

Adapted DBT Programme for Individuals with Intellectual Disabilities and Problems Managing Emotions: Staff Awareness Training

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Abstract

Purpose

The purpose of this paper is to present the development and evaluation of an original training package for staff members on an awareness of an adapted Dialectical behaviour Therapy programme, the 'I Can Feel Good' programme (Morrissey & Ingamells, 2014) designed for individuals with intellectual disabilities and problems managing emotions. The quality and effectiveness of the training was assessed and is reported in this paper.

Design/methodology/approach

The training was delivered for staff working with individuals with intellectual disabilities in a UK Medium Secure Psychiatric Hospital and was attended by nursing staff. The workshop consisted of six modules: 'Introduction to the programme', 'Mindfulness', 'Managing feelings', 'Coping in crisis', 'People skills' and 'Application and summary'. Level of self-reported knowledge, confidence and motivation regarding seven aspects of the training was measured by an evaluation questionnaire completed pre and post training.

Findings

The results of this study showed that following the training there was a significant increase in self-reported knowledge, confidence and motivation regarding the seven aspects of the training. When perceptions of staff behaviours are observed, although in the right direction, this change was found not to be significant.

Originality/value

This study highlights the potential for staff training to increase awareness of newly adapted therapeutic programmes for individuals with intellectual disabilities. The staff training may increase their ability and willingness to facilitate the running of such programmes and ability to support learning transfer in group members.

Introduction

It has been previously acknowledged that those with intellectual disabilities (ID) can experience the full range of psychological disorders and emotional difficulties (Hogue et al., 2007). Research even suggests that this population are possibly susceptible to emotional and behavioural problems to a greater extent than the general population (Lindsay, Hogue, Taylor, Mooney & Steptoe, 2006). This has been suggested to be due to a number of factors including intracerebral pathology (Hogue et al., 2007), social factors such as difficult life experiences (Taylor, Lindsey & Willner, 2008), low social status and financial difficulties (Prout & Schaefer 1985; Prout & Strohmer 1991; Bouras 1999).

However Reiss, Levitan & Syszko (1982) highlight a 'diagnostic overshadowing' in which psychiatric comorbidity within ID populations may go unnoticed due to the difficulties in identification (Sturmey, Reed & Corbett, 1991), lack of reliable normative data (Sturmey et al., 1991) and lack of appropriate assessment tools (Finlay & Lyons, 2001). This lack of appropriate assessment and subsequent intervention has led to these issues remaining untreated and persisting (Mason & Scior, 2004) with ID populations.

An analysis of psychological need was completed within a medium secure forensic environment. It was found that the severity of the emotional and behavioural problems, as reported through EPS-BRS (Prout & Strohmer, 1991), currently present within the medium secure environment were equal to and higher than those previously reported at high secure (Hogue et al., 2007). This is supported by findings from Gibbon et al., (2013). This reinforced the view that the application of a programme developed to address emotional and behavioural problems frequently displayed within ID populations (Taylor, 2005) may be appropriate. As a result, staff awareness training was considered necessary.

Dialectical behaviour therapy (DBT) (Linehan, 1993) is a psychological treatment that was initially developed for suicidal individuals with a diagnosis of borderline personality disorder. There is a body of literature which supports its application within various settings targeting different risk behaviours, (Evershed et al, 2003; Lew,

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3 Matta, Tripp-Tebo & Watts, 2006; Sakdalan, Shaw & Collier, 2010). Morrissey and
4 Ingamells (2011) developed and piloted an adapted DBT programme suitable for
5 men with mild ID with a high secure service entitled 'The I Can Feel Good'
6 programme. It combines a psychoeducation approach with cognitive behavioural
7 techniques developed to meet the needs of a male forensic population with ID.
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13 In light of the recommendations regarding continuation of treatment along the
14 care pathway (Morrissey & Ingamells, 2011), the adapted DBT skills training
15 programme, the 'I Can Feel Good' group, has been piloted within a Medium Secure
16 Learning Disability Service. Morrissey and Ingamells (2014) highlight the vital role
17 staff members play in facilitating skill generalisation through the DBT mode of
18 'Coaching' (Linehan, 1993) in their manual introduction. Therefore a staff awareness
19 training package was developed.
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26 The aims of the training were considered prior to development in order to
27 develop effective training materials (Dayal, 2001). It comprised of increasing ward
28 based staffs'; general awareness of the programme; understanding of the group
29 content, language and materials; motivation and ability to support patients in their
30 application of skills developed on the programme. It aimed to combine a facilitative
31 and a directive approach (Bee & Bee, 1998) additionally maximising experiential
32 learning in light of a review by Prince (2004) suggesting active learning maximises
33 teaching effectiveness.
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41 Training evaluation was based upon the Kirkpatrick's (1976) hierarchical model
42 of course evaluation, specifically focusing upon the initial three levels at this stage;
43 reaction, learning and behaviour. Follow up evaluation regarding the final level is
44 considered possible at a later date but is not included here.
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49 This paper aims to follow Swanson and Sleezer's (1987) evaluation model;
50 describing the training design and event, the evaluation plan and evaluation tools,
51 the training impact and feedback.
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55 56 **Training Needs Analysis** 57 58 59 60

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3 Anecdotally, following commencement of the 'I Can Feel Good' programme, it
4 became apparent that there was a staff level knowledge deficit regarding the
5 programme aims and content. This was evidenced by; staff members' lack of
6 awareness regarding the programme in discussion on ward; staff members' lack of
7 motivation and confidence to support or attend the group; group member feedback
8 regarding their experience of lack of support regarding out of session tasks or skill
9 practice. As group facilitators this highlighted a clinical need related to increasing
10 staff ability to positive affect the programme efficacy.
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18 As part of the training package evaluation, staff completed a pre training
19 questionnaire designed to highlight the potential training need. Based upon Donovan
20 and Townsend's (2004a) training needs analysis guidance the self-report
21 questionnaire was developed to assess the three areas of knowledge, confidence
22 and motivation relating to seven factors considered relevant to the 'I Can Feel Good'
23 programme.
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30 This demonstrated a deficit in staff knowledge regarding the programme
31 (specifically regarding; how they could attend the group; how they could model and
32 coach group members in the use of skills) with a relatively elevated response
33 regarding motivation.
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38 These results highlighted a training need and the specific combination of low
39 knowledge and high motivation demonstrated a potentially effective and receptive
40 training environment.
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44 **Training Design**

