

Development and delivery of cognitive behavioural therapy training  
in New South Wales, Australia - a project undertaken in the spirit of  
action research.

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### **Abstract:**

This study set out to investigate the understanding of psychological interventions and their place in practice (psychological mindedness) at an Australian mental health service and whether or not it was possible to train clinicians to introduce cognitive behavioural therapy to practice. The study investigated if, after training, clinicians' self-efficacy and readiness to use learnt skills is increased as they begin to deliver cognitive behavioural therapy (CBT) to patients.

To do this a methodological approach was adopted, developed and delivered in the spirit of action research and conducted utilising a practice development model, that employed skills based education and experiential learning methods. A staff scoping survey was conducted to ascertain the psychological mindedness of clinical staff and to gain a picture of the availability of talking therapies across the health service. Following this survey an eight-day CBT training course was developed and delivered. A pre- and post- course questionnaire was applied to gain data on participant's readiness to use skills and an increase in their self-efficacy pertinent to CBT that they learnt during the course.

The results of the scoping survey showed that there was use of talking therapies by clinicians and that these clinicians desired training in CBT. The results of the CBT course questionnaire showed that it is possible to increase clinician's self-efficacy and readiness to introduce skills to practice post attendance on an eight-day CBT training course.

The delivery of focused talking therapy training across a mental health service can over time and with adequate levels of support and supervision,

enable the delivery of CBT to service users. Principles of action research, practice development and the use of skills based education and experiential learning methods if implemented and supported actively can increase patient's access to psychological therapies and train staff in the application of the same.

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## **Chapter One**

### **Introduction:**

This thesis reports an evaluation of the development and implementation of a training project designed to enable nurses and other mental health professionals to conduct psychological interventions in clinical practice. The interventions taught to the clinicians were based on the principles and practice of cognitive behavioural therapy (CBT) and delivered as an eight-day training course. To ensure the ongoing delivery and currency of this teaching project I conducted a piece of research that was developed and delivered in the spirit of action research in parallel to the teaching intervention to ascertain whether or not participants on the training programme evidenced increased self-efficacy in their self reported readiness to use the skills they had been taught. I was also keen to see if the training programme had an impact on nurses and other mental health professionals understanding of psychological interventions.

The problem:

In New South Wales, Australia, up until 2010 there were no formal, accredited CBT training programmes for mental health professionals to enable learning in CBT and the subsequent development of CBT practice with their patients. The Australian Commonwealth Government had made provision in the 'Medicare' services (equivalent to NHS) for patients to receive up to 12 sessions of CBT. 'The 2006 government initiative, Better Access to Mental Health (COAG, 2006), which sought to reduce the extent of mental disorder by enhancing access to psychological services, extended the Medicare subsidy to cover short-term (up to 12 sessions [or 18 in exceptional circumstances] per calendar year) psychological interventions by psychologists, and appropriately qualified social

workers and occupational therapists' (Bennet-Levey & Perry, 2009, p1)

Achieving this had proved difficult due to the lack of appropriately trained mental health professionals particularly in rural, remote and some metropolitan areas (Judd & Humphreys, 2001). In Northern Sydney Central Coast Health service (NSCCH), my employer, it was not known how many 'appropriately trained' mental health professionals were available to practice, thus it was decided to identify numbers of staff. To achieve this it was decided to conduct a staff scoping survey focused on psychological interventions, this became the 'MoodMatters' research project, phase 1 of this study. Dependant on results of the survey; I hoped to develop a training programme to enable staff, over time to deliver psychological therapies, initially cognitive behavioural in approach.

Questions to be answered:

1. Can research methods developed and delivered in the spirit of action research, utilising theories of skills based education and learning, enable the development of usable CBT skills in mental health care by increasing clinician's self-efficacy?
2. Can an eight-week skills based CBT course increase mental health professionals' self reported readiness to use skills and increase their self-efficacy in the application of CBT in clinical practice?
3. Can an Area Health Service adopt practice development principles and practices to enable clinicians to deliver psychological care?

### **1.1 Research project development:**

A research approach was taken, developed and delivered in the spirit of action research. I developed a three-phased cyclic research and training model that enabled active participation by course attendees, this cyclic approach

enhanced the development and delivery of all subsequent courses. A steering committee was developed, major stakeholders were interviewed and all health service staff were sent a skills and training survey for completion ('MoodMatters' survey) before the CBT course development stage. This survey was designed to gather information and data pertinent to the perceived skills of staff, ability to deliver those skills and training and supervision received in eighteen identified talking therapy modalities.

This led on to the development of a subsequent questionnaire designed to gain an understanding of and insight into staff's pre- and post- knowledge and skill levels in talking therapies and CBT. The aim was to gather data to see if an eight-day training package would give staff the capacity to deliver low level psychological interventions, delivered broadly within a CBT model. This reflected my hypothesis that: "Nurses and some allied health professionals deliver care within a behavioural and often cognitive behavioural paradigm – they just don't know they are doing it. So if they were taught the fundamentals of CBT, would that increase their awareness?" The three phases of the research cycle are outlined in the methods section.

A brief outline of each phase:

The first phase of the research project was designed to capture a snapshot of the level of psychological mindedness, delivery of psychological therapies, and the support staff needed to offer psychological interventions in practice. To do this a staff scoping survey was developed, this later became known as the 'MoodMatters' project. This survey was circulated to all 1200 clinical staff across

Northern Sydney Central Coast Mental Health services. The CBT training course pre- and post- questionnaire, were developed after the completion and analysis of the 'MoodMatters' element of the research project and utilised a similar design to the initial staff survey. The design and development of the data gathering tools will be discussed in the methods chapter of this thesis. The second phase of the research project was the development and delivery of the CBT training course and the third was the analysis of the data gathered during the CBT training course. The second phase of the research project was delivered by employing action research cycles with all teaching and research element running concurrently.

#### Research Project:

The purpose of this study was to explore if it was possible to increase patients access to evidence-based talking therapies, initially CBT by training staff to deliver the therapy across NSCCH a large metropolitan and rural health care provider in NSW, Australia. The management of the health service, due to the paucity and availability of training in CBT across NSW (Bennett-Levey & Perry, 2009) and the limited number of health care professionals able to deliver 'formulation' based CBT, were very keen to up-skill their clinical staff in this area.

In 1989 Pearson's defined a formulation as:

'...a hypothesis about the nature of the psychological difficulty (or difficulties) underlying the problems on the patient's problem list' (p. 37). Pearson's approach aims to develop an active discussion between the patient and therapist designed to aid the clarity of problem and treatment definition. It develops a shared 'route map' that both the patient and therapist can follow,

checkout and review during and beyond therapy. A formulation is an ever-evolving description of the patients identified problem, often within a specific cognitive model.

An increase in the number of health care professionals conducting CBT with their patients would be a significant gain for NSCCH. Targeting and training other health care professionals (not just psychologists) to deliver CBT would have a marked impact on the availability of the therapy across NSCCH. A significant proportion of mental health staff in NSW are from a nursing background, who traditionally do not provide 'evidence-based talking therapies' with their patients, as they were not trained to do so in NSW (Mullen, 2009). If this traditional view can be challenged and nurses are trained to deliver CBT, many more patients will have access to talking therapies (Rossiter, Schofield, Hazelton, 2008, 2009). Thus over time, with correct managerial support and clinical supervision, services will have staff providing 'evidence-based talking therapies' at the 'coal face' of care provision. More recently qualified nurses graduate with either a first degree or masters in nursing (Wolfe, 2006). In clinical practice that academic rigor is not always translated to clinical competence and novice nurses often feel de-skilled in the area of their professional choice (ACMHN, 2010).

Post basic education in NSW, Australia for qualified nurses and allied health professionals has traditionally been developed and delivered by Area Health Services, with the focus on introduction to service and mandatory training, leading to a limited focus on clinical skills training (ACMHN, 2010).

Background to Research Project:

In the United Kingdom (UK) cognitive behavioural therapy (CBT) is

positioned as a 'first line' treatment for depression and anxiety with the same therapeutic efficacy as anti-depressant medication i.e. 60% success rate in both cases (NICE, 2010). In 2008, England introduced the 'Improving Access to Psychological Therapies' (IAPT) initiative (DoH, 2010), and since this time in England, cognitive behavioural therapy has become a major component of standard care. 'The Improving Access to Psychological Therapies programme aims to improve access to evidence-based talking therapies in the NHS through an expansion of the psychological therapy workforce and services' (DoH, 2010).

This study was conducted in New South Wales (NSW), Australia as I had taken up a position with a local health care provider that was designed to introduce a practice development ethos across the health service. In NSW 'evidence-based talking therapies' were not as available as they were in the UK, predominantly due to staffing issues and lack of training to enable staff to provide them. To address this shortfall the New South Wales Health Department was at that time considering adopting the English IAPT initiative. Health services did offer psychological therapies, but the number of clinicians trained to deliver these therapies was small and they were mainly clinical psychologists, who often preferred to deliver therapy in private clinics, and to a more 'worried-well' population, due to the nature of private work and its positioning in primary care facilities. As therapy was privately funded, individuals with serious and enduring mental illnesses such as acute depression, anxiety disorders and psychotic disorders, were often unable to access private therapy due to cost implications and incarceration in psychiatric hospitals. A number of 'Third Sector/voluntary' organizations and private concerns were also offering 'talking therapies' but this

delivery was sporadic, as there were not many therapists employed by this sector. Again this therapy was not normally available to individuals with a serious and enduring mental illness, and not often available outside the big cities.

## **1.2 Talking therapies:**

In order to explore and consider the context of the research study that will be outlined in this thesis it is important to outline the genre of interventions under consideration. The IAPT (2008) programme (Improving Access to Psychological Therapies) states the following:

“Talking therapies is a broad term covering a range of therapeutic approaches, which involve talking, questioning and listening to understand, manage and treat people’s problems. The treatment includes counselling, CBT, psychoanalysis and psychodynamic therapies” (DoH, 2010). In NSW there were no formal educational programmes or programmes like IAPT offering training in psychological therapies consistent with this definition. This led Northern Sydney Central Coast Health (NSCCH), to address this identified gap in practice by attempting to develop in house CBT training within a practice development paradigm.

Cognitive Behavioural Therapy:

The Royal College of Psychiatrists (2012) briefly defined CBT as:

A way of talking about:

- how you think about yourself, the world and other people
- how what you do affects your thoughts and feelings. (RCP, 2012)

The body responsible for accrediting and monitoring CBT and related therapies in Australia, the Australian Association of Cognitive Behaviour Therapy also offers a definition of CBT:

‘Cognitive Behaviour Therapy (CBT) is a talking therapy. It can help people who are experiencing a wide range of mental health difficulties. What people think can affect how they feel and how they behave. This is the basis of CBT.

During times of mental distress, people think differently about themselves and what happens to them. Thoughts can become extreme and unhelpful. This can worsen how a person feels. They may then behave in a way that prolongs their distress.

Cognitive and behavioural psychotherapies are a range of therapies based on concepts and principles derived from psychological models of human emotion and behaviour. They include a wide range of treatment approaches for emotional disorders, along a continuum from structured individual psychotherapy to self-help material’ (AACBT, 2012).

### **1.3 Educational models:**

One of the core approaches deployed during this research project to enable interaction with the research participants, was the use of extensive experiential learning exercises and projects as teaching tools and aids. These were developed within a practice development framework, with the use of a ‘Critical Companion’ based supportive approach, which will be expanded upon



later in this study. I, as the researcher had the responsibility of enabling the participants to gain or not quantifiable and usable CBT skills. It was hypothesised that over-time as their self-efficacy increased the participants would employ CBT skills in practice with their patients and eventually, disseminate practice skills to their colleagues and peers. This was to be done using a cascade educational approach, drawing upon action research skills and methods learnt during course attendance, such as pre- and post- evaluation. To achieve this I utilized a number of active educational methods, examples of which are; role modelling of therapeutic skills, didactic teaching/lectures, extensive role played scenarios, observed practice role plays, video work, coaching and in-depth consultations about clinical practice addressing ongoing and hypothesized CBT application difficulties.

I drew on the work of Kolb's (1984) experiential learning cycle, cognitive models of education and employed a basic humanistic approach to the educational process. Key proponents of humanism include Carl Rogers (1951) and Abraham Maslow (1970, 1971). The primary purpose of humanism could be described as the development of self-actualized, autonomous people, and in this case mental health practitioners. In humanism, learning is student centred and personalized, and the educator's role is that of a facilitator, which again fitted well with my methodology. The student's affective and cognitive needs are key considerations, and the goal is to develop these skills in a cooperative and supportive environment.

#### **1.4 Action research:**

Brief History of Action Research:

In the early part of the twentieth century Wilfred Bion (1946) experimented with 'self directed group therapy', this approach meshed with Lewin's (1946) collaborative approach to inquiry and behavioural change using group dynamics. The Tavistock institute an influential and leading body in the group dynamics movement of the 1940s, believed that "knowledge should be created from problem solving in real life situations" (Herr and Anderson, 2005 p. 11). Much of the work of the Tavistock group was conducted in active work environments such as factories and coalmines. Lewin, Bion and others challenged the Taylorite management principles employed in production industries at that time (Taylor, 1911). This has relevance in today's health service as to some extent there is still a reliance on outdated management principles and practices (Bhugra & Burns, 1995). This reliance was evident in NSW with an extended nurse management structure in place and the historical power of the Consultant Psychiatrist in mental health services design, direction and delivery underpinning service provision (Bhugra & Burns, 1995, Deem, 1988). I found the work of theorists such as Lewin, Kemmis and McTaggart and the Tavistock Institute informative and relevant whilst completing this research project, as my approach was designed to be collaborative, lead to social action and change within NSCCH, using the theories of Lewin (1948):

"The research needed for social practice can best be characterized as research for social management or social engineering. It is a type of action-research, a comparative research on the conditions and effects of various forms of social action, and research leading to social action. Research that produces

nothing but books will not suffice” (Lewin 1946, reproduced in Lewin 1948: 202-3).

I also thought that by adopting and utilising methodologies in the spirit of action research would justify social collaboration and enable collective self reflective enquiry aimed at improving the processes developed to facilitate the CBT training course delivery as discussed by Kemmis and McTaggart (1988):

“Action research is a form of collective self-reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own social or educational practices, as well as their understanding of those practices and the situations in which the practices are carried out... The approach is only action research when it is collaborative, though it is important to realise that action research of the group is achieved through the critically examined action of individual group member” (5-6).

I was also attempting to enable the NSCCH service to adopt a change methodology designed to impact on and alter key areas of the systems service provision. This approach is described by the Tavistock Institute and can be found on their website circa 2010. Although the definition is old I can see marked similarities to the structures in NSCCH and to the work I was attempting to do:

Socio-technical systems design to help clients grapple with the emerging changes in the organization’s context, encompassing job-, work- and organization design for joint optimization of both technical and psychosocial resources. This was initially developed through collaboration in English coalmines (Trist & Bamforth, 1951) and Indian textile mills (Rice, 1958).

To enable this shared growth I have drawn upon theories and models pertinent to educational and therapeutic practice in the spirit of an action research approach. Mills (2003) states that in action research:

“The information is gathered with the goals of gaining insight, developing reflective practice, effecting positive changes in the school environment and on educational practices in general, and improving student outcome”. (p. 4)

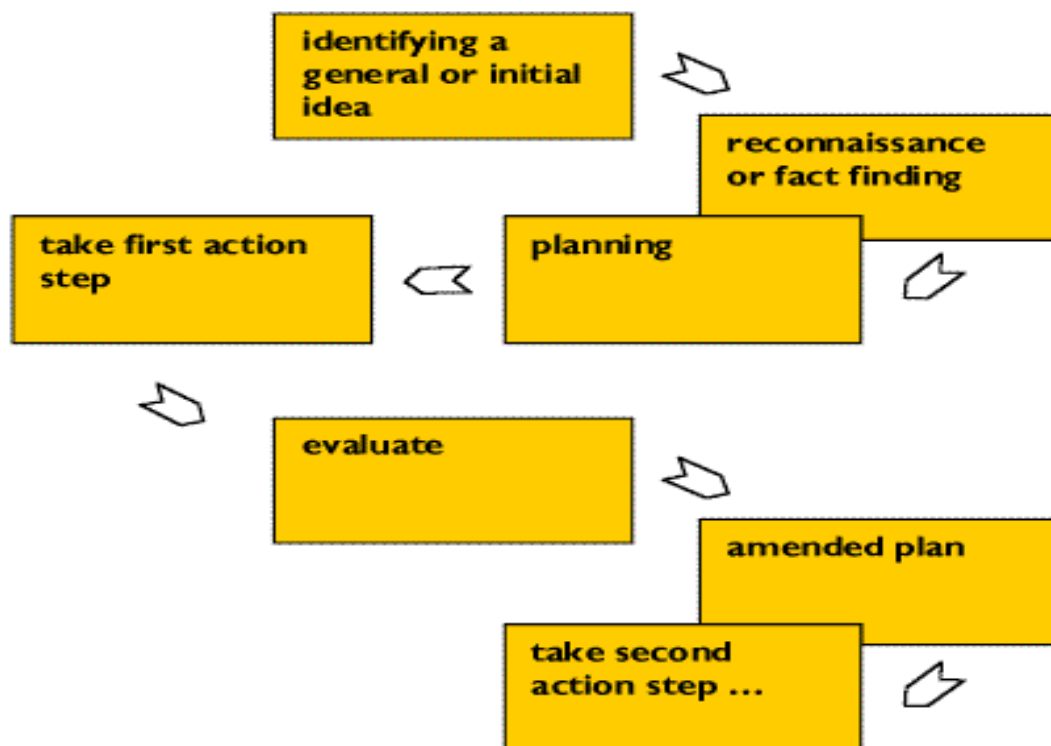
The Mills' 2003 definition of action research outlines and captures the core aims and objectives of this research project. Action research involves using cyclic research methods to plan, implement and evaluate change in practice (Parahoo, 2007) the process of change in this project was based on the deployment and success or lack of, of the cyclic intervention itself. It was designed to ascertain if teaching qualified mental health professionals CBT skills, whom, having had no core training in CBT or other equitable talking therapies post initial qualification, could change their self-reported readiness to use these skills in clinical practice. I also aimed to gain insight into the process of change; understandings of the place of skills based education in the clinical setting and develop personal reflective practice and teaching skills. It was hoped that participants would develop research, education and reflective practice skills too, and over time use them in their everyday practice.

I was keen to see as the project progressed if a positive change in the self-reported readiness to use skills and the self-efficacy of participants would be evident, which gradually post-course completion would also improve outcomes for patients and the psychological mindedness of the parent organization which I

didn't test. It was also hoped that a model for the ongoing development of practice post research would be provided by this approach.

The process of the intervention drew on the work of Mills (2003) and Lewin (1946), delivered and orientated towards the identified needs of workers and the work place. Kurt Lewin's (1948) 'Action Research Cycle' (Figure 1) outlines the approach that was adopted in this intervention, from initial idea generation to taking the second then third action steps. Problem solving is an integral aspect of CBT practice, and the utilization of the research cycle suited the action research model employed and the experiential learning cycle utilized to drive the intervention.

Figure 1. Kurt Lewin's, Action Research Cycle. (Infed, 2010)



My research cycle mirrored Lewin's work as the phases flowed from idea generation, to reconnaissance or fact-finding, which consisted of meeting with

key stakeholders across the health service. This then led to the planning of the 'MoodMatters' survey, delivery of the survey, analysis of data gathered, development of the CBT course questionnaire and the subsequent development and delivery of the CBT training course. The second action step was the gathering of CBT course related data and the cyclic development of subsequent CBT courses. Stages were repeated and the CBT course data was analysed and reported on. The ongoing developmental nature of the research project drove the process at NSCCH. The staff scoping survey 'MoodMatters' identified the direction of the research project and also the research population to be targeted (NSCCH, 2007).

This (MoodMatters) scoping survey will be outlined in more detail as it was effectively a way of identifying the sample of respondents to be included in the study. There were pros and cons in using this method of identifying participants for example small numbers of returned surveys only gave an indication of talking therapy delivery across NSCCH, and the low response rate of 10% calls into consideration the reliability and validity of the data gathered and reported that led to the development of the CBT training programme.

The potential over representation of psychologists could mask the number of other disciplines delivering talking therapies; the survey could have raised the awareness of staff about talking therapies and may have created interest in pursuing training in this area. Analysis of the survey which due to low return rates may not have been reliable and may not have provided equivocal data that led to the development of the eight-day CBT training course, the development of the pre- and post- course questionnaire (appendix 2) and the

identification of the intervention model employed during the research. As previously stated the study was developed and delivered in the spirit of action research “to improve the rationality and justice of their own social or educational practice” (Kemmis and McTaggart, 1988 p. 5-6).

I wished to achieve quantifiable and recognizable personal, professional and educational growth and development in myself, the participants and the mental health service as a whole. There is a long tradition of work place orientated action research in psychotherapy and the social sciences, but as Herr and Anderson stated in 2005;

“these traditions are distinct from and generally at odds with the mainstream academic research tradition in the social sciences” (p. 10).

However I thought I could justify the adoption of this approach, as action research is a developing field in nursing and nursing research. I was also conducting a project that focused on developing a model that would enable me to train mental health professionals in CBT. I thought that due to the nature of services provided by NSCCH, active CBT course development between each training provision would be a necessary component of successful CBT course delivery, and a cyclic approach suited this. This cyclic approach would have been augmented if I had kept the initial meeting and course written and verbal evaluation data to show progress from course one to course eight and not stored the student data as one core data set, which sadly didn't allow me to conduct a more in-depth individual participant data analysis from course one to the final course. Thus I was unable to show progression of individual students over and post duration of course of the courses delivered.

## **1.5 Overview of subsequent chapters:**

Chapter two introduces the subject area and literature, it outlines the reasons why the research project focused on the specific content area, introduces the reader to evidence based practice and cognitive behavioural therapy and discusses their place in mental health care within a nursing paradigm. It continues by drawing on the UK experience and discusses service provision in NSW, Australia. Chapter three outlines the practice development ethos that underlined the project, and discusses why I chose the particular model of practice development utilised during this project. It also discusses relevant theories and models of education and talks about the role of the critical companion in the delivery and support of the ongoing CBT training programme. Chapter four discusses the methodology and methods that underpinned this research project; for ease of reading I have presented these in two sections, section 1; methodology and section 2; methods. Chapter five introduces the reader to the pedagogy of the project and discusses the CBT training course (phase 2 of this project); this is done using two separate voices, one from an academic perspective and the other from that of a personal reflection on the research journey. Chapter six discusses the analysis of the 'MoodMatters' survey' (phase 1 of this project) and the subsequent CBT course questionnaire analysis (phase 3 of this project). Chapter seven offers the conclusion, discussion and recommendations drawn from the project. It also outlines my personal growth and development as a novice researcher.



## **Chapter 2.**

### **Why cognitive behavioural therapy and evidence-based practice?**

#### **2.1 Literature and context of the project:**

This literature review will explore selected, but key areas of knowledge in the form of research, policy and practice that frame my interest in the topic. A historical perspective on Schizophrenia will be used, as an illustrative example of a response to mental illness and this will be followed by sections on the impact of training, policy developments, evidence based practice and CBT. The purpose of this study was to explore readiness or not to use skills in CBT by staff that attended an eight-week CBT course. It was also hoped to ascertain if training and then subsequently supporting clinical staff to deliver CBT in clinical practice was possible, and to identify what were the key elements in success or failure of this approach.

Unlike the picture in the UK, the majority of mental health professionals in New South Wales have had no access to psychological or psychosocial interventions (PSI) training, supervision or practice. I had developed a model of training in the UK that was extensively modified for Australian delivery at Northern Sydney Central Coast Health Service, NSW, Australia. I was interested in being able to evidence a change in self-reported readiness (self-efficacy) to use skills developed during training in CBT, and the application of those skills post training, rather than the study of an existing skills set which to all extent and purpose, didn't exist.

Historical perspective:

Research from the UK shows that many health care providers have sent staff on skills based courses (Young & Hulatt, 2003) but on return to normal practice the trainees have found it difficult to translate the skills and knowledge gained into their current clinical practice. Since the phenomenon of schizophrenia was recognized as a clinical entity by Kraepelin (1919) in the latter part of the 19<sup>th</sup> century, notions of inevitable deterioration, indefinite hospitalization, burnout and irreparable damage to the personality have been the accepted degenerative route for individuals with schizophrenia and psychoses, this is no longer the case and the burgeoning of interventions designed to be offered early on to individuals with a psychosis attest to that (Addington et al, 2011).

The belief that psychotic symptoms were not benefited by psychotherapeutic approaches held sway. Nurses' and other mental health professionals approach to working with individuals with a psychosis was to ignore delusional and hallucinatory content and to reinforce 'objective' reality, in effect denying the 'subjective' reality of the consumer, and preventing access by the professional into the conceptual world of the individual (Chadwick, Birchwood and Trower, 1996, Chadwick & Birchwood, 1994). Consequently, despite both the severity of presentation and the long-term deficits resulting from psychosis, mental health professionals have been ill equipped to provide therapeutic interventions (Gournay & Beardsmoore, 1995). In particular, there was a failure to address the breadth of mental health, physical health and social functioning dimensions (Hannigan et al, 1997, Gournay & Beardsmoore, 1995)

which consumers and their carers' value, and which psychotic illness disrupts. Care was offered on the basis of custody, containment and maintenance by psychopharmacology (Bhugra and Burns, 1995).

Such therapeutic poverty impacted on services provided by mental hospitals, and resulted in consumers having reduced citizenship, limited treatment choice and adversarial and paternalistic 'care' both in and out of the institution. The development of community services in the 1980s began to demand a reappraisal of attitudes towards mental illness, and started to set the scene for new thinking. However the professionals' range of non-medication based therapeutic interventions remained limited (Brooker et al, 1998).

The impact of psychosocial interventions and CBT training:

Modern health services are increasingly offering evidence-based interventions and clinical services to patients and their carers (Hannigan & Coffee, 2003). To meet this demand, many educational institutions provide skills based training designed to equip health professionals with evidence-based skills to treat patients and carers. These development has been encouraged by recent governmental directives (Hails et al, in press), notably in the United Kingdom 'The National Service Framework for Adult Mental Health' and other mental health related policies (DoH, 1990, 1991, 1994, 1999, WAG, 2001, 2002, 2005) and the National Institute for Clinical Excellence Guidelines in the treatment of Schizophrenia (NICE, 2002, 2004/7, 2006, 2009).

In Australia the move has mirrored the picture in the UK to an extent, but there was not the huge drive towards deinstitutionalization that occurred in the UK during the 1960s and 1970s culminating in the majority of mental hospitals

having closed in the UK by the 1990s (Bostock et al, 2004). Care in NSW was mainly focused on institutional delivery with community care services providing care when the patient was not confined to hospital. A definition of deinstitutionalization is given below:

“Deinstitutionalization refers to the large-scale restructuring of human services delivery; usually involving the closure and downscaling of institutions and their replacement by a variety of community care services. It represents one of the most profound social policy shifts in the history of western welfare states (Mansell & Ericsson 1996a, 1996b) and since the 1960s all Australian states have pursued their own deinstitutionalization programs” (Bostock et al, 2004, P42).

The deinstitutionalization process in Australia took a slower, less prescriptive and more pragmatic approach than the UK, focusing on the nature of social, financial and therapeutic supports for people leaving institutions. But, unlike the UK, Australia did not invest in training aimed at enhancing service re-design and development (Hazelton, 2004, 2005, 2009). This training would have enabled the newly deinstitutionalized patients access to staff and services with the ability to offer a broad range of both medically and therapeutically focused interventions, designed specifically to keep them asymptomatic and out of hospital.

New South Wales ended mental health nurse training in 1986, when pre-registration training became a higher education course based in Universities and no longer in Health Services. Also at that time a single register for qualified nurses was introduced to New South Wales thus removing mental health nursing as a separate point on the register (NMBNSW, 2009). In hindsight this has been

proven to remove a level of care and professional expertise needed to provide community based and in-patient mental health services (ACMHN, 2010). Nurses were no longer trained solely to work with individuals with mental health needs and their families and subsequent to this access to psychological work became scarce. In the UK a number of post-basic courses were introduced to enable health care professionals and providers to deliver evidence based care to their patients and patient's carers. However evidence within mental health services shows that clinicians find it difficult to offer these interventions post course completion (Brooker et al, 1994, 1998, 2002, Brooker & Brabban, 2003, 2004, Brooker & Repper, 1998, Hails et al, in press).

Statistics show that 1% of the general population has Schizophrenia or a related disorder (Bhugra & Burns, 1995, ABS, 2009), 2.6% of the adult population of the United States have Bipolar Disorder and 6.7% a major depressive disorder (Kessler et al, 2005). Thus it is imperative that health care providers and educators are able to understand the difficulties staff, patients and carers face in every-day clinical practice pertinent to the use and application of evidence-based practice, PSI and CBT based service provision.

Psychosocial interventions (PSI) and CBT have emerged as a medium through which therapeutic work with individuals experiencing psychosis and their families can develop (NICE, 2010). As a profession, mental health nursing should be doing more to promote the adoption and delivery of psychosocial interventions and CBT in health and social care services (Hails et al, in press). A definition of PSI is offered below, the underpinning principles are laid out and practical application of psychosocial interventions and CBT are discussed.

Psychosocial interventions can be defined as:

“An approach that works with the individual and their systems as a whole, and collaboratively introduces interventions designed to focus on distress utilizing a holistic approach” (Hails, 2001).

“Therapeutic interventions that use cognitive, cognitive-behavioural and supportive techniques to ameliorate a client, relative or family problem associated with a psychosis. Psychosocial interventions are based on a bio-psycho-social understanding of psychosis that has recovery as a goal” (Sainsbury Centre for Mental Health, 2004).

These approaches are of relevance to mental health nurses and allied health professionals working with individuals and their families experiencing psychosis, whether practicing in in-patient or community settings. Psychosocial interventions and CBT enable the delivery of skilled and focused therapy aimed at improving the individual’s ability to cope with their psychotic experience, and reducing family and consumer distress (Gamble & Brennan, 2006).

There is conflicting research evidence as to the efficacy of psychosocial interventions and CBT for psychosis. Some studies have claimed efficacy (Lancashire et al 1997, Lancashire, Haddock & Tarrier, 2003, O’Carroll et al 2004, McCann, 2001). These studies explored the ability of clinicians trained in aspects of PSI and CBT to implement those therapies post training; it was shown that if the trainee was supported post qualification then they were able to deliver CBT based practice. While other studies have drawn attention to the limitations of PSI approaches in mainstream practice, as opposed to within trials or research studies (Clarke, 1999, Kavanagh, 1992, McCreadie et al, 1991, Bailey, Burbach, &

Lea, 2003, Holmes, 2002, Morrall & Hazelton, 2009), the major concern here was the low percentage of clinicians implementing CBT based interventions. In England the IAPT project has greatly enhanced the availability of CBT in practice settings.

CBT has to an extent been adopted by the Department of Health in England as being the specific psychotherapy of choice for anxiety and depression based complaints. Latterly Guidelines have been issued that focus on Schizophrenia and related psychotic disorders and again CBT is offered as one of a small number of non-pharmaceutical interventions that must be offered to this client group. This has drawn criticisms from practitioners of other therapeutic modalities, who argue that the 'mechanistic' approach and often-superficial focus given to the therapeutic relationship in CBT detract from the lived experience that needs to be unpacked during therapy (Palmer, 2009 in House and Loewenthal, 2009). CBT stresses that models and protocols do not alone direct therapy, but the relationship of those models and protocols to the patient's distress do. In CBT, models and protocols of therapy can be used to ascertain what is maintaining the patient's difficulties; they also enable an understanding to be developed by the patient of the relationship between cognition, emotion and their behaviour (Hoffman & Asmundson, 2008).

CBT practitioners argue that the time spent engaging and socialising a patient to CBT (Beck et al, 1979) engenders a strong therapeutic bond between the patient and the practitioner (Mansell, 2009). CBT has been criticized for ignoring the role of the therapeutic relationship (Leahy, 2008), he goes on to argue that case conceptualisation and formulation can be powerful tools for

understanding the causes of and strategies designed to overcome impasses in therapy (p. 769). Research into CBT has highlighted the importance of 'socialising' the patient to therapy, thus enabling them to understand what will happen during the sessions by giving them an outline of the therapeutic process. Other psychotherapeutic modalities rely heavily on the relationship that develops between the therapist and patient, this relationship is used as one of the core therapeutic techniques to engender change in the patient's condition. The importance of the therapeutic relationship is acknowledged in CBT, but not used to affect change in the patient to such an extent. To do this a more collaborative stance is taken, with decisions and goals being decided jointly. Cognitive behavioural therapists have proposed that this relationship reflects interpersonal schemas, attachment problems, emotional processing, failures in validation and compassion, and processes underlying non-adherence or direct resistance to therapy (Leahy, 2008).

CBT is not a magic-bullet, nor is it something that is done to the patient, it is a process of active collaboration designed to target the patient's problems and needs (DoH, 2010). Nor is CBT only about positive thinking, it aims to enable the patient to see issues and problems in a healthier and more balanced fashion (DoH, 2010). A partnership develops between the patient and therapist and at the end of therapy the patient will have a repertoire of skills learnt and practiced during CBT, designed to help them in their life post- therapy. This could be looked on as one of the strengths of CBT and may enable the patient to treat themselves to an extent. CBT is criticised for only working with patients who have a level of psychological mindedness prior to attendance; this is not the case

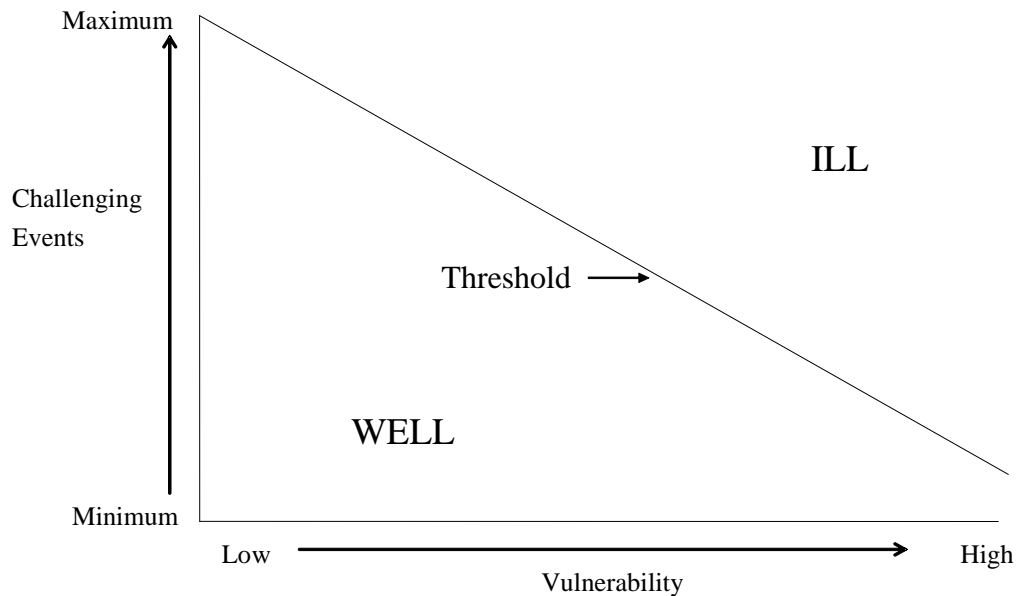


as the early sessions can be used to develop the patient's capacity to look into and understand the place of their emotions, thoughts and feelings. If patients are discharged prematurely due to a lack of psychological mindedness on their part, the CBT therapist is failing in their duty of care to help the patient and could be justifiably criticised.

Implementing CBT in practice, even by specially trained nurses, has proven to be problematic (Lancashire et al, 1997, Lancashire, Haddock & Tarrier, 2003, O'Carroll et al, 2004). Research into the ability of staff with training in PSI and CBT showed that practitioners were often unskilled or unsupported in their efforts to deliver interventions with their clients (Brooker et al, 1994). More recent work suggests that with attention to the co-ordination of PSI and CBT work, and making support available to practitioners, implementation is possible and successful, (Brooker & Repper, 1998, Brooker, 2001, O'Carroll et al, 2004, NIMHE, 2004, NICE, 2010).

The delivery of psychosocial interventions and CBT requires that the health professional works with the patient to develop a shared understanding of their illness. A collaborative approach is engendered to focus on the patient's thought processes, symptoms and social situation, as well as the effects of these on the individuals' relationships with others and their social world. PSI and CBT are dependent upon assessing and understanding the 'worldview' of patients and are underpinned by the 'stress-vulnerability' model of psychotic causation (Zubin & Spring, 1977) (figure 2).

Figure 2. Zubin & Spring's Model of the Interaction Between Vulnerability & Stress (1977)



Copyright Author acknowledges work of Zubin and Spring (1977) & Institute of Psychiatry, Maudsely Hospital, London.

PSI and CBT attempt to maximise the individuals' coping strategies, thereby minimising vulnerability due to internal and external stressors, by offering them a structured model of therapy (Beck, 1972, 1975, Beck et al, 1979).

Psychosocial interventions, CBT and mental health nurses:

No single professional group carries sole responsibility for the provision of talking therapies. In practice, nurses tends to carry the responsibility for administering and monitoring medication, and community nurses have recognized this as being both central to their role and distinguishing them from other mental health professionals (DoH, 1994, Gray et al, 2006, Clarke, 2008). Such core activities have sometimes limited mental health nurses'

psychotherapeutic roles particularly in the community (Jordan et al, 1999, Hails, 2006, Foster et al, 2008).

Cognitive behavioural and psychosocial intervention trained nurses have developed repertoires of evidence-based skills (Gray et al, 2001, O'Carroll et al, 2004, Hails et al, in press). These skills are increasingly being shared and made accessible to the broader professional community. Equally as important, the value of consumer participation in care planning as well as policy formation, service design and training of professionals is now being recognized. Recognition of the primacy of the consumer's experience in a productive partnership with mental health nurses and other professionals is no more than consumers have been calling for as the foundation of contemporary recovery based services (Campbell, 1999).

## **2.2 Policy**

Refocusing services on the needs of the severely mentally ill was a cornerstone of policy initiative during the last decades of the 20th century and has continued into the 21st century (CoA, 2000, COAG 2006, NSWDoH, 2006, Bowler et al, 2000). This has resulted in psychoses becoming a defining characteristic of the term 'serious mental illness', around which mental health service delivery was to be targeted (CoA, 2000, COAG 2006, NSWDoH, 2006). Policy was now ascribing priority status to individuals with psychotic illness. More recent policy has had a changed emphasis from generalized service design and care guidance to the necessity for individualized therapeutic care for patients with serious mental illnesses, drawing from and introducing evidence-based care.

The NSW Department of Health (2006) in publishing 'A New Direction for Mental Health' outlined service models and directions that need to be incorporated into care packages designed for individuals with serious mental illness predominantly schizophrenia and related disorders (NSWDoH, 2006). Schizophrenia can be characterised by three phases each of which has appropriate PSI and CBT options. The conceptualization of psychosis as a process following 'acute', 'stabilization' and 'stable' phases (SIGN, 1998), requires that symptoms generally, and delusions and hallucinations in particular, are viewed as complex beliefs and experiences which the individual actively constructs, in a dynamic interplay between their personality, past experience, affect and current events (Fowler, Garety & Kuipers, 1995).

It is now accepted that delusional beliefs and hallucinatory experiences have a content that is relevant and potentially threatening to the patient. Psychotic symptoms are seen as extreme variations of normal belief formulation and appraisal processes. Delusions can be seen as points along a continuum with overvalued ideas and beliefs (Chapman & Chapman 1988). The emergence of PSI and CBT has enabled the development of interventions tailored to individual needs appropriate to the experiences of the consumer (Birchwood et al, 1989). The gradual adoption of PSI and CBT by community nurses and other mental health professionals during the last two decades has helped reverse the longstanding professional axiom that psychotic phenomena were inaccessible to talking therapies.

Psychosocial approaches do not preclude pharmacological treatment, and indeed may contribute towards a more consensual way of working with the

patient regarding their medication and other aspects of their care. Medication still remains central to the effective management of the psychoses. However non-adherence with oral medication is frequent, often due to the unpleasant side effect profile, with consequential relapse rates between 8% and 16% per month (Gray et al, 2001, Gray, 1999, Gray et al, 2006). Professional over-reliance upon medication can contribute to a failure to engage with the consumer's perception of their needs. Such non-engagement with consumer's perceptions can fracture the relationship between the nurse and their patient (Gray et al, 2001, Gray et al, 2010, Maneesakorn, 2007). PSI and CBT provide an adjunct to the pharmacological and biological models of mental illness offering a more balanced and consumer friendly approach. Offering psychosocial interventions and cognitive behavioural therapy as part of the standard care package can facilitate this with patients and their families or carers (Gray, 2006).

### **2.3 Evidence-based practice:**

The growth in popularity of 'research based' 'clinical evidence', 'evidence-based policy' and 'evidence-based practitioners' over the last two decades of the twentieth century and into the twenty first, has far outpaced the health care professions ability to produce, digest and implement evidence into everyday clinical practice (Hancock, 1993, 1995, Chiles, Lambert & Hatch, 1999). Hatcher and colleagues (2005) stated how many articles a practitioner would need to read a day to keep abreast of evidence-based policy publications:

“In 2001, there were over 23,000 articles published on mental disorders, and indexed in Medline and to keep up with the literature would mean reading over 60 articles a day” (Hatcher, Butler & Oakley-Brown, 2005 p.2).

Cormack (1979) suggested that nursing would be recognized as being evidence-based when research and evidence become an integral part of nursing practice (MacLeod-Clark & Hockey, 1979, Hockey, 2000). English (1994) put forward the argument that:

“in spite of an escalation of nursing research in the last 22 years, it has generally failed to influence clinical practice. Also, in spite of a considerable increase in nursing theory, nursing still cannot claim to be a research based profession” (English, 1994, in Cormack, 2000 p.8).

Much of the ‘evidence’ utilized in nursing practice is drawn from related professional groups predominantly psychology and medicine, two professions with a long history of evidence generation and the subsequent clinical application of that evidence (Norcross, Levant & Beutler, 2005, DeAngelis, 2005).

As with nursing, medicine and psychology are still struggling to position ‘evidence-based policy’ in practice settings (DeAngelis, 2005). This is in some extent due to the historical positioning of professional groups and lack of secondary training opportunities that would enable practitioners to implement newer practices or gain support in their endeavours to do so. In Australia there was a noticeable lack of practical modality specific supervision (Hails et al, in press) and this lack inhibits the implementation of evidence-based practices such as CBT and PSIs. Other professions and bodies have struggled with the introduction and usage of evidence-based practice and policy, notably social workers, occupational therapists, housing, and non-government sectors in the caring professions and to some extent academics in higher education (Chambers, 2007).

## Evidence-Based Policy:

Evidence-based policy is difficult to quantify as most definitions describe either evidence-based practice or evidence-based medicine (Marston & Watts, 2003). Marston and Watts go on to hypothesize that evidence-based policy is based around two sets of related assumptions and quote Young et al (2002), to support this 'one referring to the way in which policy is made, the other to the evidential nature of social science itself' (p. 215). A workable definition of 'Evidence-Based Policy can be drawn from the Department of Health, Strategic Policy Making Team. In addressing the Evidence-based Practice and Policy agenda in 1999, the UK Government Cabinet Office described evidence as:

“Expert knowledge; published research; existing statistics; stakeholder consultations; previous policy evaluations; the Internet; outcomes from consultations; costings of policy options; output from economic and statistical modelling” (DoH, 1999).

This all-encompassing definition clearly positions research-based evidence as just one source amongst many, a definition that from a nursing perspective is attractive due to the constructionist or subjectivist nature of nursing research. The definition goes on to explicitly include informal knowledge gained from work experience or use of service: “There is a great deal of critical evidence held in the minds of both front-line staff ... and those to whom policy is directed” (DoH, 1999).

A number of recent policy initiatives, and practice-based guidelines have been developed using best available evidence, e.g., National Mental Health Plan 2006 to 2013 (COAG, 2006) National Mental Health Action Plan 2008 (COAG,

2006), Schizophrenia Treatment Guide for Consumers and Carers, 2005 (RANZCP, 2005), Royal Australian and New Zealand College of Psychiatrists - Clinical Practice Guidelines Team for the Treatment of Schizophrenia and Related Disorders (RANZCP, 2004), The National Service Framework for Mental Health (DoH, 1999, WO, 1998, WAG 2001, 2002, 2005), Research Priorities in Mental Health (COAG, 2002), NICE Guidelines and Policy (NICE, 2010, 2006) and The Community Care Act (DoH, 1992), and other related Department of Health Policy and guidance documentation (DoH, 1990, 1991, 1994, 1995, 1996, 1997, 1998, 1999, 2001, 2002a, 2002b, 2004a, 2004b, 2005, 2010). Much of the evidence for these and other policy and practice guidelines were and still are extracted from meta-analysis such as those conducted by Cochrane Reviews.

Arguably the reliance on 'gold-standard' research evidence such as meta-analyses, randomised control trials, integrated research reviews, experimental studies and correlation studies does not take into consideration other avenues of evidence generation. Consideration should be given to patient preference, clinical expertise, national, international and local standards, benchmarking and internal audits, in the development of services and National Practice Guidelines (Wall, 2008). Wall (2008) discusses the rise of evidence-based practice in nursing as:

"Evidence-based practice, which generally refers to the direct application of scientific (understood as quantitative/experimental) research findings to professional practice, has arisen in nursing in response to an increasing focus on research utilization in the medical profession" (Wall, 2008 p 37).

She goes on to argue that:

"There are, however, a number of powerful assumptions behind evidence-



based practice in nursing that support the persistence of liberal humanist conceptions of subjectivity, marginalize nurses' ways of knowing, and perpetuate a belief in the superiority of experimental science" (Wall, 2008 p 37).

In the treatment guidelines that have been developed, practice will become policy when the weight of scientific evidence underpinning a proposed practice advance are backed up by good randomized control trials, but as Wall argued in 2008 other evidence must be used when developing practice and practice guidelines. Policies that work in the clinical setting contain practice that is evidenced but for this to work practitioners need to understand the place of evidence-based care and where the evidence is drawn from. But, as I discovered in NSW, it can only be delivered if the work force are cognizant of the evidence-based practice identified, and able to implement that intervention into practice.

Evidence-Based Practice:

DePalma (2000) described evidence-based practice (EBP) as:

"A total process beginning with knowing what clinical questions to ask, how to find the best practice, and how to critically appraise the evidence for validity and applicability to the particular care situation. The best evidence then must be applied by a clinician with expertise in considering the patient's unique values and needs. The final aspect of the process is evaluation of the effectiveness of care and the continual improvement of the process" (p. 116).

Kessenich (1997) states that EBP: "involves an ability to access, summarize, and apply information from the literature to day-to-day clinical problems" (p. 25) and continues evidence-based practice: "requires an emphasis

on systematic observation and experience and a reliance on the research literature to substantiate nursing decisions." (p. 26).

The use of evidence-based practice allows mental health nurses and allied health professionals to meet the need for valid and reliable information. Information that can be used to inform and identify best practice in clinical situations. It allows nurses and others to enhance their clinical training and practice by using up to date research. But, for the nurse or allied health professional there has to be an understanding of this need, this also needs to be acknowledged by the employing authority. If EBP is adopted but not discussed with clinicians or middle managers and there is an expectation that it will be delivered, often the initiative will fail due to confusion or resistance by staff. The adoption of EBP will also prove problematic if staff are not supported in their practice or taught how to introduce and deliver the EBP initiative. The University of North Carolina in their online resources for nurses, suggests that nurses should be trained in how to assess and understand evidence-based practice as outlined below:

“With the large amount of research and information that exists in the medical field, learning these skills allows nurses to search for, assess, and apply the literature to their clinical situations” (University of North Carolina, 2006 p. 1).

All health care professionals have an extensive ‘experiential tool kit’ to draw upon and use in any (but not all) given situations, be they evidence-based practitioners or more traditional care providers.

What differentiates the evidence-based practitioner is the nature and scope of care given, the use of up to date research and relevant evidence-based policy and practice initiatives in their field. This ensures that the service user is in receipt of the best possible evidence-based care available (Abbott, 1988, 2005, Abbott & Wallace, 1990), although this may not enable the service user access to more traditional interventions employed prior to the adoption of evidence-based care. Other patients may not be able to access the latest care provision, as it may be unavailable in the area they reside. Thus a criticism of the global adoption of evidence-based care could be its lack of availability due to practitioners and service provider's inability to provide it; this has often been termed the 'post code lottery' of care provision (McDaid et al, 2007).

Another definition relies more on the quality of the research, the applicability of that research to clinical practice and its utility and effect once used in the clinical arena:

"Evidence-Based Policy and Practice is an approach in which clinicians and health care professionals utilize the current best evidence in making decisions about the care of patients. .... The overall goal is improving patient care through life-long learning" (The University of Minnesota, 2010).

Interestingly enough this definition interlinks the acquisition of knowledge by an evidence-based practitioner with the development of knowledge by research active nurses, other health professionals and academics. Many professional bodies, especially the bodies responsible for nursing accreditation and practice (ACMHN, 2010) are still struggling with the concept of

evidence, levels of evidence and how to evidence their professional activities as shown in table 1.

Table 1. Hierarchy of Evidence (Joanna Briggs Institute, 1999).

Level I	Evidence obtained from a systematic review of all relevant randomised controlled trials.
Level II	Evidence obtained from at least one properly designed randomised controlled trial.
Level III.1	Evidence obtained from well designed controlled trials without randomisation.
Level III.2	Evidence obtained from well designed cohort or case control analytic studies preferably from more than one centre or research group.
Level III.3	Evidence obtained from multiple time series with or without the intervention. Dramatic results in uncontrolled experiments.
Level IV	Opinion of respected authorities, based on clinical experience, descriptive studies, or reports of expert committees

A Hierarchy of evidence gives an ordinal ranking of different kinds of evidence in terms of reliability and whether or not it can be generalized to the clinical setting (Guyatt et al, 1986, Guyatt et al, 2002). As stated by Chalmers and Altman (1995) the Randomized Control Trial (RCT) is looked upon as being the gold standard research approach in evidence-based medicine. A focus on 'softer' research approaches could produce results that 'fit better' in areas where patient choice, care accessibility, collaboration and service user opinion is often more applicable in mental health care. These are areas nursing staff are employed in,

have a direct say in the approach to care taken, and are expected to organize and deliver the care regime negotiated with the service user and their carers.

With the introduction of nurse registration, and latterly evidence-based portfolios of continual professional development, nurses need to evidence continual practice development and study (NMC, 2004, NMCNSW, 2009, UKCC, 2002). Nurses and other health professionals are expected and encouraged to keep their practice up to date. They are also professionally accountable to the governing bodies to achieve this by attending courses and study days, reading and discussing articles, attending workshops and conferences and by participating in clinical and managerial supervision (NMC, 2004, MHCA, 2007).

Although nurses are expected to keep 'up to date' in their practice, in NSW there is no statutory requirement that nurses should be supervised or receive clinical or managerial supervision, (NMBNSW, 2009). Many nurses are only made aware of the use of supervision when they attend an academic course, or come into contact with a therapist. It was hoped that by attending the training I was providing, nurses would be able to access clinical supervision pertinent to their developing practice (Taylor & Hails, 2007).

Nurses upon qualification are placed on the Professional Registry of Nurses (NMBNSW, 2009); this register is accessible to all. It gives service users and carers the understanding that the worker they are dealing with has undertaken and successfully completed an academically and nationally recognized training course. It also provides a Quality Mark to compare practice against (NMC, 2004) on a National and of course International basis. Nursing was categorized as an emergent or semi-profession by academics such as Etzioni

(1969) and for the last fifty years has been struggling with the task of becoming a fully accredited profession (ANA, 2010).

#### **2.4 Evidence-based Nursing:**

Evidence-based nursing defined by Callum et al, (2007) as:

"the application of valid, relevant, research-based information in nurse decision-making...used alongside our knowledge of our patients (their symptoms, diagnoses, and expressed preferences) and the context in which the decision is taking place (including the care setting and available resources), and in processing this information we use our expertise and judgment." (Cullum et al, 2007, p 2).

The role of research in health care provision has long been recognized, and latterly the role of 'evidence-based policy and practice' and its place in modern service provision accepted (Hatcher, Butler & Oakely-Brown, 2005). In evidence-based nursing, nurses access the research literature to enable them to make clinical decisions using the best available research evidence and their clinical expertise to meet patient's needs and wants (Cullum et al, 2007). This literature, when available to the practicing nurse, is often written as a scholarly article expanding on and presenting academic or clinical research that many nurses find difficult to either understand fully or critically appraise (Fineout-Overholt et al, 2005). Nurses unless taught to, often do not have the skills to read and deconstruct an academic text. Shultz (2005) introduced the Clinical Scholar model, designed to reinforce evidence-based practice by developing mentors who encourage nurses to continuously ask questions and seek answers to those

questions. Clinical Scholars also attempt to disseminate the research either they or the mentored nurses are conducting and over time and with the publication of research findings bring evidence closer to nursing practice and thus closer to patients.

At the inception of this research project it was envisioned that the student population would become au fait with the process of research by becoming active researchers in the CBT rollout across the area health service. This would be achieved by introducing active nurse and allied health researchers who were able to alter practice by using applicable research and developing research projects. With the ever developing interest and commitment to 'evidence-based policy and practice' from service providers, service users, clinicians and policy makers, driven to a large extent by academia and Government Policy, it is imperative that the role and positioning of this 'evidence' and its use is identified, accepted and targeted effectively in clinical practice. Brooker and Repper (1998) identified that: "to date this has occurred sporadically at the best and not at all at the worst" (p. 317). Sullivan (1998) stated that:

"For evidence-based practice to become a reality, its effects must be demonstrated clearly in the clinical situation. Practitioners must be seen to access, evaluate and apply research-based evidence in their day-to-day work" (p. 35).

The Department of Health Policy Implementation Guidelines (DoH, 1991) and the National Health Service Research and Development (R&D) Policy (DoH, 1995) in the UK, focused on the provision of 'evidence-based' services and care packages to individuals and their families with a serious and enduring mental

illness. This initiative occurred in the early nineties and is still not developed across health care providers in the UK. In England the picture has changed due to the 'Improving Access to Psychological Therapies' programme (DoH, 2008), which is due to be launched in Wales on 21st of March, 2012 by the Health Minister. In Australia it is less prominent on the National agenda, but as stated earlier there is talk of adopting the English IAPT programme in its entirety.

Chambers & Wakely (2000) observed that in some institutions of higher education providing health based research, training and education is not commonplace, and Crowther (2008) stated that this is mirrored in certain areas of the Higher Education sector in NSW, Australia. There is still a limited, if growing, number of active academic nursing researchers in the clinical setting (Chambers & Wakely, 2000), that could be partly due to the lack of core research training in the updated undergraduate nursing curriculum in Australia, and the paucity of research in clinical practice (Hails et al, in press).

When health care providers adopt specific evidence-based practice such as CBT, if these practices are deployed and supported effectively, they will over time provide a clinically effective service (Thornicroft & Susser, 2001). This will hinge upon the professionals understanding of and ability to implement the intervention. The evidence-based professional will use their personal judgment and clinical skills to either deliver or withhold the care programme dependant on service policy guidelines e.g. NICE, recommendations from think tanks such as the King's Fund and patient needs and specific requests (Edwards & Elwyn, 2001).



