COGNITIVE BEHAVIOUR THERAPY (CBT):
‘SKILLS FOR PRACTICE’ TRAINING:
AN EXPLORATION OF MENTAL HEALTH PROFESSIONALS’
EXPERIENCE.

BY
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MASTERS IN COGNITIVE PSYCHOTHERAPY
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DECLARATION FORM

Course Title: Masters of Science in Cognitive Psychotherapy

Title: Cognitive Behaviour Therapy (CBT): ‘Skills for Practice’ Training: An Exploration of Mental Health Professionals Experience.

Name: Lucy Roberts

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# ABBREVIATIONS

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# ABSTRACT
Title: Cognitive Behaviour Therapy (CBT): ‘Skills for Practice’ Training: An Exploration of Mental Health Professionals’ Experience.

Name: Lucy Roberts

O Shea et al. (2010) developed a training model (CBT ‘Skills for Practice’) for the Irish Mental Health Service, which aimed to enhance skills for clinical practice for mental health professionals who provide psychosocial interventions to patients as part of their day to day work. The programme content was based upon principles and methods of evidence-based CBT practice. Williams et al. (2011) suggest that low intensity interventions can be developed within the existing workforce by training initiatives that aim to introduce CBT skills into everyday clinical practice.

This qualitative study aimed to explore mental health professionals’ experience of undertaking the CBT ‘Skills for Practice’ training, to examine the impact that the training had on their clinical practice and to identify factors that assisted and were barriers to the implementation of the CBT skills in clinical practice. A phenomenological approach was adopted to capture the lived experience of the mental health professionals who attended the CBT skills training.

In total six mental health professionals who had completed the CBT ‘Skills for Practice’ training agreed to take part in the study. Semi-structured interviews were conducted with the participants; the data was recorded and transcribed verbatim. Braun and Clarke’s (2013) thematic analysis was utilised to analyse the data and to guide the identification of the main themes. The results identified the main themes from the data which included; the experience of the CBT ‘Skills for Practice’ training, attitudes and beliefs about CBT and the training, the factors that assisted the application of the CBT skills and the factors that were barriers to the application of the CBT skills.

In conclusion, the results of this research indicated that mental health professionals’ experience of CBT skills training was a positive one and all reported use of the CBT skills within their clinical practice area. The factors that assisted some disciplines with the use of CBT skills included supervision structures, clinical management/leadership and professional autonomy. In contrast, for other disciplines, CBT skills were used in a limited way and were described as difficult to maintain in clinical practice following the training. This appeared to be related to a number of factors which included; the absence of criteria for selection to attend the training, the suitability of the clinical environment to practice the CBT skills post training, the lack of supervision structures, clinical management/leadership issues and the complex nature of their professional roles. Supervision structures for all disciplines are recommended to facilitate learning within clinical practice areas (Milne, 2009), if evidence-based psychological interventions are to be developed and maintained (Grey et al, 2008, Shafran et al, 2009).
Chapter 1: Introduction

1.1 Introduction
This thesis provides an account of mental health professionals’ experience of CBT ‘Skills for Practice’ training from a phenomenological perspective. The participants were recruited from the last two cohorts of mental health professionals who completed the CBT ‘Skills for Practice’ training within the Health Service Executive- South East (HSE-SE) region. Semi-structured interviews were conducted which were audio taped and transcribed verbatim, to examine the lived experiences of the participants’. Braun and Clarke’s (2013) thematic analysis (TA) was utilised to analyse the collected data and to identify the main themes. This chapter presents the background to the study, the aims of the study and the rationale for the study, a brief overview of the methodology and an outline of the dissertation.

A large body of literature relating to CBT skills training and its components formed the basis of this study. The literature included in the review met the following criteria: English language publication related to CBT skills and training from 1975-2013. The following databases were used to review the literature: PsychINFO, PsychARTICLES, and Pub Med. The Google search engine was utilised, the Trinity College Dublin (TCD) library and the Health Services Executive (HSE) Library, Kilkenny were also used to access journals and books relevant to the study. The search terms included; ‘Cognitive Therapy’, ‘Cognitive Behaviour Therapy’, ‘CBT skills’, ‘Skills Development in Nursing’, ‘Low Intensity Training’, ‘Dissemination of CBT’, ‘Transfer of Clinical Skills to Practice’, ‘Skills Training in Mental Health’, ‘Evidence-based Practice’, ‘An Bord Altranis’, ‘Irish Mental Health Policy and Guidelines’, ‘United Kingdom Mental Health Policy and Guidelines’, ‘Learning Theories’ and ‘Supervision’.

1.2 Background to the study
The ‘Reach Out’ Programme, Improving Access to Psychological Treatments (IAPT 2008), is a training initiative based on CBT, which
was developed to train practitioners in low intensity psychological interventions in the United Kingdom (UK). Research shows that CBT is more effective when delivered in a low intensity format compared to other types of treatment (Gellatly et al. 2007). Williams et al. (2011) suggest that low intensity interventions can be developed within the existing workforce by training initiatives that aim to introduce CBT skills into everyday clinical practice.

O Shea et al. (2010) developed a training model for the Irish Mental Health Service which aimed to enhance skills for clinical practice for mental health professionals who provide psychosocial interventions to patients as part of their day to day work. The programme content was based upon principles and methods of evidence-based CBT practice. The training was a collaborative initiative between the Regional Centre of Nurse and Midwifery Education (RCNME), Mental Health Services HSE-SE and Cognitive Therapy Training (CTT).

CBT: ‘Skills for Practice’ training was provided to mental health professionals in the HSE-SE region (which included; Tipperary, Waterford, Carlow, Wexford and Kilkenny) between 2009 and 2012. The training aimed to prepare mental health professionals to incorporate CBT skills into their practice. The course was attended by 244 staff comprising of; Staff Nurses (SN), Social Workers (SW), Systemic Psychotherapists (SP), Addiction Counsellors (AC), Counsellors, Clinical Nurse Specialists (CNS), Clinical Nurse Managers (CNM), Psychiatrists, Psychologists, Drug and Alcohol workers and Occupational Therapists (OT), eleven cohorts in total. The course was run by CT Training and facilitated by three experienced and accredited CBT therapists. The training included six day workshops, six hours per day, held monthly over a three month period which amounted to thirty six contact hours. Participants were expected to complete eighteen hours of independent reading, two hours clinical practice per week for the duration of the course (minimum of eighteen hours) and spend eight hours with an allocated practice mentor.
1.3 Aims of the study
The purpose of this current study was; to explore mental health professionals’ experience of undertaking the CBT ‘Skills for Practice’ training, to establish the impact the training had on their clinical practice and to identify factors that helped or hindered implementing the skills in clinical practice. This study aimed to explore the impact of CBT skills training within an Irish setting.

1.4 Rationale of the study
The idea for this research was generated from various sources; firstly the personal and professional experiences of the researcher who had undergone the CBT ‘Skills for Practice’ training. Secondly, from a review of the literature, evidence suggests that short term CBT skills training can have a beneficial impact on clinical practice (Duffy et al., 2013, Simons et al., 2010, Cort et al., 2009, Leff et al., 2001). However, there is also literature to indicate that short term CBT skills training has a limited impact on clinical practice (King et al., 2002, Mannix et al., 2006, Donoghue et al., 2004, Williams et al., 2010). Lastly, from anecdotal evidence, this indicated that there were discrepancies amongst mental health professionals in applying the CBT skills in to clinical practice. The current study aimed to explore the experience of CBT ‘Skills for Practice’ training in Ireland with mental health professionals using thematic analysis (Braun and Clarke, 2013).

1.5 Methodological overview
Phenomenology is a philosophy that is concerned with the question of how individuals make sense of their world (Bryman 2008). A phenomenological approach was adopted in this study to capture the lived experience of the mental health professionals who attended the CBT skills training. In total six mental health professionals who had completed the CBT ‘Skills for Practice’ training agreed to take part in the study. Semi-structured interviews were conducted with the participants; the data was recorded and transcribed verbatim. Braun and Clarke’s (2013) thematic analysis was utilised to analyse the data,
to guide the identification of the main themes and to establish the results, which were then discussed in relation to the relevant literature.

1.6 Summary
This chapter has outlined a qualitative method of exploring mental health professionals’ experience of CBT ‘Skills for Practice’. The research question, the background to the study, the aims, rationale, and methodology utilised in the study have been identified in this introduction Chapter 1. Chapter 2 will outline the theoretical literature in relation to CBT and CBT training. Chapter 3 will describe and provide a rationale for the methodological approach adopted. The results will be displayed in Chapter 4. Chapter 5 will include the discussion on the findings along with the implications and recommendations for practice and recommendations for future studies. Chapter 6 will outline the conclusions.
Chapter 2: Literature review

2.1 Introduction
The literature review will outline the changes in recent years to the Irish mental health service and to mental health services in the United Kingdom (UK). It will explore the National Institute for Clinical Excellence (NICE) guidelines and the move towards evidence-based interventions being utilised in clinical practice. The author will examine learning theories, skills development and explore training strategies utilised in relation to CBT ‘Skills for Practice’ training and evaluate the effectiveness of CBT skills training. The transfer of skills in to practice will be discussed. Factors that influence the dissemination of CBT skills, such as supervision and organisational support, will be evaluated.

Irish mental health services faced significant changes due to Ireland’s mental health legislation Government of Ireland (GOI), 2001 and by Ireland’s national mental health policy document ‘A Vision for Change’ Department of Health and Children (DOHC), 2006, which recommends the adoption of a recovery approach to mental health. This document outlines how the delivery of mental health services be moved away from the institutional model of care, to community based care and primarily delivered through Community Mental Health Teams (CMHT). The change in service delivery is aimed to facilitate and promote ‘service user recovery’ in mental health services. Recovery is about developing a purposeful and fulfilling life, despite mental health difficulties (Shepherd et al., 2008).

The Mental Health Commission (MHC) ‘The Quality Framework for Mental Health Services in Ireland’ (2007), highlighted three key enablers for service users to experience a quality mental health service which are; staff skills, competencies and expertise. The MHC ‘A Scoping Study’ (2010), found that respondents recognised the need to develop competencies in psychotherapeutic interventions such as ‘cognitive behaviour skills’ and emphasized that these skills should be
included for all mental health professionals at undergraduate and postgraduate level.

Cusack and Killoury (2012) recommended that nurses increase their clinical capacity through the development of a range of skills and interventions and that evidence-based practice should inform clinical practice and service delivery. The ‘Guiding Framework’ on the proposed Certificate in CBT (HSE, 2013) suggests that mental health nurses and other care professionals are well placed to deliver evidence-based interventions (such as CBT skills) to achieve a recovery orientated mental health service.

Between 2004 and 2007, NICE in the UK (United Kingdom) reviewed the evidence for the effectiveness of a variety of interventions and issued clinical guidelines in relation to mental health (NICE 2004a, 2004b, 2005a, 2005b, 2006.). CBT was recommended as an effective treatment for depression and all anxiety disorders. NICE advocated a ‘stepped-care approach’ to the delivery of psychological therapies in mild to moderate depression and some anxiety disorders.

Layard (2006) and Layard et al. (2007) argued that an increase in access to psychological therapies would largely pay for itself by reducing other depression and anxiety-related public costs (such as welfare benefits) and increasing revenues (taxes from people returning to work). Clark et al. (2009) report that some clients recover from mental health disorders without any professional support. Boer et al. (2009) and Ekers et al. (2013) highlight how CBT training is expensive, and that there are a limited amount of CBT therapists available.

In 2007 the UK Government announced a large-scale initiative for IAPT (Improving Access to Psychological Treatments) within the English National Health Service (NHS). The plan involved training staff to deliver both high and low intensity interventions at primary and secondary care levels. The ‘Reach Out’ programme (IAPT, 2008) was developed as a training initiative based on CBT which aimed to train
practitioners in low intensity psychological interventions in the UK. Research has shown that CBT is more effective when delivered in a low intensity format compared to other types of treatment (Gellatly et al 2007). Clark et al. (2009) found that evidence-based CBT protocols can be transferred into routine clinical settings.

Williams et al. (2011) and Waller et al. (2013) suggest that low intensity interventions can be developed successfully within the existing workforce by training initiatives that aim to introduce CBT skills into everyday clinical practice. Conversely, King et al., (2002) and Walters et al., (2005) found limited long term benefit from providing brief training programmes. Davison (2000) cautions against low intensity interventions being offered as standard treatment. They suggest that some clients may require high intensity treatments and may become disillusioned if the low intensity treatment leads to deterioration in their condition.

In Ireland, O Shea et al. (2010) developed a training model for the Irish Mental Health Service which aimed to enhance skills for clinical practice for mental health professionals who provide psychosocial interventions to patients as part of their day to day work. The initiative was based upon the UK’s training programme (IAPT, 2008) which was focused on the development of low intensity interventions. The programme content was based upon principles and methods of evidence-based CBT practice. The training was a collaborative initiative between the RCNME (Regional Centre for Nursing and Midwifery Education), Mental Health Services (HSE-SE) and CTT (Cognitive Therapy Training). CBT ‘Skills for Practice’ training aimed to prepare mental health professionals to incorporate cognitive behavioural therapy skills into their everyday clinical practice.

2.2 Learning theories
The CBT ‘Skills for Practice’ training utilised various teaching and learning methods including; Didactic Input, Interactive Group Work, Experiential learning, Role-plays, DVD Observation and Reflection,
Independent Learning, Clinical Practice and Mentoring. There were six training days held over a three month period. On completion of the programme participants were expected to have knowledge of CBT principles and know how to use selected methods in practice.

The CBT ‘Skills for Practice’ was facilitated by highly trained, accredited CBT therapists who provided didactic teaching and experiential training methods such as role play to enhance learning outcomes. Kolb and Fry, (1975) suggest that learning involves concrete experience and observation and reflection on the experience. The ‘expert’ teacher instructing and guiding the ‘novice’ trainee (Benner, 1985) so those with advanced skills help the less advanced to operate within their Zone of Proximal Development (ZPD) (Vygotsky, 1978).

Vygotsky’s (1978) social development learning theory states that social factors contribute to cognitive development, valuable learning happens through social interaction with a skilled teacher. The theory proposes that a skilled teacher More Knowledgeable Other (MKO) guides and encourages reciprocal and collaborative learning within the ZPD. The learning is heavily reliant on verbal instruction and key skills in this approach include summarizing, clarifying and scaffolding learning. The teacher helps to arrange a task so that the novice can work on it successfully.

Nestel and Tierney, (2007) found in their study that 96% of students found role play useful as they had an opportunity to observe, rehearse skills and discuss issues and concluded that social interaction was important in learning. However, Kolb (1984) suggests that learning is dependent upon a person’s learning style; a person with an assimilating style may prefer a more traditional teaching approach.

Problem Based Learning (PBL) theory is defined as a method of learning about a subject through the experience of problem solving (Barrows, 1996). New knowledge is obtained through self-directed learning in small groups where the facilitator guides rather than teaches
and students develop problem solving skills. Groups are normally organized according to the Maastricht ‘Seven Jump’ procedures; clarifying concepts, defining the problem, analysing the problem, categorising, formulating learning issues, self-study and discussion of newly acquired knowledge.

In relation to the ‘Skills for Practice’ training, each participant was allocated a practice mentor who they would meet with individually and in small groups for a minimum of eight hours. Participants were asked ‘what they already know’ and ‘what they need to know’ (Barrows, 1996) and to work collectively to enhance learning. The meetings were focused upon the transfer of course learning into practice, the acquisition of skills, sharing of information and problem-solving.

Vernon and Blake (1993) found in their meta-analysis that PBL had educational benefits compared with traditional teaching methods. In contrast, Colliver (2000) found little evidence to demonstrate that PBL assisted the acquisition of basic knowledge and clinical skills and describes the theoretical concepts as ‘weak’. Sweller (1998) cautions that novice learners may struggle with active problem solving and recommends that it be more suitable as a learner becomes more competent.

Work Based Learning (WBL) is a process of learning that focuses on learning within the workplace and involves supporting critical discussion to promote individual effectiveness (Manley et al., 2009). The process of WBL includes the theory and practice modes of learning and explicit and tacit forms of knowledge (Raelin, 1997). It provides the clinician with a method of testing out the assumptions underlying their practice and provides a forum for knowledge to be conceptualised.

