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 at al., 2007), social factors such as difficult life experiences (Taylor, Lindsey & Willner, 2008), low social status and financial difficulties (Prout & Schaefefr 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 at 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,
Matta, Tripp-Tebo & Watts, 2006; Sakdalan, Shaw & Collier, 2010). Morrissey and Ingamells (2011) developed and piloted an adapted DBT programme suitable for men with mild ID with a high secure service entitled ‘The I Can Feel Good’ programme. It combines a psychoeducation approach with cognitive behavioural techniques developed to meet the needs of a male forensic population with ID.

In light of the recommendations regarding continuation of treatment along the care pathway (Morrissey & Ingamells, 2011), the adapted DBT skills training programme, the ‘I Can Feel Good’ group, has been piloted within a Medium Secure Learning Disability Service. Morrissey and Ingamells (2014) highlight the vital role staff members play in facilitating skill generalisation through the DBT mode of ‘Coaching’ (Linehan, 1993) in their manual introduction. Therefore a staff awareness training package was developed.

The aims of the training were considered prior to development in order to develop effective training materials (Dayal, 2001). It comprised of increasing ward based staffs'; general awareness of the programme; understanding of the group content, language and materials; motivation and ability to support patients in their application of skills developed on the programme. It aimed to combine a facilitative and a directive approach (Bee & Bee, 1998) additionally maximising experiential learning in light of a review by Prince (2004) suggesting active learning maximises teaching effectiveness.

Training evaluation was based upon the Kirkpatrick’s (1976) hierarchical model of course evaluation, specifically focusing upon the initial three levels at this stage; reaction, learning and behaviour. Follow up evaluation regarding the final level is considered possible at a later date but is not included here.

This paper aims to follow Swanson and Sleezer's (1987) evaluation model; describing the training design and event, the evaluation plan and evaluation tools, the training impact and feedback.

**Training Needs Analysis**
Anecdotally, following commencement of the ‘I Can Feel Good’ programme, it became apparent that there was a staff level knowledge deficit regarding the programme aims and content. This was evidenced by; staff members’ lack of awareness regarding the programme in discussion on ward; staff members’ lack of motivation and confidence to support or attend the group; group member feedback regarding their experience of lack of support regarding out of session tasks or skill practice. As group facilitators this highlighted a clinical need related to increasing staff ability to positive affect the programme efficacy.

As part of the training package evaluation, staff completed a pre training questionnaire designed to highlight the potential training need. Based upon Donovan and Townsend’s (2004a) training needs analysis guidance the self-report questionnaire was developed to assess the three areas of knowledge, confidence and motivation relating to seven factors considered relevant to the ‘I Can Feel Good’ programme.

This demonstrated a deficit in staff knowledge regarding the programme (specifically regarding; how they could attend the group; how they could model and coach group members in the use of skills) with a relatively elevated response regarding motivation.

These results highlighted a training need and the specific combination of low knowledge and high motivation demonstrated a potentially effective and receptive training environment.

Training Design

Content

The training was designed to meet the need identified by the facilitators of the ‘I Can Feel Good’ group concerning the staff lack of awareness regarding the group programme. The aims of the programme were considered and outlined at the beginning of the training to facilitate goal attainment in line with cognitive theory principles (Knowles, Holton & Swanson, 2005). They were based upon
recommended structure provided by Donovan and Townsend (2004a) and are as follows:

- **Knowledge** - staff will demonstrate an increased knowledge of the group content, terminology and process on ward when in discussion with patients.

- **Confidence** - staff will feel more confident in supporting patients complete out of session work, encourage patients to practice their skills, role model appropriate behaviours and coach patient to use techniques and skills developed on the programme.

- **Motivation** - staff will demonstrate an increased willingness and motivation to engage, support and facilitate the running of the programme.

Based upon the facilitator training delivered previously at a High Secure service (Ingamells, 2011), the training package followed the structure of the group programme. It was designed to provide an understanding of the programme’s construction. It included an introductory module including details regarding the programme’s theoretical background. This was followed by a module focusing upon each of the programme’s four modules; Mindfulness, Managing Feelings, Coping in Crisis and People Skills. This training package attempted to emulate this structure.

