Staff perceptions of positive behavioural support in a secure forensic adult mental health setting

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Abstract
Purpose – Challenging behaviour has been a concern across forensic services. Traditionally these have been managed reactively using medication, seclusion and restraint; however, there is growing evidence that these approaches are ineffective and counter-therapeutic. A number of reports have recommended the use of preventative approaches such as positive behavioural support (PBS). The purpose of this paper is to identify “how staff within a secure forensic mental health setting perceived the application of PBS?”

Design/methodology/approach – In total, 11 multi-disciplinary staff were interviewed and thematic analysis was used to identify themes.

Findings – Five themes were identified: “The Functions”, “Appraising a new Approach”, “Collaborative Challenges”, “Staff Variables” and “Organisational Issues”.

Practical implications – PBS enables staff to understand challenging or risky behaviour. It empowers patients via collaboration, although there can be some challenges to this. Services need to invest in training, support and leadership to ensure the model is embed and promote fidelity. Consideration needs to be given to how quality of life can be improved within the limits of a forensic setting.

Originality/value – No previous studies asking staff about their experiences of PBS within a forensic mental health context.

Keywords Thematic analysis, Challenging behaviour, Forensic mental health, Mentally ill offenders, Positive behavioural support (PBS), Staff perceptions

Paper type Research paper

Introduction
Historically, staff working in inpatient settings have utilised “traditional methods” to manage challenging behaviour which include restraint, seclusion and sedative medication (Kynoch et al., 2011; Mason and Chandley, 1999). However, there has been growing evidence that questions the effectiveness of such methods (see Duxbury, 2002) and even suggest that they may be “counter-therapeutic” (Riahi et al., 2016). Various guidelines have been published which all advocate a shift towards proactive and preventative models of managing challenging behaviour, such as positive behavioural support (PBS) (Royal College of Nursing, 2008; MIND for Better Mental Health, 2013; Ministry of Justice, National Offender Management Service and Youth Justice Board, 2012; Department of Health, 2014; National Institute for Health and Care Excellence, 2015).

Gore et al. (2013) defined PBS as a “multicomponent framework for (a) developing an understanding of the challenging behaviour displayed by an individual, based on an assessment of the social and physical environment and broader context within which it occurs; (b) with the inclusion of stakeholder perspectives and involvement; (c) using this understanding to develop, implement and evaluate the effectiveness of a personalised and enduring system of support; and (d) that enhances quality of life outcomes for the focal person and other stakeholders”. Since its inception, PBS has been applied with efficacy within learning disability (see Carr et al., 1999) and school-wide services (see Sugai et al., 2000). In forensic care, PBS finds itself positioned within a context that has a greater potential to be inherently “aversive”;

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the deprivation of an individual’s liberty in a secure setting. The success of PBS may be affected by its “contextual fit” (Albin et al., 1996).

The application of PBS within forensic mental health is in its infancy. The authors have not been able to find any published information relating to: the incidence/prevalence of PBS being used within secure forensic mental health settings, the efficacy of the approach within this setting or the experiences/perceptions of staff regarding the approach. Davies et al. (2016) have explored service user experience of PBS within a forensic mental health setting. This study outlined themes illustrating how service users “experience” PBS, these included: “How I Understand PBS”, “Making the Plan Work” and “How PBS has Helped Me; The Benefits”. Another study within a forensic setting has demonstrated that staff confidence in the application of PBS can improve after receiving training (Davies et al., 2015). Davies et al. (2016) concluded that there is a need for qualitative research to gain staff views of PBS within this context. This research seeks to develop a better understanding of the perceptions of staff involved with PBS within a forensic mental health setting.

Methodology

Design

The research utilised a qualitative thematic analysis guided by the principles and phases outlined by Braun and Clarke (2006). The lead author carried out 11 semi-structured interviews with multi-disciplinary staff members who had direct experience of PBS.

Research context

All interviews were conducted within an NHS Medium Secure Forensic Hospital in South Wales.

