

Transferring new skills and knowledge to practice:
a mixed methods case study of Improving Access to
Psychological Therapy (IAPT) in a single English
region.

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I confirm that the work presented in this thesis is the work of myself as a degree candidate

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Abstract:

Background.

This thesis examined facilitative and inhibitory issues in the transfer of new skills and learning to support implementation of national policy for Improving Access to Psychological Therapy (IAPT) in primary care services within the English National Health Service (NHS). The policy for IAPT had two principal implementation strands; *a*) development of new services in primary care and development of a new, national education and *b*) training programme to support delivery of effective evidence based psychological treatments for a specified range of common mental disorders; particularly depression and anxiety.

There is a paucity of research on transfer of skills and learning from formal education programmes to application in healthcare practice.

Methodology.

A mixed methods case study design was developed to obtain quantitative and qualitative data on the experiences of IAPT therapists prior to commencing their training programme; on completion of their educational programme and again at a follow-up period. In-depth interviews were held with key policy leads that devised, developed and implemented the IAPT initiative to examine their expectations and reflections on the programme. Formal interviews were held with IAPT therapists; their managers and clinical supervisors from a single education cohort in an English region. Focus groups were also held with other IAPT therapists to examine emerging findings from the data.

Results.

A number of themes emerged from the merged quantitative and qualitative data. Motivation to maintain fidelity to the work of being an IAPT therapist was seen as crucial. This motivation was highly related to the self-reported force of external pressures to adapt IAPT practice in line with changed NHS commissioning requirements. System feedback was seen as a unique feature of the programme and part of this feedback process centred on the role of clinical supervision in supporting the transfer of learning and continuous development of practice.

Educational programmes were based on a prescribed competency model which was designed to provide core knowledge and skills to support new workers in new roles in new service providers within Primary Care. However, respondents reported high degrees of complexity, practice isolation and political and economic stressors that were not reflected in the curriculum. Therefore the role of the curriculum as a front end model to prepare practitioners for practice was questioned.

Despite this, evidence existed of high levels of confidence and capability of IAPT therapists in the extension of their core educational skills. This transfer behaviour was a feature of practice when set within the context of supported supervision.

Discussion on the implications from this research

Implementation of new services and a new workforce (such as IAPT) within the NHS remains challenging with few significant successes. The IAPT programme has a number of unique features, such as a focus on feedback processes and clinical supervision. These enabling forces particularly those of supervision, were considered to be under threat from cost saving initiatives. Such financial pressures appear to have the potential to destabilise one of the major enabling building blocks of learning transfer.

This thesis adds to the body of knowledge in workforce development and education and training in the NHS by offering a detailed case study analysis of a range of factors that can inhibit or enable transfer of learning and promote change in professional practice. There is little research in the mental health literature on the transfer of learning that takes such a comprehensive whole systems and long term perspective on this issue.

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List of Abbreviations (in alphabetical order)

AMS	Academic Motivation Scale
AQP	Any Qualified Provider
BABCP	British Association of Behavioural and Cognitive Psychotherapies
CBI	Confederation of British Industry
CBT	Cognitive Behaviour Therapy
CBTKQ	Cognitive Behaviour Therapy Knowledge Quiz
CCGs	Clinical Commissioning Groups
CDWs	Community Development Workers
CPD	Continued Professional Development
DH	Department of Health
EBP	Evidence Based Practice
ESC	Essential Shared Capabilities
GAD	Generalised Anxiety Disorder Scale
GPs	General Practitioners
HEIs	Higher Education Institutions
HI	High Intensity (IAPT therapists)
HRM	Human Resource Management
HSS	Human Services Survey (aka: Maslach Burnout Inventory)
IAPT	Improving Access to Psychological Therapies
ID	Instructional Design
IS	Implementation Science
MBE	Mind Brain Education
MCQs	Multiple Choice Questions
MOG	Measure of Generalisability
NHS	National Health Service
NICE	National Institute for Health and Care Excellence
NIMHE	National Institute for Mental Health in England
NWW	The New Ways of Working programme
PCTs	Primary Care (NHS) Trusts
PDSA	Plan; Do; Study; Act – <i>organisational change cycle</i> .
PHQ-9	Patient Health Questionnaire-9
PSI	Psycho Social Interventions
PWPs	Psychological Wellbeing Practitioners
ROI	Return on Investment
SHAs	Strategic Health Authorities
SSM	Soft Systems Methodology
STR	Support Time Recovery Workers
TARS	Transfer Acceptability Rating Scale
VAT	Video Assessment Task
VBP	Values Based Practice
WCA	Work Capability Assessment
WTE	Whole Time Equivalents
ZPD	Zone of Proximal Development

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Dedication:

This work is dedicated to my mother, Ellen (✕RIP).

Ἀν ὀηφuίλ ὀρόδ οκτ ασam anoίs mamaί?

Glossary of key terms:

IAPT: *Improving Access to Psychological Therapy (IAPT) is a national programme funded by the Department of Health. It was initially designed to deliver a range of psychological therapies (most predominantly) Cognitive Behaviour Therapy) to address issues of anxiety and depression in the general (Primary care) population.*

Learning: *a personal process of discovery on the part of all participants in the process of learning (teacher and students). It is based on the insights, reflections and experience of the individual in their 'sense-making' of the learning process within which they are engaged.*

Education: *a process that cannot be isolated from other process that help construct our reality. Education can be viewed both as a dominant ideology to constrain practice through a prescribed curriculum and also a source of liberation to challenge and develop the ways we act in the world.*

Training: *The process of learning skills to complete particular tasks.*

Transfer: *a process consisting of two dimensions a) generalisation – the extent to which knowledge and skill acquired in a learning setting are applied to different settings and b) maintenance – the extent to which changes that result from a learning experience persist over time. Blume et al (2010).*

Implementation Science: *the scientific study of methods to promote systematic uptake of research findings and other evidence based practices into routine practice, and, hence, to improve the quality and effectiveness of health services. It includes the study of influences in health care professionals and organisational behaviour. Eccles (2006).*

1. Introduction

This thesis examined the transfer of learning from a Higher Education Institution (HEI) to healthcare clinical practice. It explored the development of new knowledge and clinical skills and how processes within the practice setting had a role in either inhibiting or facilitating their use.

The literature from the 'Human Resource Management' perspective on the learning transfer represents a mature base, with a great number of empirical studies available (Tennenbaum 2002; Saks 2002; Berk 2008; Salas and Belcourt 2006). Other health literature on skills transfer in psychological therapy, was available but to a much lesser degree (Brooker *et al* 2003; Brooker and Brabban 2004; Forrest and Masters 2004).

Education transfer approaches, such as that of Kirkpatrick (1998) had focused on the pre-training and post training assessment of the learner. In general, current models of learning transfer do not provide sufficient account of the workplace characteristics nor the external work environment. These characteristics may present significant inhibitory or enabling variables in education transfer. Therefore this thesis adds value to the available literature, through a deep and systematic analysis of not only the individual transfer of learning of psychological therapy workers, but also of the clinical and external practice environment. This new knowledge was completed using a novel approach of analysing education as behaviour change and the utilisation of a behaviour change model.

To achieve this contribution to the scientific literature, the thesis reports on a new role in mental health practice based on a national education programme. Whilst such new roles have been implemented in the past, the available

empirical literature on their implementation is sparse (Centre for Workforce Intelligence 2013).

