An evaluation of the Moving Forward Making Changes training programme in the community

Moving Forward Making Changes

End of study report

RMA

Risk Management Authority

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EXECUTIVE SUMMARY

Background
The Moving Forward Making Changes (MF:MC) programme was implemented across Scotland's criminal justice face in 2013/2014. In contrast to previous interventions, MF:MC is based on the principles advocated by the Good Lives Model (GLM) (Ward & Stewart, 2003), the Risk Needs Responsivity approach (Andrews & Bonta, 2007) and desistance theory (McNeil, 2010). While evidence suggests that the GLM approach may be associated with a reduction in reoffending, the MF:MC programme has not been evaluated to date. To this end, the Risk Management Authority (RMA) has been commissioned to provide quality assurance and support the evaluation of the effectiveness of the programme in the community in collaboration with other stakeholders. In line with Kirkpatrick (1994) and Gendreau and Andrews' (2006), the evaluation of training and learning within 'real life' is essential in informing future outcomes of effectiveness.

Aims
This project aimed to systematically evaluate the learning experience of the MF:MC training delivered to community justice practitioners across Scotland.

Methods
Twenty-nine Criminal Justice social work staff across a number of staff levels were interviewed to inform a Scotland wide survey. The survey was completed by n = 124 staff across different MF:MC related disciplines (treatment manager, line manager, group facilitator and case managers).

Main findings
The overall results suggest that most participants had favourable opinions on the MF:MC programme. There are clear differences between staff groups, in particular between (1) treatment managers, group facilitators vs (2) line managers, case managers in reference to the overall training experience, the reality of applying MF:MC in practice, and the self-report ratings of learning retained and competencies in delivery. This noted, there was an overarching agreement that all staff felt their contribution to MF:MC was important, and all staff indicated an understanding for the introduction of MF:MC in practice. Caution is required when considering these findings as this study did not collate any corroborative evidence from participants' practice.

Main conclusions
This study has identified a clear need for revising various aspects of the MF:MC training materials and the manuals. Those who are required to deliver the programme particularly highlighted that the language employed in the manuals was not fit for purpose, and that the manuals lacked clarity in structure, processes and procedures.

Recommendations

Training

1. To revise the language and minimise the jargon used in the MF:MC manuals and training materials (including exercises and worksheets for clients), in particular the case managers' materials.
2. To include practical examples in all MF:MC training.
3. To consider annual MF:MC refresher training.
4. To monitor learning outcomes and competencies following MF:MC training.
5. To revise the MF:MC line manager training to increase understanding of the various work aspects case managers undertake.
6. To consider MF:MC training for treatment managers on operational aspects of MF:MC, e.g. in relation to supervision of level 1 and level 2 group facilitators.

Assessment

7. To clarify the assessment and maintenance pathways of level 1 and level 2 practitioners.

Quality assurance

8. To facilitate an MF:MC facilitator/expert in each area who should act as the main point of liaison regarding all MF:MC issues and challenges.
9. To consider conducting regular local audits and review of case managers' MF:MC pre-programme work prior to clients starting MF:MC group.
10. To consider regular local audits and review of staff eligibility to attend MF:MC training.

TABLE OF CONTENTS

	Page
Introduction	6
Aims	7
Research Questions	7
Methods	7
Data analysis	9
Results	9
Discussion	15
Limitations	17
Future research	18
Conclusion	18
Recommendations	19
References	21
Appendix	22

An evaluation of the Moving Forward Making Changes training programme in the community

INTRODUCTION

The Moving Forward Making Changes (MF:MC) programme is a treatment programme aimed at adult sex offenders across the Scottish prison service and the community. The model is partly based on the principles of the Good Lives Model (GLM) (Ward & Stewart, 2003), but has been adapted to apply to offenders within a Scottish context. When considering the theory, both the GLM and the MF:MC programme suggest that offending behaviour needs to be addressed within a holistic framework, i.e. embedded in the individual's social, cultural and physical everyday context. Ward and colleagues (2007) argue that criminogenic needs, i.e. dynamic risk factors amenable to intervention, are obstacles to achieving a good life. In this way, people are considered as active, goal seeking beings who attempt to attain basic goods which are intrinsically linked to their well being. With this in mind, it is suggested that offending behaviours such as inappropriate sexual behaviour are used to meet these basic goods or needs.

Operationally, the MF:MC programme employs a rolling format. This means that clients enter the programme and engage in a variety of modules ranging from mandatory core aspects to optional specialist areas. The programme operates outwith a pre-determined timescale or sequence of sessions. This means that each individual's treatment pathway is considered and followed up as required. This is further endorsed as suitability and need for modules are decided upon in collaboration with the client. Equally, personal barriers and incentives to achieving a good life are discussed with the client to the extent that clients are empowered to feed directly into their own good lives plan. The programme is primarily delivered by a group of trained facilitators; case managers are actively involved in the process of preparing and supporting clients on their journey through the programme. Practically though, facilitators attend an intensive three week course covering all core and optional aspects of the programme including sessions on theoretical underpinnings to MF:MC while case managers attended an abbreviated three day training event.

The RMA has been contracted to evaluate aspects of MF:MC including the implementation and the evaluation of learning. The RMA is represented on the MF:MC Project Implementation Board and is working with colleagues in the Scottish Government and Scottish Prison Service regarding the tender process for the longer term evaluation of the effectiveness of the programme. In addition, the RMA provides quality assurance to the delivery of the programme and co-ordinates the provision of clinical support to practitioners until the end of March 2016. With this in mind, the present study summarised results from a learning evaluation based on Kirkpatrick's (1994) learning and evaluation framework in order to inform future MF:MC training and quality assurance.

Rationale

The literature supports Kirkpatrick's (1994) learning and evaluation framework as a useful and suitable tool to consider the effects, or lack thereof, of training and implementations across organisations (Homklin, Takashi & Techakanont, 2013). This has proved to be a useful and effective approach as demonstrated in the RMA led implementation of the LS/CMI across Scotland. Kirkpatrick's framework maps specific assessment points along an implementation timeline. In brief, there are four levels:- reaction, learning, behaviour and results.

Aims

(1) To evaluate the MF:MC training following consolidation of training.
(2) To assess the ecological validity of the training material.
(3) To identify barriers in real life to the application of training material.
(4) To collate suggestions for improvement/amendment in the training material.
(5) To utilise results of this study to inform the analysis of further MF:MC evaluations.

Research Questions

- What are the perceived strengths and shortcomings of the MF:MC training when applied to practice?
- What are the barriers, if any, to the application of the MF:MC training to practice?
- What are suggested improvements, if any, to future MF:MC training waves?

METHODS

Design

This evaluation employed a mixed methods design. In-depth semi-structured interviews were conducted with the primary purpose to inform the design of a Scotland-wide survey.

Ethical approval

The Research and Training Committee at the Risk Management Authority approved this study as a service evaluation. Therefore ethics approval was not required.

Inclusion Criteria

Only Criminal Justice Social Work staff who had attended MF:MC training were eligible for inclusion in this study.

Participants

Interview Participants

The sample consisted of 29 participants recruited across all eight Criminal Justice Areas in Scotland. Table 1 outlines the number (%) of interviewees across the four staff groups.

Table 1 Number (%) of interviewees pre-survey

Staff role	Number (%)
Treatment managers	7 (24.1%)
Group facilitators	8 (27.7%)
Line managers	7 (24.1%)
Case managers	7 (24.1%)

Survey Participants

Out of a possible pool of approximately 313 trained MF:MC Criminal Justice Social Work staff, 124 (39.6%) completed the survey. The original sample was n = 128, however four individuals did not provide any information over and above their demographics. These were therefore excluded from the analysis.

Table 2 outlines a breakdown of responses per CJA. The majority of responses were received from two CJAs, i.e. CJA 2 and CJA 6 account for 42.7% of all responses collected in this study.

Table 2 Number (percentage) of responses per subgroup and per CJA for the full sample

Response	CJA 1	CJA 2	CJA 3	CJA 4	CJA 5	CJA 6	CJA 7	CJA 8	Total
Case managers	10	25	1	5	14	6	4	9	**74 (59.7%)**
Line managers	2	4	1	2	5	2	--	1	**17 (13.7%)**
Treatment managers	1	2	1	--	--	1	1	2	**8 (6.4%)**
Group Facilitators	4	1	2	3	2	7	2	1	**25 (20.2%)**
Total	**17 (13.7%)**	**32 (25.8%)**	**5 (4.1%)**	**10 (8.1%)**	**21 (16.9%)**	**16 (12.9%)**	**7 (5.6%)**	**16 (12.9%)**	**124**

Gender and age

The majority of respondents were female (n = 93, 75.0%), and were aged between 30 and 59 years (n = 108, 87.1%). In terms of age distribution, about one third reported to be 30 – 39 years (n = 36, 29.0%), 40 – 49 years (n = 39, 31.5%) and 50 – 59 years (n = 33, 26.6%) old respectively.

Previous training and skills

Group work skills

One quarter of participants (n = 32, 25.8%) reported to have had no previous group work training skills. Of these, four (12.5%) were group facilitators. Of those who reported training (n = 92), three quarters (n = 68, 73.9%) had attended CSOGP, 39 (42.4%) had been trained in Caledonia and one third (n = 26, 28.3%) stated they had completed Constructs training.