Participants. The inclusion criteria detailed below aimed to create a homogenous sample appropriate to answer the research question. Participants were eligible for inclusion upon meeting the following criteria:

- a member of staff employed by the secure unit for at least six months; and
- they must have experience of PBS planning with a patient and received training in PBS.

A sample of multi-disciplinary staff was selected as broadly representative of the wider staff population. The sample is heterogeneous in terms of staff job types, the rationale being that PBS is applied by multi-disciplinary staff and therefore any thematic commonality found across cases are more likely to be generalisable to the wider staff population.

A total of 11 staff were recruited into the research. In qualitative research thematic saturation should be the guiding principle in ascertaining when additional perspectives are no longer required (Mason, 2010). By the sixth participant, no further unique themes; were emerging, however, in order to ensure the sample remained broadly representative of the multi-disciplinary team, five further participants were interviewed, allowing pre-existing themes to gain more saliency and credibility, along with a continued openness for any potential new themes.

Due to the forensic nature of the setting and the small sample size, descriptions and demographics remain minimal as to protect the confidentiality of the participants. Participants included two mental health nurses, two ward managers, two health care support workers, one psychiatrist, one occupational therapist, one occupational therapist technician, one specialist trainee in psychiatry and one clinical psychologist. Five of the participants were male and six were female. Ten were aged between 31 and 45 and one of the females was aged between 45 and 60. All had been trained in PBS between 6 and 24 months prior to their participation.

Procedure

The research team developed a semi-structured interview schedule collaboratively. Potential participants were contacted either in person or via e-mail by the on-site clinical supervisor. They were offered an information sheet and a verbal description of the research. Those who
stated they would be interested in taking part were contacted by the researcher to discuss participation, and if agreeable, to organise an interview.

All interviews were “face to face” and conducted by the first author, they were recorded and transcribed then checked against the original recordings for accuracy.

**Data analysis**

Data were analysed in line with Braun and Clarke’s (2006) guidance. Braun and Clarke (2006) provided a guide through six phases of thematic analysis. To triangulate the data and reduce bias, codes and themes were presented to the research team with the aim of refining and validating the analysis. Codes and themes were compared back to the raw data ensuring they were grounded, and resonated “semantically” with the data.

**Ethical approval**

Ethical approval was granted by South-West Exeter National Research Ethics Service Committee.

**Results**

In all, 5 themes and 16 sub-themes were identified from the data.

**Theme 1: the functions**

All participants described the primary function of PBS as providing information for staff to support them in understanding behaviours so they can be prevented, along with the associated risks. PBS provided a function of individualising those with a PBS “plan” so staff are better able to see the person.

*Providing accessible information.* All participants described the function of PBS as providing information and guidelines for staff, this description is consistent with a conceptualisation of PBS as the “PBS plan”, disseminating information to staff about individual patients so they can implement appropriate strategies:

- It’s (PBS) about information sharing, what works, what doesn’t work […] (Matt).
- It (PBS) gives us some structure and some guidance in working with our patients and interventions (Helen).

A number of participants described the plan as a helpful summary, particularly for those less experienced or familiar with the patient:

- It’s really helpful to give that broad overview of the person, what’s important to them and how to best support them really […] (Kate).
- It’s a great tool to inform new staff who are getting to know my patient, which is fabulous […] (Sophie).

*Preventing escalation and managing risk.* All participants spoke about a perception that PBS enables staff members to gain a better understanding of challenging behaviour in order to prevent escalation of behaviours and manage associated risk:

- So it (PBS) gives people […] a shared understanding then […] almost like formulation but in a broader sense to understand what that person’s behaviour is about and how they can help them (Kate).

Participants talked about “prevention” of behaviours being related to the understanding of the behaviour:

- So I think it’s (PBS) helped de-escalate, because a situation has been de-escalated, it doesn’t get to the crisis, so a lot of the time we avoid some serious incidents here, and we’ve not even realised we have by using the thing (PBS plan) (Jeff).