1.1. Developing mental health services: the context of transfer of learning

The World Health Organisation (WHO) 2013 estimates that mental health problems, particularly depression, will be amongst the greatest health challenges this century. Mental ill-health presents difficulties not only to the individual but to their entire social network (family, friends etc.). The economic impact, not only to the individual, but to the wider national economy is significant (Layard 2004).

The proportion of all General Practitioner (GP) consultations which have a key mental health/illness dimension are calculated to be 1 in 4 (Chew-Graham 2011) and these occupy about one third of all GP time (Social Exclusion Unit 2004). In purely economic terms, mental ill-health had a direct impact on the national output, with the Confederation of British Industry (CBI) estimating £4 billion per year being lost due to illness associated with depression, stress and anxiety (Social Exclusion Unit 2004; CBI 2011). This lost output only accounts for the people currently in work; when those on Incapacity Benefit and out of work are factored in, the estimated lost annual output is closer to £9.5 billion (Mental Health Foundation 2010).

It is not only in terms of lost economic output that costs emerged. People in need within the primary care service receive psychiatric and other medical help from the wider National Health Service (NHS) and social care providers. They require help in the form of GP time, NHS mental health services,

medication and other treatments. In total the estimated economic costs associated with mental ill-health of £25 billion represents about 2% of all national Gross Domestic Product (GDP) (Sartorius (2001). Lord Richard Layard noted that if unemployment was once the prominent source of misery, it has now been replaced by mental ill-health (Layard 2004).

Expectations of the general UK population about the provision of health and social care are also changing (Department of Health 2007a) and in mental health services specifically, the recent growth of service user representation in service planning and delivery constitutes a profound development (National Collaborating Centre for Mental Health 2011; Repper and Breeze 2007).

Service alterations are not without challenges, none more so than bringing mental health into mainstream primary care. Both Rankin (2004) and the Association of Directors of Adult Social Services (2008) had identified the issue of stigma around mental health as an issue for service providers as well as individuals. There have been challenges in the acceptance of mental health and use of services in new settings such as primary care, and this has become a persistent theme of concern for researchers and policy leads for several years (Goffman 1963; Department of Health 2004; Gilbert 2004; Thornicroft 2006).

1.2. Psychological therapy development in primary care

The Psychiatric Morbidity Survey (Information Centre for Health and Social Care 2009) identified that as much as 16% of the working age population in the UK were suffering with a mental illness and over half of this population were experiencing serious mental health problems (affected by issues such

as redundancy and economic hardship). Such surveys are susceptible to time lag and so may not represent the present level of psychiatric morbidity in the population. This suffering affects all social strata and the associated issues of 'shame' (Gilbert 2004) and 'stigma' (Thornicroft 2006) cannot be minimised.

Mental ill-health is a major cause of disability, with nearly 40% of people receiving incapacity benefit experiencing a mental illness as their major health difficulty. Government attempts to re-engineer the benefits system have sought to manage this challenge (HM Government 2012b). Despite this, the Government approach has been successfully legally challenged. One of the key aspects of reform – the Work Capability Assessment (WCA) was found to be unfair for people with mental health problems (Ministry of Justice 2013 [MM and DM v Secretary of State for Work and Pensions [2013] UKUT 0259 (AAC)]) and considered to be at odds with the Government Mental Health Strategy 'No health without mental health' (Department of Health 2011a) and the Mental Health (Discrimination) Act (2013) (HM Government 2013).

The judicial interventions give evidence that national policy interventions (such as IAPT) present complex governmental interactions across policy arenas and can be viewed as sometimes inconsistent and lacking cohesion.

In conducting an economic analysis, Layard (2004) suggested that adding the costs of benefit payments to that of lost output and expenditure on health and social care, increases the cost of mental illness to £46 billion per annum.

In response to these arguments and identifying that mental health problems were not always intractable and could respond to effective treatment. In 2005 a manifesto pledge was made by the Labour Party who committed funds,

while in Government, to supporting people with mental health problems in primary care (Labour Party 2005). The realisation of this manifesto pledge saw the initial development of the Improving Access to Psychological Therapy (IAPT) service.

Prior to the development of IAPT services, the main treatment offered within primary care was in the form of psychotropic medications such as anti-depressants, anti-psychotics and anxiolytics (Peveler *et al* 2005). These treatments have been advocated (Taylor and Geddes 2012) but also criticised in terms of efficacy (Morrison *et al* 2012; Kinderman 2014) and side effects (Wurtzel 1995).

The development of psychological therapies over the past 40 years has added great potential to interventions to aid the distress of people with mental ill-health (Roth and Fongay 2006) and these treatments have been noted as preferable by service users (Priest *et al* 1996). Additionally, the efficacy of Cognitive Behaviour Therapy (CBT) (either alone or in combination with drug treatment in a number of different psychiatric conditions) has been demonstrated in a number of studies and now forms a recommended intervention (NICE 2006; 2009; 2011a).

Despite these recommendations people who did receive treatment were not necessarily able to access the full range of possible (talking) treatments (Lovell and Richards 2000; Mind 2014). It is estimated that prior to the development of IAPT in primary care mental health services, only 8% of people with a major depressive illness had seen a consultant psychiatrist and only 3% had seen a psychologist (Layard *et al* 2006). The unaccounted

people suffering with depression and anxiety were deemed to be receiving no form of evidence based psychological therapy at all (Layard 2004).

The development of an organised healthcare response to social and mental health issues, presented a significant policy undertaking. However, the presentation of a 'moral case' for psychological therapy intervention had to be balanced with a sufficiently convincing economic benefit analysis to gain the assent of Government treasurers and healthcare commissioners. The response of all services to this kind of workforce innovation needed to be viewed through the prism of the productivity challenge faced by the NHS; with a need to maintain services and quality while being subject to a £14 billion funding gap. The potential to address this gap had been analysed from four perspectives: Back-office costs; workforce; clinical practice and redesigning the commissioned care pathways. Greatest amongst these in terms of return on investment is the clinical practice of existing workers (Appleby *et al* 2010).

The work of mental health services had been subject to scrutiny in terms of the requirement for increased productivity (in primary and secondary care) with a concurrent focus on quality (Naylor and Bell 2010). The response of mental health workers to meeting the innovation challenge and the role of clinical leaders was viewed as critical (Maher and Plsek 2009) as was the need to challenge established patterns of practice to maximise the skills and competences of the workforce (Naylor and Bell 2010). This spirit of innovation was central to the development of IAPT services across England.

1.3. The treatment landscape

There have been attempts to previously develop the primary care mental health landscape with the NHS. The 'New Ways of Working' programme (NIMHE 2007) developed 1,000 new primary care mental health workers. These were a workforce drawn primarily from graduates who were trained (for 1 year) in basic psychological treatments and employed within GP practices. These new workers were to be supported by 500 new *gateway* workers (NIMHE 2003a). The gateway workers were more experienced mental health practitioners, whose role and function was to ensure appropriate assessment of mental health need and direct access of patients to the primary care workers.

The project drew sharp criticism, primarily because the development of a maximum of 1,500 new workers was insufficient to meet the known demand (Harkness *et al* 2006). In addition, there was concern that the level of training for the primary care mental health workers was insufficient to offer effective help for the vast majority of people suffering with mental health problems in primary care who would like access to talking treatments (Priest *et al* 1996; Rushforth *et al* 2007). The potential demand was therefore far outstripping supply particularly as at the time; the then National Institute for Health Care Excellence (NICE) proposed that CBT should be offered due to its equivalent effectiveness to anti-depressant medication (NICE 2009).

