Staff experiences of reflective practice groups in a crisis resolution and home treatment team: a mixed methods service evaluation

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Abstract

Crisis Resolution and Home Treatment Teams (CRHTTs) provide mental health support for people experiencing crises and its employees are at high risk of occupational stress. Reflective Practice Groups (RPGs) hold promise for reducing staff burnout. However, to date, there have been no evaluations of RPGs delivered in CRHTT settings. This study aimed to explore staff experiences of RPGs delivered in one CRHTT. All CRHTT staff members who had attended at least one RPG were approached to take part. Participants completed two supervision questionnaires and a semi-structured interview. Descriptive statistics were calculated to quantify staff experiences and qualitative themes were generated using thematic analysis. Thirteen people participated, all of whom reported positive experiences of RPGs. Three qualitative themes also emerged comprising 'core components of RPGs' 'benefits to staff' and 'challenges of RPG delivery'. Staff value RPGs delivered in CRHTT settings, which may reduce staff burnout and contribute to workforce development.

Key Words

Adult Mental Health; Crisis Resolution Home Treatment; Reflective Practice Groups; Supervision; Service Evaluation; Staff Views.

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Statements and Declarations

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

Introduction

CRHTTs aim to deliver 24-hour, seven day per week mental health support for people experiencing crisis. They provide rapid assessment in a least restrictive environment and offer an alternative to hospital admission through provision of immediate multidisciplinary care (Department of Health, 2000). Although earlier studies found that CRHTT staff have historically reported high levels of work satisfaction and low rates of occupational stress (Nelson et al., 2009; Johnson et al., 2012), more recent studies have now identified moderate to high rates of burnout (Menon et al., 2015). It is widely acknowledged that staff burnout is at an all-time high and prioritising the wellbeing of staff is a global priority (House of Commons, 2021; Søvold et al., 2021).

Clinical supervision is an integral aspect of clinical practice, and its restorative aspects are widely acknowledged (Milne, 2009). Although the exact mechanisms underlying restorative supervision are currently unknown (Bradley & Becker, 2021), studies have found that clinical supervision can increase staff wellbeing and reduce stress (Rothwell et al., 2021). Clinical supervision can be delivered in both individual or group formats and serve different functions depending on the context. For instance, supervision could involve case formulation, or refining clinical skills relevant to a specific therapeutic orientation. In comparison to other forms of supervision, Reflective Practice Groups (RPGs) focus upon relationships between staff and service users with an emphasis on felt experiences and/or dilemmas in clinical work (Johnstone & Paley, 2013). According to published recommendations, CRHTT staff members should have access to RPGs at least every 6 weeks (Royal College of Psychiatrists [RCP], 2019), which is widely advocated for professional development across disciplines (e.g., The Royal College of Nursing, 2022; The Health and Care Professions Council, 2022). Reflective practice has numerous benefits for multidisciplinary teams especially when delivered in groups (Knight, 2015).

Several papers have described and evaluated RPGs delivered in mental health services, including psychiatric liaison and acute inpatient care. Collectively, these studies suggest RPGs can reduce occupational stress and burnout (O'Neill et al., 2019; Sundgren et al., 2021) and can foster staff resilience and adaptive forms of coping (Davey et al., 2021). Moreover, there is also evidence that RPGs can improve quality of patient care through the sharing of staff experiences (O'Neill et al., 2019) and building of personal and professional skills (Dawber, 2013; Johnstone & Paley, 2013; Sundgren et al., 2021). Therefore, RPGs hold potential benefits for both providers and recipients of care.

To optimise the positive outcomes of RPGs in practice, several aspects pertaining to its form and delivery have been identified as important. Indeed, regular scheduling, consistent albeit voluntary attendance, effective

management of group boundaries, adherence to an agenda, and the interpersonal style of the facilitator have all been highlighted as crucial for RPGs to feel safe, restorative and effective (Reschke et al., 2021; Kurtz, 2020; Tomlin et al., 2004). Conversely, barriers to effective RPGs include a lack of organisational support, low attendance, and logistical issues of having protected time and space (Kurtz, 2020).