In the context of ‘Skills for Practice’ training, skills development was assisted by; didactic teaching, independent reading and observational learning (declarative), clinical practice of the skills for 18 hours and
mentorship (WBL, procedural) and group mentorship (PBL, reflective) (Bennett-Levy, 2006)

The ‘Skills for Practice’ training required the participant to complete 18 hours of clinical practice of the CBT skills in their everyday clinical area (over a three month period). The mentors were in place for the duration of the course to support this cycle of learning and to support the transfer of skills to practice. The mentors were not in a position to model the skills, which may have supported learning further, as role modelling enables the learner to socialise to the use of skills in practice (Murray and Main, 2005).

2.3 Skills development
The development of evidence-based skills and interventions are seen as an essential part of nursing practice (NCNME, 2004, Cusack and Kiloury, 2012). Miller’s (1990) framework for clinical assessment acknowledges the importance of knowledge but recognises that the development of competence is the ‘know how’. Competence is the ability of a registered nurse to practice safely and effectively within his/her scope of practice; the nurse must make a judgement as to whether they are competent to carry out a particular skill An Bord Altranais, (ABA, 2000).

Benner (1984) introduced the concept that expert nurses develop skills over time through a solid educational base as well as a multitude of clinical experiences. The theory proposes five stages of nursing experience; Novice, Advanced Beginner, Competent, Proficient and Expert. Schon (1983) maintains that reflection is an essential process in the development of professional expertise. When basic skills are learned, reflection can be utilised to decide in which area, under which condition and with what people, the appropriate approach to take.

Bennett Levy (2006) outlines in his model of skills development, the three principal systems are Declarative, Procedural and Reflective learning (DPR). The declarative system is concerned with ‘knowing
that'; typically declarative knowledge is learned didactically through lectures or observational learning. Procedural knowledge is the ‘how to’ and ‘when to’ apply the skills in practice, skills become automatic when there is didactic learning, modelling through supervision, practice and feedback. Reflective knowledge is achieved by reflecting on declarative and procedural knowledge to promote skills development.

Heaven et al. (2006) suggest that it is the early experience of attempting to use new skills in practice that determines whether a person maintains or abandons the skills. Also significant clinical time can be spent on administration and managerial duties which can make it difficult to protect time for direct clinical contact Sainsbury Centre Mental Health (SCMH), 2006. Policies should be aimed at developing supervision structures and protecting time for clinicians to practice CBT skills (Sin and Scully, 2008). Evidence suggests that without ongoing support CBT skills are not maintained (Mannix et al. 2006, Grey et al. 2008).

Dreyfus and Dreyfus (1986) model of skill acquisition outlines how to determine and measure the development of skills and competencies. Brosan et al. (2008) found in their study that less competent therapists over rated their level of competence in clinical practice and so it is difficult to gauge the accuracy of self assessment (McManus et al., 2012). Muse and Mc Manus (2013) concluded in their systematic review that it was difficult to evaluate CBT competence and recommended that a CBT skills and competency measure be developed.

2.4 Training strategies
Various training strategies were used in the ‘Skills for Practice’ training. Sholomskas et al. (2005) argue that dissemination methods such as brief didactic training, workshops or the use of manuals are not adequate to ensure the transfer of CBT skills to a competent level in practice. They found that the most effective training method was the combination of workshop, seminar and supervision. Miller and Mount
Rakovshik and McManus (2010) believe that CBT training methods should be evidence-based, providing theoretical instruction followed by experiential learning and ongoing supervision of cases. Yet, in practice it can be difficult for staff to access supervision (Donoghue et al., 2004, Mathieson et al., 2010). Shafran et al. (2009) suggest that dissemination is hampered by the limited relevance of research to routine clinical settings where clients present with complex and co-morbid problems. They propose that urgent research on establishing the best way to teach therapeutic skills is needed to effectively disseminate treatment procedures.

In contrast, Fixsen and Blase (2009) believe that conducting research on a programme or practice does not guarantee effective implementation and advise that a framework of implementation is adopted. Sullivan et al. (2008) found that it is the implementation methods, not the training strategy that is important in transferring clinical training into practice.

2.5 CBT skills training
Research has shown that frontline staff achieved competence in the delivery of CBT techniques following low intensity training (Cort et al., 2009, Hirai and Clum, 2006). Westbrook et al., (2008) in an uncontrolled study found that brief training in CBT could improve the competencies of clinicians and the outcome scores of patients. Waller et al. (2013) established that low intensity CBT training was effective, with significant improvements noted in client outcome measures, this was a small uncontrolled pilot- study so the findings should be carefully considered and replication advised.

Turkington et al. (2002) discovered that brief CBT skills training with Community Psychiatric Nurses (CPN) had a proven benefit in outcome measures but in this study it was not possible to control for the effects
of routine care due to the high dropout rates with Treatment as Usual (TAU). Also, there was no long term follow up to establish if skills were still being utilised in practice.

Simons et al. (2010) found that CBT was effective when delivered by community clinicians to clients with outcome results comparable to Randomised Control Trials (RCT), although clients receiving CBT were longer in treatment than clients receiving TAU. Boer et al. (2009) discovered in their review that paraprofessionals were favoured over the control group, no treatment, when treating clients with anxiety and depression. However, the review only included five studies which was not sufficient to draw conclusions comparing professional with paraprofessionals.

In contrast, it has also been argued that training in CBT skills had a limited impact on frontline staff as there is little opportunity to practice the skills, develop competence and confidence in practice. King et al. (2002) discovered that CBT skills training had little impact on General Practitioners’ (GP) attitudes and treatment of patients with depression or on patient outcomes. The limitations of the study were that patients had long term complex mental health difficulties which may have not been suitable for low intensity interventions and that several of the GPs were lost to follow up. Donoghue et al., (2004) found that although there was an increased use of CBT strategies following training, there was a limited opportunity to practice the skills taught. This was related to the lack of management support and the complex nature of the client population that impacted on the dissemination of skills into practice.

2.6 How other skills training works in practice

Sin and Scully (2008) found in their study that following education in psychosocial interventions there was a high uptake of mental health professionals that could utilise the skills in practice. This was achieved by having mechanisms in place such as peer support, sustained active clinical practice and supervision. One researcher was employed by the
healthcare trust to oversee the education and practice of the skills; this may have introduced some bias into the findings.

Miller and Mount (2001) found that following workshop training alone in motivational interviewing was unlikely to alter practice or make a difference to client outcomes. They argue that what is required for skills acquisition was working towards objectives and clinicians receiving regular feedback and support on their practice. Mathieson et al. (2010) highlight that workplaces need to support the initial training and trainees’ skills transfer to the workplace when the training is finished.

Ekers et al. (2013) found the same level of improvement in depression symptom levels, as compared with specialist staff with longer training, following brief training with mental health nurses in Behavioural Activation (BA). They propose that BA can be as effective as CBT and can be widely implemented with minimal time and cost. However, the study included a small number of therapists and participants, which limits the generalizability of the findings, but further research is proposed.

2.7 Supervision

Mentorship was offered to the trainees undertaking the ‘Skills for Practice’ training for a limited period, there was no facility to provide ongoing mentorship. Mannix et al (2006) discovered in their study that half the trainees randomized to discontinue supervision reported deterioration in their use of CBT skills after six months. Mathieson et al. (2010) suggest that trainees are supported with their training but unsupported with their ongoing practice. Studies have shown that ongoing support and supervision is limited following skills training (Williams et al., 2010, Donoghue et al. 2004).

Grey et al. (2008) state that supervision is a crucial factor in learning and applying CBT in practice and that sustained supervision over a prolonged period may be necessary to maintain competency gains (Rakovshik and Mc Manus, 2010, Lopez and Ramirez Basco, 2011).
Smith et al. (2012) discovered that workshops alone did not alter clinical practice but suggest that teleconferencing and one to one supervision could assist new skills being transferred into clinical practice. Bradshaw et al. (2007) recommended that practitioners from the trainees’ workplace be utilised to ensure that supervision continues to increase the likelihood of skills being used in practice.

2.8 Leadership and organisational support
Support was offered by management throughout the region to facilitate the ‘Skills for Practice’ trainees. Poole and Grant (2005) propose that organisational issues can hamper the clinicians’ use of skills in practice, they advise that organisations need to redesign services to support the implementation of evidence-based practices. Fixsen and Blake (2009) argue that it is the development of implementation systems which will assist the transfer of evidence practice into everyday clinical practice.

Newton and Yardley (2007) suggest that a change to more evidence-based practice can be implemented if specific individuals are appointed to advocate for change. Forsyth et al (2008) found that senior managers having ownership of the CBT strategy ensured the sustainability of CBT in practice. Barr Taylor and Chang (2008) concur that, with the right leadership, CBT skills can be diffused into practice.

2.9 Conclusion
In summary, following the perusal of the literature, the author has identified gaps in the literature which may impact on the dissemination of CBT skills transfer into everyday clinical practice. Firstly, it is difficult to decipher from the literature how training is evaluated and to establish if skills have been acquired and maintained in the longer term. Secondly, the literature recommends that supervision is required to assist the dissemination of skills in practice and yet supervision often ceases after training is completed. Thirdly, the focus of the literature tends to be on the training itself as opposed to implementation strategies, the literature on implementation systems following training is
limited. Therefore, the current study aims to expand the literature in the area of CBT skills utilising a qualitative approach.

The author will explore the experience that mental health professionals experienced undergoing CBT skills training, and investigate whether CBT skills have been acquired and maintained in practice. The author will seek to understand the levels of support/supervision offered to trainees on the course following training and examine the implementation strategies available in the region.
Chapter 3: Research Methodology

3.1 Introduction
This chapter outlines the aims and objectives of the study, a description of the research design selected and the rationale for adopting this methodological approach. It will describe the sampling process and the procedures undertaken in the research including the research context, ethical considerations, data collection and data analysis. Finally, issues relating to validity, reliability and reflexivity will be explored.

3.2 Aims and objectives
This research study aims to explore mental health professionals’ experience of undertaking the CBT ‘Skills for Practice’ training, to examine the impact that training had on their clinical practice and to identify potential obstacles implementing the skills in clinical practice. The objectives of the research study was to explore the impact of brief CBT ‘Skills for Practice’ training on mental health staff, to examine the factors that assist and are barriers to the use of the CBT skills in practice and to inform future training needs.

3.3 Research design
Quantative research methods aim to ‘establish general laws or principles’ (Burns, 2000, p.3) and focuses on ‘measuring quantities and relationships between attributes following a set of scientifically rigorous procedures (Bowlby 2005, p.190). Duffy et al., (2013) in their study of a ‘Short CBT Training Programme’, utilised pre and post self-report questionnaires to measure trainee perception of the impact of training on knowledge and skills and they found that trainees believed the course added to their skills base. The researcher was keen to investigate the experience of mental health professionals undergoing CBT ‘Skills for Practice’ training to discover whether the learning transferred into their clinical practice and to establish what factors helped or hindered the dissemination of the skills training into their clinical practice.
Phenomenology is a philosophy that is concerned with the question of how individuals make sense of their world (Bryman, 2008). The qualitative research method aims to capture the experience and meanings of individual and groups (Carter and Henderson, 2005). Braun and Clarke (2013) suggest that qualitative research is concerned with ‘meanings and the ways people make meanings’. Silverman (2005) states that richer data on the understanding of social phenomenon can be derived from qualitative research methods rather than by utilising quantitative data.

Thematic analysis (Braun and Clarke, 2013) is a method for identifying, analysing, and reporting patterns (themes) within data. A theme captures something important about the data in relation to the research question, and represents some level of ‘patterned response or meaning’ within the data set. The researcher adopted an inductive approach using this method, as the themes would be identified from the data collected through semi structured interviews (Patton, 1990).

The researcher chose the phenomenological approach as it was an appropriate method of answering the research question. This approach aimed to capture the lived experiences of the professionals who attended the CBT ‘Skills for Practice’ training. Duffy et al. (2013) had previously carried out an evaluation of the training using a quantitative method on the CBT ‘Skills for Practice’ training. Practical considerations influenced choosing the qualitative approach such as; the researcher being the only person working on the project, the time limits of undergoing the Masters course and the idea that having a smaller sample size would seem more manageable (Silverman, 2005). Yet, with this approach the researcher could still elicit ‘deep’ knowledge concerned with the meanings related to the CBT ‘Skills for Practice’ training (Braun and Clarke, 2013).

3.4 Sampling
It is recommended that purposive sampling is utilised in the qualitative research approach, such sampling is strategic and aims for the sample
to include people relevant to the research (Bryman 2008). Theoretical sampling ensures that relevant categories emerge from the research process and theoretical saturation occurs when there are no further insights to be gained and no further interviews required (Carter and Henderson, 2005). The potential sample consisted of mental health professionals who completed the ‘Skills for Practice’ six day training, a sample size of between 6 and 10 is recommended in this research approach (Braun and Clarke, 2013).

CBT: Skills for Practice’ training was provided to mental health professionals in the south east (which included; Tipperary, Waterford, Carlow, Wexford and Kilkenny) between 2009 and 2012. The course was attended by 244 staff comprising of; SNs, CNMs, CNSs, SWs, SPs, ACs, Counsellors, Psychiatrists, Psychologists, Drug and Alcohol workers and OTs (eleven cohorts in total). The researcher planned to target the tenth and eleventh cohorts. Braun and Clarke (2013) recommend that for a small research project the sample size when conducting interviews would be between six to ten participants.

3.5 Inclusion and exclusion criteria
The criteria for the inclusion of participants included; that they had completed all the requirements of the CBT ‘Skills for Practice’ training, that they were mental health professionals who had sought permission from their manager to partake in the study and that they worked within the HSE-SE region.

The exclusion criteria included participants who had not met the requirements of the training, who worked for Voluntary Organisations (VO), whose work base was outside of the region or who were not mental health professionals. Furthermore any participants working within the researcher’s multi-disciplinary team were excluded to minimize any bias.

3.6 Procedure
The researcher initially targeted the eleventh cohorts which comprised of nineteen staff who completed the training and through purposive sampling aimed to target participants from different disciplines. The idea of targeting the last cohort was that, this cohort included professionals from throughout the region and would be representative of the trainees experience in the region. The study utilised a retrospective method, this approach has been criticized as it is said that individuals find it difficult to accurately recall ‘past events, states of mind or mental processes’ (Nisbett and Ross, 1980). The researcher was aware of the potential memory bias and tried to minimize this by targeting trainees who had attended the last training in 2012, as opposed to 2010, in order to reduce the time that training had been completed. The researcher also utilised prompts in relation to the CBT ‘Skills for Practice’ (in order to stimulate memories) in the semi-structured interviews and encouraged the participant to feel free to describe their own memories and meanings (Snelgrove and Havitz, 2010).

Volunteers from the eleventh cohort were invited to partake in the study by post and by email. The researcher sent an information leaflet which outlined the title and background to the study and the qualitative nature of the research. The information leaflet (Appendix A) contained; the voluntary nature of participation in the study, the requirement of the participants to take part in a one hour semi-structured interview in a place convenient for them and it was explained that the interview would be recorded and the data transcribed.

Issues related to confidentially were explained, the research ethics approval for the study were stated from all institutions involved and the issue of the consent form explained. The researcher’s contact details were provided if participants wanted to take part in the study or ask further questions regarding the study.

The response rate from the eleventh cohort was three, the target group had nineteen participants and seven were based outside of the region and were not mental health professionals. A reminder email about the
research was sent four weeks after the initial contact and there were no further volunteers. The researcher’s academic supervisor had advised the researcher to add the tenth cohort of trainees to the ethics application form to allow for potentially poor response rates.

Utilising the same procedure, volunteers were sought from the tenth cohort of seventeen participants, seven were either based outside of the region or were not mental health professionals, the response rate was three. Ethical approval had been given on the basis that mental health staff were working within the HSE-SE, as the director of the RCNME had given approval within his area and also management structures within the HSE. The tenth cohort consisted of staff known to the researcher; Bryman (2008) argues that this may bias the interview process. However, Garton and Copland (2010) believe that the ‘acquaintance interview’ can contribute to the generation of data in a meaningful way.

