Submission to the NDIS Review

Strategies to Improve the Quality of Support for People with Intellectual Disabilities in Supported Accommodation Services

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Executive Summary

We write as researchers and focus specifically on people with intellectual disabilities living in supported accommodation services with 24-hour support. We use the term supported accommodation to differentiate this group and their services from the broader population who use services known as SIL by the NDIS.

Between 2018 and 2022 the quality of Active Support and the strength of Frontline Practice Leadership declined significantly in the accommodation services in the La Trobe University longitudinal study of 119 services. Significant differences and variability were evident between services within organisations and between organisations. A summary of these data are in the second part of this submission. Our findings suggest that staff skills and organisational enabling factors account for differences in quality of support rather than size of supported accommodation services or resources.

The impact of the lower quality of Active Support is that increasingly people with intellectual disabilities live in a ‘hotel model’ of supported accommodation, where staff are often unclear about their role, and staff do most of the tasks associated with daily living for people and provide very little support for people to exercise choice or be engaged in meaningful activity or social interaction. This means that people living in accommodation services spend a significant proportion of their time disengaged – doing nothing.

The impact of the low strength of practice leadership is that many staff do not have regular supervision, or regular and practice focussed team meetings, that shift plans or house routines are either absent or task and staff centred and provide little guidance to staff about the type of support they should provide to each person on each shift and how to do this.

Some explanations for the decline in quality are found in the barriers experienced to effective frontline practice leadership, including: perceived increase in administrative and managerial tasks, heavy reliance on casual or untrained/unskilled direct support staff; disruption to routines; unclear organisational expectations and weak practice related structures and processes; increased role overload and insufficient time of frontline managers and their lack of training, skills or confidence.

Some of these factors contributing to the decline in quality are undoubtedly related to the aftermath of COVID and are likely to dissipate over time, particularly staff issues and disruptions to routines. Importantly, COVID appears to have had less impact on the quality of support in some organisations than others, even those in the same state.
Some factors contributing to the decline in the quality of support, such as weak organisational structures and processes for staff training or practice leadership, and increased administration and coordination of multiple providers, are more clearly within the control of organisations or external agencies such as the NDIA and the NDIS Quality and Safeguarding Commission (Commission).

There is strong research evidence about what constitutes good support practice in accommodation services for people with intellectual disabilities, and factors needed to embed good practice. It is the responsibility of disability support organisations and the NDIA and the Commission to create the conditions for good support to flourish.

Our research suggests actions by the NDIS review that could redress the decline in quality of support within accommodation services, and would reduce costs associated with transactions, external providers and poor quality work by some external specialists in accommodation services.

• There should be recognition of people with intellectual disabilities living in supported accommodation as a distinctive group with very different support needs compared to other groups. Unlike many other groups of people with disability, those with intellectual disabilities living in supported accommodation are likely to require support to be engaged in simple and more complex meaningful activities and social interactions and to exercise choice and control. For them, continuing support all day every day to be engaged and exercise choice is central to their quality of life and the key role of staff working in accommodation services.

• The NDIS as a funder and the Commission as a regulator should fund and value enabling support in accommodation services for people with intellectual disabilities. They should recognise the necessity for Active Support as a model of practice and Frontline Practice Leadership as a model of frontline management, as distinct from the ‘hotel model’ characterised by attendant care support practices.

• NDIS funding should reflect the legislation that requires the use of best available evidence. Both the NDIS and the Commission should mandate the evidence informed practice of Active Support. They should require, and provide sufficient funding for, all direct support staff who work in supported accommodation services for people with intellectual disabilities to be trained in Active Support.

• Both the NDIS and the Commission should mandate the evidence informed frontline managerial practice of Frontline Practice Leadership in all supported accommodation
services for people with intellectual disabilities. This can be done through a requirement that all frontline managers of these services be trained and registered as practice leaders.

- The NDIS and the Commission should assist in restoring capacity of accommodation providers to focus on and lead good support practice by reducing volume of administration, transactions and coordination that stems from the way the NDIS and Commission operate. This could be done by the following actions:
  - The NDIS should review the use and promotion of multiple external providers of specialist support to people with intellectual disabilities in supported accommodation. This will encourage accommodation support providers to focus on the effectiveness of the enabling everyday Active Support they provide, ensure greater consistency of support and optimise use of the knowledge, skills and continuous presence of accommodation support staff. Reducing external providers will assist in creating more predictable and consistent support and reduce fragmentation, duplication and waste of resources on coordination with external professionals. This is particularly pertinent to the provision of Positive Behaviour Support which is artificially separated from Active Support by NDIS funding. The complementarity of consistently good Active Support all the time and effective Positive Behaviour Support are not recognised by the NDIS, and seldom referred to by the Commission. This is despite the necessity for Positive Behaviour Support and support plans to be implemented by accommodation support staff if they are to be effective.
  - The NDIS should review requirements for the separation of providers of support coordination and supported accommodation. If support coordination were the responsibility of accommodation providers, it might reduce the volume of administration and coordination that falls to frontline managers, optimise use of knowledge about individuals held by accommodation providers and maximise knowledge those acting as support coordinators have about individuals, avoid duplication and reduce time taken in coordination with external providers.
  - The Commission should review the processes for monitoring the quality of accommodation services with the aim of reducing the administrative burden on support providers. It should consider reporting against evidence informed indicators for good support such as the established benchmarks for good Active Support, strong practice leadership, and engagement and whether key
organisational enablers of good practice are in place. In some instances it would also be preferable to replace reporting based on existence of paperwork about processes or policies with observational methods that capture the quality of the actual support delivered to service users.

