Staff Perceptions of Positive Behavioural Support in a Secure Forensic Adult Mental Health Setting.

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ABSTRACT

***Background*:** The application of Positive Behavioural Support (PBS) has been widespread across educational and learning disability settings, typically in supporting individuals who exhibit challenging behaviour. Following espousal in various national policy and guidance, PBS is now being applied in the area of secure forensic adult mental health. To date, very little is known about the application of PBS in this area. This study aims to understand how staff within a secure forensic adult mental health setting perceive the application of PBS.

***Method*:** Using semi-structured interviews, 11 multi-disciplinary staff members were interviewed regarding their perceptions of PBS. The data was collected and subject to a qualitative thematic analysis.

Results: Five themes were identified from the data relating to staff perceptions of PBS, these were: '*The functions', 'Appraising a new approach', 'Collaborative challenges', 'Staff variables'* and '*Organisational issues'.*

Conclusion: PBS translates to a forensic mental health setting and is generally appraised positively by staff. There are however a number of issues that are perceived to impact the delivery of PBS, many of these are consistent with existing PBS literature, however a number arise from the unique nature of providing an approach underpinned by social role valorisation in a context of containment and disempowerment.

Keywords: Positive Behavioural Support, Challenging Behaviour, Secure Forensic Adult Mental Health, Thematic analysis

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1. INTRODUCTION

1.1. *Overview*

This research seeks to develop a better understanding of the perceptions of staff involved with Positive Behavioural Support within a secure forensic adult mental health setting where challenging behaviour can occur. As such, this section provides an introduction to the key ideas and areas of literature relevant to this research. Namely, definitions and descriptions of Positive Behavioural Support, Forensic Adult Mental Health and Challenging Behaviour. Following this, a systematic review is conducted in order to explore what literature currently exists regarding the perceptions of individuals who are involved with PBS more widely. Finally, the aims and rationale of the current study will be provided.

1.2. *Setting the scene of forensic mental health*

According to Mullen (2000):

> *'forensic mental health defined more broadly is an area of specialisation that, in the criminal sphere, involves the assessment and treatment of those who are both mentally disordered and whose behaviour has led, or could lead, to offending'* (p.307).

Thus, by this definition, those persons who fall within the category of 'forensic mental health' must have both components: 'mental disorder' and 'forensic behaviour'. However, other authors (Rogers & Soothill, 2008) have suggested that the boundaries in which we define forensic mental health are 'fuzzy' (p.3). These authors also suggest that Mullen's (2000) above definition should be extended to 'include offenders who are not currently mentally disordered but have the propensity to be so…' (p.4). This addition to the definition recognises, perhaps importantly, that 'prevention' should be within the remit of forensic mental health professionals.

Therefore, what defines a person in a forensic mental health setting from those in a non-forensic mental health setting is the presence of, or potential to behave in a way that meets societies definition of criminality. The term 'mentally disordered

offender' (MDO) is used in such contexts to describe a person who has committed an act of criminality and meets diagnostic criteria for a mental health disorder. However, within the wider literature concerning those individuals who access forensic mental health services, either 'patient' or 'service user' are the most common terms. There is some debate within the literature regarding which terms are most suitable when referring to such individuals (McLaughlin, 2009), however this has yet to be resolved, and as such, terms including 'MDO', 'service user', 'patient' and 'individual' shall be used interchangeably where appropriate.

1.2.1. *Where does forensic mental health occur and who is involved?*

Over twenty years ago, the Department of Health commissioned a review of health and social services for MDO's (Reed, 1994). This review noted that it was difficult to co-ordinate the large number of agencies involved, or potentially involved in the care and management of a MDO. Similarly, Bartlett & McGauley (2009) state that 'MDO's are caught in a spider's web of a system' (p.14). This spider's web typically involves health, social care, criminal justice institutions and voluntary sector organisations. MDO's are likely not a mere presence in such a web, Rogers & Soothill (2008) state that 'mental health issues are abundant in police stations, prisons, probation services, psychiatric hospitals and back in the community' (p.4). The most up to date statistics relating to MDO's shows that there were 3,937 restricted MDO's detained in secure hospitals on 31st December 2008 (MOJ, 2010). The statistics also show that between 1998 and 2008 there was a general increase each year, from 2,749 recorded in 1998, this would suggest that the present year (2016) figures are likely substantially higher than those in 2008. These figures however only represent those MDO's detained in secure hospitals. Prevalence studies of MDO's within UK prisons are also significant but variable. Senior *et al*., (2012) screened 3492 prisoners across six prisons in England and found that 23% of this sample met the criteria for mental disorder. In another study of 750 prisoners across England and Wales, Brooke *et al* (1996) found that prevalence of mental disorder was as high as 63%. This large variation in prevalence perhaps suggests that the identification of MDO's is not particularly reliable, however it does suggest that many MDO's are not only seen in hospital environments, but perhaps more-so in prisons.

For those MDO's who are admitted to secure forensic mental health settings, a number of mental health professionals are typically present to manage the care and treatment of an MDO, who then typically becomes a 'patient' or 'service user'. It has been identified that there are commonly five main professional groups concerned with the reduction of both offending behaviour and mental disorder, these are; forensic psychiatrists, forensic / clinical psychologists, mental health nurses, social workers and occupational therapists. This group of professionals largely make up what is known as a multi-disciplinary team (MDT) and, according to Rogers & Soothill (2008) have the role of balancing two often conflicting aims: 'the need to treat people who are mentally unwell and the need to protect society' (p.7). This conflict is often a cause of tension between clinical practice and political imperatives more generally, as elected servants of the public, who, like many people in society may privilege public protection over individual treatment or visa versa. Political inquiries at secure forensic hospitals (Blom-Cooper, 1992; Tilt, 2000) have meant that the pendulum of popular governance has swung between the positions of prioritising a caring environment and prioritising a secure environment. In practice, this means that staff, especially those with frequent patient contact, such as nursing staff, are often confronted with a need to act as the caring clinician and the custodian, however, as their job title defines them as a clinician, it means that much of their behaviour, even when custodial in nature, must be justified by themselves and society as in the patients clinical interest. Goffman (1968) made similar observations of this tension in secure mental health settings nearly fifty years ago, commenting that:

'professional psychiatric staff itself does not have an easy role (…) in the mental hospital their whole role is constantly in question. Everything that goes on in the hospital must be legitimated by assimilating it or translating it to fit into a medical-service frame of reference. Daily staff actions must be defined and presented as expressions of observation, diagnosis and treatment' (p.334).

Thus, staff behaviour that is consistent with the role of a forensic health professional, such as administering a 'treatment', be it medical, psychological or

social, can be legitimated medically under the assumption that the person being contained has a medical disorder and must be 'treated' to a level deemed acceptable for re-integration to society. In this example there is perhaps a more concrete balance in the dual roles of clinician and protector of society, however other practices, such as random room searches and perimeter checks seem to be far more in the domain of the custodian than the clinician.

It is perhaps interesting that similar tensions in the role of the forensic mental health professional have persisted for nearly five decades. Rogers & Soothill (2008) suggest that we have become so focused on getting the balance right between these two positions (secure environment vs. caring environment) that the issue of helping people to recover from mental disorder via an effective environment has been 'lost In the fallout' (p.8).

1.2.2. *'Challenging Behaviour' in forensic mental health settings*

Challenging behaviour commonly refers to:

> *"Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities."* (Emerson, 1995)

Within the NHS, incidents of challenging behaviour are recognised as a significant problem and are often underreported (NHS, 2013). For secure forensic inpatient settings, such incidences commonly include occurrences of aggression and violence towards others (Lussier, Verdun-Jones, Deslauriers-Varin, Nicholls, & Brink, 2010; Uppal & McMurran, 2009) and self-harm (Campbell, Keegan, Cybulska, & Forster, 2007; James, Stewart, Wright, & Bowers, 2012). The terms 'violence' and/or 'aggression' are generally far more prevalent than the term 'challenging behaviour' within the secure mental health literature. A widely used definition for violence and aggression is:

> *"any verbal, nonverbal, or physical behaviour that is threatening (to self, others or property), or physical behaviour that actually does harm (to self, others, or property)"* (Morrison, 1990, p67)

In terms of violence and aggression towards others, more than 60,000 incidents were reported against all types of NHS staff across the UK between 2012-2013, of these, 43,699 were in mental health or learning disability settings (NHS Protect, 2013). Within inpatient mental health settings, an international review of 424 studies reported that overall incidence of violence, including self-harm, by service users was 32.4% (Bowers, Stewart, & Papadopoulos, 2011). A survey of aggression and violence within a UK 207-bed provider of secure forensic mental health care found that, over a 16-month period there were recorded a total of 3,133 incidents involving 49.3% of the service users, 68.2% of these incidents were directed towards others, whilst 31.8% were self-harm (Dickens, Picchioni, & Long, 2013)

As result of such, prevention, de-escalation and resolution of such incidents becomes a key task for staff within these settings (Pulsford *et al*., 2013). Historically, staff working in inpatient settings have utilised 'traditional methods' to manage challenging behaviour which include restraint, seclusion and sedative medication (Kynoch, Wu, & Chang, 2011; T. Mason & Chandley, 1999). However, there has been growing evidence since around the turn of the century that question the effectiveness of such methods (See Duxbury, 2002) and even suggest that they may be 'counter-therapeutic' (Riahi, Thomson, & Duxbury, 2016). As such, there have been various guidelines published within the UK from multiple sources (Royal College of Nursing, 2008; MIND for Better Mental Health, 2013; National Offenders Management Services, 2013; Department of Health, 2014; National Institute for Health and Care Excellence, 2015) which all advocate a shift towards models which are proactive and preventative in their management of challenging behaviour, such as Positive Behavioural Support.

1.3. *Positive Behavioural Support*

Positive Behavioural Support (PBS) is a framework for developing an understanding of an individual's challenging behaviour and for using this understanding to develop effective support (NHSE LGA, 2013). Since its inception, PBS has been applied with efficacy most commonly within learning disability services (See Carr *et al*, 1999) and school-wide services (See Sugai & Horner, 2000). It is widely acknowledged that the

term ‘PBS’ was first used by Horner *et al* (1990) along with an original account of the key principles which underpin the approach (see Horner *et al*, 1990). Since this time, a number of authors have provided definitions and key principles of the approach (e.g. Allen, James, & Evans, 2005; Dunlap, Hieneman, & Knoster, 2000; Gore, McGill, & Toogood, 2013) with general agreement. The most recent of whom (Gore *et al*, 2013) have succinctly and helpfully drawn on previous definitions and relevant research to provide a framework for PBS consisting of ten core components shown in the figure below:

Figure 1: Core Components of PBS (Gore *et al*, 2013)

Values	1) Prevention and reduction of challenging behaviour occurs within the context of increased quality of life, inclusion, participation and the defence and support of valued social roles.
	2) Constructional approaches to intervention design build stakeholder skills and opportunities and eschew aversive and restrictive practices.
	3) Stakeholder participation informs, implements and validates assessment and intervention practices.
Theory & evidence base	4) An understanding that challenging behaviour develops to serve important functions for people.
	5) The primary use of applied behaviour analysis to assess and support behaviour change.
	6) The secondary use of other complementary, evidence-based approaches to support behaviour change at multiple levels of a system.
Process	7) A data-driven approach to decision making at every stage.
	8) Functional assessment to inform function-based intervention.
	9) Multicomponent interventions to change behaviour (proactively) and manage behaviour (reactively).
	10) Implementation support, monitoring and evaluation of interventions over the long term.

These core components will be further described in order to understand what underpins the PBS approach.

1.3.1. *The values of PBS*

PBS has been driven by a number of human rights and values-based movements in the field of learning disability (Gore *et al*., 2013). The key movement of influence has been social role valorisation (Wolfensberger, 1983). The idea of social role valorisation aims to ensure that those individuals who are at risk of being ‘devalued’ within society or their community assume valued social roles, thus increasing the likelihood that others within the community will see value in their contribution and afford them equality in the broadest sense (Wolfensberger, 1983).

With these values providing a key foundation, PBS is therefore primarily concerned with enhancing the quality of life, as both an intervention and an outcome for the focus individuals who display challenging behaviour, and for the stakeholders involved (Carr *et al*., 2002; Gore *et al*., 2013). As the ultimate aim and focus is improvement in quality of life, any associated reductions in the frequency and intensity of challenging behaviour are seen as 'secondary gains' within the PBS framework (Gore *et al*., 2013).

In order to improve a focus individual's quality of life, the PBS framework values 'constructional' approaches that seek to develop the skills and opportunities of all stakeholders. This typically involves all stakeholders supporting focus individuals to develop their skills in a broad range of adaptive behaviours, such as engaging in a full range of activities of daily living and active participation within their community, and whenever possible, promoting the individuals ability to make choices and have control over their lives (Dunlap & Carr, 2007; Gore *et al*., 2013).

Lastly, any assessment or intervention practice within the PBS framework should be informed and valued by the active participation of multiple stakeholders, including the focus individual. As such stakeholders are empowered to share their perspectives on whether proposed assessment and interventions are relevant and fit well with the focus individual and the systems surrounding them (Carr *et al*., 2002; Gore *et al*., 2013). This means all voices are valued equally and moves away from models of behaviour management that may be 'expert driven', as such, 'an egalitarian approach towards stakeholder participation has become a normative feature of PBS' (Carr *et al*., 2002, p.8).

1.3.2. *The theory and evidence base supporting PBS*

According to Gore *et al* (2013, p.17):

> *'PBS is underpinned by a conceptual model that views challenging behaviours as functional, rather than a deviancy, diagnosis, mental health condition or deliberate attempt by the individual to cause problems for themselves or others'.*

Therefore, 'challenging behaviours' should primarily be understood as 'learned

behaviour' that have developed and are maintained In order to serve a specific function. This idea has its roots in the behavioural theory espoused by Skinner (1953) popularly known as 'operant conditioning' whereby environmental antecedents or consequences can be controlled or adjusted in order to modify behaviour. The employment of this theory into practice, commonly to reduce 'challenging' behaviours and increase more socially 'desirable' behaviours became established as Applied Behavioural Analysis (ABA) (Baer, Wolf, & Risley, 1968). This functional model of behaviour is central to PBS and as a result, some authors have debated the extent to which PBS is an extension of ABA (Glen Dunlap, Carr, Horner, Zarcone, & Schwartz, 2008; Johnston, Foxx, Jacobson, Green, & Mulick, 2006). ABA, since its conception as a term and approach has become widespread and is recognised by the Journal of Applied Behaviour Analysis, which was first published in 1968 and since this time has included much research demonstrating the efficacy of ABA in reducing challenging behaviour. Along with PBS's central understanding of behaviour as 'learnt', PBS and ABA share core methodological similarities involving assessment and data-collection methods based on 'functional-analytic' techniques and interventions such as antecedent manipulation, skills and communication teaching that come from the understanding and use of ABA (Gore *et al*., 2013).

The movement towards PBS emerged largely in the 1990's where debate existed about the use of aversive techniques as a method to adjust behaviour (e.g. Allen *et al*., 2005; G Dunlap & Carr, 2007). In this context aversive techniques refer to any antecedent or consequence applied to a person that they, for example, find unpleasant, degrading or painful. This debate positioned ABA unfavourably, as in some incidences of published research, aversive interventions had been used under the 'ABA' approach (see Scotti & Evans, 1991). As a result, PBS gained momentum emphasising its values (see above) and espousing explicitly that it was 'non-aversive' or 'positive' in its application of behavioural technique.

In addition to the application of 'non-aversive' ABA-based behavioural techniques, PBS also employs other evidence based approaches to complement the direct behavioural components (Carr *et al*., 2002; Gore *et al*., 2013). These can include, for

example, interventions with support staff that are therapeutic or psycho-educational in nature (see MacDonald & McGill, 2013) and / or systemic formulation approaches to consider the wider context in which challenging behaviour can occur (e.g. Jenkins & Parry, 2006).

1.3.3. *The PBS process*

The PBS process is fundamentally values-led and data-driven (Carr *et al*, 2002) meaning that, along with incorporation of the values described earlier, any process associated with PBS should be based on data gathered about the focus-individual and his or her environment (Carr *et al*., 2002; Gore *et al*., 2013). This is primarily achieved via the process of functional analysis. A functional analysis seeks to gather a clear description of the behaviours of concern, identify the antecedents that predict when the behaviour is most likely to occur, and the consequences that reinforce and / or maintain the behaviour (O'Neill *et al*, 1997). Functional analysis is recognised as a key component of the PBS process (LaVigna *et al*, 1989; Horner *et al*, 1990; Carr *et al*, 1990; Gore *et al*, 2013; Smith & Nethell, 2014). Research has also demonstrated that interventions based upon a detailed and accurate functional analysis are more effective and successful than those that are not (Carr *et al*, 1999).

Additionally, All intervention elements are detailed and written into a multi-component PBS plan, typically containing 'primary' and 'secondary' strategies aiming to improve quality of life, minimise or eliminate antecedent contexts that may 'trigger' challenging behaviour, provide functionally equivalent alternatives to challenging behaviour and to provide long-term strategies and opportunities to minimise challenging behaviour (Carr *et al*., 2002; Gore *et al*., 2013). The PBS plan also should include 'reactive' strategies to maintain safety if challenging behaviour occurs so that that a person can return to engaging in valued activities (Gore *et al*., 2013; Hawkins, Kaye, & Allen, 2011).

Lastly, any process of PBS should include the implementation of support, monitoring and evaluation of the interventions over the long term (Gore *et al*., 2013; Sugai & Horner, 2000) in order to ensure the PBS plan remains valid and useful as time

progresses.

1.4. *PBS and secure forensic adult mental health*

1.4.1. *The emergence of PBS within secure forensic adult mental health settings*

As described earlier, a shift towards positive and preventative approaches to managing challenging behaviour has been espoused in multiple UK national guidance (Royal College of Nursing, 2008; MIND for Better Mental Health, 2013; National Offenders Management Services, 2013; Department of Health, 2014; National Institute for Health and Care Excellence, 2015). This shift can perhaps be understood in the wider UK social context, in particular the scandal at Winterbourne View where there was a focus on deficits in care, most specifically, the use of aversive strategies in the management of challenging behaviour. The proceeding investigations and reports (DOH, 2013, Francis, 2013, Keogh, 2012) concluded alongside recommendations for the use of positive, preventative and proactive approaches to challenging behaviour, that those who are providing health care services need to develop more equal partnerships with people who use services. Around the same time, the Social Services and Well-being (Wales) Act (2014) became law in Wales on 1st May 2014. This act clearly states that 'a local authority must promote the involvement of persons for whom care and support or preventative services are to be provided in the design and operation of that provision' (p.14). There is an emerging pattern whereby positive / preventative approaches to care are being recommended alongside the promotion of service user involvement. The involvement of service users in their care has been a developing approach in the NHS over recent times. From a conceptual perspective, Greener *et al* (2014) have broadly reviewed major NHS policies between 1990 and 2013 and suggest that the later 2000's saw an increase in 'local dynamic improvement', which is based on the idea of 'increasing patient and public involvement' (p.8).

Within the above social and political context, it is perhaps more clear how the PBS approach complements multi-national recommendations in terms of its non-aversive, preventative processes and particularly its value of stakeholder

participation and therefore: service user involvement. It is likely that these are the conditions that have fostered the emergence of PBS within secure forensic mental health settings.

1.4.2. *Research on PBS within secure forensic mental health settings*

The application of PBS within secure forensic mental health settings is in its infancy and as such, the author has 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 both staff and service users (in a single study) regarding the approach. In terms of what is available, very recently, Davies *et al* (2016) have explored service user experience of PBS within a secure forensic mental health setting. This study (explored further in the systematic review section) outlines a number of themes which demonstrate how service users 'experience' PBS. Another study by the same author has demonstrated that within secure forensic mental health settings, staff confidence in the application of PBS can improve after receiving training (Davies, Griffiths, Liddiard, Lowe, & Stead, 2015). Davies *et al* (2016) conclude that future research is required regarding the efficacy of PBS within secure forensic mental health, as well as a need for qualitative research to gain staff views of PBS within this context. As this area of research is at such an embryonic stage, there is a clear need for further research in general to better understand the application of PBS within secure forensic mental health settings.

1.5. *Conclusion*

It is now apparent that the areas of PBS and forensic mental health are coming together. PBS has well-established efficacy, and has largely been defined, in the service contexts of learning disability and school-wide education. As such, little is known about its application in forensic mental health.

This marriage has perhaps an obvious and curious tension at its core. This is that: within 'forensic' mental health, individuals are present within this context because they have committed, or could potentially commit a behaviour that is defined as a

'crime'. Within our historical and current culture, criminal behaviour has been routinely subject to punishment and other aversive strategies typically involving a deprivation of liberty in some form. The long existing tension described earlier between 'containment' and 'care' within secure forensic environments has the potential to mirror the earlier tensions described in the 1990's between 'aversive' and 'non-aversive' practices in relation to ABA, which likely popularised and positioned PBS as the non-aversive alternative.

PBS now finds itself positioned within a context that has a greater potential to be inherently 'aversive' by its definition and physicality i.e. the deprivation of an individual's liberty via detainment in a secure setting. Whilst this deprivation can be described as 'treatment' or 'care', there is potential for service users to perceive this as 'aversive' and for staff to perceive this as 'non-aversive' or visa versa. As a result, the success of PBS is likely to be affected by its 'contextual fit' (Albin & Lucyshyn, 1996).

This raises an important question of whether PBS can complement or 'fit' the context of secure forensic mental health should any stakeholder perceive it to be aversive, or have incompatible values or processes. As such, understanding the perception of PBS by the stakeholders involved forms the core area of that which this research is concerned.

1.6. *What perceptions do individuals hold of Positive Behavioural Support? A Systematic Review.*

1.7. *Introduction*

The current study aimed to understand the perceptions of PBS for staff within a secure forensic adult mental health setting. In order to identify and determine the extent and quality of research in this domain, a systematic review of literature was conducted. The author considered a systematic review that would specifically examine literature relating to the perception of PBS for individuals within secure forensic settings, however a brief initial search, along with consultation with research supervisors revealed there is an extremely limited qualitative literature

base in this specific area, namely two articles (Davies *et al*, 2016; Houchins & Jolivette, 2005). The author also considered the inclusion of quantitative literature, however, the review here was particularly interested in the personal perceptions and accounts of individuals *'in their own words'.* Quantitative studies in this area utilise pre-determined constructs of individual perception to aid measurement and quantification of human experience and therefore do not fit with the epistemological stance of the current research methodology or the position of the author (see Section 2.8.1). Consequently, it was decided to extend the scope of the systematic review to consider the perception and / or experiences (and similar) of individuals involved in PBS across a range of organisational settings (e.g. learning disability, education, juvenile justice). As PBS is relatively new to forensic mental health settings, the author felt it would be of interest to consider whether qualitative themes identified amongst such different contexts generalise, both between the published literature and later in the current research. As such, the specific question of the systematic review presented here is to better understand: *What perceptions do individuals hold of Positive Behavioural Support?*

1.8. *Method*

1.8.1. *The search strategy*

Six electronic databases were searched on the 14th March 2016, these were accessed using the OvidSP platform:

- *Cardiff University Full Text Journals*
- *AMED (Allied and Complementary Medicine)*
- *EMBASE (Excerpta Medica Database)*
- *Ovid MEDLINE(R) 1946 to March Week 1 2016*
- *PsycINFO 1806 to March Week 2 2016*
- *PsycARTICLES Full Text*

Additionally, a search of the Cochrane Library was conducted along with a search of 'Grey' literature from Google Scholar. A key journal, the International Journal of PBS (IJPBS) was also reviewed for published literature. The author also reviewed the reference section of retrieved full-text articles and received a relevant 'in press' article from one of the research supervisors: Dr. Bronwen Davies. This article (Davies *et al*, 2016) was subsequently published during the writing of this work (April, 2016).

1.8.2. *Search terms*

Initially, the author conducted a number of preliminary searches with various search terms to get a broad sense of the literature base and to determine which search terms would yield the most relevant results. Starting with broad search terms allowed the author to 'funnel' literature and strike a balance between the sensitivity and specificity of search terms in order to create a manageable body of literature in which to review given the constraints on individual time and resource. For example, including the acronym 'PBS' within searches greatly increased the number of hits (x100), most of which were irrelevant. As such, the primary search term used was "Positive Behav* Support". The author had also noted that a Cochrane systematic review on the 'outcomes of staff training in positive behaviour support' (MacDonald & McGill, 2013) also used an identical primary search term (i.e. "Positive Behav* Support"). The author recognised that this strategy may have missed articles in which "Positive Behav* Support" were not recognised as keywords, however the author's decision to review relevant reference sections of the retrieved full-text papers likely reduced the risk of this happening. In addition, it is very unlikely for a publication in a peer reviewed journal to use the acronym 'PBS' without the full use of 'Positive Behavioural Support' appearing either within the title, keywords or abstract.

The finalised search strategy utilised two groups of search terms:

- *"Positive Behav* Support"*

  AND

- *(Experience* OR view* OR perception* OR perspective* OR attitude* OR opinion* OR account* OR understanding OR interpret* OR outlook* OR descri* or expla* OR qualitative OR grounded theory OR "interpretative phenomenological analysis" OR IPA OR "thematic analysis")*

1.8.3. *Inclusion criteria*

- *Published after 1990 – It is acknowledged that '…the first use of PBS in the literature was by Horner and colleagues in 1990* (Horner *et al*., 1990)*' in* Dunlap, Kincaid, Horner, Knoster, & Bradshaw (2013, p.134)

- *English Language*

- *Qualitative methodology*

- *Mixed Methodology – those studies which contained both qualitative and quantitative components were included, however only the qualitative components were reviewed.*

1.8.4. *Exclusion criteria*

- *Duplicate articles*

- *Not Published in a peer reviewed journal*

- *Studies that do not look at some form of human perception, experience or similar in direct relation to the process of Positive Behavioural Support as most commonly defined (Gore et al, Allen etc).*

- *Studies that have an exclusively quantitative methodology*

- *Studies that do not include primary data within their results or findings (e.g. direct quotations from participants)*

- *Studies investigating non-organisational / non-professionalised settings (e.g. families)*

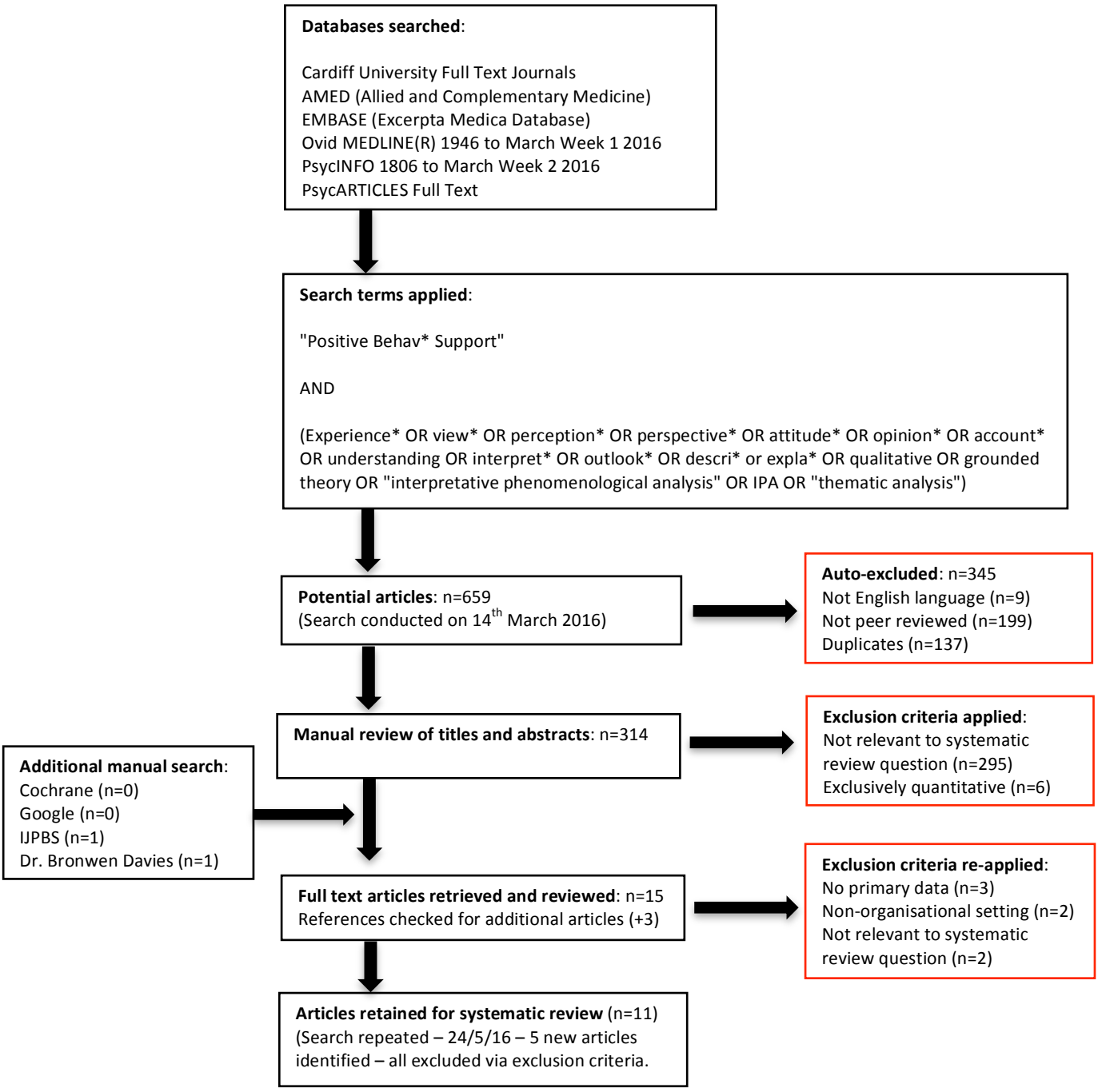
- *Review articles, commentaries, discussion pieces etc (non-research)*

1.8.5. *The search process*

The initial search of the above listed databases took place on the 14th March 2016. The above search terms were applied as 'keywords' in each of the databases, this allowed a greater scope for the search to return 'hits' due to the increased number of major fields being accessed. The complete process is displayed below in figure 2. This process, as shown, resulted in 11 papers identified as being most relevant and thus helpful to the review question posed here.

The search was repeated on the 24th May 2016 in order to ensure that the review was up to date and to determine whether further studies could be added. Since the search on 14th March 2016, a total of five new studies were identified within the databases searched, however each of these studies were excluded on the basis of the exclusion criteria, and were therefore not included for review.

Figure 2: The Systematic Review Search Process



1.8.6. *Quality of the studies*

All 11 articles presented for this systematic review are qualitative in nature. A summary table of each article is presented in Appendix A. These tables incorporate a description of each study along with a score relating to its quality as assessed by a quality framework. A number of frameworks available for assessing the quality of qualitative research (CASP, 2014; Law *et al*, 1998; Spencer *et al*, 2003; Tracy, 2010), were considered. It was decided to implement a framework specifically designed by Cardiff University's Support Unit for Research Evidence (SURE, 2013) in order to assess the quality of each of the 11 retrieved articles. The SURE framework was selected based on ease of use and the support available within the university. It was also apparent that the SURE framework contained all the sub-fields used by the CASP qualitative checklist with the addition of an extra field: consideration of issues relating to potential author sponsorship / conflicts of interest. It was also felt that as the SURE provided more 'within-field' prompts than the CASP, it enabled a better chance of rigorously reviewing the quality of each article. The SURE quality framework was applied to each of the 11 articles along with the application of an idiosyncratic numerical score denoting the author's perception of quality (see Appendix B). These scores were subsequently checked by the research supervisor as a method of inter-rater reliability. The author's rationale for the scoring system was as follows:

0 – This score indicates there to be no consideration given to the question posed by the quality review framework.

1 – This score indicates there to be partial consideration given to the question posed by the quality framework or that issues were addressed however limitations were present.

2 – This score indicates the article clearly addressed the question posed by the quality review framework in a clear and rigorous fashion.

A matrix of the scores allocated in response to each of the quality framework questions for each of the 11 articles is presented in Appendix B. The maximum

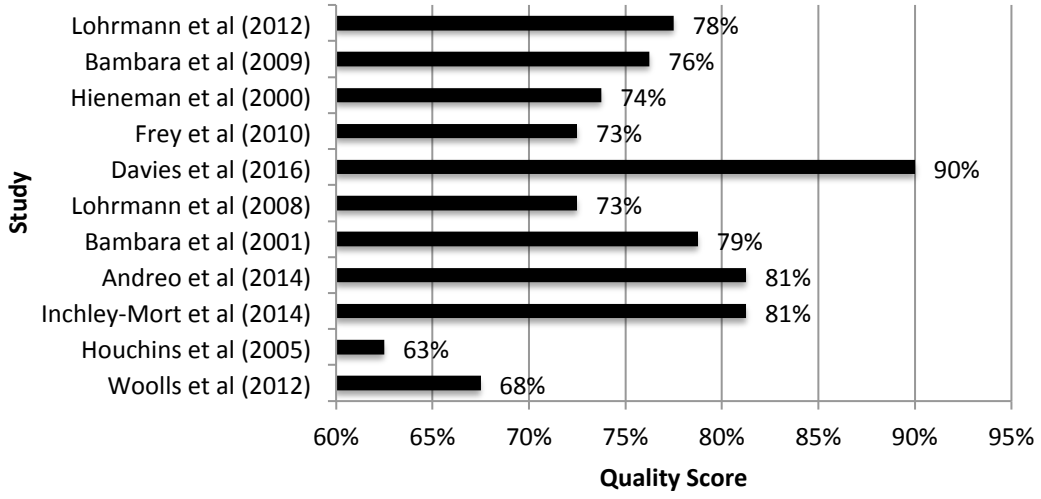
quality score achievable for a study was 80.

1.9. *Issues of quality*

An overview of the quality review table (see Appendix B) has demonstrated that the studies presented here for review are variable in their quality. The total scores for articles in the review ranged from 50 to 72, when expressed as a percentage they range from 62.5% to 90% quality.

It was considered that studies scoring over 80% were of 'high' quality, studies scoring between 70%-80% were 'medium-high' and studies scoring between 60%-70% were of 'medium' quality. Figure 4 below shows the quality score for each study rounded to the nearest whole percentage number:

Figure 3: Indication of Quality Scores across Systematically Reviewed Studies



As shown, most studies (n=6) are of medium-high quality (70%-80%), two studies are of medium quality (60%-70%) and three studies are of high quality (>80%). As such, the findings discussed here can be considered relatively credible.

A relative strength of all studies was that methods of data collection were well described, analyses and interpretative procedures were generally well-described and carried out with triangulation in all cases to improve the validity of findings. Most studies were also very transparent regarding their limitations. Relative weaknesses

across most of the studies resulting in a loss of points included a lack of description regarding why specific qualitative methodologies were chosen as oppose to others, a lack of exploration of the relationship between the researcher and participants, not reporting whether data saturation had been reached, a lack of information of how research was explained to participants, lack of details regarding ethical approval and related considerations and lastly, declaration of issues relating to sponsorship or conflicts of interest.