Unsurprisingly, given the context, participants often describe the management of challenging behaviour as synonymous with the management of risk:

- I think that would probably be the prime focus, would be the reduction in behaviour, which again, because of that link to risk, I think that is almost foremost in people’s minds within the service (Kate).
It goes hand in hand […] because if you’ve got a strategy for improving somebodies behaviour then it’s gonna reduce risks (Lindsay).

Seeing the individual. Participants commented that as PBS plans are developed collaboratively and written from the patient’s perspective (i.e. first person), they have a function of individualising those patients. Even though PBS plans have been written by staff, the language is representative of a different, more valuable, respectful relationship, whereby historically the staff and the wider system would write about patients:

[…] the language is really positive, it’s non-threatening, it’s not like the start of […] a mental health action plan, where you know; “my patient has got a diagnosis of […] ra ra” […] “has been in hospital for how many years” […] (Sophie).

This sub-theme is further strengthened by descriptions of choice and patient ownership regarding the PBS process and document:

It (PBS) does promote engagement, empowerment, choice, individuality, the patient’s view is central to it (Michael).

**Theme 2: appraising a new approach**

Overall, participants appraise PBS as being received positively, owing to a perception of efficacy, enabling patients to progress. However, the approach is perceived as still developing and needing further work to become fully established. Lastly, many participants appraise PBS in relation to other approaches employed within the setting.

*A positive and beneficial approach.* PBS was appraised by all participants as something positive, in that it was a good addition to the organisation, with clear benefits for staff and patients:

I think it’s been overall very, very positive, it’s been very rewarding, empowering, exciting (Michael).

Certainly staff that I work with on a daily basis are really positive and I think respect it as well, like I said, they’ve seen how good it is […] (Robert).

This appraisal of positivity appears linked to the perception that PBS is producing benefits for both staff and patients:

[…] because we are using it (PBS), we’ve seen a greater reduction in hostility from him (Matt).

Many participants feel that PBS complements the goal of supporting people to progress through the hospital into less secure environments:

I’ve seen patients that have moved on really well using PBS […] (Jeff).

*A developing approach.* There was a strong sense that the PBS approach is still in development, perhaps because the approach is seen to be fairly new:

[…] it’s (PBS) a newish approach for, certainly for mental health and certainly for forensic nursing […] (Michael).

Dale, Matt and Lucy also identified that the approach was still developing within the service. This sense of development is linked to perceptions that the approach can develop further from its current state. Many participants saw a need to develop the approach by improving visibility whereby the approach gains widespread adoption within the organisation:

Well I guess just trying to get it (PBS) a bit higher profile, more of a […] for it to be something that’s accepted by everyone (Lucy).

*Appraised in relation to other approaches.* Participants appraised PBS in relation to approaches that were already established. These provided a point of reference from which to identify similarities and differences. The approach of “care planning” was commonly discussed by participants in relation to PBS:

We used to do care plans where we’d sit round and sort of pontificate about what the patients problems were, where as this much more involves the patient (Lindsay).

There’s more detail in them than say care plans, yeah, there’s more detail in PBS plans, I think the construction of them is far more rigorously based upon the analysis of evidence (Michael).
There is variation amongst participants in how PBS is perceived in relation to care planning. There was an idea that staff completed care plans in a PBS-like style before PBS was introduced, suggesting that PBS is not significantly distinct from care planning:

I don’t know that it’s any more collaborative than care planning because care planning should always be done as a partnership […] (Melanie).

PBS was frequently appraised as a single approach amongst many others, this provided issues for staff in determining the efficacy of PBS alone, along with challenges in differentiating what exactly PBS entails amongst a context of multiple approaches:

I think that’s one of the challenges in evaluating them, we’re delivering a whole raft of care […] so what brings about the change is […] really hard to figure out because as well as their PBS, they have all their other risk management plans. They will be having medical treatment; they’ll be having stable professional relationships, structure, so all those things came at the same time. So it’s almost impossible to pinpoint what it is and often it’s a combination of those specifics (Melanie).