In total six participants agreed to take part in the study. Three volunteered from the eleventh cohort of training which took place from February to April 2012 and three volunteered from the tenth cohort of training which took place from September to November 2011. The participants included; two CMNs, two Psychologists, one Counsellor and one O/T all of whom worked for the HSE. Five of the participants were female and one was male. The mean amount of experience in mental health care held by the participants was eighteen years. Three of the participants were known to the researcher and three were not.

The researcher had an interview guide, questions were developed by exploring the relevant literature related to CBT skills training. Patton (2002) outlines the types of questions relevant for a qualitative interview they include; the behaviour or experience, opinion or belief, feelings, knowledge, sensory and background or demographic information and this was used as a guide.

3.7 Data collection
The researcher aimed to pilot the questions for the semi-structured interviews in order to gain experience of asking the questions, to refine any questions that may not have been understood and to see how well the questions would flow (Bryman, 2008). The pilot was tested out on one participant, however it might have been more helpful if the researcher had practiced the interview technique with a colleague as recommended by Braun and Clarke (2013). The researcher found the interview challenging due to various factors; the inexperience of carrying out interviews, the limitations of the interview guide being rather closed, rigid and structured, and the researcher experiencing ‘stage fright’ (Morse and Field, 1995).

On reflection, by listening back to the recorded interview, reading over the research diary and by going over the literature review again, the interview guide was updated by adding a variety of questions and prompts, under specific headings. This process of refinement was useful as more data was gathered through the remaining five interviews for the thematic analysis to be undertaken. Braun and Clarke (2013) suggest that the interview is viewed as a ‘flexible tool’, conducted with some structure but also with space to be spontaneous.

By forming a more comprehensive interview guide the researcher’s confidence in conducting the interviews increased (Braun and Clarke, 2013). Semi-structured interviews were held with the other five participants and included further ‘open-ended’ questions which aimed to allow participants to elaborate on areas that they felt were important, to show their meanings and perspectives (Carter and Henderson, 2005).

3.8 Research context
The interviews were conducted in different locations; three were held in the office space of three of the participants’ own working environment, one was held in the researcher’s office and two were held in an office in a day hospital HSE facility. Consent forms were signed prior to commencing the interviews and each interview was recorded. The interviews varied in length from 23 minutes and 44 seconds to 1 hour,
14 minutes and 24 seconds. Participants data was anonymised in the results and each participant was allocated a number from 1-6.

3.9 Ethical considerations

Ethics should be viewed as an ‘integral part of all stages and aspects of research’ (Braun and Clarke, 2013, p 61.) The dignity of the human being should be the fundamental consideration in all research (Polit and Hungler, 1999). Ethical approval was sought prior to commencing the study. The research was carried out as part of an MSc in CBT at TCD. A research proposal was designed with the assistance of the researcher’s academic supervisor and submitted to TCD prior to applying for ethical approval. Subsequently, ethical approvals were granted from TCD and Waterford Regional Hospital (WRH) Ethics Committees. The Director of the RCNME gave full support to the study and so did Nursing Management. The researcher is a member of ABA and is fully accredited with the British Association of Behavioural & Cognitive Psychotherapists (BABCP).

Diener and Crandall (1978) highlight four main areas to guide the ethical principles in social research;

1. Whether there is harm to participants.
2. Whether there is a lack of informed consent.
3. Whether there is an invasion of privacy.
4. Whether deception is involved.

No potential harms were perceived in the research procedure, as participants were requested to take part in a one hour semi-structured interview.

The issue of informed consent was outlined in the information leaflet. Participants were informed of the voluntary nature of the study and their right to withdraw from participation at any time without penalty or an explanation.
Participants have the right to self-determination, therefore to decide to participate or not participate in the study (Polit and Hungler, 1999). The researcher also explained that any questions in relation to the study could be asked prior to signing the consent form and this was signed prior to undertaking the semi-structured interview.

The issue of privacy was also outlined in the information leaflet. Data gathered on the audiotape was treated confidentially, the identity of the participant remained anonymous and this was achieved by assigning an identity number to each participant and storing it in a locked cabinet. Demographic information was kept separately in a locked cabinet. The computer was password accessible only. Guenther (2009) cautions that to ensure the anonymity of the data, sensitivity is required as some data could be indentifying.

There was no deception involved in the project and all procedures were overseen by the researcher's academic supervisor.

3.10 Data analysis
Braun and Clarke (2006) developed TA as a method for analysing qualitative data, by identifying and analysing patterns in data. The six phases of thematic analysis are;

1. Familiarization with the data,
2. Coding; this involves the researcher coding every data item, to capture both a semantic and conceptual reading of the data.
4. Reviewing themes,
5. Defining and naming themes,
6. Writing up the data to tell the reader a story about the data and contextualizing it into the existing literature.

Interviews were transcribed by the researcher from the recordings verbatim. The transcripts were then read three times, coded line by line and summarized. The recordings were repeatedly listened to, initial ‘noticings’ were recorded in the research diary (p.204). Familiarization
with the data helped to ensure that the researcher was ‘actively, analytically and critically’ reviewing the data (p.205). Coding was undertaken to find patterns related to the research question. A hierarchal structure of themes was produced and cross referenced to the relevant literature. Identified themes were checked by a colleague for inter-rater reliability.

3.11 Validity and reliability
Kumar (1996) defines validity as ‘the ability of an instrument to measure what it is designed to measure’ (p.137). Braun and Clarke (2013) suggest that validity sets out to measure reality, however in qualitative research there is normally numerous realities. Ecological validity is about whether the framework of data collection is related to real life (Goodman, 2008a). Validity is also concerned with what the findings are about (Robson, 2002).

Reliability is concerned with consistency of measures and the degree to which a study can be replicated (Bryman 2008). However, Braun and Clarke (2013) argue that in qualitative research the researcher uniquely influences the research and therefore it is difficult to replicate it.

Guba and Lincoln (1994) propose an alternative criterion to reliability and validity for assessing qualitative studies which are trustworthiness and authenticity. In this context trustworthiness is defined by four criteria which includes; credibility, transferability, dependability and confirmability and the criteria for authenticity is; fairness, ontological, educative, catalytic and tactical authenticity.

The researcher aimed to follow the ethical approval guidelines and was guided by the instructions of the academic supervisor. The emphasis on making the research credible is by the researcher being open to understanding the social world being explored whilst also being mindful of potential bias by naming it and exploring issues in the research journal.
All interviewees were interviewed by the same researcher and had undertaken the CBT ‘Skills for Practice’ training. The researcher made it clear that the MSc course was in CBT and was explicit about her interest in the subject. Patton (2002) believes there is credibility in being explicit about all aspects of the research process and in particular about what you want to know.

Transferability incorporates the depth of the lived experience which hopes to be achieved by holding one hour, semi-structured interviews where knowledge of the participants experience can be explored. This depth of knowledge and findings may be transferable to other settings.

Auditing can be one method of ensuring that the research is reliable and dependable (Bryman, 2008). This can be achieved by keeping records of the research process as it is undertaken, through academic supervision, issues can be explored and the process independently reviewed. Yardley (2000) supports the need for transparency.

Confirmability refers to the notion of the researcher recognising any potential bias from their own experience or from the literature which may influence the findings. The researcher aimed to be transparent about any personal bias and utilise inter-rater reliability to guard against the findings being steered towards the literature in order to suit the researcher. It is important that the findings have an impact on the community being researched, on practitioners and on theory (Yardley, 2000).

3.12 Reflexivity

Reflexivity, in research terms, acknowledges the role of the researcher in the formulation of knowledge. This process occurs by the researcher critically reflecting on their own values and biases within the situations that they aim to explore to see how this may influence the data. Functional reflexivity is concerned with the way the research methods may have influenced the research, whereas personal reflexivity is
focused on bringing the researcher into the research (Braun and Clarke, 2013).

The researcher had an interest in CBT and is interested in evidence-based psychological interventions being implemented in to clinical practice. However, it was not assumed that participants would place the same value on CBT as the researcher and so the value of the participants’ experience of CBT was emphasised. Utilising semi-structured interviews was a new experience for the researcher and one that needed to be refined during the research process. Following the first few interviews the researcher reflected that some of the questioning could be leading as opposed to probing and consciously planned to amend the interview style. By keeping a research diary, the researcher had the opportunity to reflect on the research process and the experience of the researcher which added to the data collection.

Finlay (2002) suggests that reflexivity is a valuable research ‘tool’ to explore the ‘perspective and presence’ of the researcher and provides scope for the research process to be critically examined. This was achieved as the researcher kept a research diary and reflected on the research process as a whole. By utilising reflexivity, insights were gained and biases uncovered, which added to the credibility of the research (Tracy, 2010).

3.13 Summary
This chapter outlines a qualitative method of exploring mental health professionals’ experience of CBT ‘Skills for Practice’. The aims and objectives of the study have been explained. The research design, the sampling, procedure, data collection, research context, ethical considerations and data analysis have been described. Lastly, issues concerning the validity and reliability of the study and reflexivity have been examined. The next chapter will present the findings obtained by these methods.
Chapter 4: Results

4.1 Introduction
In this chapter the findings of the study are presented. The aim of this study was to explore mental health professionals’ experience of the CBT ‘Skills for Practice’ training. Six qualitative interviews were conducted. Braun and Clarke’s (2013) TA was utilised to analyse the data, the analysis begun at the interview stage of the research process. The researcher then transcribed the interviews, read and reread the transcriptions in order to become familiar with the data for the purpose of analysis. The main themes and subthemes that emerged are described in this chapter. Examples of the subthemes are illustrated in selected verbatim quotes from the participants’ accounts of their experience. Participants are referred to as 1, 2,3,4,5 or 6 to maintain confidentiality. The data is introduced in table and text form. The main themes and subthemes that are presented in this chapter are illustrated in figure 1.

4.2 Demographic information
The participants included two CNMs, one O/T, one Counsellor and two Psychologists
See Table 1

<table>
<thead>
<tr>
<th>Gender</th>
<th>Profession</th>
<th>Age</th>
<th>Number of Years Experience</th>
</tr>
</thead>
<tbody>
<tr>
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<td>8</td>
</tr>
<tr>
<td>Female</td>
<td>Clinical Nurse Manager</td>
<td>39</td>
<td>20</td>
</tr>
<tr>
<td>Female</td>
<td>Occupational Therapist</td>
<td>45</td>
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<tr>
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<td>Counsellor</td>
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</tr>
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<td>Male</td>
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<td>27</td>
</tr>
<tr>
<td>Female</td>
<td>Psychologist</td>
<td>36</td>
<td>10</td>
</tr>
</tbody>
</table>

4.3 Main themes
4.3.1 Theme 1: Experience of the CBT ‘skills for practice’ training

Theme one described the sense of what the participants had experienced undertaking the training, the four sub themes that emerged within this main theme were the training and facilitation, role plays, mentorship and skills and knowledge. There was a general sense that the experience of the training had been a positive one and that CBT skills had been gained by the participants.

The participants described their own individual experience of attending the six day CBT ‘Skills for Practice’ training which was held over a three month period. There were various elements to the training, the course was based on the principles of adult learning theory (Kolb, 1984) and aimed to integrate both intellectual and experiential learning. Key learning methods included reading and lectures, modelling, role play,
self–experiential work, reflective practice and practice mentoring. The aspects of the training that were highlighted by all the participants were the structure and facilitation of the training, taking part in role-plays, the experience of being mentored and reflections on the skills and knowledge acquired.

The overall sense of all the participants’ was that the experience of undertaking the training was a positive one:

4.3.1.1 The training and facilitation

“The experience was very good. It was actually well done”. P.5.

“The course was very clear, the way it was structured was very clear” P.1.

Some participants’ found that it helpful that the course was held over a three month period as:

“The interest was rekindled every time you go on the course again” P.3.

“It gave you the opportunity to practice some of the skills before the next block” P.2.

Others described how the course enabled mental health staff from different disciplines to develop professional relationships and improved communication:

“a common language in how we deal with stuff even though we were all coming from different backgrounds” P.4.

All six participants spoke highly of the main course trainer, who they all viewed as highly competent, experienced and knowledgeable. This appeared to be very significant as they saw the trainer as a credible role model whom they felt they could learn from:

“The lecturer was very good, she explained things very well” P.2.
“She does have a great ability to just kind of give the information in portioned pieces, enough that you can take it in bit by bit and then it all comes together at the end, so I suppose that is a massive skill” P.3.

“She was very competent and she had a great ability to ensure that the group was actively participating” P.5.

4.3.1.2 Role-play.
The course involved undertaking role-plays in order to practice the CBT skills, some of the participants found this difficult initially:

“It was something I wasn’t used to, it was tough, something that I had not done before” P.2.

As the course progressed trainees found the role-plays more useful and perceived the role-plays as an opportunity to practice the skills being learned (P. 2, 3, 4 and 6):

“It gives you more confidence then to go and try it” P.3.

“It definitely got easier as time went on, you are there to improve your skills” P.2.

Some of the trainees embraced the challenge of taking part in the role-plays:

“I was questioning how I would use it with clients that I’m working with, I like that challenging myself” P.4

4.3.1.3 Mentoring
Four of the trainees stated that they had found the mentoring sessions helpful as it assisted them to keep focused on the course and its requirements (P.1, 3, 4 and 6). The mentoring also provided them with either individual or group support to encourage the use of the CBT skills in practice:

“There was a focus about it; you know you had to meet up with
your mentor and work out how to try the skills” P.1.

“Well the first word that comes to mind is refreshing, having a neutral person from the team and as we did it in a group, we got the added benefit of listening to others peoples experiences” P.3.

Two of the trainees (P. 2 and 5) described how the mentoring sessions had not been that helpful. They remarked on how it was more like a revision session than a chance for them to discuss using the CBT skills with their clients:

“It was a bit like a tutorial, maybe we could have discussed individual cases or difficulties we had with clients” P.2.

“It was rehashing the whole course, whereas it might have been more client or service user focused” P.5.

4.3.1.4 Skills and knowledge

Various skills were learned during the process of the course. Five of the trainees found the five area model to be a useful tool to utilise with clients (P.1, 2, 3, 4, and 5). Four of the trainees mentioned how they liked the idea of having more structure in their work with clients in clinical practice (P.3, 4, 5 and 6). Two trainees valued establishing a problem list with clients (P. 2 and 5). All participants thought that the behavioural activation skills were useful, with two participants remarking that they had already utilised this skill in their practice prior to the training (P.3 and 6). Two discovered that the goal setting helped them to focus their work more with clients (P. 1 and 3). Two reported that they utilised the psychoeducation skills more in sessions with clients (P. 1 and 6). Five participants considered utilising homework more in their one to one work following the training. Two described how they now worked with clients on their automatic thoughts (P. 3 and 5). Two stated that they had utilised Socratic dialogue by encouraging the clients to be ‘experts on themselves’ (P.2 and 6).
All participants acknowledged that some of the skills were already an existing part of their skills set so they did not necessarily attribute some of the skills to the CBT ‘Skills for Practice’ training.

4.3.1.5 Skills used in clinical practice

Table 2

<table>
<thead>
<tr>
<th>CBT Skills utilised in Clinical Practice</th>
<th>Participant</th>
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<tbody>
<tr>
<td>Activity schedule</td>
<td>All participants</td>
</tr>
<tr>
<td>Automatic thoughts</td>
<td>Participant 3 and 5</td>
</tr>
<tr>
<td>Five areas model</td>
<td>Participant 1, 2, 3, 4 and 5</td>
</tr>
<tr>
<td>Goal setting</td>
<td>Participant 1 and 3</td>
</tr>
<tr>
<td>Homework</td>
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<tr>
<td>Problem List</td>
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<td>Psychoeducation</td>
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<tr>
<td>Structure</td>
<td>Participant 3, 4, 5 and 6</td>
</tr>
<tr>
<td>Socratic dialogue</td>
<td>Participant 2 and 6</td>
</tr>
</tbody>
</table>
Some trainees found the experience of learning the skills difficult (P.5 and 6):

“it was difficult, it was different, it was difficult, the actual structure of putting it in” P.5.

“I found the problem list a challenge” P.6.

All trainees made reference to their own; expertise, competence, experience and skills set prior to the CBT skills training:

“something I did anyway was helping people to come to their own conclusions” P.6.

“you are competent in what you do” P.5.

All of the participants felt that they had acquired additional tools that added to their own skills set.