All mental health nurses and allied health professionals have been taught problem solving skills and the ability to use personal and professional knowledge when faced with a particular problem or particular service needs (Elkan, Blair & Robinson, 2001). An expansion of these problem-solving skills is the ability to critique, critically analyze, understand and use relevant research and practice based evidence in professional practice (Abbott, 1993, 2005, Abbott & Wallace, 1990). This results in the development of an evidence-based practitioner (Abbott, 1993, 2005, Abbott & Wallace, 1990). The eight day CBT course and all support and guidance that accompanied attendance on it, was designed to enable the development of these skills in the student population. By using the practice development model adopted and discussed in chapter three it was hoped to develop a 'thinking' organization across mental health services at Northern Sydney Central Coast Health.

Nursing theory or the 'epistemology' or "the nature of knowledge, its possibility, scope and general basis" (Hamlyn, 1995 p. 242), has since the advent of evidence-based policy and practice undergone a paradigm shift, the naturalistic paradigm of nursing practice has evolved into a more scientific paradigm (Bowling & Ebrihim, 2005). This methodological shift is interesting in itself, as nursing had started in the late eighties and early nineties to move away from the dominance of the traditional 'medical model' of the ontology or 'what is' of illness (Porter, 2003) and started to produce research enquiring into people's experiences of being unwell and being looked after. This process was at its infancy in nursing services in NSW, but as stated previously policy and practice

initiatives were starting to introduce the concepts of evidence-based care to health services.

Evidence-based policy and practice does not ignore qualitative experiential research, as shown in the Hierarchy of Evidence (Table 1), but there may be differing levels of importance placed on it by policy makers and service managers when searching for the best evidence. It is often difficult for nurses to know and find what the best evidence is; sources of best evidence can be gained from research and non-research foundations (Goode, 2000). Various groups have established levels or hierarchies of evidence, usually based upon scientific merit delivered in an empirically based model (ONS EBP, 2006)

Nursing became a degree only profession in Wales post April 2005, but interestingly enough has been based in Higher Education in Australia since 1986. Also at that time in NSW a single registration point was begun which removed mental health nursing as a registration entry point, thus mental health nurses were no longer catered for in undergraduate training (ACMHN, 2010). This has created an imbalance in the nursing profession in NSW with greatly reduced numbers of mental health nurses and introduced a section of nursing practice where the newer nurses do not have the skill set of the more mature nurses working in the specialty (ACHMN, 2010). As stated by Hazelton in 2009; one advantage of a Higher Education based training system was that it enabled and allowed undergraduates and subsequent post graduates access to University based training, and removed the often 'bad practices' of the apprenticeship hospital based training model. Postgraduate study has been accessible to qualified nursing staff for many years, but it was not always compulsory for

nurses to continue with their professional development post qualification (Cleverly, 1998). Very few of these post graduate courses in NSW offered training in evidence-based care and none offered training in CBT or other evidence-based psychotherapies.

The transformation of nurse education into a higher education arena and the challenging of the attitude that research was something other professions do, has led to the growing realization that quality research is central to the ongoing development of the profession, the adoption of evidence-based policy and the development of evidence-based practitioners, who are supported and encouraged strategically by the organisation (Kitson et al, 1996).

Nurses need to be taught how to evaluate and use research evidence within their clinical practice. In 1983, Stuart and Sundeen argued that theory should be developed and based on practical experience and then validated through the research process. The theories developed from this process should subsequently be used to direct clinical practice and enhance clinical outcomes. They stated as far back as 1983 that five research skills should be introduced to nursing practice:

1. Education and training – what is research and how to use it.
2. Access to facilities - finding evidence to solve problems identified during nursing intervention.
3. Changing the climate - evaluating the evidence and considering its applicability to practice.
4. Culture and practice - implementing useful findings in the clinical situation.
5. A focus on policy and documentation - evaluating the impact of implementation on clinical practice (Stuart and Sundeen, 1983).

From a professional perspective, once nurses become cognizant with research and the methodological issues inherent in applying research to practice; evidence-based practice will start to become embedded in nursing. This will lead to nurses starting to collaborate with other disciplines to develop joint research projects (Chatfield & Gelling, 2001, Gelling & Chatfield, 2005).

In both the clinical and research arenas, collaboration is becoming increasingly important as it is seen as a solution to many of the problems associated with the traditional hierarchical health structures (Henneman, Lee, & Cohen, 1995). With the continued professionalization of nursing, the advent of the evidence-based practitioner and the diversification of nursing roles the assumed hierarchical structures in health care delivery are altering. Medical practitioners, mainly due to their scarcity and cost are becoming more compartmentalized than other health care provider groups. Many professional groups have tried to distance themselves from the more traditional medical model paradigm (Cormack & Reynolds, 1992) and have attempted to define their own distinct evidence-based practice regimes. Nursing has developed a body of professional knowledge and nursing models designed to enable the enhancement of status and professionalization of nursing that moves away from the medical model and encourages a more inclusive bio-psychosocial approach (Engel, 1977, 1980, Hails et al, in press).

## **2.5 Difficulties implementing evidence-based practice and policy:**

These difficulties are prominent in Australia due to the paucity of trained psychotherapists or mental health professionals able to offer psychotherapeutic interventions. Many of the evidence-based policy initiative identified as Federal

Government Policy, are either unavailable in New South Wales, or are not as yet on the National agenda due to service shortfalls, financial constraints or training issues. Ashcroft, Hope and Parker (2001) discussed the possibility that the introduction of evidence-based policy and practice may actually reduce the number and variation of treatments that are available to service users, as many randomised controlled trials (RCTs) compare and contrast a number of very specific treatments attempting to identify which one is the more effective. This targeted research may reduce the availability of treatment options and therefore reduce patient choice. An area that could be seen to challenge the service users role in practice enhancement initiatives and helping develop and identify service provision in 21st century Australia, where increased migration and population change has greatly altered the face of traditional health care services (Koehn, 2006).

Patient choice is taken into account at service developmental stages (Edwards & Elwyn, 2001), and many patients and consumer organizations in NSW are asking for services to specifically provide CBT and other evidence-based talking therapies (SANE Australia, 2012). Patients are able to refuse treatment under Australian law, but they don't have the right to receive any treatment they may choose (Montgomery, Lydon & Lloyd, 1997). Grol (2001) stated:

“that an increasing awareness is developing that patients should play an important role in deciding on their care, in defining optimal care and in improving health care delivery” (2001, p. xvi).

The phrase 'Evidence-Based Patient Choice' was developed in the 1990s as a direct evolution of 'Evidence-based Medicine' but had little impact on service

or care as Muir-Gray pointed out in 2001:

“Evidence-based Medicine was a carefully chosen term, designed to jolt complacency about medical decision making, and to present biostatistics in a way that was fundamental to all aspects of patient care and relevant to health care professionals (including policy makers and managers) throughout their careers” (2001 p.5).

In nursing there was and to some extent still is an opposition to more scientific research principles and practices, as it was thought evidence-based practice and policy did not represent the more naturalistic core nursing competencies or acknowledge humanistic nursing abilities, thus leaving the patient out of the equation (Morse et al, 1990, Holmes, 1990). A proportion of the adoption of evidence-based interventions and policy development was as a direct consequence of the vast improvements in care provision, care interventions and patient demands (Entwistle & O’Donnell, 2001).

It is no longer acceptable to offer a treatment because “that’s how we have always done it” (nurse on long stay rehab ward, Sydney NSW, 2007), nor is it acceptable to ignore evidence and thus ignore medical progress. Many patients now have access to the Internet and do a considerable amount of research and fieldwork into their problem or diagnosis prior to and during a medical consultation or subsequent treatment. Thus in the evidence-based paradigm and twenty first century health service the evidence-based patient is now a major player in the care equation (Edwards & Elwyn, 2001).

Thus to identify clinical effectiveness, engage patients, carers and professionals and to ensure equal service access for all participants (Chambers, Boath & Wakely, 2001) health care providers should be engaging in research and

generating their own clinical data. A large proportion of the research carried-out is small-scale illness specific research, aimed at a specifically targeted client group, examples of which abound in the professional literature (Gray et al, 2001, Gray et al, 2006, Fenton, Blyer & Heinssen, 1997). What is needed is large-scale research trials aimed at improving patient outcomes by introducing 'evidence-based interventions' specifically targeted at altering service provision and increasing service provider skills. One such study was carried out in the area of cognitive behavioural therapy for psychosis, the East Anglia Randomized Control Study (Kuipers et al, 1997); this study was used as evidence during the development stage of this research project. In the UK mental health nurses have on the whole embraced evidence-based practice. In NSW, Australia mental health nurses have embraced evidence-based practice to a lesser extent. The research initiative is not always supported by the management regimes responsible for health care delivery, which often lag behind nurses at the front line providing the evidence-based care.

#### Summary:

This chapter has set the context of my study and provided evidence that there is a need for training clinicians in the application of CBT. The following chapter will detail the practice development aspects of the project that was undertaken to meet the practice requirements and chapter 4 will outline how action research was utilised to provide the research evidence for this training.

## **Chapter 3**

### **Developing practice by using practice development principles.**

#### **3.1 Practice Development:**

This chapter will discuss the model of practice development that was chosen to be implemented at NSCCH. I will briefly outline why I chose this model of practice development and not other models available. Action research in the context of learning at NSCCH will be discussed and I will introduce the concept of a 'critical companion' support model designed to enable ongoing and sustainable clinical skills development as part of this research project. Practice development can be summed up as:

The ways in which practitioners engage with, and create knowledge with which they effect development in their understanding and practice of patient care (Clarke & Wilkinson, 2002).

I had, with colleagues in West Wales been through the practice development accreditation process with Leeds University to gain approval for a local service to be granted practice development status. When I arrived in Australia, I contacted The Centre for Practice Development at Leeds University to enlist their help and approval for me to use their materials at NSCCH. This they gave, and also committed to come out to NSCCH to facilitate the practice development process, which sadly did not occur as the funding stream to cover their visit was not used in time and was thus lost. The model of practice development used to support this initiative was taken from the Leeds University Practice Development programme, as I had developed a relationship with them

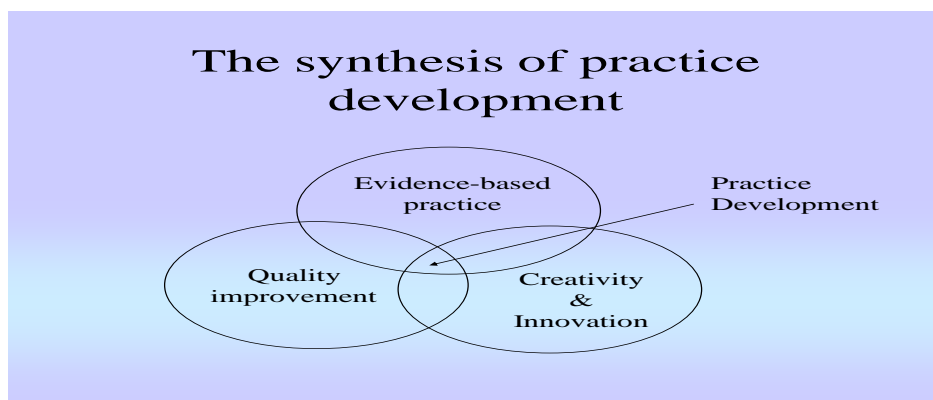


whilst employed in West Wales, and at that time no Universities in Australia were offering this service. The Leeds programme targets healthcare practice in the real world, and is designed to challenge and support corporate level services and clinical teams to improve patient care and experience. They also help to provide clear evidence of public value and improvement and develop visionary, leading edge services fit for a modernised healthcare system (Chin & Garland, 2011). Chin & Garland (2011) state that The Leeds University practice development programme:

"Is informed by a synthesis of evidence from the quality, evidence-based and innovation fields, teams are encouraged to explore ways in which they can work more effectively together and in partnership with other agencies, engage in and embrace change and provide outstanding, evidence-based care of the highest quality, within existing resources" (p.1).

Figure 3 places practice development at the middle of innovative and modern service developments and this has now being accepted across NSCCH services from the top down and bottom up levels of service provision.

Figure 3. The Synthesis of Practice Development (Leeds University, 2011)



In 2004, McCormack and colleagues described practice development: “Practice development is a term which is used to describe a variety of approaches or processes undertaken to support change in the health care setting” (McCormack, Manley & Garbett, 2004 p3).

This definition sat well with the core ethos, structures and delivery of mental health care provided by area health services and managed by NSW Health, as this care is evolving and changing at a great pace. Developments have increased the levels of expectation on services and individual clinicians to deliver contemporary evidence-based mental health care. The development of a national mental health reform agenda and subsequent National Mental Health Plan (CoA, 2000, NSWDoH, 2008) has directed mental health care delivery in Australia and the State of NSW. The Commonwealth and local NSW Mental Health Plan has promoted systemic change and introduced priority themes that endeavour to provide mental health care from a population perspective. The attitudes, skills, training and education of staff and service providers are fundamental to providing quality mental health care. In this context practice development needs to have a specific focus on strengthening and supporting health care professionals in their delivery of quality care, and to assist with the development and building of partnerships between clients and their families throughout all phases of care.

Thinking, learning and developing practice:

Contemporary literature now emphasizes the necessity that organizations become learning environments targeted and proficient at supporting professional development in core organizational values, the service

delivery rationale, mission statements and in direct service provision. Garbettand and McCormack (2002) expand upon the idea of a learning organisation and place the patient at the centre of the process:

“a continuous process of improvement towards increased effectiveness in patient-centred care. This is brought about by helping healthcare teams to develop their knowledge and skills and to transform the culture and context of care. It is enabled and supported by facilitators committed to systematic rigorous continuous process of emancipatory change that reflect the perspective of the service user” (Garbettand & McCormack, 2002. p. 88).

Practice development and the ongoing education, training and support for the work force needs to be viewed as an interrelated process between the clinicians working in the service and the service itself. It is this process that guides and underpins the contemporary drive for quality mental health care in service design, delivery and rationale. The CBT research project formed an integral part of the practice development plan for NSCCH. When seeking to maximize the quality and benefits of practice development there are three important issues that need attention:

1. the robustness of the evidence on which the development is based;
2. the process of practice change and;
3. the pervasiveness of the development on the learning of clinicians and the organization itself.

Organizations are progressively being viewed as a collection of components needed to enable optimal function, and in the case of health care

provision, that is the staff and the patients. Staff members have the potential to learn and by doing so influence and enable the direction and function of the organization, patients now have an increased voice in organizational direction and development (Rycroft-Malone et al, 2004, Scott & Caress, 2005). By conducting the CBT research project it was hoped to influence the organization in the direction of CBT and talking therapies, and by educating and empowering staff it was hoped there would be a follow on effect to patient care. This was felt possible as a major component of CBT is the education of the patient to their condition and to service provision (NICE, 2010). This can be thought of as the organization investing in and holding knowledge and skills through individual clinicians, staff and patients. This would then lead to the joint development of strategies to deliver clinical and organizational priorities via local procedures, educational initiatives and protocols.

Recent literature postulates the context and evidence in the development and delivery of practice development programs and action research initiatives across health care provision (McCormack, Manley and Garbett, 2004, Manley & McCormack, 2004). Practice development activities and action research methodologies need to explore the requirements of novice and expert clinicians, in the health care setting. The needs of patients and their carers should be considered to ensure a service is providing what is needed not just what it can or has always done. These requirements then need to be met by developing not just practice activities, but by enabling clinicians to develop 'critical thinking' skills that can be used to challenge existing practices and introduce evidence and research based initiatives to modernise service provision. Argyris and

Schön, in 1974, 1978 and more recently in 1996 discussed the theories of single and double loop learning; these theories can be utilised in a practice development approach to enable the above processes to occur.

Single loop learning is characterized by strategies or rules of activities that can change, however, the values of the theory around the actions remain static, i.e. the original theory. Double loop learning is characterized by learning producing change in the values of the theory in action as well as its strategies and assumptions, i.e. the original theory is questioned and changed. Single loop learning tends to increase the effectiveness of actions in order to achieve predetermined values and norms, but does not bring about sustainable changes. To lead to sustained change the organization will need to revisit its core values and service norms. This may then bring about double loop learning where the clinicians and the service can address the desirability of the values and norms that govern the theories in use.

It is this form of learning, like Kolb's Experiential Learning Cycle (1984) that clinicians need to gain an understanding of and practical skills in to lead organizations forward by engaging in practice development and action research projects.

The research process and CBT training course that were introduced to NSCCH was designed to enable learning to take place. This learning may initially be 'single loop' but with practical application and ongoing study of the research results may over time enable 'double loop' learning to occur. This learning would eventual lead to organizational change and adoption of practice development initiatives across the health service. Thus the action research

process has the potential to harness the identified need to move the service forward, and meet the needs of people requiring mental health care. In an educational context that supports the process of action research developed across this project Reil (2010) states that:

"Action research is a process of deep inquiry into one's practices in service of moving towards an envisioned future, aligned with values" (p.1).

More exploration of action research will be addressed in chapter 4 the methodology and methods section. In the context of the NSCCH 'project' the phases of delivery can be seen in distinct but overlapping phases. For the purpose of clarity these interlinked but discreet practice developments will be outlined.

The project:

Phase I - 'MoodMatters' psychological staff scoping survey, analysis of data and development of CBT course pre- and post- questionnaires. This scoping survey aimed to gain a picture of clinical staffs abilities in talking therapies; it was circulated to all 1200 staff across NSCCH.

Phase 2 - Development and delivery of CBT training course. The course was designed to be delivered as an 8-day course, again all clinical staff were targeted and 8 courses were delivered with 80 participants. The research project and CBT training course development was designed to evidence or not a change in self reported readiness to use CBT skills, and increase the self efficacy of the staff group towards eventual CBT provision.

Phase 3 - Analysis of CBT training course data set. At this stage the 160 pre- and post- CBT course questionnaires were analysed.

The 'MoodMatters' phase of this project articulated the identified needs of staff to be taught talking therapies - notably CBT. The cycles developed needed to reflect and achieve NSCCH goal of increasing the availability of CBT delivery by clinical staff across the organisation. The research cycles were developed to address this goal, but would evolve as participants attended the training and gave their input to the future development and direction of the training model, thus each subsequent course would evolve and develop from evaluation and feedback of the course delivered before.

Learning Environment:

The practice development initiatives were delivered within the context of a learning environment. The literature identifies a number of 'best practice' characteristics of learning environments outlined below (Denton, 1998, Dixon, 1994, Phillips, 2004, Magnusson, Ishida, & Itano, 2000, Oliver, 2001).

Characteristics of organizational learning (Denton, 1998):

1. A learning strategy
2. Flexible structure
3. Blame free culture
4. Vision
5. External awareness
6. Knowledge creation and transfer
7. Focus on quality
8. Supportive atmosphere and team working.

In 2009 the Victorian Government in Australia after consultation with health care providers and academic institutions developed a “Framework to guide Health services and training providers in the delivery of high quality clinical experiences for learners”. This framework illustrated below, was designed to enable health care providers and partner academic institutions with guidance so they could “jointly explore effective and appropriate mechanisms to achieve high quality clinical training experiences for learners” (VSG, 2009, p.2).

Best Practice Frameworks for Clinical Learning Environments:

1. An organisational culture that values learning
2. Best practice into clinical practice
3. A positive learning environment
4. A supportive health service-training provider relationship
5. Effective communication processes
6. Appropriate resources and facilities (VSG, 2009).

A practice development approach within an action research paradigm has many benefits for the service, the clinicians and importantly when discussing the introduction and research of modern evidence-based practice, the patient in receipt of care. One of the most challenging problems faced by modern health care services is becoming aware of the power, energy and desire of practicing clinicians to move patient care forward. The health care service needs to tap into the knowledge creation potential of clinicians, and then use this knowledge in a research based model to enhance current and developing organizational care delivery, and learn how to re-conceptualize patient care in modern, evidence-based paradigms.



## Conceptual framework to support practice development:

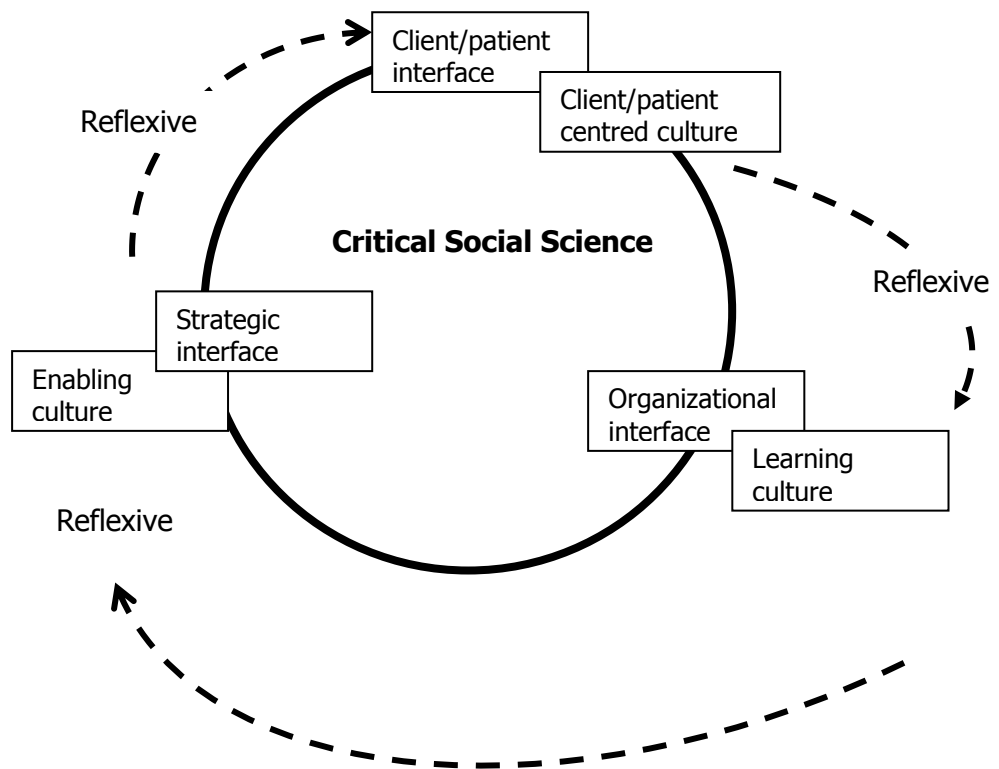
The overall goal or vision of practice development is to promote modern, patient centred care delivery (McCormack, et al, 2004). McCormack and colleagues (2004) argued that many practice development initiatives in health care settings, lack a systematic approach often being undertaken by individual practitioners who are poorly prepared or supported in their roles. This can be challenged in a culture that recognizes learning and research as an integral component of professional practice and care delivery. In order to achieve this approach a systematic framework that approaches practice development from a perspective of preparation work at three interrelated interfaces in service needs to be developed and adopted, as outlined below:

1. Staff/patient
2. Organizational and Strategic interfaces
3. State and Commonwealth Government

This framework identifies the need for practice development to extend beyond existing practice and culture and to work on the explicit knowledge and relationship between the development of patient care and an organizational and strategic culture. This culture needs to support and sustain the inherent changes that the adoption of the practice development model would entail. The framework seeks to consider individual, organizational, governmental and strategic responsibilities for the development of practice and the sustainability of this practice in the organization. The framework promotes the conceptualization that practice development not only involves initiatives that directly impact on patient care, but also on organizational developments and

long term strategic plans. This action research project was developed to target and achieve these objectives and outcomes. The analysis of the data leads one to believe that these objectives and outcomes were achieved as shown in Figure 4.

Figure 4. Conceptual Framework for Practice Development:



For such a framework to be effectively employed a number of empowering factors need to be in place (Miller & Kearney, 2003). These factors identify the cultural values that are the key foundation stones that can support the creation of a practice development ethos and culture. As shown in table 2:

Table 2. Factors that empower Practice Development. (Miller & Kearney, 2003)

Staff having an understanding of the context and culture of the service and priority themes in mental health care.
Staff committed to patient centred care and involvement
There is a recognition of the desired practice approaches that are clinically, educationally and cost effective
A culture that encourages and supports team development as a component of clinical effectiveness
Recognition that for change to occur and subsequently be successful it needs to be practitioner owned, organisationally supported and undertaken using a systematic educational and clinical approach.

The Adoption of this framework will enable the development of patient centred practices that are permitted to flourish in a service that recognizes learning and research as a necessary and explicit component of professional practice development. The use of a critical social science perspective within the framework encourages the potential for practice development to influence strategy development as well as addressing the implementation of strategic objectives on local state and federal levels. The use of social science philosophies enables the use of a ‘critical companionship processes’ (Titchen & Binnie, 1993) that locates practice development in a philosophy that creates possibilities to address and transform cultures that currently may be resistive to change. The Royal College of Nursing (2010) defined a critical companion as:

Critical companionship is a metaphor for a helping relationship, in which a critical companion accompanies another person on an experiential journey of learning and discovery. Our work has shown that critical companionship is effective in helping practitioners to:

1. develop expertise in person-centred practice

2. articulate their own professional craft knowledge and its relationship with theoretical knowledge, research findings and patients' own experiences, concerns and preferences,
3. critically evaluate their practice,
4. generate new knowledge from practice through critique
5. become facilitators of experiential learning (RCNWeb, 2010).

I will discuss the role of the critical companion at more length later in this thesis.

### **3.2 Critical social science perspective (CSSP):**

Eakin et al (1996) discussed the theory of critical social science (CSSP) in their health promotion paper, where they put forward the theory of CSSP to enable researchers and others to understand and critique the 'formal' and 'informal' structures of society within a research based paradigm. They went on to offer a perspective and attempted to position CSSP in theory and research practice:

"This perspective consists of a set of 'reflexive' questions concerning the implicit assumptions and ideology underlying the research process, and the role of power, contradiction and dialectical relationships in theory and research practice" (p.159).

Critical social theory can accommodate a number of research and developmental approaches that enable persons and systems to address constraining factors that often hinder change and creativity (Habermas, 1985, Carr & Kemmis 1986, Fay, 1987). Fay in 1987, suggested that in order to be effective it needs to be understood and utilized at both a critical and practical

level. First, there is a need to view a 'crisis' within the system and secondly that this 'crisis' is partly caused by a 'false consciousness' i.e. a mismatch between the reality of practice and the organization's perception of reality. Interpretation is the first aspect of this critical social perspective methodology, achieved through a systematic critique of staffs' perception and self-understanding of current practices and expectations within the parent organization. This approach has the potential to provide important information to allow decisions to be made as to what approaches and interventions would be appropriate for changing the prevailing cultures and power relationships.

Fay (1987) also suggests that being able to clarify factors that compromise the prevailing dominant system is the first stage of a critical science approach. By recognizing the need to start from the perspective of those engaged with direct clinical and or educational practice, engenders the use of a critical social science philosophy in practice development approaches that are committed to clinician ownership of desired changes. Practice development in this context requires the service to commit to organizational change which is described by Argyris and Schon (1999) as Model II Organizational Behaviour:

- Collaboration,
- Mutual support
- Critical challenge
- Reflexivity
- Empowerment of staff individually and collectively to change.

(Argyris & Schon, 1978, 1996)

The methodology in critical social science encapsulates the perspectives of all the stakeholders and focuses on establishing methods of data collection that express the contradictions embedded within the system or organization working against a client centred approach to practice, education and clinical effectiveness. This approach enhances the capacity to promote change and the development of a clear agenda for change and how that change once identified should take place. McCormack and colleagues (2004) identified methods of development, education and research that would be appropriate at each of the interfaces of the conceptual framework (Table 3).

Table 3. Methods of development, education and research.

<b>Development:</b>	
<b>Client/patient interface</b>	<ul style="list-style-type: none"> <li>• Attitude change</li> <li>• Confidence in identifying competencies</li> <li>• Care processes</li> <li>• Clinical leadership</li> <li>• Interdisciplinary relationships</li> <li>• Negotiated care processes</li> </ul>
<b>Organisational interface</b>	<ul style="list-style-type: none"> <li>• Model II behaviour (Argyris &amp; Schon, 1978)</li> </ul>
<b>Strategic interface</b>	<ul style="list-style-type: none"> <li>• Strategic planning</li> <li>• Political awareness</li> <li>• Population profiles</li> </ul>
<b>Education:</b>	
<b>Client/patient interface</b>	<ul style="list-style-type: none"> <li>• Reflective learning</li> <li>• Work-based learning</li> <li>• Technical, aesthetic, empirical, ethical and personal knowing</li> </ul>
<b>Organisational interface</b>	<ul style="list-style-type: none"> <li>• Organisational cultures</li> <li>• Research utilisation</li> <li>• Change theory</li> </ul>
<b>Strategic interface</b>	<ul style="list-style-type: none"> <li>• Policy development, utilisation and implementation</li> </ul>
<b>Research:</b>	
<b>Client/patient interface</b>	<ul style="list-style-type: none"> <li>• Evaluation of care processes</li> <li>• Evidence implementation/utilisation</li> <li>• Generation of inductively derived knowledge</li> <li>• Testing of deductively derived knowledge</li> </ul>
<b>Organisational interface</b>	<ul style="list-style-type: none"> <li>• Evaluation of organisational systems</li> </ul>
<b>Strategic interface</b>	<ul style="list-style-type: none"> <li>• Informing of public health agendas.</li> </ul>

(Taylor & Hails NSCCH, 2007)

It is important that these methods are not seen as a definitive list or a hierarchical order of importance; they need to be viewed more as a continuum with a focus on education, research and development, and are intended to represent appropriate foundations for practice development. An important process in this procedure is the development of critical enquiry and a 'companion' that can facilitate individual, team and service levels of change.

The role of a critical companion:

The collective, shared and individual experiences of clinicians are an important source of knowledge and a repository of skills that can be accessible to others to enhance practice. Being able to identify this 'knowledge' will enable the research team to understand the context and place of said clinical 'knowledge' in practice development. This identified 'knowledge' should, once quantified and shared, enhance and promote skills based staff education, supervision and patient care.

One key aspect of this process is the promotion of experience as learning, thus it is vital to introduce the 'critical companion' to the use of experiential learning cycles and tools. The development of a systematic approach to assist clinicians to engage in reflective practice, critically review the elements of their practice, actively engage in developing and experimenting with their practice and being able to synthesise the new learning gained from this experience is vital to the success of this approach. This approach views staff as adult learners and therefore utilizes adult learning theories which state that learning is most effective when the learner is able to make sense of the new knowledge in the

context of their immediate experience and practice (Jarvis, 1995, Schon, 1983, 1991).

Engaging in this type of process can be demanding and it is easy to underestimate the needs of staff when addressing the personal and professional challenges associated with clarifying values and critically challenging practice and culture. In recognition of this need Titchen (1998) developed an approach to help facilitate learning aimed at developing practice, by the use of a 'critical companion' who accompanies learners on their learning journey. Thus the main role of the critical companion is to help facilitate personal and professional growth and develop the maturity of the clinician and clinical setting. This is done by empowering the clinician, and enabling the development of a theoretical and practical based understanding of clinical need, through a guided critique of practice and its settings, leading to knowledge generation from the practice critique and the subsequent transformation of practice cultures (McCormack et al, 2004).

In the context of this research project and practice development approach, the critical companions' job is to help staff understand the need to change and how this change can take place to achieve culture shift and improve outcomes for patients. The Royal College of Nursing in the UK stated that:

Where an experienced facilitator accompanies a co-learner on an 'experiential learning journey'. The role of the critical companion is to help the co-learner focus on becoming increasingly effective in their work and to monitor and observe this process through high challenge and high support. The



Critical Companion facilitates the development and growth of the co-learner (RCNWeb, 2010).

The role of the critical companion is a key component of practice development and this action research project, it requires the selection of a person or persons that bring with them a repertoire of skills and characteristics that include openness: the ability to support and advocate for staff, approachability, empathy, reliability, self confidence and the ability to be non-judgmental and have the skill to observe situations from all possible angles.

The critical companion will facilitate practice development in a manner that parallels the clinicians' use of self in therapeutic interventions. A 'critical social science' approach was adopted that includes; consciousness raising, problem identification, active self-reflection strategies and critique. This was facilitated through the adoption of a variety of practical strategies that included clinical supervision, critical dialogue and reflective practices. Finally, thought was given to the positioning of the critical companion and it was decided that they would work across locality boundaries when identified and trained. In all, two critical companions were involved in the project and CBT training course. One of who went on to lead the CBT practice development initiative when I left the other went on to continue the ongoing development and delivery of the CBT training course.

The next chapter will introduce and discuss the methodology and methods that underpinned this research and training project. The methodology and methods are presented in two sections for ease of understanding and clarity.

## **Chapter 4**

### **Methodology.**

#### **4.1 Introduction:**

This chapter will be presented in two sections. Section one will discuss how the research project was informed by general methodological issues and section two will give an account of the conduct of the research itself. Section one will provide the basis and theoretical structures that enabled the research project to be conducted, this will relate to section two by providing the rationale and ethos the project was delivered in. Section one will also discuss the underlying methodology and theories that support a project developed and delivered in the spirit of action research, leading to their implementation in the phased cyclic approach that will be discussed in section two of this chapter.

#### **4.2 Section 1. Action Research:**

Rolf (1996, 1998) discusses the difficulty in reaching an agreed definition of what action research is suggesting it is "almost impossible" due to the differing strands and types of action research used in the clinical and academic fields. My approach in adopting a methodology broadly in the spirit of action research was to conduct participant action research as an insider working with other insiders to develop, fine tune and deliver a training programme. The overall aim of the training programme was to improve practice (Elliott, 1993), and to improve knowledge (Kemmis & McTaggart, 1982, 1988) in both the participants and host organisation, pertinent to talking therapies, notably cognitive behavioural practices.

As the name suggests, action research is a cyclic methodology, which has the dual aims of action and research:

- action to bring about change to an identified community, organisation or program
- research to increase the understanding of the researcher, research client or both (and often some wider community) (Dick, 1993).

The methodology that supported the development, delivery and completion of this research project was broadly supported and defined by principles of active skills-based education, designed to enable clinicians to deliver CBT in clinical practice. To achieve this it was decided that a methodology in the spirit of action research would be more fitting than a traditional research approach, as one of the core aims was skills development that over time would start to impact on practice (Elliott, 1993). Quantitative methods were used to gather data from the CBT course delivery and identify outcomes that may show a statistical improvement in clinician's perceived readiness to use skills learnt on the course. But, an integral part of the research design was the ongoing development and fine tuning of the CBT course to ensure it evolved to provide area focused training, and not just provide a one size fits all model, with limited chance for ongoing development during the lifetime of the research project.

By using the existing skills of the mental health clinicians attending the course, to offer suggestions and participate in course developments, my intention was that this would impact on the next course cyclic development and delivery. To achieve this it required participation by the clinicians in the ongoing

design of that course and this was achieved through daily and end of course formative evaluations. The 'MoodMatters' research and CBT training project targeted all 1200 clinicians across NSCCH as the population from where the research participants were recruited. To achieve the development of the 'MoodMatters' research and CBT training project, a methodological approach broadly drawn from a participative action research methodology, developed and delivered in the spirit of action research was developed. I thought this approach would be more likely to succeed as CBT training had not been delivered before at NSCCH and we had identified a gap in skills and training across all clinically active mental health professionals. This was in part due to the nature of the care provided across the health service, with the Central Coast area having a more rural focus and the Northern Sydney patch an urban one. Demographically the two areas had quite different social and economic pictures, with Northern Sydney being more affluent and multi-cultural than central coast. NSCCH had been developed out of the amalgamation of two independent mental health services, both with fiercely loyal staff and independent teams, who were now managed centrally in the Northern Sydney area. Thus, it was thought that training looked upon as being centrally developed and rolled out without local needs or interests taken into account was considered not likely to succeed. This again supported an active approach in the spirit of action research, which enabled the development of the course over time accounting for local needs and idiosyncrasies by working with local clinicians in the ongoing development cycles. One core-training course in CBT would not be fit for purpose in both areas, which was why a cyclic model was utilised in course development and delivery. This would enable the cycle employed during course development and

delivery to impact on the next course delivered. A nurse consultant from Central Coast was invited to attend the first CBT course and prior to this be active in course development and curriculum planning, it was hoped that the nurse consultant would become an active participant in the ongoing 'MoodMatters' research and CBT training project.

The type of research I was under-taking is summed up well by Gilmore et al (1986) and although their commentary on the topic is some two decades old it is still worth quoting from in full:

"Action research...aims to contribute both to the practical concerns of people in an immediate problematic situation and to further the goals of social science simultaneously. Thus, there is a dual commitment in action research to study a system and concurrently to collaborate with members of the system in changing it in what is together regarded as a desirable direction. Accomplishing this twin goal requires the active collaboration of researcher and client, and thus it stresses the importance of co-learning as a primary aspect of the research process" (p. 161).

Thus action research is an approach that is used to research practical service provision and the development and improvement of that service provision by the adoption of an educational process used to develop services across an institution often educational or health care based. Action research concentrates on improving practice rather than producing information or data, although that is an important part of the process and formed an integral part of this research project. Action research results are not always generalisable to other settings as the research is conducted in a unique environment. The training project that was developed as part of the research could be deliverable

in other areas following a similar educational paradigm. Reil (2010) defines action research as:

“Action research is the systematic, reflective study of one's actions, and the effects of these actions, in a workplace context. As such, it involves deep inquiry into one's professional practice. The researchers examine their work and seek opportunities for improvement. As designers and stakeholders, they work with colleagues to propose new courses of action that help their community improve work practices” (p.1).

Action research in the context of learning would enable the researcher to develop a programme of study designed to meet the needs of the population being taught once those needs are understood.

Reil states that:

"at the organizational level, action research is about understanding the system of interactions that define a social context. Kurt Lewin proposed action research as a method of understanding social systems or organizational learning. Action research goes beyond self-study because actions, outcomes, goals and assumptions are located in complex social systems" (p. 1).

The organization or service needs to have explicit and implicit belief in the values it promotes and the actions or behaviours that relate to these values clinically and managerially. Ideally the service needs to act as an enabler in actively pursuing and promoting individual and service practice development; it needs to favour a process of enquiry that seeks to explore client care activities that will lead to the promotion and development of new knowledge.

My motivation for the study was to improve access to psychological therapies across Northern Sydney Central Coast Health (NSCCH) for service users, by developing and subsequently supporting a workforce able to deliver such therapies. Thus the development of the research project was designed to enable patients a greater access to psychological therapies by training clinicians across NSCCH to deliver them. This was based on a professional belief that psychological therapies notably CBT when delivered properly in a safe and supportive environment will enhance the outcomes and prognosis of patients under the care of the health service. This belief is supported by the National Institute for Clinical Excellence Guidelines for treatment of common mental health disorders, depression, anxiety, schizophrenia and latterly bipolar disorder types i and ii (NICE, 2008, 2009, 2010).

The theoretical perspectives underpinning the research design and data collection methods were designed to emphasis the 'action' component of the research process i.e. the development of the CBT training programme, the outcomes of which were identified to be; increase in readiness to use skills and self-efficacy, change in clinical practice, CBT skills development and learning for those who take part (Dick, 1993, 2000). Participatory Action Research signifies an epistemology that underpins the belief that knowledge is embedded in social relationships and is most influential when produced collaboratively through action (Hawkins, 2008).

Reason and Bradbury (2008) definition of action research can be used to support the approach taken during this research project:

"Action research is a participatory process concerned with developing practical knowing in the pursuit of worthwhile human purposes. It seeks to bring together action and reflection, theory and practice, in participation with others, in the pursuit of practical solutions to issues of pressing concern to people, and more generally the flourishing of individual persons and communities" (p. 4).

Roth, Shani, and Leary (2007) stated that an approach that is showing promise in medical care and pharmaceutical settings is insider action research. Stebbins, et al, observed in 2009 that: "Action research is strongly rooted in practices of organization development and improvement of business and public sector organizations" (p.44). They go on to argue that for action research findings to be accepted by health professionals often schooled in experimental research that leads to the application of evidence based practice, the findings must have been identified through in-depth inquiry (Stebbins, Valenzuela, and Coget, 2009 p.44). Insider action research happens when actions are taken and studied as they are happening by members of the organization where the actions occur (Coghan and Brannick, 2001). Stebbins, Valenzuela, and Coget (2009) then noted that; "the key in this definition compared to participatory action research in general is of course that the research is conducted by internal actors" (p. 44).

There is no absolute common understanding about what is meant by action research; however O'Brian (2001) offers a very useful insight into the variations:

"Action research is known by many other names, including participatory research, collaborative inquiry, emancipatory research, action learning, and contextual action research, but all are variations on a theme. Put simply, action research is "learning by doing" - a group of people identify a problem, do



something to resolve it, see how successful their efforts were, and if not satisfied, try again.” (p.3)

Action research is an approach that has gained importance and increased in usage over time in health care arenas, it enables the researcher to focus on social and contextual issues and not just the clinical aspects of research (Green et al, 2001). Morton-Cooper (2000) stated that action research is something of a 'new-age' approach in health care settings; she goes on to say that it is only now beginning to be recognised and valued in its ability to pull all stakeholders together. In nursing research, an active, participatory approach has and is often adopted to gain a deeper understanding of and ultimately impact on nursing practice. Rolf (1998) identified that only latterly has nursing adopted action research as an attempt to bridge the gap between theory and practice, having for a number of years attempted to establish itself as an academic discipline by adopting the positivist research practices of medics and the medical profession (p. 173-174).

Action research enables a practitioner-researcher to work within a service and to also concurrently in partnership, research aspects of that services' care or educational provision. A broadly educational approach in the spirit of action research was adopted aiming to empower the participant, to become active in the research process, my aim and rationale being to cascade the training to other members of Northern Sydney Central Coast adult Mental Health Service and eventually across NWS Health as a whole. To do this I drew upon the thoughts and work of Kurt Lewin (1946) that you couldn't understand an organization until you try to change it. A participatory insider working with insider model in the spirit of action research was developed specifically to

enable me to gain a thorough understanding of organisational issues and needs across NSCCH as a whole. This understanding would then enable the intervention developed to be area and needs specific.

Action research demands some form of intervention; “in action research these interventions constitute a spiral of action cycles which one undertakes” (Herr & Anderson, 2005, p.5). Herr and Anderson then go on to outline Kemmis and McTaggart's 1988, Action Research Cycle:

1. to develop a plan of action to improve what is already happening;
2. to act to implement the plan;
3. to observe the effects of action in the context in which it occurs; and
4. to reflect on these effects as a basis for further planning, subsequent action and on, through a succession of cycles (p.7).

Their cycle informed the development of this research project and formed the core framework for the study. It enabled me to develop an intervention pertinent to the needs I had identified on the ground, which were to deliver the CBT course to the research participants. I was keen to observe what happened both during and post course attendance and then reflect on these observations, fine tune the current provision for the next course delivery and repeat the cycle both during and post all subsequent CBT courses. By developing this approach it was envisioned that an active and evolving learning cycle in the spirit of action research would develop throughout the research project and CBT training course time frame.

A number of cycles developed across the research process, with greater participant involvement as the project continued. My rationale for choosing a

participatory model in the spirit of action research was that it would be more appropriate to gather data and augment/update the training programme as it was being delivered, than to do it at the end of programme delivery. This was designed to show an improvement over time, but due to data collection methods was not possible as I aggregated the data sets.

As a participatory model was utilized, the research participants were expected to comment on and evaluate the training on each day of attendance. It was hoped that by adopting and developing this model of research, it would facilitate the updating and fine-tuning of the programme at all stages of the research project delivery.

Research Design:

The quote below influenced my choice of research design:

"The form of action research described is one which uses a cyclic or spiral process. It converges to something more useful over time for both action and understanding" (Dick, 2000).

The research design employed the use of three specific phases of research practice, that ran to an extent concurrently throughout 2007 to 2009, within a cyclic or spiral nature, in other words;

PLAN then DO then REVIEW then REPEAT.

Phase one:

The first stage of the research project development was to gain approval for the project development and subsequent delivery, including 'MoodMatters'

and CBT training course questionnaire development. During this developmental phase I conducted a number of meetings with NSCCH clinical staff, patients, stakeholders, service managers, directors and clinical leads. To achieve this I developed:

1. A rationale for project delivery,
2. An active, educational project specific stance,
3. A power point presentation and a management brief on deliverables and areas of added value,
4. A research bid for ethical approval (Appendix 4).

As I had already outlined the proposed CBT course to service directors, I then drafted a Project Brief that covered the content, scope, aims and proposed outcomes of the programme. It also outlined the research process to run in parallel with course delivery and highlighted some of the possible gains for the service drawing on research into CBT service development. This Brief was presented to the Executive Committee of Northern Sydney Central Coast Adult Mental Health Service. A research ethics bid was completed, as was a local ethics approval form for an in-house clinical practice improvement project (Appendix 4). The Executive Committee gave the go ahead for the project to run as a service wide research based Clinical Practice Improvement Project.

The development of the project brief and the processes of meeting with and discussing my ideas and aims with the senior management team, clinical staff and other stake holders was of vital importance to gaining approval for the research project and the ongoing development and delivery of the proposed three research phases. I had to be able to gain approval for the development of

quite a different approach to health care provision across the service, thus the project as a whole succeeded or failed at this stage. The challenges of meeting all the relevant parties proved problematic to a degree in inception and time-consuming in actioning.

The next component of phase one encompassed the 'MoodMatters' project, this project consisted of a staff scoping survey to ascertain the level of psychological care delivered on the ground, how skilled staff felt in that delivery, how they were supported to deliver it and what training they felt they needed to increase competence and access to psychological therapies across NSCCH. This survey was delivered to some 1200 clinicians by circulation to their service directors for distribution, and then returned directly to the research committee.

Although the response rate of the survey was low at only 10%, and could call in to question the reliability and also validity of the data, it was decided to continue with the training programme design, as the delivery of CBT to patients was well supported by literature and policy (NIMHE/T, 2004, NSWDoH, 2006, 2007, NICE, 2007, 2009, 2010). The 'MoodMatters' project data (appendix 1) was important as it corroborated and supported the impression I gained when meeting NSCCH staff and other stakeholders. This impression led to me thinking that by initially developing and enabling staff to deliver CBT, then other talking therapies to patients of NSCCH, it would improve and enhance their journey through NSCCH services. The development of the 'MoodMatters' scoping survey was problematic as we were attempting to gain an insight into the abilities, knowledge and skills of staff across the health services in the area of talking therapies and by taking a shotgun approach by distributing the survey to all

clinical staff, account wasn't taken of their roles, responsibilities or whether or not they were clinically active in therapy based positions. Also we wished to pinpoint what level (if any) of training and support staff were or had been in receipt of, thus we targeted the most widely available therapies at the time in NSW. By doing this we may have introduced a bias into the proceedings by focusing wholly on one or two core therapies to the detriment/exclusion of others, and also of clinicians – thus gaining the desired result that would enable me to deliver CBT training and eventually develop a CBT course.

To overcome this potential bias it was decided to include 18 therapeutic modalities in the staff survey ranging from motivational interviewing, transactional analysis, and psychodynamic psychotherapy to CBT and Rational Emotive Behavioural Therapy. The 'MoodMatters' scoping survey was designed to gather data pertinent to the current delivery and future development of evidence-based therapeutic interventions such as cognitive behavioural therapy, family work, and brief solution focused therapy, motivational interviewing and other forms of talking therapies (eighteen in total) across the health care provider.

The questionnaire was split into 3 distinct areas gathering data on staff demographics, delivery of psychological interventions, clinical practice and supervision. The sections were further sub-divided to enable the gathering of area specific data such as; therapies currently delivered by staff, requests for further training in specific therapeutic modalities, being in receipt of modality specific supervision and levels and types of qualification.

Data was analysed under each of the sub headings using a percentage or number of items classification. The data pertinent to perceived staff skills in the 18 therapeutic modalities targeted in the questionnaire and requests for future training were used in the development of the CBT Training course data gathering tools, although as previously stated the low response rate questioned the reliability and validity of the data, but pertinent literature, policies and pre-development scoping meetings supported the direction taken in the research design and subsequent course delivery.

A follow-on questionnaire was developed to enable data to be gathered from each subsequent CBT course of which there were 8 in total. This data would be used to ascertain the research participants' self-readiness to use skills learnt on the CBT course, and if there had been an increase in their self-efficacy whilst attending the course. The tool developed was a questionnaire designed to be deployed at two distinct points during the course. Point one being on the first morning of the course before any formal teaching had occurred and point two being the last day of the course.

The original UK questionnaire that I updated for use in Australia was designed, developed and validated for a community nursing population, by Richard Grey and colleagues. I was a member of this research team and actively participated in the development, piloting and delivery of the UK questionnaire (Gray et al, 2001). The UK questionnaire was designed to be a self-reporting tool, piloted with a matched population – updated post test phase, then administered to the target population of community psychiatric nurses, across the South London and Maudsley NHS Trust catchment area, where nurses who had

attended the training programme, were based. The results proved positive and the questionnaire was proven to be valid and reliable for use with this specific population. The questionnaire was then re-used by other sites that delivered training programmes in collaboration with the core research team, in differing geographical areas, eventually covering, Europe, North America, Thailand and Australia (Gray et al, 2006). The CBT Course questionnaire in Australia was piloted during the initial cognitive behavioural therapy-training course delivery (Appendix 3). Post pilot delivery the CBT course questionnaire was updated for use in Australia and re-focused on cognitive behavioural therapy with a reduction in the number of questions focused on Adherence Therapy. The CBT course questionnaire was designed to gather specific demographic details of the target population's professional background, qualification level, length of time post qualification, gender, age and ethnicity.

#### Phase two:

This phase of the research project encompassed the development and deployment of the CBT training course and data-collecting tool. The initial CBT training course, and questionnaire deployment were treated as a pilot with data gathered from the participants, using daily and end of course verbal and written evaluations. This data was then used to redefine the content and delivery style of the CBT training programme, and the CBT data-gathering tool, the CBT course questionnaire. It would have been useful to keep this data in its entirety, as it would have allowed me to demonstrate improvement over time for each subsequent course and course participant. This as stated earlier was not possible



due to an aggregated data set, thus I sadly couldn't compare course 1 with course 8.

Following completion of the 'MoodMatters' survey, I continued the development of the CBT training course. To support this I conducted an extensive literature review. This literature review formed the basis of the course content, curriculum scope and design. The course designed drew extensively on work I had conducted whilst employed at the Institute of Psychiatry, King's College London, and collaborations with the Oxford Cognitive Therapy Centre whilst employed by Pembrokeshire and Derwen NHS Trust and Swansea University. It was decided to offer an eight-day skill based course, utilizing an exploratory educational model such as Kolb's Experiential Learning Cycle (Kolb, 1984). The rationale behind this was to enable safe practice of skills in a supportive educational environment prior to actual patient contact and CBT practice.

To deliver this skills-based training to a group of staff that had become disenfranchised due to lack of focused training and the disappearance in 1986 of the core mental health nurse training in NSW, required some careful thinking. To achieve this it required a reconsideration of my initial hypothesis and research questions, re-targeting them towards the needs of NSCCH within a practice development paradigm.

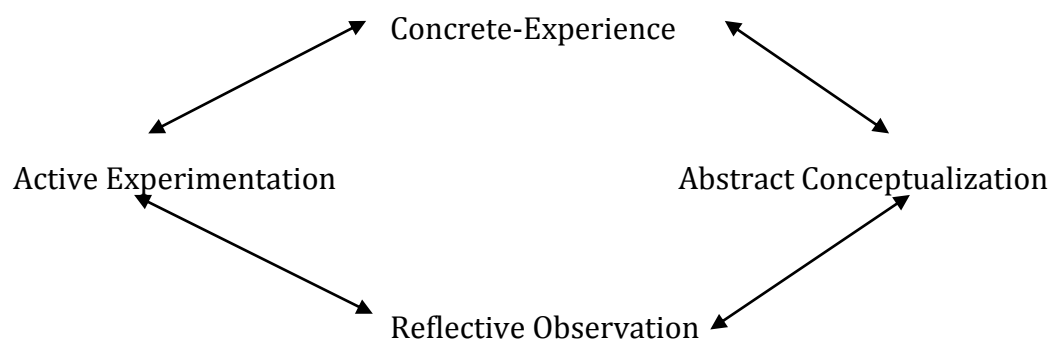
A cascade model of education (Hayes, 2000) was adopted utilizing Kolb's 1984 Experiential Learning Cycle that has validity and reliability in skills based education and training, and meshed with the approach taken in the spirit of action research (Kolb & Kolb, 2005). The Palmquist (2012) at the Colorado State

University defines validity and reliability as: "Validity refers to the degree to which a study accurately reflects or assesses the specific concept that the researcher is attempting to measure. While reliability is concerned with the accuracy of the actual measuring instrument or procedure, validity is concerned with the study's success at measuring what the researchers set out to measure" (Palmquist, 2012).

For the purpose of this study I have interpreted the experiential learning cycle as a 'training cycle', using the work in CBT of Melanie Fennell (1989) and James Bennett-Levy (2004). Smith (2001) expands upon the use of Kolb's model stating: "In this respect Kolb's model is particularly elegant, since it offers both a way to understand individual people's different learning styles, and also an explanation of a cycle of experiential learning that applies to us all" (p.2).

As stated above the training was conducted using an experiential learning developing cycle, taken from the work of Kolb in 1984: "the process whereby knowledge is created through the transformation of experience. Knowledge results from the combination of grasping and transforming experience." (Kolb, 1984, p. 41). See figure 5 for Kolb's cycle.

Figure 5. Kolb's Experiential Learning Cycle (1984, p. 41).



Kolb's model has been adopted extensively in cognitive behavioural therapy training and clinical service delivery (Bennett-Levey, 2004). Bennett-Levey (2004) used Lewin's and Kolb's work to develop a cognitive behavioural framework for supervision and training that includes four recognisable components: "plan, experience, observe, and reflect" (p19).

This framework acknowledges Lewin's formative work and Kolb's cycle. The model I used and developed in this training enables the teacher, clinician or learner to take a reflective 'cognitive' look at the processes occurring in the designated session, and then present it at supervision to their critical companion to discuss and learn from. The trainer utilized experiential education methods such as 'role play' extensively during the course. These models were targeted to enable active reflection on practice in the designated supervision slots, designed to enable the development of a 'reflective practitioner' (Schon, 1983, 1991).

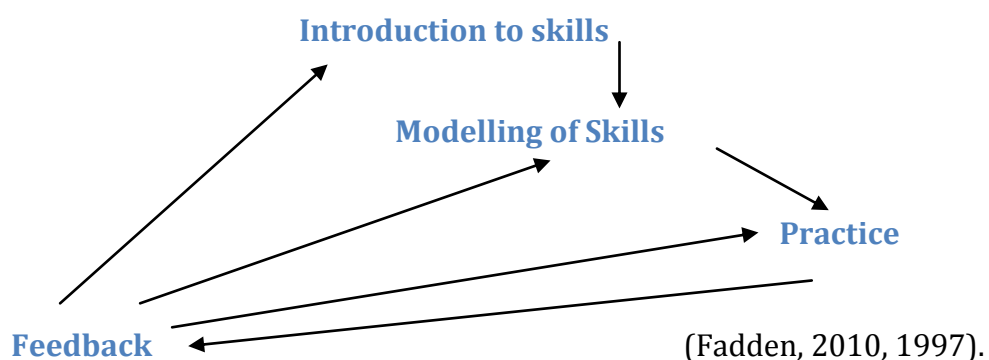
The course concentrated on teaching the students actual therapy skills designed to be utilized and practiced in ongoing and developing therapy sessions. Skills were also targeted at the developing area of cognitive behavioural therapy for psychosis (CBTp) a predominantly British development of core Beckian (1975) cognitive therapy that in standard mental health services is the core client group treated. The latter stages of the course directed the student in 'how to do it', 'why to do it' and 'where and when to do it' and provided an understanding of relapse prevention and early interventions skills (Birchwood et al, 1989, Morrison et al, 2004).