**Theme 3: collaborative challenges**

All participants commented on collaboration as being a salient component of the PBS approach. PBS was fundamentally perceived as a collaborative endeavour between staff and patient:

[…] it’s (PBS) obviously a collaborative plan that’s drawn up together, it facilitates a voice rather than the assumption that the nurse knows the patient well enough to know the triggers and the interventions that would happen (Melanie).

Challenges to collaboration were discussed by participants, issues seen to have most impact were related to engagement between staff and patient, and the impact of patients’ mental health and insight into their difficulties.

**Engagement.** Participants described that a key challenge within the PBS process is engaging patients in collaborative working and developing a “therapeutic relationship”:

I’ve got good therapeutic relationships with a couple of the guys who have been particularly well-engaged in their (PBS) plan. And yeah, you build those up over time and I think yeah, they do give you a much more solid grounding to have conversations like that (about challenging behaviour) (Helen).

Participants identified that, in order to come to a shared understanding around the individuals’ behaviour, compromise was frequently required to maintain engagement in the process and preserve a therapeutic relationship:

There were some (behaviours) that he agreed with; there were some that he definitely didn’t agree with and I reflected with him and we felt together that they weren’t that important, so we agreed to take them off the list and not focus on them (Matt).

Participants also described that patients could be ambivalent towards engaging so a collaborative process could not be adopted:

He was not in favour of the plan at all […] I won’t say fought against it but didn’t really want to recognise it and it was a bit of an area of contention for him rather than something that was helpful […] (Lucy).

**Mental health.** Participants describe that the mental health of a patient may be a challenge to collaboration. Participants frequently describe mental health and behaviour as explicitly connected:

I think […] what we see on the wards is a person’s recovery in where their mental health is at can often be judged by how they are behaving (Kate).

Participants described that patients with more severe mental health issues were less likely to be involved in a collaborative PBS process:

The guy that I primary nurse at the moment is floridly psychotic, every hour of the day, despite medication. There’s very little engagement with him because what you get back is all psychotic (Matt).
Therefore, a number of participants suggested that PBS is more suited to patients who are further on in their stage of recovery:

I suppose at the start of a journey, like a recovery from a psychosis or a schizophrenic episode or whatever [...]. I suppose you have to be a little bit further along before you can start taking it (PBS) on board and be accepting and willing to do that (Lucy).

**Insight.** The level of “insight” was seen as influencing collaboration in PBS. “Insight” refers to the patients’ ability to recognise their own difficulties. Participants describe that lack of insight can prevent patients’ collaboration in PBS:

[… they might not be in a place where they can even have the slightest insight into their own problems, you know, I don’t think they’d do the PBS plan at that stage […] (Robert).

Participants commented that once the patients have a “certain” degree of insight, they can reach a “point” whereby they are more likely to engage collaboratively:

I think the insight thing is important. I think once patients do have a certain amount, […] a certain awareness of themselves […] it’s (PBS) easier (Helen).

**Theme 4: staff variables**

This theme relates to variables perceived within staff members that influence the PBS process. Three sub-themes were developed, which relate, first, to the personal attitudes and values that staff members’ hold and how these influence their personal approach to PBS. Second, staff members are perceived to vary in their fidelity of how PBS is applied in practice and also their personal knowledge of the PBS approach. Finally, staff members, when confronted with a relatively new approach such as PBS, are perceived to have intra-personal differences in the degree to which they are resistant to the changes or new ways of working associated with PBS.

**Attitudes and values.** Participants described that the personal attitudes and values held by staff have influenced their approach to PBS and therefore how they collaborate with patients in the process, as well as how they work together with other staff to implement PBS. All participants talked about noticing differences in staff attitudes and values in relation to PBS as an approach:

Some people are very in favour of it (PBS) and can see good results with some people certainly. Whereas other people are less in favour of it and are probably, perhaps I wouldn’t say hostile to it, but they just think it’s a bit wishy washy and that it’s not needed (Dale).