45 **Content**

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48 The training was designed to meet the need identified by the facilitators of the 'I
49 Can Feel Good' group concerning the staff lack of awareness regarding the group
50 programme. The aims of the programme were considered and outlined at the
51 beginning of the training to facilitate goal attainment in line with cognitive theory
52 principles (Knowles, Holton & Swanson, 2005). They were based upon
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3 recommended structure provided by Donovan and Townsend (2004a) and are as
4 follows:
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- 8 - **Knowledge** - staff will demonstrate an increased knowledge of the group
9 content, terminology and process on ward when in discussion with patients.
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- 12 - **Confidence** - staff will feel more confident in supporting patients complete out
13 of session work, encourage patients to practice their skills, role model
14 appropriate behaviours and coach patient to use techniques and skills
15 developed on the programme.
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- 18 - **Motivation** - staff will demonstrate an increased willingness and motivation to
19 engage, support and facilitate the running of the programme.
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26 Based upon the facilitator training delivered previously at a High Secure service
27 (Ingamells, 2011), the training package followed the structure of the group
28 programme. It was designed to provide an understanding of the programme's
29 construction. It included an introductory module including details regarding the
30 programme's theoretical background. This was followed by a module focusing upon
31 each of the programme's four modules; Mindfulness, Managing Feelings, Coping in
32 Crisis and People Skills. This training package attempted to emulate this structure.
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39 An introductory theory base was included along with rationales for the group and
40 the training package, outlining the aims of the training session. Additionally,
41 information and evidence to support the group's effectiveness within the intellectual
42 disability population, was provided. This aimed to increase trainees' enthusiasm
43 regarding learning about the programme and becoming involved both aims of the
44 training. This has been shown to sustain willingness to utilise training knowledge and
45 transfer skills to their role (Tabassi, Mahyuddin & Hassan, 2012).
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52 An increase in knowledge regarding programme effectiveness was thought to
53 increase staff member's self-efficacy when considering the impact of their
54 involvement, which has been shown to effect training outcomes (Saks & Haccoun,
55 2007). Therefore, we attempted to increase the training effect upon increasing staff
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3 motivation by providing information regarding the programme outcome data,
4 highlighting the importance of their involvement.
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8 A summary section exploring potential practical application techniques regarding
9 the knowledge and skills developed through this training package was also included
10 to help facilitate consideration of this aspect, as use of organisational examples with
11 training has been shown to facilitate training transfer (Burke & Baldwin, 1999).
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16 The following seven factors were considered central to the aims of the training
17 encouraging staff involvement and expressly covered.
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21 - **Encouraging group support** - Following on from providing group awareness
22 it was hoped that this knowledge would be used to help support group to run,
23 ensuring patients were ready on time, had the correct materials and were
24 prepared.
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29 - **Encouraging group attendance** - Initially by providing awareness training it
30 was hoped ward based staff would be encouraged to become involved by
31 attending group sessions regularly, observing the topics covered and skills
32 being developed. It has been shown that individuals accompanied to
33 treatment by carers made better progress than those who attended alone
34 (Rose, Jenkins, O'Conner, Jones & Felce, 2002; Rose, Loftus, Flint & Corey,
35 2005). It was hoped that by having ward based staff members attending the
36 group we may be able to increase the effectiveness of the programme. By
37 proving this information within the training it was hoped that staff motivation to
38 attend would increase which has been suggested to increase training
39 outcomes positively (Noe, 1986).
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49 - **Homework** - An important part of many structured psychotherapies is the
50 setting, completion and review of homework (Lindsay, Jahoda & Willner,
51 2013). The importance of this within programmes designed for the ID
52 population is essential but potentially more problematic due to difficulties
53 regarding understanding and recall. Lindsey et al. (2013) highlight the
54 importance of involving carers in homework completion and encouraging
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3 successful implementation of behavioural and cognitive techniques,
4 developed during the programme, in real life settings.
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8 - **Skill Rehearsal** - Brown and Marshall (2006) highlight individuals with ID may
9 experience difficulty transferring skills to everyday life. Ward based staff
10 receiving training regarding the programme content, will be encouraged to
11 support patients to implement and practice their skills. This encouragement
12 will reinforce the use of skills and increase the effectiveness of the
13 programme.
14
15 - **Modelling** - It was thought that by highlighting the sorts of behaviours we
16 were attempting to encourage within the group (i.e. assertiveness from the
17 People Skills module) within the training programme it would provide the staff
18 with the understanding and motivation to model these types of behaviour on
19 ward.
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30 The use of supported role-play within psychological intervention for individuals
31 with ID has been advocated (Brown et al, 2006; Brown & Marshall 2006) in
32 order to demonstrate skills practically and allow for experiential learning. By
33 observing staff practicing these role-plays both in group and potentially on
34 ward, patients' use of the skills may become more effective.
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- 39 - **Coaching** - One of the four modes of DBT outlined by Linehan (1993) is that
40 of 'coaching', along with 'skills training', 'individual therapy' and 'team
41 consultation'. 'Coaching' refers to combining feedback and instructions on
42 how to put a certain skill into practice. Generally this is implemented with
43 phone contact between the client and the individual therapist.
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50 There is often consideration of how to implement the in-the-moment coaching
51 within a secure forensic environment where access to phones (and therapists)
52 can be potentially limited, due to potential risk and boundaries issues. One
53 way this has been suggested to be operationalised within a secure inpatient
54 forensic setting is to train the staff (who are available on ward at all times) with
55 the skills to be able to coach the patient in-the-moment. Highlighting this
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3 supports training transfer (Burke & Baldwin, 1999) increasing the likelihood of
4 this occurring.
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8 - **Language** – Training ward staff members, who have a detailed working
9 knowledge the communication needs of group members, may facilitate
10 information adaptation. Especially for individuals with severe cognitive
11 impairments (Brown, Duff, Karatzias & Horsburgh, 2011). Individualised
12 explanations and examples may be prepared with collaboration of ward based
13 staff in addition to in-group interpretation of issues and needs of group
14 members.
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21 An additional training benefit lay in the fact that terminology used within the
22 programme may become part of the ward vocabulary (i.e. the States of Mind).
23 This was informed following previously successful implementation of
24 therapeutic approaches into the ward milieu. RAID[®] implementation (a
25 relentlessly positive approach to working with extreme and challenging
26 behaviour, Davies, 2013) involved extensive staff training and successful
27 integration of a common vocabulary into the ward environment. A shared
28 language may facilitate transference of skills developed within the group to
29 the ward setting.
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37 38 **Style**