“I think for me in the sense that I’ve got tools that I can use with the clients I am working with” P.4.
“I think we have some strategies from a behavioural point of view” P.3.

4.3.2 Theme 2: Attitudes and beliefs about CBT and CBT training.
Theme two highlighted the sense that the participants had experienced some changes in their attitudes and beliefs about CBT by undertaking the training.

4.3.2.1 Pre training
All of the participants volunteered to go on the training, three of the participants acknowledged that they had reservations about undertaking the training (P1, 4 and 6) and two acknowledged that they had little prior knowledge about CBT (P2 and 5). Despite this, there was a general sense that on a personal and professional level they wanted to open up to CBT as they perceived CBT as having credibility as it was evidence-based and also in practice there were pressures to offer more short term interventions with clients. All participants reported that they could see CBT being useful in their practice following training and two participants believed that there were limitations to undertaking the training (2 and 5).

Three of the participants had reservations about CBT prior to the training (P 1, 4 and 6):

“I thought it was too simplistic and the way I work is more process orientated. It didn’t fit into who I was” P.1.

“It is viewed as just dealing with the issues and crisis now and not looking at the long term issues” P.4.

“I just felt to me it did not explain enough to me about the human experience “to just reduce it to thoughts, feelings and behaviours” P.6.

Four of the participants highlighted that there was a greater emphasis on offering short term interventions, some felt that this was due to the
cutbacks (P.1 and P.6), whilst others thought that they were keeping up to date by providing more focused interventions (P.2 and P.5);

“I jumped in to it as I am open to learning, I think I always question myself on what I am resisting” P.5.

“There is more emphasis on shorter work, so ok they want me to do this more so I need to equip myself better’ P.6.

Participants 3 and 4 had a good understanding about what was involved in CBT;

“It is do with a person’s behaviours and looking at different components behaviour, thinking and your emotions and physiology” P.3.

Two of the other participants stated that their understanding in relation to CBT would have been fairly limited.

“I thought CBT was about changing somebody’s thinking” P.2.

“Do you know I had actually had no understanding of it” P.5.

4.3.2.2 Post training
Following the training all of the participants seemed to highlight that undertaking the training had improved their beliefs about the usefulness of CBT in their clinical practice.

“It gave me some extra knowledge and skills to deal with people in my area of work” P.5.

“It’s not about changing the person’s thinking but it’s about the person themselves, you are just there to guide them along the way really, a big thing that came out for me” P.2.

However two of the participants recognised the limitations of the training (P 2 and 5):
Two of the participants recognised that their attitudes to CBT had undergone some changes as a result of undergoing the training:

“I am much less biased about CBT and I probably did have a bias against it” P.6.

“Yeah there has been a big shift, I would never go near it, but now I have definitely embraced it into my practice and I can see a big place for it, so for me professionally I have really shifted” P.1.

4.3.3 Theme 3: Factors that facilitated the application of CBT skills in clinical practice.

Theme three described the sense of what the participants had experienced that had facilitated their application of the CBT skills in practice. The subthemes that emerged from their experiences included personal and professional motivation, professional role and autonomy, peer support and organisational issues.

All participants acknowledged they had utilised the CBT skills in their clinical practice area and all spoke about how they were motivated both professionally and personally to improve their own skill set and ultimately assist clients they work with. All of the participants were highly experienced mental health professionals who worked autonomously within their clinical areas. Four of the participants reported that peer support had supported them applying the skills in practice (1, 3, 4 and 6).

Organisational factors were seen as crucial, all participants felt that ongoing support/supervision was an essential factor to assist with the transfer of skills to practice, three participants had existing clinical supervision structures in place (1, 4 and 6). Further training opportunities in CBT skills and access to training were seen to be beneficial (1, 2, 3, 4 and 6).
4.3.3.1 Personal and professional motivation
All of the participants described how they had been open to the training and to applying the skills in their clinical practice area.

“I was definitely quite motivated; I think the course gave me the motivation and the expectations were a good thing.” P.1.

“I suppose I was open to it, I think that probably helped, I think if anything would help the clients to overcome their distress” P.4.

Two of the participants emphasised how they had both personal and professional motivation for trying out the skills (P.3 and 5):

“I suppose one personal thing is that you might practice it yourself, say a thought record, to have tried it yourself before you ask somebody else to do it and see how hard or easy it is. I’d be happy to try some of the skills within my own life and see how does that help me make changes?” P.3.

“You are getting results with it which is personal satisfaction” P.5.

“To make things better and assist in that person’s recovery, you know, that’s a motivation, yeah that’s a motivation” P.5.

4.3.3.2 Professional role/autonomy.
All participants were highly skilled, experienced mental health professionals who worked autonomously, planning their own clinical time dealing with different client populations:

“You know you have the opportunity to do whatever work you have planned for that day” P.2.

“When you add a skill to someone who’s already a very skilled clinician then you have another tool to bring in don’t you” P.5.
Other participants adapted the skills to suit their own clinical practice area:

“The little ones sometimes find it hard to understand the concept of thoughts but if you use a puppet, coming along talking to you, I felt that worked better” P.1.

“I chose to use it more with parents as it was adult taught” P.6.

### 4.3.3.3 Peer support.

Four of the participants indicated how having colleagues who were also trained in CBT skills had a major impact on them continuing to utilise the skills in their clinical practice. (P. 1, 3, 4, and 6):

“I definitely think the peer group, that everybody on my team had done this course” P.1.

“We have a common language in how to deal with stuff even though we are coming from different backgrounds” P.3.

“Because a few of us have done the training, I was able to link in with a colleague” P.4.

Peer support or supervision was seen as an option to help with the transfer of the CBT skills, as long as the peers had more experience;

“I think peer supervision, providing that there’s someone there who is much more experienced in providing it” P.4.

### 4.3.3.4 Organisational issues

Most of the participants found having a mentor helped them to develop their CBT skills (P.1, 3, 4 and 6). Three of the participants already had supervision structures in place which included both individual and peer support so the mentorship was an additional support system during the course (P.1, P.4, and P.6):

“Well my supervisor was my mentor as well, so it was perfect” P.1.
Others stated that having access to ongoing mentorship would have been beneficial for the development of the CBT skills, but this was not available (P.2, 3 and 5):

Access to further CBT skills training was also seen to be useful in ensuring that people continued to practice the CBT skills (P.1, 2, 3, 4 and 6).

“I think it’s great that they are offering more courses” P.1.

4.3.4 Theme 4: Factors that were barriers to the application of CBT skills in clinical practice
Theme four describes the general sense of the barriers that participants experienced in the application of the CBT skills in clinical practice. The sub themes that emerged within this main theme included the client population, the professional role and limitations of it, fears and anxieties and organisational issues.

All participants recognised how there were barriers to applying the skills in clinical practice. Some participants described how professional judgement was utilised to decide whether or not to use the CBT skills in practice, participants stated that at times it was not appropriate such as if the client was acutely unwell (P.2). Three participants reported that workload pressures limited the use of the CBT skills (2, 3 and 5). Three participants expressed their how their fears and anxieties had restricted the use of the CBT skills in clinical practice (P2, 3 and 5) and how within their own organisation ongoing support/supervision was not offered to them and access to training was limited or had to be carried out in their own time.

4.3.4.1 Client population
Two of the participants found it challenging to use the skills with their client population as they were working with children and the course was geared towards using the CBT skills with adults (P.1 and P. 6):
“The little one found it hard to understand the concept of thoughts” P.1.

“Well I found it quite difficult to do that with the kind of client group that I had and I didn’t have people who were suitable on the waiting list either” P.6.

Two others commented on how they would use their professional judgement to decide when to use the CBT skills with clients that they were working with (P.2 and P.4):

“You know sometimes in hospital, they need to be better” P.2.

“With the nature of the clients I am working with in my own experience it is about, for them having the opportunity that it’s slowed down and developing a relationship before and I think that is important” P.4.

4.3.4.2 Professional role/limitations.
Three people highlighted that the pressure of their workload impacted on their ability to utilise the CBT skills in their practice (P.2, .3 and 5.):

“One of the things in our line of work because we have so many people to hit on” P.5.

“In hospital you are so busy, with work and other duties you know” P.2.

“The job changes so often” P.3.

One person expressed concern that if there were already CBT therapists in the service, that there may be some difficulty with taking on a CBT ‘role’ in their own practice.

“That there is something in place already, that person is doing it the whole time so they are probably the best placed person to do it” P.5.
4.3.4.3 Fears and anxieties.
Three participants described how they were fearful of using the skills in practice in case there could be negative consequences (P.2, 3 and 5).

“if you know that there is something you really think would help somebody, but you’re afraid, there’s a nervousness, an anxiousness attached to it, you can’t be doing this because you might bring them to a place where you can’t actually look after them” P.3.

“There’s a fear factor you see, there’s a fear factor that you wouldn’t have enough skill and then work might be allocated to you, you’d be taking on more than you could chew” P.5.

Two participants felt that their anxieties could have been dealt with if they were to have had a contact person in place (P.2 and P.4)

“is it the correct way” P.2.

“well if you had doubts or questions there are one or two people that you can contact” P.4.

4.3.4.4 Organisational issues
Some of the participants spoke about the importance of receiving support or supervision on an ongoing basis to help them maintain the CBT skills, but that this was not available to all participants (P.2, 3, and 5); "Well I suppose the experience, whilst it was good at the time, it’s the importance is actually being kind of supported in your own environment”. I think it’s a downfall” P.5.

“we haven’t had the ongoing supervision and stuff you’re kinda using it in a limited way” P.3.

“you do the six days, six days CBT as regards skills, but you are not a therapist. You do need mentorship and ongoing supervision from somebody trained in it.” P.2.
There was a sense that the CBT skills would be utilised in a limited way as a direct result of the lack of ongoing support in clinical practice. (P.2, 3 and 5):

“I think if it was possible to continue to have a mentor role or a supervisor role built in to allow you to use the skills; I mean that is number one really” P.3.

“I think that you would actually feel competent by virtue of the fact that you had someone to lean on for a while” P.5.

Participant four stated they held concerns about using the CBT skills without supervision:

“I don’t think I would like to emmm, approach, use this approach unless I had appropriate supervision around it” P.4.

Participants 1 and 5 spoke about the impact of retaining the skills without supervision:

“without supervision you would be much less likely to use the skills, because sometimes when you go on a course, you have to keep implementing it and I find if you don’t it will just fizzle out” P.1.

“you’re after getting the training and it’s worthless if you can’t use it” P.5.

Two of the participants stated that it would have been more useful for additional training and refresher days to be held more frequently as neither was able to avail of a place on the refreshers course (P.2 and 5). They also commented on the fact that team members had not got the opportunity to train:

“they haven’t done the training so it’s a bit of a barrier” P.2.
4.3.4.5 Summary
This chapter has reported the findings from the data of the participants' experience of undertaking the CBT ‘Skills for Practice’ training. Thematic analysis (Braun and Clarke, 2013) was utilised to identify themes in the participants’ accounts of their lived experience.
Chapter 5: Discussion

5.1 Introduction
This chapter discusses the findings presented in the previous chapter. The results are examined and discussed in relation to the relevant literature. The implications and findings of the study are outlined. Finally, the limitations of the study are described and recommendations for future research are stated.

5.2 Reflection on the core elements of the thesis

Rationale for the study: Evidence suggests that short term CBT skills training can have a beneficial impact on clinical practice (Duffy et al., 2013, Simons et al., 2010, Cort et al., 2009, Leff et al., 2001). However, there is also literature to indicate that short term CBT skills training has a limited impact on clinical practice (King et al., 2002, Mannix et al., 2006, Donoghue et al., 2004, Williams et al., 2010). The current study aimed to explore the experience of CBT ‘Skills for Practice’ training in Ireland with mental health professionals using thematic analysis (Braun and Clarke, 2013). The study aimed to; clarify whether CBT skills had been acquired and maintained in clinical practice, to establish the factors that assist and are barriers to the use of the CBT skills in practice and to inform future training needs.

5.3 Discussion
The discussion will reflect upon the following findings which include the context of the training, competence, skills knowledge and development, outcomes, reflective practice and supervision structures, organisational issues and the low response rate of nurses in the study.

5.4 The context of the training
The findings of this current study illustrate that the majority of the participants found the experience of the training to be a positive one. However, it appeared evident that there was little emphasis placed on the rationale for the CBT skills training or for the context of the training in Ireland to be explored.

Prior to the training some mental health professionals acknowledged their limited knowledge of CBT; the CNMs and OT were unclear about where the skills would fit within their existing role and expressed anxieties about being perceived as ‘therapists’. The trainees; two of whom were Psychologists and a Counsellor, reported that they had concerns that the CBT approach would be limited in that it may not address the human experience, address trauma or be process orientated.

In the UK, the context of CBT treatment has been shaped by various factors including, the NICE clinical guidelines and by the UK government initiating the IAPT (2007) programme which involved training staff to deliver both high and low intensity interventions at primary and secondary care levels. In Ireland, the National Mental Health Policy has been guided by the mental health legislation (GOI, 2001) and ‘A Vision for Change’ document (Department of Health, 2006), which recommended the adoption of a recovery approach to mental health. The document includes proposals to the develop CMHTs, by training and educating staff in multi-modal interventions.

O’Shea et al. (2010) developed a training model CBT ‘Skills for Practice’ that was based upon the IAPT initiative in the UK which aimed to enhance the skills of mental health professionals who provide psychosocial interventions. The initiative developed in the Irish context was a collaborative venture between the RCNME, HSE-SE and CT. Following on from this initiative, the ‘Guiding Framework’ was developed (HSE, 2013) which outlined a Certificate based training in CBT skills for Ireland similar to the UK Reach Out programme (IAPT, 2008) which aims to provide training for ‘low intensity interventions’ (this
programme is awaiting accreditation and is due to commence in September 2015).

Yet, within the CBT skills training there did not appear to be an explicit link between the current contexts of the Irish or UK settings (IAPT, 2008). Half of the participants indicated that there was an emphasis being placed upon them to provide short term interventions which they felt could be assisted by some of the CBT skills such as structuring sessions and working towards focused goals. In this study, the Psychologists and Counsellor, appeared to have clarity about their identity and professional role, they reported having structures and support systems which were established. The training was an opportunity to develop CBT skills which they might incorporate into their own discipline or professional style.

However, the other half of the participants were unclear and unaware of any context to the training, which appeared to limit the use of the skills. In this study, the CNMs and OT questioned their role, their competencies and their use of the CBT skills within their clinical practice. Without a context to the training, the nurses expressed fears that they might be perceived as ‘therapists’ and the OT reported limiting the use of the skills in case of any negative consequences.

The literature would support the idea of a context to training being crucial to its implementation. Williams et al. (2011) emphasised the context of their training which aimed to introduce Cognitive Behavioural Self Help (CBSH) to experienced mental health professionals and found that participants reported that the skills the trainees learned were used in their own clinical practice. Providing a rationale for ‘low intensity training’ has been found to be beneficial with frontline staff as competency levels were achieved and the expectations of the trainees were specified (Cort et al., 2009; Hirai and Clum 2006; Turkington et al., 2002). Whereas King et al. (2002) reported that even with targeted CBT skills training in the treatment of patients with depression there was a limited impact on their clinical skills in practice.
If the context of the training had been explored and guidelines on the stepped care approach explained, which emphasised what is involved in ‘low intensity’ interventions; there may have been more clarity and confidence from all the disciplines about applying the CBT skills in clinical practice locally.

5.5 Competency issues
In addition, this study reveals that there was confusion about what the expectations of having CBT skills might mean in their own professional role and also how they might be perceived by other colleagues and as a result half of the participants limited their use of the CBT skills. The concerns focused on wanting to work in a professional competent way and included being clear that they were working within their scope of practice (ABA, 2000). The results indicate that half of the highly qualified skilled mental health professionals were cautious and reluctant to use the skills in case their competence might be compromised.

The literature would suggest that trainees can be influenced by their early experience of using the CBT skills (Heaven et al., 2006), which may have been linked to feeling deskilled as they were learning new skills (Bennett-Levy and Beedie, 2007). Some participants (two CNMs and an OT), who had no existing supervision structures in place, reported limited support following the training and therefore limited opportunity to reflect on competency issues that were surfacing to assist with their learning (Kolb, 1984; Bennett-Levy, 2006). Robb et al. (2002) propose that assessing competency is full of difficulty but an increase in competency levels can be established by having supervision structures in place (Grey et al., 2008).