Growth and learning were facilitated by using this action learning methodology, and participant engagement in the training was monitored using

an approach in the spirit of action research; that enable participant involvement with the process, engagement with the critical companion, and part ownership of the project. This method enabled evaluation and review to occur at the end of every training day, with the results used to enhance course delivery at the next session. The overall participatory involvement and feedback went into the design and delivery of all subsequent training programmes (appendix 3), but not all this data was kept and thus modifications were not documented during project progression.

A basic CBT formulation model was employed that offered an educational, active learning and developmental approach to course delivery; this enabled the introduction of CBT skills to the student by use of didactic and experiential learning, video and role-play. The new skills were then modelled by the course leader or by video demonstration and the students then practiced the skill in the safety of the classroom and then transported those skills to their clinical setting over time. Students later in clinical supervision discussed the success or failure of introducing the intervention to their clinical practice. This process is outlined by Figure 6.

Figure 6. Basic Meriden Behavioural Family Interventions Educational Formulation.



This figure demonstrates the cyclic model employed by the Meriden Family Work training centre during the delivery of their behavioural family intervention training courses. Initially the course tutors introduce the student to the intervention being taught by the use of didactic lectures and group discussion. The skill is then modelled by either role played demonstration in class or the use of educational DVDs, the students then practice the skill in a safe and supported environment by the use of structured and directed role play. Feedback is then offered to each student who participated in the role play, to do this a feedback sandwich is used; the facilitator gives feedback on what was done well, and what could be improved, avoiding negative feedback as this is a learning scenario designed to increase the students skills and self-efficacy. The cycle draws on the work of Kolb (1984) and Schon (1983, 1991).

The cyclic nature of the phased research delivery enabled phases to be worked on concurrently, but also developed and analysed throughout the research project as a whole data set. The collection of both written and verbal evaluations of each course day delivered enabled the cyclic development of the CBT course over time, but did not enable those changes to be documented, as the data was not kept in its entirety (appendix 5).

Phase three:

Analysis and impact of the project:

As stated previously the delivery of the first CBT course was done as a pilot to ascertain which aspects of the course worked and which needed altering by gaining feedback and comments from the research participants attending

course one. All future courses were developed using the data gathered from the pilot course but each course was reviewed pertinent to feedback gained and altered if necessary before the next delivery. It was planned to deliver two courses in each of the three main sites of NSCCH - eventually eight courses were delivered. The CBT course followed a typical academic plan and format and was eight days in duration, delivered over three months with two set study days timetabled. This method of delivery was adopted to enable the respondents to gain CBT skills on the course before deploying those skills in the clinical setting post course completion. The teaching methods employed to facilitate course delivery were predominantly experiential learning based; with direct didactic and skills based lecture provision, with a number of academic approaches used in course delivery ranging from; experiential work to group tasks, video work, didactic lectures, student seminars and presentations and role played therapy sessions. The course started at 09:30 and went on to 15:45-16:15 to enable outliers to attend. The bulk of the didactic teaching was done during the morning, leaving the afternoon free to conduct role-play and receive feedback and supervision (Appendix 3).

The theory of 'learning by observing/doing' that utilized the stages of Kolb's experiential learning cycle (1984) as discussed earlier, complemented the teaching, student participation and research model I developed to conduct this project. As I was aiming to enable the development (over time) of usable CBT skills in a population of health care professionals. This population (as with the majority of all health care professionals) had undergone a core professional training, this training is recognized by the Australian Association of Cognitive

and Behavioural and Therapists (AACBT, 2012) as offering a foundation level of skills to develop and build CBT practice upon. Thus, I was teaching a group of people who already had skills and abilities in working with clients with mental health needs, so my educational rationale was to attempt to expand upon, fine tune and develop CBT skills on the back of an existing therapeutic skills set.

#### **4.3 Ethical Issues:**

The executive committee of Northern Sydney Central Coast Health approved the research project, as an internal educationally based practice development initiative, and as such did not need NSW Health ethical approval. This committee comprised of the Chief Executive Officer of the health service and all mental health directors. External scrutiny was provided initially by the University of Technology Sydney who considered the associated paperwork and latterly by an associate professor at Charles Sturt University and his team. I completed an ethical approval form, but was advised that as the project was being supported as a practice development initiative and had no direct patient contact or patient data collection impact, it was not necessary to apply to the ethics committee. All participants were given the choice to attend the course; they met with me prior to committing to the CBT course to discuss issues and concerns and were given full written information prior to joining. Written consent was gained and each participant informed they could withdraw at any stage of the research project (Appendix 6). As the researcher I needed to be cognisant with the ethical issues that may be raised by an action research study involving the respondents as active participants in the study. I needed to protect participant's confidentiality but also acknowledge their contributions

to the research project. I also needed to ensure that all stakeholders were involved in research issues such as; CBT courses cyclic development, data gathering and to an extent analysis and conclusions drawn from the project (Winter & Munn-Giddings, 2001).

As O'Brian stated in 2001; "action research is carried out in real-world circumstances, and involves close and open communication among the people involved, the researchers must pay close attention to ethical considerations in the conduct of their work" (p. 1).

I have drawn on the work conducted by Winter (1996) and Winter and Munn-Giddings (2001) in ethical considerations pertinent to action research methodologies to support and to an extent direct my ethical considerations. After consultation with the relevant persons, committees and authorities in the mental health service the principles of the study were accepted and it was decided a model in the spirit of action research was the most applicable to use to conduct the research project (Winter, 1996, p. 16-17). A research committee was formed to move forward and oversee the project as discussed in detail in chapter 4. It was agreed that all practicing mental health clinicians would have access to the training once the course had been piloted and finalised. I developed a flyer to advertise the CBT course and the research project, which was circulated to all areas of NSCCH. Places were offered on course one after I had met with clinicians to outline the project and they had expressed their desire to participate. The majority of initial respondents were recruited from the Northern Sydney area, as pragmatically that was where it was being delivered.



There were tensions inherent in securing access to clinicians, not least of which was securing the time to attend an eight-day course. The time commitment was approved by the Executive Board and signed off by their locality manager or service director. I was explicit about the nature of the research process from the beginning, and also on my personal bias and interest (Winter, 1996) in CBT. I did this as I was an accredited CBT psychotherapist, had spent a number of years being trained to offer CBT, supervised in my CBT practice and subsequently developed a number of skills based courses within a CBT paradigm. I have also seen CBT work with patients first hand so I had a belief in the efficacy of CBT as a therapeutic modality.

All research participants were able to influence the research and the training project. A recruitment process was undertaken where interested parties were given the opportunity to apply for the course; prior to acceptance on the course I met all respondents and explained the research project to them. At this stage they were given the consent form and literature pertinent to the course (appendix 6), asked to read the literature in their own time and sign the consent form if willing to participate in the research. No participants were excluded from the course if they refused to participate in research and they were made aware that they could withdraw their consent at any time, which would be respected (Winter, 1996, Winter & Munn-Giddings, 2001). In all 80 respondents over the duration of the course agreed to participate, no respondents withdrew or decided not to attend.

All participants were involved in the cyclic developmental model adopted during the research, the decisions made about the direction of the research and

CBT training course were collectively formulated and used to enhance the continual development of the research and teaching project simultaneously (Winter, 1996). All educational sources, such as DVD material, textbooks and handouts, used and developed during this research project were accessible both to all participants, and to where participants worked. Any of the small number of qualitative statements or data gathered by application of the CBT course questionnaire used in the analysis had permission granted for its publication by the respondents. As the researcher I also accepted the responsibility for maintaining confidentiality of all data generated from research participants, and the responsibility for maximising involvement in the research project for all participants (Winter & Munn-Giddings, 2001).

A participatory action research stance can introduce biases pertinent to the researcher's role and the autonomy of the research process in the area being studied. If not addressed the situational biases introduced can have a detrimental or negative effect on the researcher-practitioner, generation of data and participation of the research population. The researcher-practitioner may be too close to the population being researched and thus become a part of that population and affect the direction of research and data produced. The population studied may work harder than they normally would, as they know they are being observed this could be defined as the 'Hawthorn Effect' (Landsberger, 1958). A definition of this effect is given below:

'A term referring to the tendency of some people to work harder and perform better when they are participants in an experiment. Individuals may change their behaviour due to the attention they are receiving from researchers

rather than because of any manipulation of independent variables' (Cherry, 2011 p.1).

The researcher may also bias the project by overlooking elements of the process that do not quite fit into either their developing theory or hoped for results. Over emphasis could also be given to certain elements of the research population being studied, with other elements being neglected, sometimes identified as the halo effect (Nisbett and Wilson, 1977). The halo effect:

"describes what happens when a scientific observation is influenced by the observer's perceptions of the individual, procedure, or service that is under observation. The observer's prejudices, recollections of previous observations, and knowledge about prior observations or findings can all affect objectivity and must be guarded against" (Last, 2006, p. 148).

In other words I would need to guard against focusing on those I perceived as being good at CBT and not putting as much effort into those I perceived to be not as good at CBT. This was addressed during the project by enabling all of the student population to have equal access to the teaching and supervision resources. It was also helped by the fact that I did not know any of the students prior to the initial meeting before course attendance. The participants who applied were identified by the clinician responsible for course recruitment for each area based course delivery, thus removing any perceived favouritism and allowing focus on all participants by me as the main teacher/practitioner-researcher.

It was felt expedient to actively coach, teach and mentor the research participants during course attendance, thus a role of researcher and

practitioner-trainer was identified and adopted. The positionality of the research project was 'insider in collaboration with other insiders' (Herr & Anderson, 2005) where I was attempting to "deepen my own reflection on practice toward problem solving and professional development" (Herr & Anderson 2005 p.29). The 'insider in collaboration with other insiders' model was suited to one of the broader aims of the research that of bringing about organizational and practice change, as discussed earlier in chapter one.

Ethics forms, information sheets, consent form:

As outlined earlier, to gain approval for the research project a local ethics form was completed (appendix 4), as was a NSCCH local practice development initiative form. Local approval was given by the NSCCH Executive Committee to conduct a service wide educational practice innovation initiative. Information sheets pertinent to the research and research focus were developed and circulated across the health service to managers and directors to share with their teams in order to identify interested participants in the project. Each of these once interviewed by myself, were asked to sign a research consent form (appendix 6).

#### **4.4 Development of the instruments:**

As part of 'MoodMatters', a therapeutic skills self-assessment survey was developed and distributed. It was designed to identify perceived skill levels, training needs and use of skills by staff in their current role in specific psychological therapeutic interventions (NSCCH, 2007). At my suggestion the 'MoodMatters' staff survey committee updated a copy of the Gray et al (2001)

Scale, which as stated above was circulated as a pre-test pilot to a small group of clinicians for feedback, and then amended in the light of their comments. The purpose of the anonymous 'MoodMatters' staff survey was to provide a quick snapshot across the Area Mental Health Service of:

- i) The profession of the staff member delivering the therapy;
- ii) Current provision of therapy; including the modality of therapies being provided;
- iii) Staff members perceived skill in provision of therapy;
- iv) How much time is spent in therapy;
- v) Current modality specific supervision (if any); and
- vi) What, if any, training needs are required.

All clinical staff (i.e. psychiatrists, nurses, psychologists, social workers, and occupational therapists) employed by Northern Sydney Central Coast Adult Mental Health Service at the time were asked to complete the survey.

Thus phase 1 of the project 'MoodMatters' was designed to be delivered to all active mental health clinicians across NSCCH. To facilitate this, the questionnaire developed was initially circulated to a small group of randomised clinicians working locally to the development site, the pre-test population. This group of clinicians resembled our broader research population as they were drawn from a multi-professional group (Ruane, 2005); this pre-test population were not included in the final circulation to the clinical population. After further revision to the staff survey drawn from the initial circulation responses, staff at an acute psychiatric admissions unit (anonymised for the project) assisted in piloting the survey for NSCCH. This was conducted as a

feasibility study or a "small scale versions' or trial run, done in preparation for the major study" (Polit et al., 2001, p. 467 in van Teijlingen and Hundley, 2001) The staff survey was updated and finalised from the pilot results and suggestions then led to the 'MoodMatters' working party gaining final approval to circulating the revised staff survey questionnaire to all 1200 clinicians across NSCCH (Appendix 1). The survey was emailed to the local Service Directors who were charged by the Area Director Adult Mental Health to distribute the questionnaire to all clinical mental health staff of the health service thus hopefully providing access to all available respondents working in the specified field. All clinical staff in the areas was encouraged to complete and return the survey by their service directors. The surveys were distributed on the 28/02/2008 and the closing date for return was 20/03/2008 although a further week (until 4/4/2008) extension was given, thus allowing four weeks for completion and evaluation of the data; results of which were used to fine tune the CBT training course.

#### **4.5 Section 2 - Methods:**

The research project was designed to be developed and delivered cyclically during 2007 to 2009. The action research cycle best known in Australia is probably that of Stephen Kemmis (1988) and his colleagues at Deakin University (Dick, 2000). The steps of this cycle are:

plan --> act --> observe --> reflect (and then --> plan etc.)

The methods I used to enable the development and delivery of this research project across NSCCH were broadly; active, participatory and educational in scope and content, delivered in the spirit of action research. The development of an action research cycle enabled the planning of the research

project and training course to occur concurrently. Although the delivery was staggered, each phase flowed from and often meshed with either the one before or one after.

I conducted a number of stakeholder and gate keeping meetings with key players across NSCCH; these key players were identified by the Director of Nursing, with the express desire that I quickly gained an understanding of issues and needs on the ground. Thus I initially met with members of the management board of NSCCH, senior clinicians, clinicians in the field and an educationalist to discuss my ideas and get an idea of the health service and locality needs in the area of talking therapies and staff training in such skills. Once I had completed these meetings I again met with the Director of Nursing to share my observations and outline how I thought it would be possible to introduce a practice development initiative designed to impact on direct clinical care.

I then conducted another round of meetings this time to discuss the practice development strategy I had identified with the Director of Nursing, and introduce the idea of the research project around the CBT training course I was proposing. This was well accepted and I devised a number of short presentations and a longer study day pertinent to CBT and CBT training. In parallel to this I wrote a Service level brief to gain approval for the proposed project. As this was all background and preparatory work prior to the development of the research project, I do not include any of this in the main analysis of the research.

'MoodMatters' staff scoping survey:

The next stage of the project was to develop and implement the 'MoodMatters' staff survey; this followed a scientific design that hoped to gain an

understanding of the level of psychological mindedness of staff across NSCCH. The data collection method identified to do this was a staff scoping survey the 'MoodMatters' survey (Appendix 1). The purpose of the anonymous 'MoodMatters' survey was to provide a snapshot across NSCCH of:

- i) current provision of therapy; including the modality of therapies being provided,
- ii) how much time is spent in therapy and; and
- iii) what, if any, training needs are required.

The survey was split into distinct areas gathering data on:

1. Staff demographics.
2. Delivery of psychological interventions.
3. Clinical practice.
4. Supervision.

The sections were further sub-divided to enable the gathering of area specific data such as; therapies currently delivered by staff, requests for further training in specific therapeutic modalities, being in receipt of modality specific supervision and levels and types of qualification. This survey focused on obtaining data pertinent to the current delivery and future development of evidence-based therapeutic interventions such as cognitive behavioural therapy, family work, and brief solution focused therapy, motivational interviewing and other forms of talking therapies (eighteen in total) across the health care provider. The survey was distributed to all clinical staff, approximately 1200. The total number of survey responses was n=119, representing approximately



10% of clinical staff employed by NSCC mental health services. This was a very low response rate by staff across NSCCH, and could call into question the reliability and validity of the data, but it was thought by the management executive to represent the number of individuals who they thought had any skill at that time in talking therapies. Retrospectively the figure of 1200 practising clinicians on the ground was probably over inclusive and did not in reality reflect the number of actual clinicians practising – which was probably a lot less than 1200. This in itself if correct was a poor state of affairs and needed to be addressed. Only responses that arrived by the due date were included in the data analysis.

CBT course questionnaire development:

I then developed and gained approval for a more in-depth questionnaire that was designed to gather both quantitative and qualitative data focused on self-reported readiness to use clinical skills and an increase in the self-efficacy of the research participants in CBT practice (Appendix 2). The questionnaire was designed as a pre- and post- course completion application model, which aimed to gain a snapshot of the student's self-reported readiness to use clinical skills in CBT learnt on the eight-week course. The questionnaire was split into four specific sub sections and each had a number of specifically designed and targeted questions and questioning styles (Robson, 2002). Examples of questions from the questionnaire:

Please list the measures/tools/instruments that you routinely use in practice to conduct CBT with your patient.

This question was designed to gain an understanding of what standardised measures (if any) the student used before commencing the course and which ones they would use at the end of the course. This question enabled me to see how many mental health professionals used standardised measures in their every day practice. It was also hypothesised that respondents would be using more assessment measures on completion of the course. Other questioning styles were used to enable a score to be given to specific areas. The questions in part C of the questionnaire were designed to gain the respondents views about CBT, as shown in table 4.

Table 4. CBT questions Part C of questionnaire (Please see appendix 2 for full questionnaire)

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1. The Main reason patients are not offered CBT is because it is too difficult?					
2. Patients should be allowed to refuse therapy?					

The questions in part D were designed to gain an understanding as to how skilful (at that moment in time) the student felt in certain applications of CBT and talking therapies, as shown in table 5.

Table 5. CBT questions in Part D of questionnaire:

	Very skilled	Skilled	Neither skilled or unskilled	Unskilled	Very unskilled
3. Assessing psychotic symptoms					
4. Assessing the side-effects of antipsychotic medication					

Course development and implementation:

Following approval by the NSCCH mental health executive team to develop and deliver an eight-day CBT course, an extensive literature review was conducted. This literature review formed the basis of the course content, curriculum scope and design. As discussed earlier I used an exploratory educational model; Kolb's Experiential Learning Cycle (Kolb, 1984) to ensure the delivery of the CBT training course. The rationale behind this was to enable safe practice of skills in a supportive educational environment prior to actual patient contact and CBT implementation.

As with all core CBT training the course started with the research base for CBT, its developmental stages, then it was refined into a targeted therapy initially for depression and then anxiety. Respondents were taught the fundamentals of CBT and then moved through a logical curriculum that mirrored the delivery of CBT with a patient, to specific days offering didactic and skill based experiential learning on diagnostic groups such as depression, anxiety and psychosis. Each day was designed to enable the development of both cognitive and behavioural skills in the student. This aimed to nurture actual clinical skills and competency development, which was captured by the repetition of the questionnaire at the end of the course. Below is an extract from the first CBT course handbook: (Appendix 2)

"The course aimed to introduce mental health professionals to the underlying theory and practice of Cognitive Behavioural Interventions for use with people with a serious and enduring mental illness. Cognitive Behaviour Therapy (CBT) has been developing over the last sixty years as a psychological

treatment, and has been recognized as a treatment of choice for a number of psychological conditions. It has been particularly well evaluated in outcome studies and empirical research, providing an evidence base for practice and efficacy for working with people with anxiety and depression (NICE, 2007, 2010). More recently research has shown its value in psychosis (NICE, 2009). CBT involves working collaboratively with clients and helping them to recognize and change patterns of distorted thinking and dysfunctional behaviour. Goals are negotiated and an action plan devised using verbal and behavioural reattribution strategies.

CBT has been established as an effective method of helping, counselling and psychotherapy used as an alternative or in combination with more traditional methods of treatment such as medication. CBT is being used by a variety of mental health practitioners working in specialist roles and as techniques, which can be integrated, with other therapeutic approaches. The course would be of immense benefit to professionals working with people with serious and enduring mental health problems in health and social care settings including nurses, occupational therapists, social workers, counsellors, psychologists and psychiatrists” (UCL, 2007, CSU, 2010).

Course design:

“The course is delivered on a part-time basis for one day on consecutive weeks over a three month period. The course will run for eight hours a day and will include theoretical/practical aspects of CBT, clinical work and small group supervision. Attendees will be required to have access and opportunity to work with people with serious and enduring mental illness in their own work place.

Guided reading and practicing of skills will be expected between study day” (UCL, 2007, CSU, 2010).

Course content:

The course consists of one module, which will be recognized by the Education Department and Hospital Executive Macquarie Hospital as a site based CBT training program (NSCCH, 2007). The module aims to develop the participant’s knowledge, skills and competence in the principles of, engagement, assessment and formulation, and use of CBT interventions, appropriate to working with people with serious and enduring mental illness (UCL, 2007, CSU, 2010).

Table 6. Course content:

• Overview of historical development of CBT
• Outline of underlying principles and assumptions of CBT
• Evidence base of CBT
• Stages and structure of therapeutic work
• Engagement with clients with complex needs
• Assessment and engagement tools
• Making a formulation
• Normalising/education strategies
• CBT techniques
• Managing risk
• Relapse prevention

Course themes:

Using the literature review and pertinent CBT texts a number of themes

were developed to underpin course delivery, and also to enable data to be analysed in each specific section. The humanistic aspects of CBT draw upon the work of Carl Rogers, who in 1951 discussed at length the role of the therapist in enabling change in patient's conditions. He identified three critical conditions that prepare the way for natural change: accurate empathy, none possessive warmth and genuineness (Miller & Rollnick, 1991). Aaron T Beck and colleagues (1979) put forward the idea of 'collaborative empiricism' in the seminal CBT text, 'Cognitive Therapy of Depression' he states that in CBT:

"The therapist applying cognitive therapy is continuously active and deliberately interacting with the patient. The therapist structures the therapy according to a particular design which engages the patient's participation and collaboration" (Beck et al, 1979 p 6).

As with all talking therapies, there are certain themes that run throughout the application and clinical practice of CBT. The Cognitive Therapy Checklist – Revised (Blackburn, James and Reichelt, 2001) was used to aid the categorization of the clinical skills aspect of the questionnaire. This scale is used in all CBT training courses in the UK, as a therapist skills rating tool and is being introduced to New South Wales and Australia. These 'themes' drawn from The Cognitive Therapy Checklist – Revised (Blackburn, James and Reichelt, 2001) (Appendix 8), can be classified as the core skills needed to deliver CBT:

- warmth
- empathy
- an active therapeutic stance
- collaboration with the patient
- an ability to use basic CBT principles (Blackburn, James and Reichelt, 2001).

- medication and;
- supporting questions.

When developing the questionnaire and the eight-week course the core themes underpinning CBT were used, these core themes were instrumental in the data analysis identification and synthesis gathered from the questionnaires. The data were categorized again using the core CBT themes identified and evidence was sought to show change in self reported readiness to use skills thus evidencing an increase in student self-efficacy. These themes will be employed to discuss the findings of the research and aid understanding of the implications to ongoing educational, staff support and development and their CBT practice.

Course delivery:

As this was the first formal CBT training many of the student population had attended it was delivered at a basic or foundation level. The initial course timetable can be found at appendix 3. The timetable concurs with the core CBT themes, these themes underpinned the curriculum teaching and learning strategies employed in the delivery of the training and can be seen in the views and skills component of the questionnaire.

CBT course questionnaire data analysis:

Stages of data collection:

The three-phased approach to the research project and training initiative, delivered within a cyclic action research model enabled data to be gathered during the whole time frame of the research project. Two data collection methods were employed during this research project to gather the data that would be analysed to identify the results of the research. A staff scoping survey

and a self report questionnaires were designed, piloted and then administered to the research population at the specific phase of the research project phase 1 'MoodMatters' staff survey and phase 2 the CBT training course pre- and post-course questionnaire respectively (Appendix 1 & 2). Daily course evaluations were employed to enhance the ongoing development and delivery of the CBT training course and a more in-depth formal evaluation was conducted on the last day of each CBT course delivered (Appendix 5), these formative evaluations were used in the cyclic development of the CBT course and not in the formal data analysis. The daily course evaluations consisted of asking the respondents to feedback their experience of the CBT course attended and the more formal end of course evaluation asked the respondents to complete an evaluation to outline their experience and suggestions across the complete CBT course (Appendix 5)

The initial stage of data collection occurred during the 'MoodMatters' research project. The data gathered during this project identified the areas that would be developed and delivered during the CBT course phase of the research project.

The next stage of data collection occurred pre- and post- CBT training course delivery of the CBT course the project component of the research, this was conducted to gain data to explore if a self reported change in the participant's readiness to use CBT had occurred. The CBT specific data was gathered on a pre- and post- course model with the research participants completing a questionnaire on day one of the course and then doing it again on day eight the final day of the course. Each course averaged about 10 attendees, with some smaller numbers in Central Coast, was eight days in length and the



data was analysed post- completion of all eight courses. In all eight courses were delivered with a total of 160 pre- and post- questionnaires completed. The data pertinent to course delivery, participant opinion and suggestions for course development, was analysed during and post course to enable cyclic developments and fine tuning of the next course delivery. Thus an in and out phase of analysis was developed, enabling analysis at all stages of the three phases of the research and training project. This offered a cyclic developmental approach to the course. The stages of data collection across the research project were conducted as three phases as shown in table 7:

Table 7 - Phases of Research:

Phase one - The Research	Phase two - The Project	Phase three - The Analysis
Development of tools: 'MoodMatters' survey & CBT questionnaire.	Development of CBT Training Course.	Analysis of CBT course data set.
Analysis and Evaluation of 'MoodMatters'	Delivery of CBT Training course & CBT questionnaire, cyclic evaluation of in course formative evaluations	Impact, write-up and recommendations

The phases were developed and delivered to run concurrently, and deployed within a cyclic model of application.

Data analysis:

The stages of analysis were:

1. Initial 'MoodMatters' survey analysis.
2. Pre- and post- CBT training course questionnaire analysis.

The 'MoodMatters' survey was analysed by inputting the data into SPSS and averaging the number of respondents per target question. An example of this taken from the supervision section, asked did staff receive formal clinical supervision? The answers available were; yes, no or informal, so after percentage analysis 67% of staff stated they received formal or informal supervision, thus 33% received no supervision. This method of analysis was conducted for all sections of the 'MoodMatters' survey. Although the 'MoodMatters' survey provided data pertinent to 'talking therapy' provision across the health service, the low response rate of 10% calls into question the validity and reliability of the data set.

The 160 CBT course questionnaires were manually entered into SPSS. The questionnaire data was then analyzed using SPSS version 18 to differentiate between the student's pre- and post- course knowledge, to quantify the student's experience of CBT, experience on the course and their self-reported readiness to use skills post course completion in their clinical practice. This data also enabled me to gain an insight into the development of the respondents 'self efficacy' pertinent to CBT practice. The data was analysed using a percentage change model from data point one to data point two designed to identify any marked changes in the two data points that would show a significant move in research participants thinking about CBT practice. All the 160 questionnaires were analyzed as a unit to allow analysis of positive, negative and neutral aspects of the data sets to be identified. As the evaluation data from the course was combined a more in-depth analysis of each students pre- and post- data set wasn't possible, this made it impossible to demonstrate any improvement over

time between courses and students. Each questionnaire was also designed to enable a mixed methods analysis, using the individuals' personal statements to allow a qualitative and quantitative data perspective.

The data once submitted to PASW Statistics 18 was analyzed and compared at point 1, on the first morning of the course and point 2, after completion of the eight-week CBT course. The initial scoping of the data led me to believe that it was possible to alter attendee's views about CBT and to evidence a change in their self-reported readiness to use skills. All 33 questions were compared singularly to ascertain the percentage shift from pre- to post-course completion, using a five point satisfaction scale to target student's views of and perceived skills in CBT and will be discussed as such. Point One, "Your views about CBT" will be discussed first and Point Two, "Your views about your skills" will be presented after. Both component questions have been themed and are presented as such.

In the ideal world it would have been possible to compare each individual's responses at time 1 and 2 in order to identify changes across the individual participant's attendance on the CBT training course. As I had kept the data in aggregate form it was therefore not possible to do this, thus I analysed the data as a single two-point data set. I can therefore make gross comparisons pre- and post- because the samples were not independent. Statistical tests of significance between aggregate pre- and post-course responses were not appropriate, as they did not refer to independent samples. Therefore I have reported results that by eye show there is a discernible difference between the two data points. It was also not possible to track cohort development over time

as I had aggregate data for each individual cohort and thus I could not analyse each in its own context. As the evaluation data from all eight courses was combined it was not possible to demonstrate any improvement over time, and between courses, thus having the facility to analyse single student data would have augmented the action research process and record time related progress. Fundamentally course one and course eight were different in their application and content and it would have been useful to distinguish what elements of course eight differentiated it from all previous courses, and it would have been useful to distinguish student results from course one onwards, to ascertain the progress of the research process and fine tune future courses, also to see which components of the modified training courses were more effective. I made no attempt to make a distinction between sex, age and qualification, as the numbers were not large enough to get a meaningful sub sample.

In total 160 pre- and post- CBT training course questionnaires were analysed. By comparing time points I was aiming to identify and report changes that are clearly real and not there by chance. Thus I was looking for areas on the questionnaire survey that showed a change from time point one to two. I was also interested in areas where no change was exhibited to see if that could be accounted for within the model of educational provision adopted. It was not practically possible to apply statistical tests of difference from time point one to two, as I didn't keep the data segregated. The analysis conducted was not a follow up evaluation of practice, or a detailed analysis of individual change, it was a snapshot between two time points designed to gain an understanding of the developmental process participants underwent whilst attending the CBT

training course. Retrospectively this could be looked upon as a weakness in the research design and one could argue that my approach was more in the spirit of action research than full action research, as my data was limited in its ability to show change over time. That notwithstanding the results do show a change from points one to two, but to actually identify the course of that change would be problematic. I think the adherence to the methodologies developed would have been enhanced if I had been in receipt of supervision from an action researcher at the time of the project and not just post project and write up.

#### **4.6 Reflective considerations:**

The Australian Scholarship in Teaching Project describe the positioning of reflection and evaluation in scholarship; Reflection and evaluation, the consideration of evidence, the determination of its validity is the central ingredient of scholarship (UTS, 2012). When I reflect on my research project journey I can identify areas that I feel as a novice researcher and experienced teacher went well and other areas that could have been improved. The initial identification and subsequent inception of the research project, on my arrival in Australia attempted to address the lack of psychological therapies identified on the ground in clinical practice. This was done by conducting the 'MoodMatters' phase of the research project, which provided the data that enabled the targeting and development of the other two phases of the research project, the CBT course, delivery and data analysis. The actual response rate to the staff skills survey was very poor, only 10% of clinical staff returned the survey, which questions the reliability and validity of the data. Reflecting on this I should have developed a way of advertising the project more thoroughly and in hindsight could have

developed a second data gathering phase by conducting focus groups with staff across NSCCH to cross reference both data sets, pertinent to the CBT course development. I should also have kept the eight CBT course questionnaire data in a fashion that would enable a statistical analysis of the results, instead of having an amalgamated data set that allowed only for a comparison of data gathered on day one to data gathered on the last day of the course, day eight. The phased action research cycle developed during the research project enabled CBT course development and 'fine tuning' both during and after each delivery, I should also have kept this data and analysed it as part of the project as a whole, not just treated it as formative developmental data. Upon reflection it would have been useful to have initially developed a greater number of teachers and enabled them to develop and deliver the training in their areas. This would have been considered as a longer-term goal once the project was seen to be successful.

The next chapter will discuss my reflections of the pedagogy of the research and CBT training course development and delivery. Certain points of the chapter will appear repetitive but this is done to include a more personalised aspect of the research project. To achieve this I use my personal reflection and development which I include to expand upon the pedagogy that underpinned my development during the project. To do this I utilise two distinct voices to differentiate between my academic and personal development across this action research project.

## **Chapter 5.**

### **In the Spirit of Action research.**

#### **Pedagogical experience as a research scholar, trainer and health professional.**

##### **5.1 Introduction:**

This chapter will introduce in greater detail the pedagogy that underpinned the process as a whole, interlinking the research cycle and training programme that was developed and delivered within an active research paradigm developed and delivered in the spirit of action research. Aspects of the project that worked well and not so well will be advanced and I will outline how the course changed and developed over time by utilizing the evolving action research cycle. The organizational context in which I was employed will be outlined and how this shaped the development and implementation of the training package discussed. Adopting an approach broadly in the spirit of action research implies the development of a process of cyclic reflection, which I harnessed and implemented as a core method of training, development and delivery. This model also led to the ongoing development of practitioner training and data generation throughout the research project. The iterative research model in the spirit of action research is interlinked therefore, to capture the essence of the project. It is reported in two voices, to imply two things at once; the academic pedagogical process employed to complete it followed by my more personal reflection of the journey from its inception in the UK to completion in Australia.

## **5.2 Voice one - The project:**

Northern Sydney Central Coast Health was keen to develop 'in-house' talking therapy training for staff and subsequently enable staff to practice in a safe and supportive environment. To do this they created the position of Area Nurse Consultant in Clinical Practice Development to develop and nurture an ethos of practice across the authority. NSCCH provide care to a large area of rural NSW and to Northern Sydney and related suburbs, a population intensive area of greater Sydney. Within this area were a number of acute hospitals, rehabilitation hospitals, district general hospitals and a large and well know teaching hospital in North Sydney. They also provided extensive community care facilities and were developing a Psychiatric Intensive Care Unit. Across the health service a number of staff provided talking therapies to service users but the numbers were small and the modality and level of therapy delivered was basically unknown.

The research cycle used to guide this project was designed to enable a continual cyclic review of research and CBT training course progression taking into account participants comments and suggestions for developments. The initial elements of the cycle involved setting the scene and identifying the environment for the research project and CBT training course delivery and involved considerable ground work across Northern Sydney Central Coast mental health services. This was designed to enable me to meet and engage all key stakeholders across the whole health service. It allowed discussion of ideas regarding up-skilling staff in the delivery of psychological therapies and the development of a practice development ethos across the health services as a whole that would then enable the ongoing delivery of therapy post project



completion. The overall aim was to support, encourage, enable and empower staff to feel confident in their developing abilities to deliver psychological therapies to their patients in a supportive and nurturing environment. An environment that was aware of and understood what the clinicians were doing and what support they needed to do it. Much of the early research into the delivery of psychosocial interventions has shown that trainees find it difficult to practice post qualification (O'Carroll et al, 2004). Lately due to the success of the Improving Access to Psychological Therapies (IAPT) programme in England the 'on the ground' picture of talking therapies delivery has been turned around due to the development of a culture of understanding, therapy availability, delivery and accountability at the IAPT provider sites (DoH, 2010).

During the developmental period at NSCCH I became involved in the inception of the 'MoodMatters' project, discussed elsewhere in this thesis, and developed a staff scoping survey (Appendix 1) designed to enable service developers, managers and clinicians to gain insight into the present state of talking therapy delivery and supporting infrastructure across the mental health services. Once the data was analyzed, although due to the small response rate that calls into question the validity and reliability of this data although other anecdotal, policy and research supported this approach (as discussed in chapter 6) it lent support to the development of a CBT specific training course. This led on to the development of infrastructure to support the training such as access to supervision, time to deliver therapy and a culture of awareness pertinent to talking therapy delivery across the health service for staff. This helped my research project gain final approval as an internal educational practice development project.

The CBT training course:

The cycle then progressed into the active development phase of the training course, delivery infrastructure and support materials, although it was not entirely a forward flowing journey. Reflection was given to earlier phases of the cycle and their impact on on-going developments. This phase was conducted utilizing expertise available across NSCCH, identified and highlighted during the groundwork phase of the cycle. The stakeholders in the course were the Nurse Manager responsible for education, the Director of Mental Health Nursing for the Health Service, a senior Consultant Psychiatrist with an interest in CBT, the Head of Psychology and a Senior Lecturer from the University of Technology, Sydney. These experts later became participants in the research committee and gatekeepers of the project. The stakeholders were on the whole, helpful throughout the research project and I continued to meet with them on a regular basis. The nurse manager for education was able to organize the training venues, paying for them when necessary. She also gave useful insights into local training issues, peculiarities and needs. I met with her regularly during this phase of the project to discuss my ideas; the ongoing development and research focus and this relationship formed an integral part of the developments and evolved over time as did the research cycle. The two clinicians were of less help; their role in the training course was to add expertise from the medical and psychological disciplines and also to attract clinicians from that area into active participation in the project but this was not fully realised.

As well as the 'MoodMatters' survey deployment, I found giving an overview of the action research at service meetings, discussing it with

individuals in supervision and team meetings addressed the need for identification of people to train. Predominantly due to workload pressures of medics and psychologist, I did not receive any expressions of interest at this stage of the project. The two clinical Heads of medicine and psychology were able to contribute to the initial development of the project when their time constraints permitted them. The Senior Lecturer was again helpful but had limited experience of talking therapies, so helped out on the academic/pedagogical side, by providing elements of curricula development teaching advise, research development skills, expertise and academic support.

At this stage I introduced and updated the Institute of Psychiatry Medication Management research project questionnaire (Gray et al, 2001) that was going to be adapted for this research. The design of this questionnaire (Appendix 2) has been discussed in the methods section. I had considered conducting one to one interviews and focus groups during the cycle but had to dismiss these plans due to time constraints and geographical difficulties (distances between some centres being hundreds of kilometres). Parallel to this I was working with the Director of Nursing and another Nurse Consultant from locality based mental health services to introduce the practice development model and strategy to NSCCH mental health services, designed to support the ongoing delivery of CBT across NSCCH post research project completion (Taylor and Hails, 2007).

During this phase the experiential learning cycle, 'double loop learning' and reflective practice models (Rolfe et al, 2001, Bolton, 2010, Kolb, 1984, Kolb & Kolb, 2005, Argyris and Schon, 1974, 1978, Schon, 1983, 1991) that were utilized

both during and after the research ended, were fine tuned using on-going course feedback and evaluations. Ongoing reflection on the research cycle and changes to practice identified throughout the process, were a continual process shared across the duration of the research project.

Voice one: Academic reflection on pedagogy:

The research cycle employed a continual cyclic review and adaptation model, designed to enable optimum delivery of the identified training programme from its initial inception and pilot delivery at Macquarie Hospital to subsequent deliveries across 8 NSCCH sites. The health authority was attempting to answer the question 'How can the delivery of Psychological Therapies be increased to users of its services? The 'MoodMatters' project Phase 1 of this research project was developed to achieve this.

I initially employed a learning cycle developed at The University of Tasmania (UOT, 2010) to make the process more transparent to participants and sponsors. The learning cycle consisted of:

1. Action research cycle.
2. Development and delivery cycle.
3. Analysis cycle.

Learning cycle:

The first and probably most important element in the development of the three cycles was to negotiate and maintain access to research sites across the health service. To do this I needed to establish ongoing rapport and to build collaboration with the management board of the health service, a number of

which acted as experts throughout the research process. This proved easier to do than I had anticipated as I had been employed with the specific remit of increasing and improving clinical practice across NSCCH. The talks were delivered initially at all NSCCH localities, and this was designed to engender 'buy in' from the local clinicians and managers. If this occurred I then organized to go back and deliver longer teaching sessions followed by day long skills based workshops. The teaching goal of this was to identify people in the localities who would be interested in attending a longer training course and then attempt to champion CBT initiatives on their completion of the course. I also hoped that these champions with direct support, supervision and guidance would over time go on to develop and offer CBT supervision and training in their localities to colleagues and eventually develop into critical companions to support others in their CBT developments. It was hoped that a number if not all of these champions would become active practitioner/researchers during and beyond the project and again this was built into the evolving research cycles. This part of the learning cycle mirrored to an extent Marton's (1988. p.66) logical structure to the approach of learning, or the hows and whats of learning.

By meeting key stakeholders and teaching front line staff I was attempting to introduce and embed CBT based 'talking therapies' into:-

1. Standard clinical care.
2. Front line clinicians' and managers thinking regarding service provision.

The results chapter will highlight how far this was achieved. I aimed to get staff to think about 'How' they were going to deliver talking therapies in

practice, by either developing a personalized model or adopting CBT practice as they were taught and supervised. I also envisioned developing clinician's abilities in the 'What' aspects of learning or the meaning and significance of the task, thus deepening their understanding of CBT and its usages with their specific patient group. This was to be achieved by the introduction of talking therapies and a practice development approach to service provision across the health service. This concentrated on the development and delivery of usable and quantifiable clinical skills in a recognized talking therapy, thus the focus on CBT training. The prior learning, hopes and knowledge of staff were assessed; data was fed back to the management board, which then led to the design of the data gathering CBT questionnaire and the eight day CBT course. Paralleling this, arrangements were made to support and enable the delivery of the CBT programme across NSCCH.

#### Cohort 1 Course:

The first course cohort was identified and consisted of ten participants. The recruitment process is outlined in the methods section. Prior to acceptance on the course I met with all respondents to engage them with the course and in parallel inducted them in the research element. At this stage they were given the consent form and literature pertinent to the course; (appendix 6) asked to read the literature in their own time and sign the consent form if willing to participate in research. No respondents were excluded from the course if they refused to participate in the research and they were made aware that they could withdraw their consent at any time.

### Cohort 1 Study:

The first cohort included a nurse lecturer and a nurse consultant, who were invited to participate in the programme, as it was planned they would become co-tutors and ongoing critical companions. There were also four community nurses, two social workers, a dietician and a ward-based nurse in attendance. In class, daily and end of course informal evaluations were shared and reviewed by the research team and the course redesigned where necessary to facilitate the transfer of learning to practice. The pre- and post- CBT course questionnaires were completed and stored safely for later analysis.

### Learning culture:

To facilitate this learning cycle and to train staff to offer any form of talking therapy one would need a culture across the service designed to nurture and enable this delivery. The culture that dominated care services (more so on in-patient units) was one of custodial, medical model dominated care provision, where patients and to an extent staff were passive participants in an old-fashioned care delivery regime. A colleague and myself wrote the Practice Development Strategy that was designed to support the learning programme (Taylor & Hails, 2007) for the health authority drawing on work already drafted by the Director of Nursing, this draft strategy was circulated to the senior management team, adapted and re-drafted following a number of comments and suggested revisions and subsequently rolled out to one locality with the support of that locality's Director. Parallel to this I was developing a training programme that would teach staff how to deliver practice based CBT to/with their patients. Through both organizing and attending an extensive number of meetings with

key stakeholders, important locality managers, clinicians and the managers of wards and community units I was able to discuss the research cycle and deliverables, from this a far greater understanding of locality and health service needs was gained.

I wrote a service level brief (which eventually formed part of the research proposal), designed to begin the development of specific CBT based clinics across NSCCH (Appendix 9). The first clinic would be delivered at Macquarie Hospital by me offering CBT to patients on one of the rehabilitation wards. The clinic was designed to be supported by ward staff that would receive training as part of the clinic. This brief was approved by the Director of Nursing, presented to NSCCH mental health executive and signed off.

The research approach utilized at this stage was developed and delivered in the spirit of action research; empirical evidence was used during presentations to outline the effectiveness of the targeted talking therapies for the specified client group. This was designed to increasing awareness and understanding of 'talking therapies' across NSCCH, within an educational, evidence based model. The action learning cycle enabled the fine-tuning of delivery across NSCCH, as each session delivered was evaluated by getting the attendees to complete a written evaluation (appendix 5). The results were then incorporated into the next delivery phase to update delivery, content and make it more 'user' friendly, these evaluations within the cycle of research informed phase 2 of the project, allowing the training course to be continually refined using data and feedback generated from each course delivered, cycled into the next delivery. A number of the comments and suggestions drawn from these



initial evaluations were utilised in the ongoing site-specific development of the eight week CBT course, such as:

“use of role play during the course helped me give it a try”,

“it was helpful to watch Euan do it, it made it a bit easier”, “maybe think about less content – but more practice and demonstrations?” and

“it’s good to have this provided locally, so we don’t always have to drive to Sydney!”

Phase 1 and 2 also identified some useful contacts and later allies in each locality to continue the pedagogical process once training was delivered. During this phase a more ‘acute’ awareness developed of the aspects of the pedagogical process that worked and those that didn’t; this in itself enabled the ongoing development and fine-tuning of the evolving research cycle developed and delivered in the spirit of action research. The staff ‘talking therapies’ survey questionnaire used during the ‘MoodMatters’ phase was informative as to the state of talking therapies on the ground, to an extent but due to a low response rate of 10% the findings validity and reliability can be questioned. The survey also gave insight into the use of such a measure across NSCCH, the measure that was eventually used in the eight day CBT training course, shared aspects of the ‘MoodMatters’ survey, but was drawn from a scale used to ascertain clinicians knowledge and understanding of medication management (Gray et al, 2001), this scale was modified for an Australian audience, but retained the core focus and direction of the original questionnaire, but was delivered and gathered in a more robust manner, to hopefully gain a 100% response rate, this approach was adopted as the ‘MoodMatters’ survey had such a low response rate.

The cycle delivered in the spirit of action research enabled the course to be developed by identifying core aspects of content and knowledge of clinical staff on the ground. Both from 'MoodMatters' and personal observations whilst conducting the meetings, workshops and presentations across the locality, and also the evaluations received from attendees, timing and duration of study days and delivery style adopted whilst teaching the eight day CBT training course as the evaluation cycle developed. I adopted a supportive, empathic and nurturing pedagogy throughout the CBT training course. I utilized this approach as it was supported by pertinent CBT literature (Morisson et al, 2004, Kingdon & Turkington, 1994, Kingdon, 2000):

1. To enable staff to mirror the process of therapy (Morrison, 2004).
2. To acknowledge and affirm staffs' present ability and understanding of CBT.
3. To develop a non-threatening environment conducive to adult learning.
4. To make staff feel comfortable and at ease during course attendance
5. To attempt to develop a strong inter-group link to enable the development of, and ongoing use of a peer support and supervision groups.

As an outsider to an extent and coming from the UK, I was at pains to avoid putting peoples' 'backs up' and aimed to share a model of service provision with them. I also appreciated that to deliver this project I would have to have credibility with the clinicians I was teaching. To do this I endeavoured to develop a visibility across NSCCH. I recorded in my notes at the time, "it is important that I am perceived as being able to deliver on what I am proposing, so I must be seen

to be doing it and not only talking about it". This also sprung from some of the comments made by people taught across NSCCH who stated they got a lot from the teachings and workshops already delivered at locality sites – especially when they were able to observe me doing role plays with attendees.

The model described below taken from the University of Tasmania, Australia (UOT, 2010) is used to show the pedagogy developed across the action learning cycle. My role as teacher and facilitator was to package the 'knowledge' in such a way as to be useful and easy to assimilate for the learner, who's role was to gather the 'knowledge', 'actively' practice it to gain 'experience' and then develop the 'product' (CBT) to be delivered in clinical practice. The action learning cycle enables the student and teacher to collaborate in the process of developing a relationship that can 'mediate' between knowledge and skill development and produce a safe educational and clinical milieu for the learner to practice in.

Aims of CBT training course:

I was cognizant that the course would need to be changed between sites due to local demographics and course attendees, and that it would also change over time as we utilized the research cycle developed and delivered in the spirit of action research and continually fine tuned the course pertinent to ongoing course day evaluations and the last course day written evaluation. The core components of the course (as with all CBT based courses) remained constant, but did evolve and change over time and between sites because;

1. Cognitive behavioural therapy is an ever evolving therapy; and

## 2. The differing needs and population demographic of the delivery sites.

The pedagogical process was one of active; skills based training delivered within an experiential learning and reflective practitioner model. Elements of this pedagogy worked exceptionally well and were not specifically site dependant in their successful application. Other elements weren't so affective, and may have been impacted upon by the delivery site, which was to an extent dependent upon locality and the professional background of the staff trained.

The first course I delivered entirely on my own, but following the positive evaluation of course one, it was suggested that a joint-teaching approach would benefit the learning experience and so a co-teaching model was adopted. From that point forward the co-teacher and I did the teaching and developmental role-plays for the respondents to observe and then practice, thus the pedagogy was evolving as the educational cycle evolved. Thus educationally the process advanced from course one, as in subsequent courses we were able to offer more targeted feedback, observation and in-course supervision to respondents. The pedagogy evolved from single teacher/supervisor to a co-worker/teacher model, which was utilized in all subsequent courses and was evaluated well by the respondents that attended. I also developed a close working relationship with the co-teacher, who went on to continue delivery and refinement of the course after I was seconded out of Northern Sydney Central Coast Health to the New South Wales Health Department.

### **5.3 Voice two - The Training:**

Personal reflection on research process and methodological approach:

This area of chapter four is intended to introduce the reader to my research journey both during the research project and how I came to be in the position to develop this project in Australia. I have used this voice to expand upon and give a more personal understanding of my place in this project to the reader. I use an autobiographical style to introduce my experience in the area of teaching and CBT, this is designed to personalise this element of the chapter and give it a more human feel.

My pedagogical journey started when I first become involved in the development and delivery of skills based psychologically focused training to mental health professionals and others. This was initiated when I took over the lead role at the London Thorn Initiative, at the Institute of Psychiatry (IOP), Maudsley Hospital. I started to lead the Thorn course from 1996 onwards. At this time in the UK and Australia, there were very few Institutions of Higher Education or Health Care providers able to develop and deliver skills based educational courses. As part of my role at the Institute of Psychiatry, I developed and delivered a tranche of 'off site' courses that could be purchased by external health care providers - both NHS and non-statutory organizations. I and a team of qualified tutors from the IOP delivered these courses at the purchasing organisations place or area of work.

Personal Rationale and motivation for study:

On my return to Australia after fifteen years absence from what was then a progressive mental health nursing work force, care now seemed to be delivered within a medical model based service design with limited access to therapeutic interventions, and a reliance on medication and electro-convulsive

therapy (ECT). To fulfil my role and address this lack of therapeutic interventions, I employed tried and tested methods that I had used previously in the UK. I employed the same model of practice development to support the project, I had co-developed at Pembrokeshire and Derwen NHS Trust, the Leeds University Model of Practice Development (discussed in-depth in chapter 3).

During the developmental phase of the research project I was timetabled to meet a number of senior managers and clinicians across the health service. These meetings started to re-form my original research idea which was to replicate research I had undertaken in the UK that involved administering a questionnaire designed to give an insight into the development and subsequent delivery of specific talking therapies notable adherence therapy and CBT. However it began to dawn on me that there were not very many people who had skills in either therapy, so my planned replication study was unlikely to be possible. I took this to the Director of Nursing and we decided that as my skills lay in the delivery of CBT and in teaching health care providers how to do it, maybe we should develop or own in-house course designed to do just that. This led to the pedagogy or 'teaching process' developed in NSCCH, which was designed to enable staff to understand the positioning of cognitive behavioural therapy in secondary care services and to enable them to deliver this therapy after attendance on an eight week training course. To see if this was possible my rationale was to administer a pre- and post- course questionnaire to the CBT trainees, to gain an insight into their abilities before and after respondents had been taught CBT.

I met with a number of NUMs (Nurse Unit Managers) who were crying out for any level of training for their staff and this led directly to the development of the first CBT course. I had noted again the difference in mental health care in 2007 compared to when I last worked in Sydney in 1992. During my induction I had met a number of people who were interested in being involved with what I was suggesting, I also met a number of psychologists with whom I developed the 'MoodMatters' survey the first phase of this project.

In England and Wales I had spent a number of years developing and delivering skills based training courses at Institutes of Higher Education and health care providers. These courses trained individuals over nine months to two years to offer psychosocial interventions to their patients and patient's families. The pedagogy of those and subsequent courses I either developed or delivered was one of student-focused action based learning, designed to engender and enable the development of usable skills by the learner. The courses employed a variety of teaching methods, which were all based on the principle of "learning of something" – "not learning for learning's sake" (Ramsden, 2003), it was hypothesized that in health environments learners would have the need and developing ability (based on skills already present) to engage in using their developing skills with patients and ultimately patients and their families. Thus the developing active pedagogy was skills based in delivery and utilized a number of learning techniques, such as role play, observed role play, video/DVD watching/critiquing and field work.

The First course went well, respondent's pre- and post- CBT training course questionnaires were gathered and their experience of the course

evaluated. The evaluations were used to update and alter the next course that was to be delivered. The 2nd course was delivered at Hornsby Hospital, in the new Psychiatric Intensive Care Unit (PICU). The consultant nurse who had attended course one and I jointly delivered course 2. The course itself was different to course one as it was off site and delivered in the old management centre for Central Coast mental health services. This in itself may have caused difficulties due to the relationship between both amalgamated health care providers, but it was ameliorated to an extent by the CNCs presence. As with the other courses this course evaluated well and again results were used to update and alter where necessary the next course and so on across the research cycle. We delivered eight courses in total and taught 80 mental health professionals across the health service.

My learning across the phases, to an extent mirrored some of the attendees' comments as I was undergoing quite a profound learning curve at the time myself. Thankfully I had the support and supervision of the senior management team at NSCCH and the research committee, to guide me during Phase 1 and 2 of the project. I too was gaining an understanding of my approach to learning and teaching and the learning cycle I was attempting to develop across the health authority. By attending differing locality settings, the active participation of local staff enabled the on-going fine-tuning of the research cycle that was developed and delivered in the spirit of action research, and also the development of feedback and feed forward loops in the cycle. Phase 1 and 2 also identified some useful contacts and later allies in each locality to continue the pedagogical process once training was delivered. The theories underpinning



action research have been continually updated and refined, and literature has continued to be written to support this approach (Morton-Cooper, 2000). As my research study progressed, these actions and findings become more complex and involved, due to the amount of action focused data that was being generated. Analyzing, this data over time become more complex and at the same time our understanding of the process deepened and the research cycle developed (McNiff, 1995), this data is not presented as part of the analysis chapter but informed the ongoing cyclic development of the course. Due to this it was not possible to demonstrate any improvements over time because;

- a) while the course was modified from intake to intake as a result of course feedback, these modifications were not documented, and
- b) the evaluation data from all courses was combined.

My research journey resulted in the gathering of 120 'MoodMatters' surveys and 160 CBT training course questionnaires, and the delivery of eight CBT training courses, the analysis of the 'MoodMatters' survey and CBT course questionnaires will be discussed in the next chapter.

## **Chapter 6**

### **Data Analysis:**

This chapter will discuss the analysis of the data sets;

- 1) the 'MoodMatters' survey and
- 2) the follow-on CBT training course questionnaires.

The 'MoodMatters' survey was analysed to offer percentages of respondents abilities, skills and knowledge, where as the CBT training course questionnaire data was aggregated and analysed to show percentages of change from first application to final application of the questionnaire, as the data was aggregated it was not possible to show development or change over the time span of the project. As the 'MoodMatters' survey was phase one of this research and the results impacted directly on the development of the CBT training course project its analysis will be presented first.

Findings:

#### **6.1 Initial 'MoodMatters' survey analyses:**

The survey was designed to obtain data pertinent to the current delivery of evidence-based therapeutic interventions such as cognitive behavioural therapy, family work, brief solution focused therapy, motivational interviewing and other forms of talking therapies (eighteen in total) across the health care service. This survey was delivered to some 1200 clinicians via circulation to their service directors, and then returned within a six-week window to the research committee for data analysis. The total number of survey responses was n=119,

representing approximately 10% of clinical staff employed by NSCC mental health services, this low response rate calls into question the validity and reliability of the 'MoodMatters' survey data set, but as stated previously there was other anecdotal and policy based evidence that supported the direction of the research project. Only responses that arrived by the due date were included in the data analysis. For the purposes of clarity all statistics have been rounded up or down to one decimal place.