However, despite evidence for the utility of RPGs in clinical practice and the identification of potential moderators of outcome; to date, there have been no published papers evaluating RPGs delivered within CRHTT settings. One CRHTT began implementing RPGs in January 2021 amid the COVD-19 pandemic at a time of significant and unprecedented pressure on staff and wellbeing. Anecdotal feedback suggested that staff found the RPGs useful. However, despite offering two reflective practice groups each week, there was a lack of consistent attendance. Therefore, we aimed to evaluate staff experiences of the RPGs to formally explore its acceptability within CRHTT settings, to identify areas for improvement and optimise the potential benefits to CRHTT staff and service users in the longer term.

Methods

Design

A mixed methods approach comprising questionnaires and a semi-structured interview was used to evaluate staff experiences of RPGs. Mixed methods were deemed appropriate in order to combine the insights and understanding obtained from qualitative data with the ability to generalize to wider populations offered by quantitative data (Tariq & Woodman, 2013).

RPGs

The RPGs delivered in the current study adopted the intersubjective model outlined by Kurtz (2020) and included a 15-minute mindfulness exercise to close. This model involved eight stages: 1) contracting and review at organisational level; 2) contracting and review at group model; 3) turning in (from busy work modes into that of a reflective stance); 4) looking back (on previous meetings); 5) generation (of material for discussion); 6) free response (sharing of emotional responses about the material presented); 7) more effortful thinking (developing coherent understandings of responses); and 8) turning out (bringing the meeting to a close). The RPGs were routinely offered twice per week and all clinical staff were invited to attend, though attendance was voluntary.

The RPGs were facilitated by a Clinical Psychologist (SN). SN facilitated the groups, in person, at the same times each week and in the same room. Staff could attend in person or remotely. The RPGs were promoted through distribution of leaflets and weekly email prompts.

Procedure

Sampling and recruitment

Participants were multidisciplinary staff members, purposively recruited from one CRHTT. Each staff member who had attended at least one RPG between January 2021 and March 2022 were invited to participate in the study via email. Each participant that expressed an interest in taking part were contacted by either an Assistant Psychologist (KM) or Associate Psychological Practitioner (MJ). KM and MJ met with participants to administer two questionnaires and a semi-structured interview.

Materials

This study utilised two structured questionnaires. Firstly, the Clinical Supervision Evaluation Questionnaire (CSEQ; Horton et al 2008) was used to evaluate staff perspectives on the process and impact of group supervision. The CSEQ consisted of 14 closed ended items each rated on a 5-point Likert scale ranging from 'strongly agree' to 'strongly disagree'. To avoid confusion, when the questions were read aloud, the language was adapted from 'supervision' to 'reflective practice'. This was done to ensure that participants responded to questions whilst considering their experiences of reflective practice only, rather than clinical supervision. Secondly, the brief Appraisal of Supervision measure (AS; Priddis & Rogers, 2017) was used to measure staff satisfaction with supervision. The AS consisted of six closed ended questions each rated on a 6-point Likert scale ranging from 'not at all' to 'extremely'. References to 'reflective supervision' were changed to 'reflective practice' to ensure consistency in language and limit confusion. Both the CSEQ and the AS have demonstrable psychometric properties, including high internal consistency (e.g., $\alpha = 0.86$ and $\alpha = 0.92$, respectively; Horton et al., 2008, Priddis & Rogers, 2017). Furthermore, the inclusion of standardised questionnaires permits the examination of changes over time in future evaluations.

A semi structured interview was developed by the research team and consisted of four open ended questions to elicit qualitative feedback about participants' experiences of attending RPG's. These included: 1)

"Thinking about your experience of RPGs within CRHTT, what have you found most helpful?"; 2) "Thinking about your experience of RPGs within CRHTT, what have you found least helpful?"; 3) "Thinking about your experience of RPGs within CRHTT, how could the groups be improved?" 4) "Is there any other information about your experience of the RPGs that you would like to share?". Each interview lasted between approximately 20 – 45 minutes and was conducted in a quiet, confidential space. Interviews were conducted face to face, over the telephone or via video link to ensure that participants could attend at a convenient time. This flexibility was essential given the fast-paced and unpredictable nature of CRHTT working and ensured that as many participants as possible could participate. All responses were recorded on paper and were transcribed into an Excel database

Ethical considerations

Ethical approval was not required as the study evaluated an existing practice within the team. However, as per Trust protocol the study was approved by a Senior Leadership Team and was registered as a service evaluation with a local NHS Trust Research and Development Department. Prior to involvement, each participant was given a participant information sheet. This detailed the purpose of the study, how information would be used, issues pertaining to confidentiality and anonymity and how responses would be stored. Participants were also provided with information on how to seek support should their participation cause emotional distress. Participants signed a consent form and were informed of their right to withdraw their participation, or data, at any time. All electronic data was stored on an encrypted NHS server, in a password protected file. To ensure confidentiality, paper copies of questionnaire measures and interview responses were stored in a locked filing cabinet, in a locked room, and separate to consent forms, in accordance with the Declaration of Helsinki.