Working with clients who sexually offend

The majority of participants (n = 119, 96.0%) reported to have worked with sex offenders prior to attending MF:MC training. Three in five (n = 75, 63.0%) stated they had worked with sex offenders for more than five years – 45 of these 75 (60.0%) had more than 10 years' experience in the field. Those who had not were exclusively case managers.

SA07 and LS/CMI training prior to MF:MC training

Most respondents (n = 110, 88.7%) reported to have had Stable and Acute 2007 training. Those who negated included three group facilitators and eight case managers. The majority of the sample (n = 120, 96.8%) had LS/CMI training.

Procedure

Pre-survey Interviews

Prior to commencing the study, all service managers across CJAs were contacted and informed about the study. Approval was sought to approach all treatment managers in CJAs and recruit these to be gatekeepers. All service managers were given the opportunity to ask questions and raise concerns where relevant. Following approval, an information sheet (appendix 1) was disseminated with the purpose of treatment managers nominating eligible interview staff. That is, treatment managers identified one case manager, one line manager, one group facilitator and one treatment manager per CJA who had completed the appropriate MF:MC training. These staff then either contacted the research team, or the treatment managers provided required names and contact details to the research team to initiate contact. Of all nominated staff, all agreed and participated in the study with no exceptions, i.e. the response rate was 100.0 per cent. Both, the research assistant and the research lead conducted interviews (albeit separately). The majority of interviews were carried

out by the research assistant. Consistency in interview approach was ensured by utilising a recruitment script (appendix 2). All interviews were conducted in the relevant interviewee's work place, i.e. in a private office or meeting room. All interviews were tape-recorded and transcribed verbatim. Prior to interview commencement, all participants received written and verbal information on the study, its purpose and procedures, and opportunity was given if questions arose, and all interviewees were asked to sign a consent form (appendix 3).

Survey

Following utilisation of the interview results in the design and development of the survey, treatment managers acted as gatekeepers in the survey, i.e. circulating the survey to eligible participants and initiating/maintaining recruitment momentum. The research team primarily liaised with the treatment managers in that reminder emails regarding the purpose and function of the survey were sent to treatment managers who then circulated these wider to increase the response rate. An information sheet (appendix 4) was provided as part of the survey, which was conducted via an online provider 'Survey Monkey' which has been utilised by the RMA before (LS/CMI evaluation). Before starting the survey participants were required to give informed consent in order to move on and start the survey. The survey was anonymous and confidential.

Measures

For the purpose of this study a semi-structured interview schedule was developed (appendix 5). The results of the interviews were used to inform a survey with a core component collecting information on demographics, and a variable component assessing participants' learning and training experience according to job level (treatment manager, group facilitator, line manager and case manager). That is, the questions were similar across all staff groups, though equally reflected the specific themes that emerged in each interview group. The survey consisted of a combination of Likert-type questions (typically utilising a 5-point Likert scale ranging from strongly agree to strongly disagree) and open ended questions.

Data Analysis

Qualitative interviews and open-ended questions in the survey were analysed using Thematic Analysis (Braun & Clark, 2013) to identify patterns across all interviews. Quantitative data were analysed using SPSS V16.0.

RESULTS

The results focus on the survey only. Shared learning experiences (i.e. where the same survey questions were asked across all participants) are presented for the full sample. Staff-specific results, i.e. per sub sample (treatment manager, group facilitator, line manager and case manager) are also presented. None of the data are normally distributed.

Shared perspectives on MF:MC training

Two in five participants (n = 53, 42.4%) indicated they were satisfied with the received training, ranging from very satisfied (n = 3, 2.4%) to satisfied (n = 50, 40.0%). One quarter of the sample chose a neutral stance (n = 32, 25.6%) while 23 (18.4%) respondents indicated they were dissatisfied with the MF:MC training (including n = 3, 2.4% who were 'very dissatisfied'). Table 3 provides further data on shared perceptions on the programme's characteristics, organisation and impact on trainees.

Table 3 Shared perspectives on MF:MC training

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**	**missing**
I came away from the training enthused about the programme.	11 (9.8%)	**45 (40.2%)**	43 (38.4%)	10 (8.9%)	3 (2.7%)	12
The training was good at linking the theory behind MFMC to practice.	7 (6.1%)	**57 (49.6%)**	31 (27.0%)	16 (13.9%)	4 (3.5%)	9
The manual is difficult to understand at times.	20 (18.9%)	**44 (41.5%)**	26 (24.5%)	16 (15.1%)	--	18
I am not clear about the rationale for introducing MF:MC.	4 (3.7%)	10 (9.3%)	17 (15.9%)	**56 (52.3%)**	20 (18.7%)	17
From what I have seen MF:MC works better than CSOGP.	18 (17.1%)	29 (27.6%)	**49 (46.7%)**	8 (7.6%)	1 (1.0%)	19
My contribution to making MF:MC work is important.	39 (36.4%)	**55 (51.4%)**	10 (9.3%)	2 (1.9%)	1 (0.9%)	17

In contrast to treatment managers and group facilitators, more line and case managers tended to favour a neutral stance in response to statements.

RESULTS OF SUBGROUPS

Summary of results of Treatment Managers (n = 8) (Appendix 6, table 8 and 9)

The mean time period between treatment managers' training and MF:MC being delivered in relevant areas was 10.1 months (SD = 4.9) ranging between 6 and 21 months. Five participants (62.5%) documented they were directly involved in the delivery of MF:MC, e.g. as group facilitators.

The general tendency of responses was positive in that treatment managers indicated favourable opinions on the make up of the MF:MC programme per se. For example, most enjoyed the skills practice exercises (n = 6, 75.0%) though most (n = 7, 87.5%) noted that the training should have been role specific. In line with this, most felt undervalued at the training (n = 5, 62.5%) and that the training had been poorly organised (n = 6, 75.0%). All treatment managers expressed positive views in the adequacy of MF:MC training for their group facilitators, i.e. group facilitators were thought to be confident in using MF:MC with clients (n = 8, 100.0%). While the *purpose* for having introduced level 1 and level 2 practitioners in MF:MC was clear to half (n = 4, 50.0%), the *utility* of this approach was questioned (n = 4, 50.0%) with three treatment managers (37.5%) opting for a neutral stance.

Summary of Group facilitators results (n = 25) (Appendix 7, table 12 and 13)

Most group facilitators reported to have been assessed as level 1 (n = 16, 64.0%). The mean delay between group facilitators' training and delivery was 6.0 months (SD = 4.2) ranging between less than one month to one year and three months.

Group facilitators' experience of the MF:MC training tended to be positive. Most (n = 15, 60.0%) felt confident using MF:MC with clients after receiving the training. Though one third of group facilitators (n = 7, 30.4%) understood the purpose of level 1 and 2 practitioners in theory, 10 (43.4%) respondents questioned the utility of this distinction in practice. This is further reflected in most respondents (n = 13, 52.0%) considering the assessment of facilitators as level 1 and 2 as unhelpful. One third of

group facilitators (n = 7, 30.4%) reported that at times clients started group work without having completed all necessary pre-group assignments and sessions.

Summary of results on Line Managers (n = 17) (Appendix 8, table 16 and 17)
All except for one person had attended the MF:MC line manager awareness day. This person did not complete any of the questions on experiences and perceptions of the training, and is therefore not included in this analysis.

Though the content of the awareness day was mostly thought to be relevant to the line managers' role (n = 11, 68.8%), the majority of line managers did not feel that they had been prepared for supporting their case managers in delivering MF:MC (n = 11, 68.7%). Likewise, about one third of line managers (n = 5, 35.7%) believed that their case managers were not confident in using MF:MC with clients.

Line managers' perspective of the MF:MC case manager training
Five line managers (29.4%) also attended the case manager training days; all indicated the MF:MC case manager training was useful to their role as a line manager. This, however, did not mean that the case managers' training prepared line managers for MF:MC in practice as only one respondent gave a favourable opinion. Table 4 provides further information.

Table 4 Line Managers' perspective of case manager MF:MC training

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**
I came away from the case manager training enthused about the programme.	1 (20.0%)	1 (20.0%)	**3 (60.0%)**	--	--
The case managers' training did not prepare me for MFMC.	--	1 (20.0%)	**2 (40.0%)**	1 (20.0%)	--
The case managers' training was good at linking the theory in practice.	--	**4 (80.0%)**	1 (20.0%)	--	--
I found attending the case managers' useful for my own role.	1 (20.0%)	**4 (80.0%)**	--	--	--

Summary results of Case Managers (n = 74) (Appendix 9, table 20 and 21)
All except for two case managers (2.7%) stated they had completed either the national (n = 29, 39.7%) or regional (n = 42, 57.5%) case manager training. Despite indicating they had not attended any MF:MC training, these two case managers completed all survey sections regarding their experience of MF:MC training, and are therefore assumed to be typographical errors. Those who had attended the national training also tended to complete regional training (χ^2 = 32.366, df = 1, p < .001). It was not possible to calculate the time delay between case manager training and applying MF:MC to practice as only three CJAs had provided data on when case manager MF:MC work had commenced in each area.

