Are trainee clinical psychologists fit for delivering Positive Behavioural Support on qualification?

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Summary: Recent NHS guidance mandates that Positive Behavioural Support (PBS) should be the approach of choice across settings for those whose behaviour challenges. In this article we argue that more needs to be done to ensure clinical psychology trainees are fit for PBS practice if the discipline is to take a leading role.

Introduction: Context for Change

Events at Mid-Staffordshire NHS Foundation Trust and Winterbourne View have had a huge impact on the clinical, political and social environment, becoming drivers for a substantial change in practice in the NHS. One of the clear messages from the reviews, policies and guidance published since, is that Positive Behavioural Support *(*PBS) provides a framework for evidence based practice that should be used whenever working with people who engage in behaviours that challenge. PBS has recently been defined to reflect a UK context in terms of values, theory and evidence base, and process (Gore et al., 2013), see Table 1. As the authors note, the ten components presented in the table and considered in greater detail in the PBS Competence Framework (PBS Coalition, 2015), should not be viewed as a pick and mix menu but rather as a whole that is greater than the sum of its parts. PBS evolved to support people with intellectual and developmental disabilities, and most of the evidence base relates to this field. However, a PBS framework may also usefully inform service delivery for a range of other people (e.g., older adults, people with acquired brain injuries and individuals experiencing mental health problems; see NHS Protect, 2013; Department of Health, 2014). Accompanying guidance for NHS commissioning and workforce development (Skills for Care and Skills for Health, 2014) notes the need to develop a workforce that can work in a positive and pro-active way to minimise the use of *all* forms of restrictive practices. In this context restrictive practices can take a number of forms: physical restraint (using physical contact); mechanical restraint (using devices); chemical

restraint (using medication); and seclusion (confining or isolating people) (Department of Health, 2014). Table 1 – *Key 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 and 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

Clinical psychology, as a discipline, would seem to have good potential to utilise its breadth of skills in assessment, formulation and intervention within a PBS framework. Workforce guidance issued in *A Positive and Proactive Workforce* (Skills for Care and Skills for Health, 2014) noted that clinical psychologists, alongside others with relevant postgraduate qualifications in Applied Behaviour Analysis, might be well placed to take on supervisory roles in PBS delivery. Thus, as evidence based practitioners, clinical psychologists should not only be skilled in PBS but given their status within professional teams should demonstrate some of the highest competencies and be leading the way. Collectively we agree that clinical psychologists are potentially well placed to do this given their transferable competencies in leadership, multi-component assessment and intervention. However, we are concerned that this potential may not always be reflected in reality and feel

that there is an urgent need for the profession collectively, and training courses individually, to review to what extent they equip clinical psychologists coming out of training to deliver PBS, and to take on respective leadership roles.

The BPS Standards for the Accreditation of Doctoral Programmes in Clinical Psychology (BPS, 2015), set out nine core competencies, including that all trainees should complete supervised practice on placement working with service users with significant levels of behaviour that challenges (Standard C1.2). However, in practice the extent of this experience may differ greatly between individual trainees. Dependent upon the nature of placements and skill sets of supervisors, exposure to ways of working that are consistent with the clinical procedures and underpinning models outlined in PBS is not assured. As a result it is our experience that there is considerable variability in whether or not newly qualified clinical psychologists appear aware of and confident about fundamental aspects of PBS (that it is based primarily upon the theory and practice of behaviour analysis alongside other evidence based models that are conceptually consistent; Hastings et al., 2013) and ready to put these into practice.

The PBS Competencies Framework

Training clinical psychologists and the wider workforce is a significant challenge (Denne et al., 2015). Fortunately the core skills needed to deliver PBS have now been defined for a UK context in the form of a freely available competencies framework by a range of expert stakeholders, including clinical psychologists with a practical and academic grounding in PBS (PBS Coalition UK, 2015). This framework specifies the knowledge (the things you need to know) and associated actions (the things you need to do) that are required for the delivery of PBS. Clinical psychology training courses and post qualification programmes can use this framework to inform their curricula to ensure trainees learn the skills they need to deliver PBS effectively. The PBS competencies framework identifies three main areas of

practice. They are:

1. **Creating high quality care and support environments:** This aims to ensure that organisations, and those providing individual support, operate from a person-centred foundation.
2. **Functional, contextual and skills based assessment:** This aims to ensure that any support is based on a thorough understanding of that person's needs, preferences, abilities, communication style, and the function/meaning of any behaviour that challenges.
3. **Developing and implementing a Behaviour Support Plan (BSP):** This focuses on *emerging* or *established* challenging behaviours and aims to provide a detailed and personalised description of how best to support each person with behaviours of concern.

A summary of the core competencies under each of the three main areas of practice is presented in Table 2. Each of the core competencies comprises further skills that are detailed in the published PBS Competencies Framework (available at http://pbscoalition.blogspot.co.uk/).