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41 The package was designed using a combination of a PowerPoint presentation
42 and active tasks to increase engagement (Stuart & Rutherford, 1978) and provide
43 information. This style was decided upon due to findings that suggest learning
44 occurs best in interactive environments that are not based upon a model in which the
45 facilitator acts as the sole transmitter of knowledge (Bransford, Brown & Cocking,
46 1999). Text displayed on the PowerPoint was kept to a minimum to reduce
47 information overload (Burke & Hutchins, 2007) and key words and phrases were
48 highlighted.
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56 **When completing the Instructional Styles Diagnosis Inventory (Cripple, 1996),**
57 **which is a measure of preferred training styles, it was apparent that the facilitators**
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3 preferred style was that of 'The Coach'. It was reflected this style was suited to the
4 aims of this training; to facilitate learning to perform in new ways, with the focus
5 being upon skill development, application and confidence building.
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10 In line with the Kolb's (1984) experiential learning theory, activities utilising some
11 of the skills developed followed the theoretical aspect of each module allowing for
12 reflection, application and a snapshot of trainees learning and progress (Stuart &
13 Rutherford, 1978). Some activities were developed using Angelo & Cross's (1993)
14 Classroom Assessment Techniques as a basis.
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19 This was included to allow for practical application of techniques and to facilitate
20 consideration of how the knowledge developed could be implemented on ward (an
21 aim of the training), supporting training transfer. Additionally this more informal,
22 discursive section allowed for more experiential learning and reflection upon
23 application of the skills in line with Kolb's (1984) principles.
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29 Additionally, practicing activities from the group programme allowed for
30 experiential learning within an organisational application (Burke & Baldwin, 1999)
31 and a break from theoretical information presentations.
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36 As a form of Personal Response System (Stuart & Rutherford, 1978) an end of
37 day Pub Quiz element was included which allowed for a dynamic, enjoyable way of
38 testing immediate recall of the training material whilst ending the training on a
39 pleasant note, with prizes available for the 'winning team'.
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43 44 45 **Structure**

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48 *Insert Table 1 here*
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50 51 **Training Event**

52 53 54 55 **Attendees** 56 57 58 59 60

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3 The initial planning stages involved conversation with management staff
4 regarding facilitation of training in order to obtain managerial support, as this has
5 been shown to increase training effectiveness (Haslinda & Mayuddin, 2009).
6 Trainees were free to attend as this choice has been shown to increase attitudes and
7 motivation to attend training (Tsai & Tai, 2003). Invitations were sent out to identified
8 staff through the ward manager and followed up with a reminder email from the
9 facilitators. Final trainee cohort, comprised of two groups ($n^{\text{group1}}=5$, $n^{\text{group2}}=6$) and
10 consisted of $N=11$, with a relatively unequal gender divide ($n^{\text{males}}=10$, $n^{\text{females}}=1$) but
11 relatively equal professional divide ($n^{\text{staff nurses}}=5$, $n^{\text{healthcaresworker}}=6$). All trainees were
12 currently based on the male ID ward.
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20 21 **Facilitators**

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24 Training was facilitated by the two members of staff responsible for running the I
25 Can Feel Good group (Forensic Psychologist in Training and Clinical Psychologist)
26 as there were considered to have the most knowledge and expertise regarding
27 delivery of the programme of the internal staff. This decision was guided by literature
28 regarding trainer expertise (Driskell, 2011). Both facilitators were based on the ward,
29 were familiar with and had working relationships with the trainees which allowed for
30 training package to be tailored to suit trainees learning styles (Robotham, 1995).
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38 **Event**

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41 The training was designed to cover one day and was delivered twice, over two
42 dates provided, following discussion with the management staff to facilitate
43 maximised attendance. The training content covered 6 hours in total (including 1
44 hour break time in total) but periods were allocated prior to commencing the training
45 and post completion to allow for completion of the evaluation forms and to allow for a
46 flexibility of individuals arriving late and time for questions and feedback (2 x 15
47 minutes) therefore training was scheduled to commence at 09:30 and conclude at
48 16:00.
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56 It took place in the training room provided by the organisation and the
57 environment was set up in line with recommendations regarding seating, lighting,
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3 temperature (Townsend, 2003) to maximise training outcomes. Training content was
4 delivered by use of a computer and projector displaying a PowerPoint presentation,
5 in addition a flip chart was utilised for activities and idea generation.
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10 Hand-outs were provided which detailed the PowerPoint presentation (with
11 certain slides removed to aid learning i.e. answers to questions raised throughout the
12 day to encourage peer instruction; Mazur, 1997) and trainees were encouraged to
13 make notes.
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18 Breaks were incorporated within the training, allowing for flexibility, to ensure the
19 trainees were comfortable and their needs were catered for (e.g. toilet, cigarette and
20 drink breaks). Additionally, 'brain breaks' (Morrissey & Ingamells, 2011) were
21 incorporated into the training to allow the facilitators to respond to a perceived
22 decrease in attention with a stimulating activity (Townsend, 2003) maximise training
23 effectiveness.
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29 **Training Impact and Feedback**

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33 Following a review of evaluation techniques (Donovan & Townsend, 2004b) it
34 was decided that a combination of trainee reaction and perception along with skill
35 and knowledge development would be appropriate. Therefore, training evaluation
36 was based upon the Kirkpatrick (Kirkpatrick, 1976; Kirkpatrick & Kirkpatrick, 2007)
37 'four level' model for course evaluation.
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43 Regarding initial short term effectiveness evaluation, a focus on the first three
44 levels of Kirkpatrick's model was established. All evaluation tools developed were
45 anonymous and trainees were asked to include a unique personal identification code
46 to match the pre and post evaluation forms. The four levels of Kirkpatrick's
47 (Kirkpatrick, 1976; Kirkpatrick & Kirkpatrick, 2007) evaluation model are as follows:
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52 **Reaction**

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56 This stage measures the trainee perceptions of the training event, delivery and
57 content. This was measured using an internal adapted standard training evaluation
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3 form combining Likert rating scales and open text boxes, measuring trainees
4 reaction and perception of the:

- 5 - Presentation quality
- 6 - Facilitators knowledge
- 7 - Relevance
- 8 - Usefulness
- 9 - Enjoyableness

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16 This tool provided both qualitative and quantitative evaluation of the trainees'
17 reaction to the training event and content.

21 **Learning**

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24 This stage evaluates the impact the training has upon trainee knowledge, skills
25 and/or attitudes. A pre and post self-report evaluation was developed to assess the
26 three aims of increasing knowledge, confidence and motivation relating to the seven
27 factors outlined within the training package:

- 28 - Group support
- 29 - Group attendance
- 30 - Supporting homework
- 31 - Supporting skill rehearsal
- 32 - Modelling
- 33 - Coaching
- 34 - Language use

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45 In light of potential issues with reliability and validity of self-report measures, the
46 impact upon trainee knowledge was additionally assessed by an informal 'pub quiz'.
47 This was an informal measure of knowledge designed to provide immediate
48 feedback to the facilitators regarding the degree of learning (Stuart & Rutherford,
49 1978). This was following discussion with the Training and Development team
50 regarding previous reception of knowledge based assessments inhibiting learning
51 and performance due to anxiety. The informal nature helped to make participants
52 feel at ease and free to share their knowledge deficits transparently without the fear
53 of repercussions.