Analysis

Quantitative analysis

Descriptive statistics (Mean / SD) were used to quantify participant endorsement of individual items on the CSEQ and AS and percentages were calculated to indicate overall levels of agreement on the individual CSEQ and AS items.

Qualitative analysis

The analysis followed the six phases of thematic analysis as described by Braun & Clarke (2006) using both inductive and deductive approaches. MJ, KM and RC undertook the initial coding of the data. Participant responses were analysed iteratively, line by line, to derive initial codes, which were then elaborated on through grouping of similar features and patterns within the data set. The final codes were refined, reviewed, and agreed upon by SN and LM to reduce bias and improve reliability. Through group discussion, it was considered how different codes meaningfully combined to form initial themes. These initial themes were reviewed at a code level, considering how they fit the entire data set, and were further refined to generate three main themes. These final themes were confirmed at a latent level.

Results

Demographics

Twenty-five staff were invited to take part in the evaluation. A total of 13 participants (52%) provided feedback on the experience of RPGs. Two participants were male (15.38%) and 11 were female (84.62%). Across all participants, years in CRHTT employment ranged between six months and 13 years (M = 3.38, SD = 3.58). All participants attended between three and 24 RPGs (M = 7.77, SD = 5.95). Participant roles reflected the multidisciplinary establishment of the CRHTT and comprised three Assistant Psychologists, two Peer Support Workers, two Senior Nurse Practitioners, two STR workers, one Senior Mental Health Practitioner, one Senior Patient Flow Practitioner, one Locum Consultant Psychiatrist and one Advanced Clinical Pharmacist.

Quantitative analyses

Scores on the CSEQ indicated that participants had positive experiences of RPGs. Mean scores for each question ranged from 3.62 to 4.77 (1 = No opinion and 5 = Strongly agree), (see Table 1). Participants agreed most with the statement '*There are well established ground rules in my group'* (76.92% = strongly agree). Participants agreed least with the statements, *"I have gained new clinical insights through supervision"* (23.08% = Strongly disagree) and *"clinical supervision has helped me feel more confident about dealing with my job"* (23.08% = Strongly disagree) (see Table 2).

Scores on the AS indicated that participants experienced multiple benefits from attending RGPs. Mean scores for each question ranged from 3.38 to 4.62 (1 = No opinion and 6 = Extremely), (see Table 3). Participants agreed most that attending RPHs increased their "*Desire to actively develop my professional capabilities''* (23.07% = Extremely). Participants agreed least that attending RPGs increased their "*Confidence as a practitioner''* (23.08% = No opinion) (see Table 4).

INSERT TABLE 1. HERE

INSERT TABLE 2. HERE

INSERT TABLE 3. HERE

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Qualitative analysis

Three main qualitative themes consisting of six sub-themes were identified using an empirical thematic analysis (Braun & Clarke, 2006). A description of each theme and sub-theme is outlined below:

1) Core components of RPGs

Where participants experienced RPGs as helpful, they identified several key features they believed contributed to its effectiveness.

Practicalities

Participants identified several practicalities they believed facilitated RPG attendance. Group timings were highlighted as important as some acknowledged the Friday afternoon session allowed them to *"reflect on the week as a whole and wind down for the weekend"*. For others, the timing of RPGs was considered an important moderator of both group size and participation, *"there may be more involvement if the group was held in the morning"*. Staff appeared to value the location of the group being *"separate"* from the main office "*without the presence of managers"* and "*with less distractions"*. They also suggested that a rotation of "*clinical leads chairing the group"* could encourage attendance from a range of multidisciplinary professions. Participants identified that following an agenda created a helpful "*structure*" and ensured "*everyone had a chance to speak"* to discuss cases within the allotted time. Group size also appeared to be a key factor as smaller groups "*made it easier to discuss certain issues and felt more supportive"*.