- The NDIS should review its requirements and methods for organisational reporting on participant outcomes for people with intellectual disabilities in supported accommodation and place more emphasis on their engagement in meaningful activities and social interactions, and choice in everyday activities both in the home and the community.

We also want to draw attention to evidence that suggests people with intellectual disabilities have not benefitted from the NDIS as much as other groups (Mavromaras et al., 2018; Bigby, 2020). This is partly due to the design of the scheme but also the absence of strong voices representing perspectives of people with severe and profound intellectual disabilities (Bigby, 2021). It is this latter group who are most likely to live in supported accommodation. Many rely on others to advocate for them but lack strong independent advocates. More nuanced strategies than co design which works well for people with mild intellectual disabilities or those without cognitive impairments are required to “hear” from people with severe or profound intellectual disabilities. We suggest;

- The NDIA adopt a more determined and differentiated approach to expertise and voice to ensure issues most relevant to people with severe and profound intellectual disabilities are represented in the reformed scheme. One strategy is to recognise the validity of multiple sources of expertise about this group, including family members, long-term support staff and researchers. Without a differentiated approach, the systemic issues experienced by those who have difficulties with comprehension and self-expression will remain.
Strategies to Improve the Quality of Support for People with Intellectual Disabilities in Supported Accommodation Services

Introduction

We write as experienced researchers in the field of intellectual disability from the Living with Disability Research Centre at La Trobe University. Questions were raised by the NDIS review about the quality of services and support for people with disabilities and the effectiveness of these in supporting people to have a good life and reach their goals as constructed by the NDIS.

This submission concerns supported accommodation services for people with intellectual disabilities and the specific evidence about the quality of support and outcomes for this specific group and type of services. The first part overviews research about evidence informed practice associated with good quality support and outcomes, and the second part summarises as yet unpublished findings from data collected in 2021/2022 about the quality in supported accommodation services. Finally, the implications of these findings are discussed together with recommendations for improving and ensuring quality in these types of services.

The NDIS has led to greater individualisation of services and diversified the sources and types of funded support available to people using supported accommodation services. This can be divided into four types of support:

- **Foundation support**: relevant to everyone in supported accommodation, all the time and the responsibility of the accommodation support provider. Provided all day every day by accommodation staff. Strongly influences individuals’ engagement, choice and health.

- **Organisational enabling factors**: relevant to everyone in supported accommodation, and the responsibility of the accommodation support provider. Strongly influences the quality of foundation support and impacts on the effectiveness of specialist support and collaboration.

- **Specialist support**: relevant to some people in supported accommodation but not necessarily all the time. Increasingly, this is the responsibility of professionals or other services external to the accommodation support provider, rather than professionals employed by the accommodation support provider. The nature and intensity of specialist
support is determined by an individual’s characteristics and their support needs that cannot be met by direct support staff in the accommodation service.

- **Collaboration, coordination, planning and decision support**: relevant to everyone in supported accommodation on an episodic basis. Responsibility usually rests with professionals external to the accommodation support provider and/or the accommodation support provider.

Both specialist support and collaboration, coordination, planning and decision support require input from and joint working with staff in accommodation services. These staff often have a much deeper knowledge of individuals in accommodation services than external specialists or support coordinators. There are strong synergies between foundation and specialist support; staff knowledge about individuals should inform assessments by specialists and support coordinators; plans developed by specialists must be implemented by staff in accommodation services if they are to be of any value (especially behaviour support plans or those associated with healthy lifestyles); the plans made by support coordinators and recommendations for external service should take account of the existing support and opportunities offered by supported accommodation staff as well as their knowledge of individuals.

There are significant gaps in research about specialist support and coordination, collaboration, planning and decision support in accommodation services in the context of the NDIS. There is, however, anecdotal and emerging evidence from our research that suggests the increased number of external professionals delivering specialist support and coordination to individuals in accommodation services negatively impacts on the quality of their everyday support as well as the quality and implementation of specialist plans. For example, external behaviour support practitioners have insufficient time to fully understand individuals or their context, consult with accommodation providers or to train and support staff teams to implement plans. Support from providers external to the accommodation service also potentially duplicates support available from within accommodation providers and diverts the focus and effort of accommodation providers away from the quality of staff practice in delivering everyday support towards coordination and administrative tasks.

**Foundation Support and Organisational Enabling Factors**

Foundation support and organisational enabling factors are directly within the control of accommodation support providers. There is significant evidence about these and what is
necessary to achieve good quality support and good service user outcomes. These two factors are the focus of this submission.

The quality of foundation support in accommodation services directly and strongly impacts on a person’s choice, engagement in meaningful activities and social interactions as part of their everyday life. Engagement is often taken for granted but it is central to the quality of life of people living in supported accommodation, many of whom need support to be engaged in simple as well as more complex activities. If a person is not engaged in meaningful activities or social interactions, then they cannot exercise choice and control, learn new skills, have social relationships or be physically active. Furthermore, if a person is disengaged for long periods then they are less likely to be treated with respect by staff.