Most statements regarding MF:MC were responded positively in that case managers expressed their understanding of how MF;MC addresses clients' offending behavior (n = 48, 77.4%), most case managers regularly referred back to the training material in practice (n = 51, 78.5%) and most case managers did not feel anxious using MF:MC following training (n = 36, 53.7%). While only two in five (n = 26, 38.2%) felt confident using MF:MC with clients post training, those who attended national training only were more likely to feel less confident (χ^2 = 8.681, df = 1, p < .005) and less prepared for delivery (χ^2 = 4.148, df = 1, p < .05) than those case managers who

had attended regional training. This was also reflected in stated confidence levels following actual use of MF:MC with clients, i.e. those who had only attended national training reported less confidence than those who had received regional training (χ^2 = 7.33, df = 1, p < .01). Perhaps a matter of improvement required is the finding that the majority (n = 42, 67.7%) found the manual difficult to understand, and indeed half of the respondents (n = 30, 50.9%) indicated they had delayed or omitted MF:MC pre-group work.

Support seeking amongst Case Managers
Of those who opted to answer (n = 63), three in five (n = 39, 61.9%) felt supported in their role as case manager. About half (n = 28, 48.3%) indicated they would seek support from a group facilitator, two in five (n = 22, 37.9%) stated they would consult peer case managers with a minority of n = 6 (10.3%) seeking help from their line manager.

Learning Retained and perceived competencies in MF:MC delivery
Treatment Managers (Appendix 6, table 10 and 11)
In terms of learning retained, treatment managers' responses were positively skewed indicating a ceiling effect. Almost all treatment managers considered themselves to have 'full' or 'reasonably good' understanding of the various aspects and components intrinsic to the MF:MC programme. The only modules where some indicated a decay in learning/understanding referred to the Healthy Sexual Function module (n = 3, 35.5%), mindfulness (n = 2, 25.0%), delivery of MF:MC for personality disordered (n = 3, 35.5%) and learning disabled clients (n = 3, 35.5%). This noted, none of the treatment managers indicated they had 'no understanding at all' of any of the modules. When asked to rate the extent of competency with which MF:MC modules are being applied to practice, data are also positively skewed indicating that treatment managers considered themselves 'fully' to 'reasonably' competent in the delivery of MF:MC. In line with learning retained, some treatment managers reported to have 'some' to 'limited competence' in delivering the Healthy Sexual Functioning module (n = 3, 37.5%), MF:MC for learning disabled (n = 1, 12.5%) and personality disordered clients (n = 1, 12.5%).

Group Facilitators (Appendix 7, table 14 and 15)
Most group facilitators reported to have retained a 'full' to 'reasonably good' understanding of the different aspects of MF:MC programme. Whilst predominantly positive, a relatively large proportion (n = 9, 39.1%) of group facilitators felt they had retained 'some understanding' of how to deliver schema work. Equally, figures indicated that delivery of Healthy Sexual Functioning work (n = 9, 39.1%), mindfulness (n = 7, 31.8%), psychometrics (n = 8, 34.7%) and MF:MC to learning disabled (n = 11, 47.7%) and personality disordered clients (n = 12, 52.1%) appeared as a challenge with responses ranging between 'some' to 'no' understanding. In terms of self-rated competence, group facilitators tended to view themselves as predominantly 'fully' to 'reasonably' competent in all aspects of MF:MC delivery. The proportion of participants considering themselves to have 'some' to 'no' competence in some MF:MC aspects reflected the data from learning retained. That is, responsivity aspects such as delivering MF:MC to learning disabled clients (n = 10, 45.5%) and to clients with personality disorders (n = 11, 47.8%), delivering mindfulness (n = 8, 34.7%), the healthy sexual functioning modules (n = 7, 30.3%) and using the MF:MC psychometrics (n = 7, 30.4%) showed lower competence ratings.

Line managers (Appendix 8, table 18 and 19)
In terms of learning retained, line managers indicated positive responses (ranging between 'full' to 'reasonably good' understanding) for the national outcomes and

standards, the Good Lives Model, the RNR approach and group programme work. About half of the sample rated their understanding of MF:MC training aspects between 'some' to 'limited' and 'no' understanding, in particular in reference to the assessment process (n = 7, 50.0%), the assessment of internet offenders (n = 9, 64.3%), knowledge of essential MF:MC group work modules (n = 9, 64.3%), knowledge of optional group work modules (n = 10, 71.3%), maintenance sessions (n = 11, 78.5%), use of mindfulness (n = 8, 54.6%), and use of formulation (n = 8, 57.2%). The line managers' competence ratings reflect their learning retained ratings. The sample viewed themselves as predominantly competent in relation to national outcomes and standards, the Good Lives Model and group programme work. In contrast to learning retained, line managers also rated their competence as 'full' to 'reasonably good' on the assessment process of MF:MC and the RNR approach. More than half of the line managers thought their competence ranging between 'some' to 'none' with reference to the assessment of internet offenders (n = 8, 57.2%), knowledge of essential MF:MC group work modules (n = 9, 64.2%), knowledge of optional group work modules (n = 9, 64.2%), maintenance sessions (n = 9, 64.2%), use of mindfulness (n = 8, 53.3%) and use of formulation (n = 7, 50.0%).

Case managers (Appendix 9, table 22 and 23)
Most case managers felt they had 'full' to 'reasonably good' understanding of national outcomes and standards, the MF:MC assessment process, the Good Lives Model and the RNR approach, the use of mindfulness, and all the pre-group sessions except for precursors to change and the formulation exercise where almost half the sample (n = 28, 45.2% and n = 30, 48.4% respectively) felt they had only 'some' to 'no' understanding. The competence ratings of case managers reflect those of the learning retained. That is, the sample indicated they felt competent (ranging between 'fully' to 'reasonably competent') for national outcomes and standards, the MF:MC assessment process, the use of mindfulness, the Good Lives Model and the RNR approach. Half the sample stated they felt they had 'some' to 'no' competence in the assessment of internet offenders (n = 28, 46.7%), maintenance sessions (n = 32, 52.4%). In terms of competence for pre-group sessions, case managers mostly felt competent with typically less than one third of respondents indicating they had 'some' to 'no' competence.

Open-ended questions
Respondents' descriptions were coded into distinct themes using thematic analysis. Only higher level themes, and only those with the highest frequencies are presented. Those who tended to provide a response to the positive aspects of MF:MC (n = 79) also outlined the challenging aspects of MF:MC (n = 86) and made suggestions for future improvements (n = 64). This association was statistically significant (χ^2= 71.049, df = 2, $p < .001$).

Summary of positive aspects of MF:MC
Of all participants, 79 (63.7%) provided positive feedback on the MF:MC programme. Respondents particularly praised the strength based tone, atmosphere and engagement associated with MF:MC. This included the positive goal setting, the 'working alongside' the clients as well as the increased team cohesion across different disciplines (e.g. case managers and group facilitators). Respondents further pointed to flexibility and the opportunity to individually tailor MF:MC to their clients, thereby using a wider and more therapeutic skill set. These accounts were verified by a number of respondents who noted an observed positive impact of MF:MC on their clients in terms of engagement, motivation and insight. Table 5 provides the overarching themes and number of respondents naming each theme.

Table 5 Positive aspects of MF:MC

Theme	Number (%)
Strength based approach	28 (35.4%)
Individually tailored	19 (24.1%)
Client engagement	15 (19.0%)

Summary of challenges to MF:MC

Eighty-six respondents (69.4% of n = 124) identified their views on challenges associated with MF:MC. Reflecting some of the difficulties identified in the quantitative aspect of this survey, table 6 presents participants' accounts of challenges. In summary, the language employed in the training materials and the manuals was described as difficult. This impacted on the extent to which respondents felt they understood theories and rationales underlying MF:MC components (n = 17, 19.8%) and consequently staff found it difficult to convey these to clients. This was exacerbated by the lack of clear structures and processes in the manuals, in particular in reference to the practical delivery of MF:MC. Associated with this were respondents' frustrations regarding the increase in workload and the added complexities of employing a rolling format. The lack of timescales was also noted as a challenge as this impacted on clients' engagement and motivation as well as difficulties arising from being limited in planning resources and co-ordination of referrals. Of further note is that a number of respondents felt that MF:MC was 'too soft' and 'missing the point', i.e. not sufficiently focused on client's offending behaviour (n = 9, 10.5%).

Table 6 Challenges of MF:MC

Theme	Number (%)
Jargon	20 (23.3%)
Lack of clarity	15 (17.4%)
Uncertain timescales	15 (17.4%)
Rolling format	12 (14.0%)
Increased workload	11 (12.8%)

Summary of suggested future improvements

Of the 124 respondents, n = 64 (51.6%) provided suggestions for future MF:MC training. Table 7 outlines the majority of participants called for revisions to the language to the training manuals and exercise sheets. This was typically linked to suggestions to revise the case manager training and pre-group materials (n = 13, 20.3%), in that participants often felt that practical examples ought to be incorporated in the training materials. The need to have practical aspects reflected spanned across training for all staff. In general, respondents pointed to the need for training to be clearer on how to deliver MF:MC in practice, e.g. for treatment managers and group facilitators. This was also mirrored in six group facilitators' suggestion that the training should be revised to a two week block covering essential ground work, with follow-up workshops (individual or in a one week block) to discuss practical delivery challenges and receive specialist input. While this accounts for less than 10 percent of all respondents, this nonetheless accumulates to one quarter (24.0%) of all group facilitors. Furthermore, respondents felt the distinction and the assessment of level 1 and level 2 practitioners needed improvement. A clearly outlined assessment process, with outlined pathways into maintaining and/or improving skills and abilities on an annual basis were suggested. In line with the notion of annual assessments were participants' calls for annual refresher training, which should incorporate lessons learned since the implementation of MF:MC (e.g. in relation to resources and delivery).