Conditions

All participants described several core conditions they believed were required for a successful RPG. Adherence to group rules and boundaries *"felt containing"* and participants valued a non-judgmental approach within which they felt safe to be "*open and honest"* whilst "*not feeling pressured to discuss cases"*. They also reported that when the confidentiality was respected and observed participants "*felt safer in bringing cases to the group"*. Other core conditions included having a constructive approach to conflict, based on mutual respect and support between group members.

2) Benefits to staff

RPGs held numerous benefits for staff members, who noted improvements in their own practice and across the multidisciplinary team.

Staff wellbeing

Participants felt that RPGs helped to improve their personal wellbeing and reduce burnout. The mindfulness exercise was considered "*useful after challenging topics were discussed"* and allowed members to *"relax and wind down"* after the working day. Some participants believed RPGs enhanced team cohesiveness by allowing members to "*come together and communicate"*. This was especially valued by staff members on hybrid working patterns, *"It was good to catch up with the team whilst working from home and shielding, helped me to feel more connected"*. Participants also felt that RPG discussions helped to improve their self-compassion, which led to positive reflections and subsequent change in their clinical practice, *"I was able to reflect on and make changes to my practice, whilst not being too hard on myself"*.

Self-awareness and knowledge

Participants commented that a psychological perspective gained from RPG discussion facilitated greater compassion towards service users. Participants valued the use of evidence-based models and theories in formulating complex cases, as well as in understanding their own emotional reactions. Staff acknowledged the group allowed them to learn and appreciate different perspectives, which led to "*new ideas"* about effective working and "*allowed for more holistic thinking"*. One member stated, "*the group gives a sense of the role of*

other professionals within the team and helps to broaden my thinking around this". Participants also benefitted from having protected time to reflect on their own interactions with service users to consider "*what went well, or not so well"*, *"patients' expectations of care"*, and "*the management of complex cases",* to increase their self-awareness, knowledge and enhance their clinical practice.

3) Challenges of RPG delivery

Both staff and operational factors created challenges for the successful provision of RPGs.

Staff misunderstanding of RPGs

Participants identified that RPGs were sometimes used inappropriately or for purposes other than their intended function. Some felt that others used the group to *"vent their frustrations, rather than placing emphasis on case discussions"*. Although members acknowledged *"this was needed due to service-related issues*", it was also reflected how *"this did not serve to enhance their practice going forward"*. Furthermore, for some, the venting of frustrations was perceived as "*overwhelming"*, "*more appropriate for discussion in line management supervision"* and resulted in a subsequent lack of case discussion "*it felt disjointed, as it was hard to dedicate time to all cases"*. Participants offered suggestions for how staff understandings and expectations could be managed through the sharing of an agenda, "*sharing a pre-agreed agenda prior to the group, which could improve attendance and leave more time to discuss cases"*. Importantly, *w*hen agendas were followed, and when RPGs were used appropriately, participants found "*the sharing of opinions and ideas with the team*" helpful.

Operational issues

Operational issues were perceived as a huge challenge to the routine provision of RPGs. Participants often felt unable to attend unless they were given protected time to, "*when this (protected time) wasn't offered, attendance at the group impacts workloads and increases stress"*. Others shared how ever-increasing work demands and the busy CRHTT working environment led to feelings of dissonance and created barriers to attendance, "*I felt guilty for not being able to attend due to busy workloads"*. Participants highlighted that greater support from management would improve this, "*management need to be more committed and support staff to attend"*, as would acknowledging the equal importance of RPGs comparative to other forms of support, "*they*

should be putting time aside for RPGs, as they would for supervision". However, staff acknowledged that when they were able to attend, "*it was helpful to reflect on these issues, and how they are impacting service user care"*.

Discussion

This service evaluation aimed to explore staff experiences of RPGs delivered in one CRHTT to assess its acceptability within this setting and drive local improvements in clinical governance and service provision. Using a mixed methods approach, thirteen staff members who attended at least one RPG completed a questionnaire and appraisal measure of supervision (i.e., the CSEQ and AS, respectively) and provided qualitative feedback via semi-structured interview.