The three 'high quality' studies are the most rigorous and the findings can be considered the most credible. Two of the three 'high quality' studies are those that contained focus individuals. Both Davies *et al* (2016) and Inchley-Mort *et al* (2014) reported themes that described the importance placed on relationships of 'understanding' within PBS, they identified similar barriers to implementation and commonly concluded that PBS is perceived to be 'valued' and 'acceptable' to most focus individuals, also pointing out that future research needs to further explore the experience of focus individuals. The other 'high quality study' (Andreou, McIntosh, Ross, & Kahn, 2014) made conclusions regarding the importance of contextual adaptations in order to sustain PBS, this broadly included the fostering of environments that are 'flexible', 'creative' and contain 'foresight'.

Those studies considered to be 'medium-high quality' can also be considered relatively robust and rigorous however slightly less so than the high quality studies. Generally, these studies lost points due to a lack of consideration of researcher position, data-saturation and wider ethical considerations. These studies concluded that: perceived barriers to PBS are consistent with broader personal and organisational implementation patterns and are important to identify in order to overcome (Lohrmann, Forman, Martin, & Palmieri, 2008; Lohrmann, Martin, & Patil, 2012); perceived multi-dimensional and inter-related factors including culture, support, use of time and focus-individual involvement can impede or enhance PBS implementation (Bambara, Nonnemacher, & Kern, 2009); for PBS to be successful, plans should be contextually relevant, person-centred and based on the resources available (Hieneman & Dunlap, 2000); the goals and outcomes of PBS are supported

by key stakeholders, however the procedures required to implement PBS received less support from a social validity perspective (Frey *et al*., 2010); team members' perceived the social processes of PBS to be most important and that future research needs to more fully understand the social contexts in which PBS is implemented (Bambara, Gomez, Koger, Lohrmann-O'Rourke, & Xin, 2001).

There are a number of references in both the 'medium-high' and 'high quality' studies to social, contextual and organisational factors that are similarly perceived to be important in the implementation of PBS across studies. This suggests that further research around the nature of PBS should take into account the wider context in which it occurs, rather than focusing on specific sub-components of PBS or the perspectives of discrete groups of individuals who might be involved in its delivery.

Lastly, the two studies considered to be of 'medium quality' are relatively less reliable when compared to the other studies in this review. Both studies here lacked information regarding the sampling strategy, how and why participants were selected, whether data saturation was reached and how the results compared with those from other studies. The Woolls *et al* (2012) study is nearing the 'medium-high' bracket of quality and should be considered to be higher quality than the Houchins *et al* (2005) study, which is at the lower end of the bracket. Houchins *et al* (2005) concluded that multiple themes relating to PBS centre around 'environmental congruence', and as such, contextual issues need to be addressed if PBS is to generalise to juvenile justice settings. Woolls *et al* (2012) similarly concluded that multiple themes relating to the implementation of PBS interact in ways (as shown via a grounded theory) that can impact the success of PBS interventions.

1.10. *Synthesis of systematically reviewed studies*

This section contains a meta-synthesis of the retrieved studies in attempt to answer the systematic review question: *What perceptions do individuals hold of Positive Behavioural Support?*

A meta-ethnographic approach (Noblit & Hare, 1988) was selected based on its establishment as a leading method for synthesising qualitative research across

diverse areas of health care (Bondas & Hall, 2007; Campbell *et al*., 2011; Ring, Ritchie, Mandava, & Jepson, 2011). The seven steps outlined for meta-ethnography were utilised for this review (see figure 4). In a systematic review of studies that have utilised meta-ethnographic syntheses, it has been recognised that the approach is applied in diverse ways (France *et al*., 2014). As such, the author was also guided by 'seminal' published worked examples of meta-ethnography (Britten *et al*., 2002; Campbell *et al*., 2003) as identified by Ring *et al* (2011) and Campbell *et al* (2011).

Figure 4: The seven steps of meta-ethnography (from Noblit & Hare, 1988)

1. Getting started (the search)
2. Confirming initial interest (literature screening)
3. Reading studies and extracting data
4. Determining how studies are related (identifying common themes and concepts)
5. Translating studies (checking first and/or second order concepts and themes against each other)
6. Synthesising translations (attempting to create new third order constructs
7. Expressing the synthesis.

Steps 1 and 2 (the literature search and screening) are addressed above in section 1.8. Step 3 - 'reading studies and extracting data' was performed via detailed reading of each of the studies and extracting relevant data for each study into individual summary tables (see Appendix A). From reading the studies, a narrative overview of the articles is next presented in respect to; i) the service contexts in which studies were concerned, ii) their specific aims, iii) the characteristics of the individuals involved and iv) the methods used.

1.10.1. *Service contexts*

The broad nature of the systematic review question allowed for consideration of any service context in which PBS may occur. Of the 11 studies reviewed, four occurred within the context of community-based learning disability services (Bambara *et al*., 2001; Hieneman & Dunlap, 2000; Inchley-Mort & Hassiotis, 2014; Woolls, Allen, &

Jenkins, 2012), all of which were adult learning disability services with the exception of a single study (Hieneman & Dunlap, 2000) that occurred within the context of community-based services for children with disabilities. The most popular service context was school / educational settings. Five studies (Andreou, McIntosh, Ross, & Kahn, 2014; Bambara, Nonnemacher, & Kern, 2009; Frey, Lee Park, Browne-Ferrigno, & Korfhage, 2010; Lohrmann, Forman, Martin, & Palmieri, 2008; Lohrmann, Martin, & Patil, 2012) concerned school contexts however the school-stage (e.g. primary, secondary) did vary. All of the school-based studies concerned typically-developing children except for a single study (Bambara *et al*., 2009) that concerned an educational setting for children with learning disabilities. Lastly, two of the 11 studies concerned forensic contexts (Davies *et al*, 2016; Houchins & Jolivette, 2005). The Davies *et al* study (2016) took place within a secure forensic mental health hospital and the Houchins & Jolivette (2005) study concerned a secure juvenile justice facility where reportedly 62% of the client demographic had a diagnosis of mental health disorder.

More broadly, eight of the studies occurred within North America. Interestingly the North American studies contained all of the educational / school context studies (n=5), one of the learning disability studies (Bambara *et al*, 2001) and the juvenile justice study (Houchins & Jolivette, 2005). The remaining three studies (Davies *et al*, 2016; Inchley-Mort & Hassiotis, 2014; Woolls *et al*., 2012) all occurred within the UK. The sample here is therefore North American and UK-centric, which is not surprising given the PBS approach has largely developed and originated from these areas. As such, the safe generalisability of the review considered here should be limited to North American and UK culture. The author also noted a pattern whilst conducting the wider review of abstracts whereby PBS research relating to educational contexts occurs mostly in North America and PBS research relating to learning disability occurs more so in the UK, with some in North America. This pattern is consistent with the review articles presented here.

1.10.2. *Study aims*

As this systematic review was limited to qualitative research, the general nature of

the study aims were broadly similar in their fundamental stance; i.e. to describe, explore or investigate stakeholder views in some relation to PBS.

Four of the studies had very general, explorative aims concerning stakeholder perceptions of PBS within a service setting more globally, i.e. 'applicability of PBS' in a service (Houchins & Jolivette, 2005) or stakeholder 'experiences' or 'perspectives' of PBS within a service (Bambara *et al*., 2001; Davies *et al*, 2016; Inchley-Mort & Hassiotis, 2014).

Four of the studies were a little more specific in that their aim was the identification of factors relating to the efficacy of PBS. Woolls *et al* (2011) aimed to identify 'supportive' and 'problematic' factors, Hieneman & Dunlap (2000) aimed to establish 'factors that affect success', Bambara *et al* (2009) aimed to investigate 'barriers' and 'facilitators' and Andreou *et al* (2012) aimed to explore 'factors that help and hinder' PBS. Similarly, two studies by the same lead author had aims that related to understanding pre-determined intra-staff factors in relation to PBS application i.e. 'resistance' (Lohrmann *et al*., 2008) and 'buy-in' to PBS (Lohrmann *et al*., 2012). Lastly, the study conducted by Frey *et al* (2010) was different to the others in their specificity of aim: to assess the social validity of PBS.

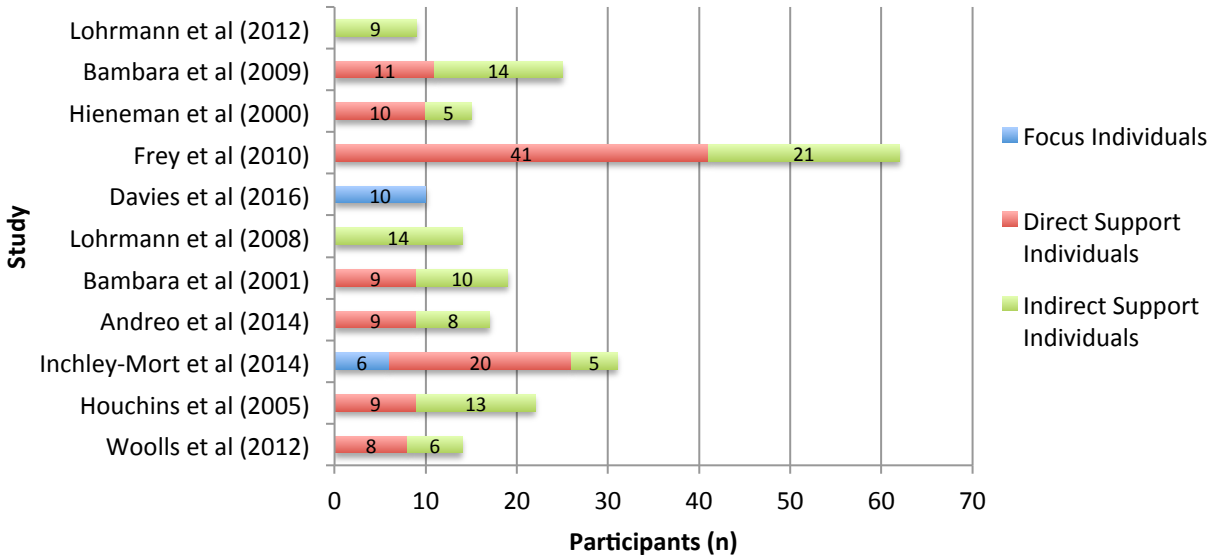
1.10.3. *The spread and characteristics of individuals involved*

As described above, PBS occurred in systems where a range of professionals existed (e.g. Community support teams, schools, forensic institutions). The studies reviewed here demonstrated that a range of individuals can hold a stake in PBS, these can be broadly organised as: individuals who are the recipients of PBS (focus individuals), the individuals directly involved in its delivery (direct-support individuals) and the individuals involved in supervising and / or training those individuals directly involved (indirect-support individuals). Typically, direct-support individuals included 'support workers', 'teachers' or 'carers' and were characterised by having a direct 'face to face' role with the focus individual and normally spend the majority of their time in direct contact. Indirect-support individuals typically included 'behaviour specialists', 'consultants' or 'administrators' and are characterised by having a direct

role with the direct-support individuals and sometimes an intermittent role with focus individuals.

All of the studies reviewed here investigated at least one of the above types of stakeholder (i.e. focus individual, direct-support individual or indirect-support individual), with many investigating a mixture in some form. Figure 3 illustrates the spread of participants across the three sub-types for all 11 studies reviewed here:

Figure 5: Spread of Participant Sub-types across Systematically Reviewed Studies



The above figure should be interpreted with some caution, as there is likely variation in the roles of individuals and also differences in how studies identified and defined their participants. In this case the author made judgments based on the information available within the studies to categorise the participants by the above three sub-types as defined above. As shown in figure 3, the largest sub-group investigated were direct-support individuals (n=117), with indirect-support individuals closely following (n=105). It is clear that focus individuals as a sub-type are relatively under-represented within the studies (n=16). Looking at figure 3 more generally, most studies involved a similar division of direct and indirect support individuals. If the Frey *et al* (2010) study is treated as an outlier and removed, direct-support individuals (n=76) are relatively less well represented than indirect-support individuals (n=84), when viewed like this, the picture of participants investigated is

most commonly those who are furthest removed from the actual day-to-day experience of PBS (i.e. indirect-support individuals). There is a likely explanation for why this pattern emerged in terms of the spread of participants and that is perhaps because those focus individuals typically in receipt of PBS are most commonly children / adolescents, people with learning disabilities / difficulties and / or people with mental health difficulties, in each of these cases, more complex issues around capacity and gaining informed consent present barriers to researchers.

In terms of the gender of those participants involved, five studies did not report or provided unclear information relating to the gender of their participants (Bambara *et al*., 2001; Frey *et al*., 2010; Hieneman & Dunlap, 2000; Lohrmann *et al*., 2008, 2012) and are therefore not considered in this section of the review. Of the remaining six studies in which gender was clearly reported, by grouping indirect and direct-support individuals together: these studies contained 71 female support-individuals and 26 male support-individuals. For focus individuals' gender: 15 were male and 1 was female. Whilst the sample sizes here are small, there is a skewed picture in terms of support-females (n=71) being far better represented than support-males (n=26). The opposite skew is apparent in the focus individuals (albeit an even smaller sample) whereby male focus-individuals (n=15) are far better represented than female focus individuals (n=1). The skew in support individuals is likely representative of the general picture of support individuals within the teaching and caring professions, whereby females are better represented than males. The skew of male focus-individuals can be explained by the fact that the Davies *et al* (2016) study, which accounts for the majority of focus individual participants in this review, sampled from male-only hospital wards.

The final key characteristic of consideration is the quality and quantity of participant experience with PBS. Of the 11 studies reviewed, seven made reference to their participants having received 'training' in PBS (Andreou *et al*., 2014; Bambara *et al*., 2009; Frey *et al*., 2010; Hieneman & Dunlap, 2000; Houchins & Jolivette, 2005; Lohrmann *et al*., 2012; Woolls *et al*., 2012). There was generally a lack of detail regarding the quality and quantity of the training received, it is therefore difficult to

make judgments on the quality of participants expertise with PBS based on the presence or not of training. As such, every study comments that participants have 'experience' of PBS *in vivo.* This experience is most commonly measured in years and was used to determine inclusion for studies in some cases. A single study required participants to have at least one-year minimum experience (Woolls *et al*., 2012), another required 1.5 years minimum experience (Houchins & Jolivette, 2005), four studies reported participants having minimum experience of two years (Bambara *et al*., 2001, 2009; Lohrmann *et al*., 2008, 2012), one study reported three years minimum experience (Hieneman & Dunlap, 2000) and one study reported five years minimum experience (Andreou *et al*., 2014). Lastly, two studies reported that participants had experience of PBS but they did not offer any quantification of this (Frey *et al*., 2010; Inchley-Mort & Hassiotis, 2014). With regard to the studies involving focus-individuals (Davies *et al*, 2016; Inchley-Mort & Hassiotis, 2014) only Davies *et al* (2016) provide information relating to the nature of their involvement, stating service users were involved in the development of plans and also provide information for each participant regarding the length of time they have had a PBS plan in place, which offers an indication of the time individuals have been 'receiving PBS'.

It can therefore be surmised that those individual participants in this review (where reported) have a range in their quantity of experience *in-vivo* (minimum 1-5 years) and also likely a range in the quality / quantity of their training (not reported). Whilst there is evidence to suggest that training for support-individuals in PBS improves outcomes for focus-individuals (MacDonald & McGill, 2013), the quantity of PBS experience and presence (or not) of training does not necessarily correlate positively with the resultant efficacy or fidelity of the PBS delivered.

As such, some studies reviewed here provided extra information (assessed via formal or informal measures) to control for the efficacy or fidelity of the PBS delivered by their participants. Two studies report that the fidelity / efficacy of PBS (as measured by the School-wide Evaluation Tool, (Sugai, Palmer, Todd, & Horner, 2001)) at each site where participants were drawn was between 86%-89% (Andreou

et al., 2014) and 80%-99% (Lohrmann *et al*., 2012). Three other studies make references to informal fidelity / efficacy measures such as selecting only participants 'successful' in PBS (Bambara *et al*., 2001; Lohrmann *et al*., 2008), or with basis of their approach containing 'key positive behaviour support characteristics' (Bambara *et al*., 2001, p.215) or having specific experience of a component of PBS such as 'functional assessment' (Hieneman & Dunlap, 2000).

Again, whilst largely unknown, the potential for variation in the fidelity and efficacy of the PBS delivered amongst the studies reviewed here is large. There is some general agreement within the literature about the characteristics and components required for fidelity to the PBS model (Allen *et al*., 2005; Dunlap *et al*., 2000; Gore *et al*., 2013) however few studies here make explicit attempts to address this issue. Whilst the review here is not concerning fidelity / efficacy of PBS, there are perhaps implications for individual experience and perception, i.e. the individual experience / perception of PBS that is carried out with fidelity and efficacy is likely to be different to that which is not.

1.10.4. *Methods used*

Generally, the methods used to collect data across all studies are well described. All 11 studies reviewed here used cross-sectional designs with qualitative methodologies. One study has a mixed methodology (Frey *et al*., 2010) whereby quantitative survey data were also used to make comparisons between multiple sites in order to evaluate outcomes associated with the presence of PBS and further compare these to their qualitative findings.

All studies employed either individual semi-structured interviews or focus groups with participants. A single study used both individual interviews and focus group methods (Woolls *et al*., 2012). Nine of the studies reported that data was audio-recorded and subsequently transcribed, of the remaining two studies, one employed 'detailed' note taking during focus groups (Houchins & Jolivette, 2005) and the other did not report how verbatim data was recorded (Hieneman & Dunlap, 2000).

All studies reviewed here adopted a process of coding the data in order to

progressively abstract themes or factors (or similar) in order to make broader sense of what individuals talked about. Woolls *et al* (2012) used a grounded theory approach, four other studies (Bambara *et al*., 2001; Houchins & Jolivette, 2005; Lohrmann *et al*., 2008, 2012) used approaches consistent with the grounded theory methodology citing either a process of 'open coding' or 'constant comparative analysis', however a grounded theory was not presented. Two studies (Hieneman & Dunlap, 2000; Inchley-Mort & Hassiotis, 2014) reported use of content analysis. Frey *et al* (2010) report using thematic analysis, Davies *et al* (2016) used Interpretative Phenomenological Analysis (IPA), Andreo *et al* (2014) used critical incident technique that identified specific and observable behavioural events, and finally Bambara *et al* (2009) used a modified consensual qualitative research process to identify codes and core ideas. Every study included a process of triangulation to improve the reliability and validity of their codes / themes etc. All studies except Woolls *et al* (2012) employed multiple researchers as part of the coding and theme development process. Woolls *et al* (2012) did however use a separate focus group to triangulate data. Also, Lohrmann *et al* (2008), in addition to the use of multiple researchers, checked codes at a later stage with their participants to further enhance their validity. Despite the methodological similarities amongst the articles reviewed here, only Woolls *et al* (2012) proposed a theoretical model in attempt to explicitly explain the inter-relation of their resultant themes, grounded in the data.

1.11. *Synthesising the findings*

Comparing the findings from the studies in order to determine how they relate (step 4) involved listing and juxtaposing key findings used in each study. Next, Noblit and Hare (1988) state that the translating and synthesising of multiple findings into each other (steps 5 & 6) entails a process of considering, for example, that 'one case is like another, except that…' (p.38). Britten *et al* (2002) describe that when determining how their review studies were related they 'looked across the different papers for common and recurring concepts' (p.211). This procedure is consistent with 'line of argument' and 'reciprocal translation' approaches (Noblit & Hare, 1988).

These approaches were utilised for this review whereby firstly, themes across papers

were compared and matched with themes from others (reciprocal translation), alongside this new levels of interpretation were offered based on the author's interpretation of those existing interpretations from within the studies (an interpretation of an interpretation). 'Lines of argument' were developed by comparing interpretations, examining similarities and differences and integrating the findings within a new interpretation (Pope, Mays & Popay, 2007) but 'retaining, as far as possible, the terminology used by the authors to remain faithful to the original meanings' (Campbell *et al*., 2011, p.10).

Many published examples of meta-ethnography utilise Schutz's (1962) notion of 'first-order', 'second-order' and 'third-order' constructs. First order constructs reflect participants' understandings, as reported in the original studies (e.g. direct quotations), second order constructs reflect the authors' interpretation of the participants' understanding and third order constructs reflect the subsequent interpretation of the original authors' interpretation. Typically, the 'data' or 'building blocks' of the meta-ethnographic approach are the second-order constructs within the original studies (Britten *et al*., 2002; Toye *et al*., 2014). The decision was taken to focus on second-order constructs in this review which is consistent with seminal published examples (Britten *et al*., 2002; Campbell *et al*., 2003) and based on the argument well articulated by Toye *et al* (2013) that putative 'first order' constructs (e.g. direct quotations) are actually 'second order' due to having been *pre-selected* from the wider data corpus:

> *"Importantly, although first-order constructs are often presented in meta-ethnographies to represent the patients 'common sense' interpretations in their own words, it is important to remember that these words are chosen by the researchers to illustrate their second-order interpretations".* (p.13)

As such, use of first order constructs, such as direct quotes, risk being subject to re-interpretation and attributed new meanings that differ from the original authors' interpretation. The process of focusing on second order constructs is thus consistent with that advised by Walsh & Downe (2005) whereby they advocate the 'preservation of meaning from the original text as far as possible' (p.208).

Therefore, for this synthesis, the studies' second order constructs (e.g. themes, concepts) were reviewed from the data extracted in the individual study summary tables (Appendix A) and subject to 'reciprocal translation' and 'line of argument' approaches.

Four superordinate and nine subordinate third-order constructs were developed and entered into a grid format in order to indicate where each construct was translated from pre-existing constructs from within the studies (see Table 1 below). Similar to the worked example outlined by Britten *et al* (2002), each column of the grid represents a third order construct. In labelling the third order constructs, the author aimed to use terminology that encompassed the most relevant and prevalent themes, concepts etc. from each of the studies in order to answer the question posed by the systematic review. Within the grid, the quality scores for each study are included, as well as the sub-types of participant involved in the studies.

Table 1: Meta-Ethnography of Reviewed Articles

Study			Third-Order Constructs									
			Individual Factors			**Organisational Factors**			**Process Factors**			**The Relationship** between direct support and focus individuals
No.*	Participant type**	Quality rating	Congruence of values with PBS	Buy-in to PBS	Understanding PBS	Congruence of organisational values with PBS	Organisational support for PBS	Resource provision (e.g. time, staffing, training, admin)	Fidelity	Collaboration / Communication	Direct supporter wellbeing (e.g. stress / burnout)	
1	a,b	68%	x		x		x	x	x	x	x	x
2	a,b	63%	x	x		x	x	x	x	x		
3	a,b,c	81%					x	x	x			x
4	a,b	81%	x	x		x	x	x	x	x		
5	a,b	79%	x			x	x	x			x	x
6	a	73%	x	x		x	x		x	x		
7	c	90%			x			x	x			x
8	a,b	73%		x				x	x	x	x	
9	a,b	74%	x	x		x	x	x	x	x	x	x
10	a,b	76%				x	x	x				x
11	a	78%		x	x	x	x				x	

* 1. Woolls, Allen & Jenkins (2011), 2. Houchins et al (2005), 3. Inchley-Mort & Hassiotis (2014), 4. Andreou et al (2014), 5. Bambara at al (2001), 6. Lohrmann et al (2008), 7. Davies, Mallows & Hoare (2016), 8. Frey et al (2010), 9. Hieneman & Dunlap (2000), 10. Bambara et al (2009), 11. Lohrmann et al (2012)
**Participant types: a=Indirect supporter, b=direct supporter, c=focus individual

1.12. *Expressing the synthesis*

Step 7 entails expressing the findings of the synthesis to maximise their impact. The following sections will summarise the third-order constructs derived from the studies.

1.12.1. *Individual Factors*

PBS is applied by systems of unique individuals in varying contexts. A key theme identified in most studies is the perception that individuals differ in particular ways, which influences their relationship to PBS. Most of the studies here commented to some extent about individual factors:

I) Congruence of values with PBS

A broad theme identified across most studies was that concerning the values of those individuals towards PBS as an approach. This concerned a perception that certain individuals possess values that are more congruent with PBS. A number of studies described this as the individuals: 'philosophy' or 'guiding values' fitting with the model (Bambara *et al*., 2001); their 'match with prevailing philosophy' (Hieneman & Dunlap, 2000); their 'philosophical agreement' (Houchins & Jolivette, 2005); 'philosophical difference' (Lohrmann *et al*., 2008); 'conflict in personal beliefs' (Andreou *et al*., 2014) or whether they 'embrace' the PBS model (Woolls *et al*., 2012).

II) Buy-in to PBS

Another term used to describe similar phenomenon is whether individuals 'buy in' to the approach at an attitudinal level (Andreou *et al*., 2014; Houchins & Jolivette, 2005; Lohrmann *et al*., 2012). In some circumstances, studies related this 'fit', 'match', 'agreement' etc. to the individuals view or opinion on using positive reinforcement and preventative strategies as oppose to punitive responses (Bambara *et al*., 2009; Houchins & Jolivette, 2005; Lohrmann *et al*., 2008) or 'consequences' (Andreou *et al*., 2014). A similar attitudinal theme is that the individual 'fit' with PBS is related to their level of 'scepticism', 'resistance' (Frey *et*

al., 2010; Lohrmann *et al*., 2008), or negative beliefs regarding the effectiveness of PBS (Frey *et al*., 2010; Hieneman & Dunlap, 2000). Additionally, a number of individuals in studies perceive positive attitudinal characteristics that are seen to promote good PBS practice, such include 'commitment' (Bambara *et al*., 2001; Woolls *et al*., 2012), 'ownership' of the model (Andreou *et al*., 2014), 'empathy' (Bambara *et al*., 2001) and 'optimism' or 'energy-level' for the approach (Frey *et al*., 2010; Hieneman & Dunlap, 2000).

III) Understanding PBS

A few studies made references to the perception that individuals involved in PBS have different levels of 'understanding' regarding the approach. This individual 'understanding' relates more generally to the PBS approach as a whole and is constructed variably including: 'knowledge and understanding of PBS' (Woolls *et al*, 2012), 'how I understand PBS' (Davies *et al*, 2016) and 'staff not understanding PBS' (Lohrmann *et al*, 2012).

1.12.2. *Organisational Factors*

In all 11 of the studies it is clear, to a greater or lesser extent, that there is a perception whereby the 'doing' of PBS cannot be seperated from the context in which it occurs. The multiple service contexts in which the studies here concern (see Section 1.9.1) are unique however a number of similar themes were identified relating to the perception of contextual or organisational factors implicated in PBS.

I) Congruence of organisational values with PBS

Many of the studies' themes related to the congruence of the values between the organisation and those associated with the PBS approach. This was constructed in variable terms including the 'ecological congruence' with PBS (Houchins & Jolivette, 2005), the 'fit' of PBS practices within the school context (Andreou *et al*., 2014), PBS as a broader 'world view' or 'philosophy' (Bambara et al, 2001), the 'responsiveness' and 'flexibility of the system' in relation to PBS (Hieneman & Dunlap, 2000), the 'culture' of the organisation 'sharing a common understanding and appreciation for

PBS' (Bambara *et al*., 2009) and the impact of 'climate and system influences' on the application of PBS (Lohrmann *et al*., 2012).

II) Organisational support for PBS

In each study participants existed within an organisational system whereby they are largely indirect or direct supporters of PBS implementation, along with those individuals who are the focus of PBS (see figure 3). A common perception within nearly all studies was that those directly supporting focus individuals value the indirect support offered and often saw this as pivotal in provding effective PBS. This notion of support appeared in multiple thematic forms including, for example: 'the visibility of external support' (Woolls *et al*., 2012); the 'availability and frequency of contact' with indirect supporters (Inchley-Mort & Hassiotis, 2014); 'access to external expertise' (Andreou *et al*., 2014); 'organisational structure in support of PBS important' (Andreou *et al*, 2014); the 'importance of district and principal level support, leadership and promotion of PBS' (Bambara *et al*, 2009) and 'support for the team' (Bambara *et al*., 2001). Similarly, another study reported a barrier to implementing PBS 'when PBS lacks support at higher levels of administration' (Lohrmann *et al*, 2008).

III) Resource Provision

A number of thematic factors were identified across the studies that can be related to specific organisational provisions perceived to be important to the successful implementation of PBS. A number of references were made to the provision of staffing needed to deliver PBS: this was referred to as the importance of 'staff team stability' (Woolls *et al*., 2012); with issues of difficulty occuring when there is increased 'staff-turnover' (Andreou *et al*., 2014); or 'too few support staff' (Frey *et al*., 2010); or 'staff resources' (Davies *et al*, 2016); or 'failures to hire staff' (Bambara *et al*., 2001). Also, a few studies made thematic reference to the organisational provision of 'time' required to implement PBS, and that 'limited time' can impact service delivery negatively (Frey *et al*., 2010; Houchins & Jolivette, 2005). Specific references are also made to the time needed for training, learning, collaboration,

communication and co-ordination (Houchins & Jolivette, 2005) and time for team meetings (Bambara *et al*., 2001, 2009).

1.12.3. *Process Factors*

In each of the 11 studies, references are made to issues of process which impacted the effiacy of PBS delivery, a number of studies term this as 'barriers' to implementation and often explored this specifically as part of their interview schedule or wider study aim (Bambara *et al*., 2009; Houchins & Jolivette, 2005; Lohrmann *et al*., 2008, 2012; Woolls *et al*., 2012). Not surprisingly, these studies identified themes that included 'barriers' or 'challenges' to the PBS process. Additionally, a number of studies that did not explicitly set out to identify process related factors or challenges to PBS also did so (Andreou *et al*., 2014; Davies *et al*., 2016; Frey *et al*., 2010; Hieneman & Dunlap, 2000; Inchley-Mort & Hassiotis, 2014).

I) Fidelity

Of the process factors described within the identified themes, the most popular arising throughout the studies was around maintaining fidelity to the PBS approach. This is frequently discussed in terms of 'consistency' of the PBS process between support staff and / or settings (Andreou *et al*., 2014; Davies *et al*., 2016; Frey *et al*., 2010; Hieneman & Dunlap, 2000; Houchins & Jolivette, 2005; Inchley-Mort & Hassiotis, 2014; Lohrmann *et al*., 2008). Woolls *et al* (2012) similarly describe this as a process of 'getting it right' where as Hieneman & Dunlap (2000) term this the 'integrity of implementation'. Additionally, both studies involving focus indivudals raised similar issues around their perception of PBS plan implementation i.e. 'staff not following guidelines put in place' (Inchley-Mort & Hassiotis, 2014, p234) and 'staff fidelity to the plan' (Davies *et al*, 2016).

II) Collaboration / Communication

A number of studies also cited poor 'communication' between support individuals as a barrier to the PBS process. This is variably constructed as 'poor internal communication' (Frey *et al*, 2010), 'communication' (Hieneman & Dunlap, 2000;

Houchins & Jolivette, 2005) and 'communication between staff' (Woolls *et al*., 2012). Similarly, the importance of collaboration between staff members is seen as beneficial to the PBS process, this is constructed for example as: 'networking and connections' between individuals who implement PBS (Andreou *et al*., 2014), 'collaboration among providers – support providers working together' (Hieneman & Dunlap, 2000), 'the importance of teams supporting each other in order to support people with challenging behaviour' (Bambara *et al*., 2001) and also 'non-collaboration' between staff as a barrier to the PBS process (Lohrmann *et al*., 2008).

III) Direct supporter wellbeing

Lastly, a number of studies commented that the process of PBS can be perceived as stressful for those supporters involved. This has been termed as 'support dealing with stress of challenging behaviour' (Bambara *et al*., 2001), 'intra-personal stress level' (Woolls *et al*., 2012), 'burnout' (Frey *et al*., 2010) and a negative impact on 'emotional wellbeing' (Hieneman & Dunlap, 2000) and 'staff morale' (Lohrmann *et al*., 2012). These themes are associated with challenges to the PBS process more generally with many of the studies advocating the need for staff to be supported adequately to manage their wellbeing whilst involved with a PBS process.

1.12.4. *The relationship between direct support and focus individuals*

The relationships between direct supporters and focus individuals are perceived to be thematically important in a number of the studies. Considering that the focus of PBS is to better understand an individuals needs and provide support, it is not surprising many individuals commented on the importance of this relationship. The nature and importance of this relationship is described in various ways, such as: 'knowing the service user' (Woolls *et al*., 2012); 'talking about behaviour and being listened to' and 'understood' (Inchley-Mort & Hassiotis, 2014); 'understanding the person' and 'seeing the person as a person' (Bambara *et al*., 2001); 'understanding me and sharing my story' (Davies *et al*, 2016); 'relationship with the individual' (Hieneman & Dunlap, 2000); and 'family', 'student' and 'community involvment' (Bambara *et al*., 2009; Frey *et al*., 2010).

Interestingly, studies with relatively higher ratios of indirect support individuals (Houchins & Jolivette, 2005) or those studies with samples that were exclusively indirect support individuals (Lohrmann *et al*., 2008, 2012) did not generate explicit themes concerning the relationship with the focus individual. In direct contrast, and perhaps importantly, the two studies which contained focus individuals (Davies *et al*, 2016; Inchley-Mort & Hassiotis, 2014) both had core themes concerning the relationship between support individuals and the focus individual, and specifically a need for 'understanding' between them.

Whilst it has already been highlighted that focus individuals are not very well represented within this review, the themes identified suggest that focus individuals and direct support individuals perceived their relationship to be important when implementing PBS.