[… when you mention PBS (some) might sort of huff or roll their eyes or something (Robert).

Participants described that the attitude and values held by individual staff members can impact the implementation of PBS, as well as the morale and enthusiasm of other staff who are working in the same environment:

If you’re quite enthusiastic about PBS and you’re on a shift and then your colleagues are not enthusiastic, it can bring you down a bit cause they say “ah, why you doing that?” and unfortunately those are some of the attitudes that are still here (Jeff).

Some participants suggested that negative attitudes and values towards PBS can stem from a feeling that PBS places additional unwelcome demands on staff:

The perception of oh, it’s just another thing to do. Or, it’s another, […] sort of more work […] to have to worry about (Lucy).

The themes of control, punishment and the need for “consequences” are the most common attitudinal and value-driven ideas that provide a tension with the values of PBS, being based on ideas of social valorisation and therefore non-punitive in its basic underpinning:

It (PBS) just cuts against their core beliefs about power, control. “I’m the nurse, you’re the patient” […] “you’re the criminal, you’re here to be punished” which isn’t our organisational philosophy at all, […] this is a hospital, this isn’t a prison (Michael).

Some people will have quite strong views […] if they have acted out or self-harmed […] (they) shouldn’t be going down what they would see as more of a reward pathway. They should […] have clear boundaries put in (Dale).
Fidelity. The PBS plan can be very prescriptive in that guidelines are provided for how members of staff should respond to patients. Participants identified that maintaining consistency amongst staff is important when implementing PBS:

An important part of PBS [...] is the fact that it needs to be [...] a degree of consistency and a degree of unity for it to work properly [...] (Dale).

Participants recognised that maintaining consistency was a challenge, and inconsistencies have occurred, particularly when the wards are in crises or that risk is elevated:

[...] when the wards can be really unsettled, when they’ve got a million things to do, [...] when there’s a crisis situation, which there might be on an ICU ward, [...] you can slip from the sort of plan really, or not have time to go and look at it, so that is a problem (Robert).

Resistance to change. As PBS is a new approach, participants describe that when it was first introduced, staff were sceptical of the idea and needed to be “convinced”, or to see it in action. Scepticism arises from the idea that many new approaches are bought into the environment, and staff must decide for themselves whether it has value, or whether it is an old idea that has been re-packaged:

I’ll be honest with you, there was a lot of resistance to it, [...] “what bullshit is this we’ve got now?” and erm “haven’t we got enough to do?”, “we do this already in our care plans” [...] (Jeff).

It was surprising that people (think) “well it’s another fad, it’s another [...] new idea or way of telling me how to do my job” (Michael).

Some felt that resistance could manifest from dislike of, or anxiety regarding change and uncertainty that a new approach brings:

I think with anything that’s new, any change, anything new there’s [...] any uncertainty becomes a bit of anxiety and that can kind of manifest in people being a little bit kind of resistant (Melanie).

Despite these descriptions of resistance to change, evidence suggests and, given time, they are able to adjust to the approach. Many participants described a process whereby staff become accepting of the approach and less resistant:

[...] I was a sceptic in the beginning, I just went along with the crowd [...] cause we all sit in the office; “PBS, what they doing?” and then as it’s moved on I think ‘yeah’, so it’s won me over (Jeff).

[...] I think it’s a gradual process of seeing that it works, I think more people are on board with it (PBS) now (Robert).

Theme 5: organisational issues

This theme relates to phenomena described as influencing the application of PBS at a wider organisational level. Three sub-themes were identified, first, MDT processes and involvement concern processes and levels of involvement that occur between the staff of different professional backgrounds. Second, a number of organisational resources were identified as being necessary in order to successfully implement PBS. When resources are not available or limited, difficulties arise in the implementation of PBS. Lastly, participants described a wider organisational culture that provides dilemmas when merging an approach that seeks to improve quality of life within a setting that is inherently restrictive to quality of life.