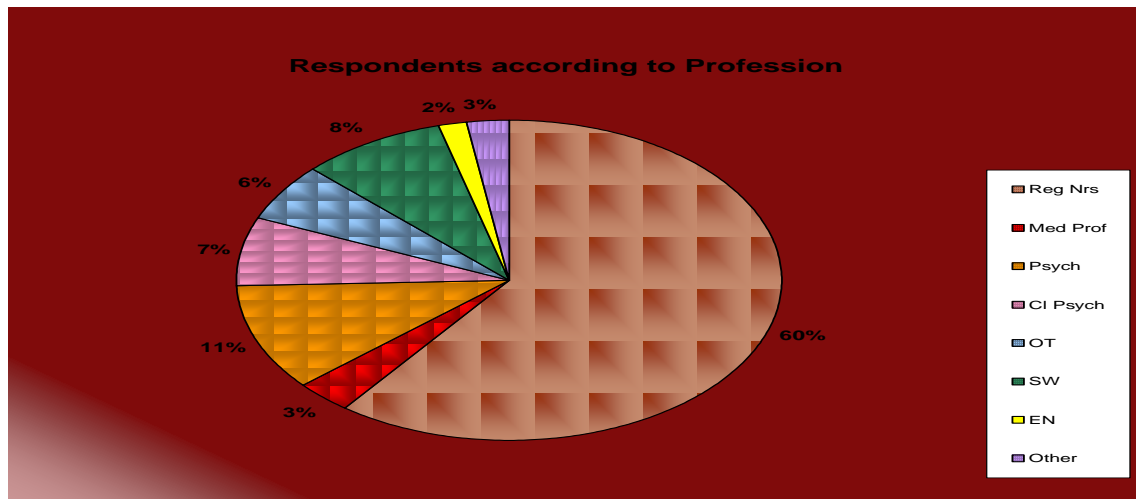
The questionnaire was split into 3 areas, gathering data on staff demographics, delivery of psychological interventions, clinical practice and supervision. The sections were further sub-divided to enable specific data gathering such as; requests for further training in specific therapeutic modalities, was staff receiving modality specific supervision and levels and types of qualification held by the clinicians. Each area will be expanded upon briefly, and graphs will be used to show specific detail pertinent to each question.

#### Part A. Demographics:

Survey respondents were 72% female and 28% male; this figure although not unexpected was thought to be an underrepresentation of the male clinicians across NSCCH. The average number of years of direct clinical experience for respondents was 16 years with experience ranging from one year to forty years. The largest group of responses came from nurses 62% (registered and enrolled) followed by psychologists/clinical psychologists 19%, next were medics with 11%, social workers 8%, occupational therapists 6% and others 3% (this group was made up of dieticians, art therapists, physiotherapists etc). There may be an

over-representation of psychologists, which reflects the subject nature of the survey and was discussed earlier in chapter 4 and 5. See Graph 1 for detail.

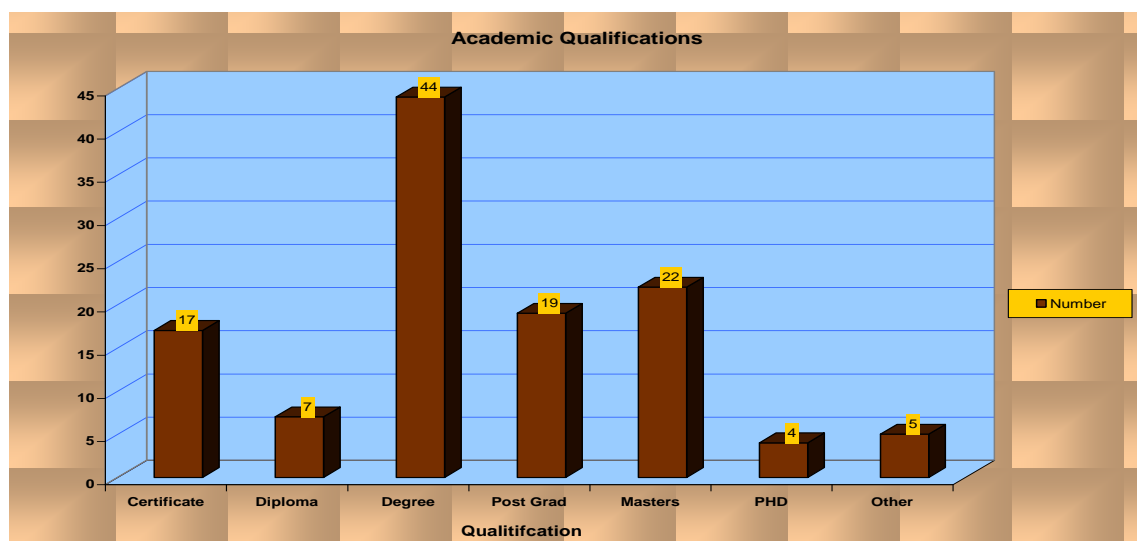
Graph 1. Percentage of respondents according to profession:



Academic Qualifications:

Graph 2 outlines the academic qualifications of respondents. There was a wide range of qualifications including 45% who had undertaken post-graduate training at postgraduate certificate, diploma, masters or PhD level.

Graph 2. Academic qualifications of respondents to survey:



### Clinical setting:

Forty-three percent of staff worked in community mental health, 33% worked in inpatient settings (acute or non-acute), 15% worked in non-clinical areas or across the area sectors and 9% of respondents localities were unreported.

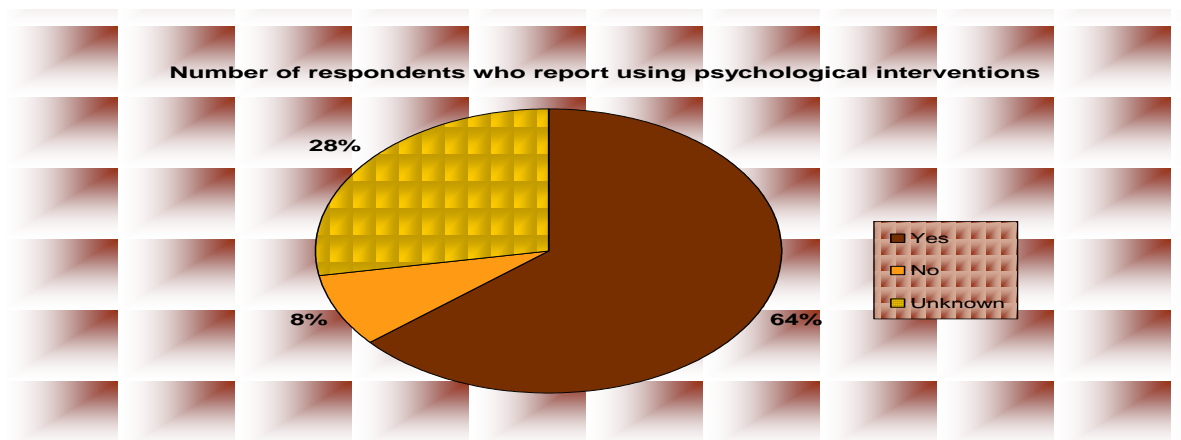
### Summary of Key Findings for Part A: Demographic Information:

1. The sample can be considered to be a reasonably representative sample of clinical staff, despite some over-representation from psychologists. The sample has a greater proportion of females, which is representative of the mental health work force, a full range of disciplines, mixture of in-patient and community staff, and variation in levels of formal training.

### Part B: Delivery of Psychological Interventions:

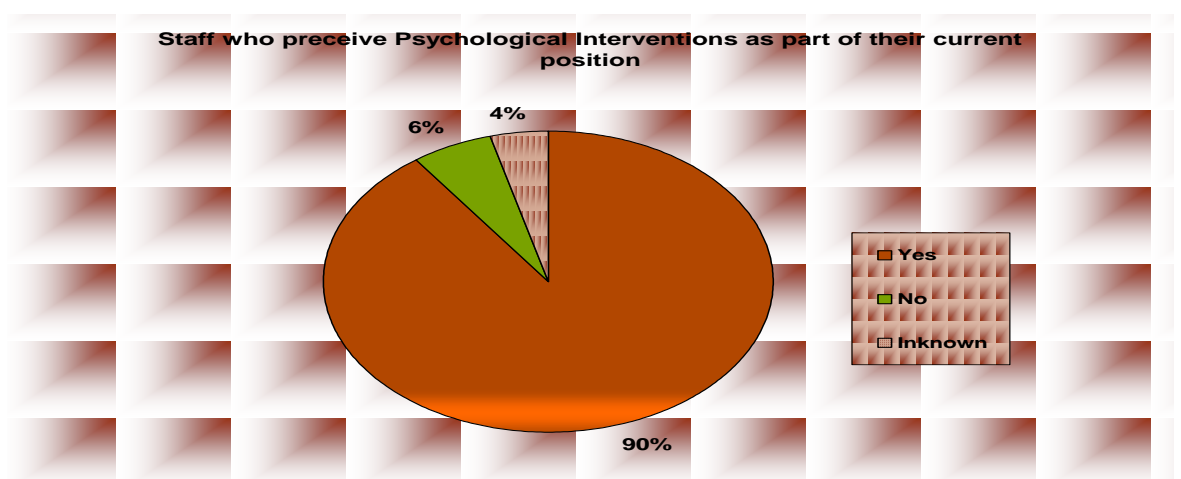
Of particular interest and one of the main aims of the anonymous 'MoodMatters' survey was identifying the use of psychological therapies by clinical staff. Sixty-four percent of staff report currently using psychological interventions, 8% do not and 28% of staff indicated that they did not currently work in a clinical environment or left the question unanswered, as shown by graph 3.

Graph 3. Percentage of staff reporting use of psychological interventions in clinical practice:



90% of clinical staff reported that they perceived delivering psychological interventions as part of their current role. This response contrasts with the 64% from Graph 7 who stated that they use these therapies. It was unclear from the data set whether staff were delivering these therapies, or simply that these therapies were part of their work but that they were not currently practicing. See graph 4.

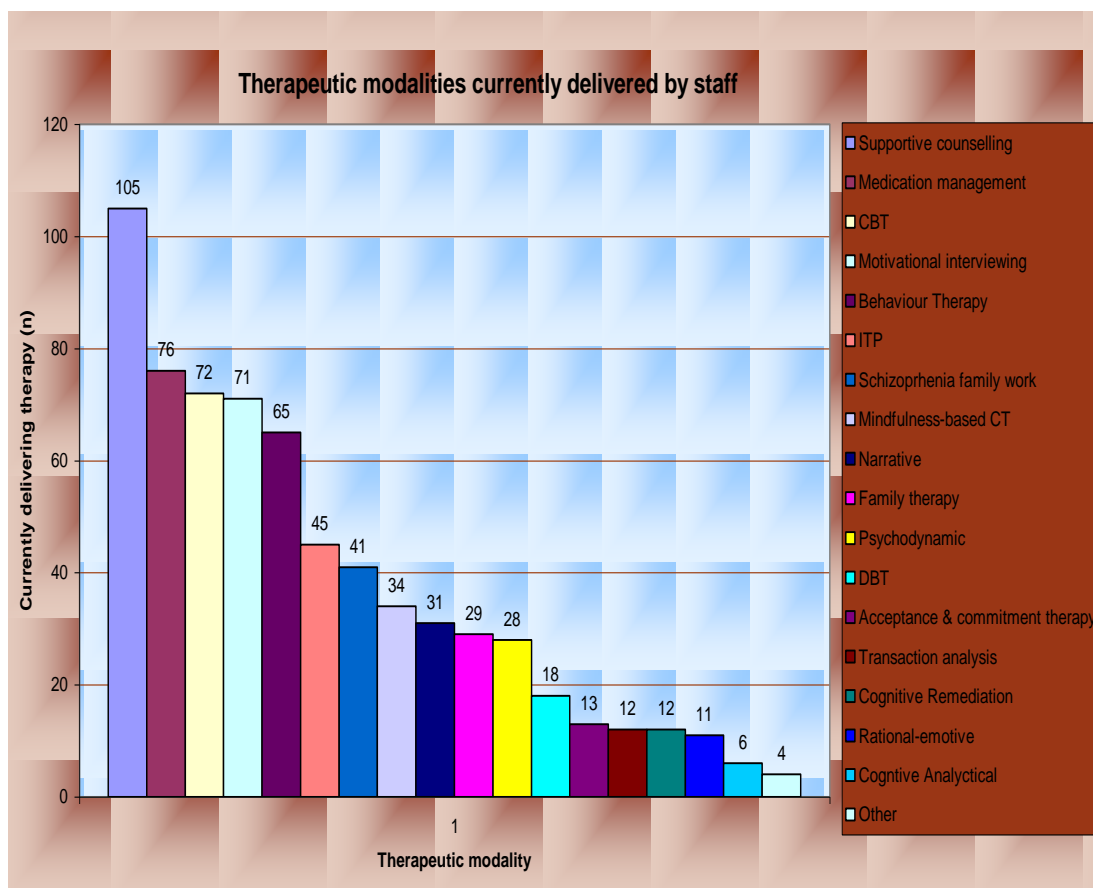
Graph 4. Percentage of staff perceiving delivery of psychological interventions as part of their current position:



Therapies currently used by staff:

Graph 5 shows which therapeutic modalities staff used and what percentage of staff delivered them. The most common therapy being delivered by staff was supportive counselling, followed by medication management and then CBT, the highest percentage of evidence-based therapy practiced by the staff.

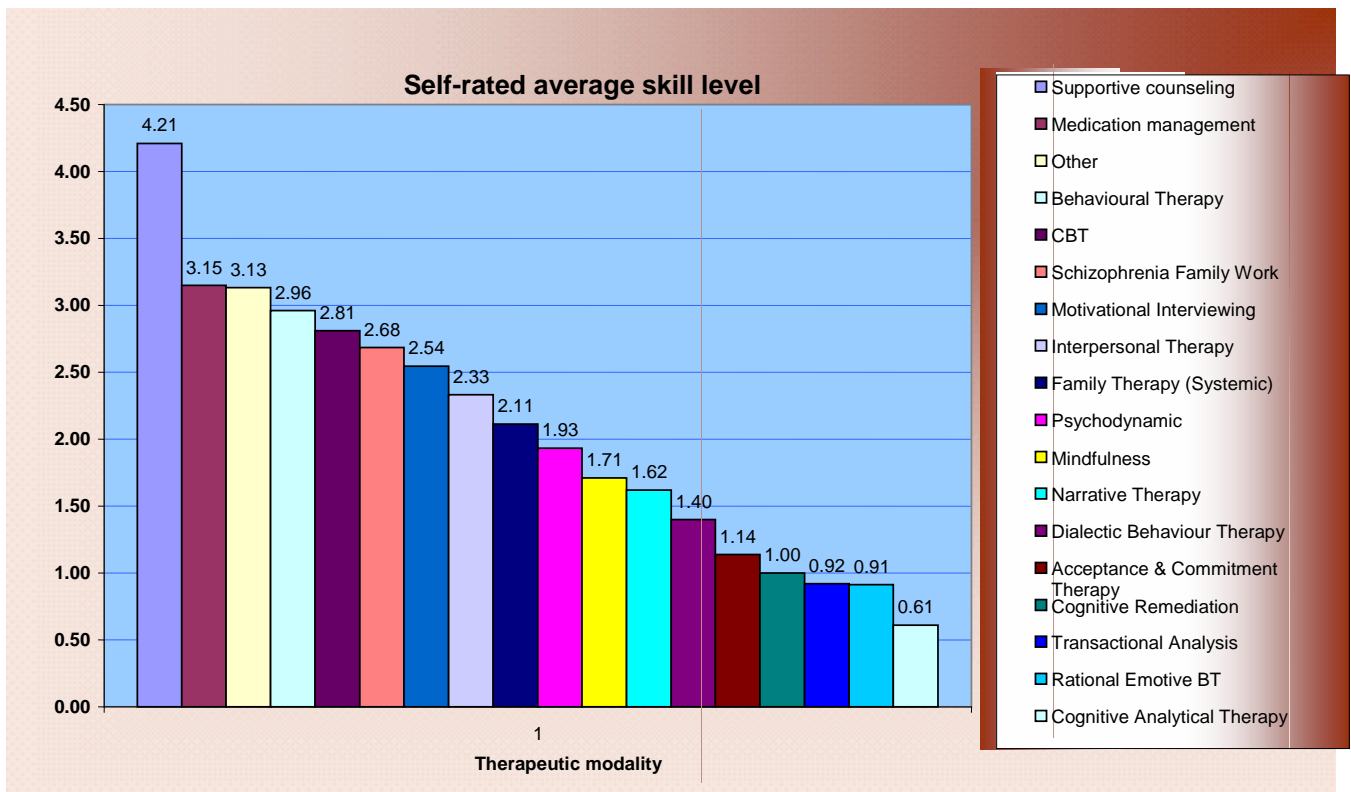
Graph 5. Therapeutic modalities currently delivered by staff:



The number of people offering supportive counselling would warrant further study as to the scope and content of the therapy delivered and the training of the staff delivering it (but this was outside the scope of this particular piece of research). The evidence base for supportive counselling is still

developing in this population, as compared to the evidence base and efficacy for CBT and therapies such as family interventions and art therapies (NICE, 2009, 2010). The evidence for these latter types of therapy are more significant and have been recommended by the National Institute of Clinical Excellence (NICE) UK, as the treatment modality of choice for a number of mental health disorders (NICE, 2004, 2009, 2010). NICE guidelines are commonly used in NSW, Australia along with a number of other UK Government health policies. This was a further reason that once the data was analysed, and the low response rate of 10% noted CBT was identified for the ongoing research and training initiative in phases two and three. Graph 6, below shows how staff rated their skill levels in all therapeutic modalities covered in the questionnaire on a 0 to 5 point scale, with 0 being no skill and 5 being very skilled.

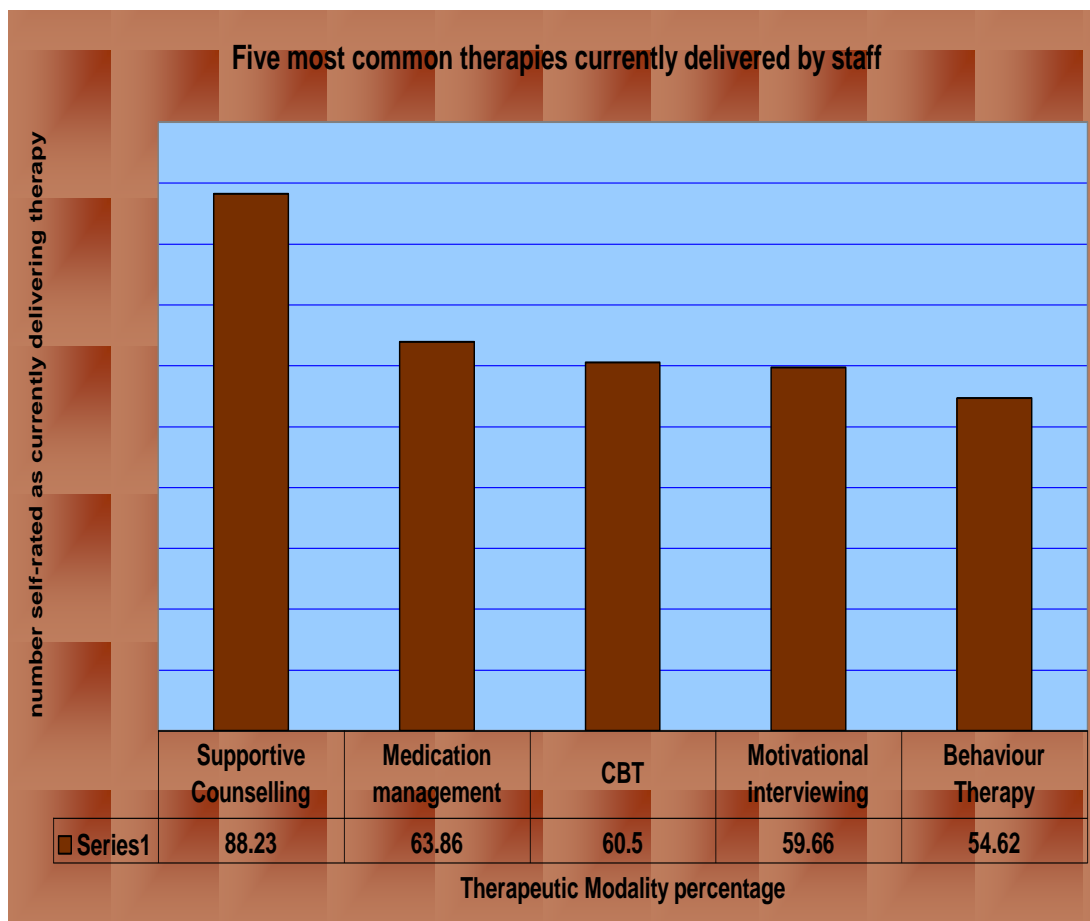
Graph 6. Self-rated average skill level:





The questionnaire gave the responder the opportunity to outline their skills in eighteen therapeutic modalities. Staff rated their skills most highly in 'supportive counselling', 'medication management' 'behaviour therapy' and 'CBT' which again to some extent mirrored delivery data. Graph 7 describes the most common therapies delivered by staff. 88% of staff reported providing supportive counselling, 64% used medication management, 60% used motivational interviewing, 61% used cognitive behaviour therapy and 55% behavioural therapy.

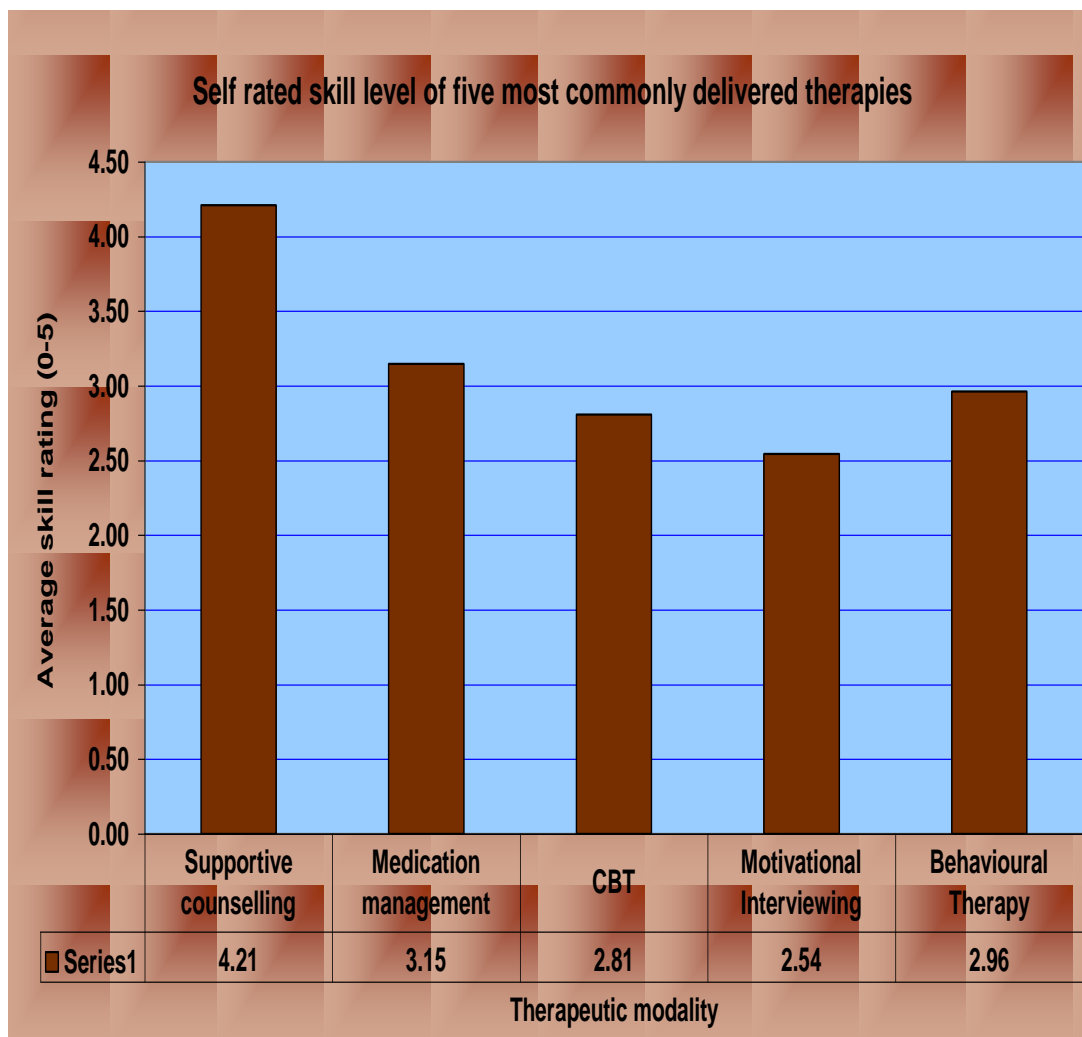
Graph 7. Five most common therapies currently delivered by staff:



As well as wanting to know what therapies staff used it was important to understand how respondents rated their skills in these differing therapies. Staff

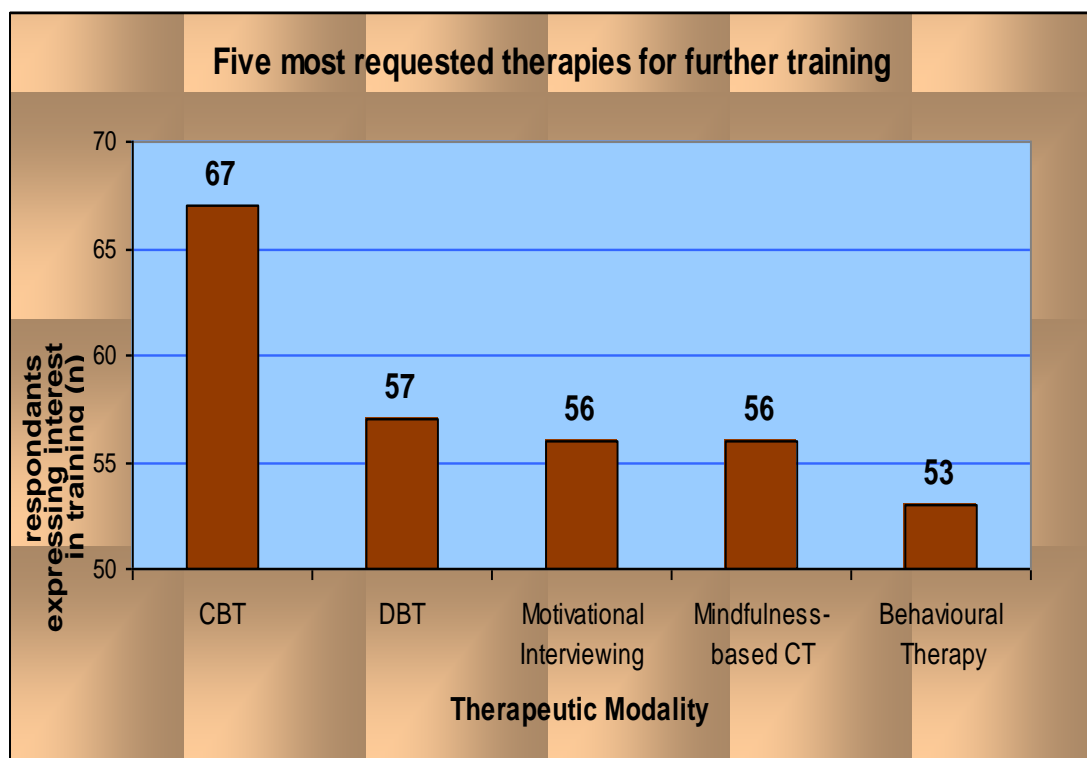
were asked to mark all the therapies they felt qualified to deliver. Graph 8 shows staff self-rated skill levels in the five most commonly delivered therapeutic modalities listed in the staff survey. Staff were asked to rate their skill levels on a 6 point scale from 0 = no skill to 5 = extremely skilled. CBT scored an average of 2.81 out of 5, which was a high score considering that there were no formal University based courses that taught CBT in NSW at the date the survey was delivered. This placed it fifth overall out of the eighteen targeted therapies in the staff survey.

Graph 8. Self rated skill level of five most commonly delivered therapies:



When respondents were given the opportunity to state what further training they would like or need, 67% of the survey population stated a desire to get further or indeed any training in CBT. This result was also instrumental in the CBT research and course developments at the Health Service, as shown by graph 9.

Graph 9. Five most requested therapies for further training:



Summary of Key Findings: Part B – Delivery of Psychological Interventions:

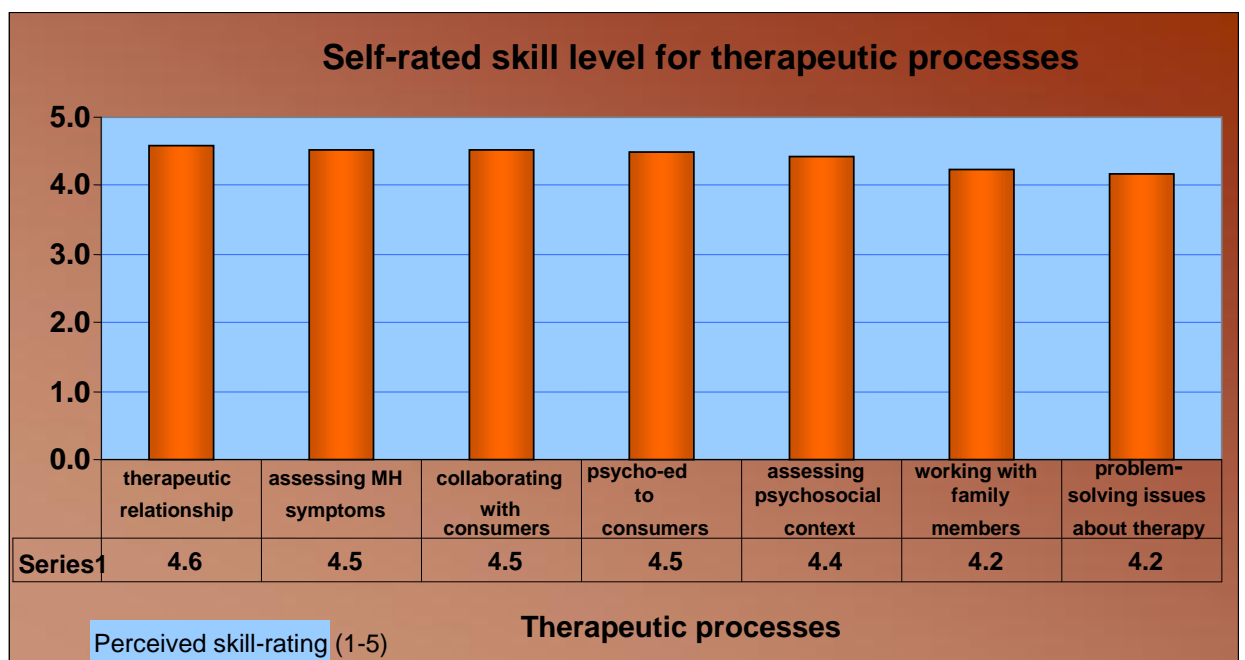
1. Supportive counselling, and to a lesser extent medication management, were the most commonly reported therapies and staff reported a high level of confidence in delivering these interventions.
2. Conversely, respondents who use cognitive behaviour therapy in their practice rated their skill levels comparatively lower and this therapy was the most requested for further training.

3. Similar to CBT, staff also reported regular use of motivational interviewing interventions, but expressed high levels of interest in further training in motivational interviewing.
4. Staff also expressed an interest in newer psychological therapies, mindfulness-based cognitive therapy and dialectical behaviour therapy (DBT).

**PART C. Clinical practice and supervision:**

Graph 10 describes how respondents self rated their process skill in assessing and engaging with consumers and their families. High ratings were given for all processes, particularly when compared to self-rated skill levels in delivering specific therapeutic modalities (in Part B). Respondents rated themselves between 4.2 and 4.6 where the rating scale range was from “Very unskilled” (1) to “Very skilled” (5). Of the 119 respondents all perceived their own level of competency for therapeutic processes to be of a high standard.

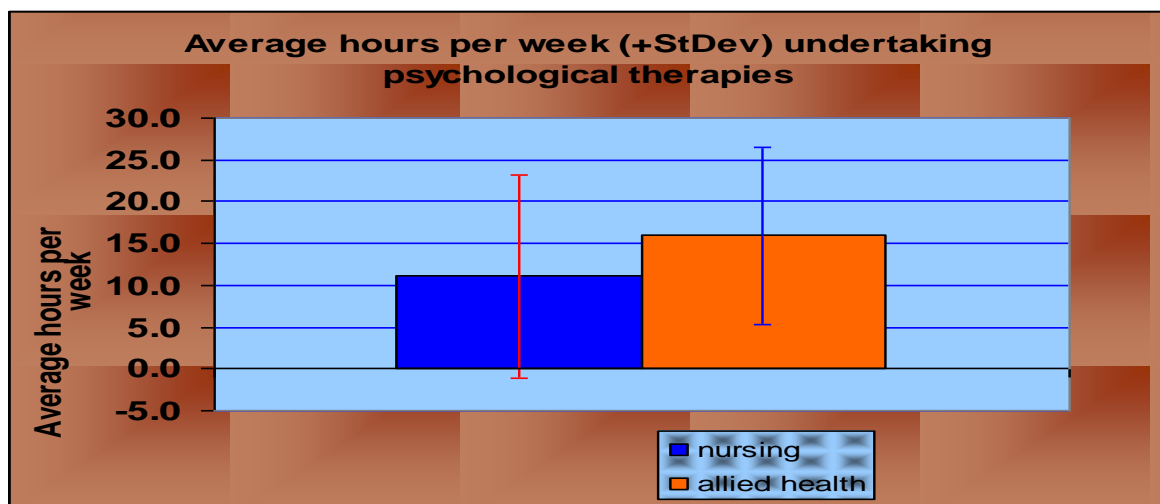
Graph 10. Self rated skill level for therapeutic processes:



Estimated hours per week using psychological therapies for each discipline:

Due to the small representation of some of the disciplines, such as social workers and occupational therapists, direct comparisons across disciplines could not be made. Disciplines were then grouped according to nursing or allied health staff. Graph 11 describes average hours of psychological therapies undertaken by Allied Health and Nursing staff, with an average of 16 hours for psychology and 11 hours for nursing.

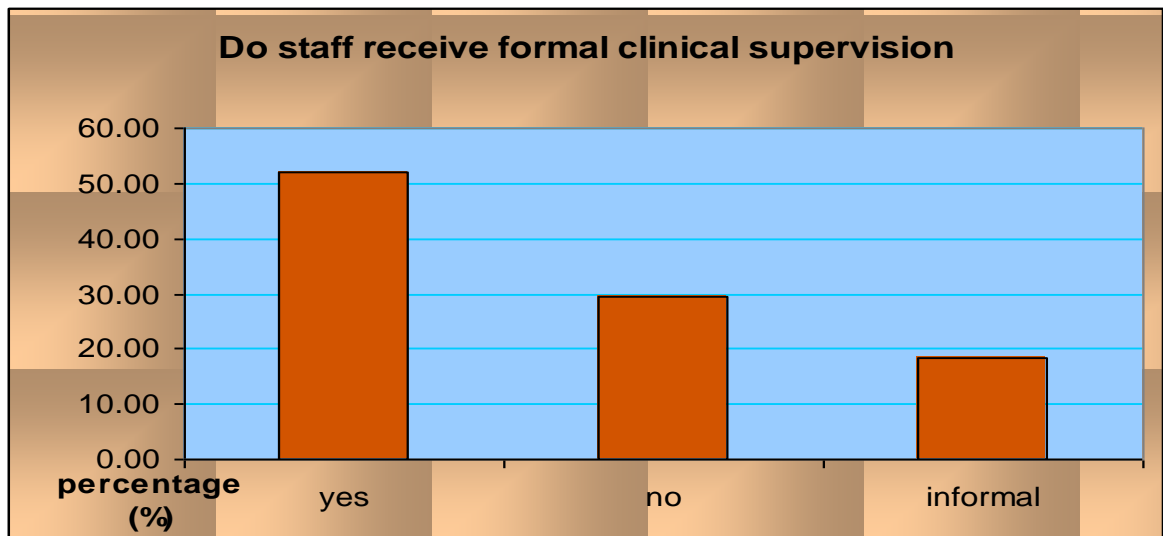
Graph 11. The average hours used by Allied Health and Nursing in undertaking psychological therapies:



Supervision:

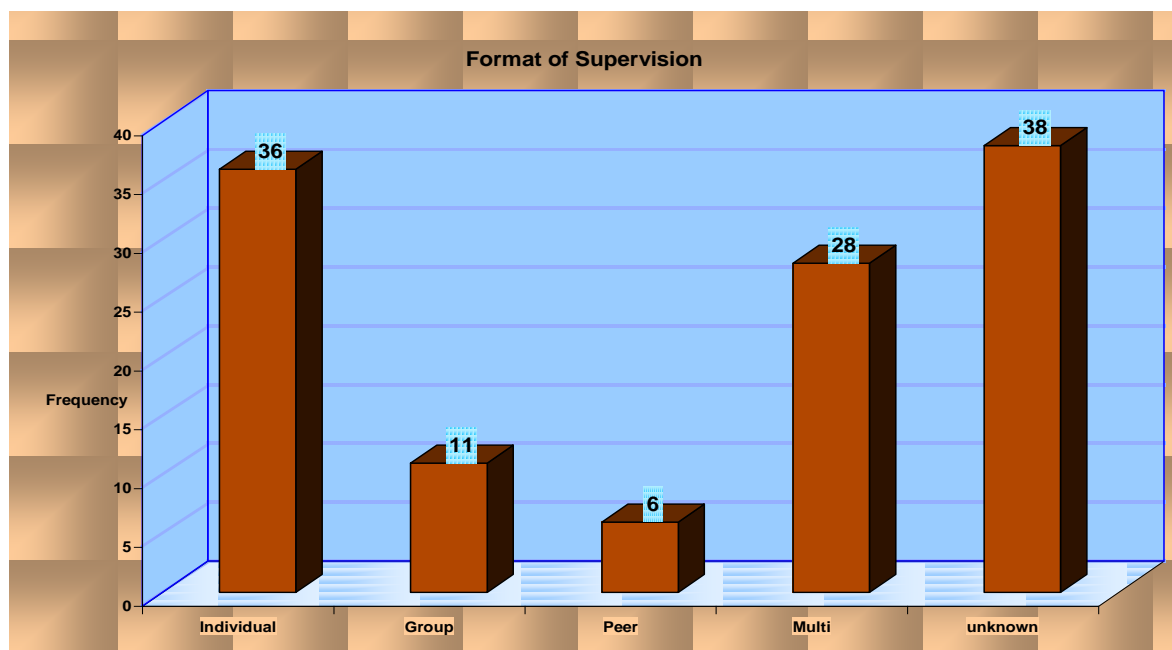
Sixty-seven per cent of respondents reported receiving either formal or informal supervision. Respondents on average receive 2 hours of professional supervision per month with a median of 2 hours, a minimum of 0 hours and a maximum of 14 hours, see graph 11.

Graph 12. Staff in receipt of supervision:



The format for supervision showed some variability where 30% receive individual supervision, 24% have multiple formats, and 14% either had group supervision or peer review. 32% of respondents did not answer this question.

Graph 13. Format of supervision received by respondents:



Outcome measures, tools or instruments used in practice:

Staff were asked to list any outcome measures used in their routine practice. A number of measures were reported, with the more frequently cited measures including: Beck Depression Inventory, Hamilton Anxiety Depression Scale and the Brief Psychiatric Rating Scale.

Summary of Key Findings: Part C – Clinical Practice and Supervision:

1. Staff report a high level of confidence in providing what may be considered core therapeutic processes such as engaging with consumers, developing and maintaining rapport, and providing psycho-education to patients and carers.
2. Approximately 70% of staff reported receiving either formal or informal supervision with a median of 1 hour per fortnight. However, at least 30% of respondents have no supervision and may still be providing therapy.
3. Nursing staff had less access to formal supervision when compared to Allied Health staff.
4. Qualitative data was provided about tools used by staff to assess and monitor treatment progress.

## **6.2 CBT training course questionnaire data analysis:**

The adoption of the action learning cycle and development of an active practice development approach enabled the eventual delivery of the eight-day CBT course at eight localities across NSCCH. Each component of the initial

course (appendix 3) was fine tuned post development, by discussing it with the research team (identified NSCCH psychological therapy experts and academic partners). This cyclic process that continued throughout all courses was instrumental in the delivery and ongoing development of the course. The research approach taken developed and delivered in the spirit of an action research cycle enabled the development of a more rounded and robust programme. Going through the cycles at each location throughout NSCCH, focused the course to achieve the area and locality specific needs identified during the 'MoodMatters' staff survey, and pre-survey meetings, supported by literature and policy.

The questionnaires were analysed together so that it would be possible to identify positive, negative and neutral aspects of the whole data set. Each CBT training course questionnaire was designed to enable a mixed methods analysis (appendix 2). My initial impression of the findings was that by using a skills based model, delivered in a practice development paradigm, it was possible to train mental health professionals to evidence a change in their self reported readiness to use CBT skills in practice and also an increase in their self-efficacy as to this practice. The Cognitive Therapy Scale – Revised (CTS-R) (Appendix 8) developed by Blackburn and colleagues in 2001, at the University of Newcastle upon Tyne was used to place the components of the CBT course questionnaire into specific CBT practice themes. The analysis will be offered under headings drawn from the sub-sections of the scale and themed accordingly. This scale was based on an earlier one devised by Young and Beck in 1980, and designed to rate competence levels of a therapist, over twelve items, ranging from Item 1 - Agenda Setting and Adherence, Item 3 – Collaboration to Item 12 – Homework



setting, and is used by an independent rater. Blackburn et al, (2001) state that the scale has a good level of validity when used by raters that have been trained in its correct application. Research also shows that there is good inter-rater reliability within the trained cohorts (Blackburn et al, 2001).

#### Part A, Demographic Data Analysis:

The demographic details when analyzed showed some surprising results in certain areas e.g. ethnicity and gender of respondents, and some expected ones in others, e.g. professional background of respondents. The gender loading within the student population drawn from the adult mental health work force was 25% male and a rather larger than expected 75% female, this mirrors the trend in general health care provision across New South Wales, but was unexpected in mental health care provision due to the historically greater number of males entering the speciality. This result closely matched the gender make-up of the respondents to the 'MoodMatters' survey. The questionnaire enabled analysis of age of respondents. It was thought that in mental health care, especially nursing, there would be an older population of nurses in their 40's, 50's and 60's. The data mirrored this to an extent with a total of 50 respondents being over 40 and 30 being under 40. This was a useful statistic to identify, as it would help with work force planning with a number of clinicians, mainly nurses close to retirement age.

The year of qualification data were unexpected; 35% of respondents had qualified in the 2000s, the next largest group 24% having qualified in the 1980's, one would have expected from the age data recorded above that more staff would have qualified in the 1980s and 1990s. The ethnicity of the population taught was 87% white, compared to 3% black, 3% Asian and 8% other

(predominantly Aboriginal, Polynesian and Latin American), this mirrored the population demographic of Northern Sydney, an affluent predominantly white and Asian area, but not so much that of Central Coast a more ethnically mixed area. Over 50% of the student population were from a nursing background, either in-patient or community based, 14% Social Workers, 12% were Occupational Therapists and one clinical psychologist and 14% were other professionals. This other group was made up of therapists such as music therapists, dieticians, educationalists and consultant nurses (interestingly enough not classifying themselves as nursing staff!). No medics attended the training. 60% of the population had a first degree, 9% had a masters degree, 3% had other qualifications such as post graduate diplomas and 22 respondents (29%), had either a certificate or a diploma. This percentage of the population would have been nursing staff qualified pre- 1986 who had not undertaken any further study or a small number of enrolled nurses who's initial qualification is a diploma or certificate.

#### Part B, Qualitative data set:

There was not enough usable qualitative data recorded from the individual's statements regarding their present level of CBT practice to provide a useful analysis. As stated earlier in the thesis this was thought to be a lack of psychotherapeutic content in core training, and limited psychological mindedness of core services. I have used student's qualitative statements in the analysis of points C and D when they show CBT understanding and actual movement in their learning.

### Part C, Your views about CBT:

This will form the bulk of the analysis chapter and be delivered under identified themes. Part C was split into two areas one with 20 questions the other with 13. Parts C and D of the CBT training course questionnaire had 33 questions in total. I will start with the analysis of the 20-question section of the CBT training course questionnaire; part C (see appendix 2).

### Theme - An ability to use basic CBT Principles:

This theme is addressed in the questionnaire by six of the twenty questions (see appendix 2). Each question to an extent allows an insight to be gained into the respondents pre- and post- course completion views about CBT, its use with patients and their understanding of the underpinning theory behind the practice. Question one, four, twelve, thirteen, sixteen, seventeen and twenty fall within this category. The questions that sit within this theme were analyzed and showed that student's views about CBT were affected by attendance and completion of the course. All of the questions pre- and post- ratings altered, but as a number only gained in agreement or disagreement scores, they will be discussed briefly, the others that had more marked changes will be discussed in more detail and the findings and implications outlined.

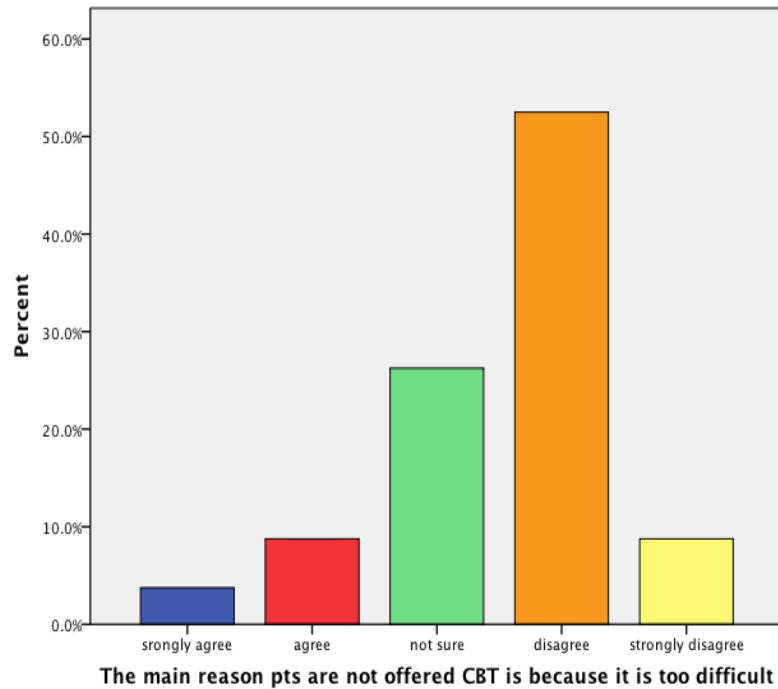
A number of graphs will be used to outline this move; others will be placed in the appendices (appendix 7). Question one was designed to gain an understanding of course participant's belief as to whether or not CBT was too difficult to be offered to patients as a first line treatment. The NICE Guidelines (NICE, 2009) states that CBT should be offered as a first line treatment in a number of psychological conditions, notably depression, anxiety and more

recently psychosis. This question was included to see if there was a shift in respondent's views about CBT being too difficult to offer to a patient as a core intervention of choice. The analyzed data showed that at the pre- course evaluation point, the majority of the respondents either disagreed or strongly disagreed with this statement, this increased at post- course evaluation.

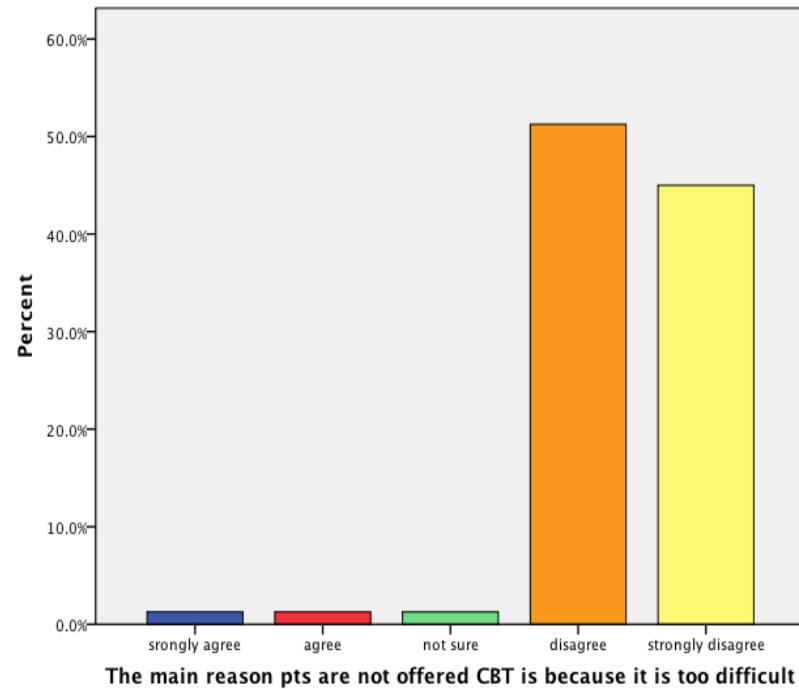
The subsequent two graphs highlight student's views as to why CBT is not offered as standard care to all patients across NSW Health. It was designed to ascertain views on the difficulty of applying CBT to clinical practice.

Question one. The Main reason patients are not offered CBT is because it is too difficult:

Graph 14. (pre course completion).



Graph 15. (post course completion).



As you can see from graph 14 pre- course completion to graph 15 post- course completion there is a marked move in respondents' views about the difficulty of delivering CBT in practice. 63% of the population pre-course completion that disagreed with this statement had risen to 97% post- course completion. This positive shift if translated to the application of CBT in practice would have a marked impact on the availability of CBT to patients across NSCCH.

Question four addressed the student's ability to collaborate with the patient. This is one of the cornerstones of successful psychotherapy and CBT is no different in this regard (Beck et al, 1979). At both pre- and post- course completion the student population held the view that this was an important aspect of their patient focused interactions and they either strongly agreed or agreed with the statement. Although all respondents still supported the place of collaboration in therapy virtually all (99%) of them had decided that this was truly a vital component of therapy post course completion. This result although still within the strongly agree/agree category is important as it shows that the course strengthened the respondents views on one of the core tenants of CBT practice. It is thought that one of the therapeutic markers of CBT that helps to achieve a positive outcome at the end of therapy is the practitioner's ability to engage with and collaborate with the patient (Morrison et al, 2004). Please see appendix 7 for all graphs not shown in the analysis chapter.

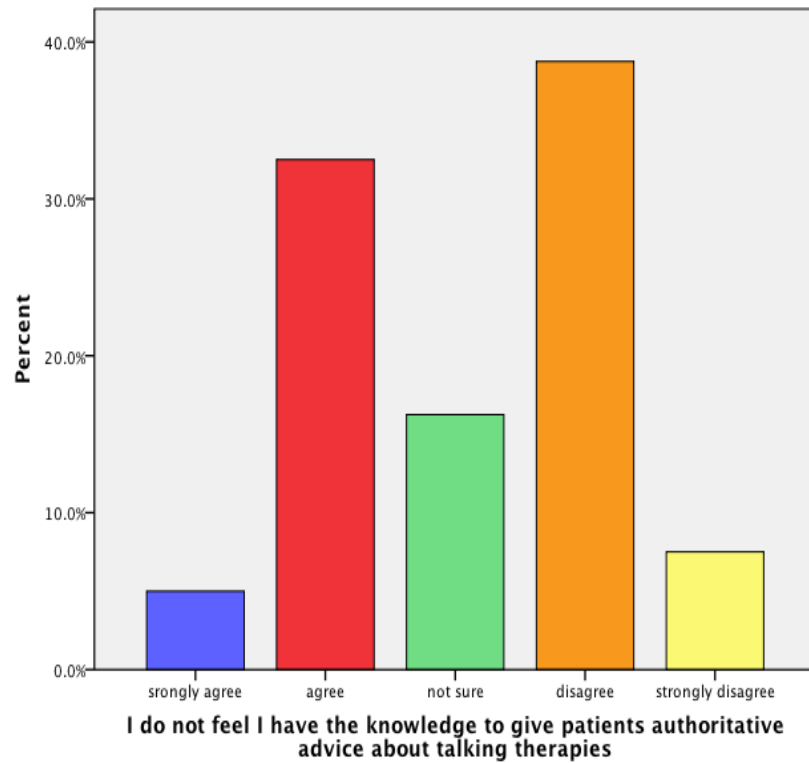
Questions twelve and thirteen (graphs 16 to 19) focused on the respondents' ability to give informative advice and to feel happy communicating with patients regarding talking therapies. At pre- course completion a similar number of the respondents rated positively or negatively their levels of knowledge and skill in this area. At the end of the course virtually all (97%) of

the student population strongly agreed/agreed that they had the knowledge and skill to offer this aspect of CBT with patients. At pre- course completion 37% of respondents strongly agreed/agreed that they did not have the knowledge to give advice to patients about CBT. Over 60% of respondents agreed/strongly agreed that they were happy talking to patients about the effects of talking therapy. Both areas had risen to over 95% by the end of the course. These figures, if carried over to clinical practice, should see a greater number of patients being in receipt of evidence-based interventions than they were before. This also, perhaps more importantly, evidences an increase in the respondents' self-efficacy in their readiness to use CBT skills, see graphs 16 to 19.

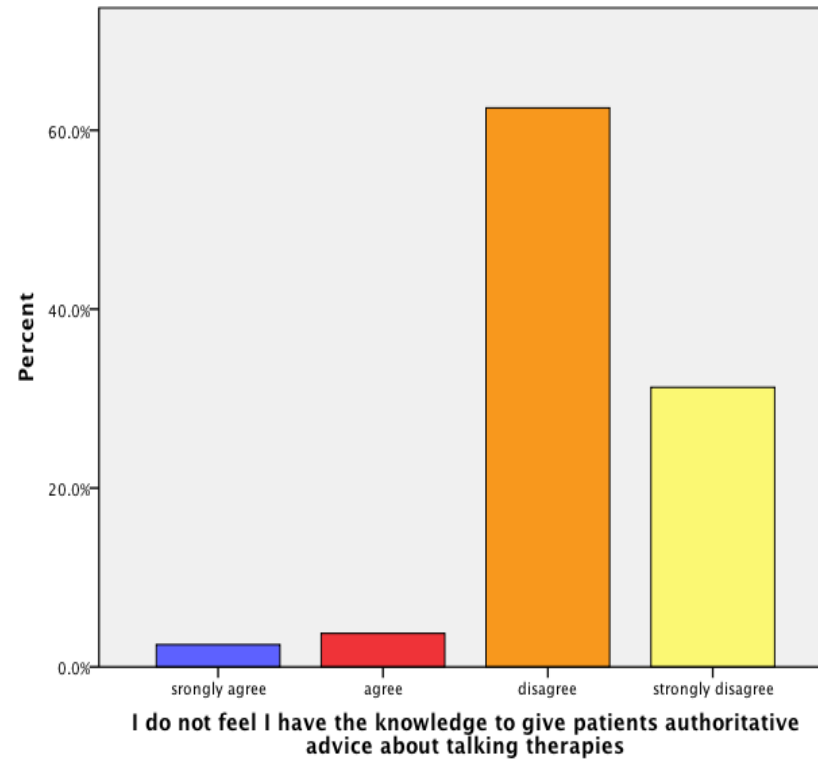
The next four graphs outline respondent's views of their knowledge and ability to apply talking therapies in clinical practice with their patients post CBT training course completion.

Question twelve. I do not feel I have the knowledge to give patients authoritative advice about talking therapies:

Graph 16 (pre-course completion).