To offer greater access to psychological treatment in primary care, it was estimated there was a need for an extra 8,000 appropriately trained therapists who could offer evidenced based psychological therapy (most often CBT) (Layard 2004).

The proposal presented by Lord Layard was to develop a service and workforce which offered evidence based interventions. The proposal sought treatment provision which was readily available and did not require long waits for access; where referral to specialist services (if needed) could be completed simply, efficiently and effectively and where patients could be offered treatments which increased their coping abilities, taught them self-help approaches and promoted resilience for future mental health challenges. Finally, it would need to be a service which promoted social inclusion and normal life patterns through access to work.

This workforce expansion represented a major investment in education and service development. The mental health strategy, 'No Health without Mental Health' (Department of Health 2011a) promoted mental health as being an issue for all government departments and health and social care services. However the companion publication 'Delivering better mental health outcomes for people of all ages' (Department of Health 2011b), made little reference to the workforce issues either in terms of numbers or roles needed to deliver the strategy.

The external political, social and economic environment may be viewed as an aspect of significant influence on the work of clinical or practice teams. In turn, this influence is directly experienced by the workforce such as recently trained IAPT practitioners. The IAPT initiative and the workforce was new, and may have been poorly understood by the wider commissioning and GP and primary care membership. This scrutiny may have increased a sense of vulnerability in the service. The examination of the ability of IAPT workers to transfer their new knowledge and skills while acknowledging the impact of

their external world on such services therefore constituted a major source of understanding in this complex issue.

IAPT services were chosen to conduct research given the political investment in the service; the uniqueness of a primary care service location and the focus on an education programme as the principal intervention for effective healthcare delivery. This made the issue of educational 'transfer' critical to the potential of IAPT services to deliver on policy aims.

1.4. The IAPT policy background

There have been significant developments in English¹ mental health policy and delivery over the past 15 years, both in terms of service structure and workforce numbers (Health Education England 2013). At the time of this study the organisation of mental health services was becoming increasingly localised and community orientated with a rapid development of health services in primary care. The mental health workforce in both primary and secondary care, was either working, with, or for, statutory; non-statutory; private or independent health care providers. During this study, the territory of commissioned mental healthcare provision remained in the throes of significant change with expectation such 'change' was likely to continue (Mental Health Foundation 2013).

The IAPT programme was developed as a means of formally establishing a mental health service in primary care (Department of Health (DH) 2008a). An analysis conducted by (Lord) Layard *et al* (2006) identified that significant numbers of people suffering with mental ill health could be effectively treated

¹ Under devolved powers from the UK Government, Scotland and Northern Ireland (since 1998) and Wales (since 1999) have been able to develop their own Mental Health policy and approaches to service delivery.

with psychological talking therapies, such as Cognitive Behaviour Therapy [CBT] (National Institute for Health and Care Excellence [NICE] 2009; 2011a). In order to respond to a perceived deficit in services, a national training and service development programme was established to prepare a new workforce to deliver psychological interventions.

These issues have direct relevance to this thesis as the response to the above issues was a significant enhancement of NHS provision for psychological therapy. Alongside this was a major growth in the availability of training programmes.

Prior to the IAPT initiative, one in six people in England met the diagnostic criteria for anxiety or depression but of this number only one in ten were receiving any formally provided psychological help (McManus *et al* 2009). Added to this by 2015, while growth in services had taken place only 13% of people who meet the diagnostic criteria are receiving an assessment and of those only 8% are receiving treatment (Layard and Clark 2015). However, such 'headline' figures should be considered cautiously as gender, household income, marital status, employment, age and ethnicity represent important risk or ameliorating factors. Previously psychological support was considered to be unevenly distributed; not evidence based and uncoordinated (DH 2000; National Primary Care Research and Development Centre 2006; DH 2004a; DH 2007a). To respond to these issues a national approach was promoted and eventually implemented across England. This represented a significant undertaking and long term financial commitment on the part of the health service. IAPT is now available in each English Clinical Commissioning Group

(CCG) area, but with wide variation in treatment availability and outcome (Health and Social Care Information Service 2014).

This level of organisational change associated with the introduction of the IAPT policy and national training programme merited deeper analysis. To achieve this, an integrative review of the literature was conducted with an emphasis placed on systematic reviews of the 'transfer of training'. Based on this review and detailed analysis of major research reviews such as Burke and Hutchins (2007) along with many earlier authors (Kirkpatrick 1998; Kirkpatrick and Kirkpatrick 2005; Holton *et al* 2000) key components of transfer were identified:

- a) the personal characteristics of the trainees;
- b) the characteristics of the training programme and (*to a much lesser degree*)
- c) the characteristics of the work setting.

The transfer of training/learning components above formed the basis of the key research question. The definitional terms associated with the following question are provided within a glossary. These definitions are developed within a higher education and NHS workplace context throughout the review of the literature.

1.5. The research question.

What are the characteristics of educational transfer which support delivery of new psychological therapy skills in the IAPT work environment?

1.6. Thesis aims

The two aims of this thesis were examined through a detailed case study:

1. To examine the transfer features that influence the ability of IAPT practitioners to utilise a competency based educational programme in their practice.

To achieve this aim the following objectives were identified:

- To undertake a survey to examine personal attributes; knowledge and skills of IAPT psychological therapy students.
- To conduct a series of interviews with practitioners and their managers to obtain a richer and deeper understanding of their perception of their role and how they consider implementation of the national policy in their daily practice.

2. To examine the process of IAPT policy development and implementation.

To achieve this aim the following objective was identified:

- To conduct detailed in-depth interviews with the national IAPT policy leads.

The development of a new workforce should be seen in the context of a growth of the established professional workforce (McGonagle *et al* 2009). Data in Table 1 provide an overview of the rise in the workforce numbers of various professions since 1997. While during this period there has been a considerable increase in workforce numbers, the reality is that the main workforce is an ageing one. There are fewer school leavers and a greater choice of career for those young people entering the work pool (Centre for Workforce Intelligence 2011). So as new and younger entrants are trained, greater numbers of older people leave and there appears little prospect of recruiting sufficient numbers to make up the shortfall (Centre for Workforce Intelligence 2011).

Table 1: Whole Time Equivalent Workforce changes and increase 1997-2014 in England

	1997	1999	2004	2014	Increase since 2004
Consultant Psychiatrists	2,206	2,525	3,231	4,125	894
Dietetics (generic)	1,864	2,058	2,664	-	
Mental Health Nurses	35,296	34,974	41,585	42,004	418
Nursing assistants and support workers	18,811	19,606	22,604	21,779	-825
Pharmacists (generic)	7,591	8,404	11,375	-	
Clinical Psychology	3,376	3,763	5,518	8,289*	2771
Art/Music/Drama Therapists	418	416	475	-	
Occupational Therapists	9,792	10,792	13,879	-	
Psychotherapy	317	365	723	-	

(Department of Health 1997a 1997b; 1999a 1999b; 2004b 2004c; Health and Social Care Information Centre 2014) *2011 last available census data.

Not only had there been a recruitment drive to the existing professions, there had also been a focus on these professionals working in new ways

(Department of Health 2007a) with examples being changes to the Consultant Psychiatrist contract (Care Services Improvement Partnership 2005; National Institute for Mental Health in England 2007); the development of non-medical prescribing and Nurse Consultants (Department of Health 2006) and the Approved Mental Health Practitioner (HM Government 2007).