In their study, Duffy et al. (2013) described how some of the trainees could identify that CBT skills training provided them with additional ‘tools’. This was found to be the case with half of the participants in the current study (two Psychologists and a Counsellor). However, Duffy et al (2013) also report that one of the trainees described themselves as
working ‘totally CBT’ after six days training. In the current study, none of the six participants described themselves as working ‘totally CBT’ and were clear about their own professional boundaries. Half of the participants were reticent about the use of the CBT skills at all without ongoing support and the other half reported using their own professional judgment to decide when the use of CBT skills was appropriate.

Dunning et al. (2003) highlight how some professionals may overestimate their expertise and be completely unaware of their own incompetence. Brosan et al. (2008) found that less competent therapists tended to overrate their levels of competence. In this study, half of the highly experienced mental health professionals appeared to underestimate their competency levels. This may have been due to the fact that after the training ended, the opportunity to reflect on the learning was not available (Kolb, 1984; Bennett-Levy, 2006) or been connected to participants feeling that they were operating outside of their ZPD (Vygotsky, 1978).

Sharpless and Barber (2009) competencey framework outlines five developmental stages of a therapist starting with the novice level and moving to the expert level. This framework could provide the information required of a trainee at the introductory novice level, to ensure that they could operate clinically within specified guidelines and within their ZPD (Vygotsky, 1978). The ‘Reach Out’ document, (IAPT, 2008) gives a comprehensive account of the expectations of the ‘low intensity interventions’. Such frameworks and documents may have increased the level of confidence and ability to utilise the CBT skills, and provided the necessary structure for competent mental health professionals to understand how to work within their scope of practice (ABA, 2000).

5.6 Skills and knowledge development
The literature supports the idea that mental health professionals need to develop skills and competencies in evidence-based psychotherapeutic interventions such as CBT (MHC, 2007; MHC, 2010; Cusack and Killoury, 2012). Yet evidence suggests that nurses’ knowledge base relies more on information from their interactions with clients and colleagues than on empirically sourced information (Estabrooks et al., 2005, Gerrish et al., 2008, HSE, 2007).

Brief short term CBT skills training with mental health professionals has been found to be effective in the treatment of mental health disorders (Turkington et al., 2002, and Waller et al., 2013). It is not clear whether the skills were maintained in practice, as there was no longer term follow up in both studies. Duffy et al., (2013) study indicated that, after a one year follow up, there were perceived gains in CBT skills and knowledge. Trainees reported higher levels of knowledge and skills than their mentors, which suggests that trainees may have over-estimated their own skills, which is comparable to the findings by Brosnan et al. (2008).

The findings in this current study suggest that all of the participants had utilised the CBT skills following the ‘Skills for Practice’ training. The direct observation of the skills being demonstrated in the role-plays during the training was found to be helpful; the experiential approach to learning gave the participants the chance to practice the skills and gain confidence (Kolb, 1984).

There was evidence in this study that factors such as reflective practice, peer support and supervision structures assisted the transfer of skills into practice, these findings are supported in the literature (O’ Neil et al., 2008; Mathieson et al., 2010). The literature also proposes that skills deteriorate following training if there is no ongoing support or supervision in place (Donoghue et al., 2004; Williams et al., 2010) which was found to be the case in this study with half of the participants.
Anecdotal evidence indicated that mental health professionals who attended the training faced challenges in implementing the CBT skills from the start. This was partly due to the fact that staff were working in areas where it may not have been appropriate for the particular client population and partially due to the fact that the staff were either in managerial roles or non-clinical roles. This meant that it was difficult for WBL to take place and curtailed the opportunity for the procedural knowledge to be obtained (Bennett-Levy, 2006).

Additionally, staff reported that they had not used the CBT skills in clinical practice as they were based in busy, acute and community settings where their role was diverse and ‘comprehensive’ and therapeutic interventions were often seen as a ‘luxury’ (Mathers, 2012). Furthermore, the issue of the workload of nurses has been well documented (Deacon 2003; Simpson et al. 2003; SCMH, 2006) and was noted within this study as a barrier in the use of CBT skills locally.

5.7 Outcomes
The literature indicates that patient outcomes have improved following skills training (Forsyth et al., 2008; Simons et al., 2010). Duffy et al. (2013) reported that outcomes had improved following the CBT ‘Skills for Practice’ training, yet objective outcome measures were not utilised and some of the managers who rated the outcomes had not undergone CBT skills training. There were so many potential variables that might have impacted on the clients’ outcomes; such as medication or the therapeutic alliance that it is difficult to establish the impact that using the CBT skills may have had.

Nonetheless, in this study there was evidence to indicate that by adding some of the CBT skills to their existing clinical practice, participants reported a positive impact on their clinical work. They described how they felt the progress of their clients was improved by structuring the time and activity scheduling while working towards collaboratively agreed goals. Duffy et al., (2013) noted that of the participants 25% had substantial improvement in outcomes and 62% had slight improvement,
as reported by the mentors, which is difficult to corroborate as this assessment was made from feedback from the trainee only.

5.8 Reflective practice/supervision structures

Supervision is a crucial element in learning and applying CBT skills in clinical practice (Sin and Scully 2008; Sholomskas et al., 2005). This was reinforced by half of the participants who described clinical supervision as an essential element of support for them clinically, both in the individual and peer support systems they had in place. Within the Psychology and Counselling disciplines there was a noticeable clarity and confidence about how the CBT skills were an ‘add on’ to their existing training and skills set.

In contrast, half of the participants did not have clinical supervision structures in place (two CNMs and an OT), which led to confusion about the use of CBT skills, increased the clinician’s anxieties and therefore limited the use of the CBT skills in their clinical practice. It has been suggested that it is difficult to maintain CBT skills without clinical supervision (Mannix et al., 2006; Donoghue et al., 2004).

Evidence suggests that mental health professionals do encounter many problems when incorporating psychological interventions into their practice (Grant and Mills, 2000; Bradshaw et al. 2007; King et al. 2002). Relational issues may also have hampered the implementation of the CBT skills, such as having the confidence, the skills or the ability to develop a therapeutic relationship (Bordin, 1994; Tone, 2012), which is seen to be key to successful psychological interventions (Safran and Muran, 2000). In this study there was confusion expressed by half of the participants about what using the CBT skills would mean within their existing role. The concerns focused on how they would be regarded; as professionals utilising skills or as ‘therapists’. This confusion heightened their anxieties and limited the use of the CBT skills.

Supervision structures have been developed in the UK from the implementation of the IAPT programme (2008). Rethink (2010)
developed a supervisor’s guide to support low intensity workers and to emphasise that both low and high intensity workers would require supervision structures to implement evidence-based interventions.

In the Irish context, the ‘Guiding Framework’ (HSE, 2013) proposes a programme which incrementally enhances CBT skills and knowledge, the learning aims to be supported by incorporating reflective practice sessions/supervision structures into clinical areas, which would be facilitated by disciplines with sufficient expertise in CBT and supervision.

From this current study, half of the participants reported that these structures had yet to be established in their own clinical areas which was seen as a major drawback in the implementation of the CBT skills. The process of reflection is seen to be one of the key stages in learning and seen to be crucial in skills development (Bennett-Levy, 2006). With that in mind, the knowledge and skills development could have been enhanced locally if established supervision systems were in place for all disciplines (Grey et al., 2008; Sin and Scully 2008). Locally, these supports were in place for the Psychology and Counselling disciplines.

5.9 Organisational issues

Sullivan et al. (2008) and Fixsen and Blake (2009) argue that it is the implementation methods, not the training strategy, that is important in transferring clinical training into practice. The literature maintains that organisational support of staff training does not ensure that there will be an organisational support to implement it (Brooker et al. 2003; Poole and Grant, 2005). In this study there were no formal implementation strategies in place following completion of the CBT skills training.

However for the Psychologists and Counsellor, their managers had undergone CBT skills training, demonstrated clinical leadership and were explicitly supportive of professional development and encouraged further attendance at CBT skills training locally. This meant that their existing organisational supports assisted the implementation of the CBT skills. This reinforces the idea that with the right leadership and
ownership of a CBT strategy, CBT can be sustained in clinical practice (Forsyth et al., 2008; Barr Taylor and Chang, 2008).

The CNMs and OT described how they were unclear and uncertain as to how the CBT skills would fit within their existing role as mental health professionals’ post training, and they remarked that they would have been more likely to have used the skills in clinical practice if they had been linked to an identified clinician who was experienced in CBT post training; which is supported in the literature (Forsyth et al. 2008 and Gerrish et al. 2011). There appeared to be a lack of clinical leadership and support in place for these disciplines; there were no identifiable clinicians or managers to advocate and drive CBT skills development. Newton and Yardley (2007) state that it is imperative to appoint individuals who can support evidence-based practices such as CBT being implemented for this process to be successful.

Anecdotal evidence indicates that the CBT skills were either utilised or abandoned in an ad hoc way for various reasons which included the work setting being inappropriate, the lack of protected time or managerial support to practice the skills, the difficulty of accessing further training and the lack of organisational support structures for their professional and clinical development.

The CBT ‘Skills for Practice’ training was well supported by the HSE-SE with almost two hundred and fifty mental health professionals undergoing the training. It is known that seven nurses who underwent the CBT skills training in the region have gone on to undertake the PGD in CBT. This appears to have been driven by both professional and personal motivation, with support from the NMPDU, rather than organisational factors or clinical leadership initiatives.

5.10 Low response rate of nurses in the study
The majority of mental health professionals who undertook the CBT ‘Skills for Practice' training were nurses (eighty five per cent) and yet only two nurses agreed to participate in the study (both of whom were known to the researcher). In this study, we can speculate from the literature and anecdotal evidence what might have influenced the low response rate from nurses.

Firstly, it could be due to the fact that nurses have such a comprehensive role that they are spending large amounts of time with administration and managerial duties which limits their ability to prioritise skills development (Mathers, 2012). Anecdotal evidence suggests that this was the case locally with some CMNs and SNs who stated that the complex nature of their role, which included managing wards and administration duties made it difficult to prioritise psychological interventions.

Secondly, it has been found that nurses do not tend to rely on evidence-based practice (EBP) as a way of informing their clinical practice, either as they have limited access to resources or refer more to their direct clinical experience (Yadav and Fealy, 2012). Anecdotally, nurses who had undergone degree training or post graduate training were more likely to refer to EBP than nurses who had not. However, this was hampered locally by staff having limited access to email and computer systems.

Thirdly, given that issues were highlighted about competency with nurses that took part in this study, perhaps this was the case with nurses who did not take part in the study. Anecdotally, nurses admitted to not using the CBT skills at all which they attributed to a lack of confidence and feeling deskilled, which is recognised as a common experience in skills development (Bennett-Levy, 2006). There may have been fears about being judged negatively as professionals and impacted on their perceived social desirability (van de Mortel, 2008) if they were perceived to have not used the skills.
Lastly, anecdotal evidence indicates that nurses have limited access to supervision structures. Nurses in this study did report their fears and anxieties regarding their competency levels utilising the CBT skills and they remarked how this could have been improved by ongoing supervision/reflection sessions in their own locality. Forsyth et al (2008) verifies this notion that CBT skills would be utilised if support and expertise were available from more experienced CBT therapists. It has been argued that Advanced Nurse Practitioners (ANP) would be well placed as ‘clinical leads’ to support frontline staff and promote evidence-based practices. However, there are no ANPs (ABA, 2014) in mental health in the HSE-SE area.

5.11 Implications and recommendations of the findings

This study offers some insights into mental health professionals’ experience of undertaking the CBT ‘Skills for Practice’ training and increased awareness of what helped and hindered the use of the CBT skills in clinical practice. Overall it became clear that the six participants in the study had found the training beneficial and that CBT skills were being utilised by all the participants in their clinical practice following the training.

The key findings indicate that the Psychologists and Counsellor who had managerial support, peer support and supervision structures in place were more likely to assimilate the CBT skills into their clinical practice. Whereas, for the CNMs and the OT who had limited clinical leadership, peer supervision or supervision structures in place, the CBT skills were used in a limited way and the CBT skills were difficult to maintain. Therefore there were unequal opportunities for mental health professionals to proceed with CBT skills development and this appeared to be dependent on their disciplinary status.

It is believed that WBL is a partnership between the learner, ‘organisation and the educational institute’, which is central to practice development (Phillips, 2012; Jackson and Watson, 2011). What is required is an organisational commitment to advancing evidence-based
clinical practice within all disciplines, as argued by Barr Taylor and Chang (2008). The learners should have equal access to support systems such as reflective sessions (Bennett-Levy, 2006) to improve their clinical skills and address learning needs (Milne, 2009). However, despite this being seen as crucial to learning by the CNMs and OT, this was absent from their own clinical environments.

It appears that nursing leadership has been instrumental in developing evidence-based staff training needs, initiated by the RCNME and further CBT training pathways are planned regionally. Perhaps education sessions outlining the nature and content of local available training could help staff to decipher the context of the training, whether specific training is going to be helpful or useful within their existing role and whether they will be in a suitable role to practice the skills learned so that training can be maximised. In addition Newton and Yardley (2007) found that appointing specific individuals to promote practice development was beneficial which has not been the case locally for CBT practice development.

5.12 Limitations and suggestions for future research

The limitations of this study were that it was a retrospective study so memory bias from the participants would have to be considered. The sample size was small, there was only one male participant and not all mental health professionals who attended the training were represented. There was a low response rate from nurses who actually made up eighty five per cent of the participants who attended the training. The two CNMs who agreed to be interviewed were known to the author. The researcher had completed the CBT ‘Skills for Practice’ training so personal bias could have influenced the analysis of the data. The researcher would like to acknowledge that the research was carried out on behalf of TCD and the RCNME. Furthermore, the time constraints of the Masters of Science studies limited the size and nature of the study.
Finally, further research could be carried out on all participants of the CBT ‘Skills for Practice’ training in the form of an anonymous survey to investigate further the low response rate from nurses, to establish whether the CBT skills training has had an impact on clinical practice, to clarify how many professionals from which disciplines are using the skills and plan to avail of further CBT training with the RCNME or other educational institutions. Alternatively, it may also capture what factors have influenced mental health professionals’ non-use of CBT skills within the region. With such knowledge, training programmes locally could be more strategically offered with increased support in practice following training to ensure evidence-based developments are promoted and sustained in clinical practice.

5.13 Summary
The results of this study have been examined in relation to the existing literature. The key areas of the discussion included the context of the training, competency issues, skills and knowledge development, outcomes, reflective practice/supervision structures and organisational issues. The factors that may have influenced the low response rate of nurses were also explored. The implications of the study and the recommendations emerging from the discussion were outlined. Finally, the limitations of the study and future research options were illustrated.

5.14 Conclusions
This is the first in-depth qualitative study of a variety of mental health professionals in Ireland which offers some insights into mental health professionals’ experience of the CBT ‘Skills for Practice’ training. The overall findings indicate that, for all the participants, the experience of attending the training was a positive one and all the mental health professionals indicated that they were using some of the CBT skills within their clinical practice. Despite some initial concerns about the limitations of CBT, there was a general consensus that the use of the CBT skills (such as structuring sessions, activity scheduling and the five areas model) had enhanced their clinical practice.
However, the findings also indicate that there was a lack of context to CBT skills training within an Irish setting (or compared with the UK) which appeared to impact on half of the participants, who questioned how the CBT skills might fit within their existing professional roles. This appeared to cause some confusion and increased the anxieties of the participants in relation to competency issues utilising the CBT skills in clinical practice and concerns about how they might be perceived as ‘therapists’.

The factors that assisted the use of CBT skills for the Psychology and Counselling disciplines included their continued access to existing supervision structures, both individual and peer group supervision, professional autonomy and clinical leadership from their managers who perceived professional development to be important, encouraged staff to attend training and supported protected time for practice development. The findings of this study indicate that organisational issues assisted the assimilation of the CBT skills into on-going clinical practice, which is endorsed within the literature (Grey et al. 2008; Rakovshik and Mc Manus, 2010).