Table 7 Suggestions for improvement

Theme	Number (%)
Revise language/avoid jargon	13 (20.3%)
Practical input MF:MC delivery	11 (17.2%)
Clarification of level 1 and 2	11 (17.2%)
Revision of three week MF:MC training	6 (9.4%)

DISCUSSION[1]

This study set out to evaluate the MF:MC training both in terms of trainees' reaction following the training, self-rated learning retained and competencies, as well as the trainees' reflections following application of MF:MC in practice. To this end, an interview study was conducted with the primary purpose of informing the content of a Scotland-wide survey on criminal justice social workers' experience of MF:MC. Only those who had attended the MF:MC training were eligible for inclusion in this study.

Operational aspects of MF:MC training

Treatment managers criticised the make-up of the training in that the training was thought to have been poorly organised, was too long and the majority indicated the training had not been relevant to their role as treatment manager. In contrast, most group facilitators considered the training to have been well organised and only some thought the training had been too long. Notably, both groups had received MF:MC training over three weeks, yet the structure and delivery of the training had been considerably changed following the treatment managers' training. Both line and case managers attended shorter training sessions (a half day awareness session and a three day course respectively), which most thought to have been well organised and relevant to their role. Equally, most survey respondents expressed favourable opinions regarding their perspective on MF:MC post training. That is, approximately half of the participants indicated they felt enthused following the training, the training had linked theory and practice well and two in five participants stated an overall positive level of satisfaction with the training. This noted, these statements ought to be considered carefully as on average, one third of the full sample chose a neutral point in response to survey questions. This was typically accumulated through line and case managers as treatment managers and group facilitators tended to be more definite in their statements. Of importance is that three quarters of respondents indicated they understood the rationale for introducing MF:MC and the majority (88%) felt that their contribution was important in ensuring that MF:MC 'works'. This is a crucial finding as previous research underlines when staff engagement and ownership are high, cultural changes such as interventions are more likely to be endorsed (Robertson-Smith & Marwick, 2009). This, however, does not necessarily infer that those interventions are also likely to be effective.

Application of MF:MC to practice

All treatment managers indicated their group facilitators were confident in using MF:MC with clients in practice. While there was a general understanding of the *purpose* of level 1 and level 2 practitioners, half of the treatment managers questioned its *utility* in practice. These data are echoed by group facilitators with the majority stating they felt confident engaging with clients within the MF:MC programme. While there were some questions as to how MF:MC addressed clients' offending, most group facilitators welcomed the strength based approach inherent to MF:MC when compared to CSOGP. Similar to the treatment managers, the

[1] The discussion section is based on the results section, i.e. the survey data. For a detailed breakdown of all survey data, please refer to the appropriately labelled tables in Appendix 6, 7, 8 and 9.

distinction of practitioners as level 1 and level 2 was criticized by two in five group facilitators. Most line managers were positive their case managers were confident in applying MF:MC to client work. This was mirrored in case managers' accounts. Line managers also implied that though their staff's workload had increased, staff were engaged with clients and adequately trained to deliver MF:MC. Case managers, however, seemed ambivalent regarding the extent to which MF:MC training had prepared them for practice, and half of the respondents indicated they had at times missed out or avoided sections of the MF:MC pre-group work. This noted, most case managers felt they could access help if they had concerns regarding MF:MC.

Challenges and suggestions for improvement

Reflecting some of the difficulties identified in the quantitative aspect of this survey, participants felt that the language employed in the training materials and the manuals was difficult. This impacted on the extent to which respondents felt they understood theories and rationales underlying MF:MC components and consequently staff found it difficult to convey these to clients. This was exacerbated by the lack of clear structures and processes in the manuals, in particular in reference to the practical delivery of MF:MC. This led respondents to call for revisions to the existing training materials, worksheets and manuals. A particular need to include more practice-based and relevant examples across all training was voiced. For example, one quarter of all group facilitators respondents suggested that the three week training should be revised to a two week block covering essential ground work, with follow-up workshops (individual or in a one week block) to discuss practical delivery challenges and receive specialist input. Furthermore, respondents felt the distinction and the assessment of level 1 and level 2 practitioners needed improvement. A clearly outlined assessment process, including pathways into maintaining and/or improving skills and abilities was suggested.

Learning retained and competence in delivering MF:MC in practice

Utilising Kirkpatrick's (1994) learning and evaluation framework, this study also included sections where respondents were asked to rate the extent to which they had retained learning from the training and the extent to which they felt competent delivering MF:MC components in practice. There seemed to be a clear ceiling effect as the majority of survey respondents indicated high levels of learning retained, ranging between fully to reasonably good understanding of most aspects of MF:MC. This was particularly evident across treatment managers and group facilitators, who notably attended three weeks of training. This said, case managers also indicated a relatively high level of learning retained, and thought themselves reasonably competent in the delivery of MF:MC. It was primarily the line managers who indicated a decay in understanding of most MF:MC aspects and who rated themselves less competent than the other staff groups. Bearing in mind that line managers received the least amount of MF:MC input, this is perhaps not surprising. Additionally, the interview strand of this evaluation (i.e. pre-survey) further highlighted that some line manager interviewees considered their role as that of providing resources and allocating manpower for MF:MC on an operational basis only. Few expressed a wish to support their case managers and understand the impact of the programme on case manager's workload. This seemed to be further supported by the finding that case managers, when seeking support in MF:MC related matters, primarily approached peer case managers. Line managers were hardly sought out for assistance and help.

Areas of concern

Study sample

Some MF:MC trainees (three group facilitators and eight case managers) in this study indicated they had not been trained in the Stable and Acute 2007 (SA07) prior to attending MF:MC training. Additionally, four group facilitators had no previous group work experience prior to MF:MC training. This is in contradiction to the set training eligibility and suitability criteria according to the MF:MC accreditation guidelines.

Time delay between MF:MC training and delivery

This survey asked all participants to document the date they attended MF:MC training, and the date when MF:MC, either pre-group or group work, went live in each area. Based on this, treatment managers were identified with a delay of ten months between training and delivery of MF:MC. This is not in line with the recommendations and requirements set out in the programme accreditation, i.e. delivery is recommended to commence within three months of having received the training. While group facilitators reported a mean of six months delay, on an individual level this ranged between less than one month to more than a year. The possible impact in terms of learning retained and competencies is not known and has not been assessed. Interviewees, however, clearly identified the time delay as a concern, particularly in reference to accreditation of level 1 and 2 practitioners. No data could be provided in relation to case nor line managers.

Non-completion of pre-group work

Further areas requiring remediation is the make-up and language employed in the MF:MC manuals and training materials. Half of the case managers indicated that they omitted or avoided certain aspects of the MF:MC pre-group work due to lack of understanding, clarity and arguably due to lack of time and resources. This was corroborated by group facilitators who noted clients starting the MF:MC group when the required pre-group work had not been fully completed.

MF:MC findings in context

These findings supplement the results gathered by the Scottish Government in a routine evaluation post each MF:MC training session, while the current evaluation also considers participants' views on the actual delivery of MF:MC in practice. It is important to note that the results here reflect some of the implementation challenges experienced prior and during the roll-out of the MF:MC training. For example, the data from treatment managers are likely to be indicative of the fact that this was the first MF:MC training block to be delivered. Perhaps most importantly, these findings must be interpreted with great caution as all data are based on self-report, and therefore cannot be assumed to infer any behavioural evidence. Future research is required to establish the actual competencies that are (a) required and (b) feasibly measured in ascertaining MF:MC is being delivered as per training and as per accreditation criteria.

Limitations

As is the challenge with all research, the sample recruited in this study may not be representative of the wider MF:MC trained taskforce. The recruitment of survey participants took place via gatekeepers, i.e. treatment managers. Though a set of recruitment rules were disseminated, the researchers could not ascertain whether all MF:MC trained staff were approached. While the overall response rate was reasonable (40%), two CJAs had notably provided 40% of all data, meaning that the views and perspectives discussed in this report are not generalisable across Scotland. Also, though the pre-survey interviews ensured the relevance and the practical value of the survey, it is possible that interviewees did not complete the

survey. This may account for the two CJAs where treatment managers did not partake in the survey. While the study provided ample suggestions for revisions to the training, with reference to challenges in the practical delivery of MF:MC, the extent to which MF:MC practitioners meet competencies in reality is not known. Furthermore, though issues were identified in reference to case managers, the sample was biased in that those who had attended the national training were also likely to have received regional training. This means this evaluation is not applicable to those case managers who only received the national training, which had been identified as 'inadequate' by interviewees at treatment manager and case manager level. Additionally, the group facilitators at level 2 were proportionally over-represented in the present study sample, i.e. nine out of a total of 14 (64.3%) level 2 group facilitators across Scotland responded to the survey. This is likely to have biased the group facilitators' results. The variations in how MF:MC is being delivered across the different CJAs could not be controlled for; future evaluations ought to include consideration of the impact of MF:MC in terms of the aims of the programme.