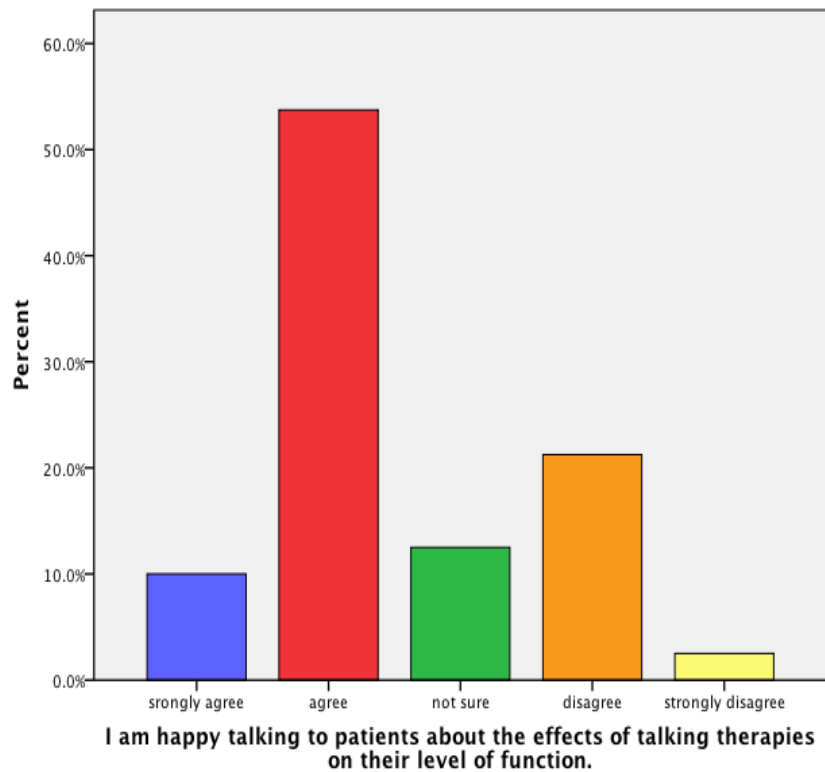
Graph 17 (post-course completion).



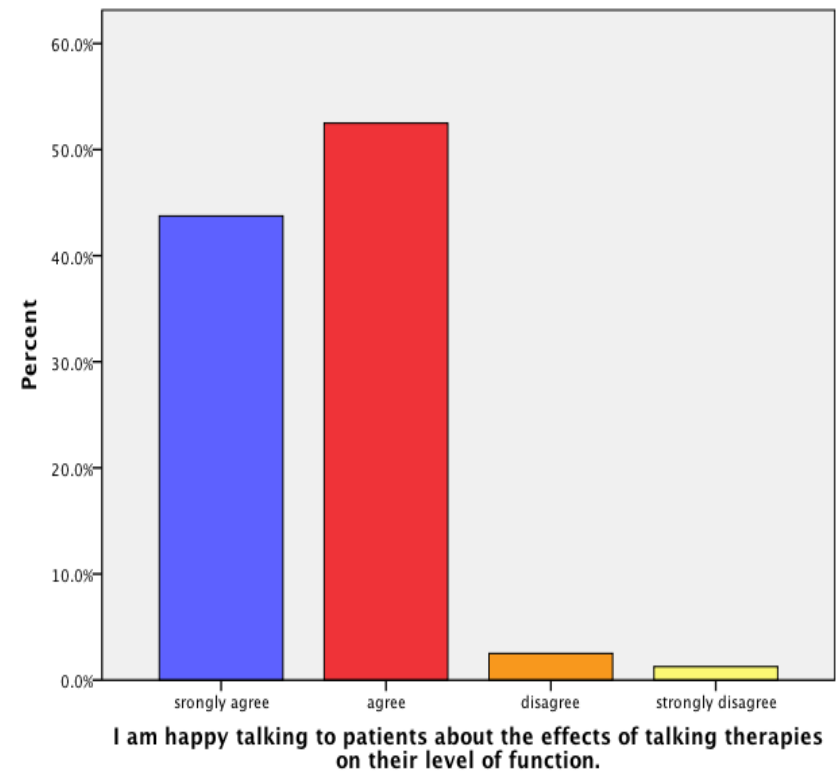


Question thirteen. I am happy talking to patients about the effects of talking therapies on their level of function:

Graph 18 (pre-course completion).



Graph 19 (post-course completion).



Pre-course qualitative statements from respondents:

“My role is not a clinical therapeutic role but, that of a liaison psychiatry role. So to participate in and be available for consultations with generalist clinicians in developing care plans for their patients” (Student 77).

“I believe I do these therapies yet I have not identified them as structured therapies” (Student 32).

“Unsure” (Student 10).

“I use a lot of validation with patients. I have limited formal experience with ‘talking therapies’” (Student 13).

“Un-confidant” (Student 24).

Depends on patient/level of their ability – to engage in talking therapy” (Student 46).

Post-course qualitative statements from respondents:

“I feel a lot more confident. I have been using basic principles of CBT but not as yet in a structured way” (Student 77).

“More confident as in the past I would hit walls and blocks I feel this will not happen as I have many tools to implement & more structure to each session” (Student 32).

“Need more practice to feel fully competent, but I believe it will be an excellent tool for future work with clients” (Student 10).

“I feel comfortable to try talking therapies with patients. I think I’ll need practice to put it in a more structured manner, but I have the knowledge now to practice this” (Student 13).

“Nervous but able!” (Student 24).

“With increasing practice and application I contrive to be a confident practitioner” (Student 46).

The qualitative statements, from the same students, pre and post intervention show some marked improvement in confidence and belief in their ability to offer CBT to their patients. Most state that they feel they will be more

able to practice CBT after attendance of the course and some mention an increase in their confidence levels and knowledge by attending the course. Although as stated earlier in this thesis the quantity of usable qualitative data was small, one can see a change in the limited examples above from the participants' perspective. From data gathering point 1 to point 2 a number of the questions such as 'not sure' have been lost as the respondents were no longer 'unsure' post course attendance. This is true for a number of the graphs and shows positive movement regarding self-efficacy and readiness to use skills by attending the course. It also shows that the cyclic developmental nature of course delivery was achieving its aim of introducing respondents to CBT skills, one could also ascertain that the respondents' input to course development by regular informal evaluations was fine-tuning the course for each subsequent delivery.

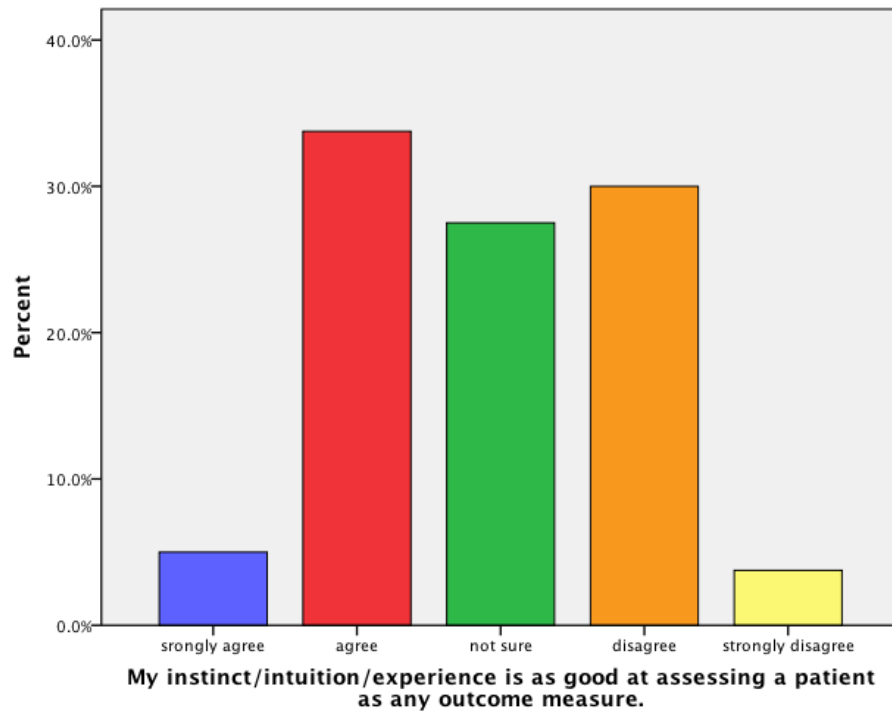
Question sixteen 'my instinct/intuition/experience is as good at assessing a patient as any outcome measure' was designed to gain an insight into student's pre- and post- course understanding of the place of outcome measures in modern mental health services and their reliance on instinct/intuition/experience to assess a patient's psychopathology. Prior to completion of the course the majority of respondents strongly agreed, agreed or were not sure about this statement, with a much smaller proportion in disagreement. There is a level of concordance between both pre- figures, and one would expect this within a population that had a relatively similar number of professionals who qualified either before 1990, 36% or after 1990, 41%. At the end of the course 80% of the population disagreed or strongly disagreed with the question. The increase here could be put down to respondents feeling more

capable i.e. their self-efficacy has improved pertinent to the correct use of scales  
- or they may have gained a greater insight into the use of standardised measures  
in health care - but may not actually be using these measures themselves.

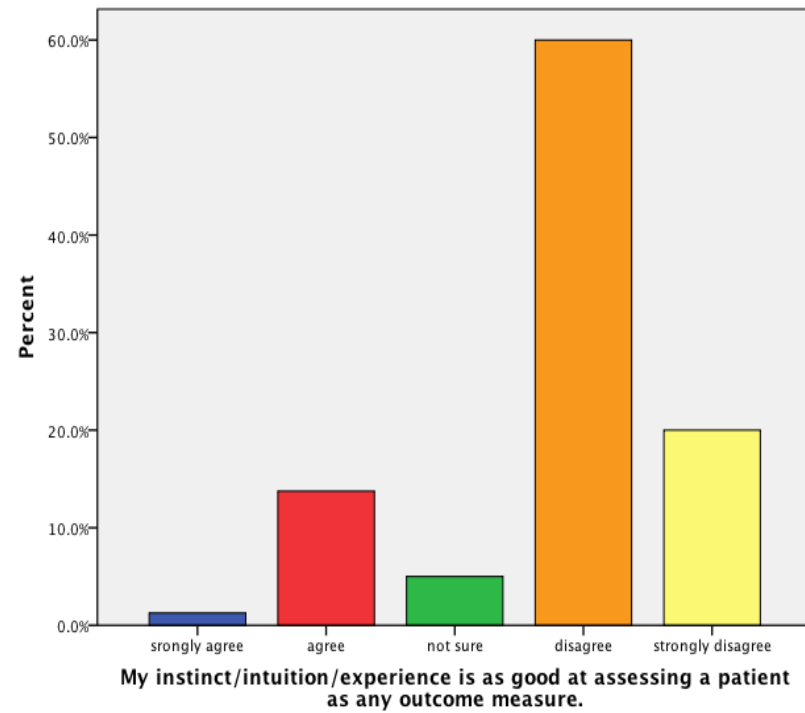
Many mental health professionals rely on their intrinsic ability to know  
'what is occurring' for their patients, this 'ability' is not quantifiable, the next two  
graphs focus on this by comparing the respondents 'intuition' to the use of  
standardized and validated assessment scales. There is a marked move from  
data point 1 to data point 2, with over 80% of respondents in disagreement.

Question sixteen. My instinct/intuition/experience is as good at assessing a patient as any outcome measure:

Graph 20 (pre-course completion).



Graph 21 (post-course completion).



Questions seventeen 'I genuinely believe talking therapies will help patients, and twenty, 'CBT is effective in reducing psychotic symptoms in the majority of patients' are both designed to gain an insight into student's views concerning the efficacy of providing talking therapies to their patients. Question seventeen attempted to gain insight into the respondents' views on whether or not talking therapies will help patients and question twenty, was designed to identify views as to whether or not CBT is effective in reducing psychotic symptoms in the majority of patients.

The NSW Government has stated that CBT should be available in all Health Care services (NSW DoH, 2008). The results from these questions came out strongly in favour of the efficacy of CBT and for the provision of CBTp, with a marked swing in the CBTp question to either agreeing or strongly agreeing with the statement, 38% pre- CBT course completion to 91% post- CBT course completion, a marked shift in the initial view of the respondents. This data shows that by attending the CBT course, respondents have changed their opinion of where CBT sits in practice. One could assume that this has occurred because the respondents have been exposed to information and training in an area that they were not sure of at the start of the programme. 89% of the population agreed or strongly agreed with question seventeen, at the start of training and 99% agreed or strongly agreed at the end of training, virtually all of the population trained. A return of nearly 100% was never envisioned at the start of the training programme development, but again if this impacts on the development and delivery of patient care over time then the course has been successful. See Appendix 7 for the graphs pertinent to these questions.

Theme - an active therapeutic stance, CTS-R Item 3 - collaboration with the patient:

Questions two 'Patients should be allowed to refuse therapy' and three 'It is part of my role to persuade patients to accept therapy' targeted the student's views as to patient's choice in either receiving or not receiving therapy and whether or not part of their role as a health professional was to persuade the patient to accept therapy. The pre- course questions showed that the majority of respondents agreed that this was an important element of their role. This did not alter greatly one way or the other at the post- course questionnaire stage. When one initially introduces CBT to patients, reliance is placed on being able to 'socialize' the patient to the model and thus 'grab' their interest and willingness to participate in the therapy. This in itself is not 'persuading' the patient as such, more offering an insight to the processes inherent within CBT, from an educational or psycho-educational perspective (Hawton et al, 1989). Please see Appendix 7 for the graphs pertinent to these questions.

Question six 'If a patient doesn't want CBT there is nothing I can do to persuade them' targeted the respondents' views on their ability to therapeutically 'convince' a patient into therapy, pre- and post- course. This question also sits in the theme of active therapeutic stance and collaboration with the patient. Staff delivering CBT as part of the therapy model will use a Socratic psycho-educational approach (Hawton et al, 1989), this is designed to 'persuade' the patient to accept therapy by leading them to the personal realization that there are advantages to accepting a course of CBT. Thus I tried to identify students pre- and post course perception of their abilities to 'persuade' a

patient to accept CBT. As with collaboration and socialization above this is a core CBT skill, with the focus on providing enough information for the patient to come to an informed and rational decision as to the applicability of CBT to their mental health needs at that time.

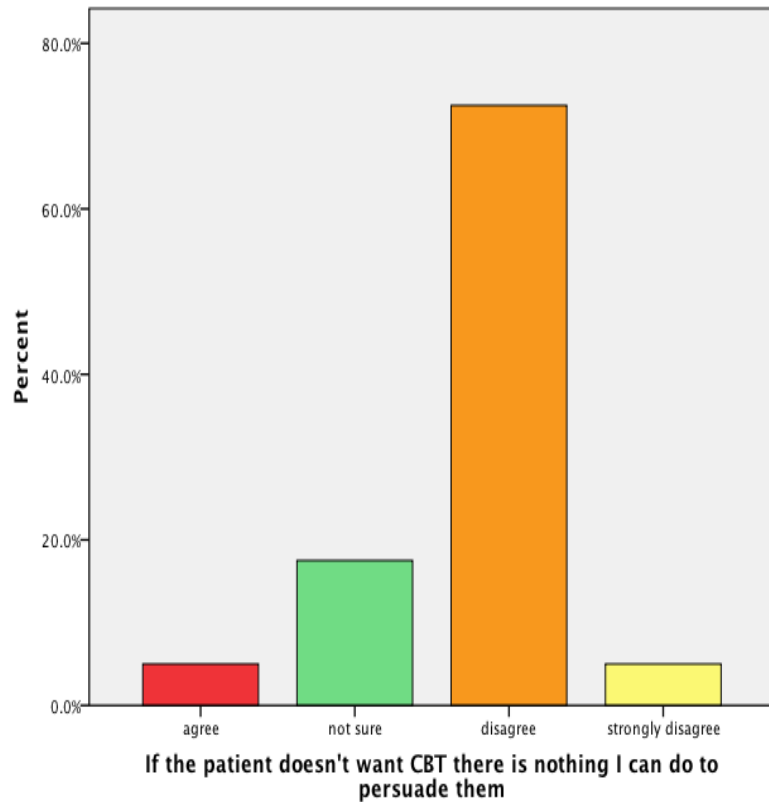
The pre-course questionnaire showed that 78% of the student population disagreed or strongly disagreed that there is nothing they can do to persuade a patient into CBT if they do not want it. Post- course showed 100 % of the student population, disagreeing or strongly disagreeing with this view. The implications for this to clinical practice are that we have a population of health professionals who show that they are able to use specific CBT engagement and socialisation strategies to 'persuade' or in other less emotive and more therapeutic words 'engage' a client with CBT.

Graphs 22 and 23 show the pre- and post- course responses to these questions. None of the students agreed or were not sure on this at data point 2.

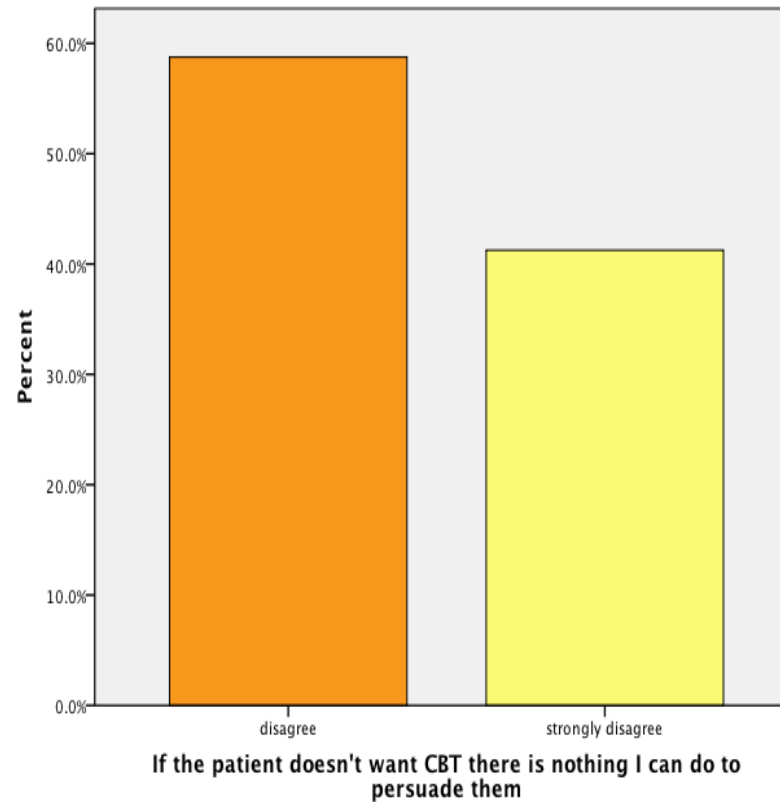


Question six. If the patient doesn't want CBT there is nothing I can do to persuade them:

Graph 22 (pre course completion).



Graph 23 (post course completion).



Theme – Medication and CTS-R Item 3 - engagement:

Questions five, 'Telling patients about the possible side effects of medication may put them off taking it', eight, 'Non-compliance with medication will result in a worse long term outcome for patients', nine, 'Giving people written information about their treatment will enhance compliance', ten, 'A patient's lack of awareness (or insight) about their mental health problems is a major cause of non-compliance with treatment', eleven, 'Most patients are not sure whether taking medication is a good idea', fifteen, 'The higher the dose of antipsychotic medication the more likely it is to get rid of symptoms', eighteen, 'Non-compliance is simply a patient expressing their desire for personal autonomy' and nineteen, 'I have no influence on what medication the doctor prescribes' are all focused on medication and therapy related treatment areas. Virtually all patients receiving mental health care in Australia were on a medication regime designed to ameliorate their symptoms and psychological difficulties. CBT can be delivered in conjunction with medication and latterly has been designated as a first line treatment option in the NICE Guidelines for a number of specific mental health problems notably depression and anxiety (NICE, 2004, 2009). It was decided to gather data that would enable me to gain an understanding as to the respondents' views of medication-focused psycho-education, compliance and non-compliance with treatment in the delivery of mental health care. It is good practice to tell a patient about the possible side effects of the medication they have been prescribed prior to starting the regime; this is outlined and expanded upon in the Maudsley Prescribing Guidelines (Taylor, Paton & Kerwin, 2007). Compliance and non-compliance in this case is focused on efficacy of the talking therapy or medication regime used in the

treatment and management of mental health problems.

These questions were analyzed together to aid understanding and enable a concise picture to be developed in the areas of medication and treatment adherence. Non-compliance with medication and treatment is a major cause of relapse and re-hospitalization in patients with a mental health difficulty (Bentall, 2009). Statistics show that in the first year post-discharge up to 50% of patients will stop taking their medication and in the second year the figure climbs to 75% (Gray et al, 2006), this causes a major problem for patients and their ongoing health needs. It also puts a strain on health service budgets and questions the efficacy of health care provision. A number of talking therapies have been developed to enhance compliance with medication focused care regimes, the majority of which are delivered within a cognitive behavioural model (Gray, et al, 2006).

The questions were posed to ascertain if the respondents thought that informing a patient of the possible side effects of their medication might put them off taking it. Prior to the course 40% of respondents strongly agreed, or agreed and 49% disagreed or strongly disagreed with this. These initial figures were surprising as it is recognized good practice to inform patients of medication side-effects, it is also good practice to assess the side-effects and a question focused on this was set in part D of the questionnaire. When analyzing the data one would need to return to the demographic details of the research population and see how many of the responders who agreed, qualified post 1986, when NSW stopped training mental health nurses. One would also need to take into account the number of allied health professionals within this population as they often have differing views regarding the use of medication.

Post- course completions 90% either strongly agree or agree with this question. These figures are impressive when compared from pre- to post- with a percentage increase of nearly 50 points. This was a positive result for the CBT course, as this was not one of the core curriculum areas. The majority of the other questions are concerned with medication, compliance and non-compliance with treatment. A marked improvement/difference occurred in student's views once the course had been completed.

Question eleven, 'Most patients are not sure whether taking medication is a good idea' asks the student population to offer an informed opinion as to their patient's thoughts about taking medication. This question was designed to gain an understanding of the respondents' ability to empathise with a patient's thought process and personal autonomy. There was no significant difference between pre- and post- scores, but interestingly enough the number of respondents unsure on this point decreased by 10%, the sharpest drop within this area.

Question fifteen 'The higher the dose of antipsychotic medication the more likely it is to get rid of symptoms' asked respondents to express their views on high dose medication and its success in reducing psychotic symptoms. The majority of respondents here went from disagreeing with the statement, to either agreeing or not knowing post- course completion. This result was unexpected, as not too much focus was placed on anti-psychotic medication efficacy and action during the course; the core focus was assessment and monitoring of side-effects within a cognitive behavioural model, e.g. affect on patients mental state or level of sedation. The standard therapeutic dose of Haloperidol for example, (a typical anti-psychotic) that blocks the dopamine

receptors in the brain is 6mg per day, any more dosage given will not reduce psychotic experiences as they are no further receptors to block, it will just increase sedation.

There was no marked change to note pre- to post- course on question eighteen as to whether or not non-compliance is simply a patient expressing their desire for personal autonomy. Question nineteen; 'I have no say over what the doctor prescribes' was designed to identify the respondents' view of their influence on medical prescribing. As with all mental health services the consultant psychiatrist has an important role to play, but in NSW this role and position was very important in care delivery and identification. Historically they have taken the lead in service provision, design and management, NSW was not unusual in this regard but it was unusual in its reliance on the medical model (Laing, 1971). NSW Health had introduced the "Recovery Model (NSW DoH, 2005) to underpin all elements of service design and provision. This was designed to increase the power of the service user and their ability to demand certain levels of service and care provision. At this stage in NSW there wasn't a programme designed to provide CBT based talking therapies to patients as there was in England, the Improving Access to Psychological Therapies (DoH, 2010).

Thus it was felt appropriate to target the lack of influence of non-medical practitioners on identifying and delivering a prescribed medication regime. 20% of the population thought they had no influence over a doctor's prescribing, with 71% disagreeing with the statement pre-course completion. On repetition of the measure at the end of the course only 3% of the population agreed with the statement whereas 93% thought they would have influence over the prescription of medication, which was evidence of the increase in their self-

efficacy as a health professional. See Appendix 7 for the graphs pertinent to this theme.

Theme – CTS-R Items 3 & 4 - therapeutic stance and other supporting questions:

Questions seven, 'Talking therapies are the responsibility of the allied health staff' and fourteen, 'Prohibition is the only way to stop patients using non-prescribed drugs (alcohol/cannabis etc)' are focused on the student populations views of who should be providing therapy and the therapeutic stance and also whether prohibition would stop patients using non-prescribed drugs and/or alcohol. Question seven was posed to ascertain which professional group was most identified with the delivery of CBT to patients with mental health needs. The reader should be mindful that that the majority of respondents (over 50%) were from a nursing background. The analysis pre-course completion showed that more than 85% of those surveyed disagreed or strongly disagreed that 'talking therapies were the responsibility of the allied health staff, with only 15% agreeing or being unsure if they held this view. Post course completion 95% of respondents disagreed or strongly disagreed with the statement and only 5% agreed. This again evidences the increase in self-efficacy of the nursing staff and the respondents' self-reported readiness to use skills, rather than the skills themselves.

The provision of CBT practice in NSW Health directly influenced the posing of this question, as the service perception was that only allied health professionals could deliver CBT. As a result of this I instigated, with the agreement of the Director of Nursing, that the provision of CBT be included in all new nursing job descriptions at NSCCH. Question fourteen, 'Prohibition is the only way to stop patients using non-prescribed drugs (alcohol/cannabis etc)'

was included to ascertain the validity of the respondents' completion of the questionnaire, as it was unusual for people's opinions in this area to change. The results mirrored this, and I was able to feel confident that respondents had completed the questionnaire properly and not just plumbed for certain answers, or merely ticked the middle box.

#### Part D. Your views about your skills:

The next part of the questionnaire was designed to get a pre- and post-course attendance understanding of the student's views about their actual clinical skills in CBT. The lead in question was 'How skilful (at the moment) do you feel you are in the following. A list of 13 items was included to be rated from very skilled to very unskilled on a five point Likert scale. All 13 questions had a clinical focus and it was decided to theme them and then group them into areas of actual clinical application. As with the section above The Cognitive Therapy Scale – Revised (CTS-R) (Blackburn et al, 2001) was used.

Theme - adherence to therapy principles, and an ability to use basic CBT principles. CTS-R - Item 7 – Eliciting Key Cognitions:

Questions one, 'Assessing psychotic symptoms', two, 'Assessing the side effects of anti-psychotic medication', three, 'Assessing depression' and four, 'Assessing cognitive dysfunction' targeted how skilful the respondents felt they were at assessing a patient's symptoms, medication related side-effects, depression and cognitive dysfunction, all skills that mental health professionals should have (Ryan & Morgan, 2004). As the student population comprised nurses, psychologists, social workers and occupational therapists and other therapists, there would have been a number of individuals that felt unskilled at assessing the side-effects of medication, as this is traditionally looked upon as a

nursing role. The data bore this out to an extent, but not as much as may have been expected.

As the results show the majority of respondents felt they were either very skilled, skilled or they were neither skilled nor unskilled in assessing the four areas, at the pre- course questionnaire application. 25% of respondents felt they were neither skilled nor unskilled in assessing side-effects of medication, which mirrored to an extent the demographic makeup of the population studied. Once the course had been completed and the respondents had had time to digest and practice the skills taught there was a marked increase in the perceptions of their skills at assessing patients; evidence of an increase in self-efficacy.

A greater proportion of respondents felt they were either very skilled or skilled on completion of the course with the number who felt they were neither skilled nor unskilled in assessment dropping considerable. Assessing side-effects fell from 25% to 11% of the respondents' post- course completion, with assessing cognitive dysfunction falling from 33% pre-course completion to 8% at the end of the course delivery period. These drops show a marked increase in the respondents' perceptions of their skill level and ability. All other areas except side-effects were in the 90% area post- course for perceived skill level having risen in most cases by over 20 to 30% post course completion.

Very few respondents rated their skill levels as either unskilled or very unskilled at the end of the course. The only area where there was a poor result was assessing side-effects, where 4% of the respondents at the end of the course felt unskilled in this area. This had fallen from 11% pre-course assessment and may mirror the respondent population and mix of professions that attended the training (i.e. not normally a part of their job). The results for these four questions

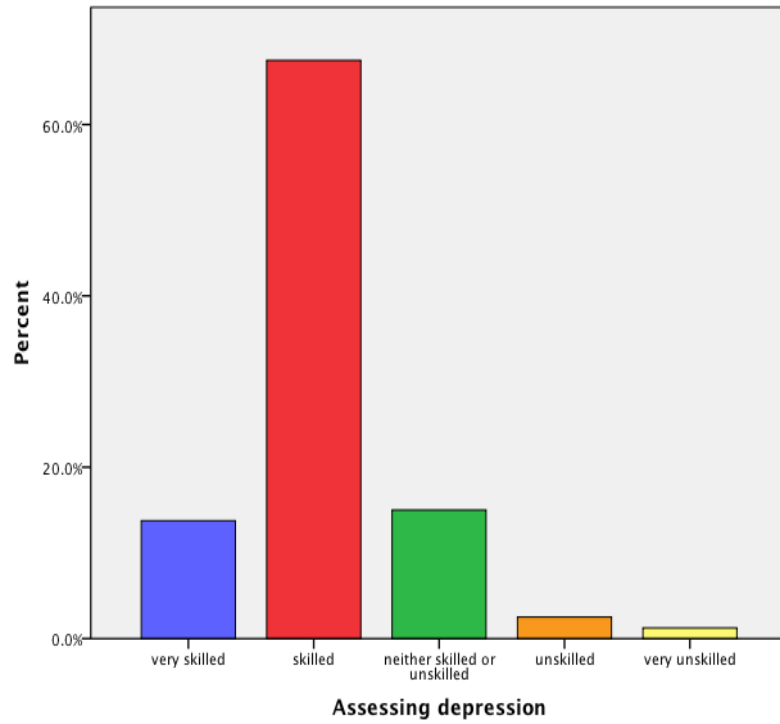


are positive and show that the respondents felt significantly more able at the end of the course than they did at the start. No respondents rated themselves either unskilled or very unskilled at the end of the course, which was again a positive result. See appendix 7 for graphs pertinent to this theme.

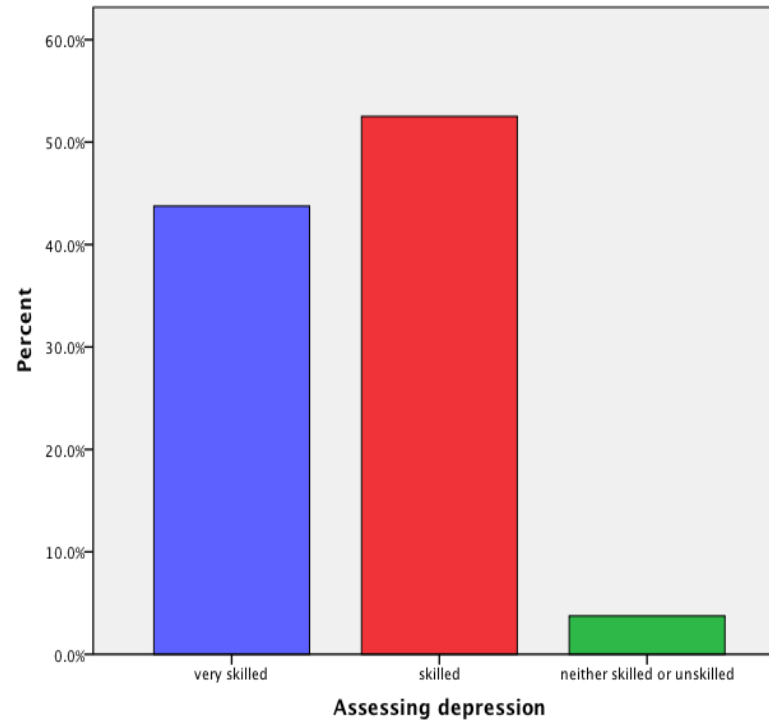
The next graphs give an insight into student's views of their skill and ability to correctly assess a patient with a diagnosis of depression.

Question three. Assessing depression:

Graph 24 (pre course completion).



Graph 25 (post-course completion).



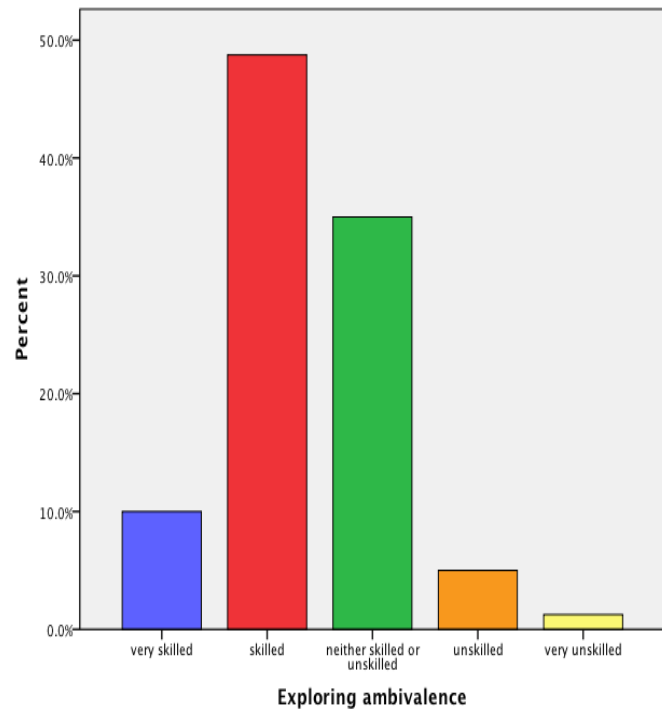
Theme – warmth and empathy. CTS-R – Item 5 – Interpersonal Effectiveness:

Questions five, 'Exploring ambivalence', eleven, 'Avoiding confrontation' and thirteen, 'Avoiding debating therapy' drew on the work of Miller and Rollnick in motivational interviewing (MI) (Miller & Rollnick, 1991). They devised a motivational based directive counselling therapy, initially targeted at smoking cessation but latterly used extensively in substance (mis) use services. This therapy was designed to prepare people to change their behaviour, initially addictive behaviour but latterly psychotic and related behaviours. About 60% pre-course completion and 95% of respondents post- course completion felt either very skilled or skilled in engaging and interacting positively with patients, using MI skills, this again mirrors findings from the 'MoodMatters' survey. The graphs will give more exact figures as only 8% felt very skilled on joining the course but rose to 26% on completion. This is again a marked increase from point 'A' to point 'B'. These figures were mirrored to an extent in the other two questions. All areas showed a significant increase from point 'A' to point 'B' in the respondents' perceived skill level and self-efficacy. A small, but significant number of respondents felt either unskilled or very unskilled at point 'A' but at point 'B' no respondents felt unskilled or very unskilled, this result is significant in the shift to a zero percentage rating. The number of respondents rating themselves as neither skilled nor unskilled also fell dramatically from point 'A' to point 'B'.

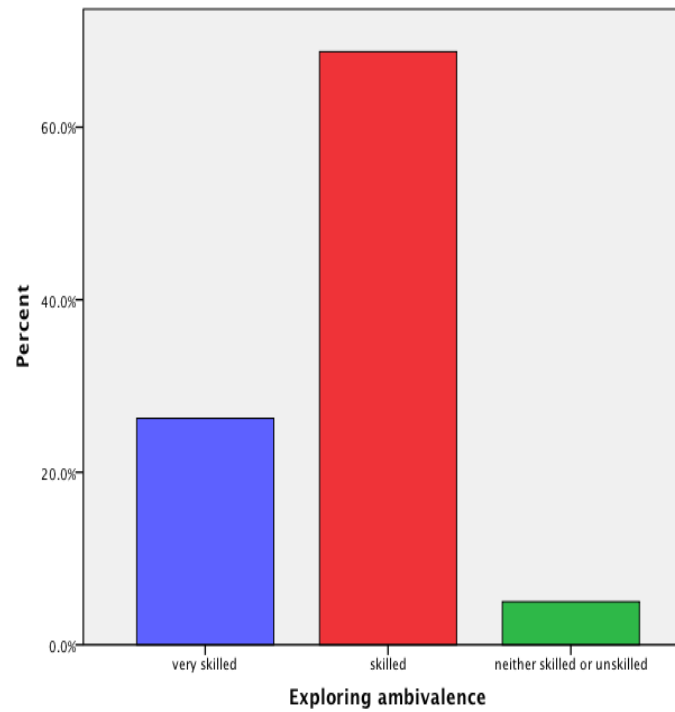
The figures for questions five and thirteen expand on the student's pre- and post- course views of their skills in the areas of working with therapy ambivalent patients (patients who do not see the benefit of therapy) and avoiding debating or arguing about therapy with their patients.

Question five. Exploring ambivalence:

Graph 26 (pre-course completion).

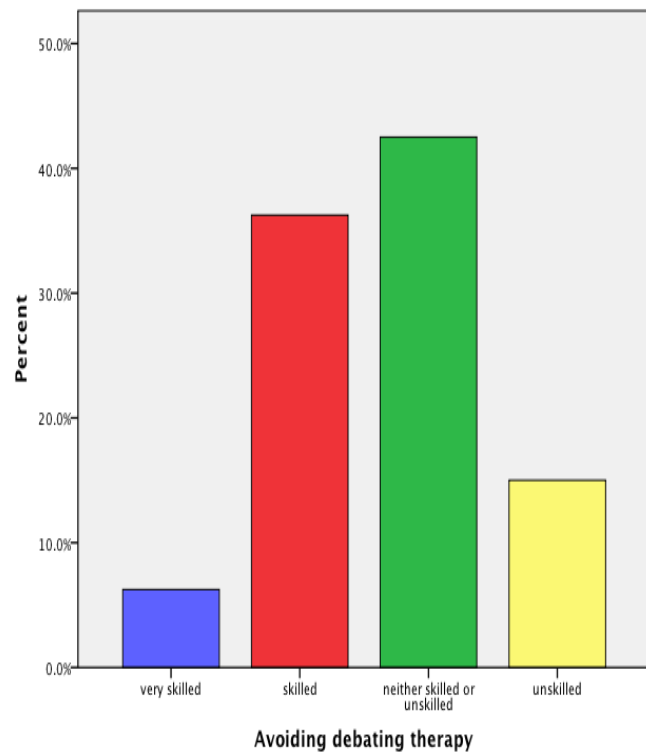


Graph 27 (post-course completion).

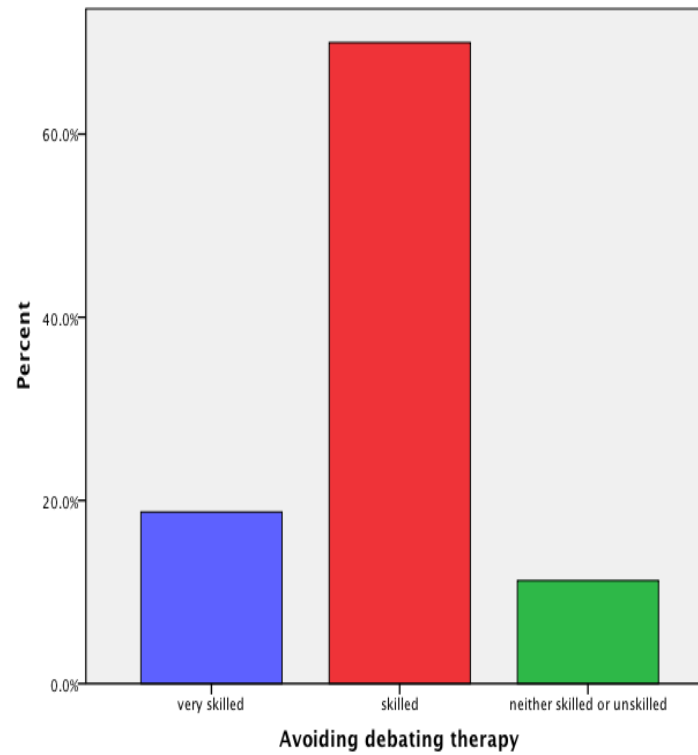


Question thirteen. Avoid debating therapy:

Graph 28 (pre-course completion).



Graph 29 (post-course completion).



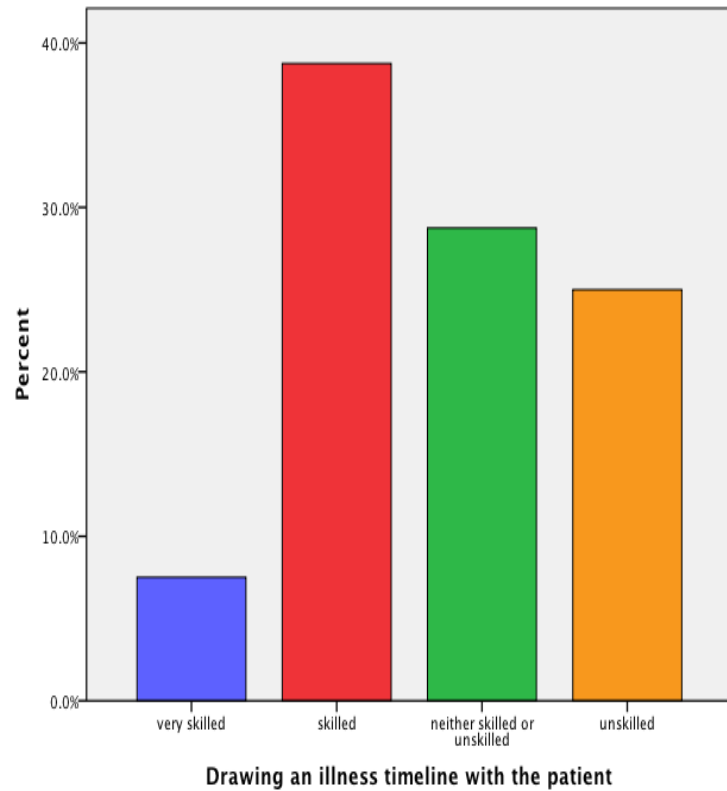
No respondents felt unskilled or very unskilled in these areas after attending the CBT training course, which again was a positive result.

Theme – Application of change methods. CTS-R – Item 10 – Conceptual Integration:

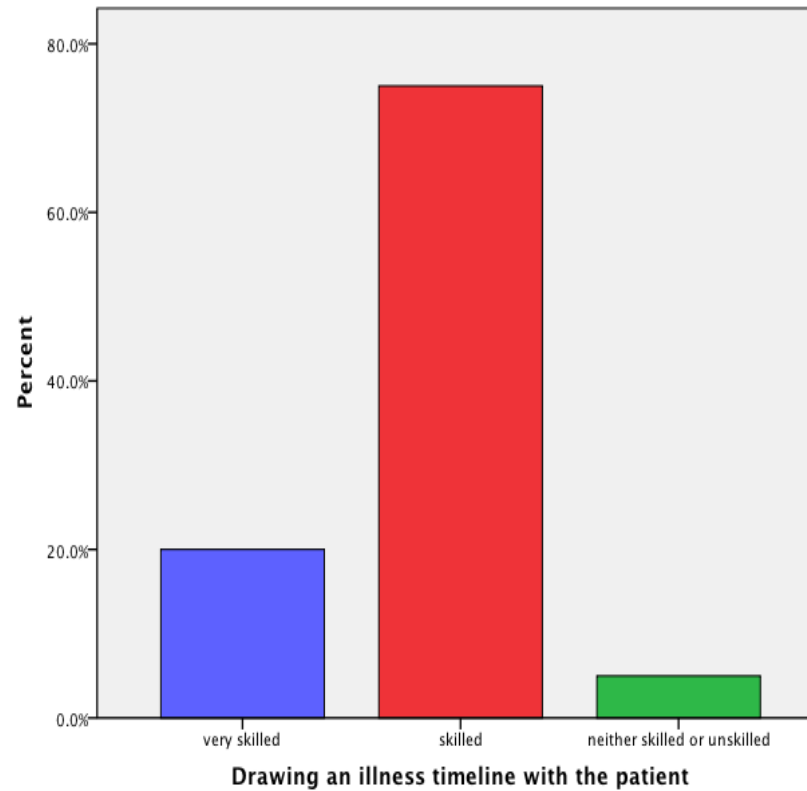
Question six 'Drawing an illness time-line with patients' targeted the respondents' skill level in a very specific cognitive behavioural intervention, used predominantly in early psychosis and relapse prevention. This is based on the research conducted by Birchwood and colleagues (1989) and updated since to become a recognized cognitive behavioural intervention strategy (Birchwood et al, 1989). Birchwood et al, (1989) showed that if a patient was trained to recognize their own prodromes (an early indicator of a condition or a relapse marker) and relapse signature, then introduced to interventions directly designed to reduce relapse they had a 77% chance of not relapsing. These figures have been replicated in a number of other studies since 1989 (Birchwood, Spencer & McGovern, 2000, Birchwood et al, 2004). At point 'A' 44% of respondents felt unskilled in this intervention and 54% felt either very skilled or skilled. At point 'B', 95% of respondents felt very skilled or skilled and only 5% felt neither skilled nor unskilled, a marked increase. Again the post- CBT course questionnaire shows a marked increase in perceived skill and readiness to conduct this significant intervention with patients. Drawing an illness time-line is a very specific skill that most mental health professionals will not use unless taught to do so. The next graph expands upon the results in this area.

Question six. Drawing an illness timeline

Graph 30 (pre-course completion).



Graph 31 (post-course completion).



No respondents felt unskilled/very unskilled in this area at the end of the course.

Themes - collaboration with the patient. CTS-R Item 3 – Collaboration and Item 5

– Interpersonal Effectiveness:

Questions seven, 'Working collaboratively with patients', eight, 'Engaging patients in therapeutic relationships' and ten, 'Giving patients information about their illness or therapy', were designed to gain an understanding of the respondents' perceived skills and ability in engaging, working collaboratively and giving psycho-education to the patient. As with question four 'Working collaboratively with patients is a vital clinical skill' in part C of the questionnaire collaboration is one of the cornerstones of talking therapy provision. The first thing a cognitive behavioural therapist is expected to do with the patient is to engage and actively socialize them to the model of CBT being employed (Morrison et al, 2004). This enables the patient to gain an understanding of what will happen in therapy, and over time will promote active collaboration and engagement (Hawton et al, 1989). As was to be expected, all but 8% of the student population felt either 'very skilled' or 'skilled' in this area at the start of the course. One of the core aims of the course was to enable trainees to become 'very skilled' in 'working collaboratively with patients' on completion of the course, so it was interesting to see if the percentage loading in either 'very skilled' or 'skilled' had altered significantly. This aim was achieved with the percentage of respondents feeling 'very skilled' rising by 40% and the skilled dropping by 34%, the number of respondents who felt 'neither skilled nor unskilled' also fell to only one individual.

These figures were mirrored by question eight, 'Engaging patients in therapeutic relationships' in the pre and post percentages of respondents who



felt 'very skilled', 'skilled' or 'neither skilled nor unskilled', with the percentage scores being virtually identical at the post course scale application. Two respondents here felt 'unskilled' at the beginning of the course but post course completion, 2 respondents felt 'neither skilled nor unskilled' which is a move in the right direction. Respondents to question ten, 'giving patients information about their illness or therapy' showed a marked change from point A to point B, but this mainly fell in the very skilled range, going from 8% pre- to 36% post-course completion. Three respondents indicated that they felt unskilled in this area, and on post course completion three respondents stated they felt 'neither skilled nor unskilled'.

Psycho-education or giving patients' information about treatment or illness is not a core component of mental health training in Australia, so most of the skills the respondents rated would have been developed post initial qualification. It is pleasing to note that the eight-week CBT course was able to up-skill the attendees in this vital area of therapeutic engagement and intervention.

Some pre-course qualitative statements from respondents:

General explanation, more detailed explanation, discuss options with client, get client to identify their goals" (Student 17).

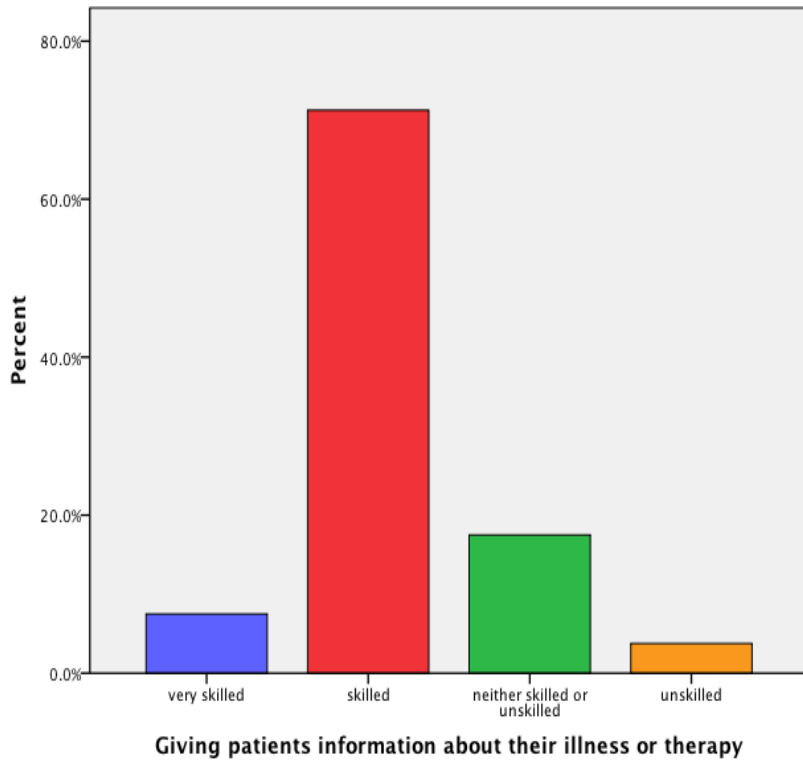
Some post-course qualitative statements from respondents:

"Introduce to patient only after form solid therapeutic relationship and thorough assessment. Give evidence; work slowly client based, time focused, goal orientated, clear/concise" (Student 17).

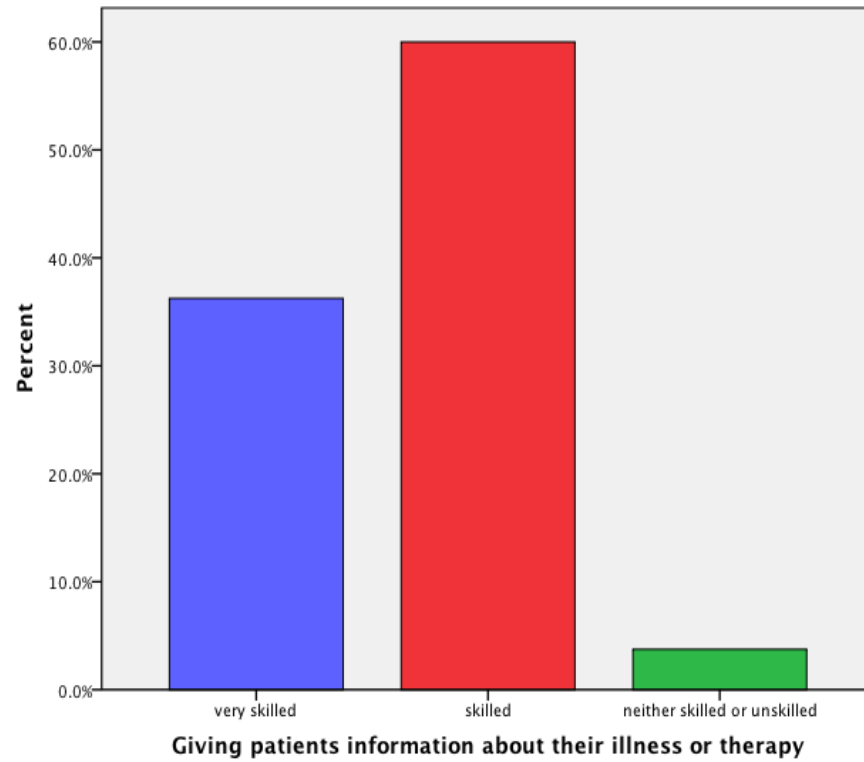
The next graphs focus respondents view to their ability to give patients' illness or therapy specific information.

Question ten. Giving patients information about their illness or therapy:

Graph 32 (pre-course completion).



Graph 33 (post-course completion).



No respondents felt either unskilled or very unskilled in these areas at the end of the course.

Theme - an active therapeutic stance. CTS-R Item 11 – Application of Change

Method:

As with question six 'Drawing an illness timeline', questions nine, 'Testing beliefs about illness using cognitive behavioural techniques' and twelve, 'Problem solving issues about therapy with patients' were designed to assess the respondents actual therapeutic ability pre- and post- course completion. Question nine, 'testing beliefs about illness using cognitive behavioural techniques', is a skill that one would only develop after either attending appropriate CBT training or being supervised by a CBT practitioner and conducting CBT in practice. Question twelve, 'problem solving issues about therapy with patients' again utilizes a very specific CBT skill, but here it is a skill that is often common in other areas of health care, it would be expected that respondents felt relatively comfortable with its use and application, but may be initially less sure of its use on 'problems in therapy'. Over 80% of respondents felt 'neither skilled nor unskilled', 'unskilled or very unskilled' pre-course completion. This result was not too surprising as very few of the respondents had had any contact with CBT prior to the training. Potentially the clinical psychologists would be providing CBT in their practice, as would a number of the Social Workers and a couple of the Consultant nurses. On completion of the course over 90% of respondents felt either very skilled or skilled. Here the figures had gone from over 80% negative pre-course completion to over 90% positive post course completion. This is a very marked shift, greater than was thought possible at the development stages of the course and also during course

delivery. If these results can be replicated in future training then the prospect of CBT delivery to mental health patients in NSW is very good.

Question twelve 'Problem solving issues about therapy with patients' was virtually a 50% split at the start of the course, this moved to 95% at course completion. 5% of respondents' post- course felt 'neither skilled nor unskilled' and this had fallen from 43% at the start of the course.

Some pre-course qualitative statements from respondents:

"I feel confident to an extent in using talking therapies and feel I can engage with the user" (Student 72)

"I feel it should be an integral part of my work, and I aim to be more committed to applying talking therapies such as CBT in a more formalized manner" (Student 26)

"CBT may help me to work more closely with my patients on their problems" (Student 50)

Some post-course qualitative statements from respondents:

"I feel much more confident in using talking therapies and now feel I can really engage with the user" (Student 72)

"Still testing the ground but I am trying to continue, harder with psychosis than depression when insight is poor" (Student 21)

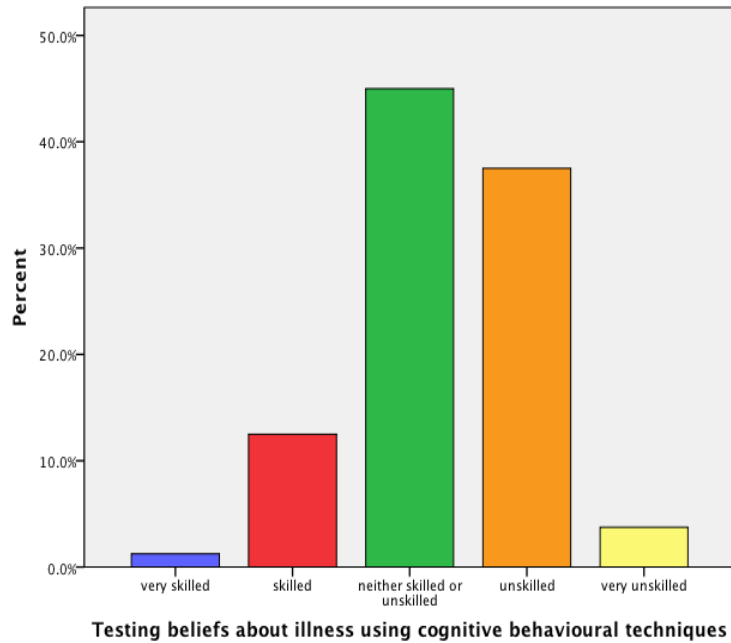
"CBT will become an integral part of my work and over time I hope to be applying talking therapies in a more formalized manner" (Student 26)

"CBT will help me to work more closely with my patients on their problems" (Student 50).