The factors that were barriers to the application of the CBT skills for the CNMs and OT included the lack of supervision structures and a lack of clinical leadership regarding practice development. These organisational factors impacted negatively on the assimilation of CBT skills into clinical practice. These issues appeared to heighten the fears of the professionals in relation to their competency levels and as a result in this study, the CBT skills were used in a limited way following the training. These findings are supported in the case in the literature (Mannix et al., 2006 and King et al. 2002). Additionally, their professional roles appeared to be complex, comprehensive and diverse with high workloads impacting on the use of CBT skills in clinical practice (Mathers, 2012; Monro et al., 2005). The findings do expose the inconsistencies of the dissemination of the training both in terms of the disciplines and within different clinical and regional areas. Cusack and Killoury (2012) argue that nurses and mental health professionals
are well placed to deliver psychological interventions. Yet this appears to require equal opportunities for all disciplines to have access to supervision and supportive clinical leadership for the benefits of CBT skills training to be maximised in clinical practice and to improve client outcomes.

It is proposed that there needs to be consistency and transparency about what mental health professionals can provide in the way of psychological interventions to clients who seek access to mental health services in Ireland for treatment with their psychological difficulties. Milne (2009) recommends that evidence-based clinical supervision (EBCS) structures are essential for facilitating and evaluating the learning needs of mental health professionals. This may ensure that evidence-based psychological interventions are developed and maintained in clinical practice (Grey et al 2008; Shafran et al 2009).
References


Colliver, J.A. *Effectiveness of Problem-based Learning Curricula: research and Theory.* Academic Medicine, Vol 75, 3, 259-266.


Sainsbury Centre for Mental Health (2006) *The Administration Workload for Mental Health Workers*, SCMH.


LIST OF APPENDICES

APPENDIX A: INFORMATION LEAFLET

Researcher: Lucy Roberts
University Department: Trinity College Dublin 2.
Academic Supervisor: Anne Marie Reynolds.
Contact Details: 087 769 6094
e-mail: Lucy.Roberts@hse.ie

Title of the study: Cognitive Behaviour Therapy (CBT) ‘Skills for Practice’ Training: An Exploration of Mental Health Professionals Experience.

Introduction

My name is Lucy Roberts and I am a Clinical Nurse Specialist in Cognitive Behaviour Therapy. I am currently undertaking a Masters Level Programme in CBT at Trinity College Dublin. I am required to undertake a research project as part of my studies and in collaboration with the Regional Centre of Nursing and Midwifery Education (RCNME). The focus of my work is to explore the impact of CBT ‘Skills for Practice’ training on staff in the HSE South East Area.

You are invited to participate in a research study focused on the experience of completing the CBT ‘Skills for Practice’ training. The research has been supported by Regional Directors’ of Nursing and by Jim O Shea, Regional Director of the RCNME.

The aims of the study are to explore the experience that mental health professionals had while undergoing brief training in CBT ‘Skills for Practice’ and to establish whether mental health professionals are utilising the CBT training in their everyday clinical practice. The objectives of the study are to identify potential factors that assist or deter utilisation of the skills in practice and to inform future training needs.

Procedures

If you decide to participate, you will be asked to take part in a semi-structured interview with the researcher at a location of your choice and a convenient time for you. The researcher hopes to include six to ten people in the study and aims to include a gender mix representative of different disciplines from different areas in the region. You will be asked to sign the consent form prior to the interview in the presence of the researcher and given time to ask any questions about the study.
Confidentiality
All the information that you provide at the interview, which will be recorded, will be kept strictly confidential and stored securely. Your name and demographic information will be stored securely with your consent form. Your first name will be utilised on the recording, your full name will not appear on any of the data and you will be assigned an identity code. The information gathered will be destroyed five years after the study is complete (as per Trinity College Dublin Guidelines).

Potential Risk/Benefit
The findings will be made available at the end of the research process, a copy of the findings can be provided by the researcher on request and a copy of the study will be stored in Lacken Library, Kilkenny. The findings may be published in a peer reviewed academic journal. It is anticipated that there will be an increase in knowledge in relation to the impact of CBT ‘Skills for Practice training. At present there are no known identified risks involved in participating in the study. Confidentiality will be assured throughout the process.

Voluntary Participation
Participation in the study is voluntary. You may withdraw from participation at any time. You will not be penalised and are not required to give any reason for your withdrawal.

Permission
Ethical approval has been given by the Research Ethics Committee, HSE South-East. Ethical approval has been given from Trinity College Dublin. If participants have concerns about this study and wish to contact an independent person please contact:

The Secretary, Trinity College Dublin Research Ethics Committee, Medical Board Secretariat, Trinity College Dublin 2. Telephone 01-414-2342.

If you are prepared to partake in the study, you can volunteer in writing to Lucy Roberts, The Department of Psychiatry, St Luke’s Hospital, Kilkenny or email at lucy.roberts@hse.ie or by telephone 087 769 6094. Thank you for your help and I look forward to hearing from you.

Yours sincerely
Lucy Roberts
APPENDIX B: INFORMED CONSENT FORM

Principal Investigator: Lucy Roberts
ID Number: 12263658
University Department: Trinity College Dublin 2
Research Title: Cognitive Behaviour Therapy (CBT) ‘Skills for Practice’ training: An Exploration of Mental Health Professionals Experience'

This study will explore mental health professionals’ experience of undertaking training in CBT ‘Skills for Practice’. The participant will be asked to take part in a semi-structured interview with the researcher and questions will be focused on their experience of the CBT ‘Skills for Practice’ training. Interviews will be recorded and all of the information given will be completely confidential. The information will not be shown to any third party, except when published as part of the final research findings in an academic journal. The information will be stored confidentially and full anonymity is guaranteed.

DECLARATION:
I have read, or had read to me, the information leaflet for this project and I understand the contents. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, though without prejudice to my legal and ethical rights. I understand that I may withdraw from the study at any time and I have received a copy of this agreement.

PARTICIPANTS NAME:
CONTACT DETAILS:
PARTICIPANT’S SIGNATURE: Date:

Statement of investigator’s responsibility: I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks involved. I have offered to answer any questions and fully answered such questions. I believe that the participant understands my explanation and has freely given informed consent

INVESTIGATORS SIGNATURE: Date:
APPENDIX C: INTERVIEW SCHEDULE

The researcher will remind the participants of the confidential nature of the interview and reiterate that consent can be withdrawn at any time during the process.

Demographic/Background Information

- What is your first name?
- What is your professional background?
- Can you tell me how long you have been qualified?
- How long have you been working as a .......?
- Where are you currently working?
- What does your work involve?

Training

- Tell me about the opportunities there are for you to attend training in your area?
- What are your thoughts on training offered within the HSE?
- How does short term workshop training impact on your professional knowledge and skills? In what way? Is it helpful or unhelpful?)

CBT ‘Skills for Practice’

- What was your understanding of CBT prior to attending The CBT ‘Skills for Practice’ training?
- What were your expectations of the training offered?
- Can you tell me about your experience of undertaking the CBT ‘Skills for Practice’ training?
Tell me what you thought about the way the training was delivered (didactic teaching, the role-plays, DVD’s etc.)

Describe what it was like to practice the CBT skills on the training days? (Was it difficult? or was it helpful?)

How does this training compare with other short term training that you have experienced?

Is there anything further you would like to say about the training?

Transferring the Skills into Your Clinical Practice

What opportunities were there to practice the CBT skills in your clinical practice area?

What was your early experience of utilising the CBT skills in your clinical practice area?

How did you feel about practicing the skills?

What went well? What didn’t go so well?

Support/Mentorship

What was your experience of the practice mentor sessions (were they useful? If yes, why?, if no, why not?)

Were there opportunities to avail of support/mentorship after the three months of training was completed. If yes, by whom, if not, why not?
Skills Development/Dissemination

- What sorts of support systems are in place within your own clinical area? Describe what is available. If none, how have you managed that?

- How would you describe your abilities to utilise the CBT skills now?

- Can you tell me what aspects of the training impacted on your clinical practice?

- Can you tell me whether you underwent any changes in your clinical practice as a result of the training?

- If you are still practicing the skills, what factors assisted the dissemination of the CBT skills into your clinical practice area? (How were skills gained and maintained).

- If you are not still practicing, what factors hindered the dissemination of the CBT skills? (Such as workload, managerial support, lack of confidence).

- What strategies do you think need to be in place to assist dissemination of training into clinical practice area?

- What are your thoughts about CBT skills for practice training now having undergone the training?

- What advice could you give to a person interested in attending the CBT skills training?

- Is there anything further that you would like to add?
APPENDIX D: ETHICAL APPROVAL FROM T.C.D

THE ADELAIDE & MEATH HOSPITAL, DUBLIN
INCORPORATING
THE NATIONAL CHILDREN’S HOSPITAL

June 19th 2013

Re: Cognitive Behaviour Therapy (CBT) “Skills for Practice” Training: an exploration of mental health professionals experience.

Please quote this reference in any follow up to this letter: 2013/06/02 Chairman’s Action

Dear Lucy,

Thank you for your recent submission of the above proposal to the SIH/AMNCH Research Ethics Committee.

The Chairman, having reviewed the proposal on behalf of the SIH/AMNCH Research Ethics Committee is of the opinion that this proposal is an audit/service review and so does not require ethical review or approval by the Research Ethics Committee.

Yours sincerely

Ms. Ursula Ryan
Secretary,
SIH/AMNCH Research Ethics Committee
APPENDIX E: ETHICAL APPROVAL FROM WATERFORD REGIONAL HOSPITAL

22nd October 2013

Ms. Lucy Roberts
Clinical Nurse Specialist
Department of Psychiatry
St. Luke's Hospital
KILKENNY

Study Title: Cognitive Behaviour Therapy (CBT) 'Skills for Practice' Training: An Exploration of Mental Health Professionals' Experience

STUDY STATUS: APPROVED

Dear Ms. Roberts,

The Research Ethics Committee Coordinator REC, HSE, South East reviewed the above study.

Expeditiated ethical approval has been granted for the above study and constitutes full ethical approval.

The following documents were reviewed and approved:
1. Ethics Submission Form
2. Research Proposal/Protocol
3. Interview Schedule/Questionnaires
4. Participant Information Sheet
5. Participant Consent Form
6. Letter to Area Director of Nursing, Director Centre for Nurse Education

The following documents were received:
1. Signed Hard Copy of Declaration Page
2. CV of Chief Investigator – Ms. Lucy Roberts

In addition, this study will be outlined at the next planned Research Ethics Committee Meeting for the HSE, South Eastern Area by the Research Ethics Committee Coordinator.

Waterford Regional Hospital Mission Statement:
Together we will provide quality patient care delivered by skilled and valued staff through the best use of available resources.
and any comments made at this meeting in relation to your study shall be communicated to you in writing.

It is a requirement of the REC, HSE, South East that you send copy of your study to the Research Ethics Office on completion.

Yours sincerely,

Ms Caroline Lamb
Research Ethics Committee Coordinator
Health Service Executive, South Eastern Area

The Research Ethics Committee, HSE, South East is a recognized Ethics Committee under Regulation 7 of the European Communities (Clinical Trials on Medicinal Products for Human use) Regulations 2004 and as such is authorized to undertake ethical review of clinical trials of all descriptions and classes for the Republic of Ireland.

The Research Ethics Committee, HSE, South East issues ethical approval on the basis of information provided. It is the responsibility of the researcher to notify the Research Ethics Office of any changes to a study to ensure that the approval is still relevant.
Ms. Lucy Roberts
Clinical Nurse Specialist – Cognitive Behavioural Therapist,
Department of Psychiatry,
St. Luke’s Hospital,
Kilkenny.

11th April 2013

RE: Research Proposal

Dear Lucy,

Thank you for your letter dated 25th March 2013 in relation to your research proposal for your Masters in Cognitive Behavioural Psychotherapy. The Regional Centre of Nursing and Midwifery Education, HSE South (South East) would be glad to support this initiative subject to approval by the Research Ethics Committee.

I wish you all the best with this endeavor.

Yours Sincerely,

James O'Shea
Director,
Regional Centre of Nursing & Midwifery Education,
HSE South (Carlow, Kilkenny, South Tipperary, Waterford, Wexford),
Waterford Regional Hospital,
Dunmore Road,
Waterford.
02 353 515 642524
02 353 87 642507
James.OShea@hse.ie
O’Dorman, Marion

From: Roberts, Lucy
Sent: 06 May 2014 15:29
To: O’Dorman, Marion
Subject: FW: Re research for msc

From: Roberts, Lucy
Sent: 06 May 2014 10:26
To: Roberts, Lucy
Subject: FW: Re research for msc

From: Ward, Martin
Sent: 07 May 2013 08:34
To: Roberts, Lucy
Cc: Egan, Margaret; Duane, John; Hughes, John; Green, David (SLC); Healy, Tim; Nolan, Karen; Lynch, Mary (Pay)
Subject: RE: Re research for msc

Lucy

I did try to contact you on receipt of your correspondence. I am happy to support your research and wish you every success in your studies.

Martin Ward
Area Director of Nursing,
South Tipperary Mental Health Services,
St. Luke’s Hospital, O’Donnell, Co. Tipperary.
052 6177414

From: Roberts, Lucy
Sent: 05 May 2013 10:21
To: Ward, Martin
Subject: Re research for msc

Dear Martin Ward

I am in the process of completing my research proposal. I am now planning to a qualitative piece of research with staff that completed the CBT skills for practice course in the south east. I wrote to you a few weeks ago to seek your permission to go ahead with the research and I have not heard back from you. I would really appreciate if you could let me know if you will support my research project, as my proposal is due in on the 13th of May. Jim O’Shea has kindly agreed to me to complete the research on behalf of the ROXME.

Yours Sincerely

Lucy Roberts

Lucy Roberts
Clinical Nurse Specialist
Cognitive Behaviour Therapist
Department of Psychiatry
St Luke’s Hospital
Kilkenny
Tel 058 7385092 Mobile 087-759-6034
Email Lucy_Roberts@hse.ie

06/05/2014
APPENDIX H: EXAMPLE OF TRANSCRIBED INTERVIEW.

Interview Code 2

L - So I just wondered if you could explain what your professional background is?

Y - [sic] Emmmm well I am a mental health nurse….emmmm I am, I suppose twenty years in the service emmm that includes my training emmm most of my experience would be in the acute mental health area emmm and for the past two years I have been working with the home based treatment team in Kilkenny.

L - The home based treatment team what does that actually involve?

Y - [sic] Emmmmm home based treatment is a crisis intervention team and it’s an alternative to hospital admission emmm. It’s a team of nurses and it consists of seven nurses’ emmm, one manager and a team coordinator emmm and we work within the community mental health team we are like a branch off it and the clients that emmm we would look would look after would generally fit the criteria for admission to hospital who are in short- term crisis and what is involved is that you would see the client intensively for a period of two to four weeks emmm on a daily basis initially, and then a needs basis after that, it is a short term intervention.

L - So emmmm when you when you talk about your work involving sort of an option to possible admission, what would you sort of skills would you need or what sort of things would you doing your practice with people that you are working with?

Y - [sic] Emmmmm generally emmmm coping strategies emmm anxiety management emmm medication management and emmm forming a therapeutic alliance with the client, gaining their trust emmm.

L - It’s in people’s homes?

Y - [sic] Emmmm the client stays at home in their own home I suppose the advantages for the client is that they are in their home environment emmm they have their loved ones around them and family their support networks and we would also be able to look at what emmm resources are available to them in the community while they are at home .Emmmm

L - So you don’t generally after two to four weeks then what happens after that you decide as a team

Y - [sic] We work with the community mental health team very closely with them so we are constantly feeding back to the team emmm so the initial plane might be home base but the plan is reassessed on a daily basis.

L - Ok

Y - [sic] On the clients’ needs emmm

L - Where might they go after they have finished?
Y - [sic] Where they might go is after us, depending on their need may just need follow up with the team on an outpatient basis emmm they may be referred to the day services for someone to one work, coping strategies, anxiety management emmm or they may wish to get involved in the group and we would also emmm again on a needs basis look at what other resources are out there that they can avail of emmm in the community as well as the HSE services emmm (silence)

L - Okay so moving on, now you know can you tell me what opportunities there are generally for you to attend training in your area.