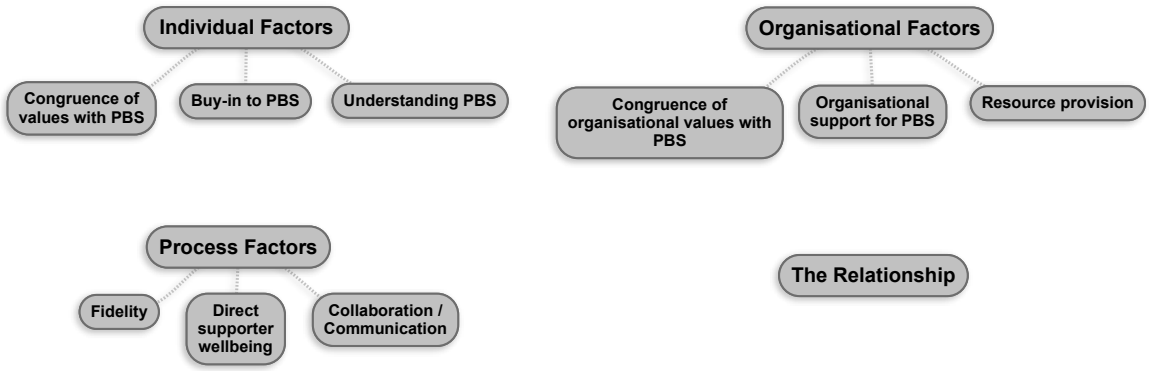
1.13. *Summary of results*

In summary, the studies here have been subject to a meta-ethnographic approach facilitating an insight into the perception of PBS across a number of different organisational settings containing different individuals with different relationships to PBS. The meta-synthesis of themes across all of the review articles helped to answer the review question: *What perceptions do individuals hold of Positive Behavioural Support?*

The methods used across the studies have all identified qualitative themes which the author has extracted and translated into four super-ordinate third-order constructs: *Individual factors; Organisational factors; Process factors* and *The relationship*. The meta-ethnography suggests that *individual factors* such as the congruence of personal values with those of PBS, the individuals degree of 'buy-in' to the approach and their understanding of it are likely important factors in the perception of PBS. With regards to *organisational factors*, the meta-ethnography suggests that, similarly to the *individual factors*, congruence of values with those of PBS are also perceived to be important at an organisational level. It is also suggested that more general *support for PBS* at an organisational level is important along with the

provision of resources to support the implementation of PBS. Additionally, a number of *process factors* are perceived as important which include: the maintenance of *fidelity* to the PBS process; the need for inter-staff *collaboration and communication* and the importance of positive *wellbeing* for those direct supporters involved. Lastly, the *relationship* between direct supporter and focus individual is perceived to be important when implementing PBS. Figure 6 presents the third-order constructs extracted and translated using the meta-ethnographic approach:

Figure 6: Diagrammatic representation of third-order constructs



1.14. *Implications for research*

This systematic review demonstrates that the current research base relating to qualitative perceptions of PBS has clear scope for further research. At present, most of the research concerns school-wide PBS or PBS within learning disability contexts, there is hence a clear need to explore and determine the generalisability of PBS in other contexts where PBS might take place.

Most studies explore the experience and perceptions of indirect and direct support individuals. Given that nearly all studies make some thematic or conclusive reference to the importance of context and inter-relation between individuals, there is a need for research that takes a 'whole picture' approach of the multiple individuals involved in PBS, especially focus individuals, who are largely underrepresented.

There is a lack of description in the qualitative studies regarding the quality of PBS

training received and the fidelity of PBS delivered by support individuals. It could be hypothesised that quality of PBS training and / or fidelity of PBS delivery impacts individual perceptions of PBS. Further research is therefore indicated in this area.

In some studies, focus-individuals and direct-support individuals perceive their relationship to be centrally important when implementing PBS. There is a need for further research to explore the nature of the relationship between focus individuals and support staff from both perspectives.

Many studies reviewed here did not, for example, describe details of why specific methodologies were used or how the unique position of researchers might impact the analysis of data and identification of themes. As such, further research will generally be more robust and credible if greater attention is paid to quality assurance across a number of areas.

1.15. *Study aims and rationale*

1.15.1. *Rationale*

Within a post Winterbourne (DOH, 2012), Francis (Mid-Staffordshire NHS Foundation Trust Public Enquiry, 2013) & Andrews (DSDC, 2014) context, the department of health have launched a two-year initiative titled 'Positive and Safe' (DOH, 2014) in order to deliver transformation across all health and adult social care regarding the management of behaviour that challenges. It is widely recognised that secure forensic mental health inpatient services are a necessary provision for those adults with significant mental health problems and forensic histories who have complex needs and can present with challenging behaviour.

The development of a 'positive and proactive' workforce has been espoused at government level, where PBS is continually cited (Skills for Care & Skills for Health (2014), NHS Protect (2013), Department of Health (2014) as the key framework in which future services are to be developed, organised and delivered.

PBS has originated and been developed largely within the field of learning disabilities and school-wide contexts. The intention, as cited in the above guidance, is for PBS to become widespread throughout all health and social care settings in the UK. At present there is little research relating to its use within forensic mental health settings despite suggestion that its utility is clearly much wider than the current contexts in which it's being employed (Allen *et al* 2005, DOH 2014).

1.15.2. *Aims*

The research described here aims to address this gap in the existing research. Specifically, this research aims to better understand the perceptions of multi-disciplinary staff regarding their experience of PBS in a secure forensic mental health setting.

A thematic analysis (Braun & Clarke, 2006) will be employed to identify themes that represent the perceptions of multi-disciplinary staff within the context of a secure forensic adult mental health setting. This research will provide some insight to the

perceptions of PBS within this specific context and provide an indication of how the approach generalises from learning disability and school-wide contexts. There are potential implications for informing direct clinical practice such as staff training and service development regarding PBS in secure forensic mental health services for adults with mental health problems that exhibit behaviour that challenges.

2. METHODOLOGY

2.1. *Overview of qualitative thematic analysis*

This study used a qualitative thematic analysis methodology to explore staff perceptions of Positive Behavioural Support in a secure forensic mental health setting. Thematic analysis aims to find patterns or 'themes' that adequately describe the data being analysed (Howitt, 2010). Thematic analysis is a flexible approach that is able to provide a rich and detailed description of the entire data set (Braun & Clarke, 2006). The flexibility of thematic analysis is related to its epistemological freedom. As such, Braun & Clarke (2006) argue that thematic analysis is not wedded to any pre-existing epistemological position and can therefore be applied from a variety of positions. Although thematic analysis is widely used, it is poorly demarcated and rarely acknowledged (Braun & Clarke, 2006). As such, Braun and Clarke (2006) offer specific guidelines regarding how a thematic analysis can be conducted along with detailing a number of decisions that researchers should consider in order to understand and clarify their position in respect to their own thematic analysis.

For this research, Braun & Clarke's (2006) guidelines were used as they offer the best available and most widely cited description of the method. In accordance with this guidance, the decisions were taken to conduct an 'inductive' thematic analysis of 'semantic' content from the interview transcripts so that 'bottom-up' or 'grounded' themes could be developed that were strongly linked to the data themselves i.e. 'data-driven' (Braun & Clarke, 2006). The research was conducted and approached from a critical-realist epistemological perspective.

Within this section, a consideration of the epistemology, guidance and associated decisions for implementing this methodology will be taken, along with discussion of the particular design and procedures that were used to ensure that issues of research governance, quality and ethics were addressed.

2.2. *Rationale for the use of a qualitative thematic analysis approach*

This research aimed to develop themes demonstrating how staff members perceive

Positive Behavioural Support (PBS) in a secure forensic mental health setting. As the nature of personal 'perception' is a broad and unspecific area, it seems pertinent to apply a qualitative methodology that does not seek to constrict or limit the researchers point of view by adopting a lens that pre-determines identified phenomena or utilises methods of 'measuring' personal perception. For these reasons it has been recognised that when exploring a relatively 'new' or substantive area it can be difficult to use quantitative methodologies. Further to this, qualitative methods allow for greater descriptions and ways of understanding personal experience that quantification would inevitably reduce (Willig, 2013). Thematic analysis was adopted primarily for its epistemological and methodological flexibility. The author had initially decided that a constructivist grounded theory (Charmaz, 2014) would be an appropriate analytical method for this research, however, after supervisory feedback and reflection, the analysis was seen to be more in keeping with a form of thematic analysis. This reflects the experience of Braun & Clarke (2006) who state that:

> *'In our experience, grounded theory seems increasingly to be used in a way that is essentially grounded theory 'lite' – as a set of procedures for coding data very much akin to thematic analysis. Such analyses do not appear to fully subscribe to the theoretical commitments of a 'full-fat' grounded theory (…) we argue, therefore, that a 'named and claimed' thematic analysis means researchers need not subscribe to the implicit theoretical commitments of grounded theory if they do not wish to produce a fully worked-up grounded theory analysis'* (p.81)

As such, the initial decision to use constructivist grounded theory was translatable to a 'named and claimed' thematic analysis, both in terms of the procedural steps of the analysis, along with the epistemological position of the research. Additionally, Braun & Clarke (2006) state that:

> *'A thematic analysis does not require the detailed theoretical and technological knowledge of approaches such as grounded theory (…), it can offer a more accessible form of analysis, particularly for those early in a qualitative research career.'* (p.81)

Whilst the author has prior experience of qualitative research methods, it was felt that thematic analysis offered a better fit with the author's current level of

theoretical and technological knowledge of qualitative methods and therefore was adopted.

2.3. *Epistemological position*

Much of modern research practice can be said to lie on a continuum between quantitative and qualitative methodologies, this is perhaps a more helpful way of viewing modern research, rather than treating the two as discrete entities. Within this continuum, a researchers claim of knowledge will be largely determined by their epistemological assumptions and influence regarding 'how' and 'what' they claim to know (Creswell, 2014). In quantitative research, knowledge claims are based on a positivist paradigm whereby assumptions typically include linear 'cause and effect' thinking, reduction to pre-determined specific variables, hypotheses and questions (See Popper, 1969). The position of the researcher is also objectified, i.e. he or she adopts a passive, observer-like, one-way relationship with the data he or she collects (Creswell, 2014).

In contrast, qualitative research is based on a constructivist or relativist paradigm whereby there is not a single 'truth', 'cause' or 'effect', but instead multiple meanings of individual experiences that are constructed within diverse historical, social and cultural contexts (Creswell, 2014; Willig, 2013). The notion of constructivism has particular relevance in the social world, whereby such multiple meanings are co-constructed between and within individuals. This notion of social constructivism can be extended to the process of research itself as existing 'between' researcher and participant. Therefore any 'data' generated is a co-construction between researcher and participant and as such, the researcher cannot adopt a true position of objectivity in relation to what they observe. In this sense, any theoretical rendering of that which is observed offers only the researcher's interpretation or portrayal (Charmaz, 2014; Guba & Lincoln, 1994).

As mentioned, epistemological positions exist on a continuum and as such, positivist and constructivist positions are not mutually exclusive. Epistemology can range from positivist traditions, through critical-realist positions, to constructivist positions

(Guba & Lincoln, 1994). Critical realism assumes that knowledge or 'truth' can exist and be shared by multiple individuals, but each individual's experience of truth will be subjectively constructed from their unique perspective (Robson, 2002). As such, 'truths' can gain momentum or saliency by accumulating evidence from multiple individuals. Critical realism is thus sympathetic to both the epistemological positions of positivism as well as constructivism (Robson, 2002). Critical realism is consistent with thematic analysis in that neither is wedded to a discrete epistemological position.

This research was approached from a critical-realist epistemological position (Robson, 2002) in order to identify commonality, patterns or 'themes' that could be considered 'truths' from the perceptions of 11 staff members regarding the application of Positive Behavioural Support within a secure forensic setting, whilst also acknowledging that the researcher is active in constructing such 'truths'. It was felt that this epistemological position best suited the unique position of the author (see Section 2.8.1). Willig (2013) suggests that cohesion between the chosen methodology and the position of the researcher is important in enabling the researcher to conduct their enquiry.

2.4. *Semantic vs. Latent analysis*

Braun & Clarke (2006) state that another decision to be made concerns the 'level' at which themes are to be identified, a 'semantic' or 'latent' level. At the 'semantic' level, 'themes are identified within the explicit or surface meanings of the data, and the analyst is not looking for anything *beyond* what a participant has said…' (Braun & Clarke, 2006, p.84). In contrast, at the 'latent' level, analysis 'goes beyond the semantic content of the data, and starts to identify or examine the *underlying* ideas, assumptions and conceptualisations – and ideologies – that are theorised as shaping or informing the semantic content of the data' (Braun & Clarke, 2006, p.84).

This analysis focused on the semantic level of interview transcripts, rather than potential latent interpretation of meaning. A semantic approach is consistent with a critical-realist position in that it restrains the over-use of subjectivity on the

researcher's part, sticking more closely and as such attempting to reflect the reality and therefore 'truth' perceived by the individual participants.

2.5. *Inductive vs. Deductive analysis*

Braun & Clarke (2006) also state that themes within the data can be identified in one of two primary ways, an 'inductive' or 'deductive' approach. An 'inductive' approach means that the themes developed are strongly linked to the data themselves, as such, 'inductive analysis is therefore a process of coding the data *without* trying to fit it into a pre-existing coding frame, or the researcher's analytic pre-conceptions' (Braun & Clarke, 2006, p.83). In contrast, a 'deductive' or 'top down' approach would typically seek to organise and code data via pre-existing evidence or theory (Braun & Clarke, 2006). However, Braun & Clarke (2006) highlight that 'researchers cannot free themselves of their theoretical and epistemological commitments, and data are not coded in an epistemological vacuum' (p.84).

Whilst recognising the impact of the author's own position and bias (see Section 2.8.1), this study sought to employ an inductive approach as far as possible in order to develop themes that were closely reflective of the participants' views, rather than seeking to match or fit them with pre-determined views or theory. An inductive approach also suits substantive areas of research (Braun & Clarke, 2006). As the application of Positive Behavioural Support to Forensic Mental Health settings is a relatively new and emerging area, very little is known about the perceptions of staff within this setting. This added further reasoning to approach the analysis inductively.

2.6. *Procedural steps of thematic analysis*

Braun & Clarke (2006) provide a guide through six phases of thematic analysis. They also highlight that these phases are 'guidelines' and not 'rules', therefore they should be applied flexibly in a non-linear fashion whereby movement back and forth between phases can occur as needed. (Braun & Clarke, 2006, p.86). The different phases are summarised below in Table 2.

Table 2: Phases of thematic analysis (from Braun & Clarke, 2006, p.87)

Phase	Description of the process
1. Familiarising yourself with the data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts (level 1) and the entire data set (level 2), generating a thematic 'map' of the analysis.
5. Defining and naming themes	On-going analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

2.7. *Ensuring Quality*

The issue of quality control in relation to qualitative research has been critiqued by a number of authors (Dingwall & Murphy, 1998; Mays & Pope, 1995; Yardley, 2000). Many of the issues centre around the potential for lack of rigour and standardisation, likely due to the term 'qualitative' encompassing a number of varied methodologies and associated epistemologies (Potter, 1996; Yardley, 2000). As a result of such critique, attempts have been made to offer quality frameworks in order to guide the qualitative researcher (Elliott, Fischer, & Rennie, 1999; Mays & Pope, 1995). Elliott *et al*'s (1999) set of guidelines aim to serve the following functions:

> *'…to contribute to the process of legitimising qualitative research; to ensure more appropriate and valid scientific reviews of qualitative manuscripts, theses, and dissertations; to encourage better quality control in qualitative*

research through better self- and other-monitoring; and to encourage further developments in approach and method' (p.215)

Elliot *et al*., offer seven guidelines, based on 40 quality standards that had been amalgamated from various other sources (see Elliot *et al*., 1999). In an attempt to ensure better quality throughout this piece of qualitative research, the author outlines below how these guidelines are being addressed.

2.7.1. *Owning one's perspective*

Authors are encouraged to specify in advance, and as they might develop during the research; their theoretical orientations, values, interests and assumptions. The author must also recognise the impact such might have on the way they interpret and analyse that which they purport to research. The disclosure of the above enables the reader to make his or her own interpretations of the researcher's data, given the context that has been supplied. The current research achieves this by the author providing a statement that outlines their position (see Section 2.8.1). Additionally the author provides example information displaying their views during the course of the research via extracts from a reflective journal (See Appendix C).

2.7.2. *Situating the sample*

Authors should describe the life circumstances of those participants included in the research. An example of good practice would entail providing some basic descriptive and / or demographic data that allows the reader to make judgments regarding the range of individuals included and how subsequent findings might be generalised. The current research achieves this by providing descriptions along with some demographic details for each participant that are relevant to this research (See Table 3).

2.7.3. *Grounding in examples*

Authors should provide examples of data that demonstrate the procedures of analysis undertaken and the subsequent understanding that has developed from the analysis. This enables the reader to appraise the fit between the data and the

understanding that the author has made. This also invites the reader to consider alternative ways of understanding the data. The current research achieves this by providing a description of themes and sub-themes that have been constructed from the data in Section 3. In addition, coded extracts from interview transcripts are provided (See Appendix I, p.207).

2.7.4. *Providing credibility checks*

There are a number of methods whereby an author can reinforce the credibility of their analysis. These include checking understanding with the participants and / or others similar to them, using other qualitative analysts to review the data, and triangulating with other external factors or data sources. This is achieved in the current research by the author discussing and checking the constructed codes, themes and sub-themes with clinical and academic supervisors as well as a trainee clinical psychologist undertaking a similar project. Furthermore, the selection of thematic analysis as a method promotes the use of 'non-linear' movement between phases of the analysis, as such identified themes are checked and re-checked with coded extracts of verbatim.

2.7.5. *Coherence*

Authors should endeavour to represent their understanding of the data in a coherent and integrated fashion whilst preserving nuances within the data. Therefore, the understanding that the author constructs should fit together to form an integrated summary or narrative that 'maps' an underlying structure. The current research outlines each phase of the analytic process, as per Table 2. These phases within the process are discussed in detail with the research team. Additionally, the results and discussion sections provide both narrative and diagrammatic interpretations of the data. Further, examples of the analytical process are provided within Appendix I.

2.7.6. *Accomplishing general vs. specific research tasks*

Authors should provide clarification regarding the extent to which their research provides a *general* or *specific* understanding of a phenomenon. Where a *general*

understanding is intended; 'it is based on an appropriate range of instances (informants or situations)…[where] limitations of extending the findings to other contexts and informants are specified' (Elliott *et al*., 1999, p.223). When a *specific* understanding is intended, authors should ensure 'it has been studied and described systematically and comprehensively enough to provide the reader a basis for attaining that understanding' (Elliott *et al*., 1999, p.223). Such research should also state any limitations of extending the findings beyond their immediate context. The current research represents a sample of staff members (n=11) who work within a secure NHS forensic hospital within the UK. Therefore the findings in this case are not considered to be generalisable to any other group. Information regarding the participants is provided within this section in order for the reader to make their own views regarding the extent to which any findings can be applied to other settings. It is the author's view that any such generalisations are made very tentatively and with caution. Limitations of this research are further considered within the discussion (Section 4).

2.7.7. *Resonating with readers*

The research presented should resonate with those who read it. Therefore, those who read it can trust it to represent an accurate reflection of the participants and author's co-constructed understanding, along with providing the opportunity for the reader to have clarified or expanded their own understanding. The current research has aimed to achieve this via providing draft versions of their emerging analyses for supervisors to read. The author actively invited feedback from supervisors during such supervisory discussions in order to increase the likelihood that any sense making from the data would ultimately resonate with those who read the research.

2.8. *Personal and Professional Reflexivity*

Within the field of qualitative research, 'reflexivity has been increasingly recognised as a crucial strategy in the process of generating knowledge…' (Berger, 2015, p.1). Reflexivity within the qualitative research process broadly pertains to the author's sensitivity to their own role and self in the creation of knowledge-claims. The process of reflexivity is normally bought about by a self-exploration of ones personal

biases, values, experiences, and how such might impact what is claimed within a 'professional' research context.

Within this research, the author is thus careful to scrutinise the research experience, decisions, and analytical interpretations that inevitably bring the self into the process. This is achieved by declaration of the researcher's values, position, interests and assumptions in order for the reader to form an opinion of the stance from which the author has conducted his research (see Section 2.8.1). Further to this, memos and extracts from the author's reflective journal are included within the appendices (see Appendix C & D) to facilitate additional transparency of the author's reflexivity.

2.8.1. *Position of the author*

The author positions himself as a 30 year old, British, white male who at the time of writing is completing the final year of a doctoral course in clinical psychology. He defines his family background as working class and politically centralist in their narratives, although he would now position himself as having moved left of centre over the past decade. He believes this movement has largely occurred due to his professional and academic journey, which, to this point has included study of psychology at undergraduate and post-graduate level, along with post-graduate study in the field of mental health. After graduating, he actively pursued a career in clinical psychology and began working in different capacities in secure forensic mental health environments. Following this the author worked in community learning disability services, an area in which he has a passion, likely as a result of growing up with a younger sibling who can be described as having a 'learning disability'. Having worked primarily in the fields of learning disability and mental health, he feels that he has been exposed to areas of society that are marginalised both historically and currently, which has had a profound impact on his world view and underlying epistemological stance. He would describe his stance as a social constructivist and a critical psychologist in relation to the areas of learning disability and mental health. His own psychology strongly takes into account an individual's subjectivity, the context of their behaviour, thoughts, feelings and the social, cultural and political context in which they can be understood and under no circumstances

separated from. As he believes self and context are inseparable, he feels uncomfortable with any psychological or sociological stance that seeks radical objectivity, neutrality, and / or claims to provide a 'truth'. He strongly believes that human life is far too fantastic and complex for us to seek reductionist explanations that can hold 'true' for all people and for all of the time. Despite this, he is very respectful of other epistemological stances held and their contributions in effort to develop better human understanding. He therefore, in no way considers his position to be 'the right one' or 'correct'.

As a result of this stance, in his relationship to areas such as learning disability and mental health, he strongly feels neutrality is not possible; he seeks to better understand the unique views of people who have been positioned by society as having a 'disability' or 'disorder', because for him, 'disability' and 'disorder' can often, inadvertently, be forms of oppression. In this sense, he believes that the person is not disadvantaged by his or her 'disability' or 'disorder'. It is not innate inability that 'disables' or 'disorders' the person, it is the hostility and naivety of society, the popularity of conservatism and reluctance to be politically adaptive or progressive that provide the real barriers for 'disabled' or 'disordered' men and women. Despite putting forward such views, the author often experiences a sense of inner conflict relating to his position and asserts that such position statements are dynamic and subject to change in response to life experiences. As a result, he believes that contradictory positions, explanations and interpretations can coexist both within himself and other people.

His interest in Positive Behavioural Support within forensic mental settings is likely a result of his interest and previous experience in forensic mental health settings. Additionally, he has applied Positive Behavioural Support in his work with people with learning disabilities. The relatively new meeting of PBS and forensic mental health therefore intrigues him. The author also hopes to gain future employment in the areas of learning disability and / or mental health services and thus wishes to further develop his knowledge in these areas.

2.9. *Design*

The current research utilised a qualitative thematic analysis guided by the principles outlined by Braun & Clarke (2006) in order to explore the perceptions of staff members working to implement Positive Behavioural Support in an NHS Secure Forensic Mental Health setting. The researcher carried out 11 semi-structured interviews with multi-disciplinary staff members who had direct experience of PBS. In particular the researcher sought to explore:

- How staff define and understand PBS.
- What processes exist when implementing PBS
- What facilitates effective implementation of PBS
- What barriers exist to the effective implementation of PBS
- The fit between PBS and the 'forensic' context

Interview questions were largely based within these above areas of exploration, however, some flexibility to the interview schedule occurred in response to identified data, where the author sought to follow-up new potential themes, as consistent with the inductive nature of the thematic analysis chosen. Data analysis was guided by the phases of thematic analysis outlined by Braun & Clarke (2006).

2.9.1. *Research Context*

All interviews for the purpose of this research were conducted within a single NHS Secure Forensic Hospital site.

2.10. *Clinical Governance*

2.10.1. *Ethical Approval*

Prior to the commencement of this research, ethical approval was sought from the South-West Exeter National Research Ethics Service (NRES) Committee, on behalf of the NHS Health Research Authority, and was granted a favourable ethical opinion in

August 2015 (see Appendix E). Ethical approval was also necessary at a local level and was sought from a local NHS Research and Development Committee and was granted permission in September 2015 (see Appendix E). In August 2016, the research supervisor of this project was changed due to unforeseen circumstances and as such a 'change of contact' was registered and participant information forms were edited to reflect the change of contact (see Appendix F). This was considered a non-substantial amendment and as such, a further ethical opinion from the Research Ethics Committee was not required, local approval was however gained (see Appendix E).

2.10.2. *Informed Consent*

Potential participants were initially identified and contacted by the on-site clinical supervisor who provided them with an information sheet (see Appendix F) and provided general verbal information consistent with that in the information sheet. On the basis of the information provided by the clinical supervisor, participants were asked to give verbal consent to be approached, in person, by the author to further discuss participation and if consenting, to participate in an interview with the author.

Having received consent to be contacted and with all participant inclusion and exclusion criteria addressed, individual participants were contacted in person by the author. At this point participants were read and / or asked to re-read the relevant information sheet and asked if they had any questions regarding the research, following this they were asked to complete a consent form (see Appendix G). Having received a completed consent form and prior to commencing the interview, participants were reminded that they were free to withdraw from the study at any point with any personal data fully withdrawn and deleted.

2.10.3. *Confidentiality*

Each interview was audio recorded using a digital audio device and transcribed either by the author or a professional transcriber subject to a confidentiality agreement. Any personal identifying information contained within the transcripts, such as references to staff members or patients were deleted. To maintain

anonymity, each participant was allocated an arbitrary number for the purposes of analysis. Only such anonymised data was viewed by the research supervisors. Within the final write-up of the results, participants were given pseudonyms in order to retain the human-nature of the verbatim.

2.11. *Participants*

2.11.1. *Sample*

This study aimed to recruit a relatively small homogenous sample for whom the research question was personally salient and applicable (Lyons & Coyle, 2007). The more inclusion and exclusion criteria that are applied to determine a sample, and the more specific these criteria are, the more homogenous the sample becomes (Robinson, 2014).There are a number of inclusion criteria detailed below which aim to create a homogenous sample appropriate to answer the research question. As the research question concerns the staff group as a whole, a purposive sample of multi-disciplinary staff members were selected as broadly representative of the wider staff population. In this sense, the sample is heterogeneous in terms of staff job types. The rationale for gaining heterogeneity in relation to staff job types is that PBS is applied by multi-disciplinary staff and therefore any thematic commonality found across cases are more likely to be widely generalisable to the multi-disciplinary staff population and not just an individual group of staff.

A total sample of 11 staff were recruited into the research. A total sample size for this research was not pre-defined as guidance on sample sizes for thematic analyses is non-specific and should be guided by the needs of the study (Braun & Clarke, 2006). Additionally, in qualitative research the concept of thematic saturation should be the guiding principle in ascertaining when additional individual 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 multi-disciplinary participants who had agreed to take part were interviewed, allowing pre-existing themes to gain more saliency and credibility, along with a continued openness for any potential new themes.

In line with the quality framework proposed earlier, details of each participant are provided within this section in order for the reader to make their own views regarding the extent to which any findings can be applied to other settings.

2.11.2. *Inclusion Criteria*

Potential staff member participants were eligible for inclusion upon meeting the following criteria:

- Males and Females over the age of 18 years
- A member of staff employed by the secure unit
- Employed on the unit for at least six months
- Must have experience of PBS planning with a patient
- Must have received training in PBS

2.11.3. *Description of participants*

The author recruited 11 participants. Due to the relatively unique forensic nature of the setting and the small sample size, descriptions and demographics remain minimal as to protect the confidentiality of the participants. In the results section, the author will assign pseudonyms to the various quotes however these pseudonyms will not be identified in this section with individual descriptions or demographics to further protect participant confidentiality. As such, in this section, individual participants are assigned an arbitrary number. Similarly, job descriptions of staff members will not be included alongside particular demographics to protect anonymity. 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.

Table 3: Staff demographics

Staff member	Sex	Age range (18-30; 31-45; 46-60)	Length of time between PBS training and interview
1	Male	31-45	6 months
2	Female	31-45	17 months
3	Male	31-45	12 months
4	Female	46-60	8 months
5	Male	31-45	8 months
6	Female	31-45	12 months
7	Female	31-45	18 months
8	Male	31-45	12 months
9	Male	31-45	9 months
10	Female	31-45	22 months
11	Female	31-45	24 months

2.12. *Procedure*

2.12.1. *Recruitment Procedure*

Following ethical approval and based on the inclusion and exclusion criteria, potential participants were contacted either in person or via email by the on-site clinical supervisor. The clinical supervisor offered potential participants an information sheet (see Appendix F) and a verbal description of the nature of the research consistent with the information sheet. Participants who stated they would be interested in taking part were asked permission if they could be contacted, in person, by the researcher to further discuss participation, and if agreeable, to participate in an interview. The period between initial contact with the clinical supervisor and contact with the researcher was at least one week, in order to give potential participants a period of time to consider the information given to them.

Upon meeting the researcher in person, participants were read the information sheet and invited to ask questions in order to ensure they were fully informed of all the relevant information. When meeting with the researcher, if participants were still happy to continue, they were asked to read and sign a consent form (see Appendix G). Following signature of the consent form, interviews were undertaken.

2.12.2. *Development of Interview Schedules*

The author, a research supervisor and clinical supervisor developed a semi-structured interview schedule collaboratively (see Appendix H). The semi-structured interview schedule was based on guidance offered by Charmaz (2014) and was selected in order to combine flexibility and control, to allow an interactional space for ideas and issues to arise, to allow possibilities for immediate follow-up on such ideas and issues, and ultimately to enable resultant themes from the researcher and interviewee's co-construction of the interview conversation. The initial interview was treated as a pilot, after which the researcher discussed the interview schedules perceived usefulness with the research supervisor and considered whether significant edits were required. In this case, it was decided that no edits were necessary and the pilot interview data was included within the research.

2.12.3. *Interview Procedure*

All interviews were 'face to face' and conducted by the author at a single NHS secure forensic unit. Each interview was recorded using a digital audio recording device. As described above, a flexible approach to questioning was maintained during the interviews, where initially, broad-based, open questions, consistent with the interview schedule, were initially asked which allowed the researcher to progressively follow-up and discuss the participant's unique narrative in more detail, rather than be constricted by a rigid and inflexible fixed questioning schedule. In this sense, the interviews conversational direction was co-constructed.

2.13. *Data Analysis*

2.13.1. *Phase 1: Familiarisation with the data*

The author transcribed the verbatim of five of the 11 interviews, the remaining were transcribed by a single professional transcriber subject to a confidentiality agreement. All transcriptions were subsequently checked against the original audio recordings for accuracy and to facilitate further familiarisation with the data. Additionally, transcripts were read and re-read, at this stage some initial notes and preliminary ideas for coding were also taken.

2.13.2. *Phase 2: Generating initial codes*

During the initial coding process, the researcher begins to make sense of the data, and this sense-making will inevitably shape subsequent analysis. By ascribing 'codes' to segments of the data, this allows data with similar action and process to be grouped together under the uniting code (Willig, 2013). The analysis described here aimed to produce codes that represented 'semantic' features of the data (as described earlier) that appear interesting to the author and assist in answering the broader research question. This is consistent with that outlined by Braun & Clarke (2006, p.87-93). Additionally, once initial codes were developed they were further reviewed and developed into more focused codes. The author utilised NVivo for Mac (Version 10.2.1) to ascribe codes to segments of verbatim. Examples of the coding process are demonstrated in Appendix I (p.206-208).

2.13.3. *Phase 3: Searching for themes*

When all data had been initially coded and collated, the analysis was refocused at the broader level of themes, this involved sorting the various codes into potential themes. This was consistent with that outlined by Braun & Clarke (2006) who state that 'Essentially, you are starting to analyse your codes and consider how different codes may combine to form an overarching theme' (p.89). At this stage, mind-maps were used (see Appendix I, p.213-215) to help visualise potential themes by considering how various codes could be combined, refined, separated or discarded (Braun & Clarke, 2006).

2.13.4. *Phase 4: Reviewing themes*

In this phase, potential themes were reviewed by checking that the coded extracts supporting them were coherent. If themes were not coherent with the coded extracts then consideration was given to whether the theme itself was problematic, or whether the supporting data extracts were problematic and in that case, either more suited to another existing theme or a completely new one, or alternatively to be discarded (Braun & Clarke, 2006). Once themes were coherent with their associated coded data extracts, a tentative thematic map was developed. At this stage, the validity of the themes were considered in relation to the data set and it was determined whether they accurately reflected the meanings evident in the data set as a whole (Braun & Clarke, 2006).

2.13.5. *Phase 5: Defining and naming themes*

Once a satisfactory thematic map was present, themes were 'defined and refined'. According to Braun & Clarke (2006) this means 'identifying the 'essence' of what each theme is about (as well as the themes overall), and determining what aspect of the data each theme captures' (p.92). At this stage, it was also identified whether themes contained 'sub-themes' i.e. themes within a theme. Following this a thematic map of the themes and sub themes was produced (see Appendix I, p.216)

2.13.6. *Phase 6: Producing the report*

Once all themes and sub-themes were fully worked out (i.e. defined and refined) they were written up as part of this research (see Section 3). According to Braun & Clark (2006) the 'write-up must provide sufficient evidence of the themes within the data – i.e, enough data extracts to demonstrate the prevalence of the theme.' (p.93).

2.14. *Triangulation of developing analysis*

As codes and themes were developed throughout the research process, they were presented to the research team and a fellow trainee clinical psychologist, who was undertaking a similar research project, in order to refine and validate the analysis by comparing it back to the raw data, thus ensuring that any codes and themes were

grounded, and ultimately resonated ‘semantically’ with the data itself.

3. RESULTS

3.1. *Overview*

This section outlines the results from the analysis of the interview data. The interview data has been organised into themes and sub-themes. Each theme and sub-theme are defined narratively and are supported throughout with illustrative quotes.

3.2. *Coding / Anonymity*

In order to maintain the confidentiality of participants in this study, each participant has been assigned a pseudonym. Any further demographic data regarding the participants is not attributed to individual comments due to the possibility of participant identification, given the sample size relative to the unique nature of the context from which the participants have been drawn.

3.3. *Overview – Staff perceptions of Positive Behavioural Support in a secure forensic adult mental health setting.*

Following the phases of thematic analysis outlined in the above section, five themes and 15 sub-themes were identified from the data:

Table 4: Themes and sub-themes

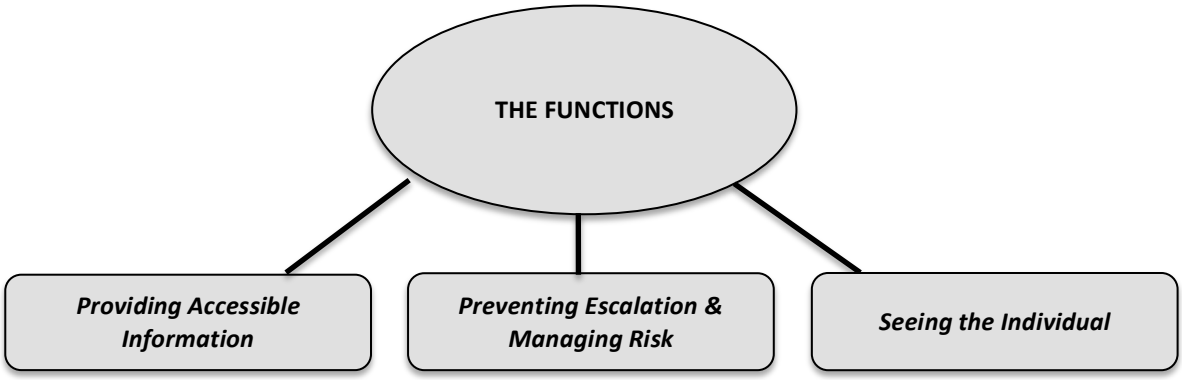
Theme	*Sub-theme*
1. THE FUNCTIONS	1.1. Providing Accessible Information 1.2. Preventing Escalation and Managing Risk 1.3. Seeing the Individual
2. APPRAISING A NEW APPROACH	2.1. A Positive & Beneficial Approach 2.2. A Developing Approach 2.3. Appraised in Relation to Other Approaches
3. COLLABORATIVE CHALLENGES	3.1. Engagement 3.2. Mental Health 3.3. Insight
4. STAFF VARIABLES	4.1. Attitudes & Values 4.2. Resistance to Change 4.3. Fidelity
5. ORGANISATIONAL ISSUES	5.1. MDT Processes & Involvement 5.2. Resources 5.3. Cultural Incongruence

Each of these themes were considered to capture something important about the interview data in relation to the research question: how do staff within a secure forensic adult mental health setting perceive the application of PBS? These themes were also considered to be those most prevalent and salient for the majority of the participants, whilst acknowledging the subjectivity of perceived 'prevalence' and 'saliency' on the part of the author. The five themes are presented equally and no hierarchy or interaction should be assumed amongst them. A thematic map of all themes and sub-themes is presented in Appendix I (p.216).