**Active Support**

Active Support is the staff support practice with the strongest evidence base in supported accommodation and the only person-centred practice with a coherent evidence base that has been translated into staff skills and effective training (Bigby & Beadle-Brown, 2018; Bigby, 2023). If staff provide good Active Support then service users experience:

- Increased engagement in meaningful activities and social interactions;
- Improvements in skills, personal development, and adaptive behaviour;
- Improvements in choice, self-determination, and autonomy;
- Reduction in behaviours of concern;
- Reduction in mental health issues such as depression; and
- Increased assistance from staff. [see table in appendix with references]

Active Support is “an enabling relationship that facilitates engagement of people with intellectual disabilities in meaningful activities and social relationships” (Mansell & Beadle-Brown, 2012). It has two complementary dimensions: how staff provide support and how they interact with the people they support.

Active Support is underpinned by theoretical knowledge about behaviour, learning and communication, and values such as respect and rights. Active Support translates complex knowledge and values into a set of skills that can be taught to frontline staff who may not have tertiary education. It also provides staff and managers with a language for talking about the quality of staff support.
Active Support represents the skills staff require to provide respectful individualised support for engagement, communication, choice and control, and social inclusion. These skills are integral to the four essentials of Active Support taught to frontline staff.

- **Every moment has potential** – There are opportunities to support a person to be engaged in many tasks, activities and social interactions that happen naturally during the day. Workers should be continuously alert to opportunities to support engagement. One way to do this is breaking down what might appear to be complex activities into parts and thinking about the various steps of the activity that a person might be involved in.

- **Graded assistance to ensure success** – There is no one way to provide support – rather support must be individualised, tailored to the person and the activity or social interaction. Workers must provide the right type of assistance for an individual to succeed. If they provide too little assistance or the wrong type the person may not succeed. If they provide too much assistance they take away opportunities for a person to participate or develop their skills. Ways of providing assistance include: asking, instructing, prompting, gesturing, demonstrating, guiding hand-over-hand or simply encouraging the person to participate and then standing back and giving them the opportunity to do it at their own pace.

- **Maximising choice and control** – Workers must offer choices and respect preferences to increase a person’s control over their life. Communication is important to offering choices and understanding preferences. Everyone has preferences but may express them differently, using words, actions or facial expressions. For people to exercise choice, workers must offer more than one option. They might use words, gestures, show a person objects, pictures or a video or assist a person to have new experiences to expand their knowledge about what’s available. Workers need to give the person time to communicate, check they have understood and act on their expressed preferences.

- **Little and often** – Some people can only sustain engagement for short periods, as they find it difficult to concentrate and need to take breaks. Workers should recognise this and support a person to dip in and out of activities as it suits them. They should ensure a person can return to an activity if they wish by avoiding packing up or finishing up an activity too soon. Many people also need time to become familiar with a new activity before sustaining it for a longer period or deciding if they enjoy it. Workers need to offer new activities more than once to give people a chance to get used to them before
making judgements about them (see Mansell & Beadle-Brown, 2012; Bigby in press; Bigby & Humphreys, 2022).

A series of 2020 publications from an ongoing Australian study provide the strongest and most rigorous evidence about what needs to be present in an organisation to embed consistent staff use of Active Support, that is the organisational predictors of good Active Support (Bigby et al., 2020a, 2020b 2020c; Bould et al., 2019). These are:

- Staff trained in Active Support;
- Strong Frontline Practice Leadership of individual support workers and staff teams by a frontline manager through regular coaching, observation and feedback about their practice, discussion of Active Support in team meetings and individual supervision, shift planning, and support to maintain focus on the quality of life of the people they support as core to everything they do;
- Frontline managers responsible for the tasks of Frontline Practice close to every-day practice;
- Staff confidence in the management of the organisation;
- Services with no more than six people living in the same house;
- Services that support people with relatively homogenous support needs but who do not all have challenging behaviour;
- Senior organisational leaders with a shared understanding of Active Support, and who recognise and value good practice.

Australian and UK research shows that these organisational factors, the way staff resources are organised and the skills of staff account for differences in outcomes rather than resources or the model of housing and support. Providing good Active Support does not require more staff resources and entails costs comparable to delivering poorer support (Beadle-Brown et al., 2021). The published Australian data and new data in the following sections supports this, demonstrating the very different quality of staff support in similar models of service with similar funding (Bigby et al., 2020c).

**Frontline Practice Leadership**

The research cited earlier that demonstrates Frontline Practice Leadership (practice leadership) as a strong predictor of good Active Support as well as other studies point to its significance for good quality of life outcomes for people in accommodation services (see appendix for summary).
Practice leadership consists of 5 tasks carried out by frontline managers in addition to other managerial tasks. The tasks are:

- Focusing staff attention on the quality of life of the people supported;
- Allocating and organising staff to provide the support people need and when they need it to maximise their quality of life through shift plans, handovers and communication during shifts;
- Observing staff, giving feedback and coaching them, as well as modelling good practice to continuously improve the quality of support;
- Supervising the practice of each staff member individually; and
- Facilitating teamwork and team meetings to share information, ensure consistency and teamwork (see recent training package, Bigby & Humphreys, 2021).

Practice leadership can be organised in different ways:

- a frontline manager (team leader or house supervisor) responsible for and based in one service, who splits their time between direct support and managerial tasks, or
- a frontline manager (service manager) responsible for several services who splits their time between services but does not provide direct support.

No model is optimal and there is no formula for the ratio of service or staff to a frontline manager as these depend on staff experience and skills and the needs of the people they support. The organising principles recommended for practice leadership are that:

- all the tasks of practice leadership should be combined into one frontline manager position;
- the manager should be located close to frontline staff;
- the manager should know the staff and the people they support;
- the manager should have sufficient time to carry out the 5 tasks of practice leadership and any other responsibilities required for their position (Bigby et al., 2020a).