Y - [sic] Emmm ........the opportunities have been quite good since we started on the home based treatment team even though we are getting very busy as time goes on and maybe we are not getting the opportunity as we are not as available as we were initially but with the starting of the home based treatment team there was a lot of training offered to the team, to the team and individuals and every individual availed of that. Emmm but we are as a team always on the lookout for any training that is available that some member of the team may be able to attend.

L - So that benefits the whole team

Y - [sic] The whole team benefits the individual I suppose, the team and ultimately the client benefits from the skills.

L - So you are building up a skill set within the team.

Y - [sic] Yeah as it happens at the moment we are trying as individuals to look at exactly what we have done, what training we have done just focusing on that to put it all together you know so

L - What training you have?

Y - [sic] We were just actually chatting about it, since we started we have actually have done a lot of training and maybe we have been so busy that we haven’t had time to acknowledge exactly what we have done you know that we are using the skills and just that emmm we can focus back on that and give ourselves time to focus on the training we have done to make sure that we are using the skills as a team.

L - As you say as you get busier with the day to day work

Y - [sic] Yeah. We do have a team building meeting every eight weeks and we do look at things like that and kind of take a breather and make sure that we are using our skills and how we can improve ourselves.

L - Oh okay. When you think about emmm what you just mentioned there about using skills and recognizing that you have a lot of training together, when you do shorter term workshops and things like that how does that sort benefit you do you think, short term training?

Y - [sic] I think it gives you a better structure, emmm it gives you an opportunity to ensure that you are using your skills and emmm and brings ideas to you profession (interrupted briefly by the phone ringing, Yvonne takes the call briefly).

L - That’s okay when you are working
Y - Sorry about that last question

L - We were talking about when you do you know short term workshop training, what sort of impact it has on your knowledge and skills, I know that you are just been interrupted there

Y - [sic] I suppose it kind of grounds you, the way you interact with clients, it makes me you more aware and how you interact as at a lot of the workshops you do role play and things like that. In some of the workshops we have done you have been videotaped as well so can see how you interact and you know that emmm

L - You sound like that has been a kind of something that you found quite helpful is it?

Y - [sic] Yeah I have to say, it’s something nobody likes to be observed but you benefit from it.

L - Yeah. What do you think you have seen, that kind of…especially being videoed and things?

Y - (Silence) [sic]……well I suppose on a positive point you see maybe you know how I suppose it’s good to have emmm to be relaxed and emmm not to be too loud (laughs) and how a client can mirror you, you know and how you need to sort of

L - mmm. That’s been demonstrated by seeing yourself

Y - Yeah, Yeah

L - Yeah, it’s quite a challenge, isn’t it

Y - yeah (both laugh)

L - Ok so just in terms of the CBT Skills for practice that you know. Would you be able to say what your understanding of CBT was prior to attending the CBT Skills for Practice training? What would your understanding have been?

Y - (Silence) [sic] emmm I suppose it would have been more broad maybe emmm before I did the training

L - What would you have thought it was? Did you think it was a particular technique? Or what would you have thought about it

Y - [sic] Well I would have thought that cognitive behavioural therapy was changing somebody’s thinking. Trying to change somebody’s thinking

L - Okay

Y - [sic]Emmm that is how I would have perceived it prior to doing the CBT

L - Okay so when you went to do the training did you think that the skills might involve helping people to change their thinking, is that what you thought it might involve

Y - [sic] I suppose yeah, maybe what I learned the most is the emmm it’s not about the therapists changing the persons thinking but it’s about the
person themselves, you are just there to guide them along the way really, a big thing that came out for me, so it think the solution focused side of it, the individual has all the answers, you have to try and draw it out of them rather than as nurses we were always I suppose always perceived to fix people, you know, but the person really has all the answers you know, you are just there to help them find them.

L - So you are saying that rather than fixing people and changing their thinking that part of the learning that you gained was recognizing well people have the answers themselves

Y - Yeah

L - and it’s about them changing their thinking

Y - Yeah

L - So it was very different to what you kind of imagined then was it.

Y - It was quite different yeah

L - Yeah so what were the expectations or what were you hoping would come out of the training or what did you think the training might be like? You know did it live up to your expectations

Y - [sic] Yeah I suppose, I was working in acute DOP at the time and I suppose I was hoping that to get more out of short interventions with clients because that is all you would get out there because a short intervention and to make the most use of that time

L - Yeah

Y - [sic] Emmm……(silence)

L - Because of the nature of being in a place that was so busy

Y - [sic] Yeah exactly. I suppose now that I have moved into home base, I have more time (laugh) and emmm

L - but at the time you were doing the training, you were managing a ward

Y - [sic] Yeah and you know I would have had minimal time interacting with clients

L - Okay

Y - [sic] Due to time schedule so emmm just to make the most use of that time

L - Okay so……when you were actually undertaking the training then, what did you feel it was like as an experience. You spoke earlier on there about that training you have done more lately has been about role-plays and more about being you know. You sort of seem to think that that was beneficial. Was the role-plays on this course

Y - That’s right
L - Did you feel used to it by then or was this you know watching people watching other people observing you was how you got

Y - [sic] Yeah I mean it was quite difficult at first

L - In what way?

Y - [sic] Emmm I suppose it was something I wasn’t used to, it was tough, something I hadn’t done before emmm ……..to be observed by so many people

L - hmmm

Y - [sic] In a role play situation emmm but it definitely got easier as time went on you know and you kind of just you know emmm, you are there to improve your skills and you kind of don’t mind what other people are thinking as time went on

L - Was that the concern in the beginning what other people might think

Y - [sic] I suppose you are in the hotspot, hotseat

L - (Laughs)

Y - [sic] but sure everyone was in the hotseat

L - Yeah so that kind of levelled out then

Y - [sic] Yeah and it was good listening to other peoples experiences and different I suppose emmm different professions and different areas of the health service you know

L - [sic] A mixture of people on the course, different backgrounds and experience yeah. So when you emmm when you completed the training was there anything you would say that you would like to have been different? Or you know did you feel that you kind of a lot of people had the training over a long period of time did you think that was useful or did you think that it could have been better to have it all together. What was your experience?

Y - [sic]Emmm I think it was maybe emmm I can’t remember now

L - [sic] Spaced out?

Y - [sic] Two days one week and then yeah emmm definitely two days in one week was enough anyway emmm cos it was quite intense

L - Yeah

Y - and it gave you the opportunity to practice some of the skills before the next block and possibly could have been a little bit closer maybe; it was a month but maybe every two weeks

L - So you had the role-plays what else it was about the training other that you noticed, what was your experience of the type of training offered

Y - [sic] the lecturer was very good emmm she explained things very well emmm I liked the solution focused thing. She threw a lot of things at us and
rather than tell us she wanted I suppose what we learned is some of what we are doing anyway. Just put it into a structure or a formulation or a formula, I mean we are doing it anyway. Just to realize how we are doing it and to be more aware of it.

L - So that the way that the trainer was training emmm was that in a way modelling or that she was trying to get you to think in a way that you might get clients to think.

Y - [sic] I think that was it yeah...emmm I think it was more to get you to think as in how you might be with a client and get them to think you know and again she wasn’t giving us all the answers cos we probably had a lot of them and she was suggesting and we were we were emmm coming up with a lot of the solutions ourselves

L - Yeah and you mentioned something there about structuring

Y - [sic] Yeah and I mean you know emmm I suppose a start a middle and an end and you know I never even thought of that in that way before

L - Yeah emmm and especially again being in the acute

Y - [sic] being restricted with time as you were saying, touching base here and to have more of a structure like that you know that somebody comes in and when they are midway through and when they are going home they are at different stages you know. Just to be more aware when you are speaking to them about what stage they are at

L - Yeah

Y - [sic] emmm and the same for home base you know

L - Yeah

Y - [sic] just to ye definitely rose awareness in that

L - So when you did finish the training? Did you find that, I know you said that you were on an acute ward so I know that there are a lot of restraints in that sense, but were there opportunities to practice the skills after the training finished or during the training even?

Y - [sic] brief interventions I did try you know following someone through but it wasn’t very practical in the area I was in at the time.

L - Yeah

Y - [sic] But I did use brief interventions and I would use some of the skills that you know emmm.

L - Did you find that you were able to use the five part model?

Y - [sic] Yeah I found even just briefly explaining that to a lot of clients was I suppose, if they were at a stage that they could understand it

L - Yeah

Y - [sic] emmm that they take in and with a few clients they found it good.
L - Did you find that you know your early experience of using the skills was a difficult transition you know when you first start launching in to something new with someone?

Y - [sic] Emmm …. (silence) ….. Yeah it probably was initially yeah it was initially yeah

L - Would you still use any of those skills?

Y - [sic] Yeah we would…… what was it now the five part model, I would use you know

L - Yeah

Y - [sic] Emm (silence)

L - Did you feel you know that did you feel the more you know how did you feel about practicing the skills more say when you were in your other job and then you moved.

Y - [sic] Yeah

L - Did you feel it gave you more of an opportunity to practice the skills, if you had stayed in your old job would that have been more of a challenge.

Y - [sic] Yeah

L - Because of the managerial role?

Y - [sic] I think so emmm, definitely in home base you have much more opportunity to use to use the skills

L - Okay

Y - [sic] Emmm you know emmm……it’s more focused and you might focus on one thing in particular with the client so you can work on that

L - Yeah

Y - [sic] Emmm you know sometimes in hospital, they need to be better

L - Yeah

Y - [sic] ahhh it’s the nurse role that is there and it’s kind of a block as people think you are there to make them better

L - Yeah

Y - [sic] Whereas people at home, I suppose it is a better opportunity to you know, they can see that they have all the answers really.

L - Using like you know what Kate might have referred to as Socratic dialogue, where you are trying to get

Y - Yeah
L - The person to come to their own answers as you were describing

Y - [sic] Yeah

L - So now is it different you know when you can see somebody now what makes that different that you can protect that time, is that a difference that you can see

Y - [sic] Yes to definitely protect the time

L - So in a way that you can’t on an acute ward, so you can plan even though it is a crisis service

Y - [sic] Yeah it is a crisis service but when you call to somebody’s home you are going to be there for an hour and you are going to give them that time.

L - Yeah

Y - [sic] Definitely and the clients would give the feedback as well that with home base you actually have much more contact with the client that you would in the hospital. In hospital you are so busy, with work and other duties you know

L - Yeah

Y - [sic] Whereas when you are with somebody from two to three, that is their time and their protected time with you

L - Yeah

Y - [sic] You know you have the opportunity to do whatever work you have planned for that day

L - Yeah

Y - [sic] or what they have planned, you know

L - So you are getting more of a sort of an opportunity. Did you find that any time when you were introducing any of the skills that things went particularly well or didn’t go well you know?

Y - (Silence).

L - You said you used it a lot with clients

Y - [sic] Emmm I suppose emmm (silence) maybe if someone was too low, too depressed to take it on board

L - Okay

Y - [sic] Emmm you know

L - How did you deal with that?

Y - [sic] Emmm I just felt that maybe it was not the right time to be maybe you know to be focusing on emmm (silence) …too intense.
L - Yeah they might be too acutely unwell is it

Y - [sic] exactly

L - To take it on board yeah, yeah.

Y - [sic] Emmm

L - And recognizing that clinically and making that judgment call

Y - [sic] Yeah. And when it went well sometimes I found with the websites that you could give the client the opportunity to look at things themselves and then they would come back to you

L - Yeah

Y - [sic] Emmm or if anxiety was a particular problem for them at that time.

L - Yeah

Y - [sic] the anxiety worksheets would be give them the opportunity to look and pick out something that they would like to do

L - So kind of like a psychoeducation

Y - Yeah

L - Around them sort of emmm having you know that collaboration

Y - [sic] They might decide what they might like to work on and

L - And kind of set an agenda on what they are bringing to the session

Y - Yeah

L - Rather than you said that you were talking about not in a place where you are fixing people but it is more about what they might bring to the session

Y - Yeah

L - Being open to that.

Y - Yeah

L - Okay what was your experience of the practice mentor sessions, how did that go for you?

Y - [sic] Emmm….. (silence)……I suppose they were good as they were a chance to reflection what we had done and…. (silence) and… emmm it gave clarity maybe on something that you might want to go over again . Emmm…..(silence) maybe something that was quite complex and spend a bit of time on that emmm……. (Silence).

L - Did you have that in a group situation or a one to one?

Y - [sic] A group situation emmm (silence)
L - Did you?

Y - [sic] I felt sometimes that it was a bit long maybe the two hours together. Emmm ….(silence) Sometimes emmm being hones there might be half an hour at the end when we might just watch a DVD or something, you know and people were probably kind of talked out, so that was beneficial too.

L - Did you feel that you could bring things that were concerning you about developing the CBT skills, did you feel you could bring them to that place?

Y - [sic] Emmm ….(silence). Yeah it was an opportunity to bring things but I don’t think people would have brought up things like that.

L - What do you think was or why do you think that was?

Y - [sic] Emmm ………(silence).………………….I don’t know really, I am just trying to think now.

L - You are saying on the on the one hand that you could go over things?

Y- Yeah

L - But it sounds like people found it hard to discuss cases was it or?

Y - [sic] I don’t think so I think it was used more as a kind of revision that anything.

L - Okay

Y - [sic] I don’t think, well maybe on one or two occasions things were brought up maybe individual clients, you know maybe case scenarios or things but it was mainly used as revision.

L - Was it?

Y - Yeah

L - So watching DVDS

Y - [sic] Yeah maybe it could have been used better you know, looking back, maybe it could have been, maybe we could have utilised it better, you know.

L - Cos you kind of sounds like you like it was

Y - [sic] It was a bit like a tutorial (laughs)

L - A tutorial as opposed to? Looking back on it

Y - [sic] Yeah maybe it was nobody’s fault, our own fault as much as the tutor so

L - Okay, looking back on it
Y - [sic] Yeah maybe we could have you know discussed individual cases maybe or difficulties we had with clients and ....(*silence)*....and I felt like with actually did that more in the group with Kate. You know?

L - Ok? so you did that more when you were at the training, than you did in your mentoring sessions

Y - Yeah

L - Yeah

Y - Yeah

L - Okay as the mentoring you know is an opportunity to

Y - Yeah. yeah

L - To go over things as well isn’t it. So after the mentorship

Y - [sic] mmm

L - finished after the three months of the training, was there any further opportunities to avail of support with practicing your CBT skills

Y - [sic] Emmm , well we have two CBT therapists working in the Department of Psychiatry and they would always offer their you know they were always there to speak to about any client, if we needed any advice or if we needed any one to one time to discuss any clients with them

L - Was that a formal arrangement or informal arrangement?

Y - [sic] Emmm........(*silence)*, I suppose it was an informal arrangement really.

L - Ok so you know if you didn’t, and have a relationship with them, there wasn’t a system in place as such when the mentorship finished, there was no kind of

Y - [sic] I suppose there wasn’t a formal, no there wasn’t a formal person there you know we knew emmm that

L - You could identify people

Y - [sic] and they made themselves identifiable

L - Yeah

Y - [sic] To approach them if there was any if we needed any advice, assistance or mentorship; it wasn’t a formal thing that was in place within the service

L - Okay, yeah. So now having said you know that that was an informal arrangement was there any sort of any support systems in place within your own clinical area to sort of support you with skills development or practicing things? What is available to you at the moment?
Y - [sic] Emmm .....(silence) ........we do have supervision as a group emmm with the family therapist emmm

L - How often does that take place?

Y - [sic] About once every eight weeks  emmm

L - Okay

Y - [sic] And that has been very good

L - What do you get to, is that a similar thing like a chance to go over things or is it different to the mentorship thing?

Y - [sic] Emmm well ...... I suppose it is working within a team, its working with any emmm issues that may arise within the team as well as any issues we may have you know, you know around clients or any difficulties we have been having or, it has been good.

L - And you have found that helpful, have you?

Y - Yeah

L - In what sort of ways, what sort of things has it

Y - (Silence) ........[sic] I suppose as a group it gives us time to ground ourselves again and just emmm be able to speak I suppose ...............In a safety net emmm I suppose the main difficulties around organisational difficulties and .......emmm you know some team members might have frustrations around that and it just gives us an opportunity to discuss it in a safety net

L - Yeah, yeah. Would there be an emphasis in supervision on sort of skills development and practice development?