Future research

Future evaluations of MF:MC in practice will be tendered by the Scottish Government. The RMA is involved in suggesting appropriate research questions and possible research foci in liaison with the Scottish Prison Service. Given the call for revisions to the training, some of the processes, the assessment procedures and the language, it is suggested that local authorities continue to monitor the impact of these on the delivery of MF:MC. This could be achieved via implementing a questionnaire based on open-ended questions on trainees' experience of the training. Alternatively, given the high response rate to the interviews conducted in the current evaluation, evaluation data derived from focus groups at the end of each MF:MC training block may be fruitful. Trainees' experience of the MF:MC training should be supplemented by trainers' observations in a structured and standardised format to ensure consistency. These ongoing evaluations are important considering the accreditation requirement of conducting an outcome evaluation of MF:MC five years post the initial accreditation.

Conclusions

This study has identified a need for revising various aspects of the MF:MC training materials and the manuals. Survey participants who are required to deliver the programme particularly highlighted that the language employed in the manuals was not easily understood, and lacked clarity. At the same time, participants indicated high levels of self-rated learning and competencies in delivery, and a strong belief in their contribution and ownership to making MF:MC a success.

RECOMMENDATIONS

Training

1. To revise the language and minimise the jargon used in the MF:MC manuals and training materials (including exercises and worksheets for clients), in particular the case managers' materials.

2. To include practical examples in all MF:MC training.

3. To consider annual MF:MC refresher training.

4. To monitor learning outcomes and competencies following MF:MC training.

5. To revise the MF:MC line manager training to increase understanding of the various work aspects case managers undertake.

6. To consider MF:MC training for treatment manager on operational aspects of MF:MC, e.g. in relation to supervision of level 1 and level 2 group facilitators.

Assessment

7. To clarify the assessment and maintenance pathways of level 1 and level 2 practitioners.

Quality assurance

8. To facilitate an MF:MC facilitator/expert in each area who should act as the main point of liaison regarding all MF:MC issues and challenges.

9. To consider conducting regular local audits and review of case managers' MF:MC pre-programme work prior to clients starting MF:MC group.

10. To consider regular local audits and review of staff eligibility to attend MF:MC training.

OUTCOME SUMMARY

Research Question	Brief summary
What are the perceived strengths and shortcomings of the MF:MC training when applied to practice?	• Participants considered the Good Lives approach, i.e. the focus on positive life goals, and the therapeutic alliance with clients as a major benefit of MF:MC. • Participants also indicated they welcomed the opportunity to apply a wider and more therapeutic set of skills in MF:MC due to the rolling format and the dynamics of MF:MC in practice. • Some respondents noted anecdotal evidence of MF:MC impacting positively on clients, i.e. these seemed to be more motivated, more engaged and responding to the strength based approach of MF:MC. Shortcomings reflected the lack of clarity in training materials and the manuals. The language and jargon used in these were criticised. Not only did this cause frustration to the staff, it was also noted that clients seemed to struggle to understand some concepts due to the language employed in the manuals. • Of concern was that the survey found that case managers (regardless of national and/or regional training) at times omitted pre-group work due to lack of understanding; this was corroborated by the group facilitators.
What are the barriers, if any, to the application of the MF:MC training to practice?	• There were concerns regarding a lack of clarity on the timescales for MF:MC, and operational aspects such as moving on from level 1 to level 2 practitioners and resource planning. • There are further concerns that MF:MC may not be applied as per accreditation criteria in terms of staff accessing MF:MC training (suitability).
What are suggested improvements, if any, to future MF:MC training waves?	• Respondents suggested revisions to all training materials and manuals with reference to clarifying processes and simplifying the language used. • Staff also stressed that practical examples ought to be utilised in the training, especially considering lessons learned since the implementation of MF:MC. • There were further suggestions to clarify the assessment process for level 1 and level 2 practitioners.

Dissemination to date

Forensic Network Research Special Interest Group, Annual Conference (5 Nov 2014). Moving Forward: Making Changes: Quality assurance and Evaluation of the Scotland wide intervention for sex offenders in the community. G Vojt (Poster).

Further Dissemination

- Project Implementation Board/Project Oversight Board
- NOTA conference 2016 (workshop)
- RMA website
- Scottish Government

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An evaluation of the Moving Forward Making Changes (MFMC) training programme in the community.

Appendix 1 Information sheet

Dear (insert name),

My name is Georgia Black and I work as a Research Assistant for the Risk Management Authority (RMA). I am writing to ask for your help in relation to the above study which will be supervised by Dr Gabriele Vojt, Research Lead at the RMA. The study has been approved by the RMA Research and Training Committee and the MFMC Project Implementation Board.

What is the study about?

We are interested in your views on the MFMC training that you attended and the extent to which it prepared you for delivering the programme. The outcome of this will inform a Scotland-wide survey designed to assess the efficacy of the first wave of MFMC training. Ultimately, this will inform advice to the MFMC Implementation Board on potential future amendments to the training programme.

What will you be asked to do?

Participating in this study means that you will be asked to take part in an interview with myself lasting approximately 45 minutes. The interview questions have been designed to capture your views on how applicable the MFMC training is in practice and within the context of your role. Your views, which will be tape recorded and transcribed, will contribute to the evaluation of the MFMC training.

Please know that all information you supply will be treated as confidential, and only I will have access to the auditory summaries of the interviews. To help us with this, please do not disclose identifiable client information during the interview. Participating in this study is voluntary. You do not have to answer any question you feel uncomfortable about. You have the right to withdraw from the study at any given point without any consequences to you.

What will happen to the information?

All information collected will be used for research purposes only. All audio recordings will be stored securely as password protected files, with only myself having access to the recordings under the supervision of Dr Gabriele Vojt. During the transcription process, all personal information will be appropriately anonymised after which original recordings will be deleted. Results will be pooled, meaning that no individual input will be personally identifiable from the final report.

The RMA aims to have this evaluation completed by the end of 2015. The findings from this study will be summarised and presented to the MFMC Implementation Board in order to inform service development and future projects. The RMA may publish findings in peer reviewed journals, which means that all anonymised data will be stored for up to 10 years following publication. Thereafter, all data will be destroyed securely.

If you have any questions or concerns regarding this evaluation, please do not hesitate to contact myself on 0141 278 4469 or at Georgia.Black@rmascotland.gsi.gov.uk. Alternatively, and if you would like to log a complaint re this study, please contact Dr Gabriele Vojt on 0141 278 4476 or at Gabriele.Vojt@rmascotland.gsi.gov.uk

Thank you for your time,
Georgia Black

Appendix 2 Recruitment Script

> Do you have any questions before I start the interview?

Start recording

> Thank you for agreeing to be interviewed.

> Just going to go over some things before starting the interview. For the purposes of the tape can you just confirm that you have read the information sheet and signed the consent form.

> Then, just to remind you that this study is voluntary, you can withdraw from the interview and that you don't need to answer any question that you do not wish to.

> The interview should take around 45 minutes and the questions are based on the MF:MC training that you received and how well you feel it prepared you for delivering the programme in real life.

TM – Half of the interview is going to be spent talking about your own experience of the training your received as a treatment manager, the second half of the interview is going to be spent talking about your views on the training of those you oversee (so the MFMC group workers)

> At times you may be asked to repeat and asked similar questions in a different way. (why). Bear with me, it is just so we understand your views as best as possible.

> So to start us off can you talk a little bit about your role.

Appendix 3 Consent Form

CONSENT FORM

Title of project

An evaluation of the Moving Forward Making Changes (MF: MC) training in the community.

Please tick box

1. I confirm that I have read and understand the information sheet for the above study and I have had the opportunity to ask questions. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason and without my profession being affected. ☐

3. I understand that my information will be anonymised and pooled with other interviewees' accounts in order to inform future MF: MC training. ☐

5. I agree to take part in the study titled 'An evaluation of the Moving Forward Making Changes (MF: MC) training in the community'. ☐

_____	_____	_____
Initial of interviewee	Date	Signature

Appendix 4 Information sheet

[embedded within online survey]

The following survey is designed to capture your views on the MFMC training you received and the programme in practice. We would be grateful if you could take some time to complete the survey. The survey is split into 4 sections and should take approximately 15 minutes. It is important to note the following:

- This study is voluntary and you have the right to withdraw at any time.

- You do not need to answer any question that you don't want to.

- All information you supply will be treated confidentially. This means that only researchers will have access to the survey responses and data will only be analysed and published at a group level. To help us to protect anonymity, please do not disclose any identifiable client information.

The findings from this study will be summarised and presented to the MFMC Implementation Board in order to inform service development and future projects. The RMA may publish findings in peer reviewed journals, in which case all anonymised data would be stored for up to 10 years following publication. Thereafter, all data would be destroyed securely.

If you have any questions or concerns regarding this evaluation, please do not hesitate to contact myself on 0141 278 4469 or at Georgia.Black@rmascotland.gsi.gov.uk. Alternatively, and if you would like to log a complaint re this study, please contact Dr Gabriele Vojt on 0141 278 4476 or at Gabriele.Vojt@rmascotland.gsi.gov.uk

Thank you for your time.