**Preliminary findings from 2022 data on Active Support and Frontline Practice Leadership**

The Living with Disability Research Centre has been conducting a longitudinal study into Active Support and Practice Leadership and presented here are preliminary findings from data collected between March 2021 to December 2022. Data were available from 382 individuals with intellectual disabilities in 119 accommodation services from 12 organisations across Australia. These data show concerning trends about the declining quality
of Active Support and Frontline Practice Leadership in accommodation services for people with intellectual disabilities which are pertinent to the NDIS review (see appendix for details of the study).

The 2022 data show statistical relationships between Active Support, Frontline Practice Leadership and Engagement similar to those identified in earlier studies.

- At the individual level, quality of Active Support strongly correlated with level of engagement ($r = .50$, $p < .001$, large effect), controlling for adaptive behaviour.
- At the service level, quality of Active Support correlated with level of engagement ($r = .43$, $p < .001$, medium effect), controlling for adaptive behaviour.
- At the service level, strength of Practice Leadership correlated with quality of Active Support ($r = .45$, $p < .001$, medium effect), controlling for adaptive behaviour.

**Decreases in quality of Active Support**

The quality of Active Support decreased between 2018 and 2022 at the individual level, halting the upward trend evident between 2013 and 2018. There is also a continuing pattern of individuals with higher support needs (adaptive behaviour less than 151) receiving poorer Active Support. Notably, such differences were reduced in several of the organisations where Active Support was strongly embedded.

Figure 1 illustrates the range and average scores for the quality of Active Support across all individual service users in 2013 (year 1 of the study), 2018 (year 6) and 2022 (year 7), and shows the lower scores for people with higher support needs (ABS < 151).

**Active Support – 2013, 2018, 2022**

![Graph showing average and range of individual Active Support scores 2013, 2018, and 2022, overall and split into high and low support needs.](image)
A decrease in the average quality of Active Support was also evident at the accommodation service level:

- In 2022, the average Active Support score was 52.95 across 116 services, which was less than the average in 2018 of 63.64 across 76 services.
- Active Support scores were significantly lower in 2022 \((M = 57.74)\) compared to 2018 \((M = 63.13)\) for the 25 services included in both years, \(t(24) = 2.20, p = .038\).

The 12 organisations included in 2022 of the study were divided into two groups; the *continuing group* of six organisations which had been implementing Active Support since at least 2013, and the *newer group* which had more recently started to implement Active Support.

Active Support was more embedded in organisations in the continuing group than the newer group as the significant differences between them show:

- The 38 services in the continuing group had significantly higher average Active Support scores \((M = 60.66)\) than the 78 services in the newer group \((M = 49.19)\), controlling adaptive behaviour, \(F(1, 113) = 12.51, p < .001\), moderate effect.
- Organisations in the continuing group had significantly higher average Active Support scores than those in the newer group, \(t(114) = 3.15, p = .002\).

Although the quality of Active Support was higher for the continuing group, there was variability between these organisations and services within them. Figure 2 illustrates the variability in quality of Active Support across services within organisations. It also shows the poorer support delivered in most but not all services where service users had higher support needs. A score of 66.6\% or above denotes good Active Support (i.e., above the green line) and 33.3\% or below poor Active Support (i.e., below the red line).
Decreases in strength of Practice Leadership

The strength of practice leadership also decreased between 2018 and 2022, halting the upward trend since 2013. Figure 4 shows the average scores from 2013 to 2022 for all the services included in each year.

Figure 3 average and range of practice leadership scores from 2013 to 2022 across all services in the study each year.

Figure 4 below shows the increase in strength of practice leadership between 2013 and 2018, as well as the decrease between 2018 and 2022 for three of five of the continuing
organisations in the study, a very slight decrease in organisation 9 and slight increase in organisation 3 (data were unavailable for the sixth organisation). The scores for 2022 for each organisation and each task are in Table 1 in the appendix.

**Practice leadership scores continuing organisations**

![Graph showing practice leadership scores for continuing organisations from 2013 to 2022.]

*Figure. 4. Average practice leadership scores continuing organisations, 2013, 2018 and 2022.*

Decreases in the strength of practice leadership between 2018 and 2022 were statistically significant for services included in both 2018 and 2022.

- Practice leadership scores decreased significantly in the 16 services included in both 2018 \((M = 3.63)\) and 2022 \((M = 2.75)\), \(t(15) = 4.04, p = .001\), large effect.
- Practice leadership scores increased significantly between 2013 \((M = 2.15)\) and 2018 \((M = 3.63)\) and decreased significantly between 2018 and 2022 \((M = 2.85)\) for the 12 services included in all three years, \(F(1, 11) = 9.85, p = .004\), large effect.

Practice leadership was significantly stronger in the continuing organisations compared to the newer organisations.

- Practice leadership scores were significantly higher in the 33 services in the continuing organisations \((M = 3.02)\) compared to the 63 services in the newer organisations \((M = 2.49)\), \(t(94) = 3.58, p <.001\).
Practice leadership scores – continuing organisations, newer organisations and whole sample

![Graph showing comparison between average scores in 2022 for continuing, newer and all organisations.](image)

**Figure 5.** Comparison between average scores in 2022 for continuing, newer and all organisations.

Practice leadership was significantly stronger in two continuing organisations (3 & 9) compared to the other three continuing organisations. Figure 7 illustrates the range of scores in each organisation and the overall averages.