Rather than attempting to solely recruit to existing professional groups, a new workforce had also been developed with an associated national implementation programme. Examples of such initiatives, akin to IAPT, were the development of health care assistant roles such as Support Time Recovery (STR) workers (Department of Health 2003a); Community Development Workers (CDWs) in the black and minority ethnic communities (Department of Health 2004b) and Gateway and Graduate Mental Health Primary Care Workers (National Institute for Mental Health in England 2003a). Despite these new roles all being considered policy priorities for development of health services in England, workforce data were sparse. There was evidence that original implementation numbers had not been recruited nor sustained (Wallymahmed 2003; Manley and Titchen 2012). Contextually, the failure to establish new roles in mental health services was an important consideration in the development of this thesis. New roles and new ways of working are seen as central to delivering a modern health service and a required response to falling workforce numbers from the traditional professions (Department of Health 2014a). Therefore it is essential to develop knowledge on the constituent parts of the establishment and sustainability of new roles in healthcare. A significant part of this analysis

focuses on the ability of new workers to make use of their clinical training in practice (Health Foundation 2013).

The above information and questions indicated that implementation of new roles; new training programmes and new services rely on a complex interaction of many factors. Policy managers who maintain a focus on policy aims may play a key role, as do educational providers who were charged with maintenance of fidelity to the training programmes that may help deliver policy objectives. Workforce managers, practitioners and supervisors were employed to maintain a focus on programme delivery in a fast changing and increasingly politicised health service. The above, as it related to the transfer of learning in practice, constituted not a linear implementation process, but a fragmented and complex mix.

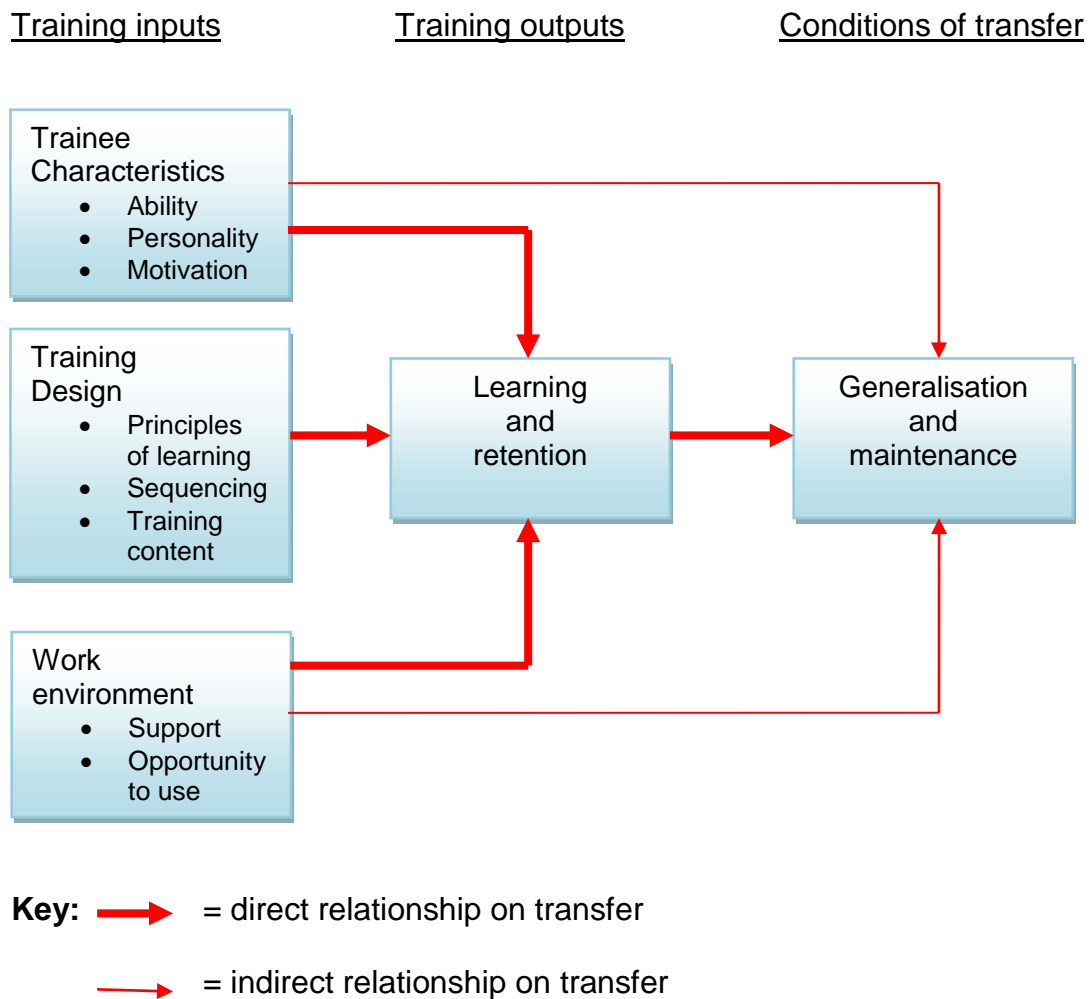
Examination of the transfer of learning was of importance given the annual training and education budget for the NHS in England was £4.6 billion (Department of Health 2014a). Studies completed in the manufacturing industry estimate that the percentage of transfer of new knowledge/skills to role performance (from training setting to the work/practice setting) is between 10-20% (Aik and Tway 2005). This estimate is contested (Fitzpatrick 2001) since the definition of transfer was too narrow and not well defined (Ford *et al* 2011). To underline the state of the empirical knowledge of this issue, Saks (2002) made an estimate of a loss of 70% of transfer behaviour after a single year. This figure was based on a survey of 150 members of an industrial society. There was no questionnaire development; no work–place data collected and analysed, but rather the self-report reflections of individuals who commissioned or managed organisations (Saks 2002).

Despite this uncertainty, understanding transfer in the NHS was crucial given the financial investment in education and training. It was important to understand the process of learning/training transfer to the work setting for two reasons. Firstly there was a quality dimension to care delivery. The use of new knowledge and skills based on systematic evidence based trials was presumed to add quality, efficacy and efficiency to service delivery. Secondly, the financial implications of the return on education investment represent an important factor in the education commissioning processes.

Many studies have focused on the individual learner, particularly exploring changes in knowledge and skills (Sheryl and Atira 2006; Noe 2008; Judge *et al* 2007). Fewer studies have taken a holistic examination of the learning experience. This thesis emphasised the importance of examining and exploring individual change in the learner: in what they have come to know (knowledge criteria) and in what they are able to do (performance criteria) within the work-setting.

One of the most pervasive models of learning transfer is that developed by Baldwin and Ford (1988) who identified the importance of the relative strength of the relationship between the attitude of the learner to their work role and their reaction to training (see figure 1 page 17). While this model is often cited (Kite Foundation 2012; Burke and Hutchins 2007) it is important to note missing elements from their analysis. The model in figure 1, proposed a weak relationship between personal characteristics and the work setting on the conditions of transfer behaviour, while training inputs have a strong relationship with learning. Without learning and retention, there can be no transfer of new skills and knowledge.

Figure 1: The transfer of training model: based on Baldwin and Ford (1988 page 65)



While this model is derived from, and widely utilised in the manufacturing industry, it may have less utility when reviewed in an analysis of transfer of learning in a healthcare context. There may be important distinctions about motivation of workers as Baldwin and Ford (1988) made no reference to the possible important relationship between motivation and identity as psychological constructs and their role in learning. Additionally the wider political, economic and social environment is absent from the discourse on transfer. In current healthcare delivery in the National Health Service (NHS)

the current political, economic and social dimensions to practice, may never have been stronger (Butterworth 2014).