3.4. *THEME ONE: THE FUNCTIONS*

All participants discussed what they perceived the function of PBS to be in the setting in which they worked. All participants described the primary function of PBS as *providing accessible information* for staff in order to support them in understanding challenging behaviour so that it can be *prevented*, along with the associated *risks*. The style and process of PBS is also perceived to provide a function of *individualising* those patients who are subject to a PBS 'plan' or approach and as such, staff are better able to *see the individual*. A thematic map of theme one is displayed below.

Figure 7: Thematic map of theme one



3.4.1. *Providing Accessible Information*

All participants described the function of PBS as broadly providing access to information and guidelines for staff, this description is largely consistent with a

conceptualisation of PBS as the physical 'PBS plan' itself, which serves the purpose of disseminating information to staff about individual patients:

> *"Yeah, Positive behavioural support, what it means to me in my job is that the patient with staff and with the team write up a plan that helps them (…) we can refer to the plan to see how the patient likes those to be addressed so we can use the plan." (Jeff)*

> *"It's (PBS) about information sharing, what works, what doesn't work…" (Matt)*

Participants described the information as largely providing guidance to staff members so they can implement strategies and work in specific ways with individual patients:

> *"It (PBS) gives us some structure and some guidance in working with our patients and interventions." (Helen)*

> *"It (PBS) offers some guidance on what support can be implemented during that time, and what should be done, we generally follow that." (Sophie)*

In a number of cases participants described that the information and guidance provided is condensed or containing information that they perceive to be most relevant, with perhaps other irrelevant information left out. This therefore makes the information more accessible as a summary to staff members:

> *"they can get, you know, a very quick snapshot of what the issues are, and I think, you know, in doing that, cause you imagine, if someone starts on the ward you get a wodge of notes, well this is all contained in a few pages, and it really distils the important things down for the patient and staff." (Lindsay)*

> *"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)*

A further perception was that the information and guidelines provided are helpful for staff of lower experience or familiarity within the organisation. The perception of such staff is those who are; 'new', 'newly qualified', 'agency' and / or 'students'. It was frequently inferred that PBS has unique benefits for this group of individuals,

where as perhaps those more experienced staff require less reliance on PBS, as they are already familiar with the patients and therefore do not need to refer to the 'information' that is provided within the PBS-plans:

"…what I like about it as well is it's a very quick reference guide to new staff who might not know the patient." (Lindsay)

"It's a great tool to inform new staff who are getting to know my patient, which is fabulous…" (Sophie)

The content of the information is most commonly perceived to relate to understanding challenging behaviour. This area is presented next.

3.4.2. *Preventing Escalation & Managing Risk*

All participants spoke about a perception that PBS, as an approach, is about providing information that enables staff members to gain a better understanding of challenging behaviour in order to prevent the escalation of such behaviour and manage the associated risk. A number of participants explicitly connected the concept of 'understanding' behaviour through PBS in order to inform action:

"So my understanding is that it's being able to understand the behaviours of a person and how best you can support the person when they are in crisis and it's about sort of primary prevention strategies, secondary prevention and then sort of reactive" (Lucy)

"So it (PBS) gives people like a shared understanding then I think. Almost like formulation but in a broader sense to understand what that person's behaviour is about and how they can help them really" (Kate)

Participants commonly talked about the 'prevention' of challenging behaviour as being highly related to the understanding of the behaviour in the first instance, i.e. once behaviours and their triggers are identified, they can be *prevented* via staff having access to, and acting on the information.

"So I think it's (PBS) helped de-escalate, I think because a situation has been de-escalated, it doesn't get to the crisis, so I think 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)

"…once we have an understanding of challenging behaviour its then looking at the primary and secondary prevention (in the PBS plan) to try to minimise the opportunity for those challenging behaviours to occur." (Michael)

The understanding and prevention of challenging behaviour is often closely linked to the behavioural concept of 'reinforcement'. 'Reinforcement' as described by the participants is commonly presented as the opposite of punishment, and therefore seems more in keeping with the concept of 'rewarding'. Participants talk about PBS as largely relating to the reinforcement of 'good' behaviours rather than the punishment of 'negative' behaviours:

"It's about reinforcing good behaviours rather than punishing negative behaviours and that's with a view to looking at sustainable long-term improvement really rather than just short-term flip flopping". (Dale)

"I guess intrinsically to me it means reinforcing good behaviours in order to hopefully change patient's behaviour longer term so that they have better ways of managing situations". (Helen)

In this sense, the function of PBS is clearly perceived to provide staff with a better understanding of individual patients' challenging behaviour. A number of participants described a need for PBS in relation to patients who have been particularly 'difficult' to manage and as such, justify a need for the approach:

"it's (PBS) borne out of people displaying what we call challenging behaviours and I think there are some people that have some really difficult… difficult to manage behaviours". (Kate)

"You know, when you've got people sort of, you know, being very aggressive and threatening to smash people's faces in, you've gotta, you know, you've gotta look at ways to solve this really, for the safety of other patients and for the safety of the staff, you have to consider it really, and PBS supports that". (Robert)

As such, participants often describe the management of challenging behaviour as

synonymous with the management of risk. Given the context is a secure forensic setting, it is unsurprising that risk is closely linked to the concept of 'challenging behaviour':

> *"It goes hand in hand doesn't it, because if you've got a strategy for improving somebodies behaviour then it's gonna reduce risks, so I cant disentangle those, they're enmeshed." (Lindsay)*

> *"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)*

As a result, participants often position PBS as a tool for managing and / or understanding 'risk' or 'risk behaviour', indeed some participants felt that PBS was best suited to patients who exhibit higher risks:

> *"…and also it (PBS) explains it better, 'so why is this risk behaviour happening?' 'It's because this could be triggering it' - and this is what you can do to support them" (Matt)*

> *"The people that benefit a lot from it (PBS) are people who are potentially high risk but can be disorganised and can make staff feel quite uneasy. And if staff have a clear way of understanding that person, knowing how to move forward at those times, as de-escalation measures that can be much better than just punitive, say stopping leaves or stopping internal activities and things like that. That can be much better." (Dale)*

3.4.3. *Seeing the Individual*

Participants commented that as PBS plans are developed collaboratively and written in a language from the patient's perspective (i.e. first person), they are perceived to have a function of individualising those patients who collaborate in a PBS process, which nurtures a stance of seeing patients more so as individuals. Even though the PBS plans have been typed up on their behalf 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, as subjects of description (i.e. third person):

"…the language is really positive, it's non-threatening, it's not like the start of maybe a mental health action plan, where you know; 'my patient has got a diagnosis of… ra ra ra' you know 'has been in hospital for how many years' it's not about that, it's about these lovely qualities that our patients have got and they seem really proud of that, which is nice". (Sophie)

"I mean it's written in the first person isn't it? So I think that's very important, I think that differentiates it from other documents. Urm, and it, you know, I think the patient feels less like an object then, you know, less part of 'the system' as it were. I think they feel, you know, It's more about them and more about their needs. (Robert)

This sub-theme is further strengthened by descriptions of choice and patient-ownership regarding the PBS process and document. Participants describe that PBS, as a process, and as a document, has far more meaning for the individual, often suggesting that other approaches may not have been as pro-choice or pro-individual:

"they don't feel as if they're getting a sort of blanket kind of arbitrary approach, and I think that they really feel that, I think they value the time that goes into it as well, they value the fact that someone's actually sitting down and taking the time to actually identify the behaviours, you know, wants to know about their past, wants to know about what upsets them, wants to know about what makes them feel good" (Robert)

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

Similarly, a number of participants frequently described the approach as being 'patient' or 'person centred'

"I think it's (PBS) about being person centred, massively person centred, which is obviously a core part of PBS. I think it's about the social roles as well, so seeing the person beyond being the patient, that they have… you know, that they are a person." (Kate)

"It's (PBS) completely patient centred isn't it, it's completely individualised for that person" (Sophie)

A number of participants felt that PBS provided more autonomy for patients over their care and put them in a position of 'leading' their care of giving them a 'voice':

"The biggest part for me is the patient having their say, I think that's urm the main thing." (Matt)

"PBS is good because the patient then can have input into their support, and how they feel, and it is nice to hear a patient say 'when I'm like this, I respond well to this'". (Jeff)

As such, participants frequently commented that their knowledge of the individual patients had improved as a result of the individualised nature of PBS. Participants often discussed 'getting to know' individuals better or developing new understandings of the individual that may previously have been understood differently or perhaps incorrectly:

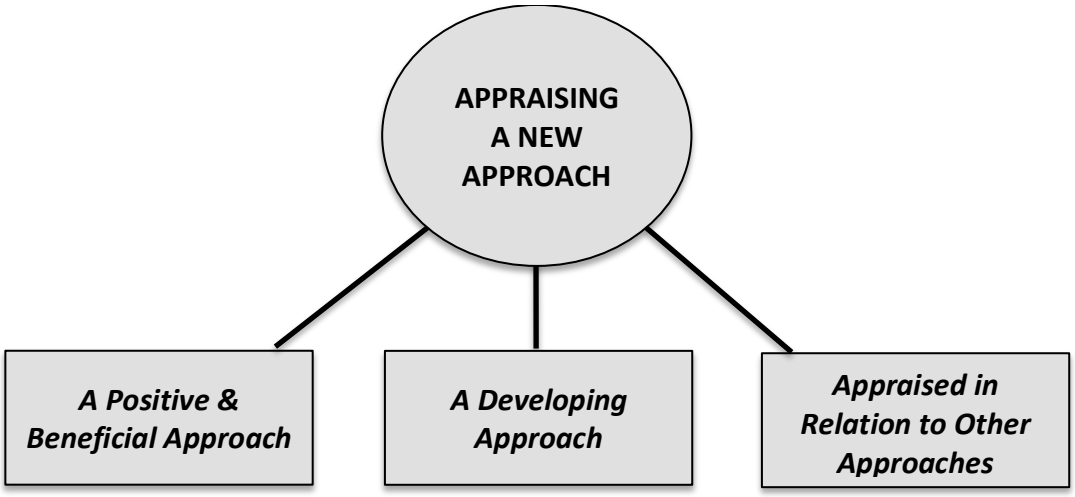
"I have learned some things about the gentleman when we do their plans that I may not have known". (Melanie)

"I think it just enables us to understand better how we do it better, and erm, and I think sometimes we all think we know what's best for the patient; 'I know what's best for so and so', and that, and urm, but I think what's best for so and so is asking them…" (Michael).

3.5. *THEME TWO: APPRASING A NEW APPROACH*

All participants describe the appraisal or evaluation they have made of the approach more generally, since it was introduced to the setting a couple of years previously. Overall, participants describe that PBS has been received positively, owing largely to a perception of general efficacy in that patients are progressing or 'moving on'. However, the approach is perceived as still in a state of 'development', and as such, needing further input or work in order to become fully established. Lastly, many participants appraise PBS in relation to other approaches that are employed within the setting, and as such, perceive the approach in terms of its distinction and similarity to other approaches.

Figure 8: Thematic map of theme 2



3.5.1. *A Positive & Beneficial Approach*

In the broadest sense, PBS is appraised by all participants as something positive in that it's a good addition to the organisation with clear benefits for staff and patients. It is frequently described by participants in positive terms, both in its theory and what has been experienced in practice:

> *"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)*

> *"I'd say it's a positive experience to be able to implement it, to be able to share it with others…" (Sophie)*

This appraisal of positivity appears linked to the perception that PBS can and is producing anecdotal benefits for both staff and patients, such benefits are often linked to a perception that PBS has positively affected frequency of challenging behaviour or that benefits have been more generalised:

> *"…because we are using it (PBS), we've seen a greater reduction in hostility from him." (Matt)*

"There are some patients who I would say anecdotally have improved with it; certainly two I can think of, that's off the top of my head, but possibly more where I think PBS probably has gone a long way to helping them." (Dale)

Additionally, many participants appraise PBS in such a beneficial way as it complements the fundamental organisational goal of supporting people to 'move on' or progress through the hospital itself and into less secure or community environments:

"I guess it is just that learning, sort of that, you know, progression, you know, and I think that's what PBS should be about, progression." (Lucy)

"I've seen patients that have moved on really well using PBS…" (Jeff)

"…it's reaping rewards really, people are progressing." (Lindsay)

3.5.2. *A Developing Approach*

There was a strong sense from the participants that PBS, as an approach, is still one that is in development. This appraisal is 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)

"But I think PBS because it is quite new…" (Kate)

This sense of development is linked to a perception that there is perhaps scope for the approach to develop further from its current state:

"I think it's (PBS) still developing." (Dale)

"I suppose it's all in development" (Lucy)

"I think it's still in its infancy really." (Matt)

Participants describe that the development of PBS is largely related to the amount of

staff being trained in, and adopting the approach as part of their practice. Many participants see 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)

"we were looking recently at how we get PBS into our clinical team meeting reports every week so it brings it more to the forefront…" (Matt)

3.5.3. *Appraised in Relation to Other Approaches*

Many participants appraised PBS in relation to pre-existing approaches that were already well established within the setting and as such, provided a point of reference from which to make similarities and differences. The approach of 'care planning' was commonly discussed by participants in relation to PBS. Whilst care planning and PBS both share the fundamental goal of 'planning' ways in which patients are to be treated, differences were experienced by participants:

"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 however variation amongst participants in how PBS is perceived in relation to care planning. The idea that staff have perhaps conducted care plans in a PBS-like style before the advent of PBS was described by some participants, and therefore, it is questionable if PBS is significantly distinct from care planning:

"I think PBS is something, in some ways, we've kind of always done (…) we've developed care plans, and cause we've got to know the patient really well, we know what works for them, without them actually telling us, so I think in a kind of roundabout way we've kind of implemented the PBS without the title or doing the plan" (Jeff)

"I don't know that it's any more collaborative than care planning because care planning should always be done as a partnership and, you know, but I think it (PBS) draws the practitioner and the service user to think about specifics and to think about what helps at different times (Melanie)

In a similar way, a number of participants talked about PBS as being closely related to the 'recovery' approach or model, which has a similar values base to PBS:

"I think there's a lot more emphasis on that recovery style model here; you see it don't you on the wards, you see it within the notes, you know, it's there, it's part of the fabric of the clinic. So maybe PBS is aspiring to be that…" (Lucy)

"I think PBS is more organised and it's more long term good can come of it, rather than the recovery model, which tends to be done and then it's done." (Matt)

"…we can also use the recovery model, we can use the tidal model, the patient story, it all sits in one sort of ethos and philosophy of care really." (Michael)

A number of participants appraised PBS as complimentary to other existing approaches and therefore something that fits very well within the setting amongst other psychological interventions. Interestingly, some participants referred to PBS and other such approaches as 'tools' from a 'box':

"I think you've got to look at it as a tool in the box to use with all the other tools and that to get a person, because I don't think we can rely solely on it…" (Jeff)

"…a lot of our patients have trauma issues, personality issues, that kind of thing, and the way that manifests in their behaviour is not something that's gonna get better with medication, and it's just one of the things in our toolbox that we can use, so you know, in its own right, it wouldn't be enough, but amongst everything else we've got to do with, you know; reflective practice, training of staff, various group work we do with patients, you know, all of that coming together as well as the PBS, that's, you know, it's reaping rewards really, people are progressing." (Lindsay)

As such, the appraisal of PBS as a single approach amongst many provides 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 and we're probably often the first period of consistency, you know, or stability in someone's life; so what brings about the change is almost 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 can at the same time. So it's almost impossible to pinpoint what it is and often it's a combination of those specifics." (Melanie)

"I mean I know some of the service users who are on PBS plans, because I know it doesn't apply to everybody. It's difficult for me to say from the work I do how much of any changing in behaviour is directly related to a PBS plan, because there's other things we're doing as well" (Helen)

3.6. *THEME THREE: COLLABORATIVE CHALLENGES*

All participants in this research commented on processes and qualities of collaboration as a salient component of the PBS approach within the setting. In most instances PBS was fundamentally perceived as a collaborative endeavour whereby staff and patient should come together:

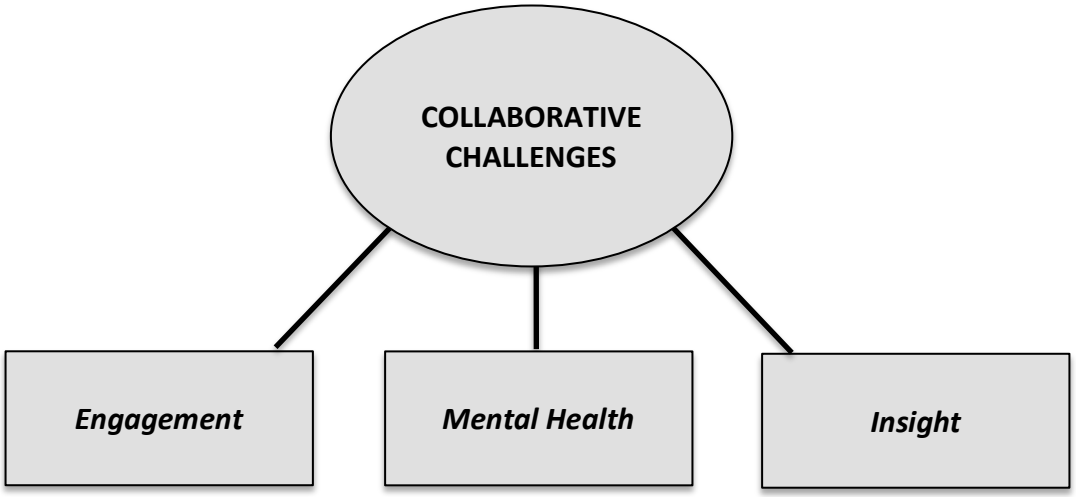
"…for me it's a very collaborative piece of work that draws together the teams views, the patients views and just enriches our understanding of the patient…" (Lindsay)

"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)

"It's about working with them to make them aware as well of the team, of what those sorts of triggers and things that might make things difficult for them in their lives." (Kate)

Challenges to the collaboration itself were widely discussed by all the participants and generated a number of sub-themes. Those sub-themes most prevalent and seen to have the most impact on the collaboration were issues relating to the negotiation of engagement between staff and patient, and the impact of patients' mental health and insight into their difficulties.

Figure 9: Thematic map of theme 3



3.6.1. *Engagement*

Participants described that a key challenge within the PBS process is engaging patients in collaborative working. Many participants perceived that the development of a 'therapeutic relationship' between themselves and patients was most important for successful engagement:

> *"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) and you feel comfortable having conversations like that and you could perhaps challenge things that haven't gone so well". (Helen)*

> *"Gaining knowledge, gaining the trust, you know, forming positive working relationships with patients gives you that ability to then think, oh, not quite*

right, something about that wasn't quite right; and, you know, just picking up on, you know, situational cues that perhaps somebody else who walked into the room wouldn't realise." (Lucy)

"I think our therapeutic relationships generally within the clinic are really crucial and it's something we do well." (Dale)

The process of co-developing a PBS plan involves engaging patients in conversations around 'challenging behaviour'. A number of participants commented that discussing challenging behaviour with patients can be difficult and as such, the therapeutic relationship is an important factor in managing this:

" I think the relationship is really important, I mean I wouldn't want to challenge someone's behaviour if I didn't have a good relationship with them" (Matt)

"If there was something that wasn't quite right (In the PBS plan) then we were happy to communicate that between each other, we've got that kind of relationship where we can, you know, talk quite openly, and take on each others ideas" (Sophie)

Participants described that often, in order to come to a shared understanding around the individuals' 'challenging behaviour', a degree of compromise was frequently required in order to foster and maintain engagement in the process and preserve a therapeutic relationship. This compromise was primarily in relation to discussions between the staff and patient regarding what specific content should be present in the PBS plan:

"there's been a few times that patients have disagreed with certain factual issues, it's the kind of document you can agree to differ on. So you don't need to make a big issue of it, other than to highlight that there is a difference in opinion." (Lindsay).

"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)

Similarly, the degree of compromise was frequently described in terms of the ratio

of input between each other. These ratios suggest that levels of engagement are not always completely balanced, but in fact variable depending on the unique quality of the relationship between staff and patient:

> *"...they were certainly very much engaged in it, but you know it wasn't 100% them, and you know, it was sort of more just, probably 60:40, just more me talking, coming up with the ideas, pushing it to a degree, but it wasn't something of 'right, I'm gonna do your PBS plan' or 'right, I've done your PBS plan, just sign that', it's a case of 'what's important to you?', 'have you thought about it this way?'" (Michael).*

> *"Well it is collaborative, but with a lead, yeah, I mean it would be looking into definitions of collaborative there. It's not entirely collaborative but it's – it's yeah, with a lead and then collaboration, yeah." (Dale)*

Additionally, participants described that in a number of instances patients will either be very ambivalent towards engaging or will not engage with PBS, which has the implication that a collaborative process cannot be adopted:

> *"he was not in favour of the plan at all; really sort of… 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. So… but then you are probably going to find that in a setting like this that people don't like seeing things written down about them that they don't agree with, you know." (Lucy)*

> *"No, sadly he hadn't been involved in his PBS plan (…) he wasn't interested" (Kate)*

3.6.2. *Mental Health*

Participants describe that a key challenge to collaborating around PBS relates to the mental health of the patient you aim to collaborate with. The primary purpose of the patient's attendance in the hospital is to receive treatment for their diagnosed mental health issues. Participants frequently describe mental health and behaviour as explicitly connected:

> *"I think lots of the challenging behaviour that we see, particularly with our psychotic gentleman is about, it's triggered by the illness…" (Melanie)*

"I think sometimes 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 on the wards." (Kate)

Participants discussed the relationship between mental health and PBS as a challenge more so to the collaboration. In particular, 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 primarily 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)

"I've tried to interact with him and sort of done the client version but (…) he believed, he had some delusional beliefs, that it was psychoanalysis and that I was doing something detrimental to his mental health. So sadly he didn't get involved" (Kate)

Participants identified that mental health has an impact on a patient's ability to collaborate with a PBS process, and as such, in some circumstances, PBS plans are developed without the collaboration of patients:

"But when someone is truly psychotic, it's probably not… and I think that's when the plans are written by the nursing staff and (the psychologist) and then they're not really written… they don't have the same genuineness and when they are written collaboratively I suppose." (Melanie)

Therefore, a number of participants suggested that PBS is more suited to patients who are further on in their stage of recovery:

"We've got some patients with very severe mental health issues at the moment, so they're not interested, they, you know they're still quite deep in psychosis and other issues so I think a patient needs to get to a certain point of recovery before you can approach the PBS thing". (Jeff)

"I suppose at the start of a journey, like a recovery from a psychosis or a schizophrenic episode or whatever it is that you know, (…) 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)

In a few instances, participants commented that patients with certain types of mental disorder, particularly personality disorder were less suitable for PBS:

"…I think that when nursing patients with personality disorder I think, though they'll agree to a plan, when you come to implement it they don't wanna know. So it's, we've come across that, especially with anti-social, to be honest if it's a diagnosis of anti social personality disorder, there's not a lot you can do to be honest, it's a difficult area." (Jeff)

"I think the guys that come in that, they might have had a psychotic episode or depression or other than personality disorder, they respond really well to it (PBS)." (Matt)

3.6.3. *Insight*

Along with improvements to mental health, participants describe that the patients' level of 'insight' influences collaboration in PBS, both in terms of quality and quantity. In this context, 'insight' refers to the patient's ability to recognise their own difficulties, and as such recognise that difficulties such as 'challenging behaviour' may stem from illness or similar, and also to recognise that a treatment or intervention such as PBS is warranted, or has the potential to be helpful. Participants describe that a lack of insight can prevent a patient collaborating in PBS:

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

"The guy I'm working with now, he's… there is no collaboration because he does, you know, (he believes) he's a doctor who is in charge of the clinic so It's very difficult for that sort of conversation, you know, people would need insight to collaborate…" (Matt)

As such, participants comment that once the patient has met a 'certain' degree of insight, they can reach a 'point' whereby they are more likely to engage collaboratively in PBS:

"I think a patient gets to the point where they think 'I'm getting better, I know I'm getting better, I realise I'm ill', I think that's a good point to bring the PBS in

as a tool to say you know 'as you can recognise these things we can help you put a plan together'." (Jeff)

"I think the insight thing is important. I think once patients do have a certain amount, you know, a certain awareness of themselves… it's (PBS) easier. (Helen)

In some instances, participants describe that collaboration in PBS is not contingent on the presence of insight, and that insight can be developed through the PBS process and collaboration itself:

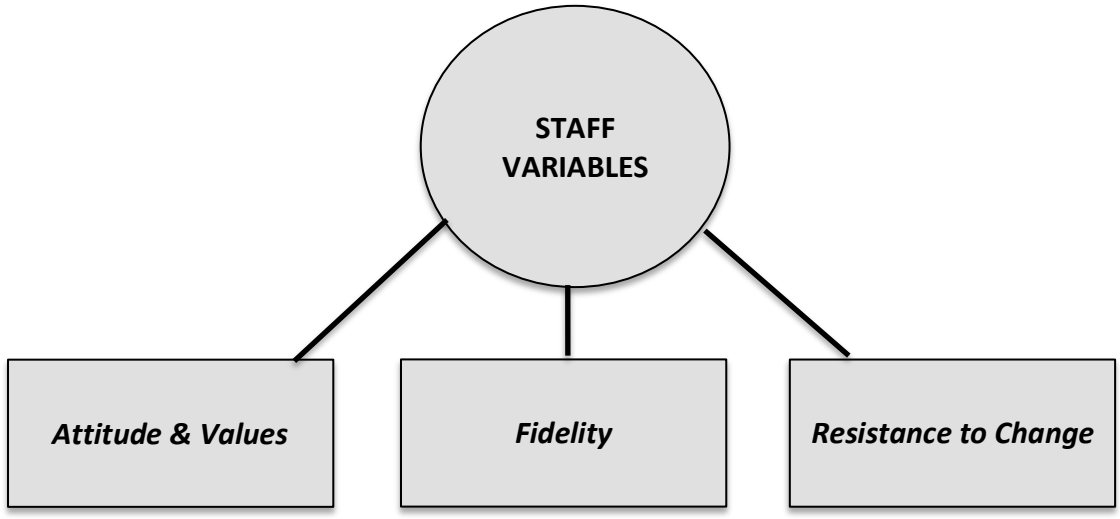
"For me PBS is sort of important because it empowers the patients in understanding themselves, you know, improving insight…" (Lindsay)

"I think, sometimes in the PBS, the patient, or the service user is enabled to have more insight into their behaviour and what triggers that behaviour…" (Helen)

3.7. *THEME FOUR: STAFF VARIABLES*

This theme relates to variables perceived *within* staff members that influence the PBS process. Three sub-themes were developed, which relate, firstly, to the personal *attitudes and values* that staff members' hold and how these influence their personal approach to PBS. Secondly, 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 *resistance to the changes* or new ways of working associated with PBS.

Figure 10: Thematic map of theme 4



3.7.1. *Attitudes & Values*

Participants described that the personal attitudes and values held by staff members seem to influence their personal approach to PBS and therefore how they collaborate with patients in the process, as well as how they work together with other staff members to implement the approach. All participants talked about noticing differences in staff attitudes and values in relation to PBS as an approach more generally, many comments related to enthusiasm or positivity about the 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)*

> *"I think some staff are more positive about it than others (…) it's just the feeling you get from them, so when you mention PBS they might sort of huff or roll their eyes or something." (Robert)*

A number of 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:

> *"I think 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 and urm." (Jeff)*

> *"It does draw out certain values and I think if you don't, if you're not invested in those yourself, then you're less likely to make the time to read a PBS plan, to try and implement some of the practices that it's recommending within it." (Kate)*

A number of participants suggested that negative attitudes and values towards PBS can stem from a feeling that PBS is 'another thing to do', that perhaps staff have enough to do already and this approach places additional demands on staff that are not welcome:

"I guess maybe the perception of oh, it's just another thing to do. Or, it's another, you know… sort of more work sort of thing, you know, just to have to worry about." (Lucy)

"It might just be a case of, 'oh here we go, here's another thing' (Helen).

"So I think it's taken on board more by some than others. I think some see it as an additional piece of work" (Kate)

When explored further, many participants mentioned that some of these attitudes and values are underpinned by the relationship staff members feel they should be cultivating with patients. As PBS involves ongoing collaboration between staff and patient, some staff members are reported to struggle with the nature of having a more collaborative relationship with patients:

"We all have different beliefs, philosophies and motivations so I think some nurses are far more ready to sit and be collaborative with their patients and some are more likely to be slightly more controlling…" (Robert)

"I'll be honest with you, yeah there's staff on my ward who will quite happily sit in the office all day doing paperwork or online shopping (laughs), I like being out in the thick of it, you know playing pool with the guys, playing cards with the guys, helping them do stuff, taking them to the gym, to the café, on grounds leave, and that's how you develop the relationship…" (Jeff)

Within this collaboration between staff and patient, the themes of control, punishment and the need for 'consequences' to behaviours' seem to be the most common attitudinal and value driven ideas that provide a tension with the inherent values of the PBS process itself, being largely based on ideas of social valorisation and therefore non-punitive in its basic underpinning. This, it seems, provides a tension for those staff that hold attitudes and values that perhaps promote the need for control and punishment:

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

"Some people will have quite strong views that people will say, if they have acted out or self-harmed or those kind of things shouldn't be going down what they would see as more of a reward pathway. They should… they should have clear boundaries put in." (Dale)

A number of participants commented that they had observed changes in staff whereby they had adopted attitudes and values more congruent with those of PBS, or become more enthusiastic regarding the approach, which has modified their behaviour:

"there's been noticeable improvements in that some teams had a reputation of being quite controlling and restrictive in their approach to challenging behaviour, , but I think even they're beginning to use the language, how, you know 'lets make our decisions in a non-punitive way', so there are shifts in that". (Michael)

"some people who I thought weren't that sort of enthusiastic have become more enthusiastic" (Robert)

3.7.2. *Fidelity*

The nature of a PBS plan, once completed can be very prescriptive in that guidelines are provided for how members of staff should respond to and treat individual patients. As such, a PBS plan often dictates that staff are consistent in their approach, this allows for patients to receive continuity of care. Many participants identified that maintaining consistency amongst staff is important when implementing PBS:

"…you do have to be consistent in the way you do it (PBS), the way you deliver it." (Matt)

"So it's about ensuring the consistency and the understanding is 'this is what we're doing and why we're doing it'." (Michael)

"So an important part of PBS I think is the fact that it needs to be, there needs to be a degree of consistency and a degree of unity for it to work properly…" (Dale)

Many participants identified that maintaining consistency amongst staff i.e. that all

staff follow guidelines within an individual patients PBS plan is a challenge, and that there have been occurrences when inconsistency arises:

> *"Yeah, we don't follow them (PBS plans) particularly well and even myself sometimes." (Matt)*

> *"Yeah, I think there's a difference between rehab staff and ICU staff, the ICU staff (…) they haven't got time to think about PBS" (Jeff)*

Some participants commented that inconsistency can arise when the wards are in crises or that risk is elevated, in these circumstances fidelity to the PBS approach can be perceived to be lacking:

> *"…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 know, 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)*

Participants hypothesise that such inconsistencies arise for reasons of the staff attitude and values (as described above) or that also because staff members have not read the PBS plan:

> *"I think that's something that… because I'm working with an individual who has changed wards a few times recently and there was a recent incident in which something triggered him off and once I'd read his PBS plan, it was really clear that that was one of the triggers of the things he finds difficult but because I think certain staff hadn't read it, hadn't had the chance to look at it, they weren't aware." (Kate)*

> *"What I see is a lot of positive engagement with patients from staff. Some not so positive… neutral let's call it, I'm not saying bad. But again it's going to depend on the individual and if they've read the plan, how likely they are… that that's going to inform their daily interactions and engagement with the patient." (Lucy)*

3.7.3. *Resistance to Change*

In somewhat of a continuation of the above sub-themes relating to staff attitude, values and fidelity, many participants described having observed 'resistance' to the

PBS approach in other staff members. As PBS is a relatively new approach, participants describe that when it was first introduced, a number of staff were sceptical of the idea and perhaps needed to be 'convinced', or to first see it in action. It seems that this scepticism arises from the idea that many approaches or new ways of working are often bought into the care environment, and staff must therefore decide for themselves whether it has value, or whether it is perhaps an old idea that has been re-packaged:

> *"I'll be honest with you, there was a lot of resistance to it, you know; '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 in some groups who were pro it and who were potentially against it, it was like 'well it's another fad, it's another you know new idea or way of telling me how to do my job, I've been doing it for twenty years, of course I know how to do these things' then other staff are very much 'we love it'." (Michael)*

A number of participants described that such resistance could manifest from dislike of, or anxiety regarding the inherent change and uncertainty that implementation of a new approach brings:

> *"I think some people don't like change and some people just (…) they've got their attitudes and set ideas already about it and it's a bit of a battle to kind of win them over." (Jeff)*

> *"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 for want of a better word" (Melanie)*

A number of participants felt that staff members who had been employed within the unit for a longer period of time were more likely to hold scepticism regarding the approach and therefore perhaps needed a greater degree of convincing or evidence that the approach has value:

> *"Some have just been here a long time and they've seen lots of different, lots of new psychological approaches before and I think they just find it a bit tiresome I think, possibly, that's probably a reason for it (scepticism)" (Robert)*

"I don't think I was particularly sceptical but I can… yeah, I mean I was aware that other people probably were feeling a bit like that." (Helen)

Despite these descriptions of resistance to change, there is evidence to suggest that such resistance can be a temporary state whereby staff, when given time, are able to adjust to the approach. Many participants described that they have observed a process whereby people or themselves have become accepting of the approach and have therefore become less resistant:

"…I was a sceptic in the beginning, I just went along with the crowd, until, 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)

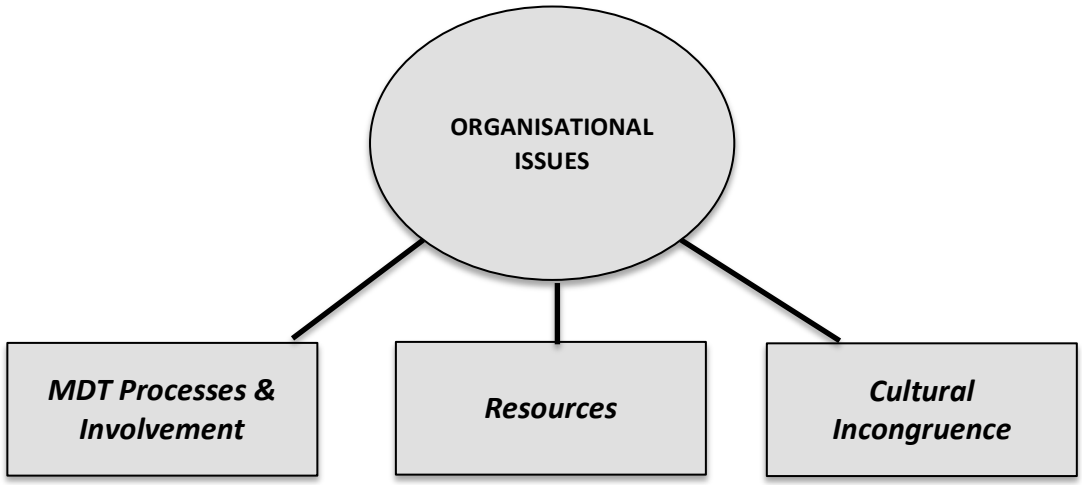
"I was open minded to it, in a sense, 'I need to see this in action' more than anything, I mean I quite liked the idea of it, but you know, I suppose I reserved judgment until I'd seen it in action and it did seem to help." (Lindsay)

3.8. *THEME FIVE: ORGANISATIONAL ISSUES*

This theme relates to phenomena that are described as influencing the application of PBS at a wider organisational or institutional level. In the case of this research the organisation is understood to be the particular setting in which the research took place, a secure forensic adult mental health unit that is a place of residence and work for a number of individuals organised for a particular purpose; to deliver and receive treatment for mental health issues within a physically secure setting. Three *sub-themes* were identified which can be defined as organisational phenomena. Firstly, the Multi-disciplinary Team and their involvement in PBS, or *MDT processes & Involvement* concern processes and various levels of involvement that occur between the staff of different professional backgrounds. Secondly, a number of organisational *resources* were identified as being necessary in order to successfully implement PBS in practice. When such resources are not available or limited, difficulties arise in the implementation of PBS. Lastly, participants gave descriptions of the 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.