MDT processes and involvement. Participants conceptualised PBS as a team or multi-disciplinary approach and that all staff of various professional backgrounds should have involvement in PBS implementation within the organisation:

It’s a collaborative effort between the staff on the ward and patient obviously, but with a few of us on the clinical team as well, some of the psychologists will actually meet to draft the plan, so I think that really helps so everyone can have input [...] (Robert).

It was observed that particular disciplines have different levels of involvement with PBS; therefore, it is not entirely multi-disciplinary, psychologists having the most involvement:

I think perhaps some disciplines might need a little bit of encouraging to get a bit more on board, but I think that applies to other things as well, not just PBS (Kate).
Some felt that psychology and nursing share a joint role in being the key professionals involved in PBS:

I see it (PBS) largely as psychology and nursing at the moment (Kate).

Hierarchy amongst MDT members was alluded to, often suggesting that those perceived to be in higher positions having more knowledge, power and influence. In relation PBS, participants perceived it as something that originated from the higher positions and has been applied to their ward-based work:

The guys at the top that are bringing it in (PBS), they push the patient side of it all the time (Jeff).

I know that ultimately it’s the nursing staff on the ground that will have to manage those plans […] with the patient so it’s back to that top down thing isn’t it (Helen).

Resources. Participants identified the need for organisational resources to support the effectiveness of PBS. Participants often cited staffing levels as a barrier to improving the quality of life:

[...] the less staff we have the less quality of life stuff we can do and I think there is a link between the quality of life and the PBS stuff isn’t there? (Matt).

To enable access to “quality of life” activities, staff members often had to respond flexibly and work in different areas in the context of limited staff resources:

I think as a clinical team we’ve offered to step in and be the extra person to come along because we know this is really important for this person to go out and access the community or have time off the ward because we know that things are difficult at the moment, so getting them off for those short periods is actually more beneficial than anything else (Kate).

In most cases, however, issues with low staffing are perceived to occur because of the presenting needs and risks in other areas of the service:

If it’s busy say on (ICU), which takes out our resources or because of sickness and there’s only three or four of us on the ward we really struggle to […] because you’ve got to maintain a minimum number of staff on the ward (Matt).

Participants commented on the length of PBS plans that they require considerable amount of staff time to read:

They are really lengthy for the reading; They are interesting because they are written in the first person and they do really get a flavour of the patient but in busy acute environments I’m not sure if enough time is given to reading them and understanding them (Melanie).

Participants also recognised that PBS plans can take considerable time to construct, limiting the number of patients who can be supported using the approach:

I think sometimes the assessments themselves because they can be quite long and involve quite a lot of time sitting with people to work through them. I think that sometimes can be a bit of a challenge (Kate).

PBS was thought to be very consuming of the psychologist’s time so it was felt one needed to be more selective with how such resource is used:

Currently some of the challenges are just to the logistics of (the psychologists) time. She still is the only person who can construct these, so until there’s more of us […] who are able to construct them, when we’re qualified through the course, […] some of it’s limitation of resource on her and her time (Michael).

Cultural incongruence. The nature of a secure forensic unit means that patients are detained against their will. As such, participants describe that tensions arise between the inherently empowering, values-based nature of PBS, taking place within a context of a secure unit, aimed at containing risk:

I think it’s (PBS) a good way of engaging the patient to make them feel empowered that they’re doing something about their care, but when they’re in a place that we have to intervene […]. PBS goes out the window because we have to make a situation safe (Jeff).

Ultimately risk will trump everything, your primary prevention strategies, your secondary prevention, your crisis management strategies, risk will trump all of those things (Michael).
The values base of PBS promotes that challenging behaviours are reduced in the context of improvements to quality of life, the primary organisational need to manage risk provides a direct tension with this:

[…] that’s where we struggle with (PBS), how can we improve someone’s quality of life if they’ve got no external leaves? They’ve got no hope of having them […] it’s difficult in that sense (Lucy).