To achieve a comprehensive analysis, this thesis utilised a framework for understanding dynamic practice environments (see figure 2 page 23). Training and education in the NHS did not happen within a vacuum of desired organisational or policy outcomes and so the external political, economic and social environment was examined for its potential impact on the transfer process.

Additionally, 'transfer' may have a psychological element, as the process of transfer may involve a *desire* to do so. Therefore psychological aspects of education and training transfer were examined. Additionally a distinction was made between 'training' and 'learning' as such a difference has important conceptual implications when examining 'transfer'.

The key construct of 'transfer' was conceptualised as the ability to use what has been learned and to maintain this usage over time. Consequently maintaining a fidelity to the model of care treatment in such a dynamic work-setting and broader developing external health care environment. The development of this new service was timely as it provided a case study for the exploration of the issues of training/learning transfer and the questions in this thesis.

1.7. The theoretical organisation of the study

Given the above analysis, a systemic view of the work of IAPT practitioners presented a level of complexity. Walshe (2007) identified the following in the examination of improvement initiatives such as the IAPT programme;

'the aim is not to find out 'whether it works', as the answer to that question is almost always 'yes, sometimes'. The purpose is to establish when, how and why the intervention works and to unpick the complex relationship between context, content, application and outcomes' (Walshe, 2007 pg 58).

The study is an examination of the analysis of not the 'sometimes' of success but the necessary requirements to *ensure* effective transfer. The thesis is a study on whether such a new workforce reported an ability to integrate new knowledge and skills for IAPT in the face of rapid development in service requirements 'on the ground'. Successful implementation of policy required more than trial and error, but careful analysis of the theoretical components that enable service development (Eccles *et al* 2005). In order to manage this it was necessary to identify a theoretical framework on which to base the analysis.

1.8. The theoretical framework

Adding a theoretical aspect to the study which incorporated as many of the key contributing variables within a unifying theoretical framework was required. Without a theoretical underpinning, it was difficult to articulate why a policy intervention, or parts of a policy, such as IAPT, would succeed or fail. The choice of models, frameworks and theories acts as an aid to explaining or understanding the influences in implementation outcomes. Nilsen (2015) provided an overview of the various explanatory frameworks available to the

researcher interested in implementation of new ways of working. These were categorised as 'process models'; 'determinant frameworks'; 'classic theories'; 'implementation theories' or 'evaluation frameworks'. Following analysis of the range of models available it was evident, based on the research question and thesis aims that a 'determinant framework' would be required since these are aimed at understanding the elements and relationships in systems which explain or interpret outcome, barriers and enablers of implementation.

Determinant frameworks describe the range of relationships and influences that are hypothesised to have a significant bearing on practice or policy outcomes. Such frameworks can be quite explicit in the identification of these influences (Greenhalgh *et al* 2004). This thesis sought an exploratory approach and so a looser framework was required to enable relationships to emerge from the data. A search was made for a determinant framework which had an accent on a 'systems based approach' as the study sought to understand the IAPT policy from initiation to implementation within an education and NHS system. This search also factored in the elements of the IAPT policy process such as the use of on-going reporting or feedback. Based on this searching process the model of Fixsen *et al* (2005) emerged as the most suitable framework.

The framework would set the contextual boundary and identify the interactions between the various components of the study. The focus of this study concerned the development and implementation of national policy relating to the improvement of access to psychological therapy in primary care. The framework (figure 2) is a model presented by Fixsen *et al* (2005) relating to 'implementation research'. The model presented in figure 3 with the elements

of the framework incorporated into the critical aspects of the IAPT programme in this thesis.

The theoretical framework for this thesis (Fixsen *et al* 2005) has five core components:

A source: Within figure 3 (page 25) 'the source' was conceptualised as the work of policy managers of the programme. These managers made use of pilot projects in two locations; Doncaster and Newham and these were used to test out the hypothesis presented by the economic and equality arguments for improving access to psychological therapy in primary care (these pilot projects are analysed in more detail in chapter 2). These pilot programmes informed the presentation of the implementation plans of the policy managers for IAPT across the rest of the country.

A destination: This is conceptualised as the people who implement or adopt the content of the source. In figure 3 (page 25) this is presented as the IAPT workforce. These are the students/graduates of the national training programme; their managers/clinical leaders and the work-setting. It is this group who can either retain or diminish the fidelity to the original policy implementation and training framework. The reasons for maintaining or losing fidelity to the original implementation plans were important components of study. The destination aspect also covered the work environment and the elements within it (organisational and social support such as supervision; organisational constraints such as bureaucracy; and other issues which may either facilitate or constrain fidelity to policy implementation).

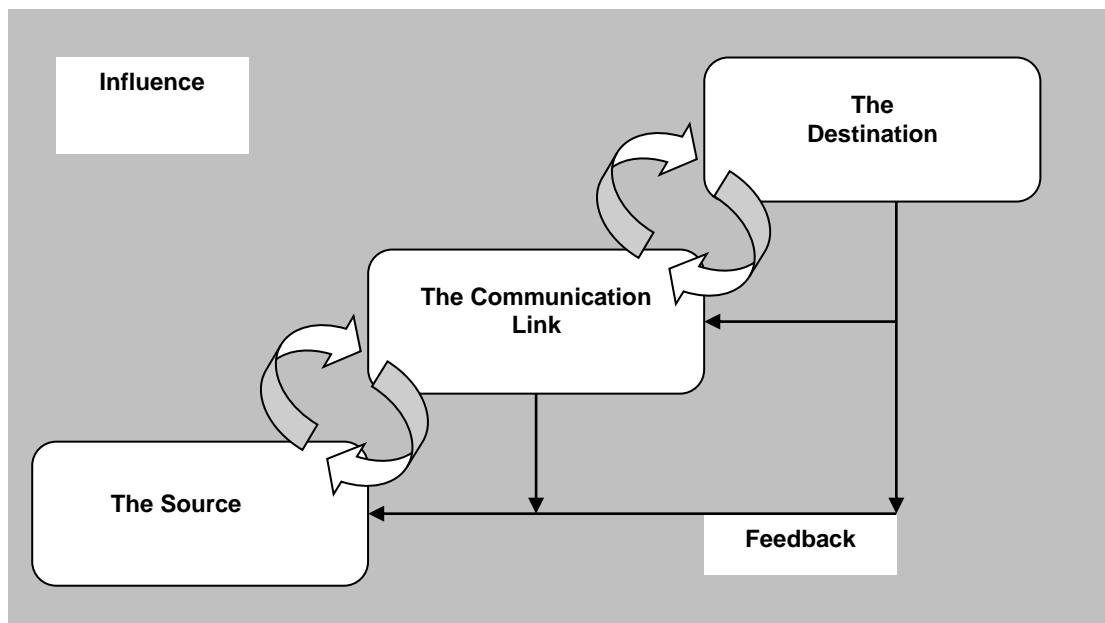
A communication process: between the above two elements lay the process by which source information/learning is translated and transferred to the destination. In figure 3, the communication link was represented by the Higher Education Institution (HEI) training programme. The national programme was designed not only to transfer the skills and knowledge required to deliver a CBT approach but also explicitly, the values of the policy (equality of access and economic benefit).

A feedback process: Within this thesis the feedback process was considered to be the regular and reliable flow of information about performance of individuals and communicators and the policy managers.