An introductory theory base was included along with rationales for the group and the training package, outlining the aims of the training session. Additionally, information and evidence to support the group’s effectiveness within the intellectual disability population, was provided. This aimed to increase trainees’ enthusiasm regarding learning about the programme and becoming involved both aims of the training. This has been shown to sustain willingness to utilise training knowledge and transfer skills to their role (Tabassi, Mahyuddin & Hassan, 2012).

An increase in knowledge regarding programme effectiveness was thought to increase staff member’s self-efficacy when considering the impact of their involvement, which has been shown to effect training outcomes (Saks & Haccoun, 2007). Therefore, we attempted to increase the training effect upon increasing staff
motivation by providing information regarding the programme outcome data, highlighting the importance of their involvement.

A summary section exploring potential practical application techniques regarding the knowledge and skills developed through this training package was also included to help facilitate consideration of this aspect, as use of organisational examples with training has been shown to facilitate training transfer (Burke & Baldwin, 1999).

The following seven factors were considered central to the aims of the training encouraging staff involvement and expressly covered.

- **Encouraging group support** - Following on from providing group awareness it was hoped that this knowledge would be used to help support group to run, ensuring patients were ready on time, had the correct materials and were prepared.

- **Encouraging group attendance** - Initially by providing awareness training it was hoped ward based staff would be encouraged to become involved by attending group sessions regularly, observing the topics covered and skills being developed. It has been shown that individuals accompanied to treatment by carers made better progress than those who attended alone (Rose, Jenkins, O’Conner, Jones & Felce, 2002; Rose, Loftus, Flint & Corey, 2005). It was hoped that by having ward based staff members attending the group we may be able to increase the effectiveness of the programme. By proving this information within the training it was hoped that staff motivation to attend would increase which has been suggested to increase training outcomes positively (Noe, 1986).

- **Homework** - An important part of many structured psychotherapies is the setting, completion and review of homework (Lindsay, Jahoda & Willner, 2013). The importance of this within programmes designed for the ID population is essential but potentially more problematic due to difficulties regarding understanding and recall. Lindsey et al. (2013) highlight the importance of involving carers in homework completion and encouraging
successful implementation of behavioural and cognitive techniques, developed during the programme, in real life settings.

- **Skill Rehearsal** - Brown and Marshall (2006) highlight individuals with ID may experience difficulty transferring skills to everyday life. Ward based staff receiving training regarding the programme content, will be encouraged to support patients to implement and practice their skills. This encouragement will reinforce the use of skills and increase the effectiveness of the programme.

- **Modelling** - It was thought that by highlighting the sorts of behaviours we were attempting to encourage within the group (i.e. assertiveness from the People Skills module) within the training programme it would provide the staff with the understanding and motivation to model these types of behaviour on ward.

The use of supported role-play within psychological intervention for individuals with ID has been advocated (Brown et al, 2006; Brown & Marshall 2006) in order to demonstrate skills practically and allow for experiential learning. By observing staff practicing these role-plays both in group and potentially on ward, patients’ use of the skills may become more effective.

- **Coaching** - One of the four modes of DBT outlined by Linehan (1993) is that of ‘coaching’, along with ‘skills training’, ‘individual therapy’ and ‘team consultation’. ‘Coaching’ refers to combining feedback and instructions on how to put a certain skill into practice. Generally this is implemented with phone contact between the client and the individual therapist.

There is often consideration of how to implement the in-the-moment coaching within a secure forensic environment where access to phones (and therapists) can be potentially limited, due to potential risk and boundaries issues. One way this has been suggested to be operationalised within a secure inpatient forensic setting is to train the staff (who are available on ward at all times) with the skills to be able to coach the patient in-the-moment. Highlighting this
supports training transfer (Burke & Baldwin, 1999) increasing the likelihood of this occurring.

- **Language** – Training ward staff members, who have a detailed working knowledge the communication needs of group members, may facilitate information adaptation. Especially for individuals with severe cognitive impairments (Brown, Duff, Karatzias & Horsburgh, 2011). Individualised explanations and examples may be prepared with collaboration of ward based staff in addition to in-group interpretation of issues and needs of group members.