[…] their liberty is deprived, we can’t do a lot of things they want to do […] even with a PBS plan, because if they like to go and run on a beach somewhere, their favourite thing to do, well they can’t (Robert).

Discussion
This study investigated staff perceptions of PBS in a secure forensic mental health setting. Five themes were identified relating to perceptions held by staff that were most prevalent and salient in answering the research question:

RQ1. How do staff within a secure forensic adult mental health setting perceive the application of PBS?

These themes included: “The functions”, “Appraising a new approach”, “Collaborative challenges”, “staff variables” and “Organisational issues”.

All staff members discussed the “functions” served by PBS within the service. The provision of information for staff is consistent with the core components of PBS outlined by Gore et al. (2013) in that “stakeholder skills” are built and that such “information” informs staff decision making. The perception that PBS is generally “accessible” to a range of individuals is consistent with a review by LaVigna and Willis (2012), and also resonates with a theme identified by Davies et al. (2016) termed “accessibility” whereby patients experienced PBS plans as accessible due to being “written in the first person” and “using easy-read language”. The explicit connecting, by staff, of “challenging behaviour” and “risk” was prominent in this study. In the forensic setting, it perhaps positions PBS more so as a “risk-management” tool when compared to pre-existing research.

Although PBS was a fairly new approach in the service, staff generally appraised it to be positive and beneficial, linking it to patients’ progressing and moving on. In a study of service users in the same setting, they also felt that the approach was positive, highlighted in the theme “noticing and wanting to change” (Davies et al., 2016). The appraisal that PBS is still in development is understandable given the new emergence of PBS in forensic settings as a response to government reports (Department of Health, 2014). PBS was also appraised in relation to other approaches, for example, care planning and recovery, participants felt that the multiplicity of approaches meant that it was difficult to determine the efficacy of PBS independently.

Poor mental health and lack of insight were perceived to provide challenges to engagement and collaboration in PBS. These findings are not reflected within PBS research to date. Developing good therapeutic relationships was recognised as necessary to engage service users in a collaborative PBS process, this is reflected in other qualitative PBS research (e.g. Inchley-Mort and Hassiotis, 2014; Hieneman and Dunlap, 2000; Woolls et al., 2012).

Participants varied in the extent that they could incorporate the core values of PBS with their personal values of care in the forensic environment (e.g. collaboration vs control). This is consistent with studies, in other contexts, that identify variations in the attitudes of staff implementing PBS (Bambara et al., 2001; Hieneman and Dunlap, 2000; Houchins et al., 2005; Lohrmann et al., 2008; Andreou et al., 2015; Woolls et al., 2012). It was reported that some staff were “resistant” or “sceptical” of PBS and needed to be “convinced” that it was effective. These findings are consistent with literature that recognised that an individual’s “fit” with PBS was related to his/her level of “scepticism” or “resistance” (Frey et al., 2010; Lohrmann et al., 2008).

Staff’s varying “Fidelity” to the PBS approach is a well-documented barrier to the implementation of PBS, with the approach being inconsistently or inaccurately applied (Andreou et al., 2015; Davies et al., 2016; Frey et al., 2010; Hieneman and Dunlap, 2000; Houchins et al., 2005; Inchley-Mort and Hassiotis, 2014; Lohrmann et al., 2008; Woolls et al., 2012), plans not being reviewed and updated when in place (Davies et al., 2016; Hieneman and Dunlap, 2000) or issues
related to communication of plans to the team (Frey et al., 2010; Hieneman and Dunlap, 2000; Houchins et al., 2005; Woolls et al., 2012).