A sphere of **Influence:** This was considered to be exemplified as the political, economic and social environment within which the whole programme sat. In figure 3, this was taken to represent the policy commissioning framework of health services in general and primary mental health care in particular. The healthcare economy and general economic environment had undergone significant changes since the implementation of the IAPT policy was first suggested. Therefore it was considered critical to understand the impact of this influential sphere on all of those involved in the policy delivery. The theoretical framework approach afforded the opportunity to offer a unique perspective in the examination of transfer of training in the practice environment (in all its complexity). The political environment will have an impact on the work of public service providers, such as the NHS and

consequently that of their workforce (Dixon and Alvarez-Rosete 2008; Taylor 2013). The political, economic and governance of the NHS had undergone fundamental change since the inception of the IAPT initiative. Policy initiatives such as the formation of Clinical Commissioning Groups (CCGs) (HM Government 2012b) were not on the political horizon let alone operational when the original IAPT policy and national training programme were developed. It was important to examine this political context and seek understanding on whether it had a role in supporting or inhibiting IAPT workers in their role performance and transfer ability.

Figure 2: The theoretical framework: after Fixsen *et al* (2005 page 12)



The original framework developed by Fixsen *et al* (2005) identified three key outcomes from any implementation programme:

1. Changes in professional behaviour;
2. Changes in organisational structures and cultures to support professional behaviour change, and
3. Changes in relationships to consumers/people who use services; stakeholders and system partners.

These outcome requirements helped generate the research question, the design and the areas of emphasis within the mature HRM literature base on transfer of learning.

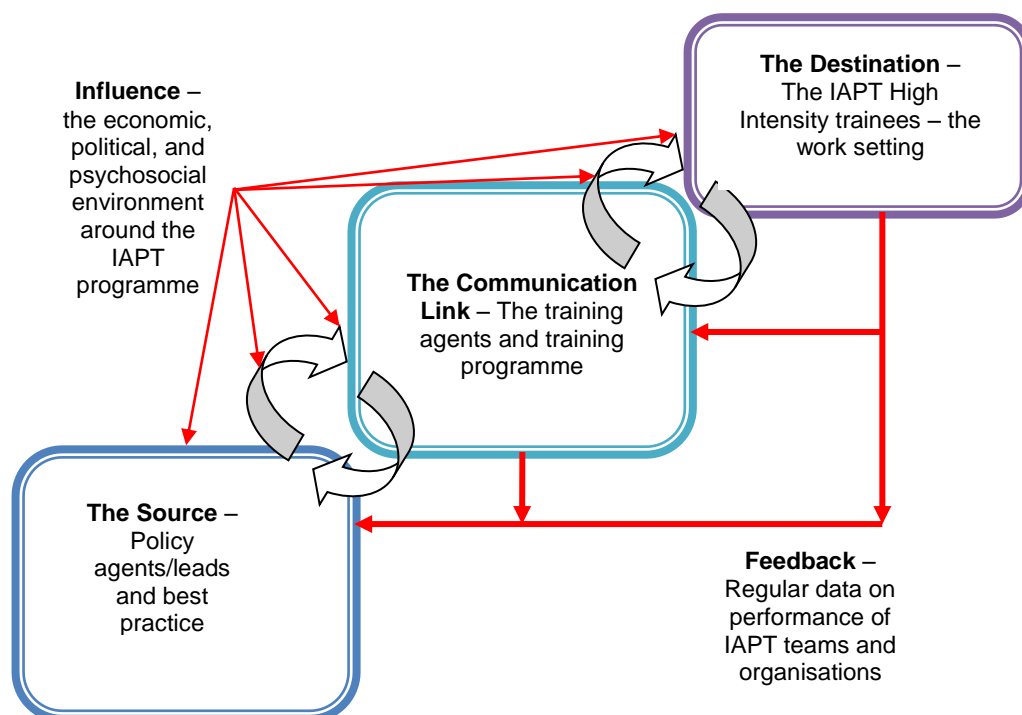
1. Changes in professional behaviour: This was examined through a quantitative questionnaire analysis on changes in the knowledge base of practitioners and questionnaire based self-report and interview on practitioner perception of behaviour change.

2. Changes in organisational structures and culture to support implementation: This was examined through questionnaire and interview data with managers and clinical team leaders of IAPT services.

3. Changes in relationships to consumers/people who use services; stakeholders and system partners: This was examined primarily through interview data generated by stakeholder analysis of the original policy managers.

To fully utilise the determinant model of Fixsen *et al* (2005) particular elements of IAPT which corresponded with the original model were presented (figure 3). The unit of analysis in this study was this complex interaction between the elements of the framework (figure 3).

Figure 3: The theoretical framework applied to this study



(after Fixsen *et al* 2005 page 12)

1.9. Implementation of IAPT policy: fixing the theoretical model.

The development of psychological therapy services in primary care was not conducted in isolation of other healthcare policy drivers. Consideration of the relationship between the IAPT programme and the broader topography of mental health primary care was a critical contextual requirement.

The delivery of care practice in the NHS did not exist within a vacuum. There were issues relating to national policy; finance; workforce numbers; workforce composition; the quality agenda; team structure and leadership. All these issues had an important relationship to the education and transfer practice approaches taken by individual workers. Much of this complexity was driven by mental health policy to promote an NHS fit for the 21st century (Department of Health 2011a).

Transforming mental health services will require the continued development of evidence based interventions (Institute of Medicine 2001; Milne *et al* 2003). The focus in health service delivery is on continual improvement and system transformation (Sholomskas *et al* 2005). Transformation of services requires strategies for workforce development, including educational initiatives and consideration of the support features within the workplace that introduce, monitor and maintain new modes of working.

The development of an Implementation Science (IS) (Health Foundation 2013) focus of research in the NHS is one that moved from efficacy (*does it work?*) to effectiveness (*if it does work, how does it work?*). It was concerned with the structure, the processes and the patterns (Plsek and Greenhalgh 2001) associated with implementation of transformational practice (Milne *et al* 2008). The approach to service development via the IS literature and research processes have been significant in their rapid development. The IS approach though has been noted to be potentially too complex (Wieringa, and Greenhalgh, 2015; Valentijn *et al* 2013).

The ability of trainees/learners (IAPT workers) to transfer their learning was of key concern, particularly in relation to the financial return on educational

investment. The theoretical framework utilised in this study analysed the aspects associated with the transfer process as it related to the promotion of innovative and transformational practice in mental health services. The transfer process not only included whether an individual could use their skills and knowledge, but also the factors that helped or hindered such application in their work setting.

1.10. The national training programme for IAPT

The implementation plan for IAPT training was published in 2008 (Department of Health 2008b). The education programmes were to be at post graduate diploma level with a central educative performance outcome that trainees would obtain clinical outcomes as reported by the NICE guidelines (NICE 2004a; 2004b). The national aims are further illustrated below:

'The course will have a cognitive behavioural theoretical base with a preference for approaches with the soundest evidence and where cognitive and behavioural techniques are integrated into the therapy. In addition to providing practical, intensive and detailed skills training to facilitate skills development to a defined standard of competence, the course will aim to increase students' knowledge base of theory and research in CBT, and to promote a critical approach to the subject. It will aim to equip students to become skilled and creative independent CBT practitioners, in accordance with the British Association of Behavioural and Cognitive Therapies (BABCP) guidelines for good practice, and to contribute to the further development of CBT' (Department of Health 2008b page 3).