An additional training benefit lay in the fact that terminology used within the programme may become part of the ward vocabulary (i.e. the States of Mind). This was informed following previously successful implementation of therapeutic approaches into the ward milieu. RAID® implementation (a relentlessly positive approach to working with extreme and challenging behaviour, Davies, 2013) involved extensive staff training and successful integration of a common vocabulary into the ward environment. A shared language may facilitate transference of skills developed within the group to the ward setting.

**Style**

The package was designed using a combination of a PowerPoint presentation and active tasks to increase engagement (Stuart & Rutherford, 1978) and provide information. This style was decided upon due to findings that suggest learning occurs best in interactive environments that are not based upon a model in which the facilitator acts as the sole transmitter of knowledge (Bransford, Brown & Cocking, 1999). Text displayed on the PowerPoint was kept to a minimum to reduce information overload (Burke & Hutchins, 2007) and key words and phrases were highlighted.

When completing the Instructional Styles Diagnosis Inventory (Cripple, 1996), which is a measure of preferred training styles, it was apparent that the facilitators
preferred style was that of ‘The Coach’. It was reflected this style was suited to the aims of this training; to facilitate learning to perform in new ways, with the focus being upon skill development, application and confidence building.

In line with the Kolb’s (1984) experiential learning theory, activities utilising some of the skills developed followed the theoretical aspect of each module allowing for reflection, application and a snapshot of trainees learning and progress (Stuart & Rutherford, 1978). Some activities were developed using Angelo & Cross’s (1993) Classroom Assessment Techniques as a basis.

This was included to allow for practical application of techniques and to facilitate consideration of how the knowledge developed could be implemented on ward (an aim of the training), supporting training transfer. Additionally this more informal, discursive section allowed for more experiential learning and reflection upon application of the skills in line with Kolb’s (1984) principles.

Additionally, practicing activities from the group programme allowed for experiential learning within an organisational application (Burke & Baldwin, 1999) and a break from theoretical information presentations.

As a form of Personal Response System (Stuart & Rutherford, 1978) an end of day Pub Quiz element was included which allowed for a dynamic, enjoyable way of testing immediate recall of the training material whilst ending the training on a pleasant note, with prizes available for the ‘winning team’.

**Structure**

*Insert Table 1 here*

**Training Event**

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

**Facilitators**

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

**Event**

The training was designed to cover one day and was delivered twice, over two dates provided, following discussion with the management staff to facilitate maximised attendance. The training content covered 6 hours in total (including 1 hour break time in total) but periods were allocated prior to commencing the training and post completion to allow for completion of the evaluation forms and to allow for a flexibility of individuals arriving late and time for questions and feedback (2 x 15 minutes) therefore training was schedules to commence at 09:30 and conclude at 16:00.

It took place in the training room provided by the organisation and the environment was set up in line with recommendations regarding seating, lighting,
temperature (Townsend, 2003) to maximise training outcomes. Training content was delivered by use of a computer and projector displaying a PowerPoint presentation, in addition a flip chart was utilised for activities and idea generation.

Hand-outs were provided which detailed the PowerPoint presentation (with certain slides removed to aid learning i.e. answers to questions raised throughout the day to encourage peer instruction; Mazur, 1997) and trainees were encouraged to make notes.

Breaks were incorporated within the training, allowing for flexibility, to ensure the trainees were comfortable and their needs were catered for (e.g. toilet, cigarette and drink breaks). Additionally, ‘brain breaks’ (Morrissey & Ingamells, 2011) were incorporated into the training to allow the facilitators to respond to a perceived decrease in attention with a stimulating activity (Townsend, 2003) maximise training effectiveness.

**Training Impact and Feedback**

Following a review of evaluation techniques (Donovan & Townsend, 2004b) it was decided that a combination of trainee reaction and perception along with skill and knowledge development would be appropriate. Therefore, training evaluation was based upon the Kirkpatrick (Kirkpatrick, 1976; Kirkpatrick & Kirkpatrick, 2007) ‘four level’ model for course evaluation.

