

# Practice leadership, Positive Behaviour Support, and reducing restrictive practices

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**Centre for the Advancement of PBS Practice Paper 3** in a series of 12 practice papers commissioned by the CAPBS to provide a reference point and discussion tool for teams wishing to develop their positive behaviour practice.

## Introduction

This paper covers:

- Brief analysis of the literature on leadership and management and learning disabilities (LD) covering:
  - The distinction between leadership and management
  - Formal/informal organisational cultures
  - A Framework to thinking about management/leadership in LD
  - Practice leadership (PL)
- Discusses how practitioners and managers seeking to influence the work of staff teams and develop PBS and reduce RP can do so through PL and organisational change in services.

This paper provides a focus for facilitated discussion for improving staff practice through the development and exercise of practice leadership by practitioners. Practitioners, includes frontline support and senior support staff, team leaders and frontline managers in an educational, housing or social care setting. Senior (strategic) managers who do not focus upon actual practice should consider how they can become so. This paper is focussed upon people with learning disabilities (LD), especially those that exhibit behaviour described as challenging (CB).

## Management versus leadership

Management and leadership are separate and distinct. Leadership is simply the exercise of social influence in a particular organisational context, intervening in a work team's values, relationships, work activities and organisational culture "a dynamic process in a group whereby

one individual influences the others to contribute voluntarily to the achievement of the group tasks in a given situation” (Cole, 1990). Management refers to the monitoring and scheduling of resources to implement established goals and tasks, mostly derived from regulation. Administration is the narrowest aspect of management, the ‘developing and maintaining of procedures’ (Cole, 1990). Management tends to be defined in terms of purpose and objectives with an emphasis upon organisational structures and roles, ‘control’ and ‘coordination’.

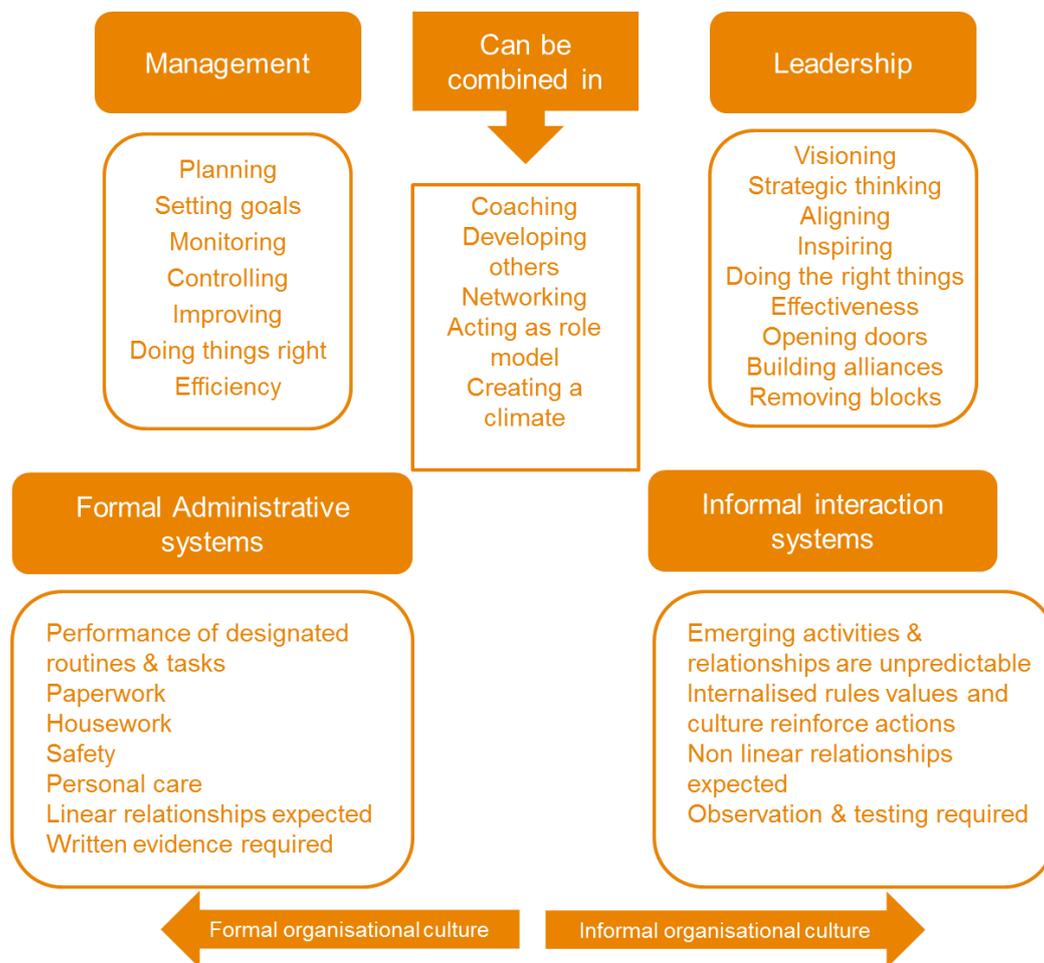
In LD services the frontline manager is supposed to exercise both management and leadership. But in reality service managers are monitored and incentivised, or not, almost entirely on the management aspects of their role; the organising and monitoring implementation of routine policies and procedures. It would not be unusual in services to observe managers who rarely come out of, or are expected to come out their offices, and get involved ‘on the floor’. Therefore, giving themselves little opportunity to provide PL. This may be getting worse with registered managers increasingly providing oversight for several settings and possibly being expected to act as administrative managers rather than practice leaders.