Behaviour

This stage measures the transfer of trainee knowledge, skills and/or attitudes. The application and behavioural transfer of the training's impact will be measured again focusing upon the three aims and seven core factors; measured by self-report evaluation forms, pre and post training, obtained from the group members (designed for use within an ID population) and facilitators regarding their perception of the training impact upon staff behaviour. Following discussion with the Training and Development department it was decided that a one month period would be appropriate to allow to behavioural change to be implemented therefore the post measures were obtained following a one month follow up after the second training date.

Results

The final stage examines the organisational impact of the training. Although difficult to measure (Donovan & Townsend, 2004b) can be assessed after a follow up period to observe whether an impact upon incident levels on ward has occurred as a result of the behavioural change of trainees.

This can be reviewed at a later stage in consultation with the ward manager and examining behavioural data from the ward, although this would be difficult to attribute to the training in isolation. A follow up period of six months was considered appropriate in consultation with the Training and Development department in line with training policy within the service.

Findings

All trainees completed the anonymous evaluation forms and outcomes are detailed below.

Reaction

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3 Quantitative - Trainees were asked to rate their experience of the training on a
4 Likert scale from 1-5 (1 indicating poor and 5 indicating excellent), Figure 1
5 demonstrates the average rating scale for all trainees.
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10 *Figure 1: about here*
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13 As can be seen the rating of the reaction to the training was very high, verbal
14 feedback supported these findings with trainees making positive comments
15 regarding the applicable nature of the training content and its relevance to their role.
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19 Qualitative - Trainees were asked to provide comments in free text boxes on the
20 evaluation sheets, guided into four areas of; 'Highlights', 'Suggested improvements',
21 'Suggestions for application' and 'General comments'. Themes were identified
22 regarding these areas. Feedback appeared to suggest that highlights included role
23 playing and mindfulness practice. Suggested improvements included "more
24 activities" and suggestion training could be "narrowed down". Suggestions for
25 application seemed focused upon using skills learned within ward based interactions.
26 Finally general comments overall were positive and included "excellent delivery",
27 "good interactions, passionate and skilled presenters" and "one of the best sessions
28 off ward I have been to".
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37 38 **Learning** 39

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41 Trainees were asked to rate, on a Likert scale (1 indicating poor and 5 indicating
42 excellent) their knowledge (Figure 2), confidence (Figure 3) and motivation (Figure 4)
43 regarding the seven factors identified, prior to and post completion of the training.
44 The findings are demonstrated in the graphs below.
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3 As can be seen, there was a self-reported increase regarding all training aims
4 across all factors. When the data was studied more closely the increase appeared to
5 be relatively consistent across the three training aims of knowledge, confidence and
6 motivation and across the seven factors.
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11 Skewness and kurtosis values were obtained regarding each of the independent
12 variables (scores regarding aims: knowledge, confidence, motivation) to explore the
13 normality of the data prior to analysis. Results indicated that all skewness values
14 were under 3.29 at the $p < .001$ alpha level recommended for a small sample size
15 (Field, 2013). Kurtosis values were also not significant at the $p < .001$ level therefore
16 data was analysed parametrically.
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23 Three paired samples t-tests were conducted to compare pre and post training
24 scores regarding the three aims. The difference between the scores regarding
25 knowledge pre training ($M = 2.81$, $SD = 0.83$) and post training ($M = 4.42$, $SD = .53$)
26 was found to be significant; $t(10) = -6.31$, $p < .001$. The difference between the
27 scores regarding confidence pre training ($M = 2.88$, $SD = 1.0$) and post training ($M =$
28 4.49 , $SD = .57$) was found to be significant; $t(10) = -4.67$, $p = .001$. The difference
29 between the scores regarding motivation pre training ($M = 3.13$, $SD = 1.06$) and post
30 training ($M = 4.51$, $SD = .69$) was found to be significant; $t(10) = -4.5$, $p = .001$.
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38 These findings demonstrate the training day had a significant impact upon the
39 three training aims of knowledge, confidence and motivation.
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43 Additionally, following the 'Pub Quiz' element it was apparent that learning had
44 occurred; with all four teams obtaining 22.5 out of a possible 40 points (around 56%).
45 demonstrating similar learning across teams and training days. It could be concluded
46 that a consistency in knowledge acquisition and quiz performance had occurred as a
47 result of the training, meeting the aims objectified.
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52 Behaviour

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56 Group members and facilitators were asked to rate staff behaviour on a 5 point
57 Likert scale (1 indicating poor and 5 indicating excellent), across the seven training
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3 aims prior to and following a one month follow up period post training to observe if
4 there had been a notable change in the perception of staff behaviour in general as a
5 result of the training. The graph below (Figure 5) demonstrates the findings of this
6 evaluation tool.
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11 *Insert Figure 5 here*
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15 Skewness and kurtosis values were obtained regarding behaviour across the
16 seven factors as a whole to explore the normality of the data prior to analysis.
17 Results indicated that all skewness values were under 3.29 at the $p < .001$ alpha
18 level recommended for a small sample size (Field, 2013). Kurtosis values were
19 significant ($p < .001$) therefore data was analysed parametrically.
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25 A paired samples t-test was conducted to compare pre and post training scores
26 regarding behaviour. The difference between the scores pre training ($M = 3.35$, $SD =$
27 $.78$) and post training ($M = 3.9$, $SD = .91$) was found to be non-significant; $t(6) = -$
28 2.43 , $p > .05$; demonstrating that there was no statistically significant impact of
29 training upon behaviour.
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35 However, as can be seen (Figure 5) there was an increase in perceived staff
36 performance across six of the seven factors, mainly regarding the language used by
37 staff. This suggests trainees have been able to implement their learning
38 behaviourally regarding their clinical work. However there has been no perceived
39 increase in staff supporting patients to practice their skills. This will inform future
40 training of staff, perhaps highlighting this as an important application of the skills
41 learned.
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48 **Conclusions and Reflections**