Appendix 5 Interview schedule

Preliminary Statement	Following the commencement of the interview, the participant will be given a brief verbal summary reminding them of what the purpose of the interview is, informing them of their ethical rights (e.g they can stop the interview at any time, they do need to answer any question that they do not wish to) and making sure they know exactly what is required of them (e.g they may be asked to repeat/simplify explanations).
Opening Question	**Tell me a little about your role and the work that you do.**
Probe/Prompt	What is your job/job title? What is your role in relation to MFMC? (How long etc).
Question 1	**In relation to the role you have, how well do you feel the MFMC training prepared you for delivering/helping to deliver MFMC in reality ?**
Probe/Prompt	>To what extent do you think the training met your learning needs? > How confident do you feel that you are delivering the programme as you were trained to? > How long between the time you received training and the time you delivered the programme? What impact has this had? > What are the challenges/barriers to applying MFMC in practice? > Do you feel the training equipped you for these challenges and > barriers? (Generally and specifically)? How do you feel this impacts on your role?
Question 2	**What aspects of the MFMC training you attended were least helpful to your role?**
Probe/Prompt	In what way was [interviewee's responses] unhelpful to your role? Can you elaborate? What were some of the other weaknesses of the MFMC training? Yes- Overall weaknesses (materials, length etc.)? Weaknesses of specific modules? No weaknesses/unhelpful aspects –Why not?
Question 3	**What aspects of the MFMC training you attended were most helpful to your role?**
Probe/Prompt	In what way was [interviewee's responses] helpful to your role? Can you elaborate? How have you used the knowledge and skills from the training at work? What were some of the other strengths of the MFMC training? Yes- Overall strengths (materials, length etc.)? Strengths of specific modules? No strengths/helpful aspects –Why not?
Question 4	**Are there any aspects of the MFMC training you would change?**
Probe/Prompt	If yes, what would you change and why? **[Refer back to responses given for question 2]** If these amendments had been made prior to you completing the training, do you think this would have made a difference in how you deliver MFMC. If yes, why? If no, why do you feel nothing needs to be changed?
Question 5	**Is there anything else you would like to add?**
Probe/Prompt	Are there any other thoughts you had/have about the MFMC training and how it has been applied in your role?
Closing Statement	Following question 5, the interview will be slowly wound down, including debriefing the interviewee, asking for feedback on what the interviewee thought of interview questions, and how she/he feels post interview.

Appendix 6

Table 8 Treatment Managers' perspectives on MF:MC training

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**
I felt the role of the treatment manager was valued at the training I attended.	1 (12.5%)	2 (25.0%)	--	4 (50.0%)	1 (12.5%)
The training did not prepare me for MFMC in practice.	--	4 (50.0%)	1 (12.5%)	3 (37.5%)	--
I came away from the training enthused about the programme.	--	7 (87.5%)	1 (12.5%)	--	--
I would have liked training to be more role specific.	2 (25.0%)	5 (62.5%)	1 (12.5%)	--	--
The training was good at linking the theory behind MFMC to practice.	--	5 (62.5%)	3 (37.5%)	--	--
The training was too long.	2 (25.0%)	3 (37.5%)	--	3 (37.5%)	--
The training was well organized.	--	2 (25.0%)	--	5 (62.5%)	1 (12.5%)
I found taking part in the skills practice exercises useful.	--	6 (75.0%)	2 (25.0%)	--	--

Table 9 Treatment Managers' perspective on MF:MC applied in practice

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**
The facilitators I oversee are confident in using MFMC with clients.	4 (50.0%)	4 (50.0%)	--	--	--
The manual is difficult to understand at times.	--	5 (62.5%)	2 (25.0%)	1 (12.5%)	--
My contribution to making MFMC work is important.	5 (62.5%)	3 (37.5%)	--	--	--
I am not clear about the rationale for introducing MFMC.	--	--	--	4 (50.0%)	4 (50.0%)
I feel that the facilitators I oversee are adequately trained.	--	5 (62.5%)	2 (25.0%)	1 (12.5%)	--
I do not understand the purpose of Level 1 and Level 2.	1 (12.5%)	2 (25.0%)	1 (12.5%)	3 (37.5%)	1 (12.5%)
From what I have seen MFMC works better than CSOGP.	3 (37.5%)	4 (50.0%)	1 (12.5%)	--	--
I did not feel involved in the implementation of MFMC.	--	--	2 (25.0%)	5 (62.5%)	1 (12.5%)
I think categorizing facilitators as either Level 1 or 2 is useful.	--	1 (12.5%)	3 (37.5%)	4 (50.0%)	--

Table 10 Treatment Managers' learning retained ratings

	Full understanding	**Reasonably good understanding**	**Some understanding**	**Limited understanding**	**No understanding**	**n/a**
Delivery of essential modules	4 (50.0%)	4 (50.0%)	--	--	--	--
Delivery of optional modules	4 (50.0%)	2 (50.0%)	--	--	--	2 (25.0%)
Delivery of schema focused work	1 (12.5%)	3 (37.5%)	2 (25.0%)	--	--	2 (25.0%)
Delivery of HSF module or discussion	2 (25.0%)	2 (25.0%)	3 (35.5%)	--	--	1 (12.5%)
Delivery of mindfulness	2 (25.0%)	4 (50.0%)	2 (25.0%)	--	--	--
Delivery of MFMC to LD	1 (12.5%)	3 (37.5%)	2 (25.0%)	1 (12.5%)	--	--
Delivery of MFMC to PD	1 (12.5%)	4 (50.0%)	1 (12.5%)	2 (25.0%)	--	--
MFMC psychometrics	3 (37.5%)	5 (62.5%)	--	--	--	--
Rolling format of MFMC	6 (75.0%)	1 (12.5%)	1 (12.5%)	--	--	--
Use of formulation	4 (50.0%)	3 (37.5%)	1 (12.5%)	--	--	--
Good Lives Model	3 (37.5%)	5 (62.5%)	--	--	--	--
Integrated theory of change	1 (12.5%)	6 (75.0%)	1 (12.5%)	--	--	--
Well being and resilience	3 (37.5%)	5 (62.5%)	--	--	--	--
Programme delivery skills	6 (75.0%)	2 (25.0%)	--	--	--	--

Table 11 Treatment Managers' competence ratings

	Full competence	**Reasonable competence**	**Some competence**	**Limited competence**	**No competence**	**n/a**
Delivery of essential modules	4 (50.0%)	4 (50.0%)	--	--	--	--
Delivery of optional modules	4 (50.0%)	2 (25.0%)	--	--	--	2 (25.0%)
Delivery of schema focused work	1 (12.5%)	4 (50.0%)	1 (12.5%)	--	--	2 (25.0%)
Delivery of HSF module or discussion	1 (12.5%)	3 (37.5%)	3 (37.5%)	--	--	1 (12.5%)
Delivery of mindfulness	--	7 (87.5%)	1 (12.5%)	--	--	--
Delivery of MFMC to LD	1 (12.5%)	5 (62.5%)	--	--	1 (12.5%)	--
Delivery of MFMC to PD	1 (12.5%)	4 (50.0%)	2 (25.0%)	1 (12.5%)	--	--
MFMC psychometrics	3 (37.5%)	4 (50.0%)	1 (12.5%)	--	--	--
Rolling format of MFMC	6 (75.0%)	1 (12.5%)	1 (12.5%)	--	--	--
Use of formulation	3 (37.5%)	4 (50.0%)	1 (12.5%)	--	--	--

Good Lives Model	3 (37.5%)	5 (62.5%)	--	--	--	--
Integrated theory of change	1 (12.5%)	6 (75.0%)	1 (12.5%)	--	--	--
Personal well being and resilience	3 (37.5%)	5 (62.5%)	--	--	--	--
Programme delivery skills	3 (37.5%)	5 (62.5%)	--	--	--	--

Appendix 7

Table 12 Group Facilitators' perspective of MF:MC training

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**
I felt confident about using MFMC with clients after training.	3 (13.0%)	12 (52.2%)	--	5 (21.7%)	1 (4.3%)
The training did not prepare me for MFMC in practice.	2 (8.7%)	4 (17.4%)	1 (4.3%)	15 (65.2%)	1 (4.3%)
I came away from the training enthused about the programme.	9 (39.1%)	10 (43.5%)	3 (13.0%)	1 (4.3%)	--
The training was too long.	1 (4.3%)	5 (21.7%)	7 (30.4%)	8 (34.8%)	2 (8.7%)
The training was well organized.	3 (13.0%)	14 (60.9%)	5 (21.7%)	1 (4.0%)	--
I feel that assessing individuals as either level 1 or 2 was unhelpful.	8 (34.8%)	5 (21.7%)	5 (21.7%)	5 (21.7%)	--
The training was good at linking the theory behind MFMC to practice.	3 (13.0%)	15 (65.2%)	1 (4.3%)	4 (17.4%)	--

Table 13 Group Facilitators' perspective of MF:MC applied to practice

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**
I am confident using MFMC with clients.	12 (52.2%)	8 (34.8%)	--	3 (13.0%)	--
I understand how MFMC addresses clients' offending.	11 (47.8%)	8 (34.8%)	1 (4.3%)	2 (8.7%)	1 (4.3%)
The manual is difficult to understand at times.	4 (17.4%)	7 (30.4%)	9 (39.1%)	3 (13.0%)	--
My contribution to making MFMC work is important.	15 (65.2%)	8 (34.8%)	--	--	--
I do not understand the purpose of level 1 and 2 in practice.	5 (21.7%)	5 (21.7%)	6 (26.1%)	7 (30.4%)	--
From what I have seen MFMC works better than CSOGP.	9 (39.1%)	9 (39.1%)	4 (17.4%)	1 (4.3%)	--
I am not clear about the rationale for introducing MFMC.	1 (4.0%)	1 (4.0%)	14 (56.5%)	8 (34.8%)	--
There have been times when clients begin a group without the pre-programme work having been fully completed.	5 (21.7%)	2 (8.7%)	5 (21.7%)	7 (30.4%)	4 (17.4%)