Figure 11: Thematic map of theme 5



3.8.1. *MDT Processes & Involvement*

All participants described and largely conceptualised PBS as a team or multi-disciplinary approach. The perception was that all staff of various professional backgrounds should have involvement in the application of PBS within the organisation:

> *"It's been so clear that when PBS has been introduced it's about that teamwork." (Kate)*

> *"I would say it's like a team approach to producing a way of working with someone" (Matt)*

Participants frequently make reference to 'the team' or 'the clinical team' during discussion however this term seems to be used to describe those staff members who are not directly involved in the day to day running of the ward i.e. nursing and support staff, but rather those staff who have intermittent contact with patients. 'The team' in this sense is used to refer to professions such as psychiatry, psychology, social work and occupational therapy and their role in the PBS process. The clinical team is often described as a discrete entity, separate from the ward-

staff, but having a collaborative role with those staff and patients who are based on the wards

> *"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)*

Participants describe the visibility of the MDT or 'clinical team' variably, in that certain members of, or particular disciplines within the clinical team have different levels of involvement with PBS in the organisation. As such, the perception is that involvement is not entirely multi-disciplinary:

> *"I would say the idea is to make it truly multi-disciplinary but I don't think we are there yet on that one" (Dale)*

> *"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)*

A number of participants described that Psychology have relatively more involvement in PBS than other professionals do, this perception likely exists as Psychology take a lead in the training of staff and have early involvement when PBS plans are initially developed:

> *"I mean obviously psychology have taken the lead, have introduced it, you know, are teaching us all about it." (Helen)*

> *"It's not split across the MDT, and it's (the psychologist) that has a hand in most of them." (Lindsay)*

Additionally, a number of participants perceive that Psychology and Nursing share a joint role in being the key professionals who are involved in PBS:

> *"I see it (PBS) largely as psychology and nursing at the moment" (Kate)*

> *"In this site it is currently weighted on more professions, as it's a duality of psychology clearly with nursing." (Dale)*

Once PBS plans have been developed, participants describe that the 'doing' of PBS is largely positioned as a nursing intervention, this is unsurprising given nursing staff and support workers have the most direct patient contact relative to other members of the professional team:

> *"I think it's delivered by nurses. I don't think it gets enough space and discussion at a multi-disciplinary level." (Melanie)*

> *"I think nursing take on quite a bit of it (PBS) actually because they know how valuable it is for them. (Kate)*

There are many examples where a hierarchy amongst MDT members is alluded to, often suggesting that those perceived to be in higher positions have more knowledge, power and influence. In relation to the PBS approach itself, participants perceived it as something that originated from the higher staff positions and has been applied to their ward-based work:

> *"I mean the guys at the top, that are bringing it in (PBS) and all that, you know, they push the patient side of it all the time". (Jeff)*

> *"I mean I know that ultimately it's kind of the nursing staff on the ground that will have to manage those plans or with the patient and… so it's a bit back to that kind of top down thing isn't it that people in one room make a plan and a decision and then other people tend to be the ones that follow it through." (Helen)*

It seems important to recognise that the presence and observation of hierarchy within this setting is not described as problematic in itself. The presence of hierarchical structures are inevitable in such a unit where staff with different levels of expertise must be organised in a way in which their expertise can be spread across the setting more broadly. Many participants make the distinction between 'qualified' and 'unqualified' staff, typically feeling that those who are 'qualified' have greater knowledge of the approach, with some commenting on a disparity whereby 'qualified' staff receive greater training in PBS then those who are not 'qualified':

> *"I think the obvious one from where I sit is that differentiation between the qualified staff and the unqualified staff; because obviously the qualified staff are*

heavily invested, well you would hope, in the creation of and support of the PBS plans." (Helen)

"If the qualified staff require a full days training, I don't see why the unqualified staff shouldn't have the same, you know, because if we're all one team and we're all supporting the patients, which we are, then we should have the same… sort of grasp on it, you know, or at least be allowed the opportunity to have the same kind of knowledge base (Lucy).

In connection to the last comment, some participants have also acknowledged a disparity in PBS training more generally across the MDT, whereby the attendance of different disciplines at PBS training is variable:

"…overall in nursing we're nearly in the high 90's percent of putting the staff through the (PBS) training, of all the grades, social work have invested in a lot of their staff attending, Psychology have been excellent in attending, OT have, the ones we've had problems with are the actual consultants…" (Michael)

3.8.2. *Resources*

There were many examples where participants made reference to the need for organisational resources to support the effectiveness of PBS. The organisational resources that were discussed most frequently, and with the most salience, were the provision of staffing and the provision of time made available to staff.

A key tenet of the PBS approach is that staff members implement primary-preventative strategies in order to improve the quality of life for patients, thus reducing the risk of challenging behaviours occurring as a side effect. This typically involves increasing a patient's access to activities they value. Staff members are often involved in facilitating this, in most cases this seems to relate to the provision of meaningful activities and supporting / supervising leave off the ward and the unit itself. However, participants describe that providing access to such activities can be challenging due to a lack of available staffing:

"…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)

"I've got a gentleman who really benefits from being down at the Sports Hall with people around. But when he's really angry you need several people to take him out of the ward environment and that's not always available" (Melanie)

A number of participants stated that in order to meet the needs of patients relating to access to 'quality of life' activities, staff members often have to respond flexibly and work on different areas of the unit in order to meet such needs in the context of limited staff resources:

"I think as a clinical team we've offered to sort of step in and be the extra person to come along because we know that 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 other areas of the unit where risks are higher demand higher staffing levels and as such, staff are often pulled from lower-risk areas in order to support staff in higher-risk areas, such as the Intensive Care Unit (ICU). Participants often cite this example as a barrier to improving the quality of life for those patients receiving PBS:

"If it's busy say on (ICU), which takes out perhaps 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. And the guy that I was just speaking about, you know, you get him to the café first thing in the morning. If you get him to the café in the morning it makes him, it helps him relax, it's a better day for him, you know." (Matt)

"I guess that can be difficult if the PBS says 'I like to go on ground leave' and you're like 'you can't!' (…) sometimes ICU will ring up and say 'so and so's really unsettled, can you send extra staff over to support us' and we have to, we can't say no, cause they're our colleagues, but then it leaves us short staffed and we're not able to give the input that we would like to give to our patients, so it does happen, unfortunately." (Jeff).

Although it seems there can be issues relating to inadequate staffing levels and access to activities, some participants commented that the level of resource is variable between different types of setting, such as alternate wards within the hospital, other less-secure hospitals or a supported community settings, and as such,

the implication is that the on-going success of PBS may be more strained in such environments, where resource levels are perhaps likely to be less:

"In terms of the activities, the positive activities that could happen (…), say on the intensive care ward, because they've got so much support, maybe they wouldn't have that input in the community, you know, there are people there in the same building as them all the time, able to really sort of micro-manage them in a way, so maybe you wouldn't get that in the community" (Robert)

"…but the resources that are available on my ward I should imagine are quite different to what would be available for the other chaps." (Sophie)

The other resource commonly perceived to be lacking is that of 'time' for staff to do PBS. Many participants comment on the length of completed PBS plans and that they require a considerable amount of time for the staff to read, considering there is a large number of staff employed within the unit. Again, this use of staff time is recognised as a resource that can be scarce in the context of a busy ward environment:

"I think it's like lots of things that we have, documents about people, they can be quite long and I think it puts people off to think that we're on a busy ward, I've got things to do, I haven't got time to sit down and read perhaps a 20-page document, which… is difficult because it's got so much valuable information, yet I can understand how people wouldn't have time, you know, when staff are stretched you can understand that. So it is quite a barrier I would say." (Kate)

"They are really lengthy for the reading; I mean 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)

Along with the perception that PBS plans can take a long time to read, a number of participants similarly commented that they can take considerable staff time in order to construct, which places limitations on how quickly PBS plans can be developed and 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)

"…but it's doing the work, it's doing all the functional analysis, taking all the assessments, it's drawing on the themes, putting the primary prevention together, secondary.. so it's a lot to process and formulate from, urm, so that is urm a limit and a barrier at present" (Michael)

In addition It is also recognised by participants that psychology have had a comparatively larger amount of input in the development of the PBS plans when compared to other professions within the organisation, and therefore, PBS is quite consuming of the psychologist's time. As a result some participants describe that there is a need to be more selective with how such resource is used:

"I think that currently some of the challenges are just to the logistics of [the psychologists] time. Cause she still is the only person who can construct these, so until there's more of us urm who are able to construct them, when we're qualified through the course, urm, some of it's limitation of resource on her and her time." (Michael)

"It's not split across the MDT (…) I mean [a psychologist] has had to do a lot of them and I know that they're very time consuming, so it's the time it takes to do them (…) cause they take so much clinical time we need to be quite circumspect about who we pick to do it with, so we target those who we think it would help the most." (Lindsay)

3.8.3. *Cultural Incongruence*

The nature of a secure forensic unit means that patients are physically detained against their will under the Mental Health Act (1983). As such, participants describe that tensions arise between the inherently empowering, values-based nature of PBS, taking place within a culture of disempowerment.

The key purpose of a physically secure unit is to provide containment of potential risks to patients themselves, and the public. Whilst this is not something that can be overcome, participants often talk about the overarching need to contain risk above all. As such, participants have mentioned that the requirement to contain risk will 'trump' what might be written within a PBS plan. The ultimate implication of this is that guidance within a PBS plan will be followed unless a person's safety becomes at 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, I mean cause sometimes we have to and the PBS goes out the window in a sense because we have to make a situation safe so we will take control but what's good about the clinic is that you know, we're not a punitive service, it's to get the patient moved on quickly from a situation and back on their pathway to recovery." (Jeff)

"Ultimately, as we say in training, 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. Many participants commented that the primary organisational need to manage and contain risk provides a direct tension or conflict with this:

"Even though quality of life is very important, the likelihood, the possibility I should say, not likelihood, of them causing harm to others particularly under certain circumstances is high. Those two things are in conflict. I think in any secure sense that would be." (Dale)

"You can't just send them out into the community to access a college course or something like that, so I think it… I think it definitely has massive impact the fact that it's in a forensic setting." (Kate)

As a direct result of this conflict, many participants perceive that improving quality of life is a fundamental challenge to providing PBS in a forensic culture:

"…that's where we struggle with, you know, 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. So obviously there are limits to what you can actually do, even with a PBS plan, because, you know, if they like to go and run on a beach somewhere, their favourite thing to do, well they can't." (Robert)

4. DISCUSSION

4.1. *Summary of the main findings*

This is the first study (of awareness to the author) to investigate the perceptions of PBS for staff in a secure forensic mental health setting. 11 interviews were conducted, transcribed and subject to a process of thematic analysis. From the analysis, five themes were identified relating to perceptions held by staff that were most prevalent and salient in answering the research question: 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'*.

4.2. *Research findings in relation to existing literature*

The findings of this study are now considered in relation to existing literature and psychological theory. The aim of this study was to explore the perceptions of staff regarding their experience of applying PBS in a secure forensic mental health setting. The author identified only a single other study (Davies *et al*, 2016) that explored a similar topic in a similar setting, but with service users, and using a different methodology. The fact that staff views have been explored here is unique, and as such, adds a contribution to the forensic-PBS literature base, along with building further on pre-existing literature more generally in the field of PBS. Each of the five themes identified by this research are now considered subsequently.

4.2.1. *THEME ONE: THE FUNCTIONS*

All staff members discussed the functions served by PBS in the specific context of the secure forensic setting in which they work. Those functions primarily identified included: *providing accessible information for staff*; *preventing escalation and managing risk* and *seeing the individual* patients via the PBS process.

The sub-theme of *providing accessible information for staff* resonates with a conceptualisation of PBS as the 'PBS plan' itself, the 'PBS plan' being the medium in which information relating to the support of individual patients is disseminated. It

can be argued that 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', being 'data-driven', informs staff decision-making. The accessibility of the information was a part of this sub-theme as many staff perceived that the information provided was 'condensed' or 'summarised' and as such provided a good starting point for 'new' or other less experienced staff members. The perception that PBS is generally 'accessible' to a range of individuals is consistent with a review by LaVigna & Willis (2012) whereby they conclude PBS appears to be 'easily accessible to everybody working in the field of challenging behaviour' (p.194). The specific finding of accessibility of information within PBS plans 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' (p.10).

Staff perceived that this *information* was largely relating to the understanding of challenging behaviour in order to *prevent* the escalation of such behaviours and manage the associated *risk.* In this sense, staff largely perceived that the function of PBS was to provide accessible information to staff in order to develop their understanding of an individual's challenging behaviour. This perception is consistent with a number of widely accepted definitions of the function of PBS; as a multicomponent framework for developing an understanding of the challenging behaviour displayed by an individual (Dunlap & Carr, 2007; Gore, McGill, & Toogood, 2013; LaVigna & Willis, 2012). This demonstrates broadly, that the commonly accepted function of PBS appears to translate to a secure forensic setting. What is perhaps more prominent in this study, when compared to other functional definitions of PBS, is the explicit connecting, by staff, of 'challenging behaviour' and 'risk'. This finding is unsurprising given the nature of the setting and organisational purpose to contain risk. However, in the forensic setting, it perhaps positions PBS more so as a 'risk-management' tool to a greater extent when compared to pre-existing research. This distinction is likely one of culture, as the majority of PBS research has occurred within education and learning disability settings, behaviours in these settings are typically referred to as '*challenging* behaviours' (Dagnan, Trower,

& Smith, 1998; Emerson, 1995) , where as in forensic settings they are more typically referred to as '*risk* behaviours' or '*offending* behaviours' (Mullen, 2000). These differences in terminology are largely arbitrary, suggesting that PBS, as an approach translates into a forensic culture from a functional perspective. This is consistent with the suggestion in previous literature that the utility of PBS is much wider than the historical contexts to which it has been applied (Allen, James, & Evans, 2005).

The sub-theme *'seeing the individual'* related to a perception that PBS functioned to increase a sense of individualisation amongst patients. This is not a theme that is explicitly replicated in other qualitative PBS research however it is clearly aligned with the notion of 'social role valorisation' (Wolfensberger, 1983) underpinning the values base of PBS (Gore *et al*., 2013). This sub-theme may moreover be specific to the forensic setting and culture researched here. Firstly, this likely occurs because the PBS approach within the research site invites collaboration with patients, as they have a level of functioning that means they are able to collaborate and as such, be empowered as an individual. Within learning disability and educational settings (where PBS has mostly occurred and been researched), collaboration is more difficult due to an individual's level of learning disability or ability. Secondly, empowerment and individualisation may seem more distinct within a secure forensic context that often invites, or has historically invited disempowerment and deindividualisation, such as the use of 'traditional methods' in managing mental distress and challenging behaviour including restraint, seclusion and sedative medication (Kynoch *et al*., 2011; Mason & Chandley, 1999). The involvement, individualisation and empowerment of patients in their care, often referred to as 'client' or 'person- centred' care, or 'service user involvement' has been a growing feature of mental health policy since around the beginning of the 2000's (Davidson, 2005., Greener *et al*, 2014). As such, a perception within this study that PBS serves a function to better 'see' the individual patients seems to be congruent with the more general movement of increasing service user involvement. Individualisation is also a key tenet of the 'Recovery' approach. Within the mental health context, most popular definitions of 'Recovery' (e.g. Anthony, 1993; Deegan, 1988) describe it as something (e.g. support needs, preferred life, future goals) that only the individual

can define themselves. 'Recovery' has received widespread application across UK mental health services as a result of governmental mental health policy and strategy (HM Government and Department of Health, 2011) advocating 'recovery' focused care. As such, 'Recovery' has also been adopted within secure forensic mental health sites, often referred to as 'secure recovery' (Drennan & Alred, 2013). 'Recovery' ideas have their roots in person-centred planning, service user and carer involvement and social valorisation (Davidson, 2005) which are very closely aligned, if not identical, with those roots described for PBS. With this context considered, it is understandable that the sub-theme *'seeing the individual'* was identified as a functional aspect of PBS, as it is related clearly, and fits with the wider contextual movements within mental health of 'service user involvement' and 'Recovery'. This finding is also in line with the theme emerging most frequently within the Davies *et al* (2016) qualitative study of patient's valuing 'involvement' with PBS.

4.2.2. *THEME TWO: APPRAISING A NEW APPROACH*

The second theme relates to how staff members have *appraised* an approach (PBS) perceived to be 'new' within the secure forensic setting. Within this theme, three sub-themes were identified relating to the appraisal of PBS as *a positive and beneficial approach*, *a developing approach*, and that it was largely *appraised in relation to other approaches*.

Staff generally appraised PBS to be a *positive and beneficial* approach within the setting. This general finding is supported somewhat by the only other PBS study, identified by the systematic review; in this study service users were interviewed in a secure forensic mental health setting and the approach was reportedly 'valued' by service users (Davies, 2016). Within this study, the general positive and beneficial appraisal of the approach was closely linked by staff to the idea that PBS aided patients in *progressing* or 'moving on'. Staff defined 'moving on' in terms of patients progressing towards discharge from the hospital and as such towards increasing personal liberty. This specific notion was also reflected somewhat by Davies *et al* (2016) under the theme 'noticing and wanting to change', whereby 'service users were using their PBS plans like a road map to guide their progression through the

service' (p.12). The idea of 'progression' within secure forensic services is perhaps an overarching appraisal theme for staff within such settings, as ultimately, the progression of patients from a state of detainment to freedom is the goal of rehabilitation and recovery; the overarching purpose of the organisation. This is consistent with a variety of other qualitative literature from forensic mental health settings whereby individuals appraise clinical approaches as being positive when they support 'hope' of, or progression towards freedom (Barsky & West, 2007; Nijdam-Jones, 2015; O'Sullivan, Boulter, & Black, 2013).

The appraisal that PBS is still *in development* is understandable given the relatively new emergence of the approach in forensic settings as a response to government advice that PBS should be extended to all health and social care settings (DOH, 2014). Staff commonly linked this perception to a need for PBS to have greater visibility within the setting and as such become more embedded within practice. This indicates an implication for on-going support and development of the model within the service. This resonates somewhat with other qualitative PBS research which identified core themes whereby staff feel on-going 'professional development' is needed in order for PBS to become more embedded within their organisations (Bambara *et al*, 2009; Frey *et al*, 2010).

PBS was commonly *appraised in relation to other approaches* that also exist. Staff most frequently made comparisons with 'care planning'. Such a comparison in this study is perhaps not surprising given the pervasiveness of 'care planning' across mental health services in the UK as a key tennet of the Care Programme Approach (CPA) (DOH, 1990). The CPA provides a framework for good practice in delivering care to individuals who access mental health services, with 'service user involvement' as a key principle (Kingdon, 1994). As such, it is likely the written 'plan' and 'service user involvement' components of care planning that resonate most closely with the values and approach of PBS. Further, a number of staff felt that the multiplicity of approaches within the organisations meant that it was difficult to determine the efficacy of PBS independently. This has implications for the on-going evaluation of PBS in such environments where multiple approaches are applied. As of yet, reviews that highlight the efficacy of PBS in reducing incidences of challenging

behaviour (e.g. LaVigna & Willis, 2002) have not been extended to forensic mental health settings and remain largely within the learning disability and school-wide fields.

4.2.3. *THEME THREE: COLLABORATIVE CHALLENGES*

All staff described PBS as a collaborative process involving patients, primarily in the development of PBS plans. As part of developing a collaborative relationship with patients, staff talked about a number of challenges that impact the collaboration and as such the relationship. These challenges are represented by three identified sub-themes: *Engagement*, *Mental Health* and *Insight.*

The sub-theme of *engagement* refers to the propensity for individual patients to 'engage' with staff to begin collaborating in a PBS process. This was closely linked to the sub-themes of *mental health* and *insight*. Many staff members held the perception that poor mental health and lack of insight provided challenges to both engagement and therefore collaboration in a PBS process. These findings are not explicitly reflected amongst PBS research at this time, this is likely because much PBS research has taken place within learning disability and school-wide settings whereby individuals have not typically been involved in a collaborative PBS process, nor are mental health issues as prevalent. These findings are perhaps explainable by a variety of studies which have demonstrated that in forensic settings, those with mental health disorders experience difficulties engaging in therapeutic treatments due to issues such as motivation and readiness for treatment (Day, Howells, & Casey, 2009; Rosen, Hiller, & Webster, 2004) impulsivity, rationality (McMurran, 2008) and negative understanding of self (Sheldon, Howells, & Patel, 2010). Further to this, literature has suggested that forensic mental health *inpatients* engage less well with therapeutic activities than those patients within community settings (McMurran, 2002).

In terms of psychological theory, a number of studies apply the Stages of Change model (Prochaska & DiClemente, 1986) in understanding the engagement / disengagement of individuals within therapeutic activities, both in mental health

populations (Carey & Purnine, 2002; DiClemente, Nidecker, & Bellack, 2008; McConnaughy, 1989) and offending populations (McMurran, Tyler, & Hogue, 1998). The Stages of Change model postulates that individual engagement within a therapeutic treatment designed to bring about positive change (such as PBS) is understood by the 'stage' in which the individual presides, five stages are suggested which include 'pre-contemplation', 'contemplation', 'action', 'maintenance' and 'relapse' (see Prochaska & DiClemente, 1986). This model could perhaps offer a framework for staff to better understand *the collaborative challenges* when applying PBS in a forensic mental health setting.

In this research, staff also commented on the need to develop good therapeutic relationships with patients in order to engage them in a collaborative PBS process. The importance of developing a good relationship with the focus individual of a PBS approach is something reflected in other qualitative PBS research more generally (e.g. Inchley-Mort & Hassiotis, 2014; Hieneman & Dunlap, 2000; Woolls *et al*, 2012) and moreover, the development of a therapeutic relationship has long been recognised within the field of mental health as an important factor for both engagement and treatment outcomes (Gaston *et al*, 1998; Martin *et al*, 2000; McCabe & Priebe, 2004). Further, in forensic mental health settings, Adshead (1998) demonstrates that relationships between psychiatric staff and patients can resemble attatchment relationships and may be useful for understanding challenging behaviour. Adshead (2002) has further suggested that attatchment theory is particularly applicable to forensic institutions, as 'staff and residents are involved in long-term dependency relationships that involve both care and control' (p.31). Attatchment theory postulates that individuals are essentially social beings who inherently require relationships for survival, such relationships, particularly early relationships with primary care-givers provide a 'secure base', from which the individual can safely explore the world and enter into, form and manage healthy inter-personal relationships using an adaptive 'internal working model', developed as a result of secure attatchment experiences (Bowlby, 1980, 2005). Psychological research has suggested that attatchment-insecurity and associated behavioural difficultuies, particularly within inter-personal relationships may be more prevalent

in offending populations (Levinson & Fonagy, 2004) and amongst those with a range of 'psychiatric disorders' such as anxiety, depression, eating disorder, borderline personality disorder (Fonagy, Leigh, & Steele, 1996) and psychosis (Berry, Barrowclough, & Wearden, 2008). Therefore, patients with both forensic histories and mental health difficulties are perhaps more likely to experience difficulties with inter-personal relationships and as such, this offers a tentative explanation as to why *collaborative challenges* were identified by staff and represent a key theme within this research.

4.2.4. *THEME FOUR: STAFF VARIABLES*

The fourth theme in this research relates to variables within staff that are perceived to influence the process of PBS. Three sub-themes were identified: '*attitude & values*', '*resistance to change*' and '*fidelity*'.

The sub-theme '*attitudes and values*' refers to the personal attitudes and values held by staff members that seem to influence their personal approach to PBS. In this study the perceived *attitudes and values* of staff related to their general positivity and enthusiasm for the PBS approach and how they personally view and manage the tensions between collaboration and control. The findings of this study revealed a perception that staff members vary in the extent to which they can incorporate and merge the core values of PBS (e.g. social role valorisation) with their personal values of care in the forensic environment.

These findings are consistent with themes identified across all the studies in the systematic review, primarily that variations exist regarding the attitude of those individuals who support others using a PBS approach. For example, a number of studies describe similarly that individuals': 'philosophy' or 'guiding values' (Bambara *et al*., 2001) can fit to differing extents with the model, their 'match' with prevailing philosophy' (Hieneman & Dunlap, 2000), their 'philosophical agreement' (Houchins & Jolivette, 2005), 'philosophical difference' (Lohrmann *et al*., 2008), 'conflict in personal beliefs' (Andreou *et al*., 2014) or whether they 'embrace' the PBS model (Woolls *et al*., 2012) or 'buy in' to the approach at an attitudinal level (Andreou *et*

al., 2014; Houchins & Jolivette, 2005; Lohrmann *et al*., 2012). Perhaps most closely resembling the findings in this study, a number of studies related this 'fit', 'match', 'agreement' etc. to the individuals view or opinion on using positive reinforcement and preventative strategies as oppose to punitive responses (Bambara *et al*., 2009; Houchins & Jolivette, 2005; Lohrmann *et al*., 2008) or 'consequences' (Andreou *et al*., 2014). These findings are very consistent with those of this study, particularly regarding staff's personal management of the tension between care and control, which is likely more salient due to the secure forensic context. In this study, the issues of staff *attitude and values* commonly identified within the narratives describing differences in how staff respond to challenging behaviour. As such, we can perhaps consider that the *attitudes and values* of staff are central to how challenging behaviour is understood to be caused and subsequently responded to.

In terms of psychological theory, staff attitudes and beliefs regarding the causes of challenging behaviour (i.e. their causal attributions) have been addressed largely in relation to individuals with learning disabilities (e.g. Hastings, 1997; Hill & Dagnan, 2002; Lowe *et al*., 2007), but also with individuals in forensic settings (e.g. Davies *et al*., 2015; Leggett & Silvester, 2003). These relevant areas of literature relating to staff attribution perhaps provide a supportive explanation as to why a perception exists, in this study, that staff *attitudes and values* vary in their understanding of challenging behaviour. Weiner's (1986) attribution theory has been previously demonstrated as a model that can be applied to helping professionals' understanding of, and responses to challenging behaviour (Dagnan, Trower, & Smith, 1998; Jones & Hastings, 2003; Sharrock & Day, 1990). The sub-theme of *attitudes and values* identified in this study resonates with Weiner's (1986) intra-personal dimensions of 'locus', 'stability' and 'controllability'. 'Locus' is the degree to which support staff attribute factors responsible for challenging behaviour as being internal (e.g. mental health, personality) or external (e.g. environmental stimuli) to the individual. 'Stability' is the degree to which support staff believe challenging behaviour can change over time or remain static. Lastly, 'controllability' is the degree to which support staff believe that challenging behaviour is within the self-control of the individual. Attribution theory, when applied to challenging behaviour within a

secure forensic setting, such as this study, would suggest, as an example, that if a staff member attributes a patients challenging behaviour to 'internal' and 'controllable' factors with additional belief that this would not change over time, the model would predict that the staff member may be more likely to position responsibility *within* the patient, and as a result become more negative regarding the application of preventative-type interventions that seek to improve quality of life. Alternatively, if the challenging behaviour was perceived to be 'externally' influenced, 'uncontrollable' and has the potential to change, the staff member may instead respond in a more positive, empathic way, consistent with the values of PBS. Attribution theory therefore provides a framework that is consistent in explaining why staff may vary in their *attitudes and values* towards challenging behaviours, and therefore more generally to the PBS approach.

The sub-theme '*resistance to change*' is closely related to the previously discussed sub-theme '*attitudes and values*' in that an individual may adopt a 'resistive' attitude in relation to something. It is however constructed as a separate sub-theme due to its emerging prevalence and saliency. Many of the narratives took place within a broader discourse that positioned PBS as a 'new approach', staff members described that when it was first introduced, a number of staff were 'resistant' or 'sceptical' of the idea and perhaps needed to be 'convinced'. These findings are consistent with some of the literature identified in the systematic review whereby an individuals 'fit' with PBS was related to their level of 'scepticism' or 'resistance' (Frey *et al*., 2010; Lohrmann *et al*., 2008) in regard to the approach. Similarly, some studies discussed variable degrees of 'commitment' to the PBS approach (Bambara *et al*., 2001; Woolls *et al*., 2012) which perhaps also relates to the theme of 'resistance'. Within other, non-PBS related literature, issues of staff resistance to change have been documented within mental health settings (Pearlin, 1962; Rapp *et al*., 2010). More widely, the relevance of resistance of staff to organisational change is well documented (see Bovey & Hede, 2001). A recent scoping review of 49 studies by Williams, Perillo, & Brown (2015) regarding factors of organisational culture in health care settings which act as barriers to the implementation of evidence-based practice, identified a professional culture of resistance to change in 14 of the 49 studies. As

such, the sub-theme of '*resistance to change*' identified in the study is well supported in other qualitative PBS literature and more generally supported in other health care literature. In order to better understand 'resistance to change', Erwin and Gaman (2010) reviewed existing literature and found that resistance is largely understood as 'multi-dimensional involving how individuals behave in response to change (behavioural dimension), what they think about the change (cognitive dimension), and how the feel about the change (affective dimension)' (p.42). This would suggest that behavioural, cognitive and affective dimensions of individuals are worth paying attention to in order to understand and overcome resistance. In addition to this individually based conceptualisation of resistance, Lewin's (1945,1947) seminal work positions resistance more systemically via 'Field Theory'. Field Theory explains resistance by arguing that organisations are held in a steady state or 'equilibrium' by equal and opposing forces. In this sense, the organisation is viewed as a system whereby resistance is the force that counterbalances the driving forces of change. Importantly, resistance can occur anywhere within the system, from the change recipients to the overarching political context. Ultimately, this literature would suggest that resistance to change can be understood both individually and systemically, and therefore any interventions that seek to address such resistance should consider both.

Moreover, the sub-theme of '*resistance*' in staff is reflective of the sub-theme; '*engagement*' in the previous sub-section and as such, there is perhaps the potential for parallel processes to interact whereby staff are variable in their *resistance* to the approach and patients are variable in their *engagement* towards the approach. In both processes (*engagement* and *resistance*) the Stages of Change model (Prochaska & DiClemente, 1986) may be helpful, along with Attributional theory (Weiner, 1986) in understanding such variation and further, to help develop motivation to change.

The identified sub-theme of 'fidelity' relates to the perception that staff members vary in their fidelity to the PBS approach. This finding is supported by nearly all the studies identified within the systematic review and referred to frequently as a common barrier to implementing PBS. These studies commonly include the perception that support staff can apply PBS inconsistently or inaccurately (Andreou

et al., 2014; Davies *et al*., 2016; Frey *et al*., 2010; Hieneman & Dunlap, 2000; Houchins & Jolivette, 2005; Inchley-Mort & Hassiotis, 2014; Lohrmann *et al*., 2008; Woolls *et al*., 2012), or a perception that once a PBS plan is put into place, there are difficulties related to staff not monitoring and reviewing the plan (Davies, 2016; Hieneman & Dunlap, 2000). Other studies also identified a perception that staff encounter issues communicating amongst one another regarding PBS (Frey *et al*., 2010; Hieneman & Dunlap, 2000; Houchins & Jolivette, 2005; Woolls *et al*., 2012). Therefore, this study supports a large number of other qualitative PBS studies in that perceptions exists which question the fidelity in which staff implement PBS. A common reccomendation and outcome in such studies is that staff fidelity will benefit from training in PBS via improving knowledge of the approach. A Cochrane review of the literature has demonstrated that PBS training has a positive impact on staff knowledge, their emotional responses to challenging behaviour, and lastly; reduces levels of challenging behaviour (MacDonald & McGill, 2013). In closer relation to this study, it has also been demonstrated that the confidence of staff in a forensic mental health context improved after training (Davies *et al*., 2015).

4.2.5. *THEME FIVE: ORGANISATIONAL ISSUES*

The fifth theme relates to organisational issues perceived to impact the application of PBS. In the case of this research the organisation is understood to be the particular setting in which the research took place, a secure forensic adult mental health setting involving the wider group of staff at various levels. Three sub-themes were identified that include '*MDT processes & Involvement*', '*Resources*' and '*Cultural Congruence*'.