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52 In conclusion, from the tools developed and utilised, the training seemed to have
53 had a positive impact upon all identified training aims.
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57 There was limited constructive or negative feedback via the evaluation tools
58 despite prompts to include suggestions for improvement. This may limit my ability to
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3 improve the package based upon such trainee feedback. This may have been due to
4 my being an internal staff member and concerns about criticising my practice if we
5 had to then work together inhibiting feedback. Future training may benefit from being
6 facilitated by an external trainer possibly allowing for more open and honest
7 evaluation feedback.
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13 For future delivery, preparation regarding developing my knowledge of how the
14 audio-visual equipment works rather than reliance upon technical staff would be
15 beneficial to a smoother running of the training. Additionally, in light of the
16 behavioural impact findings, the training package may benefit from more focus upon
17 staff modelling the skills, supporting patients with their homework and skill practice.
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23 Potential involvement of group members within the training package
24 development or even delivery may be beneficial to enhance training application to
25 ward based situations, whilst also enhancing the 'Coaching' (Linehan, 1993) element
26 of the programme (Morrissey & Ingamells, 2014).
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32 More long term evaluation of the training's effectiveness may be possible in the
33 follow up months extending to the final level of Kirkpatrick's evaluation model
34 (Kirkpatrick, 1976; Kirkpatrick & Kirkpatrick, 2007).
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38 This paper has wider implications of practice regarding the importance of
39 development, implementation and evaluation of staff awareness training regarding
40 the psychological interventions designed for ID populations. The potential for greater
41 staff awareness regarding psychological models, approaches and interventions to
42 positively impact upon the efficacy of psychotherapeutic intervention is highlighted
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49 This has been highlighted as a key element to increasing the effectiveness of
50 psychological interventions used specifically with ID populations (Morrissey &
51 Ingamells, 2014). This paper demonstrates how if effort is placed into facilitating
52 such training, staff members feel more knowledgeable, confident and motivated to
53 support effective running of such psychological interventions with ID populations.
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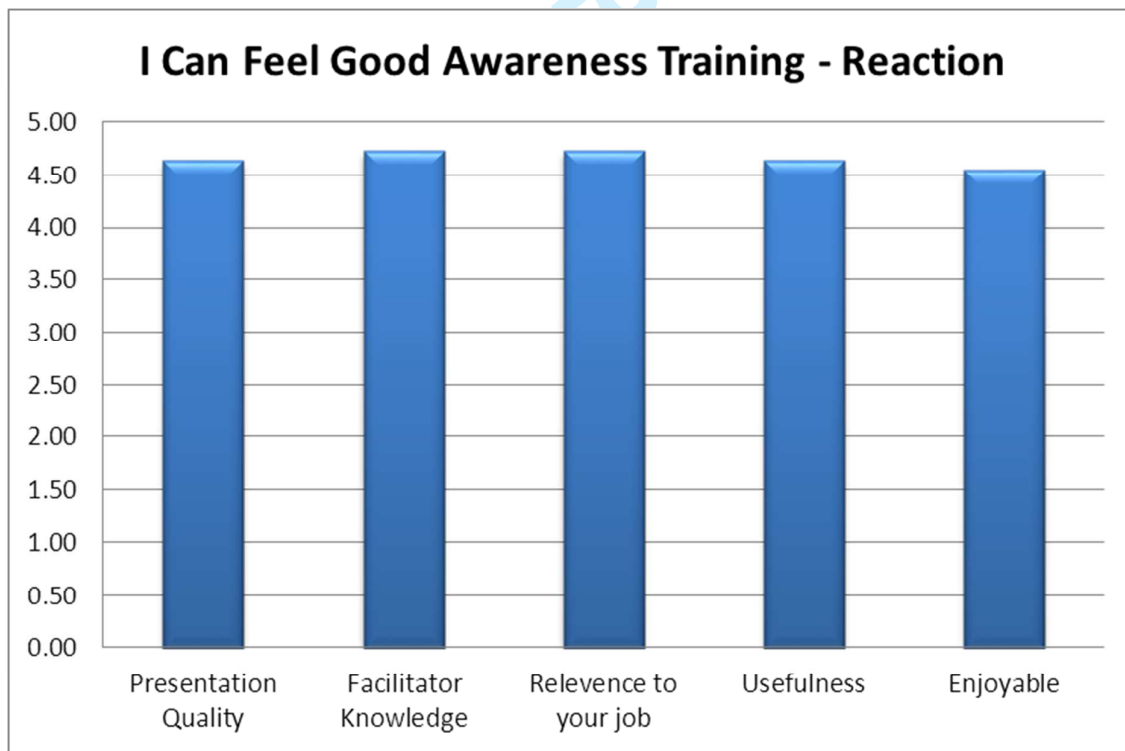
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Tables and Figures

Table 1: Training Structure

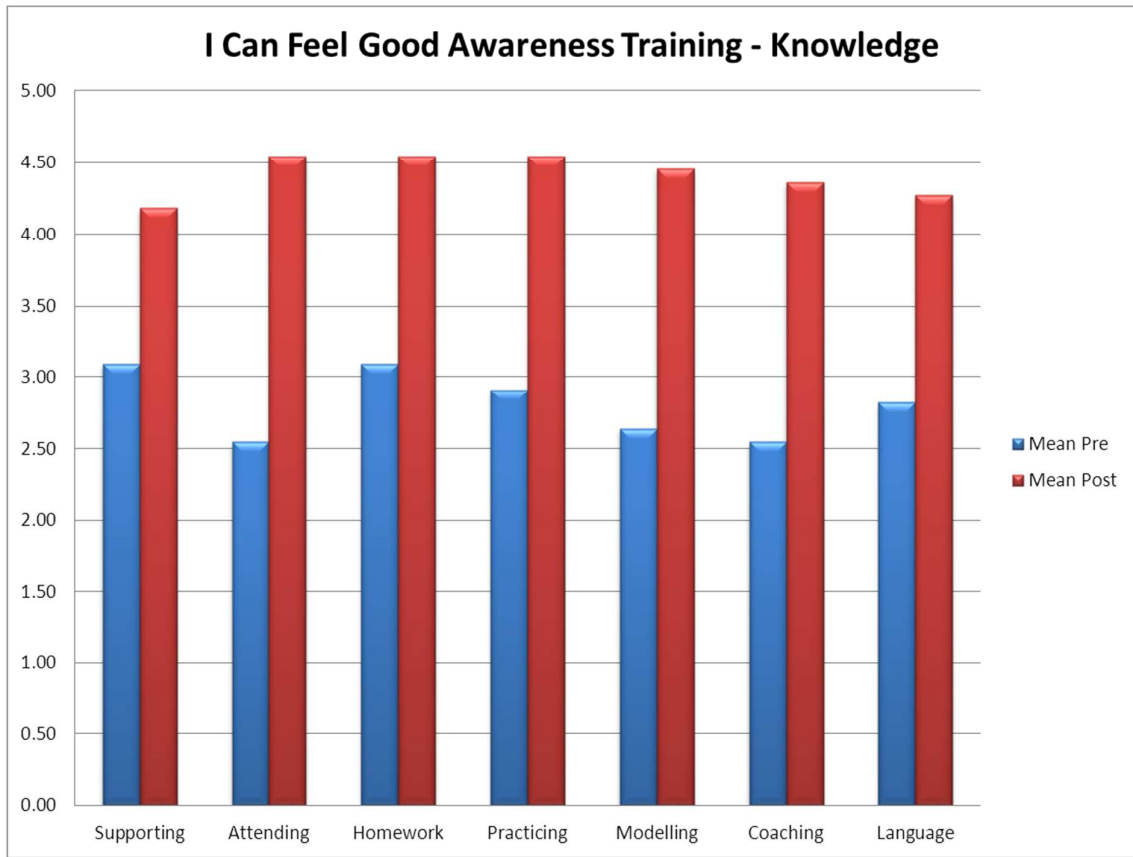
Content	Duration (mins)
<i>Registration and pre-evaluation</i>	15
<i>Activity – Ice Breaker</i>	15
Introduction	45
Break	15
Module 1 - Mindfulness	30
<i>Activity – Eating biscuit mindfully</i>	15
Module 2 – Managing Feelings	30
<i>Activity – Fun activities and happiness scale</i>	15
Break	30
Module 3 – Coping in Crisis	30
<i>Activity – Role play with Henry’s head</i>	15
Module 4 – People Skills	30
<i>Activity – Practice out of session support</i>	15
Break	15
Application and Summary	45
<i>Activity – Pub Quiz</i>	15
<i>Post-evaluation and feedback</i>	15