Table 14 Group facilitators' learning retained ratings

	Full understanding	**Reasonably good understanding**	**Some understanding**	**Limited understanding**	**No understanding**	**n/a**
Delivery of essential modules	13 (56.5%)	8 (34.8%)	--	2 (8.7%)	--	--
Delivery of optional modules	5 (21.7%)	13 (56.5%)	1 (4.3%)	2 (8.7%)	--	2 (8.7%)
Delivery of schema focused work	4 (17.4%)	6 (26.1%)	9 (39.1%)	3 (13.0%)	--	1 (4.3%)
Delivery of HSF module or discussion	5 (21.7%)	7 (30.4%)	6 (26.1%)	3 (13.0%)	--	2 (8.7%)
Delivery of mindfulness	7 (31.8%)	8 (36.4%)	5 (22.7%)	2 (9.1%)	--	--
Delivery of MFMC to LD	1 (4.3%)	7 (30.4%)	7 (30.4%)	3 (13.0%)	1 (4.3%)	4 (17.4%)
Delivery of MFMC to PD	--	7 (30.4%)	6 (26.1%)	5 (21.7%)	1 (4.3%)	4 (17.4%)
MFMC psychometrics	4 (17.4%)	6 (26.1%)	3 (13.0%)	2 (8.7%)	3 (13.0%)	5 (21.7%)
Rolling format of MFMC	12 (52.2%)	8 (34.8%)	--	--	2 (8.7%)	1 (4.3%)
Use of formulation	6 (26.1%)	12 (52.2%)	4 (17.4%)	1 (4.3%)	--	--
Good Lives Model	11 (47.8%)	12 (52.2%)	--	--	--	--
Integrated theory of change	8 (34.8%)	11 (47.8%)	4 (17.4%)	--	--	--
Personal Well being and resilience	8 (34.8%)	10 (43.5%)	5 (21.7%)	--	--	--
Programme delivery skills	11 (47.8%)	8 (34.8%)	2 (8.7%)	1 (4.3%)	1 (4.3%)	--

Table 15 Group Facilitators' competence ratings

	Full competence	**Reasonable competence**	**Some competence**	**Limited competence**	**No competence**	**n/a**
Delivery of essential modules	11 (47.8%)	10 (43.5%)	1 (4.3%)	1 (4.3%)	--	--
Delivery of optional modules	2 (8.7%)	12 (52.2%)	4 (17.4%)	1 (4.3%)	--	4 (17.4%)
Delivery of schema focused work	2 (8.7%)	9 (39.1%)	8 (34.8%)	1 (4.3%)	--	3 (13.0%)
Delivery of HSF module or discussion	2 (8.7%)	12 (52.2%)	5 (21.7%)	1 (4.3%)	1 (4.3%)	2 (8.0%)
Delivery of mindfulness	5 (21.7%)	10 (43.5%)	5 (21.7%)	2 (8.7%)	1 (4.3%)	--
Delivery of MFMC to LD	--	7 (31.8%)	9 (40.9%)	1 (4.5%)	--	5 (22.7%)
Delivery of MFMC to PD	--	6 (26.1%)	8 (34.8%)	3 (13.0%)	--	6 (26.1%)
MFMC psychometrics	4 (17.4%)	7 (30.4%)	5 (21.7%)	2 (8.7%)	--	4 (17.4%)
Rolling format of MFMC	9 (42.9%)	9 (42.5%)	2 (9.5%)	--	1 (4.8%)	--
Use of formulation	3 (13.0%)	14 (60.9%)	5 (21.7%)	1 (4.3%)	--	--

Good Lives Model	8 (38.1%)	11 (52.4%)	1 (4.8%)	1 (4.8%)	--	--
Integrated theory of change	5 (21.7%)	14 (60.9%)	3 (13.0%)	1 (4.3%)	--	--
Personal well being and resilience	6 (26.1%)	12 (52.2%)	4 (17.4%)	1 (4.3%)	--	--
Programme delivery skills	11 (47.8%)	8 (34.8%)	3 (13.0%)	1 (4.3%)	--	--

Appendix 8

Table 16 Line Managers' perspective of MF:MC training

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**
I came away from the awareness day enthused about the programme.	--	4 (25.0%)	12 (75.0%)	--	--
The awareness day did not prepare me for MFMC in practice.	1 (6.2%)	10 (62.5%)	1 (6.2%)	4 (25.0%)	--
The awareness day was well organized.	2 (12.5%)	7 (43.8%)	6 (37.5%)	1 (6.2%)	--
The awareness day did not provide me with enough information to support my case managers.	2 (12.5%)	9 (56.2%)	3 (18.8%)	2 (12.5%)	--
The awareness day was good at linking the theory behind MFMC to practice.	--	4 (25.0%)	8 (50.0%)	4 (25.0%)	--
The training content of the awareness day was relevant to my role.	--	11 (68.8%)	3 (18.8%)	2 (12.5%)	--

Table 17 Line Managers' perspective of MF:MC applied in practice

	Strongly agree	**agree**	**Neither agree nor disagree**	**disagree**	**Strongly disagree**
The case managers I oversee are confident using MFMC with clients.	1 (7.1%)	7 (50.0%)	1 (7.1%)	5 (35.7%)	--
I am not clear about the rationale for introducing MFMC.	1 (7.1%)	2 (14.3%)	3 (21.4%)	8 (57.1%)	--
My staff are as engaged with MFMC as they are with CSOGP.	3 (21.4%)	6 (42.9%)	3 (21.4%)	2 (14.3%)	--
Some of the terminology in the manual is difficult to understand.	--	6 (46.2%)	4 (30.8%)	3 (23.1%)	--
My contribution to making MFMC work is important.	4 (28.6%)	7 (50.0%)	2 (14.3%)	1 (7.1%)	--
I feel that the workload of my team has increased due to MFMC.	2 (14.3%)	6 (42.9%)	4 (28.6%)	2 (14.3%)	--
I feel that the case managers I oversee are adequately trained.	2 (14.3%)	5 (35.7%)	3 (21.4%)	3 (21.4%)	--

Table 18 Line Managers' learning retained ratings

	Full understanding	**Reasonably good understanding**	**Some understanding**	**Limited understanding**	**No understanding**	**n/a**
National outcomes and standards	8 (57.1%)	5 (35.7%)	1 (7.1%)	--	--	--
Assessment process of MFMC	2 (14.3%)	5 (35.7%)	6 (42.9%)	1 (7.1%)	--	--
Assessment of internet offenders	--	5 (35.7%)	5 (35.7%)	4 (28.6%)	--	--
Knowledge of essential MFMC group work modules	1 (7.1%)	4 (28.6%)	6 (42.9%)	2 (14.3%)	1 (7.1%)	--
Knowledge of optional group work modules	1 (7.1%)	3 (21.4%)	8 (57.1%)	1 (7.1%)	1 (7.1%)	--
Maintenance session	--	2 (14.3%)	9 (64.3%)	1 (7.1%)	1 (7.1%)	1 (7.1%)
Good Lives Model	3 (21.4%)	8 (57.1%)	1 (7.1%)	2 (14.3%)	--	--
Risk Need Responsivity	4 (28.6%)	6 (42.9%)	2 (14.3%)	2 (14.3%)	--	--
Use of mindfulness	1 (7.1%)	5 (35.7%)	5 (35.7%)	2 (11.8%)	1 (7.1%)	--
Use of formulation	1 (7.1%)	5 (35.7%)	4 (28.6%)	2 (14.3%)	2 (14.3%)	--
Group programme work	3 (21.4%)	7 (50.0%)	3 (21.4%)	--	1 (7.1%)	--

Table 19 Line Managers' competence ratings

	Full competence	**Reasonably good competence**	**Some competence**	**Limited competence**	**No competence**	**n/a**
National outcomes and standards	7 (50.0%)	6 (42.9%)	1 (7.1%)	--	--	--
Assessment process of MFMC	1 (7.1%)	11 (78.6%)	1 (7.1%)	1 (7.1%)	--	--
Assessment of internet offenders	--	6 (42.9%)	6 (42.9%)	2 (14.3%)	--	--
Knowledge of essential MFMC group work modules	1 (7.1%)	4 (28.6%)	7 (50.0%)	1 (7.1%)	1 (7.1%)	--
Knowledge of optional group work modules	1 (7.1%)	4 (28.6%)	7 (50.0%)	1 (7.1%)	1 (7.1%)	--
Maintenance session	--	5 (35.7%)	7 (50.0%)	1 (7.1%)	1 (7.1%)	--
Good Lives Model	1 (7.1%)	11 (64.7%)	1 (7.1%)	1 (7.1%)	--	--
Risk Need Responsivity	3 (21.4%)	7 (50.0%)	3 (21.5%)	1 (7.1%)	--	--
Use of mindfulness	--	6 (46.2%)	5 (38.5%)	2 (7.7%)	1 (7.1%)	--
Use of formulation	--	7 (50.0%)	5 (35.7%)	1 (7.1%)	1 (7.1%)	--
Group programme work	2 (14.3%)	11 (78.6)	--	--	1 (7.1%)	--