Staff held the perception that PBS is an *MDT process* with *involvement* across all disciplines, however the levels of involvement amongst different disciplines and their visibility to those staff on the wards or 'front line' was variable. In this study, staff frequently made reference to 'the team' or 'the clinical team' as a reference to staff members who are not directly involved in the day to day running of the ward, but rather those staff who have intermittent contact with patients such as psychiatry, psychology, social work and occupational therapy. This sub section of the

MDT were discoursed similarly to that of 'indirect supporters' referred to in the systematic review. In this context, indirect supporters are often perceived to have more expertise and this was consistent in this study whereby a hierarchy of staff was inferred whereby 'the team' were seen as possessing greater expertise and in PBS, however staff often positioned nursing as those staff who deliver the approach on the ground. In this study, the visibility of 'the team' was perceived as being important in order to support a collaborative PBS process, however this visibility and the associated levels of involvement at an MDT level were perceived as variable. The importance of external support for direct support staff is consistent with a number of the studies in the systematic review including 'access to external expertise' (Andreou *et al*., 2014), support and leadership of PBS at a principal and organisational level (Andreou *et al*., 2014; 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 & Hassiotis, 2014). Such notions are supported more broadly in the literature whereby a number of studies demonstrate the benefits of good communication and support within MDT's in delivering therapeutic interventions for service users in both general mental health (Corrigan & McCracken, 1995; Liberman, 1992) and secure forensic mental health contexts (Taylor, Butwell, & Dacey, 1991; Telfer, 2000). Therefore, the findings of this study are consistent with the literature around MDT working in both the PBS literature and the more general literature around delivering therapeutic interventions. This implies that within MDT's, support for those delivering PBS more directly, such as nursing, is likely important.

Additionally, organisational *resources* were frequently identified as being necessary in order to support the successful implementation of PBS in practice. The resources that were overwhelmingly described were that of 'staffing' and 'time'. The PBS approach privileges prevention of challenging behaviour via making improvements to an individual's quality of life. Within this study, it was identified that improvements to quality of life for patients (e.g. access to activities, community leave) were often contingent on staff availability in order to provide this. An example

is that many patients detained under the Mental Health Act (1983) require a staff 'escort' in order to access the community under section 17 of the act. This is perhaps a unique challenge for the application of PBS when applied to secure forensic mental health institutions whereby restrictions exist to an individual's liberty. This finding is consistent with that of Davies *et al* (2016) whereby 'staff resources', particularly in relation to the number of staff on shift were seen as one of the main barriers to implementing PBS within a secure forensic mental health setting. Similarly, the other non-forensic PBS studies identified in the systematic review commonly identified barriers to implementation that related directly to the provision of staffing which included: 'staff team stability' (Woolls *et al*., 2012), issues of difficulty relating to high 'staff-turnover' (Andreou *et al*., 2014), 'too few support staff' (Frey *et al*., 2010) or failure to hire staff (Bambara *et al*., 2001). Also, more broadly, research has long identified that the provision of adequate staffing is a key factor in the efficacy of behavioural interventions such as PBS (Burdett & Milne, 1985; Corrigan, 1992; Emerson & Emerson, 1987).

Within the literature regarding organisations who support people that display challenging behaviour, a number of studies demonstrate that issues of staffing such as availabilty, turnover and attrition are frequently linked to 'stress' and 'burnout' within staff teams (Devereux, Hastings, & Noone, 2009; Hastings, Horne, & Mitchell, 2004; Mitchell & Hastings, 2001; Rose, D., Horne, S., Rose, J. L., & Hastings, 2004). Furthermore, issues of staff 'stress' (Bambara *et al*., 2001; Woolls *et al*., 2012) 'burnout' (Frey *et al*., 2010) 'emotional wellbeing' (Hieneman & Dunlap, 2000) and 'staff morale' (Lohrmann *et al*., 2012) were identified in the systematic review. However, this was something not mentioned by participants in this study. This may be because the focus of interviews were not directly concerning organisational issues of staffing, however it may also reflect that the staff within the organisation in which this research took place were well supported.

Some tentative explantations were at times offered in this study relating to staffing issues, the most common theme being that staff, at times, had to prioritise security over, for example, faciliating community leave when risk related incidents occurred elsewhere in the hospital that required increased staffing, drawing staff from more

'settled' areas of the hospital. Similar organisational tensions of staff needing to manage both risk and person-centred approaches in forensic mental health settings have been outlined by other authors as a 'top concern' (Davidson, O'Connell, Tondora, Styron, & Kangas, 2006).

In this study, closely linked to the provision of 'staffing' were also issues of time availability. This primarily included the time required for staff to read PBS plans that could be lengthy. Comments were also made by participants that PBS, especially the development of PBS plans, is very time consuming for the profession of Psychology and as such, impacts the time in which PBS plans can take to develop. These findings relating to the provision of time are consistent with a few other studies identified in the systematic review which discuss the provision of 'time' required to implement PBS, and that 'limited lime' can impact service delivery negatively (Frey *et al*., 2010; Houchins & Jolivette, 2005). Specific references were also made to the time needed for training, learning, collaboration, communication and co-ordination (Houchins & Jolivette, 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. There is clearly some incongruence between the forensic culture and the values or culture of PBS. This notion of organisational or contextual congruency with PBS is a pattern supported by numerous literature identified within the systematic review which include similar themes of 'ecological congruence' (Houchins & Jolivette, 2005), the 'fit' of practice within the context (Andreou *et al*., 2014; Woolls *et al*., 2012), 'responsiveness' and 'flexibility of the system' in relation to PBS (Hieneman & Dunlap, 2000), the 'culture' (Bambara *et al*., 2009) and the influence of the 'climate' (Lohrmann *et al*., 2012). The findings of this study therefore add further support to the notion of 'contextual fit' (Albin & Lucyshyn, 1996) which suggests PBS plans are likely to be most effective when there is general congruence between focus indivdiduals and the wider setting. Indeed, participants in this study provided examples in which PBS processes could be incongruent with the wider context, most commonly due the nature of the secure forensic context.

If we consider the context as inseperable from the individuals who are active within it, then the use of PBS to manage challenging behaviour must be considered in the context of the organisation and its culture and values. A more contextual view of challenging behaviour resonates with the ideas of social constructionism, whereby 'problems' such as 'challenging behaviour' are positioned and understood within 'problem-determined' systems or contexts (such as secure forensic settings), rather than any individual (Goolishian & Anderson, 1987). An implication of such findings would be to question how the forensic setting is ultimately organised to apply PBS and whether further adaptation or flexibility is required to implement the approach in a more values-congruent way. This is similar to the notion of second-order cybernetics (Howe & Von Foerster, 1974) which forms a basis for questioning the positions of the staff and the overarching organisation as being 'external' or 'neutral' in their relationship with patients and the approaches applied to them (first-order cybernetics). As such, a systemic approach to thinking about and managing these challenges in the future would be indicated.

4.3. *Clinical & Service Implications*

This research explored staff perceptions of PBS in a secure forensic mental health setting. As outlined within section 1, literature to date regarding the application of PBS to forensic settings is minimal. This research aimed to address this gap, and in doing so provide useful information to guide future clinical practice within this area. The findings from this study raise a number of clinical and service implications relating to the application of PBS within secure forensic mental health settings for the multi-disciplinary professionals involved.

The perceived functions of PBS in the forensic setting researched here were broadly in line with those documented in the wider PBS literature. This suggests that from a functional perspective, PBS translates to forensic settings and has a perceived function to provide information for staff members in order to support them in understanding challenging behaviour. This research identified a perception that the constructs of 'challenging behaviour' and 'risk' were closely related and largely interchangeable, moreover, 'risk behaviour' as a construct is more embedded within

forensic services and as such, PBS may be better promoted within this setting as an approach for understanding 'risk behaviour', as staff in this setting are likely more familiar with this terminology. Also, PBS within this setting was seen to function as an approach that empowers patients by inviting them to collaborate in the PBS process. This empowerment function resonates with existing approaches in forensic mental health such as increasing 'service user involvement' and the 'recovery' movement, as such, this suggests PBS fits well alongside existing approaches applied within the forensic mental health setting that are underpinned by similar values.

PBS was qualitatively appraised within the research setting as largely positive, owing to a perception that it supports patients to progress in the recovery journey. Despite this, PBS was still appraised as being in a phase of on-going development, and as such, needing continual investment and support in order to further develop the approach. The implication here is that services need to continue to invest in PBS, largely from a training perspective in order to fully embed PBS within the service and increase its visibility to all staff. Additionally, staff commonly appraised PBS in relation to existing approaches within the setting. Staff described that PBS is one approach amongst many and as such, provides difficulty in appraising the efficacy of PBS alone. The implication here is that it will be difficult for forensic mental health services to isolate the efficacy of PBS as a standalone approach given its existence amongst a number of approaches such as 'care planning', 'recovery' and medical interventions. As such, it will be important for services to monitor outcomes related to challenging behaviour and quality of life for patients before and after a PBS approach is applied within any forensic mental health service, as efficacy data for forensic-PBS is lacking within the literature more broadly.

A number of issues were perceived to provide challenges to staff in order for them to collaborate with patients in a PBS process. Primarily, engagement within a collaborative PBS approach was perceived as most frequently impacted by issues relating to a patients mental health and their level of insight of such. In order to improve patient engagement within PBS, assessment of an individual's motivation to engage using a stages of change model (Prochaska & DiClemente, 1986) might be helpful in targeting interventions. For example, patients that remain dis-engaged

with PBS might benefit from techniques of motivational interviewing (Miller & Rollnick, 2012). Also, there was a perception that patients with more severe mental health difficulties are less likely to engage in PBS due to a lack of 'insight' into their mental health difficulties. This is supported by evidence that suggests that level of insight is positively correlated with therapeutic engagement more broadly (Johnson & Penn, 2008; Svensson & Hansson, 1999; Wittorf *et al*., 2009). As such, a clinical implication in this regard would be that staff consider interventions that might improve the insight of patients in order to improve the likelihood of engagement with PBS. Moreover, there is a further consideration for services to make in that those patients with the least amount of insight may be the ones who stand to benefit the most from a PBS approach, as currently, there is a perception that the patients who engage more collaboratively, are those perceived to be in a phase of 'recovery' rather than 'acute' mental distress.

Additionally, staff perceived that engagement in a collaborative PBS approach was more successful within the context of a good therapeutic relationship. The importance of therapeutic relationships in engaging patients in collaborative approaches is not a novel finding when considered more generally, significant literature has long promoted and emphasised therapeutic relationships between care-givers and receivers as being (likely the most) important factor for effective clinical outcome (Gaston *et al*, 1998; Horvath, 2001; Lambert & Barley, 2001; Martin *et al*, 2000; McCabe & Priebe, 2004). The key implication therefore is for staff to prioritise their relationships with patients in order to deliver effective, collaborative PBS. The consideration of these findings in relation to existing literature would suggest that staff take into account how their position of relative power might impact their relationship with patients. Attachment theory (Bowlby, 1980) might provide a helpful framework for staff to better understand and develop therapeutic relationships with patients in the context of a collaborative PBS approach.

In relation to implications associated with the *staff variables* identified within this study, a clear implication of this study will be to further assess *staff resistance* in order to provide interventions that aim to reduce such levels of resistance, in the hope PBS will be more efficacious. Previous research, particularly around challenging

behaviour, has suggested that staff are more resistant or hold *attitudes and values* incongruent with those of PBS when they attribute challenging behaviour to intra-personal factors rather than external factors (Dagnan *et al*., 1998; Jones & Hastings, 2003; Sharrock & Day, 1990). Interventions including network training (Jenkins & Parry, 2006) and team formulation (Bruch, 2015; Whomsley, 2009) may be helpful in supporting staff members to attribute or understand 'challenging behaviour' in new, more adaptive ways that lends itself to a less resistive approach in terms of PBS delivery. Additionally, it may be useful for any such training to incorporate the perspectives of staff who had previously been sceptical but subsequently convinced by the approach.

This study also found that staff perceive issues around fidelity to the PBS approach. Implications for addressing staff fidelity to PBS have been widely discussed within the more general PBS literature (see previously) and should now be applied similarly to the area of forensic-PBS. The implication here is for the organisation to ensure that staff possess and maintain an adequate knowledge and skills base to deliver PBS with fidelity. This will likely be achieved by ensuring service managers and those who 'lead' PBS, such as nurse-leaders and clinical psychologists, provide on-going support, supervision and practice leadership to the staff more directly involved in the delivery of PBS. The importance of practice leadership in relation to PBS has been emphasised within the more general PBS literature (Frey, Lingo, & Nelson, 2008; Mansell, Hughes, & McGill, 1994). An e-learning training has been developed within a local service (Allen *et al*, 2008) for the purpose of increasing the skill base of PBS in organisations. Such an increase in skill base would likely improve the fidelity of staff to the PBS model and approach.

In this study, PBS was perceived as an MDT approach requiring involvement from multiple disciplines. Organisational *resources* related to staffing and their time were perceived as barriers and thus an outstanding need is to have more staff capacity to improve the quality of life for patients (e.g. staff availability and time to provide escorted community leave). Whilst this study did not investigate the causes of staffing issues, a further implication will be for such organisations to consider how staff teams can be stabilised in order to provide safe and effective PBS for patients.

Lastly, for the organisation, there is clear tension between the values base of PBS and those of secure forensic mental health care. The impact on patients is that, at times, issues of security take precedent over opportunities to improve quality of life. This tension has been well described and discussed within the literature (Dorkins & Adshead, 2011). It has also been recognised that organisational cultures that overly prioritise 'risk' can sometimes influence staff into feeling constrained to practice defensively (Langan & Lindow, 2004). Despite this tension, the implication here is that the organisation will need to give wider consideration to how quality of life can be improved within the limitations of the forensic setting and the Mental Health Act (1983). Ramon (2005) makes the point that 'risk taking is necessary in each aspect of mental health where the primary purpose is that of improving quality of life of service users' (p.49). In this respect, secure forensic mental health settings will perhaps need to consider that PBS, as an approach will be most congruent within a culture of positive risk taking, whereby support professionals display a willingness to take appropriate risks, to discuss them, and to consider the needs of the patient more broadly.

4.4. *Strengths & Limitations of the study*

4.5. *Design & Methodology*

The qualitative design can perhaps be considered a strength of the study given that the aim was to explore the perspectives of staff regarding the application of PBS in a secure forensic adult mental health setting. Qualitative methods tend to allow for richer descriptions and ways of understanding personal experience (Willig, 2013), to which this study was particularly interested. A thematic analysis was considered most appropriate as the approach enables flexibility in epistemology and methodology (Braun & Clarke, 2006). This flexibility was important given a transition was required in that some data was re-analysed, having previously been subject to a Grounded Theory approach (See Section 2.2).

The position of the researcher, as outlined previously (see Section 2.8.1) is important to consider as this was inherently implicated in how the themes were identified. The epistemological stance of critical realism acknowledges that the researcher is part of

the world they study, the data they collect, and the analyses they produce. As such, the author acknowledges that another researcher with similar aims and rationale may have produced a different analysis. It is of note that the author had previously worked as a staff member in a similar forensic mental health setting prior to this study and as such had likely developed pre-assumptions, attitudes and values, which influenced the questions they asked, and the way verbatim data was interpreted.

4.5.1. *Recruitment & participants*

A purposive sample of 11 multi-disciplinary staff members were selected as broadly representative of the wider staff population. Whilst this is a relatively small sample in comparison to quantitative methods, in qualitative research, the concept of theoretical saturation should be the guiding principle in ascertaining when additional individual perspectives are no longer required (Charmaz, 2014; Mason, 2010). Moreover, guidance on sample size for thematic analyses is non-specific and should be guided by the needs of the study (Braun & Clarke, 2006). Smith and Eatough (2007) suggest an absolute minimum of six participants and Bird (2005) states between eight to 20 is appropriate. It was recognised by the author that a pragmatic number of interviews would lay between 10 and 15, it was also felt that this struck the right balance between an in depth understanding of multi-disciplinary staff perceptions, characteristic of smaller sample sizes in qualitative research and sufficient representation of the wider staff population, whilst minimising the risk of superficial analysis associated with larger scale studies (Boyatzis, 1998). The author recognises that there is debate within the literature pertaining to quality issues around theoretical saturation (see Guest, 2006; O'Reilly & Parker, 2012), and indeed, whether it can be said that 'saturation' has been reached, is a question of subjectivity. The author, with support of the research team, felt a point of saturation had been met that was adequate enough to derive themes that were grounded in the data. However, the author acknowledges that further interviews, and therefore a larger sample, may have yielded new information that could have resulted in the identification of new or different themes. For this reason, the author reiterates that any generalisations from these findings are made with caution.

Further to this, the staff sample were drawn from a mixture of professional backgrounds. Whilst it is acknowledged that this lack of professional homogeneity further reduces the generalisability, it was not the aim of the study to seek the perspectives of a particular professional group, the author sought to invite multiple perspectives of all staff that may have involvement with PBS, as such, the staff 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 the theme of '*staff variables*' contains a number of sub-themes relating to intra-staff factors (e.g. fidelity, resistance) that were largely the perceptions participants held regarding *other* staff members, however few acknowledged these themselves. As such, it may be possible that the sample was biased more towards those staff that were more pro-PBS.

Additionally, participants were purposively selected by the on-site clinical research supervisor, who also had considerable involvement in the development of PBS in the research setting, along with the training of staff members. As such, it is possible that participants were subject to sampling bias, as the supervisor may have been more likely to select participants that they felt would provide positive perceptions of PBS.

4.5.2. *Data collection & analysis*

Firstly, the depth and quality of the interviews and subsequent interpretations may have been impacted by the fact participants were in contact with the researcher for only a single meeting, this may have affected the quality of rapport developed within the research relationship and as such, may have impacted the content of narratives.

Credibility checks of analyses were undertaken with the research team, this helped to ensure that the resultant analysis was semantically reflective of the participant verbatim, also quotes have been included throughout the results section to support interpretation. A limitation of this study was that it was not possible due to time constraints to carry out credibility checks with the participants subsequent to their original interview. For example, a focus group with staff could have been utilised to check the identified themes and provide further credibility.

Further, the author set out to use a semantic and inductive thematic analysis to identify themes that were grounded in the verbatim data provided by the participants. However, due to an emergent need to re-analyse some of the data after having previously coded it, the author, despite their attempts to resist this, experienced tensions in the collection and analysis of subsequent data that often pushed them towards a more deductive approach, i.e. understanding emergent data in the terms of previously identified codes / categories. Despite this, it is felt that the themes identified remain true to the staff accounts.

4.6. *Suggestions for future research*

The application of forensic-PBS remains embryonic at present, as such there is a clear need for more research that includes the views of those individuals involved in the delivery and receipt of PBS e.g. patients and staff members. Should PBS continue to grow in secure adult forensic mental health settings, there will likely be more scope to research this sample of individuals. As this research took place within a single secure forensic setting, replication of this study at other similar sites where PBS is applied will help to determine whether these findings extend to other forensic mental health settings.

This study considered all professional staff groups in order to provide a broad overview of staff perception, it may however be interesting to provide a more 'in detail' view of nurse and / or support worker perceptions, as they seem to be implicated most closely with PBS delivery, especially in terms of collaborating directly with patients.

Service users, such as mental health patients have been less well represented in health and social care research relative to staff (Beresford, 2002). This is also apparent for research around forensic-PBS and PBS more broadly (see systematic review in Section 2), as such further research concerning patient perceptions of PBS is indicated. More specifically, it would be interesting to explore patient perceptions of PBS within a secure forensic setting and to compare these findings against those in this study to see whether any similarities and distinctions are present.

Finally, further research that explores the efficacy of PBS within secure forensic mental health settings will be important particularly in understanding whether the presence of PBS improves the quality of life for patients and reduces incidences of challenging behaviour. This would extend the evidence base for PBS more widely and further validate the policy and guidance that espouses PBS as good practice within secure forensic mental health services settings.

4.6.1. *Conclusions*

PBS has now been introduced to the area of secure forensic mental health. The perceptions and efficacy of PBS, to date, have largely been defined in the service contexts of learning disability and school-wide education. As such, little is known about its application in forensic mental health. Via exploration of the literature it was identified that this area of research is lacking and further exploration was required. The current study locates itself at an embryonic stage of the research within this area and therefore sought to better understand staff perceptions of PBS within a secure forensic mental health setting.

A thematic analysis identified five themes concerning the perceptions held by staff relating to the application of PBS in a secure forensic mental health setting. These were: '*The functions', 'Appraising a new approach', 'Collaborative challenges', 'Staff variables'* and '*Organisational issues'*. These themes were discussed in relation to existing literature. Overall, PBS appears to translate into a forensic mental health 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 context of containment and disempowerment.

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6. Appendices

A. Systematic Review Summary Tables

B. SURE Quality Framework

C. Examples from Reflective Journal

D. Examples of Memo's

E. Ethical Approval Documentation

F. Participant Information Sheet

G. Participant Consent Form

H. Semi-Structured Interview

I. Thematic analysis process

i) Phase 2: Generating initial codes using NVivo for Mac
ii) Examples of initial codes and focused codes alongside verbatim
iii) Phases 3 & 4: Searching for and reviewing themes
iv) Phase 5: defining and naming themes: Thematic map developed from mind map

Appendix A - Systematic Review Summary Tables

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Woolls, Allen & Jenkins (2012)	UK	To explore what care-staff think is supportive and problematic in implementing PBS with people with learning disabilities and challenging behaviour.	*For Interviews:* 8 direct-care staff (Registered nurse n=3, non-registered nurse n=1, social care manager n=1, support workers n=3) *For focus group*: 6 indirect-care staff (Behaviour specialists n=4, clinical psychologists n=2)	Female n=6 Male n=2 Female n=5 Male n=1	4 staff from NHS managed specialist residential services with training in PBS, other 4 from social care services, involved with PBS for minimum of 1 year, generally less training in PBS compared to NHS staff. All involved in the development of PBS plans. Range of experience working with challenging individuals; 3-19 years.	**Recruitment technique:** Not specified **Design:** Qualitative **Data collection:** Grounded theory process via semi-structured interviews and focus group **Interview schedule:** Explored themes around what facilitates effective implementation of PBS, what are the barriers and how can barriers be overcome. **Data analysis:** Grounded theory process; progressive abstraction of themes from interviews, focus group used to triangulate themes from interviews.	*For Interviews:* 1. External Support – knowing the service user / visibility of external support, relationship with direct-care staff and level of training received. 2. Internal support – commitment towards embracing the PBS model, Organisational and staff team stability, internal support within their organisation, communication between staff re: PBS 3. Mediators (Intra-personal) – expectations, attitude to PBS, Knowledge and understanding of PBS, stress level. 4. Delivering PBS in practice – getting it right, maintaining consistency, becoming second nature, problem solving. *For focus group:* 1. Service delivery (amongst MDT professionals) – competing priorities, lack of joined-upness. 2. External Support – size of the plan / readability, shorter in length, relationship with direct care staff 3. Internal Support – provider skills and training, commitment, organisational stability, managerial support. 4. Mediators (Intra-personal) – Expectations, attitude, knowledge and understanding, stress.	The grounded theory shows that a diversity of factors (as shown in the results) interact in ways that can maximise and minimise the success of PBS interventions. The factors identified were generally supportive of PBS. Generally, there was more agreement than disagreement between the direct and indirect staff.	54/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Houchins et al (2005)	USA	To develop common themes around the applicability of PBS within juvenile justice settings and what PBS may look like within juvenile justice settings.	22 Juvenile Justice staff – Administrators (n=6), teachers (n=9) and clinical staff (n=7).	Male n=8 Female n=14	All staff trained in PBS over 1.5 year period prior to study. PBS had been implemented within the facility since the training started.	**Recruitment technique:** Not specified **Design:** Qualitative **Data collection:** Grounded theory via three focus groups **Interview schedule:** Questions around; elements of PBS observed and missing in practice, compatibility of PBS with current assessment and treatment approach, barriers to implementation, training needs, potential and actual benefits on implementation, **Data analysis:** Grounded theory process – cites 'constant comparative analysis' to develop themes, categories and their inter-relationship, triangulation via use of multiple researchers for theme agreement.	Findings produce eight interconnected themes forming a model for understanding PBS in Juvenile Justice: 1. Ecological congruence – correction model (e.g. power, punishment & expediency) Vs. PBS model (e.g. individual control over lives, positive reinforcement etc) 2. Role clarity – staff power, position and managing conflicting policies (e.g. punishment vs. PBS) 3. Philosophical shift and agreement – concern with changing staffs beliefs and thinking processes (e.g. changing from a correctional model to a PBS model), reverting back to correctional model at times of crisis, holding students accountable for behaviour. (biggest theme) 4. Cache of pro-active / preventative strategies – access to reinforcers that are not contraband as central concern, tension between access to motivational reinforcers and security compromise. 5. Consistent practices – difficulties with ensuring consistency across multiple settings and staff members within the facility. The availability of 'time' also identified as a barrier to consistent practice. 6. Logistics – relating to the issue of 'time' (e.g. time for training, learning, collaboration, communication and co-ordination) Also identifies time needed for personal change. 7. Data-based decision making – getting staff to value / 'buy in' to the collection and use of data to improve practice (e.g. use of functional analysis). 8. Achievement outcomes – identified need for PBS to be linked to improved academic achievement (smallest theme).	Multiple themes centered on environmental congruence emerged that will need to be addressed if PBS is to generalise to juvenile justice settings. Future research on applicability, feasibility and practicality of PBS in juvenile justice settings required.	50/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Inchley-Mort & Hassiotis (2014)	UK	To describe service user, and paid and family carer experiences of a 'complex behaviour service' (based exclusively on PBS model)	25 carers – Family carers (all mothers) (n=8), paid carers (n=9), managers of supported living accommodation (n=3), professionals (care managers) (n=5) 6 service users – all reported to have mild intellectual disability and sufficient verbal skills to express their ideas and discuss opinions.	Carers – Male (n=8) Female (n=17) Service users – Male (n=5) Female (n=1)	All participants had experience of PBS via their interaction with the complex behaviour service	**Recruitment technique:** Convenience sampling of those receiving support from the complex behaviour service **Design:** Qualitative **Data collection:** via semi-structured interviews **Interview schedule:** a topic guide included; reasons for referral, contact with the service, the assessment period, intervention and overall satisfaction. **Data analysis:** Conventional content analysis via multiple researchers to develop codes and subsequent themes, used multiple researchers to check validity of interpretations.	1. Availability and frequency of contact – good service satisfaction linked with increased availability and contact. 2. Talking about behaviour and being listened to – nature of relationship between service user / carers and professionals important. 3. Being understood – when understanding between service user / carers and professionals was achieved, interviewees describe a positive experience of the service 4. Change – the impact of the (PBS) service had a positive effect on level and frequency of challenging behaviour. Also relates to affecting posiitve change in interviewees understanding on behaviour. 5. Longer engagement and crisis support – Interviewees would like more / ongoing support from the service. 6. Challenges – difficulty completing behavioural monitoring forms, language barriers, change in living environments, staff not following guidelines put in place, guidelines too long.	The targeted focus on challenging behaviour as provided by PBS is acceptable to both service users and paid and family carers of people with intellectual disability and challenging behaviour. The themes derived reflect useful aspects of PBS and also, features deemed important by carers and service users alike that should be considered in creating future services.	65/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Andreou et al (2014)	Canada	To explore the perspectives of school and district personnel regarding events that affect tier 1 school-wide PBS.	17 educators: administrators (n=4), district consultants (n=4), special education teachers (n=3), general education teachers (n=6)	Female (n=12) Male (n=5)	Schools had been implementing PBS for between 10 and 14 years, fidelity to PBS model rated as adequate (range: 86%-89%) All participants had received training in PBS and had experience implementing PBS in practice (average experience = 9 years, range = 5-15 years).	**Recruitment technique:** Convenience sampling **Design:** Qualitative **Data collection:** via semi-structured interviews **Interview schedule:** Questions adapted from previous research – details not provided. **Data analysis:** Used Critical Incident Technique (CIT) – a phenomenological qualitative research method to identify specific, observable behavioural events (called Critical Incidents) that are perceived as helping or hindering the PBS process. Analysis utilised multiple researchers to improve inter-coding reliability.	1. Continuous teaching – refers to consistency of PBS approach within the teaching culture. 2. Positive reinforcement – important in sustaining PBS 3. Team effectiveness – organisational structure in support of PBS important, effective teams promote good PBS. 4. Staff ownership – Teacher-generated and owned as opposed to 'top down' imposition. Teacher 'buy-in' and involvement important. 5. Adaptation – adapting PBS practices to 'fit' local school context. 6. Community of practice – networking and connections between those implementing PBS important. 7. Involving new personnel – bringing in new ideas, energy and perspectives, grounding in recruitment. 8. Use of Data – importance of having observable and measurable data for successful PBS. 9. School administrator involvement – principals support and leadership of PBS important. 10. Staff turnover – hindering effective PBS 11. Conflict in personal beleifs – divergent beliefs around equity, social behaviour norms, rewards and consequences as barriers to engagement. 12. Access to external expertise – seen as important. 13. Maintaining priority – important for PBS to have a 'high profile' within the school and to be valued.	The themes / events identified illustrate that sustaining PBS in this environment requires foresight, flexibility and creativity. Affirms the need for specific strategies to enhance ownership by staff and administrators to counter staff turnover, such as including new personnel in PBS as early as possible. Contextual adaptation crucial to sustainability.	65/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Bambara et al (2001)	USA	To describe the experiences and perspectives of staff teams providing ongoing PBS to adults with learning disability & challenging behaviour.	19 team members of community based teams supporting adults with learning disability (range of positions including agency directors, behaviour specialists, direct support staff and consultants) – inclusion criteria of at least 1 team leader and 1 direct support staff member per team.	Not reported	Staff teams who have provided PBS for 2 or more years. Staff teams that used / contained key PBS characteristics as described in PBS literature (criteria specified)	**Recruitment technique:** Purposive sampling – selected based on nominations from trainers of 'good examples' of teams using PBS. Then staff team leaders selected 'core team' members. **Design:** Qualitative **Data collection:** semi-structured interviews **Interview schedule:** Questions focused on; individuals who are supported, team processes, support provided, team members experience of PBS, aspects of support that are most essential for success. **Data analysis:** Grounded theory constant comparative method. Adapted procedure for consensual agreement and data reduction within research teams. Five stage process refining codes between multiple researchers and then checks with original participants for accuracy.	Three key interrelated theme areas emerged pertaining to the teams' experience: 1. Guiding Values – 'more than a set of techniques' – PBS as a 'context', 'world view' or 'philosophy' for understanding people / behaviour – 'seeing the person as a person' , 'following the person's lead' (taking direction from the person). 2. Support for the team – importance of teams supporting each other in order to support people with challenging behaviour, cultivating / investing staff in the teams values and practices. Support dealing with stress of challenging behaviour. Managing inter-team arguments. Conflicts with 'upper administration' outside of their team – disillusionment with decisions driven by fiscal or regulatory priorities. Time for team meetings, failures to hire staff who can drive. Creating atmosphere 'where all are listened to and heard'. Addressing the personal / emotional needs of staff. Staying person centered. 3. Direct supports – participant views on the essential elements of support: The relationship between staff and person as most essential element of support. Nature / importance of relationships. Relationships foster staff commitment and motivation, relationships facilitated understanding and empathy, relationships facilitated a sense of security and trust for the focus person. Supportive listening. Building a quality life. Honesty and limi setting	Team members stressed the social process of their work. Findings suggest a need to more fully understand behaviour as an interactive process, 'moving beyond techniques' – 'this study calls for a greater understanding of social contexts in which PBS is implemented'.	63/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Lohrmann et al (2008)	USA	To document and contextualise staff observations and perspectives about what factors influenced or explained staff resistance toward implementing the universal level of school-wide PBS	14 educational consultants providing technical assistance to schools implementing PBS. Average experience in setting – 14 years Qualification level: PhD (n=10), Masters (n=4).	Not reported	Participant had to have (a) at least 2 years 'successful' experience providing direct on-site assistance for PBS to at least one school and (b) report providing on-site technical assistance for a period of 1 year to at least one school where implementation was hampered by barriers. Average experience of PBS – 7 years (range 3-10 years)	**Recruitment technique:** Purposeful sampling of indirect technical assistance staff on basis they witness barriers to PBS implementation in their direct role of supporting schools to overcome such barriers. Four methods used to identify p's across states of the USA. **Design:** Qualitative **Data collection:** via three separate semi structured interviews **Interview schedule:** interview 1 – background info and beliefs about PBS, interview 2/3 – observations and beliefs about school personnel's adoption of interventions. **Data analysis:** Grounded Theory open coding method. Codes developed by a primary coder and then checked by a consensus partner. Codes then checked with each subsequent participant. Codes and definitions then organised into thematic categories. Participants then checked final themes and asked for agreement.	Five barriers to change emerged when implementing PBS in schools: 1. Lack of administrative direction and leadership – when PBS lacks support at higher levels of administration e.g. principal. 2. Scepticism that the universal intervention is needed – individual staff scepticism regarding the approach of PBS and whether it is required. 3. Hopelessness about change – individual staff can't see the possibility of improvement via PBS approach. 4. Philosophical differences with PBS – when staff wanting to emphasise punitive responses vs proactive, when staff feeling that adults should not have to change for students to act appropriately, when staff believe that students should be intrinsically motivated to behave and thus philosophically opposed to providing extrinsic motivation. 5. Staff feel disenfranchised from each other, the administrator, or the mission of the school – staff needing a certain degree of comfort and security to risk making changes to their practice. Negative staff to staff relationships. Defensiveness, inconsistency, passivity, non-collaboration and resistance.	Participant's observations about the barriers they encounter in schools are consistent with other research. Strategies to overcome resistance can be thought of in the same way as those espoused by PBS to overcome problem behaviour. Assessing barriers is helpful in determining the amount of support a school will require.	58/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Davies, Mallows & Hoare (in press)	UK	To explore how forensic mental health service users understood and experienced PBS.	10 service users, detained in a medium secure forensic mental health service under the mental health act (1983) Service users have exhibited behaviours that challenge staff members. Service users have received mental health diagnoses.	All Male (n=10)	Service users who have received a PBS plan.	**Recruitment technique:** **Design:** Qualitative **Data collection:** via semi structured interviews **Interview schedule:** semi-structured interview schedule provided within appendices **Data analysis:** IPA, single researcher used for interviewing and transcription, multiple authors used for coding and triangulation.	Four main themes emerged: 1. My plan: understanding me & sharing my story, good days, bad days, triggers for behaviour, feeling involved with the development of the plan. 2. How I understand PBS: Tells people how to care for us, provides strategies for prevention, uncertainty about why I have a plan – not clearly explained to us, Accessibility – liked it being written in 1st person, although not referred back to it since initial development. An efficient summary. 3. How PBS has helped me, the benefits: Reflecting on my behaviour – increasing insight, linking behaviour and mental state. Noticing and wanting to change – changing as a result of PBS involvement – progression through the service. 4. Making the plan work: Staff fidelity to the model / plan – inconsistency perceived amongst staff. Keeping the plan alive – lack of reviewing the plan and reading it after completion. Implementation – staff resources to deliver PBS.	The PBS model implemented within the service appears to have been valued by most of the participants, allowing them greater involvement with their care.	72/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Frey et al (2010)	USA	To assess the social validity of program-wide PBS within early childhood school context	62 administrators and staff: Management team (n=5), PBS trained teachers (n=20), untrained teachers (n=8), family service workers (n=13), resource teachers (n=13), disability liaison (n=3)	Not reported	Mixture of experience 20/62 formally trained in PBS. All staff have working experience of the approach.	**Recruitment technique:** Purposive sampling of staff perceived to be supportive and non-supportive of PBS. **Design:** quasi-experimental **Data collection:** 8x focus groups, surveys, observation **Interview schedule:** semi-structured interview **Data analysis:** Thematic analysis using multiple researchers.	Four major themes emerged: Program strengths: voluntary participation, school role, family role, classroom climate, Program concerns: general concerns – feeling ineffective due to limited time and resources and too few support staff, skepticism about consistency of implementation, burnout, poor internal communication. Outcomes: Positive effects on student performance, doubt re effectiveness, optimism re positive change. Suggested changes: Modify instruction, professional development, family and community involvement.	The goals and outcomes of PBS are supported by key stakeholders. The procedures were difficult to implement and received less support from a social validity perspective.	58/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Hieneman & Dunlap (2000)	USA	To establish factors that may affect the success of community based PBS for children with severe disabilities.	15 stakeholders – Trainer / consultants (n=5), parents or guardians (n=5), direct service providers (n=5). Although noted further on that some participants hold more than one of the above positions.	Unclear for all participants, of 'direct service providers' – males (n=6), females (n=4)	Participants required to have 1 or more training experiences in PBS and to have used functional assessment to design behavioral interventions. Minimum working experience – 3 years Professionals required to have supported a minimum of 10 individuals in community settings.	**Recruitment technique:** Purposive sampling –individuals nominated by state PBS training team. **Design:** Qualitative **Data collection:** Semi-structured phone interviews **Interview schedule:** semi-structured telephone interview schedule provided **Data analysis:** Content-analysis via multiple researchers.	12 factor categories emerged from the data: 1. Characteristics of the focus individual - that would affect the persons ability to respond to intervention efforts e.g. communication skills, independent living skills. 2. Nature and history of the behaviour – type, frequency, intensity etc. 3. Behavioural support plan design – e.g. importance of ecological and functional assessment. 4. Integrity of implementation – e.g. consistency, ongoing monitoring, decision making, evaluation. 5. Nature of the physical environment – e.g. availability of material resources, organisation of environments, facilities, equipment space etc.. 6. Buy-in with the intervention – e.g. support-provider commitment, satisfaction with plan, beliefs re: effectiveness. 7. Capacity of support providers – e.g. support provider's energy reserves for putting interventions in place, emotional wellbeing, physical health, confidence. 8. Relationships with the individual – e.g. acceptance and respect for the individual, understanding and appreciating their strengths and limitations, valuing dignity, privacy and autonomy. 9. Match with prevailing philosophy – obstacles included traditional expert models, layers of bureaucratic structures and competing priorities within systems. 10. Responsiveness of the system – flexibility of system in responding to individual needs, ensuring support plan implementation. 11. Collaboration among providers – support providers working together, communication, shared vision. 12. Community acceptance – socio-cultural values associated with disability inclusion etc improve access to community support…	The study reiterates the value of designing contextually relevant, person centered plans that are based on the resources available in natural settings and the preferences of support providers.	59/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Bambara et al (2009)	USA	To investigate team members perceptions of barriers and facilitators to implementing PBS in school settings.	25 stakeholders involved in school based PBS (included classroom teachers (n=6), school administrators (n=5), parents (n=5), external PBS facilitators (n=4) and internal PBS facilitators (n=5).	Male (n=3) Female (n=22)	Minimum criteria: intensive training in designing PBS plans, current participation in a PBS team with experience in all stages of plan development, at least 2 years experience leading PBS teams for facilitators, 2 years experience for administrators and 1 year for teachers and parents who had participated in a PBS team. Range = 1-15 years experience	**Recruitment technique:** Purposive sampling via nominations by PBS consultancy organisations **Design:** Qualitative **Data collection:** via semi-structured interviews **Interview schedule:** interview guide used around three broad categories: typical PBS development process, barriers, facilitators. **Data analysis:** modified Consensual Qualitative Research	Five broad thematic areas emerged: 1. School culture – the most pervasive theme – sharing a common understanding and appreciation for PBS, misunderstanding PBS, prevention vs punishment. 2. Administrative support – importance of district and principal level support, leadership and promotion of PBS. Providing resources – time for planning and meetings. 3. Structure and the use of time – importance of allocated and structured time for PBS related team activities, e.g. meetings. Can be viewed as too time consuming or labour intensive. Contextual fit. 4. Professional development and support for professional practice – training opportunities, continuous support, professional development, technical assistance. 5. Family and student involvement – active participation, consistency between school and home.	The findings reflect the multi-dimensional and inter-related nature of the factors perceived to either impede or enhance the implementation of PBS. Sustained implementation will require change and support at multiple system levels.	61/80