![Graph showing comparison of practice leadership mean scores in services and organisations.](image)

**Figure 6.** Comparison of practice leadership mean scores in services and organisations.
Accounting for Decreased Quality

The decreased quality identified in these data can be explained by a combination of service and organisational level factors.

Organisational level explanations relate to differences between organisational expectations, structures and processes about staff and managerial practices, such as practice frameworks, policies about timing and format of staff training in Active Support and practice leadership, strategies for implementing practice leadership such as the design of frontline manager roles, templates for and expected frequency of team meetings, supervision, observing practice and mechanisms for supporting and monitoring practice of staff and frontline managers.

Service level explanations more likely relate to skill and motivation differences of direct support staff and frontline managers, and their compliance with organisational polices. The skills of individual support staff or frontline managers may in some services compensate for weak organisational structures, or conversely can be inadequate despite strong organisational structures in place (see for example, organisations 9 and 16 in Figure 6 above).

Differences between the continuing organisations - where Active Support and Practice Leadership is more embedded and the newer organisations, together with the challenges identified by frontline managers help to explain the decline quality. In turn these indicate changes the NDIS may make to address this decline and to improve quality of support in accommodation services over time.

Accounting for decline in continuing organisations

The differences in practice leadership scores between the continuing organisations were not related to the models of frontline management. The two organisations with significantly stronger practice leadership had different models of frontline management. The frontline managers in both organisations understood and articulated the value and benefits of practice leadership in maximising the use of staff resources and avoiding incidents. Their primary focus was leading staff practice rather than administration or coordination. As one of the managers said, most of their time “was spent on staff support; mentoring staff, working with staff on how to support some people’s challenging behaviours, ensuring staff well-being, and overseeing and making sure appointments have been followed up as needed”. Both these organisations had structures for supporting frontline managers as practice leaders and processes for their accountability through monitoring, supervision and coaching them. Both of these organisations also had good internal capacity for training new staff in Active Support.
using both classroom and hands-on methods. Only one other organisation had this type of internal training capacity and support and accountability in place for frontline managers in relation to practice leadership tasks.

Frontline managers in the continuing organisations perceived changes in their workload and identified other factors that interfered with effective practice leadership. These were:

- **Perceived increase in administrative and managerial tasks.** This was particularly noted by long term managers who identified changes that created more ‘paperwork’ and administration such as reporting on participants’ support and goals to the NDIS, negotiating individual funding, coordinating an increased number of external specialist providers such as behaviour support practitioners, community access support workers and support coordinators for individuals. They also noted increased administration associated with compliance requirements of the NDIS Quality and Safeguarding Commission and service auditing. They perceived these changes as meaning they spent a greater proportion of their time on administration and coordination than in the past.

- **Heavy reliance on casual or untrained or unskilled staff.** Staff turnover, absence, health and exhaustion related issues, difficulties with recruitment and suspension of face-to-face training which occurred during and in the aftermath of COVID meant that frontline managers perceived they spent more time on staff related administration such as rostering, filling vacant shifts, and supervising casual staff than in the past.

- **Disruption to routines.** The physical presence of frontline managers in services and the regularity of team meetings, supervision, observations and coaching of staff and staff training had been disrupted by COVID. Many of the disrupted routines had not yet been fully addressed.

- **Unclear organisational expectations.** Some frontline managers were unclear about their role as practice leaders, suggesting there were either no organisational processes that supported these tasks, or they were unaware of these processes or unable to comply with them. These types of processes were related to the regularity and format of staff meetings, supervision or observations and pro forma templates for shift planning and house routines.

- **Increased role overload and insufficient time.** Frontline managers identified the heavy demands on their role, the difficulties of balancing its different aspects and their lack of time to complete all the tasks required of them. They saw this as impacting most heavily on their time available for practice leadership tasks.
• **Lack of training, skills or confidence** in practice leadership tasks. Some frontline managers, particularly those newly appointed felt ill equipped to carry out the tasks of practice leadership as they had not had any training or orientation to the role, and received little supervision or support.

**Accounting for differences between continuing and newer organisations**

The tasks of practice leadership and a focus on leading practice were generally not incorporated in the role of frontline managers in most of the newer organisations. Their roles were predominantly managerial and task rather than practice focussed. This was summed up in the comments of one frontline manager who said their role was comprised of, “Paperwork. There’s a hell of a lot of paperwork. Which extends to behaviour support plans, allied health, organising doctors’ appointments, finances, budgets”. In some of the organisations, managers were office based and spent very little time in services, and in others they were based in services but spend their time on administrative tasks or direct support. Though most frontline managers were very committed to ensuring the people they supported had good lives, they had limited knowledge about Active Support or strategies for improving practice. There were few structures and processes in these organisations to either embed Active Support or Frontline Practice Leadership.

**Summary and Suggestions for Action**

Between 2018 and 2022 the quality of Active Support and the strength of Frontline Practice Leadership declined significantly in the accommodation services in the La Trobe University longitudinal study of 119 services. Significant differences and variability were evident between services within organisations and between organisations. This finding suggests that staff skills and organisational enabling factors account for differences in quality of support rather than size of supported accommodation services or resources.

The impact of the lower quality of Active Support is that increasingly people with intellectual disabilities live in a ‘hotel model’ of supported accommodation, where staff are often unclear about their role, and staff do most of the tasks associated with daily living for people and provide very little support for people to exercise choice or be engaged in meaningful activity or social interaction. This means that people living in accommodation services spend a significant of proportion of their time disengaged – doing nothing.