Appendix 9

Table 20 Case Managers' perspective of MF:MC training

	Strongly agree	agree	Neither agree nor disagree	disagree	Strongly disagree	Missing
I felt confident about using MFMC with clients after training.	2 (2.9%)	24 (35.3%)	15 (22.1%)	23 (33.8%)	4 (5.9%)	7
The training did not prepare me for MFMC in practice.	3 (4.5%)	22 (32.8%)	16 (23.9%)	21 (31.3%)	5 (7.5%)	8
I came away from the training enthused about the programme.	2 (3.1%)	24 (36.9%)	27 (41.5%)	9 (13.8%)	3 (4.6%)	10
The training content was relevant.	6 (8.8%)	43 (63.2%)	16 (23.5%)	3 (4.4%)	--	7
The training was too long.	1 (1.5%)	12 (17.9%)	22 (32.8%)	30 (44.8%)	2 (3.0%)	8
The training was good at linking the theory behind MFMC to practice.	4 (5.9%)	33 (48.5%)	19 (27.9%)	8 (11.8%)	4 (5.9%)	7
I felt more anxious about MFMC after attending training.	3 (4.5%)	15 (22.4%)	13 (19.4%)	27 (40.3%)	9 (13.4%)	8
I regularly refer back to the training material.	18 (27.7%)	33 (50.8%)	11 (16.9%)	3 (4.6%)	--	10

Table 21 Case Managers' perspective of MF:MC in practice

	Strongly agree	agree	Neither agree nor disagree	disagree	Strongly disagree	Missing
I am confident using MFMC with clients.	7 (11.5%)	28 (45.9%)	18 (29.5%)	6 (9.8%)	2 (3.3%)	14
I understand how MFMC addresses clients' offending.	10 (16.1%)	38 (61.3%)	10 (16.1%)	4 (6.5%)	--	13
The manual is difficult to understand at times.	16 (25.8%)	26 (41.9%)	11 (17.7%)	9 (14.5%)	--	13
My contribution to making MFMC work is important.	15 (24.2%)	37 (59.7%)	8 (12.9%)	1 (1.6%)	1 (1.6%)	13
I am not clear about the rationale for introducing MFMC.	2 (2.7%)	8 (10.7%)	13 (17.3%)	31 (41.3%)	5 (10.7%)	13
MFMC concern	13 (17.3%)	41 (54.7%)	7 (9.3%)	1 (1.3%)	--	13
I am not clear about what my role is in relation to MFMC.	2 (3.2%)	7 (11.3%)	6 (9.7%)	37 (59.7%)	10 (16.1%)	16
From what I have seen MFMC works better than CSOGP.	3 (5.0%)	10 (16.7%)	42 (70.0%)	4 (6.7%)	1 (1.7%)	15
There have been times when I have missed out or delayed sections of the pregroup sessions.	6 (10.2%)	24 (40.7%)	11 (18.6%)	14 (23.7%)	4 (6.8%)	16

Table 22 Case Managers' learning retained ratings

	Full understanding	Reasonably good understanding	Some understanding	Limited understanding	No understanding	n/a	Missing
National outcomes and standards	18 (28.6%)	34 (54.0%)	7 (11.1%)	2 (3.2%)	1 (1.6%)	1 (1.6%)	12
Assessment process of MFMC	5 (8.1%)	35 (56.5%)	16 (25.8%)	4 (6.5%)	--	2 (3.2%)	13
Assessment of internet offenders	3 (4.8%)	19 (30.2%)	25 (39.7%)	10 (15.9%)	3 (4.8%)	3 (4.8%)	12
Knowledge of essential MFMC group work modules	6 (9.8%)	26 (42.6%)	20 (32.8%)	6 (9.8%)	2 (3.3%)	1 (1.6%)	14
Knowledge of optional group work modules	5 (8.1%)	23 (37.1%)	25 (40.3%)	7 (11.3%)	1 (1.6%)	1 (1.6%)	13
Maintenance session	4 (6.5%)	14 (22.6%)	26 (41.9%)	16 (25.8%)	1 (1.6%)	1 (1.6%)	13
Good Lives Model	14 (22.6%)	30 (48.4%)	16 (25.8%)	1 (1.6%)	--	1 (1.6%)	13
Risk Need Responsivity	17 (27.4%)	29 (46.8%)	15 (24.2%)	--	--	1 (1.6%)	13
Integrated theory of mind	6 (9.5%)	25 (39.7%)	23 (36.5%)	7 (11.1%)	1 (1.6)	1 (1.6%)	12
Use of mindfulness	6 (9.7%)	29 (46.8%)	21 (33.9%)	3 (4.8%)	2 (3.2%)	1 (1.6%)	13
Use of formulation	7 (11.3%)	21 (33.9%)	22 (35.5%)	8 (12.9%)	3 (4.8%)	1 (1.6%)	13
Pre-group session 1 – programme description	14 (23.0%)	27 (44.3%)	17 (27.9%)	2 (3.3%)	--	1 (1.6%)	14
Pre group session 2 – self calming exercise	13 (21.3%)	28 (45.9%)	19 (31.1%)	--	1 (1.6%)	--	14
Pre group session 3 – social support network	18 (29.0%)	28 (45.2%)	14 (22.6%)	1 (1.6%)	--	1 (1.6%)	13
Pre group session 4 – precursors to change	12 (19.4%)	21 (33.9%)	20 (32.3%)	3 (4.8%)	5 (8.1%)	1 (1.6%)	13
Pre group session 5 – the good lives plan	13 (21.0%)	22 (35.5%)	25 (40.3%)	--	1 (1.6%)	1 (1.6%)	13
Pre group session 6 – keep safe plan	13 (21.0%)	23 (37.1%)	25 (40.3%)	--	--	1 (1.6%)	13
Pre group session 7 – formulation exercise	12 (19.4%)	18 (29.0%)	25 (40.3%)	5 (8.1%)	--	2 (3.2%)	13

Table 23 Case Managers' competence ratings

	Full competence	**Reasonable competence**	**Some competence**	**Limited competence**	**No competence**	**n/a**	**Missing**
National outcomes and standards	17 (28.3%)	29 (48.3%)	8 (13.3%)	--	1 (1.7%)	5 (8.3%)	15
Assessment process of MFMC	4 (6.6%)	35 (57.4%)	13 (21.3%)	3 (4.9%)	1 (6.7%)	5 (8.2%)	14
Assessment of internet offenders	4 (6.7%)	22 (36.7%)	16 (26.7%)	9 (15.0%)	3 (5.0%)	6 (7.9%)	15
Knowledge of essential MFMC group work modules	4 (6.7%)	29 (48.3%)	17 (28.3%)	2 (3.3%)	2 (3.3%)	6 (7.9%)	15
Knowledge of optional group work modules	5 (8.2%)	24 (39.3%)	21 (34.4%)	4 (6.6%)	1 (1.6%)	6 (9.8%)	14
Maintenance session	5 (8.2%)	15 (24.6%)	23 (37.7%)	8 (13.1%)	1 (1.6%)	9 (14.8%)	14
Good Lives Model	13 (21.3%)	25 (41.0%)	16 (26.2%)	3 (4.9%)	--	4 (6.6%)	14
Risk Need Responsivity	11 (18.3%)	27 (45.0%)	15 (25.0%)	3 (5.0%)	--	4 (6.7%)	15
Integrated theory of mind	7 (11.7%)	23 (38.3%)	17 (28.3%)	7 (11.7%)	1 (1.7%)	5 (8.3%)	15
Use of mindfulness	23 (38.3%)	17 (28.3%)	8 (13.3%)	3 (5.0%)	--	5 (8.3%)	15
Use of formulation	7 (9.3%)	18 (24.0%)	20 (26.7%)	6 (8.0%)	3 (4.0%)	6 (8.0%)	15
Pre-group session 1 – programme description	12 (16.0%)	24 (32.0%)	16 (21.3%)	2 (2.7%)	1 (1.3%)	5 (6.7%)	15
Pre group session 2 – self calming exercise	10 (13.3%)	23 (30.7%)	19 (25.3%)	2 (2.7%)	1 (1.3%)	5 (6.7%)	15
Pre group session 3 – social support network	14 (18.7%)	26 (34.7%)	14 (18.7%)	1 (1.3%)	1 (1.3%)	5 (6.7%)	14
Pre group session 4 – precursors to change	11 (14.7%)	19 (25.3%)	16 (21.3%)	5 (6.7%)	5 (6.7%)	5 (6.7%)	14
Pre group session 5 – the good lives plan	11 (14.7%)	19 (25.3%)	24 (32.0%)	1 (1.3%)	1 (1.3%)	5 (6.7%)	14
Pre group session 6 – keep safe plan	11 (14.7%)	19 (25.3%)	24 (32.0%)	1 (1.3%)	1 (1.3%)	5 (6.7%)	14
Pre group session 7 – formulation exercise	10 (13.3%)	17 (22.7%)	25 (33.3%)	1 (1.3%)	1 (1.3%)	7 (9.3%)	14

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