Overall, the RPGs were experienced as positive by attending staff members in terms of form, content, and delivery. Mean scores out of five on the CSEQ ranged from 3.62 – 4.77, indicating a degree uniformity across all items. Notably, the most endorsed items were, 'There are well established ground rules in my group', 'I believe that any confidences I share are respected' and 'The purpose of clinical supervision is to improve client care'. Least endorsed items were, 'Clinical supervision has helped me feel more confident about dealing with my job', 'There is mutual trust between the members in my group' and 'Clinical supervision has definitely had a positive impact on the quality of care I provide'. A similar pattern was also observed on the AS measure where scores out of six ranged from 3.38 – 4.62. Participants agreed strongly that RPGs improved their 'Ability to be reflective after interactions with clients' and least strongly that it helped them to develop 'Practical skills'. These quantitative results were supported by three qualitative themes derived by thematic analysis, including 'Core components of RPGs', 'Benefits to staff', and 'Challenges of RPG delivery'.

Taken together, our results suggest that CRHTT staff valued RPGs that were structured, in which the presence of ground rules, confidentiality and mutual respect between group members facilitated conditions of safety. These align closely with previous studies that have identified the importance of regular scheduling and group boundaries in moderating the outcomes of RPGs delivered in other settings (Reschke et al., 2021; Kurtz, 2020; Tomlin et al., 2004). Furthermore, staff believed RPGs led to improvements in staff wellbeing, team cohesiveness and clinical practice. The building of personal and professional skills has been linked with RPG attendance in other work (Dawber, 2013; Johnston & Paley, 2013; Sundgren et al., 2021) and its restorative effects on occupational stress have been widely documented (O'Neill et al., 2019; Sundgren et al., 2021; Davey et al., 2021). Therefore, RPGs should be considered an integral part of CRHTT staff provision given the degree of

burnout experienced in these settings (Menon et al., 2015) and recent priorities concerning the wellbeing of mental health staff (House of Commons, 2021; Søvold et al., 2021).

Although RPGs in this evaluation were perceived as positive, CRHTT staff also highlighted several challenges regarding its delivery. At times, RPGs were used for purposes other than its intended function, which led to feelings of overwhelm and limited its utility. The sharing of an agreed agenda and the interpersonal and professional skills of the facilitator to empathically challenge could be important solutions to this. Furthermore, in contrast with previous studies (Johnstone & Paley, 2013), improved staff and service user relationships were not outcomes recognized by CRHTT staff who attended RPGs. Given the importance of the therapeutic relationship in moderating CRHTT outcomes (Morant et al., 2007; Middleton et al., 2011; Mulligan et al., 2022) a more explicit focus on staff and service user relationships might optimize RPGs delivered in this setting. The greatest challenges to RPG delivery were operational in nature as staff struggled to prioritise attendance alongside ever-increasing caseloads and busy working environments. If CRHTTs are to provide its staff with access to RPGs in line with recommended guidelines (RCP, 2019), then flexible operational and managerial support would be imperative to ensure CRHTT staff are encouraged to, and can, attend. Such support is likely to be important for the successful delivery of RPGs in other settings and with different health professionals.

There are some limitations to this evaluation, which require consideration. Firstly, only thirteen staff members took part. A larger sample could have elicited different responses and richer accounts of participant experiences of RPGs. Secondly, only participants who attended at least one RPG were invited to interview. Although this made pragmatic sense to facilitate reflections on the experience, practitioners who chose not to attend RPGs were inadvertently excluded. Therefore, it is possible the sample was biased and may underrepresent those with negative or less-aligned views. Finally, the data was collected by an Assistant Psychologist and Associate Psychological Practitioner who were known to the participants and this could have resulted in demand characteristics. Further studies employing a greater sample size, recruiting those with no attendance and using researchers not known to participants to collect the data could mitigate these risks.

Conclusions

In conclusion, staff appear to value RPGs delivered within CRHTT settings, which play an important role in reducing staff burnout and contributing to workforce development. Staff appreciated RPGs that are structured, consistent, non-judgmental and with established ground rules, which contribute to safety. However,

the beneficial effects of RPGs to staff wellbeing and development were challenged by staff and organisational factors. Therefore, the effective provision of RPGs in CRHTT settings requires proactive support from senior managers to facilitate and optimise staff attendance. To our knowledge, this is the first evaluation of RPGs delivered in CRHTT settings and should act as a catalyst for further research in this area.

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Table 1. Mean and standard deviation of participant endorsement of individual CSEQ items (1=No opinion, 5=Strongly agree).