The impact of the low strength of practice leadership is that many staff do not have regular supervision, or regular and practice focussed team meetings, that shift plans or house routines
are either absent or task and staff centred and provide little guidance to staff about the type of support they should provide to each person on each shift and how to do this.

Some explanations for the decline in quality are found in the barriers experienced to effective frontline practice leadership, including; perceived increase in administrative and managerial tasks, heavy reliance on casual or untrained/unskilled direct support staff; disruption to routines; unclear organisational expectations and weak practice related structures and processes; increased role overload and insufficient time of frontline managers and their lack of training, skills or confidence.

Some of these factors contributing to the decline in quality are undoubtedly related to the aftermath of COVID and are likely to dissipate over time, particularly staff issues and disruptions to routines. Importantly, COVID appears to have had less impact on the quality of support in some organisations than others, even those in the same state.

Some factors contributing to the decline in the quality of support, such as weak organisational structures and processes for staff training or practice leadership, and increased administration and coordination of multiple providers, are more clearly within the control of organisations or external agencies such as the NDIA and the NDIS Quality and Safeguarding Commission (Commission).

There is strong research evidence about what constitutes good support practice in accommodation services for people with intellectual disabilities, and factors needed to embed good practice. It is the responsibility of disability support organisations and the NDIA and the Commission to create the conditions for good support to flourish.

Our research suggests actions by the NDIS review that could redress the decline in quality of support within accommodation services, and which would reduce costs associated with transactions, external providers and poor quality work by some specialists in accommodation services.

- There should be recognition of people with intellectual disabilities living in supported accommodation as a distinctive group with very different support needs compared to other groups. Unlike many other groups of people with disability, those with intellectual disabilities living in supported accommodation are likely to require support to be engaged in simple and more complex meaningful activities and social interactions and to exercise choice and control. For them, continuing support all day every day to be
engaged and exercise choice is central to their quality of life and the key role of staff working in accommodation services.

- The NDIS as a funder and the Commission as a regulator should fund and value enabling support in accommodation services for people with intellectual disabilities. They should recognise the necessity for Active Support as a model of practice and Frontline Practice Leadership as a model of frontline management, as distinct from the ‘hotel model’ characterised by attendant care support practices.

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Behaviour Support and support plans to be implemented by accommodation support staff if they are to be effective.

- The NDIS should review requirements for the separation of providers of support coordination and supported accommodation. If support coordination were the responsibility of accommodation providers, it might reduce the volume of administration and coordination that falls to frontline managers, optimise use of knowledge about individuals held by accommodation providers and maximise knowledge those acting as support coordinators have about individuals, avoid duplication and reduce time taken in coordination with external providers.

- The Commission should review the processes for monitoring the quality of accommodation services with the aim of reducing the administrative burden on support providers. It should consider reporting against evidence informed indicators for good support such as the established benchmarks for good Active Support, strong practice leadership, and engagement and whether key organisational enablers of good practice are in place. In some instances it would also be preferable to replace reporting based on existence of paperwork about processes or policies with observational methods capturing the quality of the actual support delivered to service users.

- The NDIS should review its requirement and methods for organisational reporting on participant outcomes for people with intellectual disabilities in supported accommodation and place more emphasis on their engagement in meaningful activities and social interactions, and choice in everyday activities both in the home and the community.

We also want to draw attention to evidence that suggests people with intellectual disabilities have not benefitted from the NDIS as much as other groups (Mavromaras et al., 2018; Bigby, 2020d). This is partly due to the design of the scheme but also the absence of strong voices representing perspectives of people with severe and profound intellectual disabilities (Bigby, 2021). It is this latter group who are most likely to live in supported accommodation. Many rely on others to advocate for them but lack strong independent advocates. More nuanced strategies than co design which works well for people with mild intellectual disabilities or those without cognitive impairments are required to “hear” from people with severe or profound intellectual disabilities. We suggest;
• The NDIA adopt a more determined and differentiated approach to expertise and voice to ensure issues most relevant to people with severe and profound intellectual disabilities are represented in the reformed scheme. One strategy is to recognise the validity of multiple sources of expertise about this group, including family members, long-term support staff and researchers. Without a differentiated approach, the systemic issues experienced by those who have difficulties with comprehension and self-expression will remain.
# Appendix and References