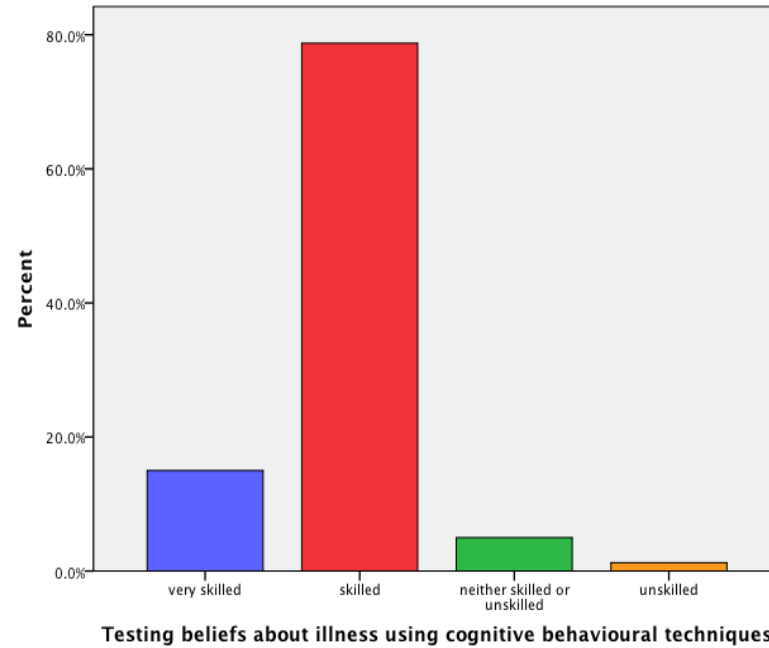
The next four graphs are focused on specific CBT skills and student's views about their skill levels in these areas.

Question nine. Testing beliefs about illness using cognitive behavioural techniques:

Graph 34 (pre-course completion).

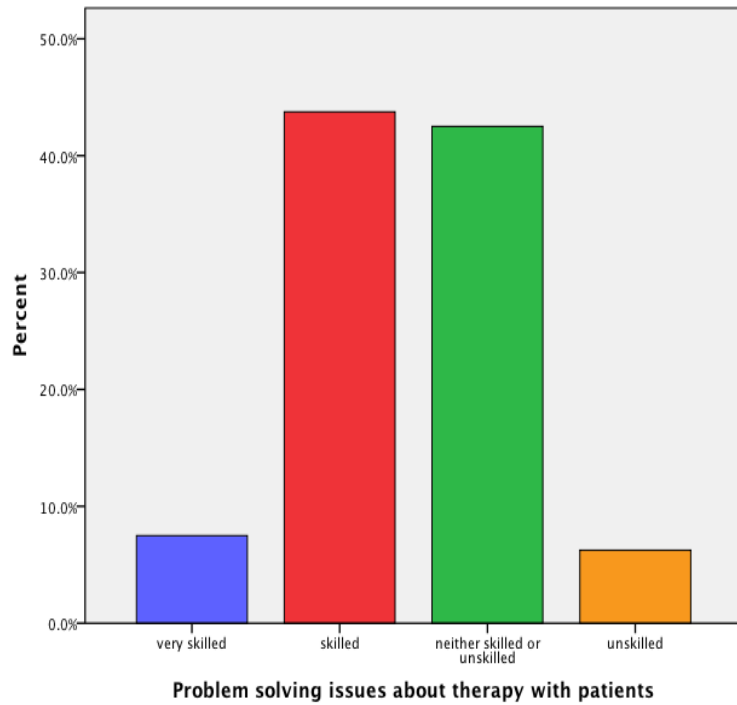


Graph 35 (post-course completion).

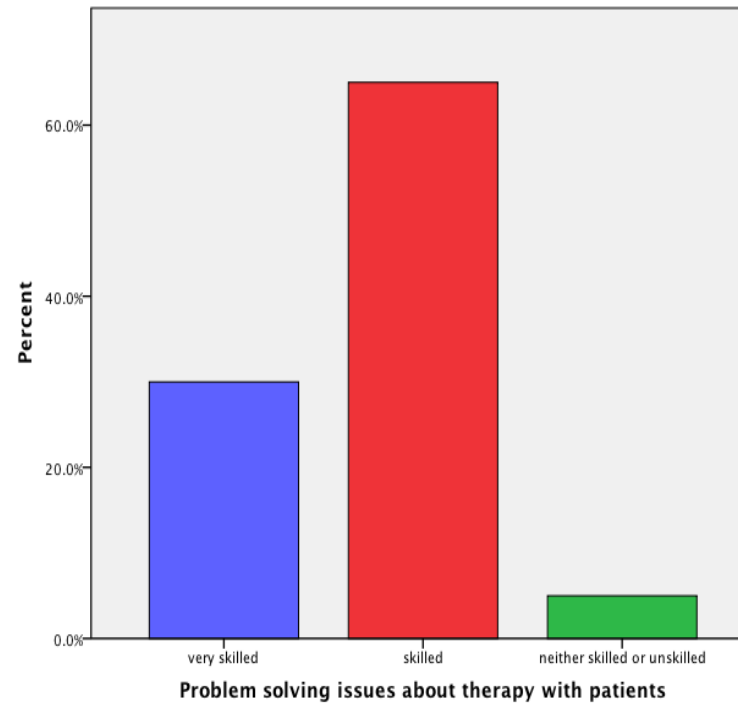


Question twelve. Problem solving issues about therapy with patients:

Graph 36 (pre-course completion).



Graph 37 (post-course completion).



The analysis of the data gained from the questionnaire shows a marked improvement from pre- to post- scores in all areas that have a significant place in modern mental health care. The questions that were placed in the questionnaire to check validity on completion showed no marked change from pre- to post-course completion. From this it can be identified that the CBT training course questionnaire achieved what it was designed to do. There was a qualitative component to the scale, but sadly not enough questions were completed to warrant an in-depth analysis, but in a number of the scales, where these questions were completed a clear increase in student's ability and confidence was evidenced.

The analysis of parts C and D of the two-part cognitive behavioural therapy course questionnaire show some interesting and unexpected results. The findings of the analysis point to quite a high skill level in certain aspects of talking therapies pre-course completion, and this was to be expected as the greater majority of mental health professionals in NSW Health have undergone a comprehensive University based core professional training. A number have also completed post qualification training. Looking at the results this training would have been in interpersonal and core counselling skills. This is evidenced by the high percentage of respondents who's understanding of core talking therapy principles, viewed their skill levels positively both pre- and post- course. This was most notable in the areas of engagement, medication and views about the placing of therapy in a patients care package.

A number of questions only altered slightly post- course completion as the pre-course completion point the scores were within the positive domains. Others showed a marked difference at the two points. These questions focused more on

the actual application of skills inherent in CBT. This again was expected, as there had been limited CBT training available in NSW Health to mental health professionals not from a psychology background. The findings have implications for the delivery of future training and clinical work across NSCCH and NSW; they highlight an area where improvements could be made. They also have implications for the future training and positioning of nursing staff in NSW Health, as they show that when nurses are trained in CBT or talking therapies they will be, over time, able to deliver therapy with their patients. This again will have role related implications, but will increase the access to psychological therapies tenfold.

The key areas of CBT training that the course has highlighted fall mainly within the skills of CBT and ability to apply the model with patients. The core skills taught, mirror the CTS-R Scale (Blackburn, et al, 2001), and have been shown to be transferable from a training environment to clinical practice. These skills consist of humanistic and therapeutic principles, core CBT skills, an ability to apply the model in a structured manner and interpersonal effectiveness.

In hindsight the ability to analyse individual student data sets, and to track any changes in course outcome over time as the course developed would have proven valuable. Also due to expediency of storing the data and transferring it back to the UK, the ability to statistically analyse pre- and post- CBT course questionnaire results for individual respondents was lost, this made it impossible to identify significant individual respondent changes pre- and post-course.



## **Chapter 7**

### **Conclusion**

#### **7.1 Brief recapitulation of initial research:**

The previous chapters have introduced the reader to the research and training project and a literature review has been provided to introduce evidence-based practise and CBT in the context of this project. An approach broadly in the spirit of action research was the core methodology used within a critical social science perspective. A Practice development ethos has been discussed as it was intended to underpin the project and support its continuity. I have included a chapter on my personal reflections on the pedagogy of this project and a chapter that analyses the data gathered across this project. This chapter will discuss the implications and recommendations drawn from this project.

This research and training project employed a cyclic approach in the spirit of action research to initially gather data by the use of a staff scoping survey to identify the psychological mindedness of staff and what type of talking therapy training needed developing. This data once analysed showed that the staff surveyed wished to gain a greater understanding of CBT and to be in receipt of formalised CBT training. Although the reliability and validity of this finding can be questioned, other sources both academic and policy driven, were used to support the approach taken. These findings supported the development and delivery of an eight-day CBT training course. Each course was developed following evaluation, and by incorporating students' feedback to support this process a practice development ethos was introduced to NSCCH which

supported the research and training project. This methodology was designed to enable ongoing development and delivery of CBT training and practice post completion of this research project.

## **7.2 Key findings:**

One key finding of the research and training project data evaluation, showed that there was a willingness across NSCCH to learn or enhance existing skills in talking therapies; notably CBT. This finding was one of the major components of the 'MoodMatters' survey; other findings of note were the limited number of clinicians offering talking therapy as part of their everyday practice, the professional breakdown of practicing clinicians and the number of clinicians in receipt of ongoing support and supervision, again limited. The key findings evidenced by the data analysis following the CBT training course and as indicated by the pre- and post- course questionnaires, showed that staff could increase their self-efficacy and reported readiness to use skills learnt, after attending an eight-day CBT training course. This was supported by a limited number of qualitative statements made by individuals that indicated an increase in ability and confidence post course completion. Based on my experiential knowledge of training in this area I found that by using a cyclic research approach across the 3 phases of the project it was possible to develop and fine tune the delivery and content of the CBT training course by involving participants in the evaluation and development of each course delivered, this I could not demonstrate from the data collected. I also noted experientially that my skills as an educationalist and researcher developed as the phases of the project progressed.

Questions I aimed to answer were:

Question 1; Can research methods developed and delivered in the spirit of action research, utilising theories of skills based education and learning, enable the development of usable CBT skills in mental health care by increasing clinician's self-efficacy? I can identify from the data analysis a positive move in respondents' clinical self-efficacy. It is more difficult to identify that the eight-day CBT course enabled the development of useable CBT skills but it certainly increased the clinicians' readiness to employ CBT skills learnt on the course, but from my experiential knowledge in this area and having provided supervision to the students I can ascertain that many of them were ready to introduce CBT as part of their clinical practice.

Question 2 asked; can an eight-week skills based CBT course increase mental health professionals' self reported readiness to use skills and increase their self-efficacy in the application of CBT in clinical practice? The analysed data showed that the course did enable mental health professionals to recognise their readiness to use skills and as indicated by some of the qualitative statements, their intention to start to develop these skills in their clinical practice. It also showed that their self-efficacy increased by attending the course, and again some of the (limited number of) qualitative statements showed an improvement at the pre- and post- data points in their perceived skill and confidence base. As with question one, having trained a great number of health professionals in this area either on short or longer courses, I have witnessed a marked increase in students' self-efficacy and readiness to use the skills they have learnt.

The final question attempted to ascertain if by introducing a practice development ethos to the sponsoring authority it would enable continued development and delivery of skills developed on the CBT training course. To achieve this will be largely dependent on the ability of the sponsoring organisation to provide enough support (via for example clinical supervision) to ensure that participants felt empowered to translate that readiness into actual clinical practice. From my experiential knowledge of the structures and practice development ethos developed across NSCCH, and having witnessed similar processes at other health care providers, notably the accreditation and ongoing journey of the practice development unit at Pembrokeshire and Derwen NHS Trust, leads me to believe that this development over time will enable the continued development and delivery of skills developed on the CBT training course. This will be an ongoing action point for NSCCH and potentially could have been monitored by repeating the post course questionnaire at a later date. Certainly the respondents I met with and spoke to post course completion were keen to continue with CBT practice development. To this end it is imperative that health care provider organisations in NSW, Australia, continue to develop a shared practice development ethos and strategy. The data analysed during the progress of this research project support and encourage these developments, as does my experiential knowledge across a long career in mental health care provision and education.

The pre- and post- course data analysis did not show any marked difference in the skills or views of the nurses when compared to that of the allied health staff, neither did it show any difference in the level of readiness to use

skills. The only areas where a difference was notable were in the questions that asked directly about psychopharmacology, where the nurses showed higher knowledge and acceptance levels, probably as medication is viewed as a nursing role. The question that asked 'should talking therapies only be delivered by allied health professionals?' revealed quite a difference with the nursing staff strongly disagreeing with the statement and the allied health staff strongly agreeing with it, again from my personal experience in Australia I would support this finding

The qualitative aspects of the CBT course questionnaire were completed only sporadically by the study population. This did not give enough data for an in-depth analysis to be conducted and thus the qualitative aspects of the analysis are missing from what became a more quantitative data set. But, I have included qualitative statement in the data analysis chapter when they show actual development from point 1 to point 2. This resulted in the evidence that was analysed and presented in this thesis being mostly quantitative. At the time of development of the CBT course questionnaire I was only just becoming aware of how little was known about talking therapies and their delivery by clinicians in NSCCH, as the research progressed I became more aware of this and from my own experiential knowledge in the field, noted a change in the psychological mindedness of trainees, and the host organisation as the research project progressed. This is not supported by the data analysed and presented in the previous chapter, as I was unable to show improvement over time due to the data storage and collection methods I employed.

From my own experiential knowledge of the field I hypothesised this was because I was asking respondents to comment directly on their CBT skills which

it turns out they did not have until after course completion, thus it was difficult for them to make comments about areas they were unsure of. The findings support that there was more qualitative data entered at the post-course stage, but again not enough to analysis pertinent to CBT skill development. They also support that some of the student statements show growth in the area of CBT application from point 1 to point 2 of the data gathering stage of the research project. Where data was available this has been included in the analysis as supporting statements to qualify the quantitative data analysed and presented in chapter 6.

### **7.3 Implications:**

The findings show that at the end of the course the views of respondents regarding CBT and its application or place in clinical practice in NSW were more positive than at the beginning as evidenced by the analysis chapter. Questions such as the 'The main reasons patients are not offered CBT is because it is too difficult' showed an increase from under 60% initial disagreement to over 90% disagreement post course. Most questions in this area showed a marked positive change between the start of the course and completion. Questions in Part D of the CBT course questionnaire were designed to gain an understanding as to how skilful (at that moment in time) the student felt in certain applications of CBT and talking therapies. Questions enabled the student to judge if they had increased their skill levels in CBT application, or acknowledged that they were ready to use skills developed during the course as they felt that their self-efficacy had improved and they felt more able to offer CBT. As in Part C, the findings show that there was a marked positive change between the two data gathering

points. The question ‘Testing beliefs about illness using cognitive behavioural techniques’ showed that at the start of the course under 15% of respondents felt skilled in this area, but at the end of the course over 90% of respondents felt ready to attempt this. As with Part C, of the CBT course questionnaire (appendix 2), the majority of the responses to the thirteen questions in this area showed a marked positive change between the start and completion of the course, and again this is supported by the findings. My experiential knowledge in the area and not to such an extent the findings of the project lead me to believe that there are major implications here for NSCCH as CBT practice will need to be supported if it is to continue. I believe that by placing CBT in all new job descriptions the authority has shown a positive move to continue developing and supporting the provision of CBT and other talking therapies across its practice domains, this could be looked upon as a direct result of course delivery, but cannot be supported by the analysed findings as this was not part of the data focus or analysis, but is supported by my experiential knowledge in the area.

#### **7.4 Recommendations:**

My experiential knowledge of CBT teaching and practice would support that the delivery of CBT and other talking therapy courses needs to continue in line with government policies and clinical practice guidelines, and a range of new National and local champions need to be identified and nurtured to ensure this does occur. The formative evaluation drawn from the delivery and development of the eight CBT courses would support the development and introduction of lecturer practitioner positions across NSW, with health and education sectors working jointly on developing services and researching service provisions. The

fact that the findings showed that students showed an increase in their readiness to use CBT in their practice would also offer support for this recommendation. From my experiential knowledge in this area those appointed to these positions must be given time to establish their academic credentials and be able to maintain clinical credibility to teach and supervise ongoing CBT and talking therapy courses. The findings to an extent support the aim that talking therapy provision should become part of standard care across NSW and Australia. This would negate the need for individual health services to go it alone in future developments.

From my experiential knowledge in this area I can say that it is now accepted that CBT should form part of standard care provision, this is supported by the literature review that was conducted as part of this research project and reported in chapter 2, and that the life benefits to patients and their carers are good.

Research has also shown there to be a cost benefit when you compare CBT and other talking therapies to standard care priced on bed day usage (Brooker, 2001), a cost benefit analysis was not part of this project, but from my experiential knowledge in this area and results from an audit I conducted across Hywel Dda Health Board in 2010 supports this cost differential. CBT is cheaper to provide as staff do not cost as much as a night in hospital which in Sydney equated to about \$800. There are also many positives to having a skilled and motivated workforce at your disposal, who are able to work with patients and patient groups to achieve patient focused recovery from mental health difficulties.



## **7.5 Discussion:**

Conducting any research project is a personal journey of discovery, but I found that adopting methods and practices broadly in the spirit of action research, delivered in a practice development model or paradigm enabled me to share this journey with others, this in itself made the research journey a more shared and collaborative venture. I have grown and developed as a researcher and educator by undertaking this journey, and I hope that the people who undertook it with me have too.

The research findings show that the respondents learnt about CBT practice and increased confidence in their self reported readiness or self-efficacy to use CBT skills and eventually deliver CBT to their patients. From my experiential knowledge in this area I can say that evidence drawn from post-course evaluations show that some respondents also gained awareness of research with a number developing post- course CBT practice initiatives in their own clinical areas, whilst some also went on to deliver CBT training post completion of course.

From my experiential knowledge in this area and having worked extensively both in the UK and Australia as a nurse, educator and cognitive behavioural psychotherapist, I saw an area where there was the potential to roll out an evidence-based intervention with proven efficacy for patients. I had developed and taught a number of CBT based training programmes in the UK, but had never implemented a research project to run in parallel with the training. As the availability of psychotherapies in NSW was limited, I thought that

the introduction of a self-sustaining training course would have a good chance of succeeding and training staff in therapeutic interventions.

From my experiential knowledge in this area I considered it necessary to develop a notion of ownership across NSCCH, and of a 'team' within and beyond each cohort of CBT respondents taught. I nurtured the 'team' as active research participants and on occasion's research or course leaders. This team model was designed to develop a peer support network where individual cohort members could go to others in their group for support and advice. One of the positive effects of this was the development of a peer support network for CBT across NSCCH services, and some very keen and motivated participants, who felt empowered to attempt to replicate certain elements of the educational course in their clinical settings.

As time progressed local journal clubs were to be developed, and CBT champions would be identified in each of the health services regions. I actively evaluated all training programmes after the study day and more formally at the middle and end of the course. These evaluations informed immediate change to the ongoing programme and revisions to the next planned course structure and delivery. This process was one of the research cycles that enabled in-put into the course. It recognised the vast skills and experience of participants in their current roles and their desire to increase their CBT knowledge and experience within their learning frameworks. Participants thus were able to fine tune delivery of the course for themselves and for the next group, this was supported by the formative pre-project work and ongoing course evaluations, these

findings are not part of the data set presented in the analysis chapter but from my experiential knowledge in this area I witnessed their development.

I became involved with the development and growth of each cohort taught, and the findings showed that the respondents themselves developed skills, and from my experiential knowledge in this area I recognised that these skills could not only be utilised for course developments, but for developments in their own clinical areas. The findings show that these skills were developing across all the cohorts taught, but due to my data collection methods I am unable to show that these skills improved over time, but from my experiential knowledge in this area I could see that they were used differently by different respondents and areas. I was lucky enough to identify one participant from cohort one, who following coaching and recognition of his existing skill set; I was able to nurture as a co-teacher, researcher and facilitator on all subsequent courses delivered.

From my experiential knowledge in this area I found that my interpersonal skills developed greatly during course delivery, and that I became more able to share my own psychotherapeutic and teaching skills with the respondents, as with the point above this did not form part of the research project but I was personally able to track my development as an educationalist and novice researcher. This I did by discussion of cases I had treated, modelling therapeutic work in class by role-played clinical examples and on-going supervision of attendees, and my own personal supervision. The respondents stated in ongoing evaluations that they enjoyed and gained a lot from this area, so it was subsequently utilized in all future training I have delivered. This

evidenced the direct feedback and feed forward that the respondents had to the developmental nature of the cycles developed both pre- and during course delivery.

My educational delivery and evaluation skills developed and I became aware of the joint nature of the research being undertaken, and the place of the respondents in the process. Action research is like a 'growth journey' shared with the participants involved in the research process, actions are always being added to the initial design and outcomes grow by sharing the process with the burgeoning number of respondents taught. At the beginning of each course the participants would be given an introductory morning to the course, the research component information, questionnaire to complete and an option to attend the course without participating in the ongoing research. None of the student population refused to participate and a number of them became active researchers post course completion. The cyclic research model deployed encouraged and enabled active participation in the research process (and generally greater participation with increased confidence), and this then started to break down the barriers between course participants and the management structures of NSCCH.

My prior experience in this area leads me to believe that the active elements of the research process had a direct impact on course delivery and evolution. I began with an eight-day CBT course but feedback from course participants, and managers led to the development of an additional study day in CBT for psychosis. Following on from this development and further feedback, a three-day intensive CBT module was developed to deliver useable therapy skills

to a greater number of core mental health staff, who would eventually be supervised by their more skilled colleagues who had attended the eight-day course. After this project finished a number of ex-respondents who completed the eight-day course and had expressed an interest in becoming involved with the ongoing dissemination were recruited and offered the opportunity to gain further teaching and supervision skills. To do this they were supervised and mentored by either myself or the co-course leader or critical companion identified from cohort one. These co-researchers became the identified CBT Champions in their specific clinical areas, supervised and led by the co-course leader, who eventually took on the role of Practice Development Lead for NSSCH services, and continued the ongoing CBT developments.

As a researcher I have learnt that it is important not to be overly ambitious when developing ones research project and to spend more time on the actual foundation aspects of the research process. It is important to have all parties on-board and be cognisant of your research ideas. The methods have to be meticulously planned and implemented and understood by the participants involved.

The methodology underpinning the process also needs to be transparent, and theoretically supported. The importance of understanding and developing your research construct is paramount, as is identifying the correct research approach to enable completion of the project. I found using a model that was broadly in the spirit of participatory action research, meshed well with the core theoretical model of education and CBT developed throughout the process. I have increased my skills as a researcher by adopting this approach, but am

cognisant that a mixed methods approach of gathering both qualitative and quantitative data sets needs to work within the research model adopted; the findings also support this statement as they were predominantly quantitative. With this project there was a limited amount of qualitative data gathered that didn't enable a focused analysis and identification of themes. The adoption of a scale devised in the UK missed elements of service provision and population demographics in NSW, Australia. I found the process of enabling participants to become involved with the project as active members both enjoyable and on occasions challenging, but, enjoyable as you get to see the participants owning the developments that resulted from the process, and challenging because some of the course revisions due to evaluation and feedback, I would not have contemplated if I had been delivering a stand-alone educational programme. The course developed at a quicker rate than I was used too, and I sometimes felt unsure as to the direction we were taking, and to my ability to deliver it. My co-worker was thus invaluable for discussions and support at these points. The findings as they were unable to show improvements and development over time are unable to support this but my experiential knowledge in this area does.

I have become aware that I need to be more systematic in my data collection methods, as a number of questionnaires could have been lost if I wasn't there to collect them, and the way I stored the data for transport home to the UK made it impossible to carry out a statistical analysis of individual pre- and post- questionnaires, a weakness of the model.

I am also aware that by developing the respondents there was a possibility they may have been keen to submit the data requested and also to

have answered the questionnaire more positively to enhance the research outcome, to make me look more favourably upon them. This was countered by the anonymity of each pre- and post- questionnaire, which again made the data analysis more problematic in some respects.

Conducting this research project and drawing on my experiential knowledge in this area, has made me aware of areas of unmet need within mental health care in NSW, Australia, this is also supported by the findings that showed development in readiness to use skills learnt, but highlighted the lack of CBT based therapy provision on the ground. I have drawn these areas to the attention of service providers and developers. I have also learnt that I enjoy the challenges of conducting research, and enabling others through the research process to conduct research themselves, and to gain skills in areas they may not have had before, thus lifting skills upwards and broadening services that can be offered to patients, a finding that is supported both by research as has been outlined in this thesis and my experiential knowledge in this area.

## **7.6 Conclusion:**

The findings show that the analysis of this project evidences a change in mental health professionals' self-reported readiness to use skills learnt on an eight-day CBT training course. This would indicate that the respondents' self-efficacy and belief in their ability to offer CBT to their patients has developed too. Anecdotal evidence post-project completion has to an extent shown that you can also train staff to deliver some low level CBT techniques after attendance on an intensive three day course, to achieve this support structures and a service delivery ethos either needs to be in place or adopted by the sponsoring

organisation. The implication of this if born-out by ongoing research will impact significantly on service delivery in rural and remote areas of NSW.

The findings show that by training staff to offer CBT (and evidencing an increase in their self-reported readiness to use skills learnt during training) will over time improve the availability of CBT to patients in NSCCH. From my experiential knowledge in this area I can attest to that by offering a research based talking therapy the profile of nursing care delivery should move away from a custodial focus to a therapy and psychological focus, thus introducing a level of psychological mindedness to the profession at NSCCH. The findings show that to an extent the project has also made nurses aware of the place and value of supervision in both maintaining and advancing practice. This aspect of the project is ongoing and developing as the practice development ethos grows to encompass all areas of practice at NSCCH.

From my experiential knowledge in this area, mental health nurses who are aware of their personal development requirements in relation to cognitive behavioural psychosocial interventions might consider how to develop their own practice with the support and guidance of a CBT practitioner. Many cognitive behavioural and psychosocial intervention focused courses now exist in the UK and are designed to equip professionals with the necessary skills to practice (Hannigan and Coffey, 2003), this is presently not so in NSW, Australia. The other necessary component of the translation of learning to practice is the provision of targeted and modality specific supervision, again supported by the findings of this project. This supervision needs to be provided by an individual equipped to deliver the high levels of support and guidance needed. This as well as the



adoption of an experiential learning model by NSCCH supported the development and delivery of this research project, and should enable the continued development of staff who feel ready and empowered to use their skills in practice. The expansion of the availability of CBT in NSW for patients and their carers was one of the desired outcomes for this research project.

From my experiential knowledge in this area tells me that to enable the continued growth and development of CBT further research and training initiatives need to be developed. As with all talking therapies ongoing support and supervision is an integral element of the successful delivery of the therapy and CBT is no exception. There is a developing movement in Australia to empower and enable mental health nurses to participate in the ongoing delivery, development and targeting of CBT as an integral component of mental health service provision (NSWDOH, 2006, 2007); these developments are supported by the findings of this research project. A number of educational institutions and area health services are developing CBT based courses to enable staff to deliver cognitive behavioural therapy, dialectical behaviour therapy, family work and adherence therapy. This is being supported on the ground by the development of targeted supervision structures and networks, and at a tertiary education and health department level by the development of joint training initiatives and policy formulation.

From my experiential knowledge in this area I would say that one of the strengths of this project was the adoption of a Practice Development ethos and strategy across the sponsoring health service. The findings showed that this strategy could be thought of to empower staff who attended the course to move

towards practicing CBT post- course completion. This was further enhanced by NSCCH stating that the nurse had to provide CBT to their patients, by placing CBT provision into all new or re-advertised jobs and position descriptors. The shortened three-day CBT course was also included in the NSCCH mental health staff induction programmes and due to the findings of this research project it was expected that all nursing staff in positions where clinical contact formed the bulk of their role attended the eight-week CBT course.

### **7.7 Further research:**

A project to ascertain whether or not the sponsoring agency committed to the ongoing support and development of the CBT practitioners should be developed to see if they are able to use CBT skills and continue to develop their self-efficacy and their skills post course completion.

The respondents who attended the CBT training course should be followed up and complete a further CBT course questionnaire to see what progress has been made in practice. Further development of the questionnaire to enable data to be gathered pertinent to actual clinical skill deployment would be recommended.

### **7.8 Final thoughts:**

The findings show that this project has shown that it is possible to increase the self-efficacy of staff with limited or no prior knowledge of CBT, who after attendance on an eight-day CBT course, feel they are ready to use skills developed during the course in their practice. From my experiential knowledge in this area this leads one to believe that if mental health professionals are given good quality CBT training, if they are in receipt of targeted clinical supervision

and are able to practice in a supportive environment, over time they will be able deliver low level CBT as part of their clinical skills set. This in turn will lead to increased opportunities for patients to receive an evidence-based intervention of proven and developing efficacy, that has been shown if applied correctly to bring about improvements in patient care. The findings of this research project have shown that you can increase clinicians' readiness to use CBT in practice and improve their self-efficacy and willingness to introduce CBT to their clinical work. Likewise my previous knowledge in this area gives me greater confidence that the practice development ethos developed across NSCCH will support the staff who are leading this development of CBT provision, and also the clinicians offering CBT in practice.

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## Appendix 1 'MoodMatters Survey.



NORTHERN SYDNEY  
CENTRAL COAST  
NSWHEALTH

### **'MoodMatters'**

#### Staff Scoping Survey

In order to work towards achieving greater consistency across the Area, the members of the Psychosocial Working Party have worked together to develop a brief survey of current levels of staff therapeutic skills.

The purpose of this anonymous survey is to provide a snapshot across the Area of current provision of therapy; including the modality of therapies being provided, how much time is spent in therapy and what, if any, training needs are required.

We ask that all **Psychiatrists, Nurses, Psychologists, Social Workers, and Occupational Therapists** (even if you do not undertake any therapy), take the time to complete this brief survey by the **21<sup>st</sup> March**.

*It is important that we have responses from all multi-disciplinary groups whether you undertake therapy or not.*

Once the survey is completed, **please return it to your service director via your team leader** who will then pass it back to us.

The research project team in anticipation thanks you for your response and appreciates the time you have taken to complete the survey.

# Psychological Therapies Survey

## Section A: Information about you

### 1. Gender

Male  Female

### 2. Year of qualification

In what year did you obtain your professional qualification? Year: 1987\_\_\_\_

### 3. Clinical Practice

How many years in direct Clinical Practice? \_\_20\_\_\_\_

Do you currently use psychological interventions in your clinical practice? Yes/No

### 4. Professions

What is your profession?

- a. Registered Nurse
- b. Physician/Medical Doctor
- c. Psychologist
- d. Clinical Psychologist
- e. Occupational Therapist
- f. Social Worker
- g. Enrolled Nurse
- h. Other (specify)  \_\_\_\_\_

### 5. Academic qualification

What is your highest academic qualification?

- a. Certificate
- b. Diploma
- c. Degree
- d. Post Grad Cert/Dip
- e. Masters
- f. MPhil/PhD
- g. Other (specify)  \_\_\_\_\_

### 6. In what clinical setting do you mostly work?

- a. Acute inpatient
- b. Non-acute inpatient
- c. Community Mental Health  (circle) Acute / Non-Acute / Mixture
- d. Other, please specify  \_\_\_\_\_

### 7. In what sector do you work?

- a. Central Coast
- b. Ryde/North Shore
- c. Hornsby Ku-ring-gai
- d. Northern Beaches

**Part Two: Psychological therapies I am able to deliver competently:**

**8. Please mark those therapies you can deliver and whether you have any interest in further training.**

	Do you currently deliver this therapy  Y/N	Rate from 0-5 your skill level in this therapy 0 = very unskilled 5 = very skilled	List training source Options: a-g  <i>(Refer to legend below table)</i>	Interest in further training?  Y/N
Supportive counselling				
Cognitive Behavioural Therapy				
Dialectic Behaviour Therapy				
Behavioural Therapy				
Family Therapy (Systemic)				
Schizophrenia Family Work				
Rational Emotive Behaviour Therapy				
Psychodynamic Psychotherapy				
Medication Management/Concordance Therapy				
Transactional Analysis				
Cognitive Analytical Therapy				
Interpersonal Therapy				
Narrative Therapy				
Cognitive Remediation Therapy				
Motivational Interviewing				
Acceptance and Commitment Therapy (ACT)				
Mindfulness-based Cognitive Therapy?				
Any other psychological therapies please list below:				

**Training Source Legend**

**For each therapy: indicate the source (if any) of your training**

- a.** As part of my studies (e.g. degree)
- b.** Short courses

- c.** 1-2 day workshops
- d.** Supervision
- e.** On the job training
- f.** Other (specify)
- g.** Nil, I have no training

**9. How skilful do you feel you are in the following? (mark with an 'x')**

	Very skilled	Skilled	Neither skilled or unskilled	Unskilled	Very unskilled
a. Assessing mental health symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Assessing psychosocial context	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Engaging consumers in a therapeutic relationship.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Working collaboratively with consumers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Working collaboratively with family members	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Giving consumers information about their illness or therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Problem solving issues about therapy with consumers.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**ABOUT YOUR PRACTICE**

**10.** Do you consider the delivery of psychological interventions part of your current position? Yes/No

**11.** How many hours per week, if any, do you estimate you would undertake psychological therapies?  
 8 \_\_\_\_\_

**12.** With what population do you mostly use psychological therapies?  
 \_\_\_\_\_

**13.** Do you receive any formal supervision Yes / No / Informal

**14.** If yes, please circle what format of supervision? Individual / Group / Peer

**15.** How many hours per month do you receive professional supervision?  
 \_\_\_\_\_



**16.** Please list any measures/tools/instruments that you routinely use in practice to assess/monitor psychological symptoms in patients.

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**17.** Any additional comments or areas you think have been missed?

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**Thank you, Area Mental Health Services.**

## Appendix 2 CBT Questionnaire.



### **Cognitive Behavioural Therapy Course**

This questionnaire is in 3 parts

- Part one should be completed now at the start of training
- Part two will should be completed at the end of training
- Part three should be completed six months after the end of training

The person who is training you will give or send you the 3 parts of the questionnaire at the appropriate time. You are encouraged to complete and return it as soon as possible. The information that you give will be held in the strictest confidence and held on a computerised database at the Institute of Psychiatry, Kings College, London, and Macquarie Hospital Nurse Education Department, North Sydney Central Coast Area Health. It will not be possible to identify you individually from the questionnaire.

#### **Centre use only**

Course Number:

No of training hours: 1 day  3 days  8 days  other  specify \_\_\_\_\_

#### **Part one: to be completed on the first day of training**

Pre-Training questionnaire

Date of completion [dd/mm/20yy]

\_\_\_/\_\_\_/20\_\_

#### **Section A: Information about you**

##### **Gender**

1. Male

2. Female

**Age** How old are you? \_\_\_\_\_ Years

### Year of qualification

In what year did you obtain your professional qualification (e.g. as a nurse)? 19 \_\_\_\_\_ Or  
20 \_\_\_\_\_

### Ethnicity

What is your ethnic origin?

1. Black
2. White
3. Asian
4. Other  specify \_\_\_\_\_

## Professions

What is your profession?

1. Registered nurse (ward based)
2. Registered nurse (community)
3. Physician/medical doctor
4. Psychologist/clinical psychologist
5. Occupational therapist
6. Social worker
7. Other (specify)  \_\_\_\_\_

### Academic qualification

What is your highest academic qualification?

1. Certificate
2. Diploma
3. Degree
4. Masters
5. Mphil/PhD
6. Other (specify)  \_\_\_\_\_

## ABOUT YOUR PRACTICE

Please be as thorough as possible when answering these questions.

1. Please list the measures/tools/instruments that you routinely use in practice to assess/monitor **psychological symptoms** in patients.

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2. Please list the measures/tools/instruments that you routinely use in practice to conduct CBT with your patients.

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3. Please list the measures/tools/instruments that you routinely use to assess/monitor patient's **beliefs/attitudes** towards therapy.

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4. Please make comments on how you feel you apply talking therapies with patients?

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**Continued on next page**

### Your views about CBT

Listed below are 20 statements about talking therapies. What do you think? Remember there really is no right answer!

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1. The Main reason patients are not offered CBT is because it is too difficult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients should be allowed to refuse therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. It is part my role to persuade patients to accept therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Working collaboratively with patients is a vital clinical skill.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Telling patients about the possible side effects of medication may put them off taking it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If a patient doesn't want CBT there is nothing I can do to persuade them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Talking therapies are the responsibility of the allied health staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Non-compliance with medication will result in a worse long term outcome for patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Giving people written information about their treatment will enhance compliance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. A patients lack of awareness (or insight) about their mental health problems is a major cause of non-compliance with treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Most patients are not sure whether taking medication is a good idea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I do not feel I have the knowledge to give patients authoritative advice about talking therapies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I am happy talking to patients about the effects of talking therapies on their level of function.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Prohibition is the only way to stop patients using non-prescribed drugs [alcohol/cannabis etc]	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

15. The higher the dose of antipsychotic medication the more likely it is to get rid of psychotic symptoms.
16. My instinct/intuition/experience is as good at assessing a patient as any outcome measure.
17. I genuinely believe that talking therapies will help patients.
18. Non compliance is simply a patient expressing their desire for personal autonomy.
19. I have no influence on what medication the doctor prescribes.
20. CBT is effective in reducing psychotic symptoms in the majority of patients.

## Your views about your skills

**How skilful (at this moment in time) do you feel you are in the following?**

	Very skilled	Skilled	Neither skilled or unskilled	Unskilled	Very unskilled
1. Assessing psychotic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessing the side effects of antipsychotic medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assessing depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assessing cognitive dysfunction.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Exploring ambivalence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Drawing an illness timeline with the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Working collaboratively with patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Engaging patients in a therapeutic relationship.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Testing beliefs about illness using cognitive behavioural techniques.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Giving patients information about their illness or therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Avoiding Confrontation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Problem solving issues about therapy with patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Avoiding debating therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



**Part Two: to be completed at the end of training**

Post-training Questionnaire

Date of completion [dd/mm/20yy]

\_\_\_/\_\_\_/20\_\_

**ABOUT YOUR PRACTICE**

Please be as thorough as possible when answering these questions.

1. Please list the measures/tools/instruments that you routinely use in practice to assess/monitor **psychological symptoms** in patients.

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2. Please list the measures/tools/instruments that you routinely use in practice to conduct CBT with your patients.

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3. Please list the measures/tools/instruments that you routinely use to assess/monitor patient's **beliefs/attitudes** towards therapy.

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4. Please make comments on how you feel you apply talking therapies with patients?

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**Continued on next page**

## Your views about CBT

Listed below are 20 statements about talking therapies. What do you think? Remember there really is no right answer!

	Strongly agree	Agree	Not sure	Disagree	Strongly disagree
1. The Main reason patients are not offered CBT is because it is too difficult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Patients should be allowed to refuse therapy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. It is part my role to persuade patients to accept therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Working collaboratively with patients is a vital clinical skill.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Telling patients about the possible side effects of medication may put them off taking it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. If a patient doesn't want CBT there is nothing I can do to persuade them	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Talking therapies are the responsibility of the allied health staff	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Non-compliance with medication will result in a worse long term outcome for patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Giving people written information about their treatment will enhance compliance.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. A patients lack of awareness (or insight) about their mental health problems is a major cause of non-compliance with treatment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Most patients are not sure whether taking medication is a good idea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. I do not feel I have the knowledge to give patients authoritative advice about talking therapies.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. I am happy talking to patients about the effects of talking therapies on their level of function.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Prohibition is the only way to stop patients using non-prescribed drugs [alcohol/cannabis etc]
15. The higher the dose of antipsychotic medication the more likely it is to get rid of psychotic symptoms.
16. My instinct/intuition/experience is as good at assessing a patient as any outcome measure.
17. I genuinely believe that talking therapies will help patients.
18. Non compliance is simply a patient expressing their desire for personal autonomy.
19. I have no influence on what medication the doctor prescribes.
20. CBT is effective in reducing psychotic symptoms in the majority of patients.

## Your views about your skills

**How skilful (at this moment in time) do you feel you are in the following?**

	Very skilled	Skilled	Neither skilled or unskilled	Unskilled	Very unskilled
1. Assessing psychotic symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Assessing the side effects of antipsychotic medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Assessing depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Assessing cognitive dysfunction.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Exploring ambivalence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Drawing an illness timeline with the patient	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Working collaboratively with patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Engaging patients in a therapeutic relationship.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Testing beliefs about illness using cognitive behavioural techniques.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Giving patients information about their illness or therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Avoiding Confrontation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Problem solving issues about therapy with patients.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Avoiding debating therapy.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Appendix 3 CBT Course Handbook



NORTHERN SYDNEY  
CENTRAL COAST  
NSW HEALTH

Clinical Practice Development Unit

### **Area Mental Health Nursing Administration**

Macquarie Hospital Campus

## **Title: Cognitive Behavioural Assessment and Intervention Skills**

**(8 week skills based course)**

Course Handbook

**MHNSCCH: CPDU.**

### **SECTION ONE: KEY INFORMATION**

Welcome to this course in which you will learn about Cognitive Behavioural Assessment and Intervention Skills.

This module will form the foundation for your future practice in Cognitive Behavioural Therapy (CBT). It will provide you with the theoretical and practical underpinnings of the model. As well as training you how to assess and formulate cognitive behavioural clinical cases.

This course is designed to target, enhance and augment mental health professionals' knowledge and clinical skills in CBT. It further aims to address the identified need of the introduction of CBT for Psychosis into long term hospital care and subsequently into the community setting by facilitating the

development of reflective practitioners who are able to develop and deliver CBT based care packages drawing upon their advanced and targeted communication and interpersonal skills. It enables practitioners to develop new knowledge and facilitates and enhances the skills needed to make accurate and systematic assessments of clients needs.

The course provides a standardised framework, mode of intervention delivery and a rationale to practice within. The course is delivered within the theoretical and clinical boundaries of the stress and vulnerability model. Emphasis will be given to the development of a broad repertoire of research based, assessment and psychosocial intervention skills, drawing upon psychosocial theories, stress and vulnerability and a cognitive behavioural model of clinical work.

The module will form the practice foundation for the remaining clinical courses presently being developed in the Clinical Practice Development Unit, NSCCH and UWS and inform and teach CBT focused clinical skills within the patient arena.

#### **Course Leader and Course Team Members;**

Your Course leader is Euan Hails, Area Clinical Nurse Consultant and Cognitive Behavioural Psychotherapist.

Your course team is Kris Taylor, Clinical Nurse Consultant, Hornsby, NSCCH.

You can contact them all at:

Clinical Practice Development Unit, Nurse Education Department at Nurse Administration, Macquarie Hospital, North Ryde.

Telephone 02 98875082

Euan's email is [EHails@nscch.health.nsw.gov.au](mailto:EHails@nscch.health.nsw.gov.au)

## Course Rationale:

This course aims to introduce mental health practitioners to the underlying theory and practical techniques of Cognitive Behaviour Interventions for use with people with a serious and enduring mental illness. Cognitive Behaviour Therapy (CBT) has been developing over the last fifty years as a psychological treatment, and has been recognised as a treatment of choice for a number of psychological conditions. It has been particularly well evaluated in outcome studies and empirical research, providing an evidence base for practice and efficacy for working with people with anxiety and depression. More recently research has shown its value in psychosis. CBT involves working collaboratively with clients and helping them to recognise and change patterns of distorted thinking and dysfunctional behaviour. Goals are negotiated and an action plan devised using verbal and behavioural reattribution strategies.

CBT has been established as an effective method of helping, counselling and psychotherapy used as an alternative or in combination with more traditional methods of treatment such as medication. CBT is being used by a variety of mental health practitioners working in specialist roles and as techniques, which can be integrated, with other therapeutic approaches. The course would be of immense benefit to professionals working with people with serious and enduring mental health problems in health and social care settings including nurses, occupational therapists, social workers, counsellors, psychologists and psychiatrists.

Cognitive Behavioural Therapy (CBT) is an established model of psychotherapy which is increasingly accepted as a valid and robust set of interventions successfully applied to the treatment of a wide range of psychological disorders. This course is provided for Mental Health Professionals wishing to develop a specific skills based focus for assessment and intervention within a cognitive-behavioural framework.

Areas of study will include:

- Empirical Measures within Cognitive Behavioural Therapy
- Pragmatic Interviewing
- Disorder specific assessment and treatment protocols
- Application of Evidence Based Interventions to Clinical Practice



This course will be 8 weeks in duration, with an appropriate mix of classroom and clinically based learning.

**Course aims:**

1. To develop participants' knowledge and understanding of cognitive behavioural approaches used in clinical practice.
  
2. Insofar as cognitive behavioural therapy treatment is geared towards providing opportunities for utilising new learning that will facilitate change and enhance the patient's behaviour it is also recognised that the course will enhance clinical practice.

**Timetable:**

	Times	Content	Teacher	Venue
	0930-1630	Overview of historical development of CBT & Evidence base	Euan	
	0930-1630	Outline of underlying principles and assumptions	Euan	
	0930-1630	CBT/Stages and structure of therapeutic work	Euan	
	0930-1630	Engagement with clients with complex needs	Euan	
	0930-1630	FBA/Assessment tools. Making a formulation	Euan	
	0930-1630	Normalising / education strategies / CBT techniques	Euan	

	0930-1630	Clinical time		
	0930-1630	Clinical time		
	0930-1630	Relapse prevention	Euan	

## Learning Outcomes

By the end of the course, the participant will be able to:-

1. Have a detailed knowledge of assessment, and skill to assess by using validated standardised measures the needs, problems and strengths of patients.
2. Practice within the dimensions of the stress and vulnerability model.
3. Perform and analyse a functional/behavioural analysis of problems collaboratively with patients, recognising their abilities to engage in the assessment.
4. Formulate a coherent cognitive behavioural case conceptualisation.
5. Design an effective plan of care based on evidence in collaboration with the patient recognising the nature of the patients'.
6. Identify ways of influencing the organisation to enable the barriers to the application of CBT to clinical practice can be overcome.
7. Think about the roles of others within the multi professional team, and the significance of inter-disciplinary working.
8. Introduce the PSI/CBT model taking into account the evidence basis, demonstrating effective practice as a CBT worker.

## Course content:

The course consists of one module, which will be recognised by the Education Department and Hospital Executive Macquarie Hospital as a site based CBT training program. We are also looking into the feasibility of accrediting the course with a local University as a PGCert. The module aims to develop the

participant's knowledge, skills and competence in the principles of, engagement, assessment and formulation, and use of CBT interventions, appropriate to working with people with serious and enduring mental illness.

- Overview of historical development of CBT
- Outline of underlying principles and assumptions of CBT
- Evidence base of CBT
- Stages and structure of therapeutic work
- Engagement with clients with complex needs
- Assessment and engagement tools
- Making a formulation
- Normalising/education strategies
- CBT techniques
- Managing risk
- Relapse prevention

**Methods of learning and teaching:**

A variety of methods will be employed, such as lectures, seminars, problem-solving exercise and group presentations. Student-centred learning will be promoted, encouraging wide reading, discussion and inquiry.

## Core Texts:

- Beck, A.T., Emery, G., & Greenberg, R. (1985). *Anxiety disorder and phobias: a cognitive perspective*. London: Basic Books/Harper Collins.
- Beck, A.T., Freeman, A.M. (2003). *Cognitive therapy of personality disorders*. (2<sup>nd</sup> ed.). London: Guildford Press.
- Bruch, M., & Bond, F.W. (1998). *Beyond diagnosis: case formulation approaches to CBT*. New York: Wiley.
- Clark, D.M., Fairburn, C.G. (1997). *The science and practice of cognitive behaviour therapy*. Oxford: Oxford University Press.
- Davidson, K. (2000). *Cognitive therapy for personality disorders*. Oxford: Butterworth Heinemann.
- Hawton, K. (1989). *Cognitive behaviour therapy for psychiatric problems: a practical guide*. Oxford: Oxford University Press.
- Kazdin, A.E. (2000). *Behaviour modification in applied settings*. (6th ed.). Belmont: Wadsworth Thomson Learning.
- Kingdon, D., & Turkinton, D. (1994). *Cognitive behavioural therapy of schizophrenia*. Hove: Psychology Press.
- Kingdon, D.G. (2000). *The case study guide to cognitive therapy of psychosis*. London: Wiley.
- Greenberger, D., & Padesky, C.A. (1995). *Mind over mood: change how you feel by changing the way you think*. London: Guildford Press.
- Morrison, A.P. (2003). *Cognitive therapy for psychosis: a formulation based approach*. London: Bruner-Routledge.
- Persons, J.B. (1989). *Cognitive therapy in practice: case formulation approach*. New York: Norton.
- Richards, D., & Macdonald, R. (1990). *Behavioural psychotherapy: a handbook for nurses*. London: Heinemann.
- Sheldon, B. (1995). *Cognitive behavioural therapy: research practice and philosophy*. London: Routledge.
- Tarrier, N., Wells, A. & Haddock, G. (1999). *Treating complex cases: the cognitive behavioural therapy approach*. Chichester: Wiley.

Wells, A. (1997). *Cognitive therapy of anxiety disorders: a practice manual and conceptual guide*. Chichester: Wiley.

Wright, J.H., Thase, M., Beck, A.T., & Ludgate, J.W. (1993). *Cognitive therapy with inpatients: developing a cognitive milieu*. New York: Guildford Press.

Zubin, J, Spring, B (1977) Vulnerability - a new view of schizophrenia. *Journal of Abnormal Psychology*. 86 (2) 103-126.

## **Appendix 4 Ethics Bid.**

Northern Sydney Health Human Research Ethics Committee

### **Unit One:**

### **Core Application Form**

Please read the *Unit One: Core Application Form Guidelines* before you begin

#### **Full Study Title**

Part A - The delivery of psychosocial cognitive behavioural therapy training to nurses and care co-ordinators.

#### **Short name by which the study will be known (if applicable)**

Cognitive Behavioural Therapy Training course.

#### **Indicate the location(s) where the study will be undertaken in Northern Sydney Health**

Macquarie Hospital Campus + NSCCH sites.

#### **List the sites other than the above location(s) where the study will be undertaken**

N/A

### Summary of the study in plain English (in less than 200 words)

The cognitive behavioural therapy (CBT) service will offer holistic person centred and evidence based talking therapies training to nurses and care co-ordinators who will then work with individuals suffering distressing positive symptoms of psychosis, or secondary emotional problems to offer over time, a self-help type of therapy consisting of talking to clients about their prioritised difficulties, how they arose and what they understand about them. The aim is not necessarily to get rid of symptoms but to alleviate distress and disability. New ways of reframe experiences or new strategies to cope - are discussed and practiced outside of sessions. There will also be an educational/supervisory component implicit within the service design to enable mental health professionals to teach using a cascade model, CBT interventions to their colleagues. The service will offer up to date holistic evidence based intervention and also conduct focused research and training during the delivery of care. Consultative guidance will also be offered pertinent to on-going patient care.

### Investigator Details

Please note that all correspondence will be addressed to the Chief Investigator

#### Chief Investigator

Name: Euan Hails

Title: Mr

Qualifications: RMN, MSc (CBT), DIP HE (Thorn), Dip PSY/Con, Degree Level Thorn, PGCE, RNT, ENB A48,

Positions Held: Area Clinical Nurse Consultant – 3 & Cognitive Behavioural Psychotherapist.

Full Mailing Address: Macquarie Hospital, PO Box 169, North Ryde, NSW, 2113

Telephone Number: 02 98875082

Fax Number: 02 98887186

E-mail Address: [EHails@nsccha.health.nsw.gov.au](mailto:EHails@nsccha.health.nsw.gov.au)

#### Co-Investigator Details (please copy this section if necessary)

Name: Mark Ayling

Title: Mr.

Qualifications: MSc, BSc, RN,

Positions Held: Acting Service Director Macquarie Hospital.

Full Mailing Address: Macquarie Hospital, PO Box 169, North Ryde, NSW, 2113

Telephone Number:

Fax Number:

E-mail Address: [MAyling@nsccahs.health.nsw.gov.au](mailto:MAyling@nsccahs.health.nsw.gov.au)

Name:

Title:

Qualifications:

Positions Held:

Full Mailing Address:

Telephone Number:

Fax Number:

E-mail Address:

Data Manager(s) Details (if applicable)

Name:

Title:

Full Mailing Address:

Telephone Number:

Fax Number:

E-mail Address:

**Discipline** (for the study):

Nursing

Medical

Psychology

Science ✓

Other

**Is this a student study?**

Yes ✓

No



If yes, please state the supervisor:

Dr. A Crowther.

### Proposed commencement date of the study

Applicants are reminded that projects may not commence without written approval from the HREC

01/08/07

### Proposed duration of the study Two years

### Has this study been submitted to any other HREC?

Yes  If yes, please complete the table below and attach all correspondence

No

Site	Approved by HREC?	Correspondence attached? (Y/N)

### Does the research involve a sponsor (e.g. pharmaceutical company or other commercial entity – please see guidelines for definition)?

Yes  If yes, refer to the NSH HREC Legal Guidelines for additional Requirements

Sponsor's Name \_\_\_\_\_

No

## Funding

Is the study part of an application for research funding?

- Yes  If yes, please complete the table below  
 No  If no, please go to question 9

Funding Body	Status of Funding		Amount (please include this in section 16 - Budget)
	Applied For Yes/No	Granted Yes/No	

Will the research proceed if funding is not obtained?

- Yes  No

## Nature of the Research

Give details on the nature of the research (e.g. questionnaire, psychology, behavioural research, human tissue research and drug trial).

**NB: If the project uses drugs or therapeutic devices you must also complete *Unit Two: Application for Use of Drugs and Therapeutic Devices*.**

The research will be delivered using a mixed methods approach drawing on an action research model using naturalistic and scientific paradigms. CBT will be delivered following on from formal, CBT training, a manualised approach will be utilised by all therapist. A tranche of validated standardised measures will be employed to ascertain the patient’s psychopathology pre, during and post therapy treatment. An independent assessor will meet with the patient pre and post therapy to conduct a Quality of Life Interview and to discuss their satisfaction with services. A validated skills based questionnaire will be used to gain an insight into the pre, mid and post therapy skills of the therapists providing the interventions (Cognitive Therapy Check List, Beck, 1994). Individual semi-structured questionnaires will be conducted with the therapist pre and post involvement in the research to gain an insight into their understanding of CBT and perceived skill levels pre and post course completion.

**Consequences of Participation in the Study. Please complete the following:**

Benefits (direct or indirect): Improvement students knowledge of CBT, hope long term improvements in quality of life for patients. A direct improvement in staff's knowledge in the delivery of CBT, a direct improvement in their ability to engage with and work with patients within a talking therapy based paradigm, improved staff moral and retention.

Potential harm (including physical and psychological stress): CBT is an evidence based psychotherapy, evidence shows that on delivery of a course of CBT patients often find the areas covered in sessions distressing – part of the role of therapy and the therapist interlinked with the unit based multi professional team is to support the patient through the initial engagement and assessment phases of the therapy.

What is the current best treatment in ordinary practice: Psychopharmacology.

**Is human tissue or genetic information used, stored or collected? (e.g. bloods, breast tissue, spinal fluid, tooth)**

Yes

If yes, please complete *Unit Three: Application for the Use of Human Tissue* and/or *Unit Four: Application for the Use of Genetic Information*

No

**Will the subjects/investigators be exposed to ionising radiation?**

Yes

No

If yes, Radiation Safety approval may be required. Please contact the Radiation Safety Committee for advice, and forward confirmation of approval or notification that approval is not required, to the HREC when received. One copy of the application to Radiation Safety must be submitted with the application to the HREC.

### Will recombinant DNA techniques be used?

Yes

No

If yes, contact the Biosafety Committee to determine whether approval is required. Please forward confirmation of approval or notification that approval is not required, to the HREC when received. One copy of the application to the Biosafety Committee must be submitted with the application to the HREC.