		Mean	Standard deviation
1.	The purpose of CS is to improve client care	4.62	0.51
2.	I feel safe sharing clinical issues in supervision sessions	4.46	0.88
3.	I believe that any confidences I share are respected	4.62	0.51
4.	I have gained new clinical insights through supervision	3.92	1.26
5.	There is mutual trust between the members in my group	3.85	1.34
6.	Clinical supervision has definitely had a positive impact on the quality of care I provide	3.85	1.34
7.	Being part of a clinical supervision group is helping to develop my self-awareness	4.38	0.51
8.	Clinical supervision has helped me feel more confident about dealing with my job	3.62	1.39
9.	The purpose of CS is to enable clinicians to feel confident in their own practice	3.85	1.21
10.	I feel confident about bringing issues to CS	4.38	0.87
11.	Clinical supervision has helped me cope with any stresses at work I may have	3.85	0.99
12.	Clinical supervision has made me more aware of areas of skill I need to improve	3.77	1.17
13.	There are well established ground rules in my group	4.77	0.44
14.	I am clear about what I want to get out of CS	4.46	0.66

Table 2. Percentage of combined participant endorsement of individual CSEQ items.

		Strongly agree	Agree	Disagree	Strongly disagree	No opinion
1.	The purpose of CS is to improve client care	61.54%	38.46%	0.00%	0.00%	0.00%
2.	I feel safe sharing clinical issues in supervision sessions	61.54%	30.77%	0.00%	7.69%	0.00%
3.	I believe that any confidences I share are respected	61.54%	38.46%	0.00%	0.00%	0.00%
4.	I have gained new clinical insights through supervision	46.15%	23.08%	7.69%	23.08%	0.00%
5.	There is mutual trust between the members in my group	38.46%	38.46%	0.00%	15.39%	7.69%
6.	Clinical supervision has definitely had a positive impact on the quality of care I provide	38.46%	38.46%	0.00%	15.39%	7.69%
7.	Being part of a clinical supervision group is helping to develop my self-awareness	38.46%	61.54%	0.00%	0.00%	0.00%
8.	Clinical supervision has helped me feel more confident about dealing with my job	30.77%	38.46%	0.00%	23.08%	7.69%
9.	The purpose of CS is to enable clinicians to feel confident in their own practice	30.77%	46.16%	7.69%	7.69%	7.69%
10.	I feel confident about bringing issues to CS	53.85%	38.46%	0.00%	7.69%	0.00%
11.	Clinical supervision has helped me cope with any stresses at work I may have	23.08%	53.85%	7.69%	15.38%	0.00%
12.	Clinical supervision has made me more aware of areas of skill I need to improve	23.08%	53.85%	7.69%	7.69%	7.69%

13.	There are well established ground rules in my group	76.92%	23.08%	0.00%	0.00%	0.00%
14.	I am clear about what I want to get out of CS	53.85%	38.46%	7.69%	0.00%	0.00%

Table 3. Mean and standard deviation of participant endorsement of individual AS items.

	Mean	Standard deviation
Confidence as a practitioner	3.46	1.51
Practical skills	3.38	1.39
Theoretical knowledge	3.53	1.51
Ability to be reflective during interactions with clients.	4.38	1.19
Ability to be reflective after interactions with clients.	4.62	1.26
Desire to actively develop my professional capabilities.	4.46	1.45

Table 4. Percentage of combined participant endorsement of individual AS items.

	Extremely (%)	Very Much (%)	Moderately (%)	Somewhat (%)	Slightly (%)	No Opinion (%)
Confidence as a practitioner	0.00%	23.08%	46.15%	7.69%	0.00%	23.08%
Practical skills	0.00%	15.38%*	53.85%*	0.00%	15.38%*	15.38%*
Theoretical knowledge	7.69%*	15.38%*	38.46%*	15.38%*	7.69%*	15.38%*
Ability to be reflective during interactions with clients.	0.00%	69.23%	15.39%	7.69%	0.00%	7.69%
Ability to be reflective after interactions with clients.	7.69%	76.93%	0.00%	7.69%	0.00%	7.69%
Desire to actively develop my professional capabilities.	23.07%	38.46%	15.39%	15.39%	0.00%	7.69%

*When rounded to 2 decimal places, these data sets represent 99.99%