Staff held the perception that PBS is an MDT process with involvement across all disciplines. The MDT were seen as possessing greater expertise in PBS; however, staff often positioned nursing as those who deliver the approach on the ground. The visibility of “the team” was perceived as being important in supporting a collaborative PBS process, however, this was variable. The importance of support for direct care staff is consistent with other studies, for example, “access to external expertise” (Andreou et al., 2015), support and leadership of PBS at a principal and organisational level (Andreou et al., 2015; Bambara et al., 2009; Lohrmann et al., 2008), “support for the team” (Bambara et al., 2001), “the visibility of external support” (Woolls et al., 2012) and the “availability and frequency of contact” with indirect supporters (Inchley-Mort and Hassiotis, 2014). Additionally, the organisational resources of “staffing” and “time” were frequently identified as being necessary to support the successful implementation of PBS. Improvements to quality of life for patients (e.g. access to activities) were often contingent on staff availability. This finding is consistent with that of Davies et al. (2016) whereby “staff resources” were seen as one of the main barriers to implementing PBS. The most common explanation being that staff had to prioritise security over facilitating leave, e.g. when risk-related incidents occurred elsewhere in the service requiring staff movements. Other studies have identified the provision of staffing as a barrier to implementation including: “staff team stability” (Woolls et al., 2012), issues of difficulty relating to high “staff-turnover” (Andreou et al., 2015), “too few support staff” (Frey et al., 2010) or failure to hire staff (Bambara et al., 2001). Time availability to develop and read PBS plans was also recognised as a resource issue. Other research has discussed the “time” required to implement PBS, and that “limited time” can impact service delivery negatively (Frey et al., 2010; Houchins et al., 2005). Specific references were also made to the time needed for training, learning, collaboration, communication and co-ordination (Houchins et al., 2005) and time for team meetings (Bambara et al., 2001, 2009).

Lastly, staff described fundamental tensions between the values base of PBS and the ultimate risk containing function of the organisation. This notion of organisational or contextual congruency with PBS is recognised in other studies which include similar themes of “ecological congruence” (Houchins et al., 2005), the “fit” of practice within the context (Andreou et al., 2015; Woolls et al., 2012), “responsiveness” and “flexibility of the system” in relation to PBS (Hieneman and Dunlap, 2000), the “culture” (Bambara et al., 2009) and the influence of the “climate” (Lohrmann et al., 2012).

There are a number of limitations to this study that should be considered. In total, 11 multi-disciplinary staff members were selected as broadly representative of the wider staff population. Whilst this is a relatively small sample theoretical saturation was reached. The lack of professional homogeneity may reduce generalisability; however, seeking the perspectives of a particular professional group was not our aim, the sample is homogenous in that they had all been involved with PBS. In a number of instances participants described perceptions of other staff's responses to PBS, for example, fidelity and resistance. Few acknowledged these themselves so it may be possible that the sample was biased more towards those staff that were pro-PBS. In addition, it was not possible, due to time constraints, to carry out credibility checks with the participants subsequent to their original interview. Further research exploring the efficacy of PBS within forensic settings will also be important in understanding whether it improves the quality of life for patients and reduces incidences of challenging behaviour.

Implications for practice:

- PBS enables staff to understand challenging behaviour;
- “Challenging behaviour” and “risk” were closely related and largely interchangeable, PBS may be promoted as an approach for understanding “risk behaviour”;
- PBS is an approach that empowers patients, inviting collaboration, although this research recognises there are challenges to this;
- services need to invest in PBS, from a training and resource perspective in order to fully embed PBS;
service managers and those who “lead” PBS should provide ongoing support, supervision and practice leadership to staff to promote fidelity to the model; and

despite obvious tensions an organisation needs to give consideration to how quality of life can be improved within the limitations of the forensic setting.

In conclusion, PBS appears to translate well into a forensic setting and is generally appraised positively by staff. There are, however, a number of factors that are perceived to impact the delivery of PBS, many of which are consistent with existing PBS literature; however, a number of issues arise from the unique nature of providing an approach underpinned by social role valorisation in a forensic context.

References


Royal College of Nursing (2008), Let’s Talk about Restraint: Rights, Risks and Responsibilities, Royal College of Nursing.


Further reading


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