Y-  [sic] I suppose well it would not be focused on that I think it is more around emmm .....organisational and emmm clients and stuff like that

L - Okay

Y - [sic] More professional and skills and things like that emmm but I suppose as a group we would talk about it.

L - Yeah cos you mentioned earlier about coming together and actually starting to recognise your skills

Y - Yeah

L - Where does that take place then? Is that a team or is that a different meeting

Y - [sic] We usually combine the two, we might have our clinical supervision in the morning and then we come back and have a team building meeting

L - Okay
Y - [sic] We keep an agenda and we get all the members to write down things that we think should be discussed

L - mmm

Y - [sic] Emmm

L - How often does that take place?

Y - [sic] Emmm I would say emmm every eight weeks

L - Okay and in the team building what’s that an opportunity for you to do? People can put things on the agenda.

Y - [sic] Well I suppose emmm you know in the home base I suppose there are so many things happening emmm so it gives us an opportunity maybe to say we always say to team members to write things down as there are happening as there maybe an experience that they have had or something they are not happy about……….something happened with a client or emmm

L - Is this the forum when you said you were all sort of starting to acknowledge what are the skills set that make up this team

Y - Yeah

L - Would other people in the team have undergone the CBT skills for practice training

Y - [sic] Well actually they haven’t, they would not have actually done the six days but they would have done a lot of other things. Solution focused work and they do use the get self help

L - Yeah

Y - [sic] website a lot and I think they are actually using them, without doing the course are using some of the

L - Is that with your kind of influence? Or your experience of doing it

Y - Well,

L - The training?

Y - [sic] I would have brought some of it to the team emmm yeah and a lot of the girls have done a lot of reading I suppose and a lot of research themselves, yeah and so

L - Yeah and was there a particular reason why you are the only person in the team trained or did it just work out that way?

Y - [sic] It just worked out that way. Emmm it just worked out that way, there was only so many people trained three or as far as I know three groups trained locally and I was in the third group.

L - Yeah
Y: [sic] Only so many people got the opportunity to train and it just so happens that it wasn’t any of the girls.

L: That you were working with yeah so they kind of

Y: [sic] Yeah they would have been working in different areas at the time.

L: So would they look to you to kind of for advice on things to do with the get self help and the CBT skills or is it just.

Y: [sic] Yeah I think, you know I think emmm we would have actually sat down as a team and been through the get self help and how we complete certain emmm…… worksheets.

L: Yeah.

Y: [sic] and the girls would have completed the worksheets and came back and

L: Tested them out.

Y: Tested them out.

L: Yeah.

Y: [sic] They seemed to be getting on fine you know so emmm so I suppose so doing a small bit.

L: Yeah, it sounds like it is quite informal, you know.

Y: Yeah.

L: Part of your skill set yeah.

Y: Yeah.

L: So how would you describe you know your ability to use the CBT skills now?

Y: (silence)…. [sic] emmm yeah I feel I am , I do use them . I have to stop myself and I do you know I suppose, you do get caught up sort of again in the daily seeing people and you just need to make sure that you stick to some kind of structure.

L: So.

Y: [sic] Well maybe you’re like, maybe a refresher in it would be good or something you know. Yeah just to make sure that, I know that I am using the skills but just to you know I suppose just to make sure that……you go back to the structure and things like that.

L: So it’s the structuring and you know if I was to say the aspects of the training that impacted on your clinical practice you are saying that one of the aspects is it actually reminds you that you know that it can be helpful to have a structure.
L - Was there any other things that came up from that you kind of, I know that you mentioned the five part model?

Y - Yeah

L - You used that with people and the Socratic dialogue, you mentioned as well

Y - Yeah emmm.......I suppose the problem list and breaking down the problems which is helpful for people I think because

L - Yeah

Y - Because they think that they have a million problems

L - Yeah

Y - You know you can break it down for them and categorise it in to three problems you know

L - Yeah, yeah

Y - to look at and I have done that with people

L - Yeah

Y - Emmm......

L - And does that lead on to setting goals you know like you say categorizing the problems

Y - Yeah and even with the activity sheets, I have done them a lot as well

L - Yeah. What do you find helpful about those?

Y - Emmm .........I suppose again people think that they are not doing anything and when they write it down they find that they are doing a lot

L - Yeah

Y - and they can see that

L - Yeah

Y - So.........I didn’t nothing today, when they actually put it down on paper they

L - Yeah

Y - you know if you put on a wash, it’s a big thing, you know when you are feeling depressed
L - Yeah of course it is

Y - you know they can acknowledge that I did do something today, you know so.

L - So what you are saying is you know you help people by using the activation things that would help with behaviours and the structure of things. So what about with the .....cognitions and the thoughts do you find that that you did any of the things from the skills you know do you find that you are targeting different things. What about the thoughts and dealing with them. You said that in the beginning that you are not trying to change people’s thoughts, that you are getting people to maybe

Y - [sic] Yeah mmm

L - Get people to change their thinking

Y - Yeah

L - you know, do you by using the five areas

Y - [sic] Yeah, yeah, yeah....

L - Yeah, it sounds like you have taken on a lot from the course.........Emmm If you think about now the things that when you are practicing the skills what factors helped or assisted you to do that in terms of your work environment and what things helped do you think?

Y - [sic] Emmmm......the work base environment with the home based treatment team and you know

L - In what way?

Y - [sic] Being community based and in somebody’s home and having the time

L - Yeah

Y - [sic] protected time

L - Yeah and working quite autonomously

Y - [sic] Yeah emmm ......(silence) ......................

L - Sounds like there is a general feeling among your team that they are open to taking on new skills, there is a culture of that within the team

Y - Yes definitely

L - That’s what you seem to be saying, you share things and you try and informally

Y - [sic] Yeah and I forgot a lot of the team are young, with fresh ideas and emmm they take new things on board very easily emmm and practice them which can be a positive thing within the team.
L - So you think that the fact that they are young and open to it

Y - [sic] Yeah they are adaptable to change all the time

L - Yeah

Y - [sic] which is a big factor and could be a huge block to individuals

L - Yeah

Y - [sic] But they do take on change very well and are always open to new ideas so

L - If you think of some people who maybe are not practicing the skills or maybe not having the opportunity as work is getting busy. What sort of things do you think might get in the way of practicing the skills and maintaining the practice of the skills? What sort of things do you think might hinder that?

Y - [sic] Emmm ….(silence)…..well I suppose if it’s very busy

L - Yeah

Y - [sic] and I suppose there have been occasions where you might have to cancel a client as there is an urgent assessment and we have just not got the resources so that might obviously be that we might have to say to a client is it okay if we just talk over the phone today, Is it okay we reschedule or something like that and I suppose that is one factor.

L - Yeah. And the fact that going back to something that you said that you are the only person in the team, do you think that in a way hindered, that if there were other people around who had gone through a similar experience

Y - Yeah

L - I am just putting that out there

Y - [sic] That would as well, yeah, yeah and the girls would have all loved to have done it you know and its definitely using worksheets without having done training on it you know it would definitely be great for them to do the training and I suppose they are very solution focused in the work that they are doing. So emmmm in an informal way they are using some of the skills and yet they haven’t done the training so ye that is a bit of a barrier.

L - If so for some people like you say it could be workload, some people might not have the confidence, or they might not get managerial support. You don’t sound like there have been any obstacles in terms of anybody saying well you can’t do that. It’s more the workload and the nature of the service you run

Y - [sic] Yeah no its quite autonomous emmm I mean the opportunity is there to go and do it with the client, workload is one factor emmm

L - Would you think if you had the a mentor or the mentorship relationship would have been extended and would have been a different format

Y - Yeah
L - Do you think that would have made a difference.

Y - Yeah it would have alright, because if you decide to do a particular piece of work emmm it would be good to have a mentor there emmm to relay it back to you know.

L - Yeah. How do you deal with that when you are using the skills and you have that going on and you can’t bump in to the CBT therapists informally you know

Y - mmm, mmm

L - What happens then?

Y - Emmm……(silence), well I suppose you don’t have that mentorship there, you’re, you’re doing the piece of the work that you are doing and often what would happen is that we would refer people on to coping skills and flowing on that path they might get a little bit more intense as they go on to coping skills

L - Yeah

Y - Yeah

L - So you feel

Y - well it would be, for having a mentor if you were doing a little piece of work with somebody and they were going on to coping skills that there would be some kind of a link maybe between us and going on to coping skills. That the person would be getting the same type you know you know that the person would be moving forward rather than starting a new piece of work emmm and if there was somebody there to link it all together like a mentor would be good.

L - Somebody to help make that transition

Y - Yeah to make that transition you know cos I suppose we do our best like if somebody is going on to see Siobhan, that we can say well we started to do this piece of work

L - Yeah

Y - And this is where they are coming in to you

L - Yeah.

Y - well I suppose if you did have a mentor to speak to about that and they could maybe guide you, you know ehhh and the next nurse that is going to be doing the coping skills that you’re all going in the right direction so

L - Yeah

Y - That would be good yeah
L - So you’re kind of recognising that you know you are starting maybe using the skills and it being helpful and sometimes wondering if the person

Y - [sic] Mmm

L - Is the person you are handing over to like Siobhan done the CBT skills training

Y - [sic] Yeah it does Siobhan and Fiona have done the training and it makes it easier

L - In what way?

Y - [sic] Well I suppose if, if there was particular area you were working on with a client you can kind of say exactly what you did with them

L - Yeah

Y - [sic] It might have only been a small piece of work but you can kind of saying this is what I was doing

L - Yeah

Y - [sic] and you know at least then they might be able to pick up from that you know

L - Yeah and like you say to carry on the work

Y - Yeah

L - Yeah

L - What sort of things you know what factors separate from your own team might be helpful like in assisting the skills that people learn in training how to disseminate or transfer them into clinical practice outside of your own area within the service. What sort of things do you think might be in place? People might say well I went on the training but I can’t remember any of it

Y - [sic] Mmm

L - Or some people say I went on the training and I have been practicing things and it’s been . What things do you think needs to be in place to help when people learn skills at a workshop and keep those skills and develop them

Y - [sic] Well like you say like mentorship emmm….silence where emmm if you are using the skills you have somebody there to talk to about how you are using the skills, when you are using them and are you using them correctly and I suppose if you are not getting the opportunity to use them that you have a mentor there to speak to about why you have not been able to use them. Is it the area you are working in emmm, maybe not getting the opportunity in the area you are working in or you are not getting the time err. So I think that that might be helpful alright.
L - To have a kind of link person

Y - [sic] Yeah, maybe like maybe somebody trained in CBT who you can link back to and emmm maybe you meet with them every six weeks or something like that

L - Yeah

Y - [sic] Like your own sort of supervision I suppose, you know emmm because you know you do the six days, six days CBT as regards skills but you are not a therapist. You do need mentorship and you do need

L - Yeah

Y - [sic] Emmm ongoing supervision from somebody who is trained in it so

L - Do you think that you know there is some confusion over that you are developing skills but you are not a therapist you know does that come up for ya when you are using the skills

Y - [sic] Yeah I suppose the clients call you all sorts of things, a counsellor you know and you kind of have to make it clear that you are not actually their counsellor you know. You are a nurse on home base treatment team here to help you through this difficult period and this is what we want to focus on while we are working with you.

L - Yeah

Y - [sic] What would you like to focus on while we are working with you emmm yeah. You have to think in your own mind that you are not their therapist, you’re not, its brief interventions

L - You seem quite clear about that

Y - [sic] Yeah you are not going to be able to do a load of work with this person but basically you want to get them from being maybe in a crisis state and out of the crisis and that’s about as much as you can do

L - Yeah

Y - So

L - Well it sounds as if you are explicit with people, I am your specialist nurse

Y - Yeah

L - Using CBT skills, not a therapist.

Y - [sic] Yeah and you do have to make that clear to people; well you know you are not there to solve all their problems emmm you know that you are there to you know to guide them to help them move out of the crisis. They have all the answers you know but emmm you might be able to do a small piece of work with them just to move them to start the ball rolling with them and get an idea or ideas that are in their head, you are not going to be able to
do anything intense you know even to get them in the mind frame of you are in control

L - Yeah

Y - Yeah

L - And you know you said that you did the six day training was there opportunities within the service, say in your area was there the opportunity to go on from the six days

Y - [sic] Emmm Yeah there has been well there has been a refresher day and there has been a two day anxiety and a two day depression emmm and due to workload I emmm I am doing the anxiety one at the moment but I didn’t get to do the one on depression. Hopefully it will come up again. With workload it’s not possible to get away to everything, so that’s the one I picked so and again I didn’t get to go to the refresher cos of the workload at the time

L - Earlier you were saying that to do a refresher course would have been a good place.

Y - [sic] Yeah it would have been good but there is seven members on the team and you know

L - Yeah

Y - [sic] and there is so much workload and I suppose you know everyone gets the opportunity to do some kind of training and we are not going to be able to do everything that we want to do so

L - Yeah

Y - [sic] We pick what we would really like to do and share it out. Yeah

L - Yeah Okay

Y- [sic] But I have been lucky enough as I did and in general we have got to do more training than we would have if we were on the wards, you know.

L - Is that because it’s a specialist area or what do you think it’s down to.

Y - [sic] I suppose it’s down to the management of our team, cos we do our own rosters so we try to we try to get a little bit of training for everyone

L - So support each other and cover each other

Y - Yeah, yeah

L - So what are your thoughts about the CBT skills for practice training now that you have completed the training you know is it something that you know. What do you think of the whole experience?

Y - [sic] I know after I finished it I thought it was really good, you know I thought God that was great a great course to do, you know emmm. I put my hand up and say that I should do a bit more reading……(laughs)
L - (Laughs), well we all should do that.

Y - [sic] But ehm I think the important thing is to ye to keep it up and to just to do a bit of reading to keep it up and to keep practicing it

L - You were sort of saying that if you could have a mentor in place or have something there to refer back to

Y - [sic] Yeah I think that that would be the key because then you know you can kind of check in with your mentor and talk about what you were doing and are you doing it right, should you have been doing it with that client and you know is there anything you could have been doing differently, you know reflecting

L - Mmm reflecting

Y - [sic] Evidence-based, is it the correct way

L - Yeah

Y - [sic] so I think if you did have a mentor to check in with ehm I think you would definitely be more confident using the skills

L - Yeah. What advice would you give to a person who was interested in attending the CBT skills training?

Y - [sic] I would say definitely it is a very good course to do

L - In terms of like the interesting thing that you said you at the beginning which was that CBT was about changing people’s minds

Y - [sic] Yeah, it definitely makes you think differently and that was the one thing that stood out for me at the training

L - In what way Yvonne

Y - [sic] Again the whole idea about nurses’ ehm was all about fixing people and doing things and coming up with the solutions ehm it’s the whole ehm

L - Being the expert

Y - [sic] Yeah being the expert you know yeah

L - Yeah

Y - [sic] You know the whole thing now is that the client is the expert on themselves and they have all the answers and you just have to draw it from them I suppose or guide them

L - Yeah

Y - [sic] and you know ehm people and I suppose I have found that initially some clients don’t like that but when they do start talking about.

L - What do you think that they don’t like about that?
Y - [sic] Well some people find it challenging, they are not used to it I think
L - Not used to?
Y - [sic] Emmm maybe they are used to being told this is what you have to do, this is how you fix this problem and you know emmm when you want them to come up with it they find it challenging maybe
L - Right
Y - [sic] but emmm maybe client who have not been used to that kind of maybe having been in the mental health services for quite some time and maybe, this may be a new way of therapy for them Emmm and then mostly though the clients like to come up with the solutions themselves I think and like to get time to think and so yeah
L - Yeah okay. Is there anything further you would like to add?
Y - [sic] Emmm (silence) I think that if the refresher days would be good if they came up more often maybe, ye and just really I suppose emmm I think there has possibly been two since I did the training in 2012 which was about two years ago but I haven’t been able to avail of it you know
L - Yeah
Y - [sic] They might come up once a year but if they would come up more often, there might be more of an opportunity to attend
L - Okay
Y - [sic] Yeah and if you did maybe formally have a mentor that you could
L - Yeah
Y - [sic] where you could formally meet, whatever many time s a year or every couple of weeks or something and even as a group
L - Yeah
Y - [sic] That would be good too.
L - Okay, well that is brilliant thanks a million
Y - Thank you
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