*Table A1. Summary of research on impact of Active Support*

<table>
<thead>
<tr>
<th>Effect</th>
<th>Main sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased engagement in meaningful activity or social interaction</td>
<td>Baker et al. (2017); Beadle-Brown et al. (2008, 2012); Beadle-Brown et al. (2021); Bradshaw et al. (2004); Felce et al. (2000); Jones, Felce, Lowe, Bowley, Pagler, Gallagher, et al. (2001); Jones, Felce, Lowe, Bowley, Pagler, Strong, et al. (2001); Koritsas et al. (2008); Mansell et al. (2008); Mansell et al. (2002); Rhodes and Hamilton (2006); Riches et al. (2011); Stancliffe et al. (2007); Stancliffe et al. (2010); Toogood (2008); Totsika et al. (2010)</td>
</tr>
<tr>
<td>participation in household and community-based activities</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No Change: Chou et al. (2011); Qian et al. (2019)</td>
</tr>
<tr>
<td>Improvements in skills and personal development or adaptive behavior</td>
<td>Beadle-Brown et al. (2012); Chou et al. (2011); Stancliffe et al. (2010)</td>
</tr>
<tr>
<td></td>
<td>No Change: Koritsas et al. (2008); Stancliffe et al. (2007)</td>
</tr>
<tr>
<td>Improvements in choice, self-determination and autonomy</td>
<td>Beadle-Brown et al. (2008, 2012); Chou et al. (2011); Koritsas et al. (2008); Shipton and Lashewicz (2017)</td>
</tr>
<tr>
<td></td>
<td>No Change: Riches et al. (2011); Stancliffe et al. (2007)</td>
</tr>
<tr>
<td>Reduction in behaviours of concern</td>
<td>Positive: Beadle-Brown et al. (2012); Jones, Felce, Lowe, Bowley, Pagler, Strong, et al. (2001); Koritsas et al. (2008); Rhodes and Hamilton (2006); Riches et al. (2011); Stancliffe et al. (2007); Stancliffe et al. (2010); Totsika et al. (2010)</td>
</tr>
<tr>
<td></td>
<td>No Change Over Time or Increase: Bradshaw et al. (2004); Chou et al. (2011); Toogood (2009)</td>
</tr>
<tr>
<td>Reduction in mental health issues such as depression</td>
<td>Riches et al. (2011); Stancliffe et al. (2007)</td>
</tr>
<tr>
<td></td>
<td>No change: Chou et al. (2011); Stancliffe et al. (2007)</td>
</tr>
<tr>
<td>Staff assistance increased</td>
<td>Baker et al. (2017); Beadle-Brown et al. (2012); Jones, Felce, Lowe, Bowley, Pagler, Gallagher, et al. (2001); Stancliffe et al. (2007, 2008); Toogood (2008); Totsika et al. (2010)</td>
</tr>
<tr>
<td>Staff satisfaction increased</td>
<td>Rhodes and Hamilton (2006); Rhodes and Toogood (2016); Riches et al. (2011)</td>
</tr>
</tbody>
</table>
Research on Frontline Practice Leadership

Reflecting findings in the mainstream management literature, research about accommodation services for people with intellectual disabilities identifies the influence of frontline managers. The span of competences and tasks expected of frontline managers of supported accommodation were identified in the early literature (Clement & Bigby, 2012; Hewitt et al., 2004; Larson et al., 2007). These were far ranging and included 14 domains and 141 competences. Since 2014 evidence about the positive influence of Practice Leadership has increased, both as a predictor of good Active Support as well as something that front line managers and direct care staff perceive as important to practice and achieving good QoL outcomes. Mansell et al. (2008) identified Practice Leadership as a style of frontline of management, that was needed to improve practice in supported accommodation services. Practice leaders were seen as leaders rather managers of practice, and Practice Leadership was defined as having 5 domains. Bigby & Humphreys (2021) refer to the 5 domains as 5 tasks given the differing terms used to refer to front line managers of accommodation services. These tasks and associated skills are explained more fully in a recent training package, which for the first time provides concrete examples of applying generic management skills to front line management roles in supported accommodation (Bigby & Humphreys, 2021). Analysis of a large data set from the Australian longitudinal study identified the strength of Practice Leadership as a predictor of good Active Support and a significant influence on QoL in supported accommodation (Bigby, et al., 2020a, 2020b; Bigby, et al., 2020b; Bould et al., 2019). This study provides the most rigorous data to date about Practice Leadership.

Studies of culture in supported accommodation services highlight the significance of Practice Leadership. For example, a qualitative study of culture in better group homes showed staff perceived these services to have strong Practice Leadership, characterised by leaders setting expectations for staff, leading by example, giving feedback to staff about practice, facilitating teamwork and generating a common sense of purpose among staff aligned with the values of the organisation (Bigby & Beadle-Brown, 2016; Bigby et al., 2015). Similarly, a quantitative study of culture in supported accommodation services found that where staff felt there was a culture of effective team leadership and their leaders’ values aligned with those of the organisation there were better outcomes for people living in services (Humphreys et al., 2020). These findings about a culture of strong leadership in better supported accommodation services contrast to cultures of weak leadership in
underperforming services where power is held by staff factions whose values do not always reflect those of the organisation (Bigby et al., 2012).

Several small qualitative studies show that frontline managers of supported accommodation services perceive Practice Leadership as important to achieving good QoL for the people they support. For example, in UK and Swedish studies, frontline managers thought they directly influenced staff practice by using tasks of Practice Leadership at the Frontline (Berlin Hallrup et al., 2019; Deveau & McGill, 2016). The frontline managers in these studies valued being present in services to provide support and feedback to their staff on a daily basis and regarded themselves as role models. These studies also suggested that receipt of Practice Leadership had a positive effect on staff satisfaction and levels of stress (Berlin Hallrup et al., 2019; Deveau & McGill, 2016). Conversely, studies have identified the negative impact of weak frontline management on staff and the people they support. For example, inadequate or inconsistent leadership and support for frontline staff and lack of monitoring have been associated with the culture in underperforming group homes (Bigby et al., 2012), risks for abuse, (Collins & Murphy, 2022; Marsland et al., 2007), staff mistrust and uncertainty about management (Hutchison & Kroese, 2016) and obstacles to implementing Active Support (Qian et al., 2017). Frontline managers themselves also perceive the negative impact of weak frontline leadership. For example, participants in a Delphi study of managers identified poor leadership as the primary obstacle to building and sustaining effective teams and providing high-quality services (Gomes & McVilly, 2019).