Figure 1: Reaction



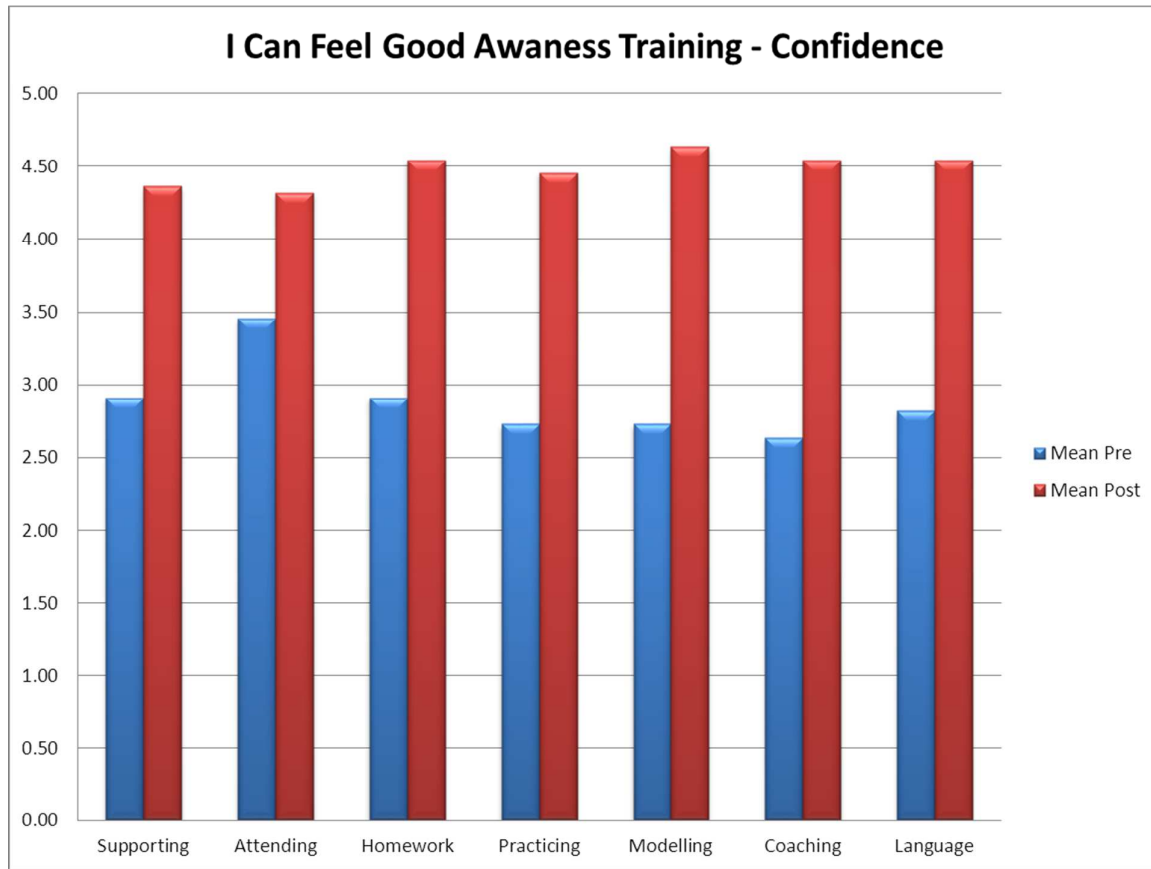
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Figure 2: Knowledge



Review

Figure 3: Confidence



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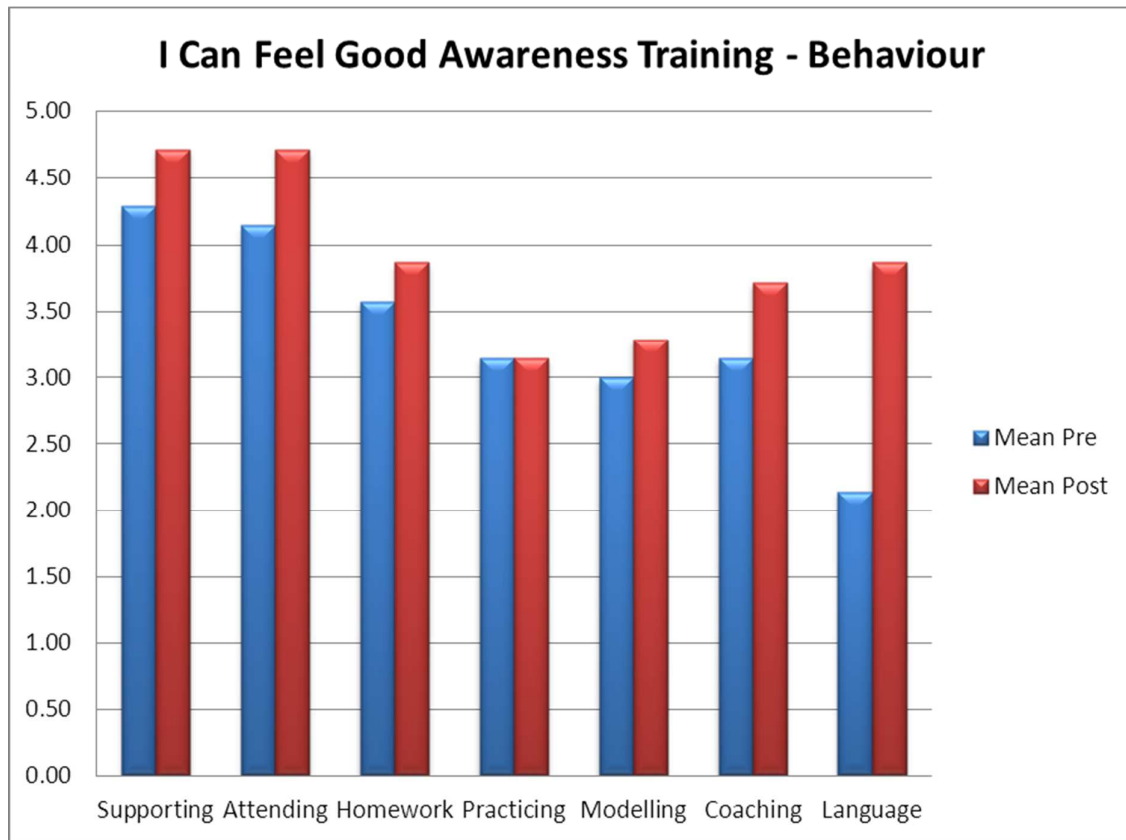
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Figure 4: Motivation



