and less severe disability. Difference in levels of assistance was accounted for by service users with more severe disabilities (Mann-Whitney $z = -3.257, p = 0.001$); there was no difference across the observational groups for service users with less severe disability (Mann-Whitney $z = -0.546, p = 0.585$).

Table 1 Characteristics of participants in the two observational groups

		Practice leadership		Statistical comparisons
		Present (n = 65)	Absent (n = 122)	
Age (years)	M	43	43	t -1.687 $p = 0.094$
	Range	20 to 67	18 to 76	
Males	M	52%	48%	$\chi^2 = 0.264$ $p = 0.607$ t -1.687 $p = 0.094$
	Range	31–260	22–263	
Part 1 ABS score	M	150	133	z -1.443 $p = 0.149$
	Range	0–110	0–97	
ABC Total Score	M	20	27	χ^2 3.488 $p = 0.062$
	Range	0–110	0–97	
Service users with >5 severe behaviors on ABC	M	6%	16%	χ^2 0.882 $p = 0.348$
	Range	0–110	0–97	
Non-verbal	M	28%	34%	
	Range	0–110	0–97	

The length of time that service users received contact from staff was also significantly higher when the practice leader was present than when absent (Table 2). Again this difference was accounted for by those with more severe disabilities (Mann–Whitney $z = -2.837$, $p = 0.005$); there was no difference in levels of contact between the two observational groups for service users with less severe disability (Mann–Whitney $z = -0.904$, $p = 0.366$).

Practice leadership

At the service user level, a mean practice leadership score was calculated across the five domains of the Observed Measure of Practice Leadership. The overall practice leadership scores across the whole sample was 2.43 (range 1 to 5), indicating overall, low levels of practice leadership. Comparison of the mean practice leadership scores across the two observational groups showed that the overall score was significantly higher in services in which the practice leader had been present ($M = 2.73$) during the EMAC-R observation than in services in which the practice leader had been absent.

Discussion

Overall, findings from this exploratory study revealed a pattern whereby levels of engagement and the quality of support observed were generally higher when the practice leader was present during the EMAC-R observation than when absent. The findings that these differences existed according to practice leader presence and that, overall, practice leadership was not strong, suggested that a culture of good practice had not become embedded in these services. If such embedding had occurred through strong practice leadership, we would have expected to find that staff were internally motivated to work in this way, thereby not requiring that their practice leader be present in order to provide good quality of support, which would result in positive outcomes for service users.

Differences across service users were also evident, such that the presence of a practice leader was more likely to result in higher rates of engagement and more assistance from staff for service users with more severe disability, but not those who had milder levels of disability. This difference according to level of disability most likely reflects the greater need of service users with more severe levels of disability to receive assistance from staff to initiate engagement in activities. In contrast, service users with less severe disabilities were able to access at least some level of engagement without staff support. In addition, the right level of active support for this group of people is often standing back and letting the person get on with what they are doing, providing encouragement, and reassurance. This discrepancy has been found in the early stages of implementation of active support in previous studies (Mansell and Beadle-Brown 2012; Mansell et al. 2013).

The explanation for the association between staff practices and the practice leaders' presence is likely to relate to

overall quality of practice leadership. In order to observe, give feedback and model, practice leaders must be present often enough and for long enough to see how staff are working. For practice leaders to be considered credible, they also need to be seen by staff as being able to work in this way themselves. Furthermore, for staff to know that enabling and empowering the people supported is the most important part of their tasks, they need to know that this is what their leaders (and indeed managers at all levels) want to see first and foremost when they are in services. As such, being present in the setting would appear important, but the presence must be in a particular form in order to be consistent with practice leadership.

As indicated by Beadle-Brown et al. (2014, 2015), practice leadership is an important but only partial explanation for whether active support is well implemented and embedded in the culture of any setting. There is still more research needed in terms of working out other factors that contribute to organizational culture, and systems and processes that may support the implementation of active support. There also needs to be more research on the different models of providing practice leadership. For instance, in the longitudinal study from which these data were drawn, differences across organizations in the way they organize front-line leadership have been evident. Examples include whether each service has a dedicated front-line leader or one leader covers two or more services; whether the front-line leader works on the shift roster or not; the balance of administrative and practice roles in the job specifications of front-line leaders; and whether they are located in a central office, have mobile offices or an office within each service. Also evident in our longitudinal data have been differences across organizations in terms of where their investment in practice leadership lies — that is, with front-line managers or dedicated specialist positions. As more individualized and dispersed service models develop, new challenges are emerging for organization of practice leaderships: for example, in situations in which a team of staff are supporting individuals in their own home, especially on an outreach basis, research is needed to identify systems and structures that must be in place to ensure that those staff also receive practice leadership.

Conclusions

This study provides preliminary evidence based on analysis of data from a longitudinal study, which points to the influence of the presence of practice leaders in services on the quality of active support and outcomes for services users, especially those with more severe disability. It should be noted that we did not record details of the practice leaderships' presence in the service such as the proportions of time they were in the office or supporting residents or staff. Other limitations of the study include a large service user sample size difference across groups for which the practice leader was present or absent at the time of the observations. To confirm the findings of this study, it

would be necessary to visit each service on two occasions, and conduct the EMAC-R and ASM when the practice leader was both present and absent. Further, given the exploratory nature of the study, we did not directly investigate factors other than the simple presence or absence of a practice leader (which may have stronger influences on outcomes) or the potential for this variable to act as a proxy for some other trait or skill base, or service characteristic. Additional research that helps to uncover and then test the role of these variables offers the potential to contribute to increasing evidence about how high levels of active support can be best be achieved and maintained.

Conflict of interest

No potential conflict of interest was reported by the authors.

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