**Summary the La Trobe Longitudinal Study Participants and Methods 2022**

All the people in the study had intellectual disability and lived in supported accommodation with 24-hour staffing. On average, the homes accommodated 3.4 people, and ranged from 1 to 8. Notably, the majority of people lived with 3 or 4 other people. The average age of service users was 52 years (23-86 years), and their average level of adaptive behaviour was 157 (36-282) (where 151 indicates high support needs) and 56% were male. Twenty-five percent did not use speech to communicate and 7% had displayed more than 5 severe behaviours on the Aberrant Behaviour check list in the last 4 weeks.

The quality of Active Support is scored using the Active Support Measure (ASM) for each individual after a two hour observation. The strength of Frontline Practice Leadership is scored on a five point scale using the Observational Measure of Practice Leadership after an interview with the frontline manager and review of documents (For more details see Bigby et al., 2020a)
<table>
<thead>
<tr>
<th>Organisation</th>
<th>Whole Sample</th>
<th>Org 3</th>
<th>Org 4</th>
<th>Org 5</th>
<th>Org 8</th>
<th>Org 9</th>
<th>Ogr 15</th>
<th>Org 16</th>
<th>Org 18</th>
<th>Org 20</th>
<th>Org 23</th>
<th>Org 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services</td>
<td>(n =96)</td>
<td>(n =7 )</td>
<td>(n =4 )</td>
<td>(n =8 )</td>
<td>(n =8 )</td>
<td>(n =6 )</td>
<td>(n =6 )</td>
<td>(n =26 )</td>
<td>(n =9 )</td>
<td>(n =6 )</td>
<td>(n =6 )</td>
<td>(n =10 )</td>
</tr>
<tr>
<td>FLPL Task</td>
<td>Average (range)</td>
<td>Average (range)</td>
<td>Average (range)</td>
<td>Average (range)</td>
<td>Average (range)</td>
<td>Average (range)</td>
<td>Average (range)</td>
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<td>Average (range)</td>
<td>Average (range)</td>
<td>Average (range)</td>
<td>Average (range)</td>
</tr>
<tr>
<td>Focusing staff attention on quality of life</td>
<td>2.70 (1-5)</td>
<td>4.25 (3-5)</td>
<td>2.33 (2-3)</td>
<td>2.13 (1-3)</td>
<td>3.13 (2-5)</td>
<td>3.8 (2-5)</td>
<td>2.4 (2-3)</td>
<td>2.4 (1-5)</td>
<td>2.75 (2-4)</td>
<td>2.5 (1-3)</td>
<td>2.33 (2-3)</td>
<td>3 (3-3)</td>
</tr>
<tr>
<td>Allocating and organising staff support</td>
<td>2.86 (1-5)</td>
<td>3.75 (3-5)</td>
<td>2 (1-3)</td>
<td>2.83 (2-3)</td>
<td>3.25 (2-5)</td>
<td>3.6 (1-5)</td>
<td>2.8 (2-3)</td>
<td>2.50 (1-5)</td>
<td>2.75 (1-4)</td>
<td>2.33 (1-3)</td>
<td>2.83 (2-3)</td>
<td>4 (4-4)</td>
</tr>
<tr>
<td>Observing, giving feedback, coaching and modelling</td>
<td>2.41 (1-5)</td>
<td>3.75 (3-5)</td>
<td>2 (2-2)</td>
<td>1.83 (1-2)</td>
<td>2.5 (1-4)</td>
<td>3.8 (2-5)</td>
<td>2.4 (2-3)</td>
<td>2.15 (1-4)</td>
<td>2.75 (2-3)</td>
<td>2.17 (1-3)</td>
<td>2.17 (1-3)</td>
<td>2 (2-2)</td>
</tr>
<tr>
<td>Supervising the practice of each staff member</td>
<td>2.40 (1-4)</td>
<td>2 (2-2)</td>
<td>2.33 (2-3)</td>
<td>2.17 (2-3)</td>
<td>3 (2-4)</td>
<td>3.6 (3-4)</td>
<td>2.2 (2-3)</td>
<td>2.50 (1-3)</td>
<td>2.5 (2-3)</td>
<td>1.17 (1-2)</td>
<td>2.33 (1-3)</td>
<td>2 (2-2)</td>
</tr>
<tr>
<td>Facilitating team work through team meetings</td>
<td>2.96 (1-5)</td>
<td>4 (3-5)</td>
<td>2 (1-3)</td>
<td>2.83 (2-4)</td>
<td>3.25 (2-4)</td>
<td>3 (1-4)</td>
<td>3 (2-4)</td>
<td>2.90 (2-5)</td>
<td>3 (2-4)</td>
<td>2.83 (1-4)</td>
<td>2.67 (2-3)</td>
<td>3 (3-3)</td>
</tr>
<tr>
<td>Overall</td>
<td>2.67</td>
<td>3.55</td>
<td>2.13</td>
<td>2.33</td>
<td>3.03</td>
<td>3.56</td>
<td>2.56</td>
<td>2.49</td>
<td>2.75</td>
<td>2.2</td>
<td>2.47</td>
<td>2.8</td>
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</tbody>
</table>

(1-4.6) | (2.8-4.2) | (1.6-2.8) | (1.6-2.8) | (2-4.2) | (1.8-4.6) | (2.2-3.2) | (1.6-4.4) | (2.2-3.6) | (1-2.8) | (2-3) | (2.8-2.8) |
References