### Will drugs/devices be used?

Yes

No

If yes, please ensure you complete the most up to date version of Unit 2. The Research Office will forward your completed ethics application including Unit 2 to the relevant Drug Committee with a copy of the Investigator's Brochure and Clinical Protocol for assessment.

## Participants

### Are any of the participants under 18 years of age?

Yes  if yes, Guardianship Tribunal approval may be required

No

### Are any of the participants unconscious, critically ill or in circumstances where they may not be able to give informed consent?

Yes Please explain why. In addition, Guardianship Tribunal approval may be required

No



**How many participants will be recruited?**

Initial 80 in the training.

**How will the participants be recruited and from where will they be recruited? (if an advertisement, letter or circular is to be used, please include a copy with this application)**

The nurse/care co-ordinator will be taught CBT by attending an 8 week course. CBT will be discussed with patients by their primary nurse/care co-ordinator, subsequent to this the multi professional team will meet to decide on the applicability of CBT for the patient within the general mutli-professional team meetings (ward rounds). Patients will be recruited from the adult psychiatric units at Macquarie Hospital, North Sydney Central Coast Area Health.

**Give details on how the investigator/s intend to approach potential subjects**

A general expression of interest will be issued to all nurse/care co-ordinator wishing to attend training.

**Will the participant receive any payment/reimbursement for their involvement in this project?**

Yes

No



If yes give details

**Give details of what procedures are in place to manage, monitor and report adverse and unexpected events.**

**NB: All serious and unexpected adverse events should be reported to the HREC within 15 days. Refer to the *Unit One: Core Application Guidelines* for further information.**

Close supervision, mentorship and monitoring by course leader. The development of a critical companion model of support. Identification of CBT champions.

**Describe what provisions are in place if participants wish to withdraw their consent and the consequence of a subject's decision to withdraw from the research and procedures for orderly termination of participation by the subject including withdrawal of research data.**

All participants will be free to withdraw at any time, the data gathered will be kept as part of the trial unless the student asks for it to be destroyed.

### **Other ethical issues concerning participants**

Discuss any other ethical issues relevant to the participants in this project. Give details and explain how they have been addressed.

CBT is an evidence based intervention and its delivery to the student population is supported by the Area Executive Team. To aid support and delivery the training has been situated in the Nurse Training Department and all students will have direct access to a highly skilled CBT or educational supervisor.

## **Participant Information and Consent**

**Will a Participant Information Sheet be provided and written consent obtained?**

Yes

No

If yes, attach a copy of the Participant Information Sheet and Consent Form that you intend to use to explain the project to the participant. Make sure it has a version number and date (refer to the NSH HREC sample consent form)

If no, please explain why

**How will consent be obtained from subjects with a non-English speaking background?**

Consent will be gained by using a suitably qualified interpreter if this event occurs.

## Privacy

It is necessary for you to complete this part of the application form in order to ensure that you comply with the Health Records and Information Privacy Act. This enables the HREC to properly assess the protocol under the Act; and ensures the HREC meets its statutory obligations to report to the Privacy Commissioner on its activities under the Act.

**Is there a requirement for the researchers to collect, use, or disclose information of a personal nature (*either identifiable or potentially identifiable*) about individuals without their consent:**

- From Commonwealth departments or agencies? Yes  No
- From State departments or agencies? Yes  No
- From other third parties, such as non-government organisations? Yes  No

If you ticked yes to one or more of the above boxes, please state what information will be sought and how many records will be accessed.

12.2. **Is there a requirement for the researchers to collect, use, or disclose personal health information about individuals without their consent which is identifiable or potentially identifiable?**

**YES** – go to question 12.3.

**NO**  – go to 12.6

**12.3. Indicate the reason(s) why de-identified information cannot be used**

The project involves linkage of data

Scientific deficiencies would result if de-identified information was used. Please provide details.

Other. Please provide details

**12.4. Why is it impracticable to obtain the consent of the individual to the collection, use or disclosure of their health information?**

The size of the population involved in the research.

The proportion of individuals who are likely to have moved or died since the health information was originally collected.

The risk of introducing potential bias into the research, thereby affecting the generalisability and validity of the results.

The risk of creating additional threats to privacy by having to link information in order to locate and contact individuals to seek their consent.

The risk of inflicting psychological, social or other harm by contacting individuals with particular conditions in certain circumstances.



The difficulty of contacting individuals directly when there is no existing or continual relationship between the organisation and the individuals.

The difficulty of contacting individuals indirectly through public means, such as advertisement and notices.

Other – please give details.

**12.5 Explain why the collection, use or disclosure of this information is in the public interest, and why the public interest in the project substantially outweighs the public interest in the protection of privacy.**

**12.6 Will a study code be generated? If using potentially identifiable or identifiable information to code participant records, this must be included in the Consent Form (refer to Guidelines for Unit One, and the sample consent form).**

Yes  if yes, please give details

No

All questionnaires will be anonymous + data analysed as a core unit.

**12.7 Will the subjects be video/audio taped or will any other electronic medium be used?**

Yes

No

**12.8 How will the investigators protect the privacy of the participants and their personal details specifically relating to all patients that attend Northern Sydney Health sites (e.g. a locked filing cabinet)?**

**12.9 Storage & Security of Information relating to all Northern Sydney Health sites. Please complete the following:**

Security of data storage: All data collected will be stored in a locked cabinet, at the data analysis phase of the project all data coded and entered to electronic research tools will be password protected.

Location of stored data: In a non-clinical area of the mental health service

Format of stored data: Paper files and electronic data.

Duration data will be kept: 7 years.

Method of destruction of data: Shredding/deleting of electronic files.

**12.10 Does the project involve the transfer within or outside Australia of a subject's personal information? (e.g. date of birth, initials, name and/or address being transferred in a serious adverse event form or a Case Report Form)**

- Yes  if yes, complete the following table & ensure points 13 & 14 of the NSH Consent Form are included
- No

Specify type of information (as detailed above)?

Where will the information be transferred from and to whom?

How will the patients' information remain confidential during the transfer process?

**12.11 Please confirm that information which identifies individuals or from which an individual's identity can be reasonably ascertained, WILL NOT be published in any generally available publication?**

Yes  Confirmed published data will not identify participants. As the  
Publication of identifiable data is not permissible under the Act

## The Research Application

### Please provide details of the research proposal

**This should include:**

- **Details of the primary hypothesis, project design, method of randomisation, clinical protocol study flow chart (if appropriate), any procedures involved and their sequence, parameters and outcomes.**
- **Procedures differing from routine Clinical Practice/Management of patients - state whether the research involves procedures different from and/or additional to those involved in the normal care of the patient.**
  
- **Inclusion and exclusion criteria.**
- **Concomitant medications and non-drug therapies (permitted and prohibited medications)**
  
- 1. **Details on the termination criteria including circumstances in which the Investigator would withdraw an individual from the study and circumstances in which the entire project would be terminated (if applicable).**
  
- **Details of statistical analyses and sample size calculations to ensure that the project contains appropriate number of participants.**
- **Response variables to be measured and methods used to measure them.**
- **Major anticipated sources of bias and details of dealing with these.**

The purpose of this research project is to evaluate the impact of a CBT training programme. It will look at students understanding of CBT, and belief in their ability to deliver it pre and post course. This will be done by drawing on work previously conducted in the UK.

### **Research questions:**

Can an eight week skills based CBT course significantly impact on mental health professionals' views of and skill application in their CBT clinical practice?

Does an active action research model employing practice development principles and theories of skills based education and learning, enable the development of usable CBT skills in mental health care?

Can an Area Health Service adopt 'psychological' principles to enhance care delivery?

The purpose of the study is to increase access to evidence based talking therapies, particularly CBT for patients of NSCCH a large metropolitan and rural health care provider in NSW, Australia and to look into the feasibility of accrediting the programme and rolling it out across NSW if results are positive enough, this is due to the paucity and availability of training in CBT in NSW and the limited number of health care professionals able to deliver 'formulation' based CBT. This action research project was designed to ascertain if teaching qualified mental health professionals, having no core training in CBT or other equitable talking therapies post initial qualification, would change their views of the application of CBT and talking therapies in clinical practice. It also aims to determine if the students thought their skills in the therapeutic modality had improved. It was postulated that as the project progressed a positive change in the therapy behaviour of students would be evident, outcomes for patients would be improved and the psychological mindedness of the parent organization where the research was conducted would be enhanced. Data will be gathered in four areas by the use of a questionnaire that covers demographics of the population, data pertinent to CBT skills and delivery of those skills on a pre and post course application model. The core components of the questionnaire is designed to gain an understanding of and gather data outlining whether or not students change their views of CBT and their delivery skills in CBT with their patients post course completion.

Students will voluntarily opt into the course, there will be no exclusion criteria but all attendees must have a recognised qualification in mental health.

80 students will be recruited + the quantitative data analysed using SPSS and manual coding for the qualitative data set.

As this is the first such course offered in NSW the major bias will be teacher student interaction, the teacher will receive supervision from a senior nurse educator and the students will have access to an educational team outside of the course.

### **How will the results of the research be disseminated?**

Publication in peer reviewed journals, presentations at conferences and academic events.  
Publication of in-depth trial report. Presentations and written reports and recommendations with in the Area Health Service and partner organisations. Discussion with participants and Unit teams.

Please indicate any other ethical implications or issues relevant to the protocol

## Monitoring

Please give details of your monitoring procedures. This includes internal, independent and external monitoring (refer to Guidelines for Unit One for definitions).

Internal – By project steering committee, chief investigator reporting to same and to Hospital Executive. Clinical supervision of all trial staff by area Cognitive Behavioural Psychotherapist.

Independent – Feedback of findings to Project Steering Committee, storage of data generated in line with research protocol.

External – Within the policy and procedures of University of Western Sydney.

Has an Independent Safety and Monitoring Board been established?

(Only applicable for commercially sponsored trials)

Yes

No

NA

If yes, please give details of the constitution of the members

If no, please explain why

# Budget Outline

All Heads of Assisting Departments (e.g. Biochemistry, Pharmacy, Medical Records etc.) must approve the part of the budget that is relevant to their department. (Refer to attachments XX). Irrespective of the source of funding, all costs associated with the research project (excluding standard treatment) should be included in the outline.

**Note:** Please complete the spreadsheet entitled "Clinical Trials Budget Proforma" to provide the following data for clinical trials which can be downloaded from the website.

## Income

Please complete the following:

### Details of Funding:

External support of project  
(e.g. From funding body or sponsor) = \$ 0

Reimbursement per subject entered  
(if applicable) = \$ 0

**Total Income = \$ 0**

## Expenditure. Please complete the following:

### Personnel (insert rows if necessary)

Position	Hrs on Project	Cost/Hr	Total Cost
Chief Investigator	8 per week	\$42.99	\$17883.84
8 x RN's yr 8	4 per week	\$31.19	\$51900.16
1 x Independent External Assessor	20 hrs in total	\$38.57	\$771.45

**Total \$70555.45**

**Service Costs**

This includes laboratory tests (e.g. Haematology, Biochemistry, Microbiology), investigations (eg. endoscopy, ultrasound, MRI), Pharmacy Services, Medical Records, bed costs etc.

NB: Separate forms are to be included for each department. Quotes must be obtained if using laboratory services (See attachment XX)

**Total \$\_\_0\_\_**

**Administrative Costs**

This includes photocopying, stationery, postage etc.

**\$\_\_1000\_\_**

**Data Handling/ Computing**

Specific payments for these services.

**\$5000.00**

**Patient/Subject Costs**

This includes travel, accommodation costs, supplies and consumables

**\$N/A**

**Equipment**

This refers to equipment that will specifically be purchased or hired for the purposes of this study

**\$1000.00**

**Other Costs**

e.g. payments to volunteers

**\$\_\_\_\_\_**

**Levy – (see Fee Policy)**

**\$\_\_\_\_\_**

**TOTAL EXPENDITURE**

**\$\_\_\_\_\_**

**15.2.10 TOTAL EXPENDITURE - INCOME**

**\$\_\_\_\_\_**

\* If there is a surplus, please detail how the surplus will be used. If there is a deficit, please detail which department will cover the cost associated with the study

APPROVAL FOR ASSISTANCE FROM ANOTHER DEPARTMENT

If the resources of other departments are to be used, this form must be completed and signed by the Head of the Assisting Department. This includes all tests or services that are to be performed in addition to normal treatment i.e. for the purposes of research.

**Project Title:**

**Department from which assistance is sought:**

Head of Department Declaration:

**I have discussed this study with the investigator and have agreed to provide assistance in the form of: (brief description)**

Absorbed within core nursing budget.

The investigator and I have discussed financial reimbursement for these tests and have agreed upon a budget as outlined on the following page.

**Name:** \_\_\_\_\_

**Department:** \_\_\_\_\_

**Position:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



The cost of tests/services performed by \_\_\_\_\_ are as follows:  
(name department)

Test or Service	Cost/test	No. Tests	Total cost
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Total: \$\_\_\_\_\_

Financial reimbursement will also be required for the following:

Staff: Estimated cost \$\_\_\_\_\_

Equipment: Estimated cost \$\_\_\_\_\_

Maintenance: Estimated cost \$\_\_\_\_\_

The estimated total cost for assistance to this study will be \$\_\_\_\_\_

The Cost Centre to which payment should be made is:

\_\_\_\_\_  
(fund source/cost centre)

\_\_\_\_\_  
(Name of Account)

and the amount to be deposited is \$ \_\_\_\_\_

It is expected that these tests will be need to be performed \_\_\_\_\_  
(daily/ weekly/monthly)

over the following period: \_\_\_\_\_ to \_\_\_\_\_

Comments/Special conditions: (e.g. out of hour's service)

APPROVAL FOR ASSISTANCE FROM PHARMACY DEPARTMENT

Project Title:

\_\_\_\_\_

*Please consult the Clinical Trials Pharmacist (9926 7737) prior to completing this form.*

1. Set Up Fee (once only payment) \$
  
2. Ongoing Administration \$ per year
  
3. Completion \$
  
4. Dispensing / Drug Accountability/Manufacturing Fees

**Total No. of Patients in Trial** \_\_\_\_\_

**Expected No. of Visits per Patient** \_\_\_\_\_ at \_\_\_\$ \_\_\_\_\_ per visit.

**Expected No. of items to be manufactured per patient** \_\_\_\_\_ at \_\_\_\$ \_\_\_\_\_ per item.

**Total Cost:** \$ \_\_\_\_\_

5. Storage \$ per year
  
6. Drug Transfer Costs \$50 per event + transport costs
  
7. Miscellaneous \$.....

**The Set Up Fee (1) is to be paid at the start of the trial.**

**Fees 2,3,4,5,6+7 are charged four times a year, in January, April, July & October and will be transferred from your cost centre \_\_\_\_\_**

**to Pharmacy's cost centre 201 - 23 - 63010 - \_\_ - 33181.**

Head of Department Declaration:

**The financial reimbursement for this study has been discussed with the investigator and the budget as outlined above agreed upon.**

**Name:** \_\_\_\_\_

**Position:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Please complete the following two pages, Selection of Scientific Assessors and the Declaration of Researchers.**

## Northern Sydney Health Human Research Ethics Committee

### SELECTION OF ASSESSORS FOR THIS APPLICATION

Please note: This **must** accompany your application  
 You may wish to include assessors outside of Northern Sydney Health

**(A) RECOMMENDED ASSESSORS SUITABLE FOR PEER-REVIEW OF THIS APPLICATION  
 (at least one of these should not be associated with the department conducting the research)**

Full Name		Has the assessor agreed?	
Department			
Institution			
Address			
Phone		Fax	
E-mail			

Full Name		Has the assessor agreed?	
Department			
Institution			
Address			
Phone		Fax	
E-mail			

Full Name		Has the assessor agreed?	
Department			
Institution			
Address			
Phone		Fax	
E-mail			

**(B) NON-ASSESSORS NOT SUITABLE FOR PEER-REVIEW OF THIS APPLICATION**

Full Name	
Institution	
Reason	

- The protocol is a multi-centre clinical drug trial that been forwarded for scientific assessment to the NSW Health Pilot Shared Scientific Assessment Scheme (SSAS).

## Declaration of Researchers

*I/we apply for approval to conduct the research. If approval is granted, it will be undertaken in accordance with this application and other relevant laws, regulations and guidelines.*

### Signature of Chief Investigator or Project Supervisor

Name ..... Signature: ..... Date: .....  
(print)

**I Confirm that the protocol does/does not require review by the Institutional Biosafety Committee**

### Signature of Chief Investigator or Project Supervisor

Name ..... Signature: ..... Date: .....  
(print)

### Signature of Co-Investigator(s) or Student(s)

Name ..... Signature: ..... Date: .....  
(print)

Name ..... Signature: ..... Date: .....  
(print)

Name ..... Signature: ..... Date: .....  
(print)

Name ..... Signature: ..... Date: .....  
(print)

- *After careful consideration and appropriate consultation, I am satisfied that the scientific merit of this work justifies its being performed and that the information that will be obtained justifies the inconvenience, discomfort and risks to subjects.*
- ***I acknowledge that the researcher is an employee of Northern Sydney Health and WILL / WILL NOT be conducting the research as part of their employment (delete whichever not applicable).***

Signature of appropriate senior officer NOT ASSOCIATED with the research (e.g. Head of School / Department / Unit / Dean of Faculty).

Name: .....

(print)

Title: .....

(print)

Position: .....

(print)

Signature: .....

Date: .....



## Appendix 5 Course evaluations.

NORTHERN SYDNEY  
CENTRAL COAST  
NSW HEALTH

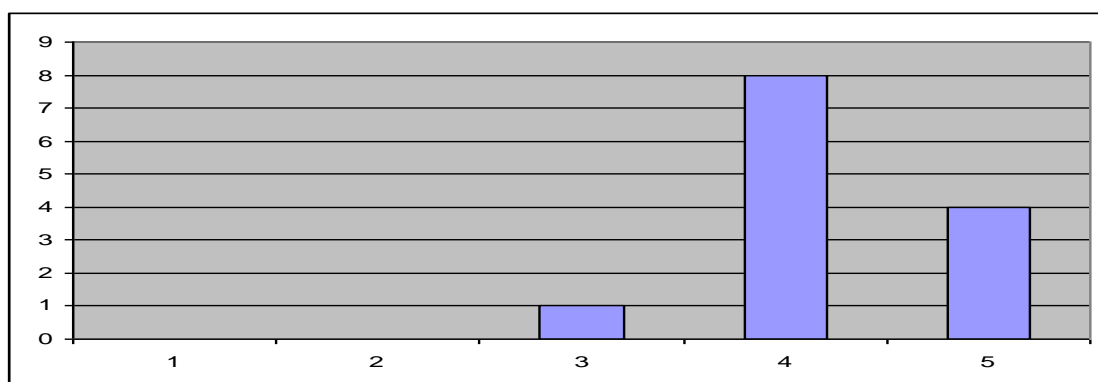
# Mental Health Practice Development Program

## Cognitive Behavioural Therapy Course

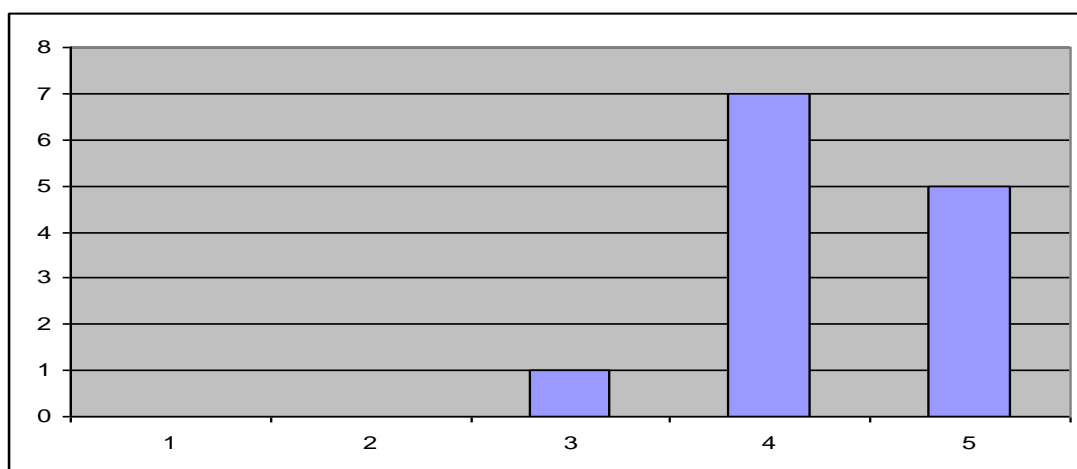
Supporting evidence based and recovery focussed practice through the development of interventions that promote self-efficacy

### Central Coast Evaluation

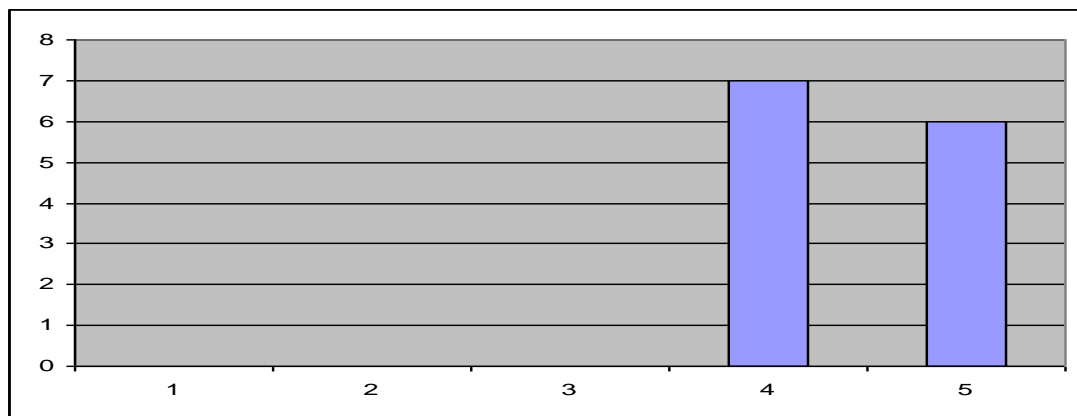
The course fully informed me of clinical issues involved?



The course was presented in a manner that held my interest?



The material was relevant to level of knowledge and experience?



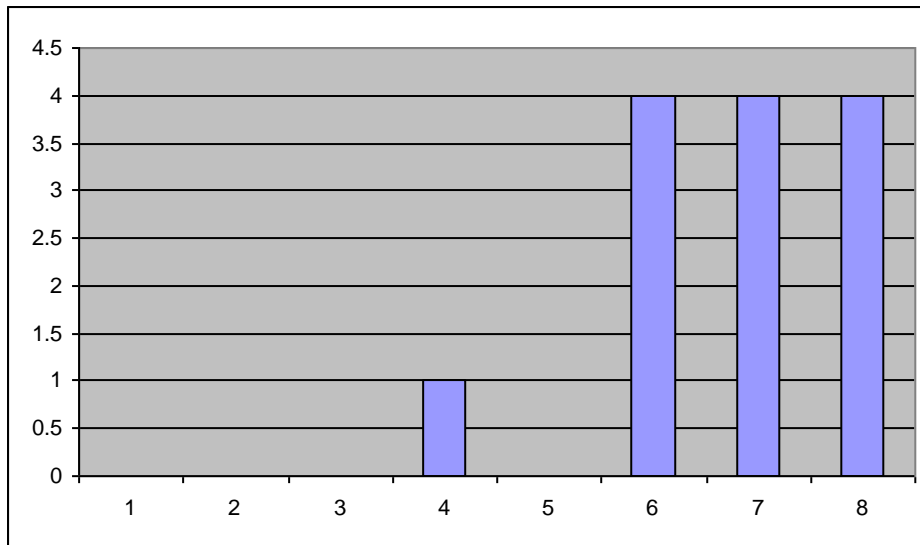
**What was the most informative part of the course?**

- ⇒ *Role Plays*
- ⇒ *Found all content informative*
- ⇒ *That I can use CBT approaches in dealing with clients that I see.*
- ⇒ *Learning to utilise the model and ways of explaining CBT with client.*
- ⇒ *Practice s applying CBT*
- ⇒ *All of it! - Great skill/tools for future, looking forward to using CBT but a little bit scared about putting it into practice!*
- ⇒ *What is CBT – How we can relate it to our practice not relate our practice to it. Didn't have much knowledge before course now understand basic principles and how I can relate that to my practice.*
- ⇒ *Found overall course all very informative.*
- ⇒ *Role play and practicing skills*

**What was least informative about the course?**

- ⇒ *Nothing*
- ⇒ *Found all info useful particularly the slow pace*
- ⇒ *More info on Psychosis (not enough time..!)*
- ⇒ *I needed more focus on cognitive reframing and challenging negative thoughts*

On a 0-8 scale please score the relevance of the CBT course to practice.



Please add any further comment regarding any suggestion for how this course may be delivered in the future?

- ⇒ Liked the fact that the info given wasn't too technical for level of knowledge and also that lots of examples and opportunities to role play were given.
- ⇒ Very applicable to my area
- ⇒ I think it does all it can in 8 days. Follow up course every 3 months could work very well.
- ⇒ Thought the course was well presented – variety & interchange of presenters kept the process alive.

**Appendix 6 Consent form.**



**Clinical Practice Development Unit**

Area Mental Health Nursing Administration

Macquarie Hospital Campus

**CONSENT FORM**

**Title of Research Project:** Cognitive Behavioural Assessment and Intervention Skills (8 week skills based course).

**Name of Chief Investigator:** Euan Hails

Please initial: ( )

\* I confirm that I have met and discussed this project with the Chief Investigator and have asked and received answers to any questions raised. I have been given a copy of the course handbook and understand the contents and scope of course attendance and study participation.

( )

\* I understand that my participation is voluntary and that I am free to withdraw at any time without giving a reason and without my rights being affected in any way.

( )

\* I understand that the researchers will hold all information and data collected securely and in confidence and that all efforts will be made to ensure that I cannot be identified as a participant in the study (except as might be required by law) and I give permission for the researchers to hold relevant personal data.

( )

\* I agree to take part in the above study.

( )

Name of Subject:

Signature:

Date:

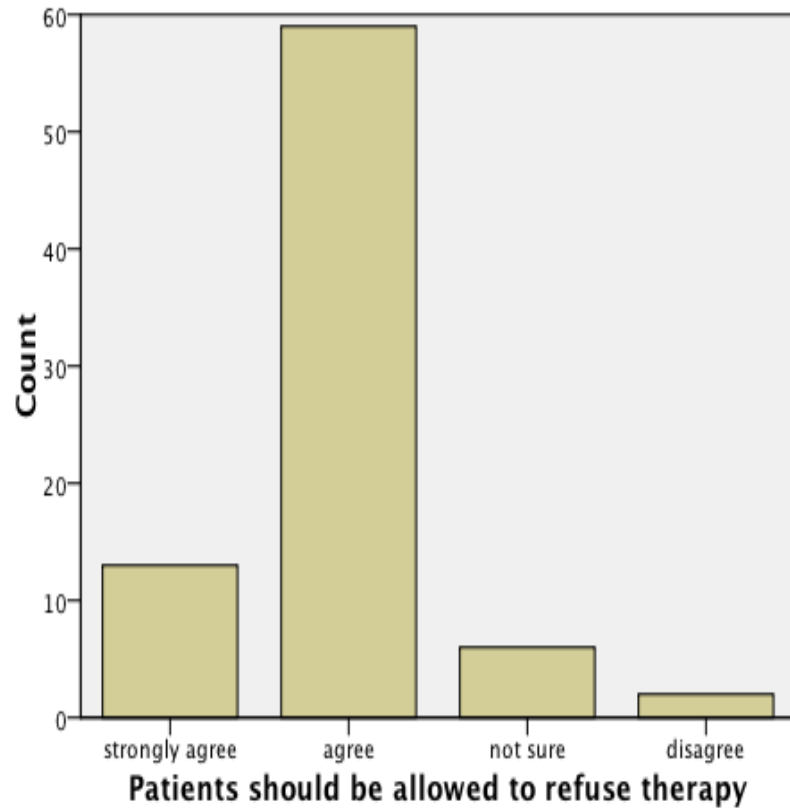
Name of person taking consent:

Signature:

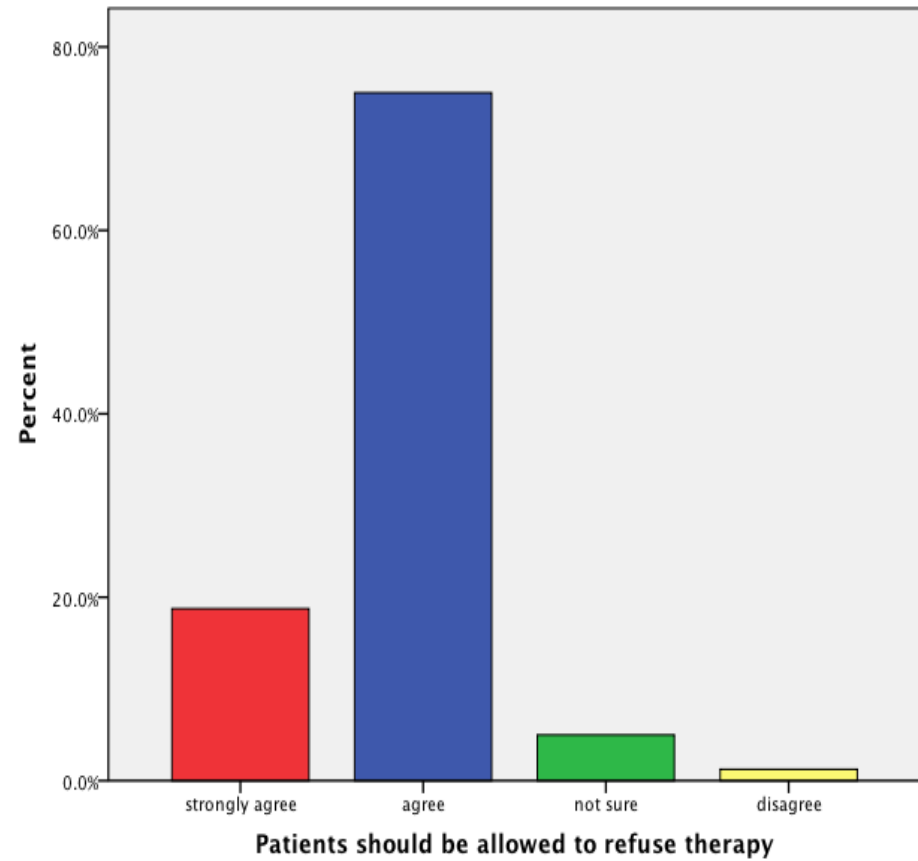
Date:

### Appendix 7 Figures

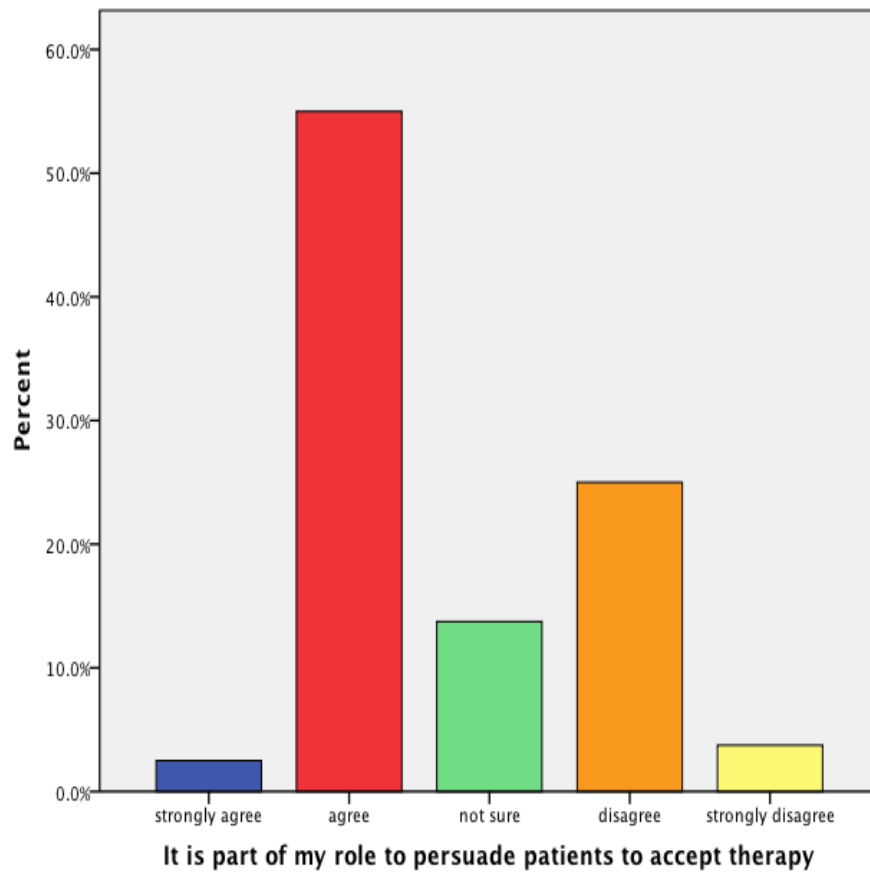
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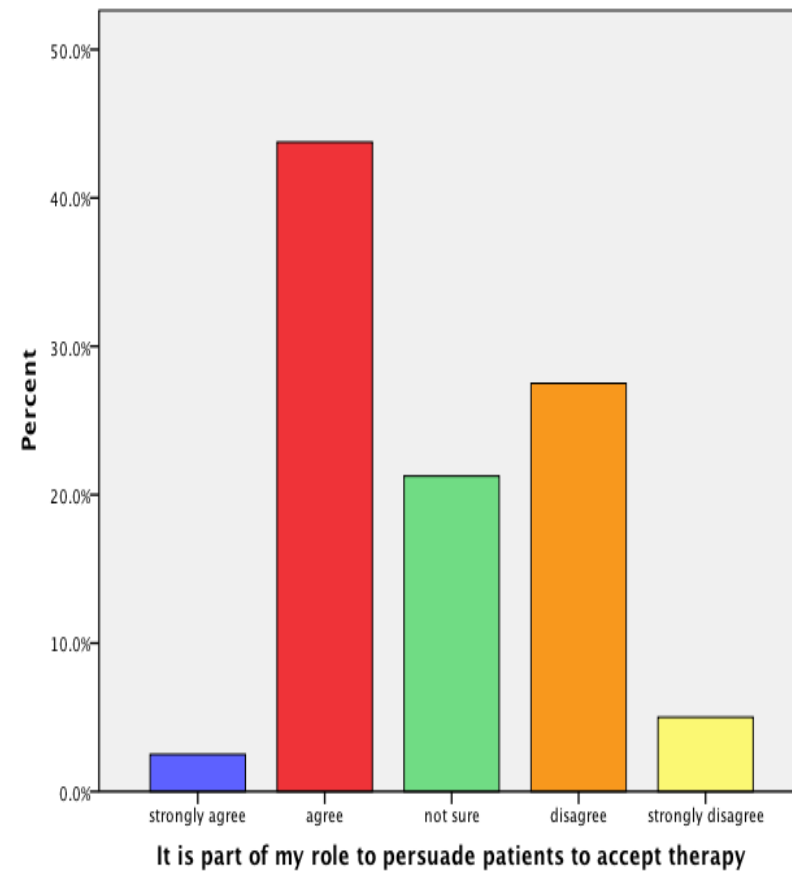
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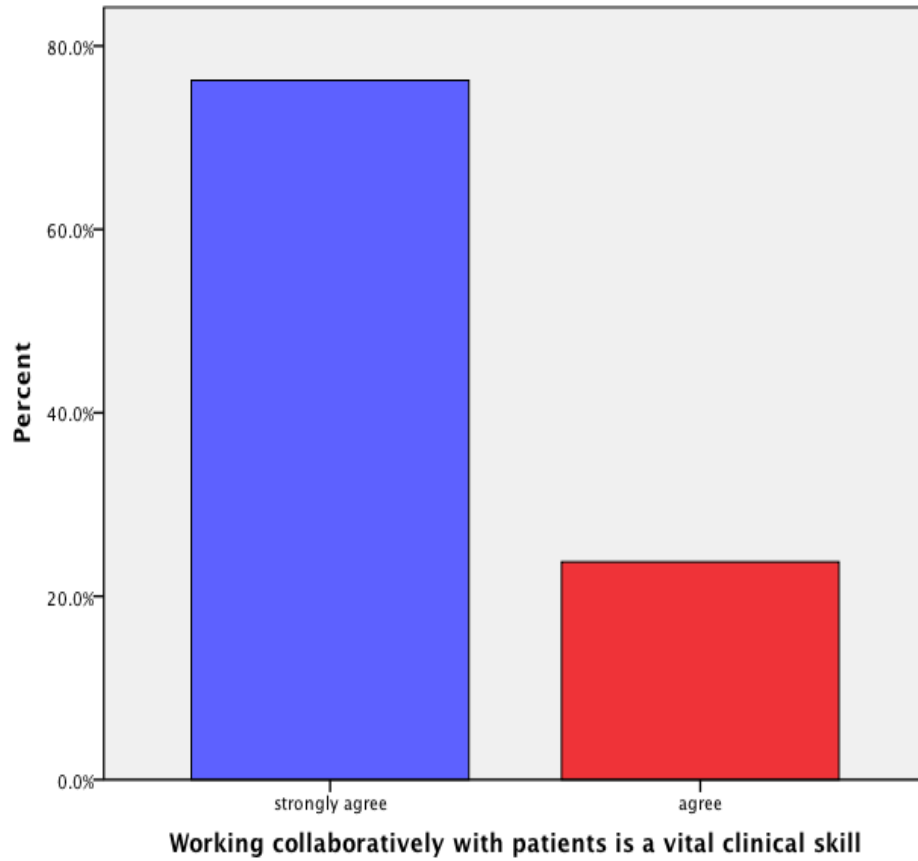
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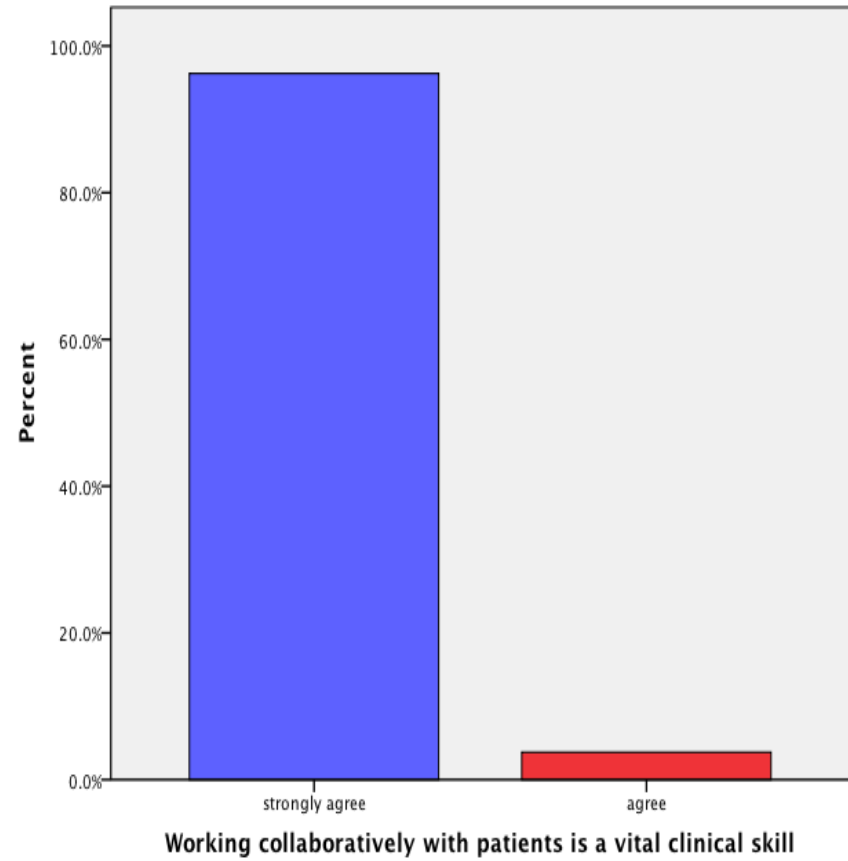
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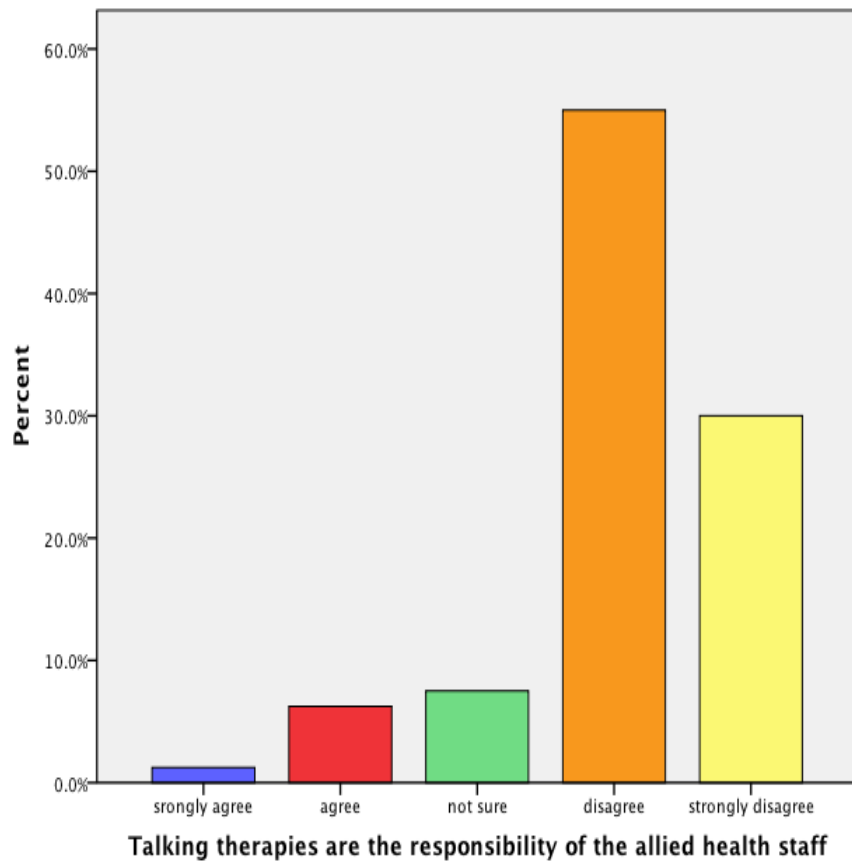
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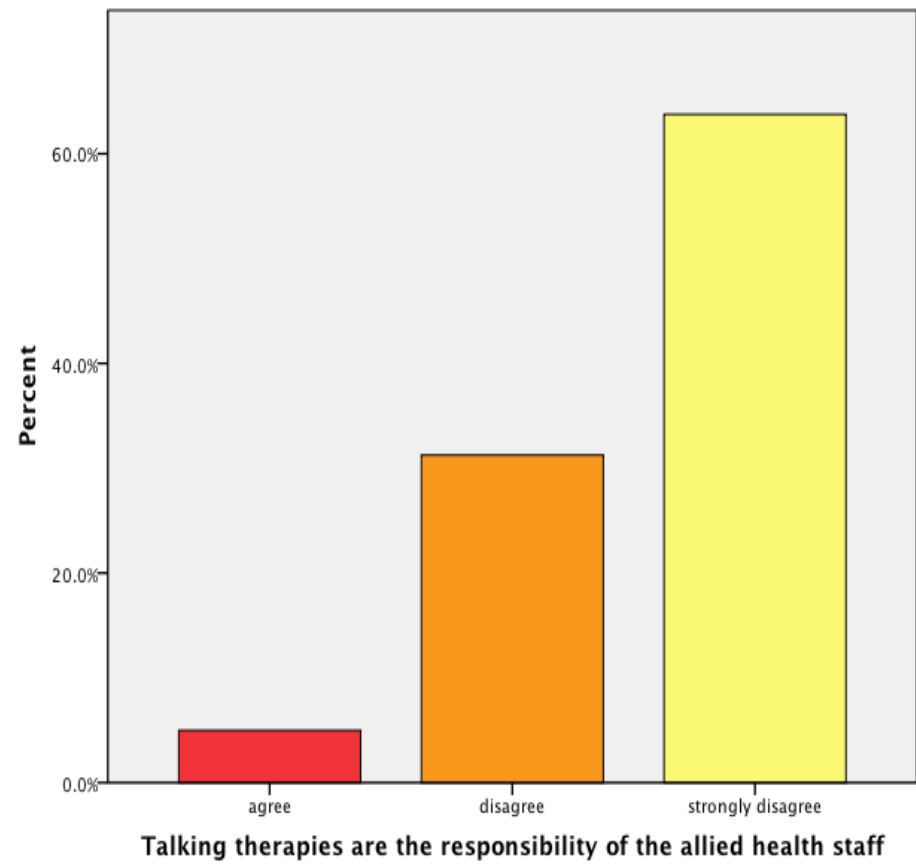
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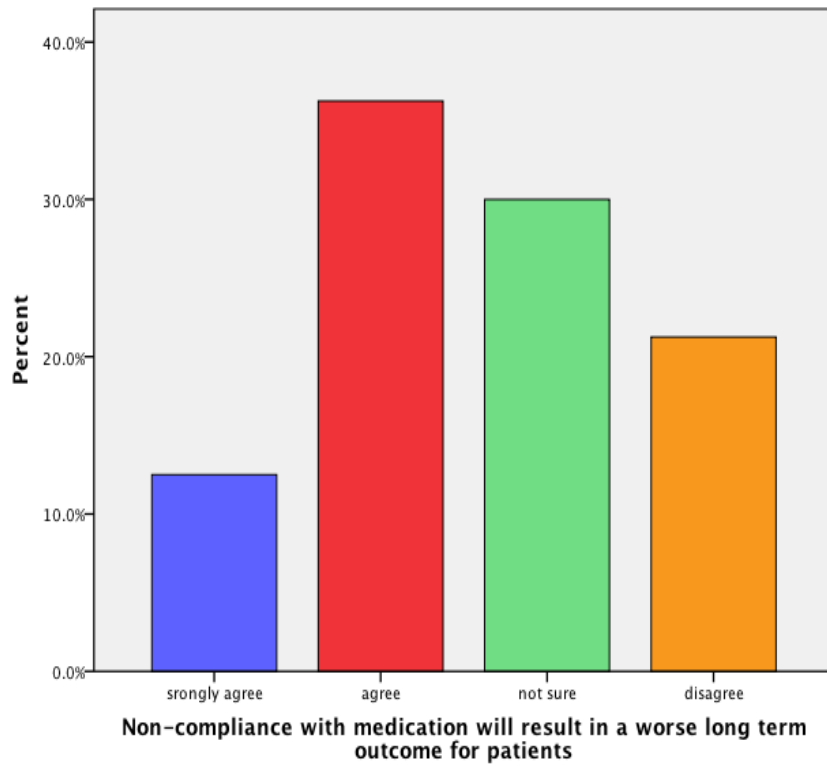


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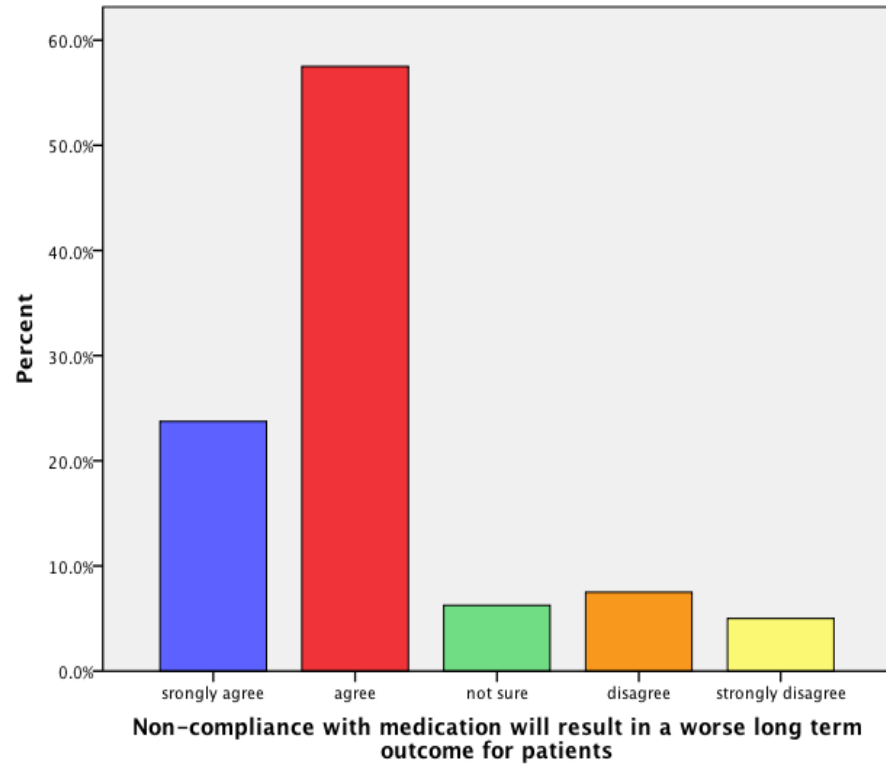




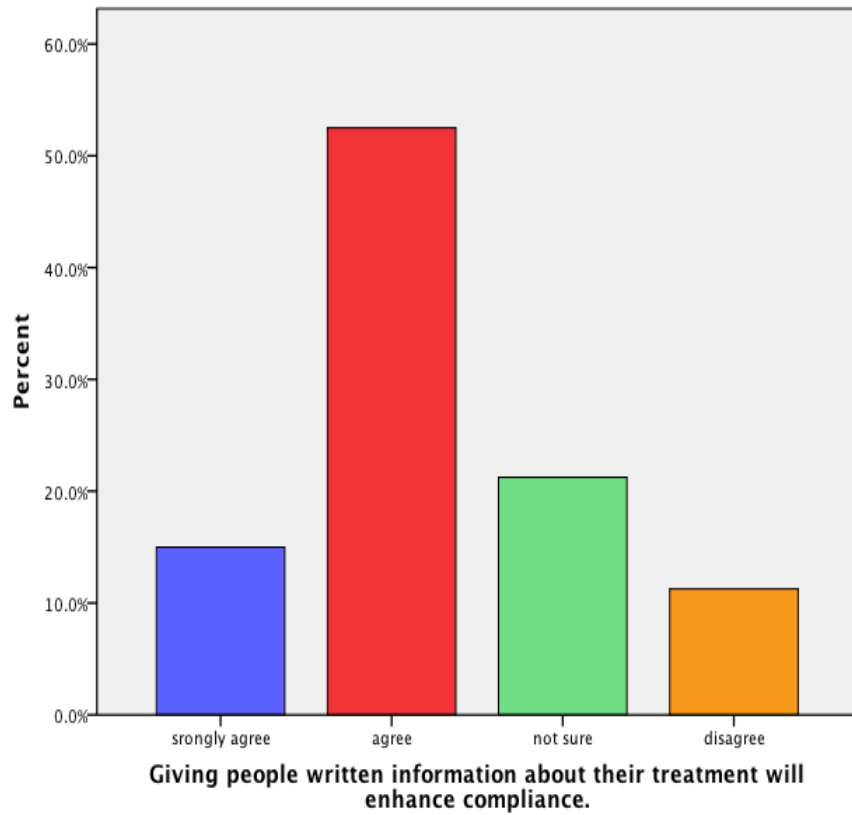
Question 8 - Point 1; pre- course completion:



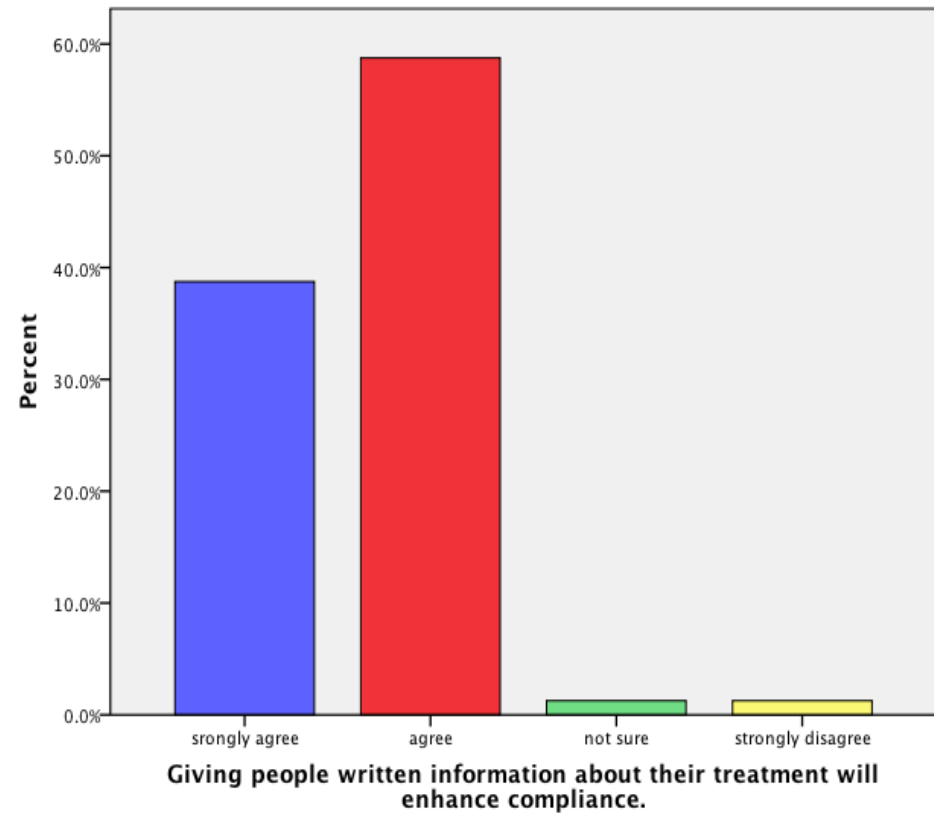
Point 2; post- course completion:



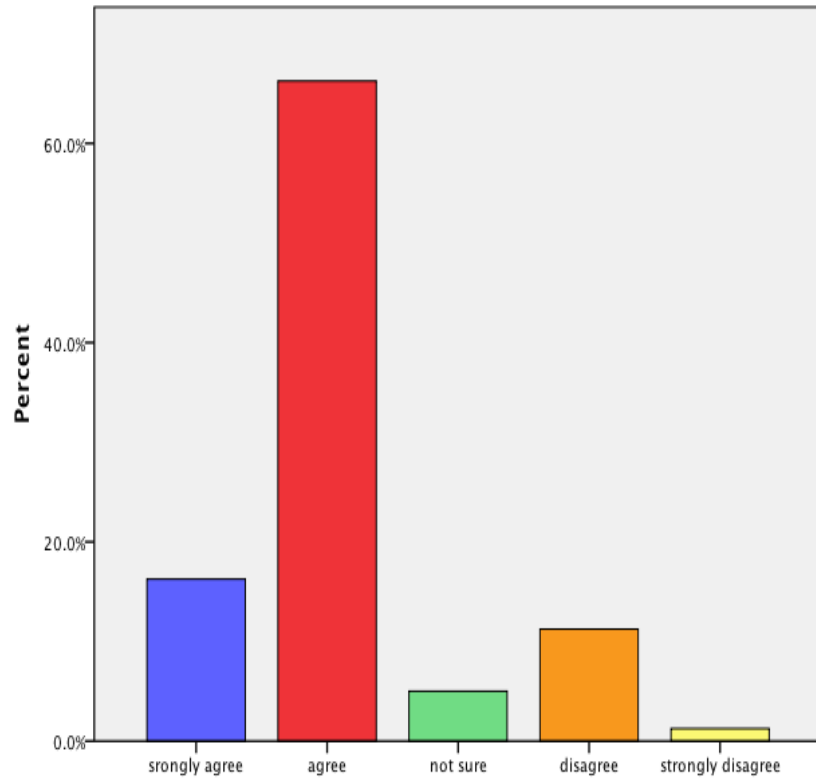
Question 9 - Point 1; pre- course completion.