### **Organisational cultures**

Enquiries into failures in public services have highlighted the importance of problems of organisational cultures e.g. Mid Staffordshire hospital failings (NHS) Winterbourne View Hospital (NHS & Social Care). Figure 1 highlights some of the distinctions between formal and informal organisational cultures and managers work roles. Formal cultures are described in official policies, goals and values found in written documents. Informal cultures are what staff teams actually do, particularly when not directly supervised. The creation and maintenance of appropriate organisational cultures is the main priority of managers at all levels, according to some management experts. Organisational culture can be seen simply as “how things are done around here.... the grown up pattern of accepted and expected behaviour” (Drennan, 1992).

Figure 1. Framework for thinking about management/ leadership within ID (Deveau & McGill, 2015)

Table on next page.



The distinction between informal and formal organisational culture has been made in LD e.g. Feldman et al. (2004) showed that frontline staff often respond to CB using preferred (informal) methods rather than follow written behaviour support plans BSP and expert advice.

**Which do you think, informal or formal organisational culture would have the greater effect upon frontline staff day-to-day practice**

**What makes great leaders? Followers.**

Practitioners wanting to develop PBS and reduce RP hold a wide variety of work roles, some have roles with plenty of organisational power; some do not. Leadership can be and is exercised by all people in a staff team. Leaders have to employ a range of emotional and interpersonal skills to develop a culture and values that reinforce positive practice in a process of ‘winning hearts and minds’. This applies to support workers as much as service managers or behavioural advisory teams.

The huge range of literature, on this subject, highlights a confusing range of characteristics potentially needed to become a ‘leader’ e.g. emotional intelligence. However, the well developed, long standing, NHS Leadership development programme has just been revised in light of the recent failings of NHS leadership. As an author of the Kings Fund publication ‘Leadership and

leadership development in health care – the evidence base (2015) Michael West comments:

*“One observation to come out of this work is that much of what is written about leadership and (the millions of pounds spent) on leadership development in the NHS is based on fads and fashions rather than hard evidence..... The evidence is clear though: leadership at every level – from frontline leadership in wards, primary care and community mental health teams to board leadership in trusts to national leadership in overseeing bodies – is influential in determining organisational performance.”*

### **Practice Leadership and management in LD**

The central role of the frontline service manager in LD for ensuring good quality support is recognised in regulation and inspection but has only recently received attention from the research and training community. For frontline managers, the focus upon practice, as in leadership of practice or ‘practice leadership’ is closely associated with the work of the Tizard centre and was first used in LD by the late Professor Jim Mansell. Commenting upon the establishment and maintenance of community placements for the most complex people moving out of long stay hospitals in late 1980s (Mansell et al., 1994) he said:

*“Perhaps the most difficult part of the interventions was redefining the role of house managers and patch managers as primarily concerned with ‘practice leadership’ rather than administration” (p276)*

Recent research examining the work of service managers/supervisors has been conducted by the Tizard centre (Beadle-Brown et al., 2013; Deveau & McGill, 2014) and in Australia and the USA (Clement & Bigby, 2007; Hewitt et al., 2004). The later work focused upon ‘job analyses’ and developing ‘competency statements’.