Table 2 – *PBS core competencies under the three main areas of practice*

1.	Creating high quality care and support environments	2.	Functional, contextual and skills based assessment	3.	Developing and implementing a Behaviour Support Plan (BSP) Evaluating intervention effects and on-going monitoring
1.1	Ensuring that services are values led	2.1	Working in partnership with stakeholders	3.1	Understanding the rationale of a BSP and its uses
1.2	Knowing the person	2.2	Assessing match between the person and their environment and mediator analysis	3.2	Synthesizing data to create an overview of a person's skills and needs
1.3	Matching support with each person's capabilities and with goals and outcomes that are personally important to them	2.3	Knowing the health of the person	3.3	Constructing a model that explains the functions of a person's challenging behaviour and how those are maintained
1.4	Establishing clear roles and effective team work	2.4	Understanding the principles of behaviour (4 term contingency); understanding the function of behaviour	3.4	Devising and implementing multi-element evidence based support strategies based on the overview and model Antecedent strategies • Antecedent strategies • Developing functionally equivalent alternative behaviour (to CB) • Increasing skills and communication • Systems change and contextual interventions
1.5	Supporting communication	2.5	Supporting data driven decision making		
1.6	Supporting choice	2.6	Assessing the function of a person's behaviour		
1.7	Supporting physical and mental health	2.7	Assessing a person's skills and understanding their abilities	3.5	Devising and implementing a least restrictive crisis management strategy
1.8	Supporting relationships with family, friends and wider community	2.8	Assessing a person's preferences and understanding what motivates them		• Arousal curve • Reactive strategies
1.9	Supporting safe, consistent and predictable environments			3.6	Developing the plan; outlining responsibilities and timeframes
1.10	Supporting high levels of participation in meaningful activity			3.7	Monitoring the delivery of the BSP (procedural/treatment fidelity/integrity)
1.11	Knowing and understanding relevant legislation			3.8	Evaluating the effectiveness of the BSP
1.12	A commitment to Behaviour Skills Training			3.9	The BSP as a live document

While some competencies are required by everyone, there are also specialist skills which will be the focus of practitioners such as clinical psychologists, psychiatrists, speech and language therapists and behaviour analysts. For this reason, the framework is also divided into three functional levels. They are:

1. **Direct contact:** all those providing direct support to people displaying behaviour that challenges.
2. **Behaviour Specialist/Supervisory/Managerial:** for anyone involved in supporting those who provide direct contact.
3. **Higher Level Behaviour Specialist/Organisational/Consultant**: for those responsible for embedding PBS into and across services and building capacity. This includes expert clinical competencies required for the most complex systems and cases.

Clinical psychologists can work across all three competencies levels and therefore will need a comprehensive training programme to support the development of all these skills.

This is particularly the case if clinical psychologists are to provide leadership to PBS services. We suggest that PBS training whilst on clinical psychology training should be provided explicitly as well as gained through integration and elaboration of existing teaching.

We are mindful that such teaching may currently be delivered across a considerable time span and without necessarily optimal integration of material that would be relevant to PBS. Therefore we recommend that courses should provide some integrated teaching across the broad range of clinical areas and settings where restrictive practices are more likely to be used. A clear PBS framework should be incorporated into the current curriculum for clinical psychology training courses. This should not necessarily require additional teaching hours but is highly likely to call for more integration and a clear mapping of teaching to the aforementioned PBS core competencies (for some initial suggestions that require further development, see Morris, 2014). Current teaching on psychological assessment, formulation and intervention when working with people who engage in behaviours that challenge across settings and clinical groups should draw centrally on processes of PBS theory and practice. In addition, courses should highlight other curriculum content that is consistent with PBS, so that trainees are exposed to a clear narrative of their skill development relating to PBS throughout training. However, PBS is more than just the 'first among equals', but the primary framework for intervention and support for people who display behaviour that challenges. Therefore it should be a core focus during training and taught as a coherent whole, not just pieced together from a range of sources. To this end we recommend courses use the PBS Competencies Framework to audit their current training curriculum and to develop a curriculum that covers all the key aspects of the model.

We recognise that changing the clinical psychology training curriculum to include a more comprehensive delivery of core PBS competencies will not necessarily be straight forward. For instance, there might be a lack of trained PBS practitioners linked to the course

who are able to help change the curriculum and/or a lack of experienced supervisors in the local area to support training and skills development. Practical factors such as these will present significant challenges for courses and may slow down the introduction of PBS training, but keeping up with new advances in the evidence base and ensuring they become part of the training of new practitioners is a central part of the role of training courses.

Without relevant clinical placement experience trainees are unlikely to complete training with a skill set that makes them fit to implement, and more so lead in the implementation of PBS in NHS settings. At present, there are several unknowns that the profession and training community will need to address as a matter of urgency. These include a clear sense of the extent to which delivery of PBS is reflected in the work of trainee and qualified clinical psychologists across the wide range of settings where service users may present with behaviour that challenges. Closely linked to this issue is the question to what extent trainees and supervisors are being supported to develop the necessary skills, knowledge and experiences to implement PBS. This would most sensibly be clarified by a systematic mapping of course content and experiences to the PBS competencies guide. Both of these areas appear necessary to build capacity for trainees to experience teaching and placements that ground them in the theory and practice of PBS and to identify any need for post-qualification training in the framework.

Conclusions

Clinical psychologists are potentially well placed to deliver PBS, and to lead in the implementation of a PBS framework across health service delivery to individuals who display behaviours that challenge. However, this will only happen if we equip ourselves with the core skills set out in the PBS Competencies Framework. In this article we have argued that more needs to happen to ensure that trainees routinely leave training courses fit to deliver PBS. This will require a systematic programme for developing the core PBS competencies during

training and beyond. As many PBS skills are relevant and transferrable across a range of specialities, it should be possible to map some of the PBS Competencies Framework onto existing training curricula. For example, some of the theoretical base of PBS can be taught when other behaviour analytic models like Acceptance and Commitment Therapy, Dialectical Behaviour Therapy or parent training programmes like Triple P are introduced.

In order to ensure that training providers and placement supervisors are well placed to support trainees in developing PBS competencies, they likely need to advance their own competence in PBS via post-qualification training. Given that the effective delivery of PBS requires a multi-disciplinary approach, knowledge and skills development in PBS offers a clear opportunity for interdisciplinary learning and is likely to require the forging of closer working alliances with other professional groups within the 'PBS community'.

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