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Figure 5: Behaviour



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Tables and Figures

Table 1: Training Structure

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Break	15
Application and Summary	45
<i>Activity – Pub Quiz</i>	15
<i>Post-evaluation and feedback</i>	15

Figure 1: Reaction

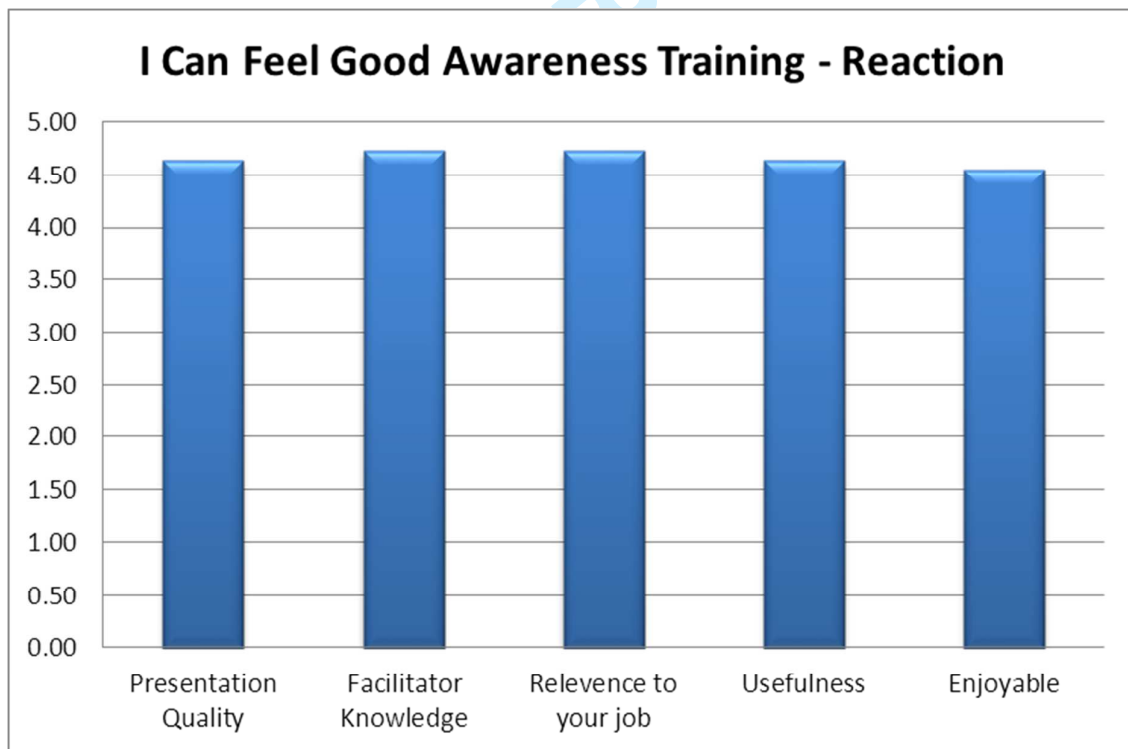
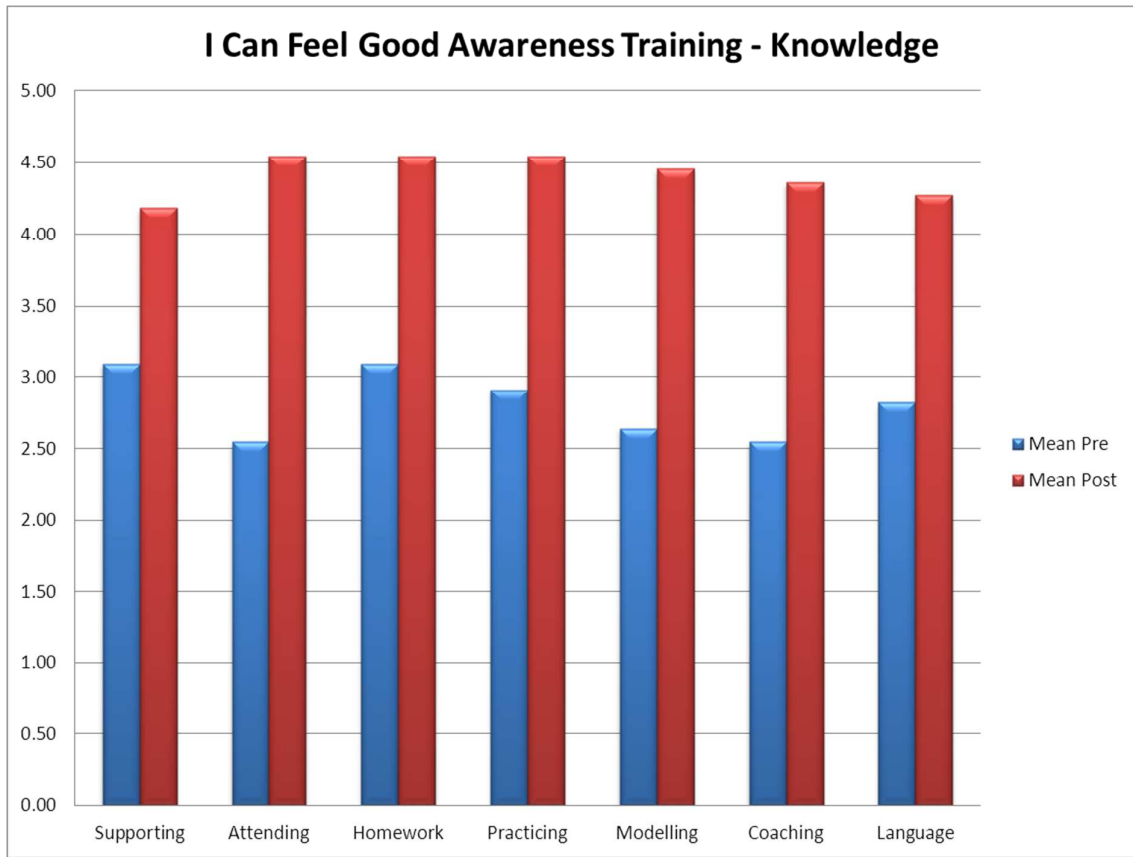