The intended recruitment pool for IAPT trainees were clinical psychologists and psychotherapists as well as others who may have had previous experience in delivering mental health care. The competences for the IAPT training were developed by Roth and Pilling (2007) and incorporated general therapeutic competencies and ones which were specific to the delivery of CBT. All approved IAPT courses ran for one academic year with a prescribed three module course structure for each participating HEI. All students were required to have demonstrated competence in treating at least eight people (under close supervision) over the duration of the programme. The students were monitored by experienced CBT therapist trainers on their achievement of therapeutic skills and achievement of expected treatment outcomes.

The teaching strategies recommended by the Department of Health included experiential and skills based teaching and supervision around the clinical skills associated with effective CBT treatments.

Completion of the course included recordings of treatments sessions with clients and written assessment work on CBT related treatment and research (Department of Health 2008b).

From the above description of the IAPT training programme there were a number of themes that required a detailed analysis. These themes had a direct bearing on the research conducted for this thesis and influenced the design and execution of the study. These themes are indicated below:

- The recruitment pool was intended to be for psychologists and psychotherapists and others with previous experience of delivery of mental health care. This had implications for exploring the role of

education in supporting the development of an *identity* as an IAPT worker rather than one allied closely to a core profession (aims 1 and 2).

- A focus on ‘competence’ in education is a debate about whether ‘competence’ was an appropriate outcome for healthcare practice. The theoretical framework which guided the thesis identified the complex care environment within which IAPT workers operated. Identifying if, and how, IAPT education programmes prepared workers to use their sense of therapeutic agency (aim 1).
- The role of supervision was engrained within the programme as an assurance mechanism to support practitioners in delivering prescribed evidence based interventions. Reviewing the role of supervision in education and workplace practice was an important literature that required a critical review (aim 1).

1.11. The distinction between ‘Training’ and ‘Learning’

In this introduction, reference has been made to the wealth of data from Human Resource Management on transfer processes. It is notable however that such literature used the terms ‘training’ and ‘learning’ interchangeably. This study has examined the issues of transfer of learning in the Improving Access to Psychological Therapy (IAPT) national policy programme in England. The need for precision in examining the transfer of learning is evident and so attention should be paid to clarification of key terms. A cursory examination of key documentation for IAPT is provided as an illustration, as

the national policy for IAPT instigated a national 'training' programme (Department of Health 2008b; 2012a). Additionally, much of the literature in 'transfer' relates to the transfer of training, rather than learning (Burke and Hutchins 2007; Noe 2008).

To clarify the terms used, this thesis made a distinction between '*learning*' and '*training*'. Within the IAPT training initiative, both elements of training and learning had an important status and so the philosophical and epistemological roots of education for adults were explored via critical reflection on the main theories of adult learning and training. Educational theory was used to guide the development of programmes such as the one under investigation. As epistemology is the study of knowledge, obtaining clarity of understanding of the sufficient conditions that supported knowledge and skills gains on the part of IAPT trainees, it was necessary to interrogate this closely when reviewing the national training programme for IAPT. The IAPT training programme formed the establishment of training cohorts and as such training and learning as experienced on an individual and group level.

The issues under examination were not new, and the philosophy of education has a long history when imparting significance to this 'social' domain. Dewey (1916 [2004]) identified the significance of raising questions on the purpose of education; is it the transmission of knowledge? or an approach to foster a spirit of enquiry in the learner? Is the purpose of education to make learners subservient to those with greater knowledge? or with more power? or is to engender a sense of growing autonomy (Jonas 2010)? These questions reflect aspects of the policy drive in developing a new workforce who are

charged with delivering evidenced based interventions and equality of service in primary care.

The IAPT programme had a focus on knowledge and skill development, but it is necessary to ask, 'what is this knowledge? What are the skills and how is the learning made possible, if it is possible at all?

Critical to a thesis on the transfer of learning is the question, what is it to have learned something? Were IAPT trainees socialised into a role; that of an IAPT worker or were they individuals within a defined group who were able to make distinctive contributions to the development of new knowledge? These issues remain at the heart of the epistemological and ontological debates about education (Curren 2003; Jonas 2010).

Exploring the philosophy for education, entails a search for meaning around the perspective of education as communication. Dewey (1916; 1938) promoted a view of education as 'growth' a metaphor which extolled the virtue of an on-going process which continues throughout our lives. Learning is also a personal hermeneutic process where in any given learning experience individuals will derive their own personal and unique meaning – *the learner as an interpreter* (Mezirow 1997; Fagerberg and Norberg 2009). Dewey was interested in what helped and hindered growth in the individual and so is directly relevant to the themes noted earlier. The 'destination' aspect of the theoretical framework makes a relationship to transfer of training activity in the work setting with a primary focus on its ecology as a place of help or hindrance to the process of transfer. Having placed an emphasis on the transfer process, this thesis emphasises the exploration of the relationship

between the educational programme and the culture of the organisation, the managerial and supervisory support and the role of the practice team.

The role of the training design itself has received less interest in the research literature. This thesis explored whether the IAPT training and development programme integrated transfer issues into the overall design of the training programme and supported the individual in their transfer efforts.

Dewey's (1916) writings on education as a life-long unending process based on learning from experiences as well as more formal educative routes have influenced key thinkers in this area such as Schön (1983). Yet theorists such as Lewin (1947) and Kolb (1984) have been significantly influential in the development of experiential learning and education. The question of '*how can we know someone has learned something?*' is a challenging one. The application of new learning may be immediate (*near learning*) or it may be months, if not years later, when individuals make full use of previous learning experiences (*far learning*) (Broad and Newstrom 1992). Learning as a *process*, rather than a *one-off* event, would support an epistemological position which sees the gathering and use of knowledge and skills as an on-going developmental activity (Winter and Szulanski 2001).

Dewey's (1938) perspective was that for real learning to take place the educational experience needed some applicability in daily life or practice. This issue represents the further distinction regarding *learning* from an 'adult' perspective. This androgogical stance of a learner as self-directed and self-regulating participant in a learning process was a central tenet of the social constructivist basis of an adult educational epistemological view (Knowles 1990). The attention on 'the self' represents a self-regulating process, where

attention by the individual has been given over to the maintenance of some degree of self-integrity and resistance to external negative influences.

Taking an adult learner stance, the IAPT trainee could be viewed as an active agent in the process and more likely to be motivated to engage in the learning opportunity. Consequently the motivation of the learner emerged as an important theme in the transfer of learning. The trainee may have been motivated to apply for a training course but not motivated to use the material and skills gained. Consequently the construct of 'motivation' within the learning process was reviewed and analysed (section 2.4.4).

The relationship between 'training' and 'learning' does not form an absolute divide, with Wilson (2005) noting that training does relate to the issues of knowledge gain, attitude change and skills development, but is highly 'work situated'. As noted earlier, much of the 'transfer' literature was related to 'training', while learning new skills, values, knowledge and attitudes is based on seeing the IAPT (indeed any health/social care) training programme from a deeper 'learning' perspective. Using this lens, transfer can be viewed as the ability to utilise new knowledge and expertise in unfamiliar and dynamic circumstances. The areas of 'influence' (figure 2 page 23) the political, social, economic factors hold a significant impact on the work of IAPT therapists in primary care, integrating knowledge and skills that have been practiced to perform through training with additional psycho-social processes such as team working, support, communication and values (Argote 2013).