Regarding initial short term effectiveness evaluation, a focus on the first three levels of Kirkpatrick’s model was established. All evaluation tools developed were anonymous and trainees were asked to include a unique personal identification code to match the pre and post evaluation forms. The four levels of Kirkpatrick’s (Kirkpatrick, 1976; Kirkpatrick & Kirkpatrick, 2007) evaluation model are as follows:

**Reaction**

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

- Presentation quality
- Facilitators knowledge
- Relevance
- Usefulness
- Enjoyableness

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

**Learning**

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

- Group support
- Group attendance
- Supporting homework
- Supporting skill rehearsal
- Modelling
- Coaching
- Language use

In light of potential issues with reliability and validity of self-report measures, the impact upon trainee knowledge was additionally assessed by an informal ‘pub quiz’. This was an informal measure of knowledge designed to provide immediate feedback to the facilitators regarding the degree of learning (Stuart & Rutherford, 1978). This was following discussion with the Training and Development team regarding previous reception of knowledge based assessments inhibiting learning and performance due to anxiety. The informal nature helped to make participants feel at ease and free to share their knowledge deficits transparently without the fear 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**
Quantitative - Trainees were asked to rate their experience of the training on a Likert scale from 1-5 (1 indicating poor and 5 indicating excellent), Figure 1 demonstrates the average rating scale for all trainees.

Figure 1: about here

As can be seen the rating of the reaction to the training was very high, verbal feedback supported these findings with trainees making positive comments regarding the applicable nature of the training content and its relevance to their role.

Qualitative - Trainees were asked to provide comments in free text boxes on the evaluation sheets, guided into four areas of; ‘Highlights’, ‘Suggested improvements’, ‘Suggestions for application’ and ‘General comments’. Themes were identified regarding these areas. Feedback appeared to suggest that highlights included role playing and mindfulness practice. Suggested improvements included “more activities” and suggestion training could be “narrowed down”. Suggestions for application seemed focused upon using skills learned within ward based interactions. Finally general comments overall were positive and included “excellent delivery”, “good interactions, passionate and skilled presenters” and “one of the best sessions off ward I have been to”.

Learning

Trainees were asked to rate, on a Likert scale (1 indicating poor and 5 indicating excellent) their knowledge (Figure 2), confidence (Figure 3) and motivation (Figure 4) regarding the seven factors identified, prior to and post completion of the training. The findings are demonstrated in the graphs below.

Insert Figure 2 here

Insert Figure 3 here

Insert Figure 4 here
As can be seen, there was a self-reported increase regarding all training aims across all factors. When the data was studied more closely the increase appeared to be relatively consistent across the three training aims of knowledge, confidence and motivation and across the seven factors.

Skewness and kurtosis values were obtained regarding each of the independent variables (scores regarding aims: knowledge, confidence, motivation) to explore the normality of the data prior to analysis. Results indicated that all skewness values were under 3.29 at the p < .001 alpha level recommended for a small sample size (Field, 2013). Kurtosis values were also not significant at the p < .001 level therefore data was analysed parametrically.

Three paired samples t-tests were conducted to compare pre and post training scores regarding the three aims. The difference between the scores regarding knowledge pre training (M = 2.81, SD = 0.83) and post training (M = 4.42, SD = .53) was found to be significant; t(10)= -6.31, p < .001. The difference between the scores regarding confidence pre training (M = 2.88, SD = 1.0) and post training (M = 4.49, SD = .57) was found to be significant; t(10)= -4.67, p = .001. The difference between the scores regarding motivation pre training (M = 3.13, SD = 1.06) and post training (M = 4.51, SD = .69) was found to be significant; t(10)= -4.5, p = .001.

These findings demonstrate the training day had a significant impact upon the three training aims of knowledge, confidence and motivation.

Additionally, following the ‘Pub Quiz’ element it was apparent that learning had occurred; with all four teams obtaining 22.5 out of a possible 40 points (around 56%). demonstrating similar learning across teams and training days. It could be concluded that a consistency in knowledge acquisition and quiz performance had occurred as a result of the training, meeting the aims objectified.

**Behaviour**

Group members and facilitators were asked to rate staff behaviour on a 5 point Likert scale (1 indicating poor and 5 indicating excellent), across the seven training
aims prior to and following a one month follow up period post training to observe if there had been a notable change in the perception of staff behaviour in general as a result of the training. The graph below (Figure 5) demonstrates the findings of this evaluation tool.