Point 2; post- course completion:

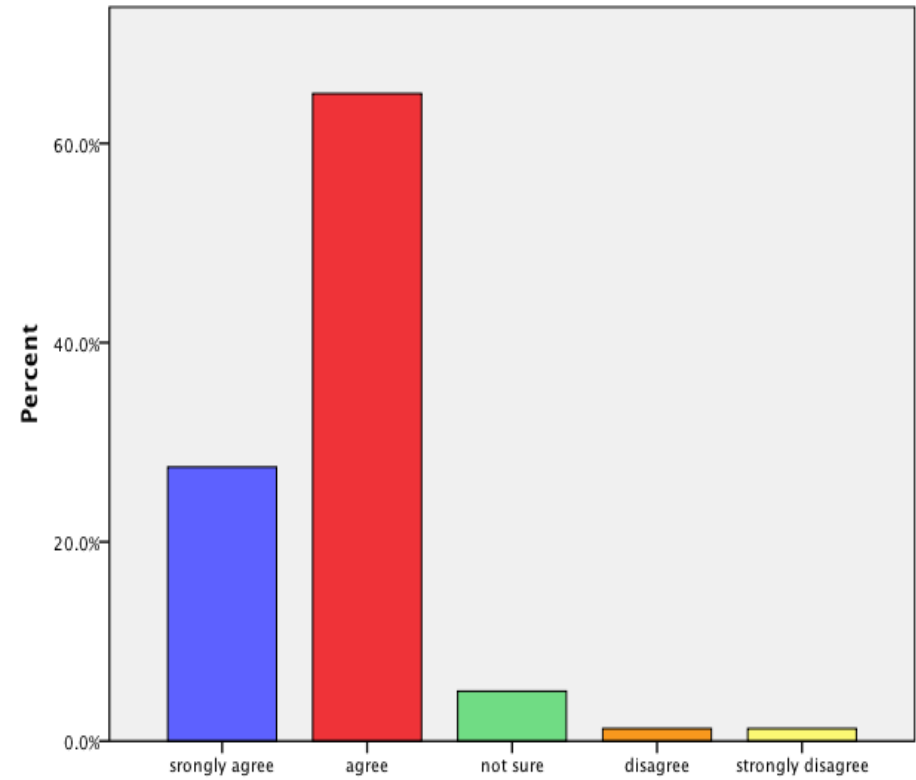


Question 10 - Point 1; pre- course completion:



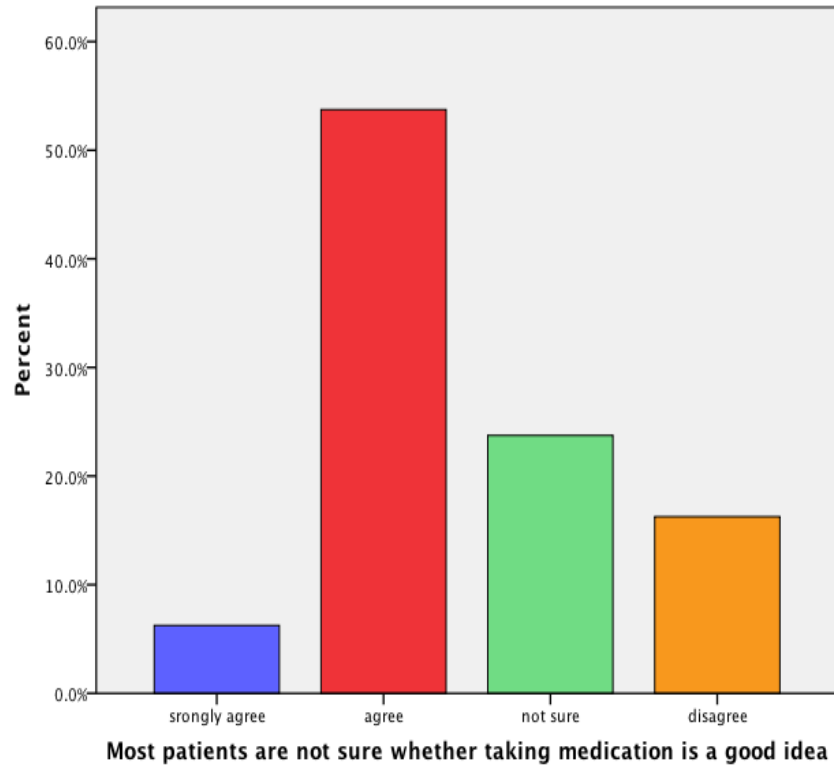
**A patients lack of awareness (or insight) about their mental health problems is a major cause of non-compliance with treatment.**

Point 2; post- course completion:

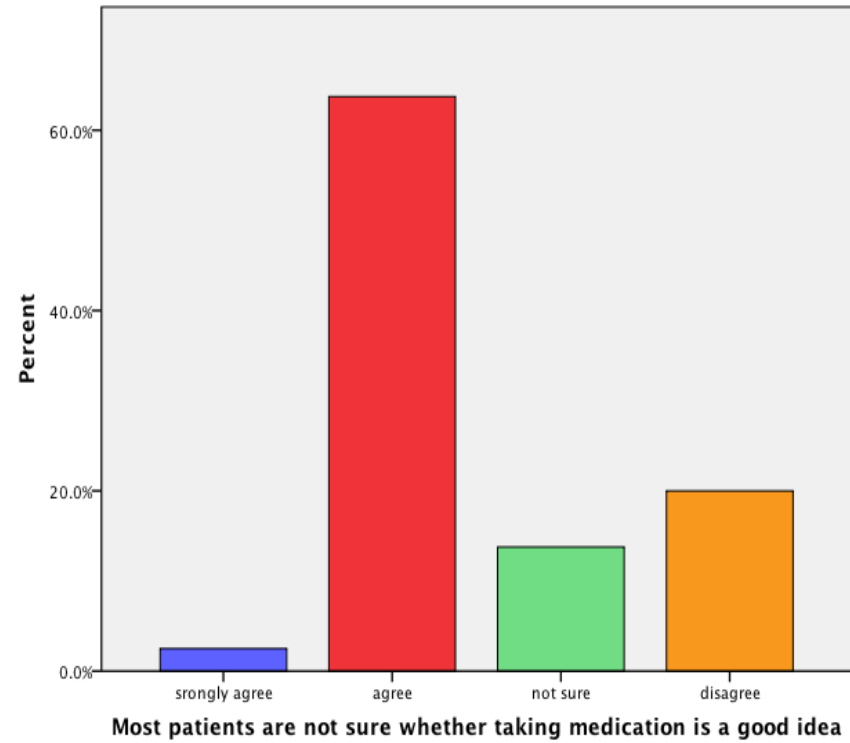


**A patients lack of awareness (or insight) about their mental health problems is a major cause of non-compliance with treatment.**

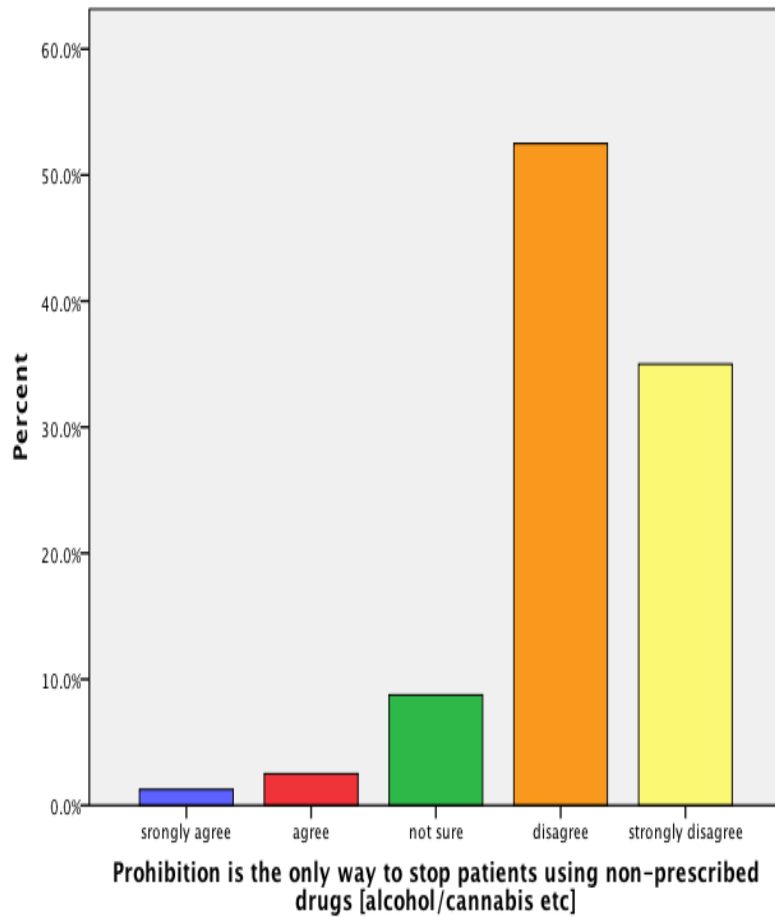
Question 11 - Point 1; pre- course completion:



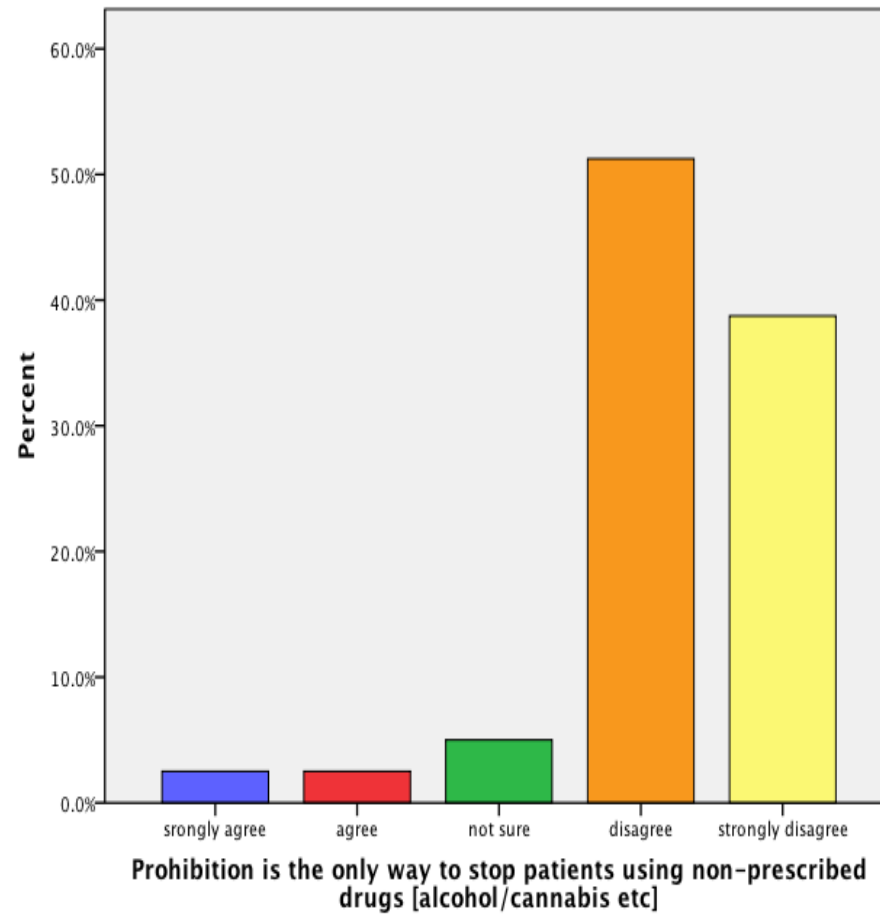
Point 2 - post- course completion:



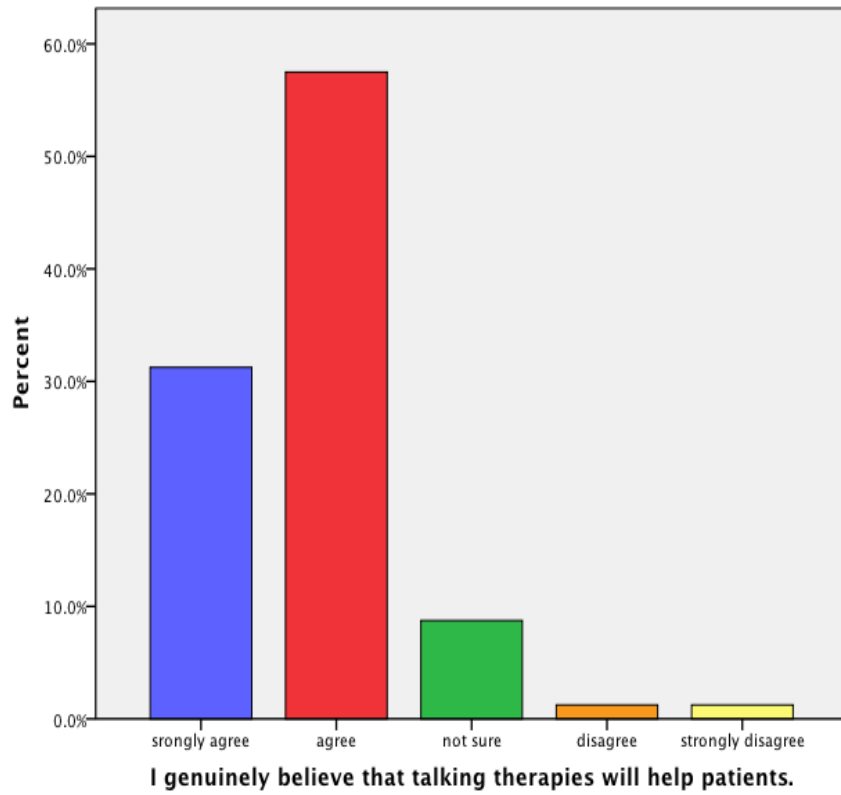
Question 14 - Point 1; pre- course completion:



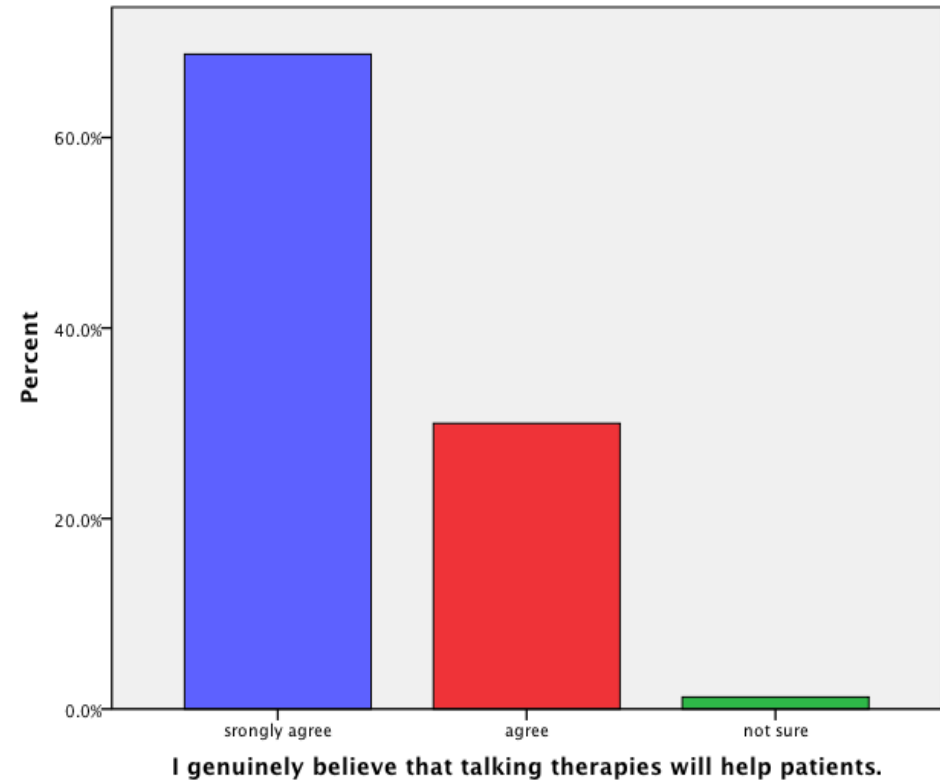
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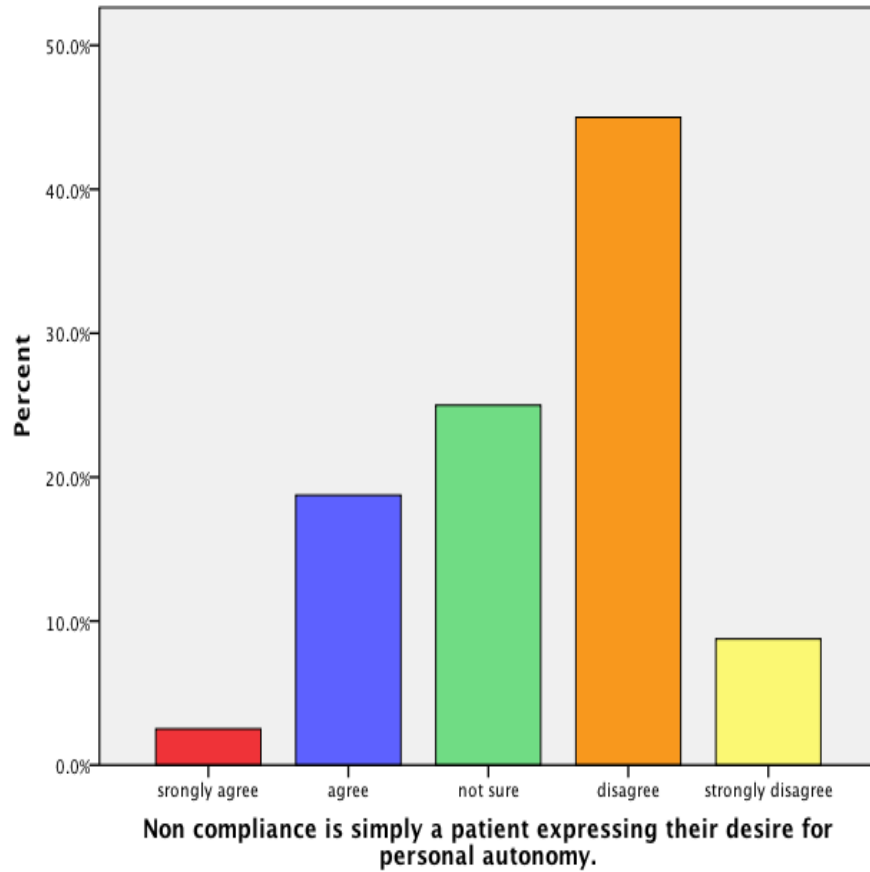
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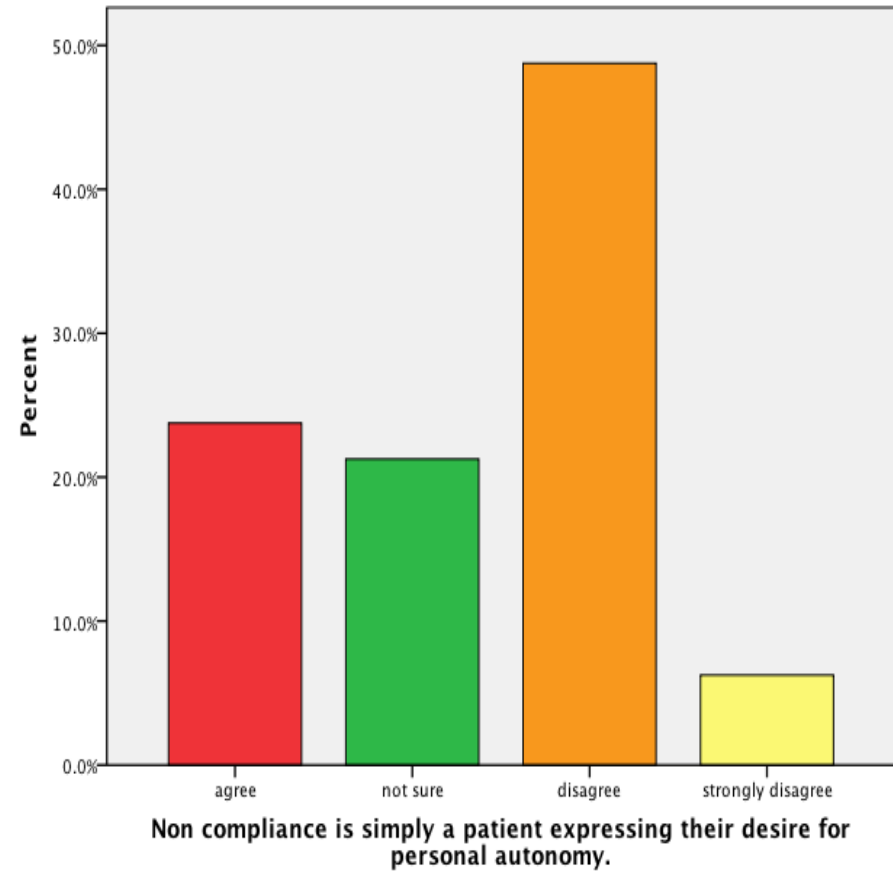
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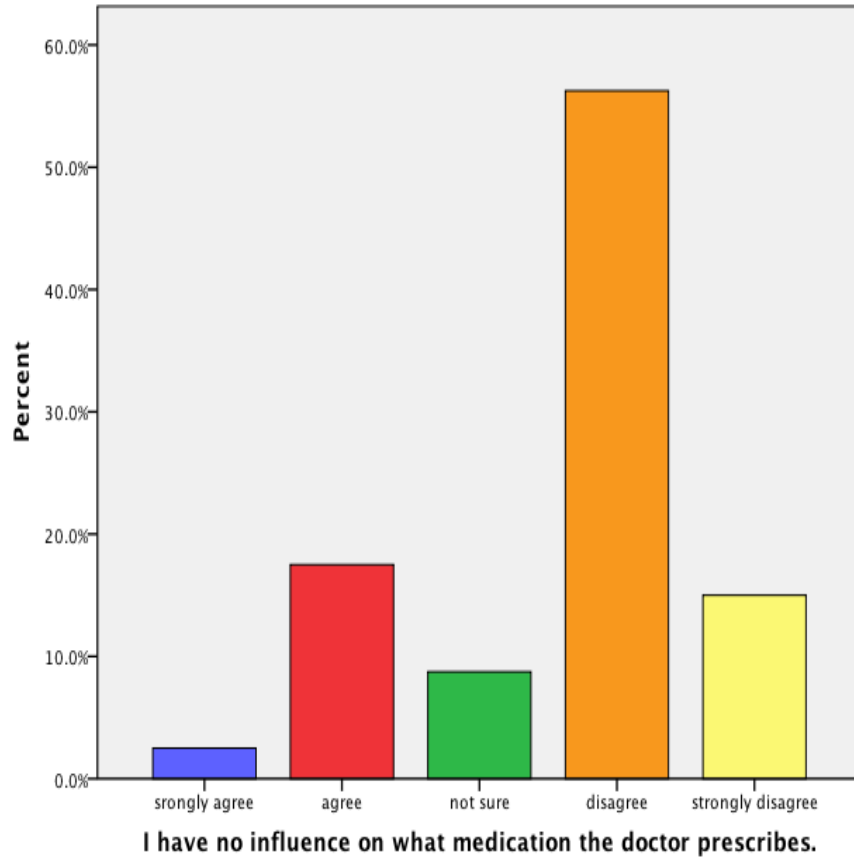
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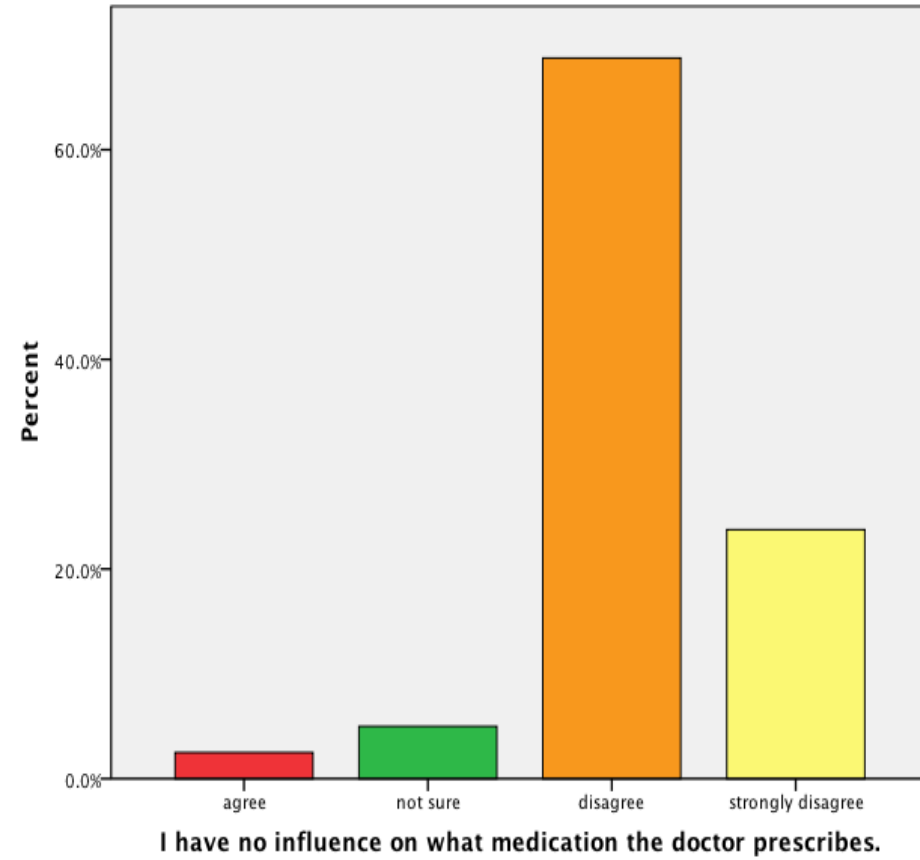
Point 2 - post- course completion:



Question 19 - Point 1; pre- course completion:

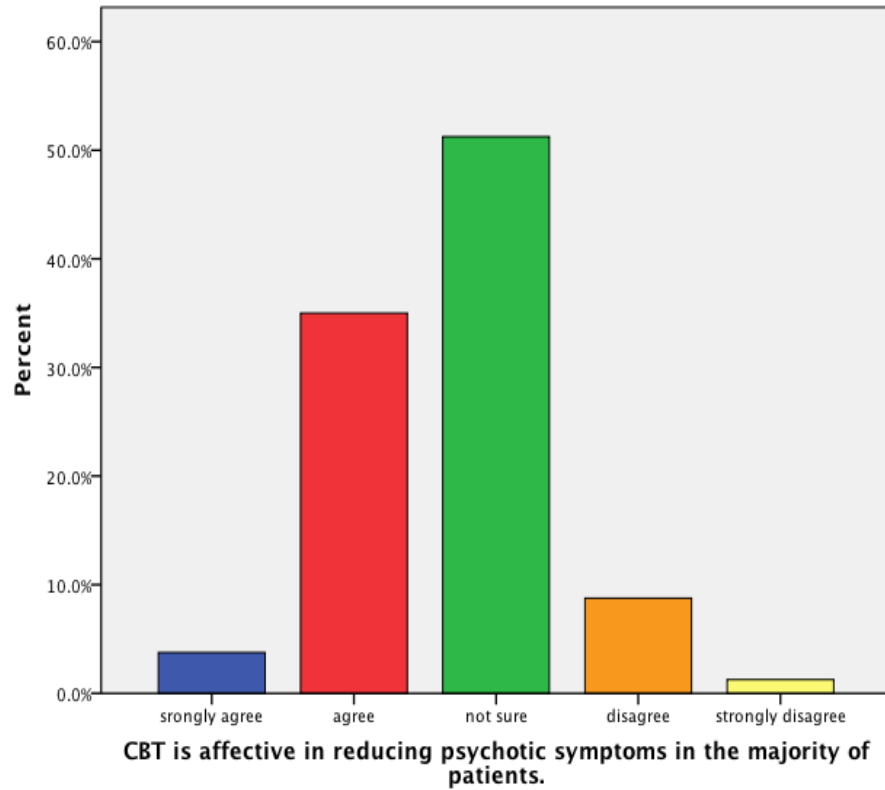


Point 2 - post- course completion:

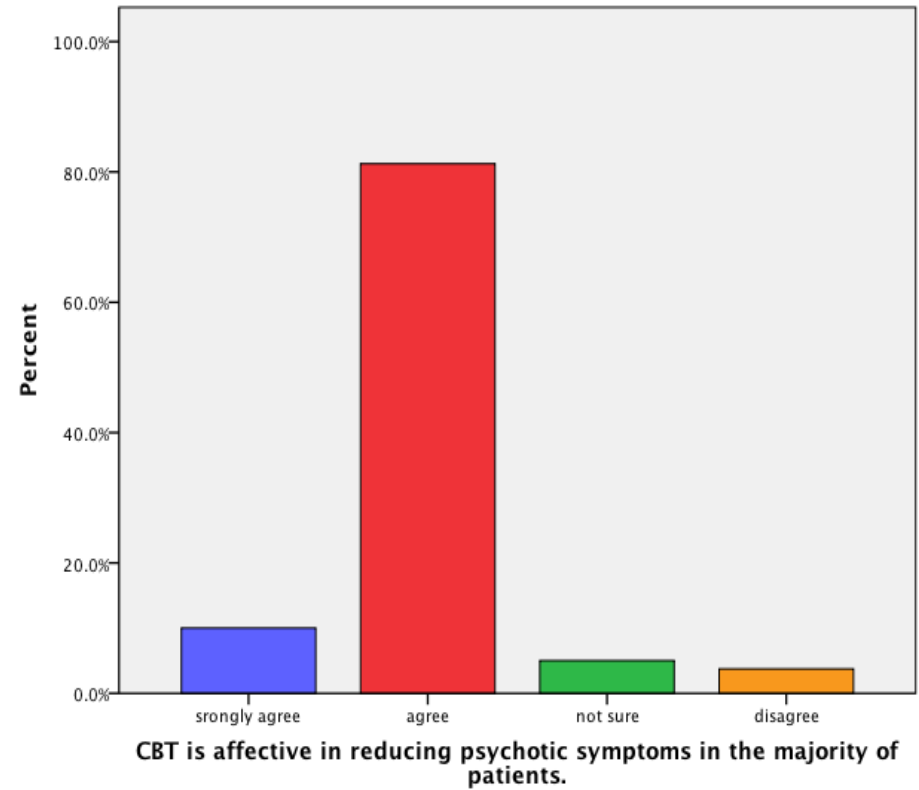




Question 20 - Point 1; pre- course completion:



Point 2; post- course completion:



**Appendix 8 CTS-R.**

**Cognitive Therapy Scale - Revised (CTS-R)**

I.-M. Blackburn, I.A. James, D.L. Milne & F.K. Reichelt

Collaborators: Garland, C. Baker, S.H. Standart & A. Claydon

Newcastle upon Tyne, UK

December 2001

Name: \_

Scorer: \_

Date: \_

Session: \_

## COGNITIVE THERAPY SCALE – REVISED (CTS-R)

### The rating of the scale

The present seven point scale (i.e. a 0-6 Likert scale) extends from (0) where the therapist did not adhere to that aspect of therapy (non-adherence) to (6) where there is adherence and very high skill. Thus the scale assesses both adherence to therapy method and skill of the therapist. To aid with the rating of items of the scale, an outline of the key features of each item is provided at the top of each section. A description of the various rating criteria is given in the right hand margin - see example below in Figure 1. Further details are provided in the accompanying manual. The examples are intended to be used as useful guidelines only. They are not meant to be used as prescriptive scoring criteria, rather providing both illustrative anchor points and guides.

### Adjusting the scale in the presence of patient difficulties

The scale's dimensions were devised for patients assessed as being well/moderately suited for cognitive therapy (Safran & Segal, 1990). As such, adjustments may need to be made when patient difficulties are evident (e.g. excessive avoidance). Indeed, with problematic patients it is sometimes difficult to apply CT methods successfully; that is, with desirable change. In such circumstances the rater needs to assess the therapist's therapeutic skills in the application of the methods. Thus even though the therapist may be unsuccessful at promoting change, credit should be given for demonstrations of appropriate skilful therapy.

Safran, J.D. & Segal, Z.V. (1990) *Interpersonal processes in cognitive therapy*. New York, Basic Books.

Figure 1: Example of the scoring layout

Key features: this is an operationalised description of the item (see examples within the CTS-R).

Mark with an 'X' on the vertical line, using whole and half numbers, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

N.B. When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy and perceived patient difficulty

Competence level Examples

	0	absence of feature, or highly inappropriate performance
Incompetent (0-1)	1	Inappropriate performance, with major problems evident
Novice (1-2)	2	evidence of competence, but numerous problems and lack of consistency
Advanced beginner (2-3)	3	competent, but some problems and/or inconsistencies
Competent (3-4)	4	good features, but minor problems and/or inconsistencies
Proficient (4-5)	5	very good features, minimal problems and/or inconsistencies
Expert (5-6)	6	excellent performance, or very good even in the face of patient difficulties

\* The present scale has incorporated the Dreyfus system (Dreyfus, 1989) for denoting competence, which is described fully in the manual. Please note that the top marks (i.e. near the 'expert' end of the continuum) are reserved for those therapists demonstrating highly effective skills, particularly in the face of difficulties (i.e. highly aggressive or avoidant patients; high levels of emotional discharge from the patients; and various situational factors).

The 'Key Features' describe the important features that need to be considered when scoring each item. When rating the item, you must first identify whether some of the features are present. You must then consider whether the therapist should be regarded as competent with the features. If the therapist includes most of the key features and uses them appropriately (i.e. misses few relevant opportunities to use them), the therapist should be rated very highly.

It is important to remember that the scoring profile for this scale should approximate to a normal distribution (i.e. mid-point 3), with relatively few therapists scoring at the extremes.

Dreyfus, H. L. (1989). The Dreyfus model of skill acquisition. In J. Burke (ed.) Competency based education and training. London: Falmer Press.

## ITEM 1 - AGENDA SETTING & ADHERENCE

Key features: To address adequately topics that have been agreed and set in an appropriate way. This involves the setting of discrete and realistic targets collaboratively. The format for setting the agenda may vary according to the stage of therapy - see manual.

Three features need to be considered when scoring this item:

- (i) presence/absence of an agenda which is explicit, agreed and prioritised, and feasible in the time available;
- (ii) appropriateness of the contents of the agenda (to stage of therapy, current concerns etc.), a standing item being a review of the homework set previously;
- (iii) appropriate adherence to the agenda.

Mark with an 'X' on the vertical line, the level to which you think the therapist has fulfilled the core function. The descriptive features on the right are designed to guide your decision.

NB: Agenda setting requires collaboration and credit for this should be given here, and here alone. Collaboration occurring at any other phase of the session should be scored under Item 3 (Collaboration).

Competence level	Examples NB: Score according to features, not examples!
0	No agenda set, highly inappropriate agenda set, or agenda not adhered to.
1	Inappropriate agenda set (e.g. lack of focus, unrealistic, no account of patient's presentation, homework not reviewed).
2	An attempt at an agenda made, but major difficulties evident (e.g. unilaterally set). Poor adherence.
3	Appropriate agenda, which was set well, but some difficulties evident (e.g. poor collaboration). Some adherence.
4	Appropriate agenda, minor difficulties evident (e.g. no prioritisation), but appropriate features covered (e.g. review of homework). Moderate adherence.
5	Appropriate agenda set with discrete and prioritised targets, reviewed at the end. Agenda adhered to. Minimal problems.
6	Excellent agenda set, or highly effective agenda set in the face of difficulties.



## ITEM 2 - FEEDBACK

Key features: The patient's and therapist's understanding of key issues should be helped through the use of two-way feedback. The two major forms of feeding back information are through general summary and chunking of important units of information. The use of appropriate feedback helps both the therapist to understand the patient's situation, and the patient to synthesise material enabling him/her to gain major insight and make therapeutic shifts. It also helps to keep the patient focused.

Three features need to be considered when scoring this item:

- i. presence and frequency, or absence, of feedback. Feedback should be given/elicited throughout the therapy - with major summaries both at the beginning (review of week) and end (session summary), while topic reviews (i.e. chunking) should occur throughout the session;
- ii. appropriateness of the contents of the feedback;
- iii. manner of its delivery and elicitation (NB: can be written).

Competence Level	Examples NB: Score according to features, not examples!
0	Absence of feedback or highly inappropriate feedback.
1	Minimal appropriate feedback (verbal and/or written).
2	Appropriate feedback, but not given frequently enough by therapist, with insufficient attempts to elicit and give feedback (e.g. feedback too vague to provide opportunities for understanding and change).
3	Appropriate feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery.
4	Appropriate feedback given and elicited frequently, facilitating moderate therapeutic gains. Minor problems evident (e.g. inconsistent).
5	Highly appropriate feedback given and elicited regularly, facilitating shared understanding and enabling significant therapeutic gains. Minimal problems.
6	Excellent use of feedback, or highly effective feedback given and elicited regularly in the face of difficulties.

### ITEM 3 - COLLABORATION

Key features: The patient should be encouraged to be active in the session. There must be clear evidence of productive teamwork, with the therapist skilfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making) and take responsibility. However, the therapist must not allow the patient to ramble in an unstructured way.

Three features need to be considered: the therapist style should encourage effective teamwork through his/her use of:

- i. verbal skills (e.g. non-hectoring);
- ii. non-verbal skills (e.g. attention and use of joint activities);
- iii. sharing of written summaries.

NB: Questioning is a central feature with regard to this item, but questions designed to facilitate reflections and self discovery should be scored under Item 9 (Guided Discovery).

Competence level	Examples NB: Score according to features, not examples!
0	Patient is actively prevented or discouraged from being collaborative.
1	The therapist is too controlling, dominating, or passive.
2	Some occasional attempt at collaboration, but didactic style or passivity of therapist encourages passivity or other problems in the therapeutic relationship.
3	Teamwork evident, but some problems with collaborative set (e.g. not enough time allowed for the patient to reflect and participate actively).
4	Effective teamwork is evident, but not consistent. Minor problems evident.
5	Effective teamwork evident throughout most of the session, both in terms of verbal content and use of written summaries. Minimal problems.
6	Excellent teamwork, or highly effective teamwork in the face of difficulties.

#### ITEM 4 - PACING AND EFFICIENT USE OF TIME

Key features: The session should be well 'time managed' in relation to the agenda, with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason.

Three features need to be considered:

- i. the degree to which the session flows smoothly through the discrete phases;
- ii. the appropriateness of the pacing throughout the session;
- iii. the degree of fit to the learning speed of the patient.

Competence level	Examples NB: Score according to features, not examples!
0	Poor time management leads either to an aimless or overly rigid session.
1	The session is too slow or too fast for the current needs and capacity of the patient.
2	Reasonable pacing, but digression or repetitions from therapist and/or patient lead to inefficient use of time; unbalanced allocation of time, over time.
3	Good pacing evident some of the time, but diffuse at times. Some problems evident.
4	Balanced allocation of time with discrete start, middle and concluding phases evident. Minor problems evident.
5	Good time management skills evident, session running smoothly. Therapist working effectively in controlling the flow within the session. Minimal problems.
6	Excellent time management, or highly effective management evident in the face of difficulties.

## ITEM 5 - INTERPERSONAL EFFECTIVENESS

Key features: The patient is put at ease by the therapist's verbal and non-verbal (e.g. listening skills) behaviour. The patient should feel that the core conditions (i.e. warmth, genuineness, empathy and understanding) are present. However, it is important to keep professional boundaries. In situations where the therapist is extremely interpersonally effective, he/she is creative, insightful and inspirational.

Three features need to be considered:

- i. empathy - the therapist is able to understand and enter the patient's feelings imaginatively and uses this understanding to promote change;
- ii. genuineness - the therapist has established a trusting working relationship;
- iii. warmth - the patient seems to feel liked and accepted by the therapist.

Competence Level	Examples NB: Score according to features, not examples!
0	Therapist's manner and interventions make the patient disengage and become distrustful and/or hostile (absence of/or excessive i, ii, iii).
1	Difficulty in showing empathy, genuineness and warmth.
2	Therapist's style (e.g. intellectualisation) at times impedes his/her empathic understanding of the patient's communications.
3	The therapist is able to understand explicit meanings of patient's communications, resulting in some trust developing. Some evidence of inconsistencies in sustaining relationship.
4	The therapist is able to understand the implicit, as well as the explicit meanings of the patient's communications and demonstrates it in his/her manner. Minor problems evident (e.g. inconsistent).
5	The therapist demonstrates very good interpersonal effectiveness. Patient appears confident that he/she is being understood, which facilitates self-disclosure. Minimal problems.
6	Excellent interpersonal effectiveness, or highly interpersonally effective in the face of difficulties



## ITEM 6 - ELICITING OF APPROPRIATE EMOTIONAL EXPRESSION

Key features: The therapist facilitates the processing of appropriate levels of emotion by the patient. Emotional levels that are too high or too low are likely to interfere with therapy. The therapist must also be able to deal effectively with emotional issues which interfere with effective change (e.g. hostility, anxiety, excessive anger). Effective facilitation will enable the patient to access and express his/her emotions in a way that facilitates change.

Three features have to be considered:

- i. facilitation of access to a range of emotions;
- ii. appropriate use and containment of emotional expression;
- iii. facilitation of emotional expression, encouraging appropriate access and differentiation of emotions.

Competence Level	Examples NB: Score according to features, not examples!
0	Patient is under- or over stimulated (e.g. his/her feelings are ignored or dismissed or allowed to reach an unmanaged pitch). Or the therapist's own mood or strategies (e.g. intellectualisation) adversely influences the session.
1	Failure to facilitate access to, and expression of, appropriate emotional expression.
2	Facilitation of appropriate emotional expression evident, but many relevant opportunities missed.
3	Some effective facilitation of appropriate emotional expression, created and/or maintained. Patient enabled to become slightly more aware.
4	Effective facilitation of appropriate emotional expression leading to the patient becoming more aware of relevant emotions. Minor problems evident.
5	Very effective facilitation of emotional expression, optimally arousing the patient's motivation and awareness. Good expression of relevant emotions evident - done in an effective manner. Minimal problems.
6	Excellent facilitation of appropriate emotional expression, or effective facilitation in the face of difficulties

## ITEM 7 - ELICITING KEY COGNITIONS

Key features: To help the patient gain access to his/her cognitions (thoughts, assumptions and beliefs) and to understand the relationship between these and their distressing emotions. This can be done through the use of questioning, diaries and monitoring procedures.

Three features need to be considered:

- i. eliciting cognitions that are associated with distressing emotions (i.e. selecting key cognitions or hot thoughts);
- ii. the skilfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);
- iii. choosing the appropriate level of work for the stage of therapy (i.e. automatic thoughts, assumptions, or core beliefs).

NB: This item is concerned with the general work done with eliciting cognitions. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (change methods).

Competence Level	Examples NB: Score according to features, not examples!
0	Therapist fails to elicit relevant cognitions.
1	Inappropriate cognitions and emotions selected, or key cognitions/emotions ignored.
2	Some cognitions/emotions (or one key cognition, e.g. core belief) elicited, but links between cognitions and emotions not made clear to patient
3	Some cognitions/emotions (or one key cognition) elicited in a competent way, although some problems evident.
4	A number of cognitions and emotions (or one key cognition) elicited in verbal or written form, leading to a new understanding of their relationship. Minor problems evident.
5	Effective eliciting and selection of a number of cognitions/emotions (or one key cognition), which are generally dealt with appropriately. Minimal problems.
6	Excellent work done on key cognition(s) and emotion(s), or very good work done in the face of difficulties.

## ITEM 8 - ELICITING BEHAVIOURS

Key features: To help the patient gain insight into the effect of his/her behaviours and planned behaviours with respect to the problems. This can be done through the use of questioning, diaries and monitoring procedures. This item helps ensure that the therapy is fully integrated with the patient's environment.

Two features need to be considered:

- i. eliciting behaviours that are associated with distressing emotions (including, use of safety seeking behaviours);
- ii. the skilfulness and breadth of the methods used (i.e. socratic questioning; appropriate monitoring, imagery, role-plays, etc.);

NB: This item is concerned with the general work done with eliciting behaviours. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (change methods).

Competence Level	Examples NB: Score according to features, not examples!
0	Therapist fails to elicit relevant behaviours.
1	Inappropriate behaviours focused on.
2	Some behaviours elicited, but links between behaviours and emotions not made clear to patient.
3	Some behaviours/emotions elicited in a competent way, although some problems evident.
4	A number of behaviours/emotions elicited in verbal or written form, leading to a new understanding of their importance in maintaining problems. Minor difficulties evident.
5	Effective eliciting and selection of a number of behaviours/emotions, which are generally dealt with appropriately. Minimal problems.
6	Excellent work done on behaviours and emotions, or very good work done in the face of difficulties.

## ITEM 9 - GUIDED DISCOVERY

Key features: The patient should be helped to develop hypotheses regarding his/her current situation and to generate potential solutions for him/herself. The patient is helped to develop a range of perspectives regarding his/her experience. Effective guided discovery will create doubt where previously there was certainty, thus providing the opportunity for re-evaluation and new learning to occur.

Two elements need to be considered:

- i. the style of the therapist - this should be open and inquisitive;
- ii. the effective use of questioning techniques (e.g. Socratic questions) should encourage the patient to discover useful information that can be used to help him/her to gain a better level of understanding.

Competence Level	Examples NB: Score according to features, not examples!
0	No attempt at guided discovery (e.g. hectoring and lecturing).
1	Little opportunity for discovery by patient. Persuasion and debate used excessively.
2	Minimal opportunity for discovery. Some use of questioning, but unhelpful in assisting the patient to gain access to his/her thoughts or emotions or to make connections between themes.
3	Some reflection evident. Therapist uses primarily a questioning style which is following a productive line of discovery.
4	Moderate degree of discovery evident. Therapist uses a questioning style with skill, and this leads to some synthesis. Minor problems evident.
5	Effective reflection evident. Therapist uses skilful questioning style leading to reflection, discovery, and synthesis. Minimal problems.
6	Excellent guided discovery leading to a deep patient understanding. Highly effective discovery produced in the face of difficulties, with evidence of a deeper understanding having been developed.

## ITEM 10 - CONCEPTUAL INTEGRATION

Key features: The patient should be helped to gain an appreciation of the history, triggers and maintaining features of his/her problem in order to bring about change in the present and future. The therapist should help the patient to gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to his/her problem. A good conceptualisation will examine previous cognitions and coping strategies as well as current ones. This theory-based understanding should be well integrated and used to guide the therapy forward.

Two features need to be considered:

- i. the presence/absence of an appropriate conceptualisation which is in line with goals of therapy;
- ii. the manner in which the conceptualisation is used (e.g. used as the platform for interventions, homework etc.).

NB: This item is to do with therapeutic integration (using theory to link present, past and future). If the therapist deals specifically with cognitions and emotions, this should be scored under Items 6 (Facilitation of Emotional Expression) and 7 (Eliciting Key of Cognitions)

Competence Level	Examples NB: Score according to features, not examples!
0	The absence of an appropriate conceptualisation.
1	The lack, or inappropriateness or misapplication of a conceptualisation leads to a neutral impact (e.g. interferes with progress or leads to aimless application of procedures).
2	Some rudimentary conceptualisation arrived at, but not well integrated with goals of therapy. Does not lead to a clear rationale for interventions.
3	Cognitive conceptualisation partially developed with some integration, but some difficulties evident (e.g. in synthesising and in sharing it with the patient). Leads to coherent interventions.
4	Cognitive conceptualisation is moderately developed and integrated within the therapy. Minor problems evident.
5	Cognitive conceptualisation is very well developed and integrated within the therapy - there is a credible cognitive understanding leading to major therapeutic shifts. Minimal problems.
6	Excellent development and integration evident, or highly effective in the face of difficulties.

## ITEM 11 - APPLICATION OF CHANGE METHODS

Key features: Therapist skilfully uses, and helps the patient to use, appropriate cognitive and behavioural techniques in line with the formulation. The therapist helps the patient devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions. The therapist also helps the patient to both apply behavioural techniques in line with the formulation, and develop suitable plans to promote effective change. The therapist helps the patient to identify potential difficulties and think through the cognitive rationales for performing the tasks. The methods provide useful ways for the patient to test-out cognitions practically and gain experience in dealing with high levels of emotion. The methods also allow the therapist to obtain feedback regarding the patient's level of understanding of prospective practical assignments (i.e. by the patient performing the task in- session).

Three features need to be considered:

- i. the appropriateness and range of both cognitive methods (e.g. cognitive change diaries, continua, distancing, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.) and behavioural methods (e.g. behavioural diaries, behavioural tests, role play, graded task assignments, response prevention, reinforcement of patient's work, modelling, applied relaxation, controlled breathing, etc.);
- ii. the skill in the application of the methods - however, skills such as feedback, interpersonal effectiveness, etc. should be rated separately under their appropriate items;
- iii. the suitability of the methods for the needs of the patient (i.e. neither too difficult nor complex).

NB: This item is not concerned with accessing or identifying thoughts, rather with their re-evaluation.

Competence Level	Examples NB: Score according to features, not examples!
0	Therapist fails to use or misuses appropriate cognitive and behavioural methods.
1	Therapist applies either insufficient or inappropriate methods, and/or with limited skill or flexibility.
2	Therapist applies appropriate methods, but major difficulties evident.
3	Therapist applies a number of methods in competent ways, although some problems evident (e.g. the interventions are incomplete).
4	Therapist applies a range of methods with skill and flexibility, enabling the patient to develop new perspectives. Minor problems evident.
5	Therapist systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.
6	Excellent range and application, or successful application in the face of difficulties.



## ITEM 12 - HOMEWORK SETTING

Key features: This aspect concerns the setting of an appropriate homework task, one with clear and precise goals. The aims should be to negotiate an appropriate task for the stage of therapy in line with the conceptualisation; to ensure the patient understands the rationale for undertaking the task; to test out ideas, try new experiences, predict and deal with potential obstacles, and experiment with new ways of responding. This item ensures that the content of the therapy session is both relevant to, and integrated with, the patient's environment. There are three aspects to this item:

- i. presence/absence of a homework task in which clear and precise goals have been set;
- ii. the task should be derived from material discussed in the session, such that there is a clear understanding of what will be learnt from performing the task;
- iii. the homework task should be set jointly, and sufficient time should be allowed for it to be explained clearly (i.e. explain, discuss relevance, predict obstacles, etc.).

NB: Review of homework from the previous session should be rated in Item 1 (Agenda Setting)

Competence Level	Examples NB: Score according to features, not examples!
0	Therapist fails to set homework, or sets inappropriate homework.
1	Therapist does not negotiate homework. Insufficient time allotted for adequate explanation, leading to ineffectual task being set.
2	Therapist negotiates homework unilaterally and in a routine fashion, without explaining the rationale for new homework.
3	Therapist has set an appropriate new homework task, but some problems evident (e.g. not explained sufficiently and/or not developed jointly).
4	Appropriate new homework jointly negotiated with a clear goals and rationales. However, minor problems evident.
5	Appropriate homework negotiated jointly and explained well, including an exploration of potential obstacles. Minimal problems.
6	Excellent homework negotiated, or highly appropriate one set in the face of difficulties.

## **Appendix 9: CBT based clinic bid.**



### **PROPOSAL**

**The delivery of a psychosocial interventions (PSI) clinic to patients with psychosis from a holistic person centred approach, drawing on cognitive behavioural (CBT) and other psychotherapeutic approaches.**

**Psychosocial Interventions/Cognitive Behavioural Therapy Clinic for patients with Psychosis**

**AT MACQUARIE HOSPITAL**



#### **Service:**

The PSI/CBT service will offer holistic person centred and evidence based talking therapies to individuals with distressing positive symptoms of psychosis, or secondary emotional problems in the context of a history of psychosis. It is a self-help type of therapy consisting of talking to clients about their prioritised difficulties, how they arose and what they understand about them. The aim is not necessarily to get rid of symptoms but to alleviate distress and disability. New ways of reframe experiences or new strategies to cope - are discussed and practiced outside of sessions. There will also be an educational/supervisory component implicit within the service design to enable mental health professionals to learn and deliver PSI/CBT interventions with their clients. The service will offer up to date holistic evidence based intervention and also conduct focused research during the delivery of care. Consultative guidance will also be offered pertinent to ongoing patient care

**The service is for:**

The service will accept referrals for individuals who experience distressing positive symptoms such as hallucinations, delusions and thought disturbances. Also referrals for individuals with a history of psychosis, whose main current difficulties are secondary emotional problems, will be considered.

**Opening Hours**

1 day per week between 0930 and 1230.

**Other Information**

Therapy involves meeting with a therapist regularly for up to 6 months, usually weekly or fortnightly for approx 1 hour. The service provides psychological input only and does not have the expertise to offer medication review or prescribe medication. This level of consultation can be offered under the guise of medication management/compliance therapy.

The service therapists are mental health professionals who specialist in PSI/CBT, or are mental health professionals undergoing CBT training. The clinic will be run by Euan Hails, Area Clinical Nurse Consultant and Cognitive Behavioural Psychotherapist in conjunction with medical and psychology colleagues. For further information please contact Euan on 98875082.

Research Plan/proposal:

Rationale:

Referrals accepted from Macquarie Hospital Units for individuals with psychosis.

The population (all referrals) will be randomised into an experimental and treatment as usual (TAU) groups.

Methodology:

Mixed method approach utilising scientific and humanistic principles and methods of data collection and analysis.

Method:

Identification of referrals on Units, referrals to central point – then randomisation into control + experimental groups. Then replication of therapy to control group post completion with experimental (to ensure all patients get the same treatment). An initial cohort of up to 8 patients will be identified by the multi-professional teams to form the experimental and control groups.

Application of MH-oeT pre – randomisation + at follow-up.

Application of therapy specific scales at baseline, half way through therapy, at the end the 6 and 12 months post therapy.

Assessment of pts pre and post by external assessor.

Scales, (CAVS, KGV, BDI, BAI)

Data collection:

Pre-treatment by key worker on Unit (MHOET).

Independent assessor pre-treatment.

During therapy by therapist.

Post treatment MH-oeT by key worker on Unit.

Post treatment by independent assessor.

Data analysis:

NVivo 7.

SPSS.

MH-oeT data tool.

Ethical considerations:

Ethical approval will be sort and gained prior to the start of the trial, patient information sheets will be developed, as will patient consent forms. The patient will be able to withdraw from the trial at any stage, and will be fully informed of their randomisation status.

Time scale:

Pore treatment:

3 to 6 months.

Treatment:

6 to 8 months.

RP 6 then 12 months.

Repeat for control group.

Definition of treatment as usual: –

As PSI/CBT will be a planned addition to the multi-professional patient centred care plan for the purpose of this trial. A comparison will be made to the usual patient centred treatment plan whilst randomised patient referrals are on the therapy waiting list. This will involve administration of the MH-oeT data set and therapy based scales that will be used in PSI/CBT treatment. Results will be compared once the data set is gathered and analysis conducted. The

aim is to identify a difference in patient psychopathology and levels of function pre and post inclusion in the therapy stream and not to prove that CBT/PSI is better than TAU, but that it is a useful adjunct therapy to patient outcomes and recovery. The focus of this researcher is to examine "real-world" practice settings and the subsequent dissemination and implementation of CBT/PSI strategies to the Units if efficacy is proven.