Authors	Country	Aim	Participants			Method (design, data collection, data analysis)	Results / Main themes	Conclusion	Quality rating
			Role / Status	Gender	Experience of PBS				
Lohrmann et al (2012)	USA	To investigate how problems with stakeholder buy-in of the universal intervention (of PBS) manifest and are resolved from the perspective of internal and external coaches.	9 paired internal and external PBS coaches (total n=18)	Not reported	Pairs discuss a single site of PBS activity whereby fidelity measures achieve a score of at least 80%. Comprehensive PBS experience detailed for both internal and external coaches. (e.g. years experience: range = 2-20, mean = 6.25) All had received formal PBS training.	**Recruitment technique:** Mixed – convenience for initial identification then purposive. **Design:** Qualitative **Data collection:** individual phone interviews – audio recorded **Interview schedule:** two-part schedule, background information then barriers. **Data analysis:** Grounded theory – open coding process using multiple researchers to audit codes, constant comparative method.	Four main themes emerged: 1. Barriers – 'not worth the effort', Teaching and reinforcing behaviour is not acceptable, Administrators not participating. 2. Climate and System influences – Staff not understanding PBS, Poor staff morale, Administrator sanctioned opting out. 3. Resolution contributors – Administrator left and support improved, district support available, staff experienced firsthand successes. 4. Resolution status – barriers resolved, barriers partially resolved, unresolved.	Barriers consistent with Kincaid et al (2007) and Lohrmann et al (2008) The findings are consistent with personal and organisational implementation patterns observed as enablers and barriers in the broader context of implementation research.	62/80

Appendix B - SURE Quality Framework

	Woolls, Allen & Jenkins (2012)	**Houchins et al (2005)**	**Inchley-Mort & Hassiotis (2014)**	**Andreou et al (2014)**	**Bambara et al (2001)**	**Lohrmann et al (2008)**	**Davies, Mallows & Hoare (in press)**	**Frey et al (2010)**	**Hieneman & Dunlap (2000)**	**Bambara et al (2009)**	**Lohrmann et al (2012)**
1. Does the study address a clearly focused question / hypothesis ?	Yes – Exploration of care-staff views of PBS (2)	Yes – Identification of themes associated with implementation of PBS (2)	Yes – to describe stakeholder experiences of a PBS based service. (2)	Yes – Exploration of professional perspectives regarding events that affect PBS (2)	Yes –to describe experience and perspectives of staff teams implementing PBS (2)	Yes – identify factors related to staff resistance when implementing PBS in schools. (2)	Yes – exploration of service user views of PBS (2)	Yes - to assess the social validity of program-wide PBS (2)	Yes – to establish factors affecting efficacy of PBS (2)	Yes - to investigate team member perception of PBS (2)	Yes to investigate PBS coaches perception of stakeholder buy-in to PBS (2)
Setting?	Yes – Adult learning disability services (2)	Yes – Female Juvenile Justice setting (2)	Yes – Adult learning disability services (2)	Yes –School / education setting (2)	Yes – Adult learning disability services (2)	Yes – School / educational settings. (2)	Yes – Forensic adult mental health (2)	Yes – early childhood school settings (2)	Yes – children with severe disabilities (2)	Yes – school / educational / disabilities (2)	Yes – middle level schools / educational (2)
Perspective ?	Yes – direct and indirect professionals (2)	Yes – multiple professionals / staff (2)	Yes – multiple stakeholders, carers, support staff, professionals & service users (2)	Yes – multiple professionals (2)	Yes – multiple team members / professionals (2)	Yes – multiple educational consultants (2)	Yes – perspective of adult male inpatients (2)	Yes – perspective of educational professionals (2)	Yes – perspective of multiple stakeholders (2)	Yes – perspective of multiple stakeholders (2)	Yes – perspective of PBS coaches (2)
Intervention or Phenomena	Yes – experience of PBS (2)	Yes – experience of PBS (2)	Yes – experience of PBS service (2)	Yes – experience of PBS (2)	Yes – experience of delivering	Yes – perception of barriers to PBS (2)	Yes – perception / understand	Yes – perception of social validity of	Yes - perception / experience	Yes – perceptions of PBS (2)	Yes – perceptions of stakeholder

					PBS (2)		ing of PBS (2)	PBS (2)	s (2)		s involved in PBS (2)
Comparator/control (if any)?	Partial – some general comparison between direct and indirect staff (1)	None (0)	Partial – some comparisons made between service users and non-service users. (1)	None (0)	Yes – comparisons made between 4 independent staff teams (2)	None (0)	None (0)	None (0)	Partial – some comparisons between participant groups considered (1)	None – (0)	Partial – comparisons made within pairs although not integral to validity (1)
Evaluation /Exploration?	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)	Yes – exploration (2)
2. Is the choice of qualitative method appropriate?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Is it an exploration of e.g behaviour/ reasoning/ beliefs)?	Yes – an exploration of staff perspectives (2)	Yes – exploration / investigation of staff perspective (2)	Yes – exploration of stakeholder experience (2)	Yes – exploration of professionals perspectives (2)	Yes – exploration of team member perspective (2)	Yes – exploration of indirect professionals perspective (2)	Yes – exploration of service user perspective (2)	Yes – exploration of professionals perspective / views (2)	Yes – exploration of professionals perspective (2)	Yes – exploration of team members perspective (2)	Yes – exploration of indirect professional perspective (2)
Do the authors discuss how they decided which	Yes – GT used as little known about subject	Yes – GT / constant comparative method used as no previous	No (0)	Partial – discussed why qualitative was used broadly but	No (0)	No (0)	Yes (2)	No (0)	No (0)	No (0)	No (0)

method to use?	area (2)	research exists (2)		not why specific method. (1)							
3. Is the sampling strategy clearly described and justified?	No (0)	No (0)	Yes - convenience sampling until saturation reached. (2)	Yes - convenience sample meeting specified criteria. (2)	Yes – purposive – described (2)	Yes – Purposive – described (2)	Yes – Purposive – described (2)	Yes – purposive – described but lacks detail (1)	Yes – purposive – described well (2)	Yes – purposive – described (2)	Yes – mixed strategy, convenience and purposive. (2)
Is it clear how participants were selected?	No (0)	No (0)	Partial – some description relating to the service user participants (1)	Yes - those meeting criteria based on experience of PBS (2)	Yes – well described (2)	Yes – via four described methods (2)	Yes – based on a described criteria (2)	Partial – unclear how 'supportive' and 'non-supportive' of PBS was determined (1)	Yes – via stated criteria based on PBS experience (2)	Yes – based on nominations and screening for minimum criteria (2)	Yes – based on screening – meeting specified criteria (2)
Do the authors explain why they selected these particular participants?	No (0)	No (0)	Partial – service user participant criteria described (1)	No (0)	Yes – based on fidelity to PBS model and achieving good outcomes for service users (2)	Yes – based on response to request and meeting of minimum criteria (2)	Yes – based on informed consent and having a PBS plan – (2)	Yes – based on supportiveness of the PBS model (2)	Yes – based on nominations and criteria (2)	Yes – based on meeting criteria and informed consent (2)	Yes – based on response to advert and screening against criteria (2)
Is detailed information provided about participant	Partial, some collective information regarding	Partial, participant demographics are presented	Partial – participant demographics listed and	Yes – ranges given for participant demograph	Yes – demographics provided for teams,	Partial – some description and ranges of	Partial – detailed info about participants is provided	Partial – some information relating to	Partial – some information relating to	Partial – detailed info / demographics about	Partial – demographics provided however

characteristics and about those who chose not to participate ?	participant demographics given as ranges (1)	in table format (1)	reference to service users who could not provide informed consent (1)	ics and quantity of training / experience (2)	team members and the service users who were discussed (2)	demographic data (1)	for those who took part but not those who declined (1)	profession but no other demographics (1)	demographics – given as ranges (1)	those who participated but not those who didn't (1)	gender not disclosed, information missing for one participant (1)
4. Is the method of data collection well described?	Yes – (2)	Yes – (2)	Yes – (2)	Yes – (2)	Yes – (2)	Yes – (2)	Yes – (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Was the setting appropriate for data collection?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial – team members were interviewed in the care setting in which they worked (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Is it clear what methods were used to collect data? Type of method (eg, focus groups,	Yes – interviews and a focus group, both audio recorded (2)	Yes – 3 focus groups were conducted, notes were taken by another researcher	Yes – interviews audio recorded (2)	Yes – interviews audio-recorded (2)	Yes – Phone screening followed by audio-recorded interviews (2)	Yes – x3 semi structured interviews, audio recorded (2)	Yes – audio recorded interviews (2)	Yes – multiple methods stated, focus groups audio recorded (2)	Yes – phone interview using semi structured interview guide Unsure if collected	Yes – telephone interview – audio recorded (2)	Yes – telephone interview – audio recorded (2)

interviews, open questionnaire etc) and tools (eg notes, audio, audio visual recording).		and displayed on screen for participants to check (2)							via audio or notes(1)		
Is there sufficient detail of the methods used (eg how any topics/questions were generated and whether they were piloted; if observation was used, whether the context described and were observations made in	Partial – some information suggesting GT method of transcription and analysis between interviews as to provide themes for triangulation. (1)	Yes – good detail of methods including the role of multiple researchers in the development of themes and the observation of focus groups to improve reliability. (2)	No (0)	Yes – good level of methodological detail and explanation of roles of multiple researchers (2)	Yes – good methodological detail of a five stage coding process for consensual agreement and data reduction (2)	Yes – coding sequence described, codes checked with each subsequent participant, final themes checked with participants for accuracy (2)	Yes – good level of methodological detail and explanation of the role of each author (2)	Yes – methods are well detailed. (2)	Yes – methods well detailed including their development – used pilot also. (2)	Yes – method well detailed (2)	Yes - multiple stages are well described relating to the method. (2)

a variety of circumstances?											
Were the methods modified during the study? If YES, is this explained?	No modification (2)	No modification (2)	No modification (2)	No modification (2)	No modification (2)	No modification (2)	No modification (2)	No modification (2)	No modification (2)	No modification (2)	No modification (2)
Is there triangulation of data (ie more than one source of data collection)?	Yes – triangulation via focus group, checks with 'third parties' (2)	Yes – multiple researchers used to triangulate data via checking codes / themes. Researchers also checked notes during focus group with participants for accuracy (2)	Yes – use of multiple researchers for data collection and independent researchers for code checking. (2)	Yes – triangulation via multiple researchers and re-checking of codes with participants after interviews for accuracy. (2)	Yes – triangulation between staff teams, between researchers and code checks with participants at later stage (2)	Yes – triangulation between multiple researchers and code / accuracy of theme checks with participants (2)	Yes – triangulation between multiple researchers (2)	Yes – multiple triangulation between researchers (2)	Yes – triangulation between multiple researchers (2)	Yes – multiple researchers used to triangulate (2)	Yes – triangulation using multiple researchers (2)
Do the authors report	Not reported (0)	Not reported (0)	Yes (2)	Yes (2)	Not reported (0)	Not reported (0)	Not reported (0)	Not reported (0)	Not reported (0)	Not reported (0)	Not reported (0)

achieving data saturation?											
5. Is the relationship between the researcher(s) and participants explored?	Yes (2)	No (0)	Yes (2)	Partial – some brief description of researcher position in relation to schools (1)	No (0)	No (0)	Yes (2)	No (0)	No (0)	No (0)	No (0)
Did the researcher report critically examining/ reflecting on their role and any relationship with participants particularly in relation to formulating research questions and collecting data).	Partially, author reflects generally on factors that might have influenced / inhibited participant response (1)	No (0)	Yes (2)	No (0)	Partial – described developing questions flexibly allowing participants to direct conversation, however question guide also ensured key areas were covered (1)	No (0)	Yes (2)	No (0)	No (0)	No (0)	No (0)

Were any potential power relationships involved (ie relationships that could influence in the way in which participants respond)?	Yes, author discusses position in the service and relationship to head of service (2)	There is potential but this is not explored (0)	Yes, author discusses position of power as researcher and how this may have influences participants and interpretation of findings (2)	No (0)	Not reported / discussed (0)	No (0)	Yes, authors explore their power in relation to participants (2)	None explored (0)	Not explored (0)	Not explored (0)	Not explored (0)
6. Are ethical issues explicitly discussed?	Partial – single reference to participants being assured of anonymity, confidentiality and right to withdraw. (1)	No (0)	Yes - Informed consent, confidentiality, anonymisation (2)	Partial – reference made to informed consent (1)	Partial - reference to informed consent (1)	No (0)	Yes (2)	No (0)	No (0)	Partial – reference made to informed consent (1)	No (0)
Is there sufficient information on how the research	No information (0)	No information (0)	No information (0)	No information (0)	No information (0)	No information (0)	Partial – (1)	No information (0)	No information (0)	Partial – email sent to participants with informatio	No (0)

was explained to participants?										n (1)	
Was ethical approval sought?	Not mentioned (0)	Not mentioned (0)	Yes (2)	Not mentioned (0)	Not mentioned (0)	Not mentioned (0)	Yes (2)	Not mentioned (0)	Not mentioned (0)	Not mentioned (0)	Not mentioned (0)
Are there any potential confidentiality issues in relation to data collection?	No – all data anonymised (2)	Yes, detailed participant demographics are provided and the sample if relatively small meaning participants and quotes may be identifiable. (1)	No – all data anonymised (2)	No – all data non-identifiable (2)	No – all data anonymised. (2)	Partial – unclear whether names reported and associated with direct quotes are pseudonyms (1)	No – all data anonymised (2)	No – all data anonymous (2)	No – all data anonymised (2)	No – all data anonymised (2)	No – data anonymised (2)
7. Is the data analysis/interpretation process described and	Partial – reference to analysis organised in a way that's consistent	Yes – data analysis procedures are well described in a step-wise	Partial – some description of code / theme development but lacks	Yes – data analysis and interpretation process well described	Yes – process well described (2)	Yes – process of code and theme development well described	Yes – process well described (2)	Yes – process well described – use of Nvivo(2)	Yes – multiple steps to analysis are explained (2)	Yes – multiple stages described (2)	Yes – multiple stages are well described (2)

justified?	with GT (1)	fashion. (2)	detail (1)	(2)		(2)					
Is it clear how the themes and concepts were identified in the data?	Partial / unspecific – reference to triangulation between interviews and use of focus group (1)	Partial – no description of theme development, only reference to using constant comparative methods (1)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Was the analysis performed by more than one researcher ?	Not discussed (0)	Yes, this is described (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are negative/discrepant results taken into account?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
8. Are the findings credible?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are there sufficient data to support the findings?	Yes – direct quotes support themes and sub	Yes – direct quotes supports main themes (2)	Yes – direct quotes in support of themes (2)	Yes – direct quotes in support of themes / codes (2)	Yes – direct quotes in support of themes / codes (2)	Yes – direct quotes in support of themes (2)	Yes – direct quotes in support of themes (2)	Yes- direct quotes in support of themes (2)	Partial – only a single quote in support of	Yes – direct quotes in support of themes (2)	Yes – direct quotes in support of themes and sub themes

	categories (2)								each theme (1)		(2)
Are sequences from the original data presented (eg quotations) and were these fairly selected?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are the data rich (ie are the participants' voices foregrounded)?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Partial –as above (1)	Yes (2)	Yes (2)
Are the explanations for the results plausible and coherent?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
Are the results of the study compared with those from other	No (0)	No (0)	No (0)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)

studies?											
9. Is any sponsorship/conflict of interest reported?	No (0)	No (0)	No (0)	Yes (2)	None reported (0)	None reported (0)	Not reported (0)	Yes (2)	Partial – information relating to sponsorship and author position is declared but not described as potential conflict (1)	No (0)	Yes (2)
10. Did the authors identify any limitations?	Partial – some limitations considered in conclusion (1)	Partial – limitations are discussed but are applied more generally to the focus group methodology rather than to the study itself (1)	Yes – multiple limitations explained (2)	Yes - limitations offered (2)	Yes – multiple limitations (2)	Yes – multiple limitations (2)	Yes – multiple limitations (2)	Yes – multiple limitations (2)	Yes – multiple limitations (2)	Yes – multiple limitations (2)	Yes – multiple limitations (2)

Are the conclusions the same in the abstract and the full text?	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)	Yes (2)
TOTAL SCORE	**54/80**	**50/80**	**65/80**	**65/80**	**63/80**	**58/80**	**72/80**	**58/80**	**59/80**	**61/80**	**62/80**
(Expressed as percentage)	67.5%	62.5%	81.25%	81.25%	78.75%	72.5%	90%	72.5%	73.75%	76.25%	77.5%

Appendix C - Examples from Reflective Journal

1/09/16

The re-analysis using TA is going well, again, I'm really noticing a tension in my ability to remain inductive as I can't just delete all the previous work I did from my head. Will be interesting when (trainee) looks at my coding, check I'm not mis-representing the verbatim.

19/08/16

Having returned to the unit and interviewed more staff I'm starting to feel more positive about this project again. I'm really trying hard to remain open to new ideas but everything I'm hearing just seems to fit within existing categories / codes I've previously developed. I'm sure an adequate level of saturation has been met however I'll interview the other staff who've agreed as different disciplines may bring something else.

27/7/16

Nearly completed the meta-ethnography of my systematic review articles. The approach makes sense and definitely improves the review overall. I am however even more aware of my reduced neutrality when I come to re-interview and re-analyse the new interviews I'm arranging.

19/3/16
Finally on to the systematic review and I can now really see why Charmaz / GT recommends reviewing the literature after finishing analysis, it's quite relieving to see themes that have emerged in other studies that are similar to mine and knowing that their presence didn't influence me when I was interviewing. Whilst it was anxiety provoking to not have started the review when my fellow DClinPsy-ers clearly had, I def feel relief / more relaxed now. Woop!

1/12/15
Concern that the discussions are 'surface level' and lacking the depth of personal experience. Worrying that I won't be able to generate a meaningful theory from the data. Perhaps I need to be more focussed and probing of how participants think / feel / relate to PBS, as it seems participants are describing a professionalised / medicalised / positivist relationship with PBS. Coding is taking a lot longer than I expected!

18/11/15
Has similar research on WRAP taken place in Forensic environments? There could be a lot of crossover? Found a paper titled 'a typology of advance statements in mental health care' - this could prove to be interesting and a must for my introduction.

16/11/15
Interview didn't seem to go well today. Participant seemed uncomfortable from

early on, stating tiredness. I got a strong sense that the participant didn't want to talk 'deeply' which was reflected in something she liked about her PBS plan - a lack of depth. Still feeling that I'm not discussing behaviours themselves, the elephants in the room. I feel this is because of some reluctance on my part, not wishing to cause discomfort, but also because of the potential shaming of the participant, in having to discuss behaviours that society define as 'challenging'.

2/11/15
Attended the hospital today however both participants from the female ward declined to take part in the research. This disengagement after prior agreement to engage in my research highlighted a process which is evident in my data; that motivation to engage is a factor that likely transcends this environment and is likely influenced my many other factors including mental and physical health.

30/10/15
It's hard, tiring work to interview, and then to transcribe (often on the same day), and then to consider and create tentative initial codes in order to enact theoretical sampling when my interviews are so clustered together. If I had a better understanding of the GT process prior to beginning data collection, I would have tried to space the interviews out more, I guess this was however partly prescribed by Bronwen's ability to access participants and their time / availability - as well as my own time pressures of completing a thesis in 31 weeks (from now). I have inadvertently jumped in the deep end but am enjoying the sense of immersion! The evolving and seemingly plastic process of GT is exciting me and melding well with my constructivist leaning! The sense of methodological freedom is quite liberating.

Appendix D - Examples of Memo’s

18/8/16
Different levels of involvement in PBS amongst the MDT is potentially something new?

4/1/16
Is PBS working more so within the 'recovery' phase of the patient journey through the secure unit? If so, this is a time when both mental health and behaviour are likely improving. Does PBS need to be viewed more as something that can be helpful with the most challenging / unwell patients? There are perhaps bigger issues around the fit of PBS and mental health.

22/12/15
Is empowerment a big theme here? Is PBS more empowering for staff or service users? Empowerment is a process here...

21/12/15
Different process roles emerging amongst different members of the clinical team. Both OT and Psychiatry have identified their role as more of a quality control / checking position after the bulk of the plan has finished. Interesting the different relationships to PBS that may exist; e.g collaborator, deliverer, checker, writer etc.

30/11/15
Possible new theme of prioritisation in PBS, I.e: those patients who are more 'complex' / challenging need PBS more. Also links to the time constraints of those who develop plans.

30/10/15
Tentative codes and early reflections: Attitude towards PBS? Punishment & Control Vs Giving in / empathy (s) ?? A helpful document for the staff (su) helpfulness for others vs self?? Tokenism? Us and them - powerlessness / imbalance?

26/10/15
Staff inconsistency - staff age / level of qualification - consultants lacking awareness. Agency staff lacking awareness or interest (staff variables). "Who's read it?" "How do I know?" - is it being used?

19/10/15
Reluctance to define or operationalise challenging behaviour - shame / guilt / 'disclosing behaviour' .The language of PBS. The collaborative ratio (60:40 or 50:50?)

Appendix E - Ethical Approval Documentation

[redacted]

[redacted]

Dyddiad/Date: 21st September 2015

Mr Graeme Karger
Cardiff & Vales University Health Board
South Wales Doctoral Programme in Clinical Psychology
Cardiff University, 11th Floor Tower Building
70 Park Place,
Cardiff, CF10 3AT

Dear Mr Karger

Re: Implementing PBS within a Forensic Mental Health Setting
IRAS Ref: 170390
Sponsor: Cardiff & Vale University Health Board

Thank you for submitting the above named research proposal to [redacted] for NHS R&D permission. The attached listed documents were reviewed.

Health Board R&D Governance checks have been completed and passed. Please accept this letter as confirmation of local NHS R&D Health Board permission.

As part of Research Governance, you are required to:

1. Adhere to the protocol approved and inform the R&D office and the relevant Research Ethics Committee of any changes to the study, including the end date, for review/approval and record update.
2. For Health Board Sponsored studies, notify the R&D office of serious adverse events immediately upon knowledge, in accordance with local Standard Operating Procedure on Pharmacovigilance and as outlined in your Study Initiation meeting.
3. For Externally Sponsored studies, the Health Board should only be notified of SAEs or Suspected Unexpected Serious Adverse Reaction (SUSAR) arising in local [redacted]
4. Complete any interim and final reports requested by the R&D office. If sponsored by ABMU Health Board, you will be asked to complete a 6 monthly progress report for submission to the Joint Scientific Review Committee along with your final report at study completion.
5. Ensure that your research complies with any relevant regulatory requirements and legislation relating to: Clinical Trials, Data Protection Act 1998, Health & Safety, Caldicott Guidelines, the use of Human Tissue for research purposes, Mental Capacity and ICH Good Clinical Practice (GCP). The R&D team can advise you on applicable regulatory and statutory requirements relevant to your study.
6. Comply with Data Protection requirements, notably no personal or patient identifiable data should leave the Health Board unless explicit consent from the individual or patient has been taken and documented. Unless consent is present, all study related documents must be either fully or linked anonymised. *'Identifiable patient data includes name, address, full postcode, date of birth, NHS number and local patient identifiable codes as well as photographs, videos, audio tapes or other images of patients. Personal identifiable information includes the member of staff's name, address, full post code, date of birth, NI number and staff number as well as photographs* [redacted] Protection & Confidentiality Policy, Version 2.1 September 2013.

[redacted]

7. Ensure that all training courses requested by the Sponsor are completed by all relevant members of the research team before any research activity is carried out. All research staff undertaking clinical trials of an investigational medicinal product (CTIMPs) must be GCP trained, and should continue to update their GCP training every 2 years. Copies of GCP certificates should be filed in the Trial Site File, with a copy forwarded to the R&D Department.
8. Ensure the research is undertaken in compliance with all Health Board R&D Standard Operating Procedures (SOPs). The latest versions of all SOPs can be obtained by contacting the R&D Department or from the R&D Intranet pages
9. If the study is sponsored by [redacted] you must notify the R&D Office of your intention to open the study in other sites.
10. For [redacted] Sponsored studies, sign a Conditions of Sponsorship Agreement & attend a Study Initiation meeting as organised by the R&D Department.

NISCHR Clinical Research Portfolio Studies
If your study has been adopted onto the NISCHR Clinical Research Portfolio (CRP), it will be a condition of our permission that the Chief Investigator site uploads local recruitment data onto the portfolio database.

For more information on the process of uploading recruitment data please look at the following link: http://www.crncc.nihr.ac.uk/aboutus/processes/portfolio/precruitment

Uploading of recruitment data will enable NISCHR to monitor research activity within Health Boards, resulting in NHS R&D allocations to be driven by activity.

For more information and advice on the NISCHR Clinical Research Portfolio please email: portfolio@wales.nhs.uk

Amendments to the Study
Any changes made to the study after the issue of this letter will be treated as an amendment. Amendments can be 'substantial' or 'non-substantial'. It is the duty of the Sponsor to classify the amendment and notify all relevant regulatory bodies accordingly, this duty may be delegated to the Chief Investigator or other authorised individual.

For a substantial amendment, the Sponsor or delegated individual will be required to submit a Notice of Substantial Amendment form to the REC, NISCHR PCU and MHRA (if applicable). [redacted] sponsored studies substantial amendments must first be submitted to the JSRC for approval prior to submitting to REC and NISCHR PCU (**Research-permissions@wales.nhs.uk**).

For non-substantial amendments, the Sponsor or delegated individual are required to simply notify the [redacted] and relevant REC via e-mail or letter of the proposed non-substantial amendment.

Details of how to classify your amendment as substantial or non-substantial are available from Health Research Authority - http://www.hra.nhs.uk/research-community/during-your-research-project/amendments/

Indemnity Arrangements

The Sponsor indemnifies and holds harmless [redacted], its employees and agents for any harm caused by negligence on behalf of the Sponsor, including any harm caused to participants by the administration of the investigational product. However, please note that the Sponsor will not indemnify [redacted] for any harm caused by negligence on behalf of the research team or other individual or agent.

Please discuss any planned use of in-house work instructions/sops with the Sponsor company during Initiation to ensure localised documents correctly summarise the protocol requirements and this is agreed to, in writing, by the Sponsor Company.

Researchers employed by [redacted], including those holding Honorary Contract status are indemnified against actions for negligent harm via standard arrangements with Welsh Risk Pool (WRP). Provision for 'no-fault' compensation is limited under the scheme and is only available on an ex gratia, discretionary basis where the Sponsor is a NHS Organisation.

[redacted] reserves the right to suspend approval of any research study where deviation from appropriate RG & GCP standards is uncovered.

May I take this opportunity to wish you well in undertaking the research. We will write to you in the future to request updates on the progress of the research and look forward to receiving outcomes of the study.

Yours sincerely,

pp **Professor SC Bain**
Assistant Medical Director (R&D)
[redacted]

[redacted]

NHS
Health Research Authority

NRES Committee South West - Exeter
Whitefriars
Level 3
Block B
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1387

24 August 2015

Mr Graeme Karger
South Wales Doctoral Programme in Clinical Psychology
Cardiff University, 11th Floor Tower Building
70 Park Place, Cardiff
CF10 3AT

Dear Mr Karger

Study title:	**Implementing Positive Behavioural Support (PBS) within a Forensic Mental Health Setting, Staff & Service User Experiences.**
REC reference:	**15/SW/0211**
IRAS project ID:	**170390**

Thank you for your letter of18th of August 2015 , responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a Sub-Committee of the REC. A list of the Sub-Committee members is attached.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Mr Mark Dawson, nrescommittee.southwest-exeter@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation

as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only) [University Insurance]	1	02 July 2015
Interview schedules or topic guides for participants [Service User Interview Schedule]	4	20 July 2015
Interview schedules or topic guides for participants [Staff Interview Schedule]	2	20 July 2015
IRAS Checklist XML [Checklist_17082015]		17 August 2015
Letter from sponsor [Sponsor Letter]	1	20 July 2015
Participant consent form [Service User Participant Consent Form]	2	17 August 2015
Participant consent form [Staff Participant Consent Form]	2	17 August 2015
Participant information sheet (PIS) [Service User Participant Information Sheet]	4	17 August 2015
Participant information sheet (PIS) [Staff Participant Information Sheet]	4	17 August 2015
REC Application Form [REC_Form_10072015]		10 July 2015
Research protocol or project proposal [Research Proposal]	1	02 July 2015
Summary CV for Chief Investigator (CI) [Graeme Karger CV]	1	10 February 2015
Summary CV for supervisor (student research) [Rosemary Jenkins CV]	2	02 July 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/SW/0211	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project.

Yours sincerely

PP
Dr Denise Sheehan
Chair

Email:nrescommittee.southwest-exeter@nhs.net

Enclosures: *List of names and professions of members who were present at the meeting and those who submitted written comments*
"After ethical review – guidance for researchers" *[SL-AR2]*

Copy to: *Miss Helen Falconer*
Professor Jonathon Bisson, Cardiff & Vale University Health Board

NRES Committee South West - Exeter

Attendance at Sub-Committee of the REC meeting on 18 August 2015

Committee Members:

Name	*Profession*	*Present*	*Notes*
Dr. Roy J. Powell	Research Design Consultant	Yes	
Dr Denise Sheehan	Consultant Oncologist	Yes	Chair

Also in attendance:

Name	*Position (or reason for attending)*
Mr Mark Dawson	REC Manager

Research and Innovation Services
Director Geraint W Jones
Gwasanaethau Ymchwil ac Arloesi
Cyfarwyddwr Geraint W Jones

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Llawr 7
30 - 36 Heol Casnewydd
Caerdydd CF24 0DE
Cymru Y Deyrnas Unedig

20th of July 2015

Dr Rosemary Jenkins,
School of Psychology
Cardiff University
11th Floor
Tower Building
70 Park Place
Cardiff
CF10 3AT

Dear Dr Jenkins

Title: Implementing Positive Behavioural Support within a Forensic Mental Health Setting, Staff & Service User Experiences

Short title: Implementing PBS within A Forensic Mental Health Setting

I understand that you are acting as Chief Investigator for the above Professional PhD project to be conducted by Graeme Karger.

I confirm that Cardiff University agrees in principle to act as Sponsor for the above project, as required by the Research Governance Framework for Health and Social Care.

Scientific (Peer) Review
I can also confirm that Scientific (Peer) Review has been obtained from the DClinPsy Supervisory Team.