Figure 2: Knowledge

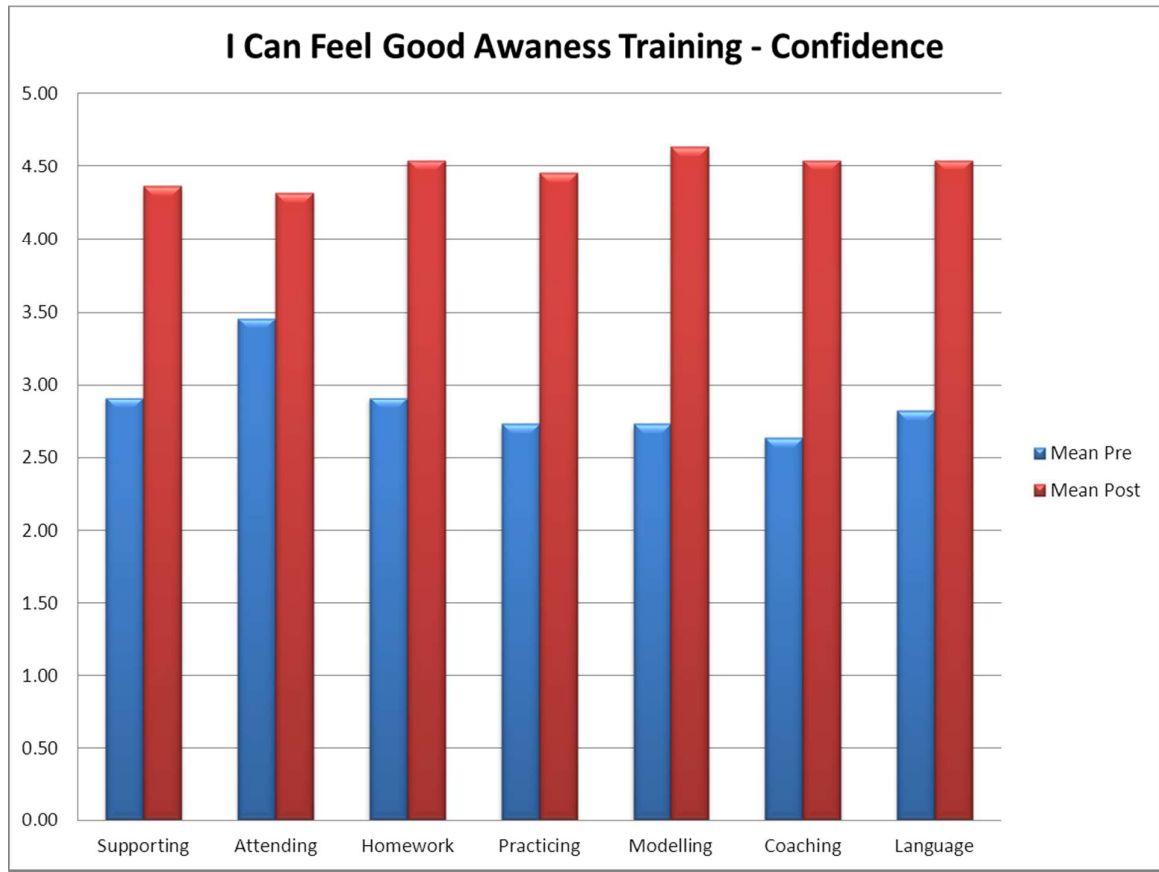


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Figure 3: Confidence



Review

Figure 4: Motivation

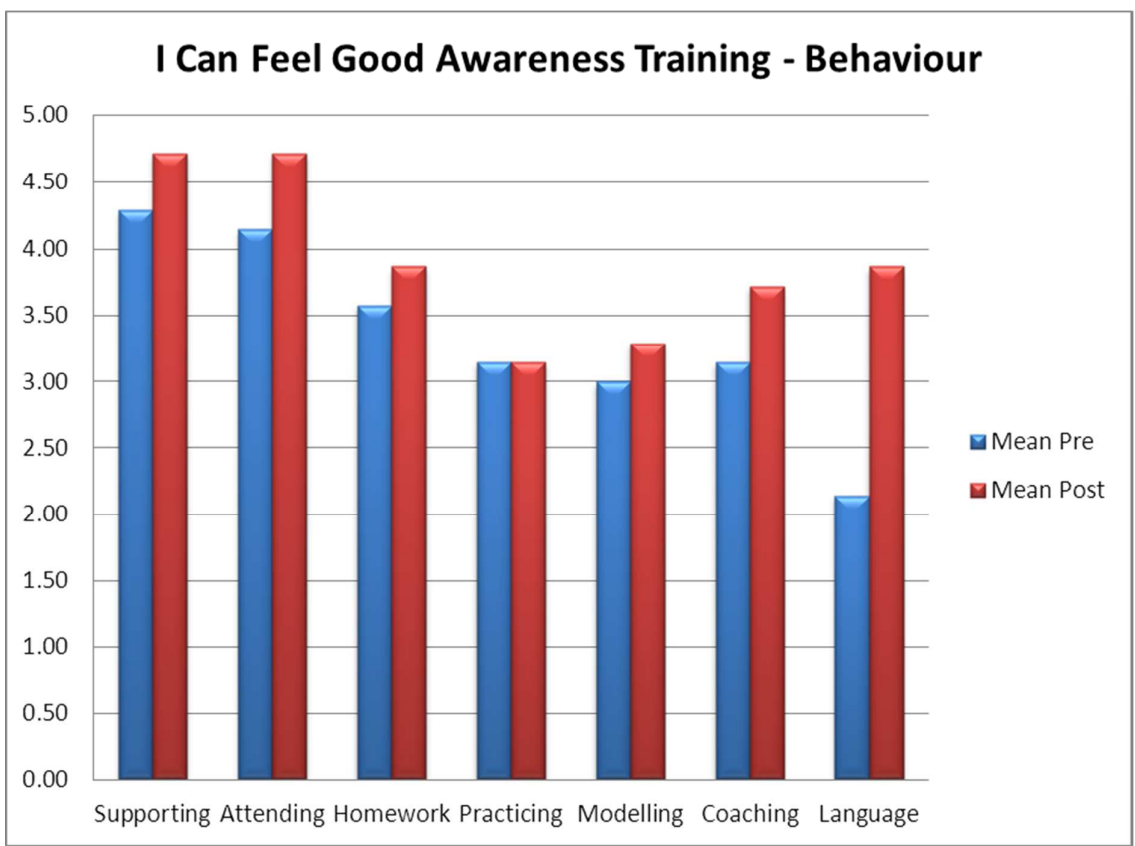


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Figure 5: Behaviour



Review