Beadle-Brown et al. (2013) used a questionnaire measure of PL, to examine its effect upon the implementation of Active Support (a key aspect of PBS). PL was defined as:

*“the development and maintenance of good staff support for service users through managers: spending time observing staff work and providing feedback and modelling good practice; providing staff with regular one-to-one supervision; and team meetings focussed upon improving service user engagement and staff -service user relationships.”*

Using the PL measure has shown that staff have better work experiences of CB and better implementation of Active Support (Deveau & McGill, 2014; Beadle-Brown et al., 2013).

## So what can help develop leadership (of practice) in practitioners?

Crucial to PL, in terms of creating positive workplace cultures and PBS practices is the idea that: In order to lead, leaders have to manage themselves

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## Specific approaches that may be helpful to developing PL

The literature on leadership is very complex and all thoughtful practitioners will have a view on how best to practice, promote and describe what they believe in. The following suggestions come from interviews with a group of service managers (*the managers*) who spoke of their experiences, in services for adults with LD and CB; from personal experience and the research literature.

### 1. Knowing what's going on

The *managers* observed staff practice informally, covertly, more so than formally e.g. whilst 'sitting around' or working alongside staff. They operated an 'open office door policy', personally undertook the range of staff 'jobs' and used hearing as well as observing. The *managers* needed to feel assured that they knew from personal observations, conducted in a relaxed way how staff were behaving; rather than rely upon other's (verbal or written) reporting.

Benefits: the *managers* felt they knew how staff 'really behaved'. Some managers recognised emerging/developing staff practice as positive or potentially negative/abusive by being able to observe informally.

Considerations: The research literature and expert PBS practitioner training generally promotes the use of planned, structured observation of staff practice linked to feedback. This tended not to be used by the *managers*.

**How do you know what is going on in your area of responsibility, especially if responsible for more than one or two wide spread services? How might you use reflective practice sessions (see below) to monitor practice.**

### 2. Developing staff practice for PBS and reducing RP:

Staff 'involvement' in developing PBS and behaviour support plans

**Benefits:** better plans and better implementation. Managers cannot directly observe all areas of daily practice, particularly personal care routines that can be very important for triggering CB. Involved staff that feel 'ownership' and a sense of empowerment are also committed, motivated and energetic; qualities which are vital for high quality support for people who challenge and to implementing PBS and reducing RP.

**Considerations:** Involvement is not the same as free, unguided expression which can create different 'camps' or groups that work against each other. Good PL includes providing the expectation of and incentives for teamwork and sharing views and practices that support PBS.

## **Managing staff/service user: rapport, relationships and emotional experiences**

Recent research and some practice has focussed upon difficult emotional responses by staff to CB and to profound disability. Staff will have a variety of emotional experiences which influences their practice e.g. overly parental or controlling interactions, these may be positive or potentially harmful. Staff require a PL style of management to influence and develop these experiences. For example, positive staff often develop forms of 'banter' to manage their interactions particularly with people who exhibit CB and have mild LD. The potential for banter to develop a slippery slope towards abusive or restrictive practice is clear.

Managers/leaders need to provide forums for staff to share/explore their emotional experiences in a 'safe' environment. The leader acts as facilitator for the staff group to explore and REFLECT upon practice and experiences. This is a sensitive and difficult leadership role, staff do need to express their feelings and practices to peer review and support. Leaders need to be able to move between facilitation and assertive leadership e.g. to stop different groups/camps forming with lack of cooperation. At times it may become clear that the practices being discussed need to change and this should be clearly expressed.

**Moving between different roles, from facilitator to assertive manager is very challenging and leaders need to think about and practice how to do this in a way that is comfortable for them and their staff. Good leaders develop 'tricks of the trade' to demonstrate this clearly for staff. Think about how you manage these different leadership roles, or if you do.**

### **3. Shaping staff practice**

Staff practice is always changing and emerging. Emerging staff practice can provide positive 'tacit knowledge', knowledge which develops during staff and service users daily interactions, rather than being taught. Emerging staff practice has potential for being useful and positive or not. To shape practice based upon PBS and reducing RP managers should create the necessary EXPECTATIONS and INCENTIVES (Mansell et al., 2004).

#### **Expectations**

The *managers* talked about explaining/discussing and demonstrating or role modelling what they expected; 'Read that BSP and sign it' was not seen as nearly enough. Demonstration of good PBS was seen as something they should be using more often. Providing role models to develop staff practice was mostly used during induction, being employed at other times to support staff through 'difficult patches' in their relationship with particular service users. Staff, especially those who had good rapport with particular service users, were used as role models.