*Insert Figure 5 here*

Skewness and kurtosis values were obtained regarding behaviour across the seven factors as a whole to explore the normality of the data prior to analysis. Results indicated that all skewness values were under 3.29 at the $p < .001$ alpha level recommended for a small sample size (Field, 2013). Kurtosis values were significant ($p < .001$) therefore data was analysed parametrically.

A paired samples t-test was conducted to compare pre and post training scores regarding behaviour. The difference between the scores pre training ($M = 3.35$, $SD = .78$) and post training ($M = 3.9$, $SD = .91$) was found to be non-significant; $t(6) = -2.43$, $p > .05$; demonstrating that there was no statistically significant impact of training upon behaviour.

However, as can be seen (Figure 5) there was an increase in perceived staff performance across six of the seven factors, mainly regarding the language used by staff. This suggests trainees have been able to implement their learning behaviourally regarding their clinical work. However there has been no perceived increase in staff supporting patients to practice their skills. This will inform future training of staff, perhaps highlighting this as an important application of the skills learned.

**Conclusions and Reflections**

In conclusion, from the tools developed and utilised, the training seemed to have had a positive impact upon all identified training aims.

There was limited constructive or negative feedback via the evaluation tools despite prompts to include suggestions for improvement. This may limit my ability to
improve the package based upon such trainee feedback. This may have been due to my being an internal staff member and concerns about criticising my practice if we had to then work together inhibiting feedback. Future training may benefit from being facilitated by an external trainer possibly allowing for more open and honest evaluation feedback.

For future delivery, preparation regarding developing my knowledge of how the audio-visual equipment works rather than reliance upon technical staff would be beneficial to a smoother running of the training. Additionally, in light of the behavioural impact findings, the training package may benefit from more focus upon staff modelling the skills, supporting patients with their homework and skill practice.

Potential involvement of group members within the training package development or even delivery may be beneficial to enhance training application to ward based situations, whilst also enhancing the ‘Coaching’ (Linehan, 1993) element of the programme (Morrissey & Ingamells, 2014).

More long term evaluation of the training’s effectiveness may be possible in the follow up months extending to the final level of Kirkpatrick’s evaluation model (Kirkpatrick, 1976; Kirkpatrick & Kirkpatrick, 2007).

This paper has wider implications of practice regarding the importance of development, implementation and evaluation of staff awareness training regarding the psychological interventions designed for ID populations. The potential for greater staff awareness regarding psychological models, approaches and interventions to positively impact upon the efficacy of psychotherapeutic intervention is highlighted here.

This has been highlighted as a key element to increasing the effectiveness of psychological interventions used specifically with ID populations (Morrissey & Ingamells, 2014). This paper demonstrates how if effort is placed into facilitating such training, staff members feel more knowledgeable, confident and motivated to support effective running of such psychological interventions with ID populations.
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Tables and Figures

*Table 1: Training Structure*

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

*Figure 1: Reaction*
Figure 2: Knowledge

![Graph showing knowledge improvement](image-url)
Figure 3: Confidence

![Confidence Chart]

Legend:
- Mean Pre
- Mean Post
Figure 4: Motivation

I Can Feel Good Awareness Training - Motivation

- Mean Pre
- Mean Post

- Supporting
- Attending
- Homework
- Practicing
- Modelling
- Coaching
- Language
Figure 5: Behaviour

![Graph showing changes in behaviour](image)

**I Can Feel Good Awareness Training - Behaviour**

- Mean Pre
- Mean Post
Tables and Figures

Table 1: Training Structure

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

Figure 1: Reaction

I Can Feel Good Awareness Training - Reaction

- Presentation Quality
- Facilitator Knowledge
- Relevance to your job
- Usefulness
- Enjoyable
Figure 2: Knowledge
Figure 3: Confidence

![Bar chart showing I Can Feel Good Awareness Training - Confidence](image)
Figure 4: Motivation

I Can Feel Good Awareness Training - Motivation

- Supporting
- Attending
- Homework
- Practicing
- Modelling
- Coaching
- Language

- Mean Pre
- Mean Post
Figure 5: Behaviour

I Can Feel Good Awareness Training - Behaviour

Supporting  Attending  Homework  Practicing  Modelling  Coaching  Language

Mean Pre  Mean Post