Insurance
The necessary insurance provisions will be in place prior to the project commencement. Cardiff University is insured with UMAL. Copies of the insurance certificate are attached to this letter.

Approvals

On completion of your IRAS form (for NHS REC and NHS R&D approvals), you will be required to obtain signature from the Sponsor ('Declaration by the Sponsor Representative').

Please then submit the project to the following organisations for approvals:

- An NHS Research Ethics Committee;
- Health & Care Research Wales Permissions Coordinating Unit (formerly known as NISCHR PCU) -to arrange host organisation R&D approval for Welsh NHS sites).

Once Research and Innovation Services has received evidence of the above approvals, the University is considered to have accepted Sponsorship and your project may commence.

Roles and Responsibilities
As Chief Investigator you have signed a Declaration with the Sponsor to confirm that you will adhere to the standard responsibilities as set out by the Research Governance Framework for Health and Social Care. In accordance with the University's Research Governance Framework, the Chief Investigator is also responsible for ensuring that each research team member is qualified and experienced to fulfill his delegated roles including ensuring adequate supervision, support and training.

If your study is adopted onto Health & Care Research Wales Clinical Research Portfolio you are required to upload recruitment data onto the portfolio database.

The Queen's Anniversary Prizes 2013
INVESTORS IN PEOPLE
Registered Charity, 1136855 *Elusen Gofrestredig*

Contracts
No research-specific tasks delegated to NHS Host Organisation (staff acting as participants) and roles and responsibilities are adequately detailed in the research protocol – no contract required.

May I take this opportunity to remind you that, as Chief Investigator, you are required to:

- ensure you are familiar with your responsibilities under the Research Governance Framework for Health and Social Care;
- undertake the study in accordance with Cardiff University's Research Governance Framework and the principles of Good Clinical Practice;
- ensure the Research complies with the Data Protection Act 1998;
- inform Research and Innovation Services of any amendments to the protocol or study design, including changes to start /end dates and ensure any such amendments are submitted to, and approved by, the relevant bodies (e.g. RECs and/or R&D offices);
- co-operate with any audit inspection of the project files or any requests from Research & Innovation Services for further information.

You should quote the following unique reference number in any correspondence relating to sponsorship for the above project:

SPON 1438-15

This reference number should be quoted on all documentation associated with this project.

Yours sincerely

Dr K J Pittard Davies
Head of Research Governance and Contracts
Direct line: +44 (0) 29208 79274
Email: resgov@cardiff.ac.uk

Cc Graeme Karger

From: [redacted] **Subject:** 170390 - Implementing PBS within a Forensic Mental Health Setting - AM 09.08.16

Dear All,
My sincere apologies for the delay with this. Please see below amendment approval.

IRAS Ref:	170390
Short Study Title:	Implementing PBS within a Forensic Mental Health Setting
Date received by Permissions Service:	09 Aug 2016
Amendment type:	Minor
Amendment No./ Sponsor Ref:	Contact change
Amendment Date:	09 Aug 2016
UK Amendment Category:	A
35-calendar day implementation date:	13 Sep 2016
REC favourable opinion for the amendment:	Not applicable
MHRA Notice of Acceptance of the amendment:	Not applicable
Amendment received from:	Chief Investigator
ReDA Cymru (ReDA system for permissions) folder name:	01 - cat A - 09Aug2016 - Contact change

The documents attached were received and have been added to the R&D file on this study.

[redacted] Health Board Research & Development department has no objection to this amendment on the basis of the information provided. The 'no objection' has been issued **on the condition that:**

1. **All necessary regulatory approvals are in place.**
2. **Any additional resources from support departments both financial and workforce are identified and agreed prior to implementation.**
3. **Correct versions of the protocol/documents are provided to the PI/Local research team and support departments.**
4.

Local PI/Research Team Any inability to support the amendment should be discussed with the Sponsor as soon as possible.

Sponsor It is the *responsibility of the Sponsor to ensure that all the above conditions are met* and discussed with the local PI/research team before an amendment can be implemented at site.

Many Thanks
Kirsty

Kirsty Price
Senior Data & Finance Analyst | Research & Development | [redacted]
Uwch-ddadansoddwr Data a Chyllid | Ymchwil a Datblygu | [redacted]

Research & Development, [redacted]

Appendix F - Participant Information Sheet

ii) Staff information sheet Version 4

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 4 - 17.08.2015

STAFF PARTICIPANT INFORMATION SHEET

Implementing Positive Behavioural Support (PBS) within a Forensic Mental Health Setting, Staff & Service User Experiences

My name is Graeme Karger (Trainee Clinical Psychologist) and I would like to invite you to take part in a research study, which is being carried out by myself, under the supervision of Dr. Bronwen Davies (Clinical Psychologist, [redacted]), Dr Rosemary Jenkins (Consultant Clinical Psychologist, South Wales Doctoral Programme in Clinical Psychology) and Professor Kathy Lowe (Service Development Consultant, [redacted]).

I am conducting this research as part of the academic requirements for my qualification as a Clinical Psychologist. I am not being paid for conducting this research.

Before you decide whether to take part it is important for you to understand why the research is being done, and what it would involve for you. Please take time to read the following information carefully. If you want to ask any questions or would like further information then please free to contact me via the address, email or telephone number below.

What is the purpose of this study?
Positive Behavioural Support (PBS) is a relatively new approach in forensic mental health services. The purpose of the current study is to explore staff and service users' experiences of PBS in [redacted]. The study aims to obtain service users' views, as well as those of staff members via interview to better understand their experience of PBS.

Forensic inpatient services support adults with mental health difficulties who occasionally present with significant challenging behaviour. PBS is an approach, which has been recognised as helpful in managing challenging behaviour and increasing a person's quality of life. However, to date, nearly all research has occurred within the Learning Disabilities population and very little research has been done to find out what service users and staff think and feel about PBS

within adult forensic inpatient units. The current study therefore aims to address the lack of research in this area and contribute to a better understanding of service user and staff experiences.

It is hoped that the findings from this study will enhance the support service users receive in forensic inpatient units, inform staff training and contribute to service/policy development.

Why have I been invited to take part?

You have been invited to take part in this research because you have been identified by Dr. Bronwen Davies as someone who has experience of PBS within [redacted].

You have been invited to take part because you are:

a) A member of staff, employed for at least the last 6 months at [redacted], who has supported a service user with the development and implementation of a PBS plan.

and

b) Has received training in PBS.

Do I have to take part?

No, this research study is voluntary. It is entirely up to you if you want to take part or not. You should take time to consider if you wish to take part. You should discuss whether or not to take part with another professional or personal contact. If you decide to take part you will be given this information sheet to keep and asked to sign a consent form.

If you decide to take part and then change your mind later, you will be free to withdraw from the study at any time and this will not affect your position at [redacted]. You will not have to give any explanation and any information you have given up to that point will not be used in the research.

What am I being asked to do?

If you decide to take part in the study you will be asked to sign a consent form and allow the researcher to contact you whilst at work. The researcher will then contact you to explain more about the study and to answer any questions you may have. If you are still happy to take part the researcher will arrange a time to meet with you to carry out an interview.

During the interview the researcher will talk to you about your experience of PBS at [redacted]. You will be asked about your own experience of PBS and how you think service users have experienced PBS.

The interview will take place privately at the [redacted] and will last around 60 minutes. The interview will be audio recorded so that a written record of the interview can be made for the researcher to use in their analysis.

Who else will take part?

Four or five service users and staff members will also be interviewed regarding their experiences of PBS.

What are the possible advantages of taking part?

It is hoped that participants will welcome the opportunity to contribute to a better understanding of staff and service users' experiences of PBS in an adult forensic mental health unit and inform future service development and delivery. In addition to this it is hoped that findings from this study will help to identify further staff training needs, identify ways of helping service users to better understand PBS and to help role out PBS in other forensic services.

What are the possible disadvantages of taking part?

There are no known risks involved in taking part in this study, however, some participants could find the topic sensitive and issues may arise which could cause upset. If this occurred during the interview and you did not wish to continue, the researcher would stop immediately and provide support. It could also be arranged for you to speak with someone independent of the research if you wished (e.g. a ward manager). You would be under no obligation to continue: the interview could be rearranged or you could withdraw from the study altogether.

Will my taking part in this study be confidential?
Yes. The researcher follows a strict ethical and professional code of conduct that requires all information obtained to remain confidential and anonymous. You will not be able to be identified by anyone other than the researcher. Each of the audio-recordings will be given a code and stored safely in order to maintain your anonymity. All names will be changed in the written record of your interview and therefore you will not be identifiable. The audio-recordings and written records will be stored in a locked cabinet within the University Health Board, and only the researcher will have access to this data. Once a written record of your interview has been made the audio-recordings will be deleted.

This confidentiality would only be broken if I became aware of malpractice, misconduct or possible risk to you or another person. If this occurs, I will discuss this information with the [redacted], or Lead Manager, in accordance with NHS procedures and my professional codes of practice. I will let you know that I am going to do this.

What will happen to the findings of the study?

The results of the study will be written up as a doctoral thesis and submitted as part of my examinations towards a Doctorate in Clinical Psychology. Direct quotations from the interviews will be included in the thesis, but all identifiable information will be removed. Upon completion of the study a summary sheet outlining the main findings will be sent to those participants who have indicated that they would like a copy of the research outcome. It is hoped that the findings from this study will be presented in an academic publication, local service meetings and/or at national conferences.

What if I have a problem with the study?

If you are unhappy or require further explanation regarding any aspect of this study or have any concerns, please contact the researcher, Dr Bronwen Davies or alternatively Dr Rosemary Jenkins (contact details below). If you remain unhappy and wish to complain formally we will give you contact details of other people who may be able to respond to your concerns.

Who has reviewed this study?

All research carried out by the NHS is reviewed by an independent panel called the Research Ethics Committee. This is to ensure the safety, rights and welfare of anyone who participates in a research project. This study has been reviewed and received favourable opinion by the South West Exeter Research Ethics Committee.

Further information

If you have any further questions about taking part in the study or require any more information please do not hesitate to contact me (Graeme Karger) on 07835184478, email me at: kargergw@cardiff.ac.uk or contact me at the address below, and I will get back to you as soon as possible.

THANK YOU FOR CONSIDERING TAKING PART AND TAKING THE TIME TO READ THIS INFORMATION SHEET

South Wales Doctoral Programme in Clinical Psychology
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Tel: 02920870545
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ii) Staff information sheet Version 5 (after contact change)

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 5 - 02.08.2016

STAFF PARTICIPANT INFORMATION SHEET

Implementing Positive Behavioural Support (PBS) within a Forensic Mental Health Setting, Staff & Service User Experiences

My name is Graeme Karger (Trainee Clinical Psychologist) and I would like to invite you to take part in a research study, which is being carried out by myself, under the supervision of Dr. Bronwen Davies (Clinical Psychologist, Caswell Clinic, Abertawe Bro Morgannwg University Health Board), Dr Dougal Hare (Reader in Clinical Psychology, South Wales Doctoral Programme in Clinical Psychology) and Professor Kathy Lowe (Service Development Consultant, Abertawe Bro Morgannwg University Health Board).

I am conducting this research as part of the academic requirements for my qualification as a Clinical Psychologist. I am not being paid for conducting this research.

Before you decide whether to take part it is important for you to understand why the research is being done, and what it would involve for you. Please take time to read the following information carefully. If you want to ask any questions or would like further information then please free to contact me via the address, email or telephone number below.

What is the purpose of this study?
Positive Behavioural Support (PBS) is a relatively new approach in forensic mental health services. The purpose of the current study is to explore staff and service users' experiences of PBS in Caswell Clinic. The study aims to obtain service users' views, as well as those of staff members via interview to better understand their experience of PBS.

Forensic inpatient services support adults with mental health difficulties who occasionally present with significant challenging behaviour. PBS is an approach, which has been recognised as helpful in managing challenging behaviour and increasing a person's quality of life. However, to date, nearly all research has occurred within the Learning Disabilities population and very little research has been done to find out what service users and staff think and feel about PBS within adult forensic inpatient units. The current study therefore aims to address the lack of research in this area and contribute to a better understanding of service user and staff experiences.

It is hoped that the findings from this study will enhance the support service users receive in forensic inpatient units, inform staff training and contribute to service/policy development.

Why have I been invited to take part?

You have been invited to take part in this research because you have been identified by Dr. Bronwen Davies as someone who has experience of PBS within Caswell Clinic.

You have been invited to take part because you are:

c) A member of staff, employed for at least the last 6 months at Caswell Clinic, who has supported a service user with the development and implementation of a PBS plan.

and

d) Has received training in PBS.

Do I have to take part?

No, this research study is voluntary. It is entirely up to you if you want to take part or not. You should take time to consider if you wish to take part. You should discuss whether or not to take part with another professional or personal contact. If you decide to take part you will be given this information sheet to keep and asked to sign a consent form.

If you decide to take part and then change your mind later, you will be free to withdraw from the study at any time and this will not affect your position at Caswell Clinic. You will not have to give any explanation and any information you have given up to that point will not be used in the research.

What am I being asked to do?

If you decide to take part in the study you will be asked to sign a consent form and allow the researcher to contact you whilst at work. The researcher will then contact you to explain more about the study and to answer any questions you may have. If you are still happy to take part the researcher will arrange a time to meet with you to carry out an interview.

During the interview the researcher will talk to you about your experience of PBS at Caswell Clinic. You will be asked about your own experience of PBS and how you think service users have experienced PBS.

The interview will take place privately at the Caswell Clinic and will last around 60 minutes. The interview will be audio recorded so that a written record of the interview can be made for the researcher to use in their analysis.

Who else will take part?

Four or five service users and staff members will also be interviewed regarding their experiences of PBS.

What are the possible advantages of taking part?

It is hoped that participants will welcome the opportunity to contribute to a better understanding of staff and service users' experiences of PBS in an adult forensic mental health unit and inform future service development and delivery. In addition to this it is hoped that findings from this study will help to identify further staff training needs, identify ways of helping service users to better understand PBS and to help role out PBS in other forensic services.

What are the possible disadvantages of taking part?

There are no known risks involved in taking part in this study, however, some participants could find the topic sensitive and issues may arise which could cause upset. If this occurred during the interview and you did not wish to continue, the researcher would stop immediately and provide support. It could also be arranged for you to speak with someone independent of the research if you wished (e.g. a ward manager). You would be under no obligation to continue: the interview could be rearranged or you could withdraw from the study altogether.

Will my taking part in this study be confidential?
Yes. The researcher follows a strict ethical and professional code of conduct that requires all information obtained to remain confidential and anonymous. You will not be able to be identified by anyone other than the researcher. Each of the audio-recordings will be given a code and stored safely in order to maintain your anonymity. All names will be changed in the written record of your interview and therefore you will not be identifiable. The audio-recordings and written records will be stored in a locked cabinet within the University Health Board, and only the researcher will have access to this data. Once a written record of your interview has been made the audio-recordings will be deleted.

This confidentiality would only be broken if I became aware of malpractice, misconduct or possible risk to you or another person. If this occurs, I will discuss this information with the Caswell Clinic Manager, or Lead Manager, in accordance with NHS procedures and my professional codes of practice. I will let you know that I am going to do this.

What will happen to the findings of the study?

The results of the study will be written up as a doctoral thesis and submitted as part of my examinations towards a Doctorate in Clinical Psychology. Direct quotations from the interviews will be included in the thesis, but all identifiable information will be removed. Upon completion of the study a summary sheet outlining the main findings will be sent to those participants who have indicated

that they would like a copy of the research outcome. It is hoped that the findings from this study will be presented in an academic publication, local service meetings and/or at national conferences.

What if I have a problem with the study?

If you are unhappy or require further explanation regarding any aspect of this study or have any concerns, please contact the researcher or Dr Bronwen Davies. If you remain unhappy and wish to complain formally we will give you contact details of other people who may be able to respond to your concerns.

Who has reviewed this study?

All research carried out by the NHS is reviewed by an independent panel called the Research Ethics Committee. This is to ensure the safety, rights and welfare of anyone who participates in a research project. This study has been reviewed and received favourable opinion by the South West Exeter Research Ethics Committee.

Further information

If you have any further questions about taking part in the study or require any more information please do not hesitate to contact me (Graeme Karger) on 07835184478, email me at: kargergw@cardiff.ac.uk or contact me at the address below, and I will get back to you as soon as possible.

THANK YOU FOR CONSIDERING TAKING PART AND TAKING THE TIME TO READ THIS INFORMATION SHEET

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Appendix G - Participant Consent Form

ii) Staff Consent Form

SOUTH WALES DOCTORAL PROGRAMME IN CLINICAL PSYCHOLOGY
CWRS DOCTORIAETH DE CYMRU MEWN SEICOLEG CLINIGOL

VERSION 2 17.08.15

STAFF PARTICIPANT CONSENT FORM

Study Title: Implementing Positive Behavioural Support (PBS) within a Forensic Mental Health Setting, Staff & Service User Experiences

If you decide to take part in this study, all of the information you provide will be kept confidential. You are under no obligation to participate and have the right to withdraw at any time.

Name of researcher: Graeme Karger

	Please initial the boxes if you agree	Please initial each box if you agree
1. I confirm that I have read and understood the information sheet version 4 17.08.15 for the above study. I have been given the opportunity to consider the information and have any questions answered adequately.	[ ]	
2. I understand that my participation is entirely voluntary. I will be free to withdraw at any point, without giving any explanation, and any data I have given up to that point will not be used for analysis.	[ ]	
3. I understand how my confidentiality will be ensured.	[ ]	
4. I agree to take part in an audio-recorded interview and to this data being included in a report to be submitted by the researcher as part of his doctoral qualification.	[ ]	
5. I agree to take part in the above study.	[ ]	
6. I would like a summary of the research findings on completion of the study.	**Please circle YES NO**	
If you have indicated 'yes' to the above question please provide details of where you would like the summary sent (i.e. email or address): _____		

_____ _____ _____

Participant's name (printed) Signature Date

Contact Number_____

_____ _____ _____

Name of person taking consent (printed) Signature Date

South Wales Doctoral Programme in Clinical Psychology
School of Psychology
Cardiff University
11th Floor
Tower Building
70 Park Place
CARDIFF CF10 3AT
Tel: 02920870545

Appendix H - Semi-Structured Interview Schedule

Staff Semi-Structured Interview Schedule

The following questions will provide a framework for the interview.

Introduction:
Thank you for meeting with me today. I would like to read through the information sheet again to remind you what the project is about and to check you are still happy to take part (read information sheet and sign consent form again).

I would like to talk to you about your experience of Positive Behaviour Support (PBS) whilst you've been working at [redacted]. Are you happy for me to ask you some questions about that? Remember, you can say no if you want at any time and we will stop. Is there anything you would like to ask me before we start?

Core themes and prompts for discussion:

1. Understanding 'Positive Behaviour Support' (PBS)

Possible Prompts

- What does the term 'PBS' mean to you?
- How would you describe it to someone who's never heard of it?
- Why do service users need a PBS plan? / What is it used for?
- Is PBS different to other care plans you have perhaps written?
- What have other staff told you about PBS?
- What's PBS got to do with behaviour?
- Why is it 'positive'?
- Who is the PBS plan for? / is it for staff? / service users? / both?

2. The process of PBS

Possible Prompts

- What has been your personal experience of contributing to PBS?
- What involvement have you had in developing PBS plans?
- What does the PBS process involve?
- Have you felt supported during the process?
- Did the service user agree to the plan before it was implemented?

3. Challenges and Barriers to Implementation

Possible Prompts

- Have there been any challenges in developing or putting PBS plans into practice?
- What has been most difficult about setting up PBS plans?
- Do you see any challenges in the future regarding the use of PBS as an approach?

4. Evaluating PBS

Possible Prompts

- What has it been like to contribute to PBS planning?
- Has involvement with PBS planning been helpful or challenging to you?
- How can you tell if PBS plans are 'working'?
- Has anything changed since PBS plans have been implemented? For example patient distress levels, behaviour, mental health or opportunities/ activities?
- Do other staff seem different with patients once they have a PBS plan? If yes how?
- What's been the most/ least helpful part of PBS?
- For a patient, does having a PBS plan influence their opportunities to work towards their goals or discharge pathway?
- Would you recommend having a PBS plan to another patient?
- Is there anything you think needs to change about either the process of developing the PBS plan, or the implementation of the plan? How can we improve this?

5. Goodness of fit; PBS in Forensic settings

Possible Prompt

- Have you noticed any changes in the QOL of patients since their PBS plan has been in place? These may be small or big… perhaps how staff are interacting with them or perhaps what activities are offered.
- Is it possible to improve the quality of your life of a patients whilst there in this environment?
- Do you think service users are developing any new skills since their plan has started, for example coping better when they are angry? Assertiveness etc
- Do you think PBS works/fits in this environment?
- Would it be different in the community / less secure unit?

6. PBS and Recovery

Possible Prompts

- What does 'recovery' mean to you in this environment?

- Does having a PBS plan influence a patients recovery / moving on / discharge pathway?
- How does PBS / behaviour relate to mental health?
- Is recovery linked to behaviour change? Can you give examples?
- Does PBS fit with your view of recovery?
- Does the PBS plan fit with other aspects of a patients treatment / things that happen here?

7. Overall experience

Possible Prompts

- Tell me what you have thought about your overall experience of PBS support whilst you've been working here?
- How has the relationship been between yourself and the patients that you've supported with PBS? – how has this felt?
- Has the planning process felt like a joint effort / collaboration with patients?
- Does the plan feel like it's 'owned' by the patient?

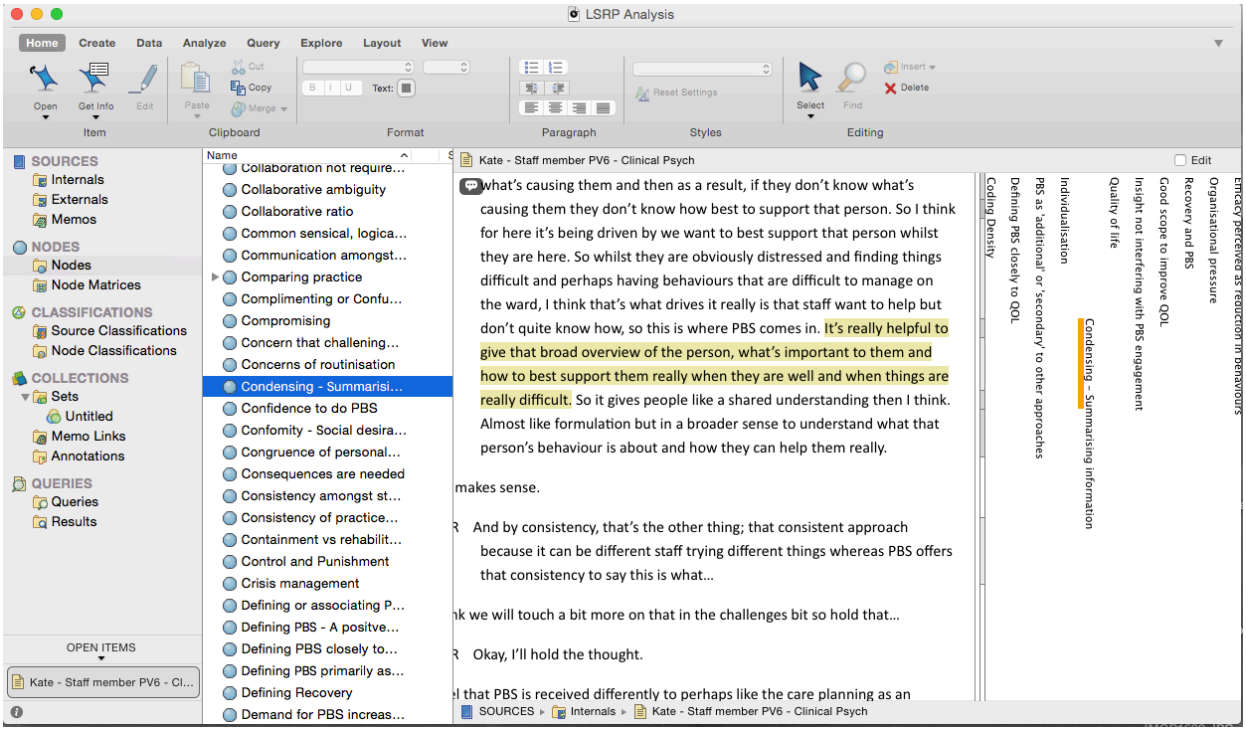
Closing questions:

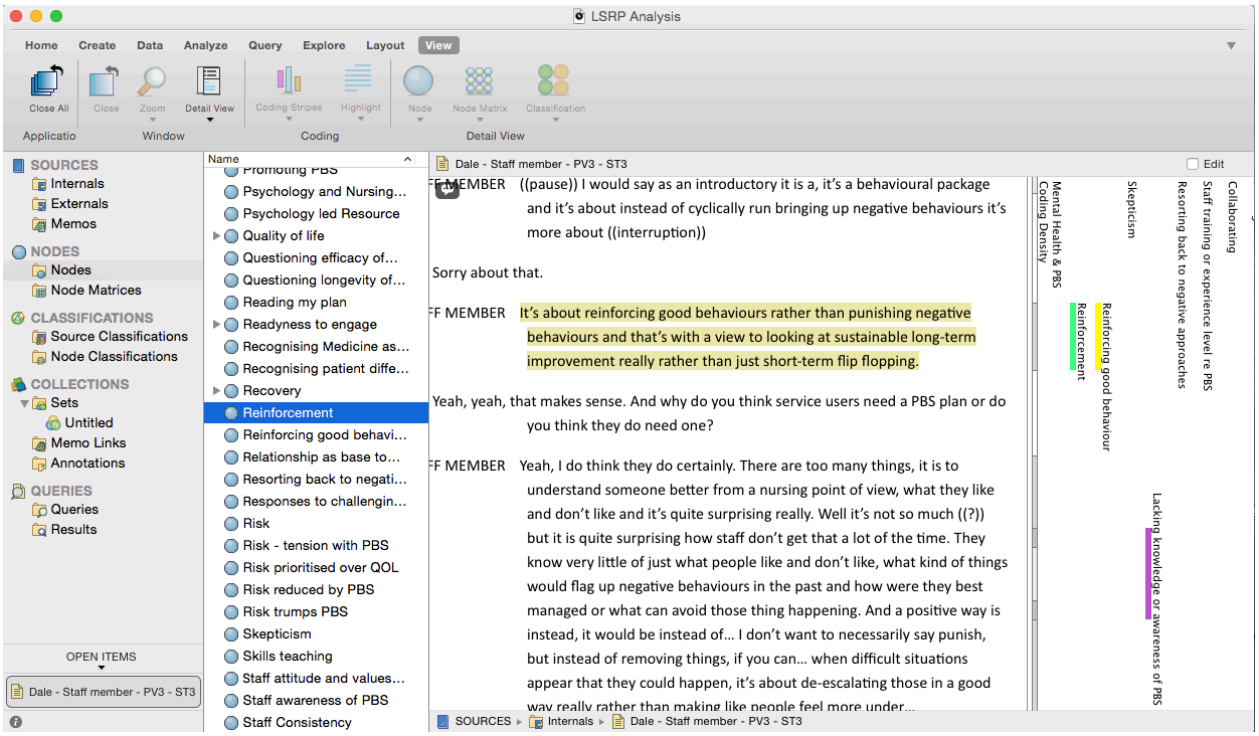
- Is there anything else you would like to say?
- Have you enjoyed talking about this?

State the interview has ended. Thank the staff member for taking part and praise them for their contribution, explaining how useful it will be. Verbally re-affirm that the staff member is happy for you to use their interview in the research.

Appendix I – Thematic analysis process

i) Phase 2: Generating initial codes using NVivo for Mac





ii) Examples of initial codes and focused codes alongside verbatim

Extract 1:

Focused Coding	***Initial Coding – line by line***	***Verbatim***
		G: What do you feel, like the staff I guess, consensus sort of view of PBS is?
Staff inconsistency	Staff are changing. PBS brought in as approach. Differences in understanding	P: It's changing urm for the better, when it was first brought in, this was four or five years ago, the, some staff were very, they understood it, they conceptualised it, they appreciated the benefits of it and its ethos, urm, other staff
Attitudes / Values / matching PBS	Differences in appreciation of 'ethos' of PBS	were less, urm, were less likely to think that way
		G: Ok
Inconsistency	Staff differences in behaviour, engagement and collaboration with patients. Staff being empowering, staff being punishing.	P: You could see some staff, there was very much a, urm, staff who wanted to engage and empower patients and be collaborative and there was staff who wanted to be controlling, urm, punitive without them knowing that they were being punitive and urm to some degree quite limited in their thinking and that's staff of all levels and all experiences and all genders, so you know it wasn't , you couldn't say it was one just particular group, it was surprising that people in some groups who were pro it and who were potentially who were against it, it was like 'well its another fad, its another you know new idea or way of telling me how to do my job, ive been doing it for twenty years ofcourse I know how to do these things' then other staff are very much 'we love it, we love the language, urm, we love how integrated it can be, we love how empowering to our patients and
Engagement Collaboration		
Empowerment		
Disempowerment	Limits to staff thinking. Patterns of thinking prevalent across whole staff group.	
Inconsistency		
Staff inconsistency, 'fit' with approach	Staff for and against.	
Resistance	Staff thinking PBS is a 'fad'	
Power	Feeling instructed.	
Resistance	Already have experience, resistant to approach.	
Acceptance & Positivity re: PBS	Accepting of PBS approach. Positive about PBS. PBS as	
Collaborative,	integrative and	

Empowerment Understanding Inconsistency Progression amongst staff Commitment Organisational hierarchy 'Fit' of staff with PBS Differences between staff Engagement Resistance 'Fit' of PBS with attitudes / beliefs Power PBS 'fit' with organisation	empowering. Understanding challenging behaviour. Variation in staff response Progress via training Commitment to the philosophy & ethos of PBS Hierarchy amongst staff. Higher ones role modeling. Staff beliefs impacting engagement with PBS Staff feeling frustrated by other staff who are not engaging with PBS. PBS plans for staff… Staff resistance to new ways of thinking. Staff beliefs not fitting with those of PBS. Power and control. Organisational philosophy different to that of some staff	the care and understanding the challenging behaviours that is. G: Ok P: So it was a mixed bag, I mean slowly over the years, as we've done more and more training, as there's more of us commited to the philosophy, to the ethos of PBS, and in fairly senior positions role modeling those requirements, its you know, it is improving G: Yeah P: There is still some outliers I think amongst the staff group who, for whatever their own beliefs are just… G: Have you found that challenging? Managing those different staff attitudes? P: Yeah, Oh definitely, yeah, urm, yeah it is challenging, its frustrating at times, urm, yeah, its almost like you need a PBS plan for staff sometimes G: That's interesting P: Yeah, I think, I'd be amazed if nobody could think that way, I think some of them don't want to think that way G: Yeah, ok P: It just cuts against their core beleifs about power, control, 'I'm the nurse, you're the patient' urm ' you're the criminal, you're here to be punished' which isn't our organisational philosophy at all, you know, this is a hospital, this isn't a prison

Containment vs care Staff attitudes and values Inconsistency amongst staff group. Resistance. Motivation.	members. Rehab not punishment… Suggesting staff should be non-judgemental. The need for staff behaviour to be congruent with the values of PBS. Differences amongst staff, limitations to thinking . Resistance to change. Levels of motivation.	G: Yeah P: Urm, this isn't a court, people are here because of their health needs, urm their offending is linked to that, we need to be nurturing and caring not controlling and punitive. P: And some staff are limited In their thinking, limited in possibly their abilities to think, or limited in their ambition to think differently.

Extract 2:

Focused Coding	***Initial Coding – line by line***	***Verbatim***
		G: That makes sense. So if you were to like describe PBS to like someone who had never heard of it, like a new colleague or something, what would you say? Would it be similar to what you've just told me or would you…?
Team approach / Collaboration Knowing the patient Information Collaboration Engagement Understanding Behaviour Collaboration	PBS as a team approach Collaborating with patients – getting to know them Likes & dislikes Identifying info Supporting via collaboration Patient ideally engaged Behavioural approach Assessing and analyzing functions of behaviour Developing awareness Collaboration with the patient and the team	P: Yes, it probably would be, it would be about… I would say it's like a team approach to producing a way of working with someone that gets to know them better. Gets to know their likes and dislikes; the things that work to keep them happy and healthy and all those sorts of things and then ways that when things aren't going so well, the best way to support that person but in a collaborative way that's with that person on board to say, yes, this is what I find most helpful and this is what I find unhelpful. And also I describe it as having, being quite behavioural so it's using skills of functionality to actually look quite closely then and analysing what exactly are somebody's triggers

Understanding Behaviour	Understanding behaviour	because they might not be aware. It's about working with them to make them aware as well of the team, of what those sorts of triggers and things that might make things difficult for them in their lives. G: Thanks. So what do you think, like is, this might seem a bit of a strange question, but why do you think service users need a PBS like here? P: Here? That's a really good question. I think it's borne out of the complete opposite to what I answered in my first question; it's borne out of people displaying what we call challenging behaviours and I think there are some people that have some really difficult… difficult to manage behaviours. I think particularly for the staff on the front line it's really hard to know what's causing them and then as a result, if they don't know what's causing them they don't know how best to support that person. So I think for here it's being driven by we want to best support that person whilst they are here. So whilst they are obviously distressed and finding things difficult and perhaps having behaviours that are difficult to manage on the ward, I think that's what drives it really is that staff want to help but don't quite know how, so this is where PBS comes in. It's really helpful to give that broad overview of the person, what's important to them and how to best support them really when they are well and when things are really difficult. So it gives people like a shared understanding then I think. Almost like formulation but in a broader sense to understand what that person's behaviour is about and how they can help them really.
Challenging behaviour as focus	Need related to challenging behaviour	
Understanding behaviour	Difficulties managing behaviours – front line staff	
Knowing the patient	Difficulty understanding behaviours	
Challenging behaviour	Not knowing how to support the person	
Understanding Behaviour	Supporting the patient	
Summarising / provision of info	Behaviours that are difficult to manage	
Understanding Behaviour	Developing staff understanding of behaviour	
Staff consistency	Developing a summary of the person for staff	
	Developing information	
	Developing a shared understanding	
	Formulating behaviour	
	Undertanding behaviour so you can help.	
	Developing a consistent approach	
	Staff inconsistency in	

	managing behaviour PBS offers consistency.	G: Yeah, that makes sense. P: And by consistency, that's the other thing; that consistent approach because it can be different staff trying different things whereas PBS offers that consistency to say this is what…

iii) Phases 3 & 4: Searching for and reviewing themes:

Beginning to input focused codes into mind-maps and linking with other codes to form potential themes:

Further adding of focused codes and linking to form potential themes:

Further development and searching for themes:

Beginning to cluster codes into potential themes for review:

Further reviewing of themes:

iv) Phase 5: defining and naming themes – Final thematic map developed from mind maps