#### **Incentives**

The *managers* discussed giving feedback on staff's practice, both positive and negative/corrective. Research shows that staff feel they are mostly given feedback on poor practice or things they haven't done. Feedback to be effective in shaping practice must be, both positive and corrective. Opportunities for staff to develop (e.g. being given more responsibility, training,

guided practice) within the team were used to incentivise positive practice.

The *managers* described being patient and provided lots of training/guided opportunities and feedback to improve practice BUT were also happy to 'let people go' once they were satisfied they were not going to develop and practice to expectations.

**Key to providing practice leadership is recognising positive staff practice and incentivise this e.g. by saying well done, discuss it with other staff and promote it within the whole staff team. To change practice - recognise good stuff and reward it.**

#### **4. External organisations e.g. employers and regulatory agencies**

These have huge influence upon managers/practitioners and provide the main source of administrative demands (paperwork), the *managers* reported these demands as mitigating their ability to provide PL. Good practice leaders know that managing the 'boundaries' of services/homes offers access to quality of life enhancing experiences, opportunities and risks. How do you manage these demands and opportunities? Think about openness. Behavioural advisors can provide valuable supports for developing PBS and reducing RP. Good practice leadership is required to ensure their advice is clear, adapted to the staff's abilities and skills, and takes account of the staff culture to be implemented effectively.

#### **5. Personal characteristics and actions of successful leaders**

Despite the significant amount of research into personality or personal characteristics that may be associated with successful leadership, this has not been conclusive e.g. good leaders do not have to be dynamic extroverts. However, some qualities/skills are evidently needed. The *managers* were able to **communicate** their feelings and values clearly and **assertively** when this was felt to be required. This sharing of values and feelings about what is right helped to create the core values of the leadership/management team. It has been assumed in this paper that managers/practitioners will recognise staff practice that is positive and likely to lead to reduced reliance upon RP. It is not always clear that this is so.

Good practice leadership will involve working with the staff team to develop and incentivise those staff that support what you believe in and to enable empowerment and ownership.

## **References**

Beadle-Brown, J., Mansell, J., Ashman, B., Ockenden, J., Iles, R & Whelton, B. (2013) Practice leadership and active support in residential services for people with intellectual disabilities: an exploratory study. *Journal of Intellectual Disability Research*, volume 58 part 9 pp 838–850 September 2014

Clement, T. & Bigby, C. (2007) *Making life good in the community: The importance of practice leadership and the role of the house supervisor*. Department of Human Services, Victoria Government: Melbourne, Australia.

Cole, G.A. (1990) Management Theory and Practice, 3rd Edition. DP Publications: London.

Drennan D (1992) Transforming Company Culture: Getting Your Company from Where You Are Now to Where You Want to Be. McGraw-Hill, London.

Deveau, R. & McGill, P. (2014) Leadership at the frontline: impact of practice leadership management style on staff experiences in services for people with intellectual disability and challenging behaviour. Journal of Intellectual and Developmental Disability. 39, 1, 65-72.

Deveau, R. & McGill, P. (2015) Practice Leadership at the Front Line in Supporting People with Intellectual Disabilities and Challenging Behaviour: A Qualitative Study of Registered Managers of Community-based,

Staffed Group homes. Journal of Applied Research in Intellectual Disabilities, <http://onlinelibrary.wiley.com/doi/10.1111/jar.12178/abstract>

Feldman M., Atkinson L., Foti-Gervais L. & Condillac R. (2004) Formal versus informal interventions for challenging behaviour in person with intellectual disabilities. Journal of Intellectual Disability Research, 48, 60–68.

Hewitt, A.S., Larson, S.A., Lakin, K.C., Sauer, J., O'Neil, S. & Sedlezky, L. (2004) Role and Essential Competencies of the Frontline Supervisors of Direct Support Professionals in Community Services. Mental Retardation 42,122-135.

Mansell, J., Hughes, H. and McGill, P. (1994) Maintaining local residential placements. In Emerson, E., McGill, P. & Mansell, J. (Eds.), Severe Learning Disabilities and Challenging Behaviour: Designing High-Quality Services. London: Chapman and Hall.

Mansell J., Beadle-Brown J., Ashman B. & Ockendon J. (2004) Person-Centred Active Support: A Multi-Media Training Resource for Staff to Enable Participation, Inclusion and Choice for People with Learning Disabilities. Pavilion, Brighton.

West, M., Armit, K., Loewenthal, L., Eckert, R., West, T. and Lee, A. (2015) Leadership and Leadership Development in Healthcare: The Evidence Base. London, Faculty of Medical Leadership and Management.

**May 2015**

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