1.12. Conclusion to the introduction

A feature of the IAPT initiative was the development and delivery of a nationally agreed education programme as the principal agent of change. As a consequence, this thesis sought to provide a deeper understanding of the factors supporting or inhibiting effective transfer of education in NHS clinical practice in primary mental health care.

A rationale for such an analysis was rooted in the expenditure associated with education and training in the NHS on an annual basis. As noted above, the NHS total annual education levy for all the commissioned education and training for pre-professional registration and continuing professional development is currently almost £5 billion (Department of Health 2014a). While much of this is allocated against undergraduate education across many disciplines, there remains a significant proportion for Continued Professional Development (CPD) which often went unevaluated at an estimated cost of £169 million (Universities UK 2012).

In undergraduate Higher Educational Institutions (HEIs) programme outcomes were measured against a range of internal and external quality indicators, but most broadly against attrition and completion rates. The transfer success of programmes such as IAPT into the NHS had little or no systematic measurement so formal evaluation of impact on practice was limited.

This thesis sought to improve understanding on the features of successful implementation of education based policy initiatives such as IAPT. New roles emerge in the NHS as a response to the challenges of changing patient demand and a stronger emphasis on the health delivery in primary care services. There is a sparse literature on the transfer of education to practice

in mental health. It is essential that a deeper understanding of the enablers and barriers to successful transfer are analysed and communicated.

The national programme for Improving Access to Psychological Therapy (IAPT) was utilised in this study. The IAPT programme was a national service development and training programme aimed at increasing the numbers, knowledge and skills of mental health practitioners in primary care services in England. This study sought to explore the ability of IAPT training programme participants to transfer newly acquired knowledge and skills in practice. In doing so, a comprehensive analysis of the national training programme, exploring this issue of educational transfer from the 'classroom' to the practice setting has been conducted. The study utilised a longitudinal case study design to follow a cohort of students through their educational programme and back in their place of work. A number of key constructs were examined in this process, most notably 'motivation'; do students feel motivated to use their new learning and 'identity' – do the students view themselves differently as a result of the training programme? Ideas about change (both personal and organisational) were introduced and so the thesis was set within a context of implementation of change in public services primarily, the NHS in England.

Chapter 2: The review of the literature

The introduction to this thesis presented a theoretical framework which was used as a basis for guiding the research (page 25). The framework was used to guide elements of the literature review given the complexity of the contextual setting.

This thesis used an integrative literature review process as a strategy to collate, critique and synthesise a representative literature on the topics under consideration (Torraco 2005; Whittlemore and Knafli 2005). The rationale for an integrative process was based on the nature of the breadth of research topics present within the framework for this thesis. The topic of transfer represents a mature literature, where the knowledge base has a large breadth and depth of material available. The aim of an integrative review is to support new re-conceptualisation through a synthesis of available material. This integrative approach to literature review is also supported via the development of the conceptual framework that guides this thesis. The conceptual structuring of policy development, educational delivery and workplace transfer provides a guide through the literature source topics implicit in the process.

2.1. Literature search methodology

The review of literature focused on the seminal publications that were viewed as critical in a number of disciplines around the transfer of learning. To conduct a broad but systematic process of searching a number of data bases were used. In the first instance it was identified that the bulk of material around 'transfer' was located in the Human Resource Management (HRM) literature. Therefore three of the Academy of Human Resource Development

journals were systematically searched ('Human Resource Development Review'; 'Human Resource Development International' and Human Resource Development Quarterly'). The Academy of Human Resource Development is the renowned international body for Human Resources and publishes the highest impact HRM journals. Keywords and Boolean operators were identified for this aspect of the review: train* and transfer; Work* or employee; barriers and Behavi*r; Qual* or Quant*.

Based on the above, the original search generated 467 papers. Given the need to generate a comprehensive understanding of the topic, over time, these papers were manually examined via abstract review. To identify seminal texts, key papers found via this manual search were further explored by their reference lists. Most often cited papers were further identified and coded for comparative analysis regarding subject matter and major findings.

In addition to the Human Resource integrative review process, an additional search strategy was commenced to explore the health related transfer literature.

The databases of CINAHL, Medline, Science Direct, and Web of Science were originally searched over a six month period in late 2008. The search was generated again in 2012 using the additional 'Find it at Lincoln' portal. This additional process was designed to identify any recent publications and through the integrative nature of the 'Find it at Lincoln' databases, Medline, PsychINFO and CINAHL were again reviewed.

The search process utilised the following search phrases and terms where appropriate.

- Learn* OR Train* or Transfer OR Policy
- Education OR IAPT OR Psychological Therapy
- Workplace OR Clinic* OR Primary care
- Transfer OR Improve* OR Challenge* or Enable*

Throughout the process of this thesis, secondary searching was performed on a continual basis. Reference and author lists of papers were examined and periodically searched for updates to inform the broad integrative literature review process.

2.2. Literature analysis

The titles of all papers were screened to examine the adherence to the conceptual framework and the topic of learning transfer. In addition where available, the abstracts were read to further ensure fidelity to the examination of the topics under review. The nature of this mature literature resulted in significant textual support and so a sample of key referenced texts were retrieved for the integrative review. Torraco (2005) and Callahan (2010) explained how within an integrative process not all literature will be examined, but rather sourced literature will be explored via the specific aspects of the study and the literature is critically evaluated.

The conceptual framework provided a broad and heterogeneous literature selection, covering a wide range of subjects. In keeping with the requirements of an integrative literature review the papers were reviewed to

synthesise findings to support new interpretations on the transfer of training process.

Seminal papers were identified to benchmark key integrative literature sources. Through this process the meta-analysis of Burke and Hutchins (2007) was identified as a foundation for examination of the key elements associated with the transfer of learning. The rationale for this was based on the acknowledgement that the literature is 'mature' and extensively examined. However there are areas of dispute and these informed the critical examination of source literature from previously published meta-analyses. The review conducted by Burke and Hutchins (2007) identified 30 distinct relevant themes. These related to personal characteristics; training programmes and the work environment. These variables were consistent with those identified by Fixsen *et al* (2005) covering personal, organisational and training characteristics pertinent in transfer of new skills.

With reference to the research design, the variables associated with personal characteristics indicated a design which incorporated some elements of quantitative data collection using validated instruments. Likewise it was identified that a number of questionnaire instruments were available to explore workplace characteristics. However the number of questionnaires covering both personal and workplace characteristics was considered to be too large and so a number of variables were removed from consideration (conscientiousness; extrovertism; over-learning; cognitive overload; technical support and accountability). The integrative review process identified the themes of 'motivation'; 'Self-Efficacy' and burn-out/job satisfaction' were the most critical aspects of the transfer process.

Variables were identified to explore through a quantitative and qualitative examination using questionnaire; interview and/or observation. These related to the training programme design and implementation and the workplace characteristics associated with the delivery of IAPT in primary care.

In this literature review motivation as a broad psychological construct was reviewed and subjected to detailed analysis.

The workplace or organisational context provides an opportunity to analyse some of the key aspects of work which may have hindered or enabled practitioners to transfer their learning in the IAPT setting. There are a number of quantitative scales which examine the issues of workplace characteristics which play a role in supporting or hindering the transfer of learning in mental health. These scales were utilised along with an interview protocol to seek qualitative understanding from IAPT workers on the impact of training/education and the workplace enablers /barriers to the transfer process.

The literature review is divided into three complementary elements which reflect the theoretical framework. The '*source*' literature focuses on the published policy related work which helped develop the IAPT initiative. Published papers which relate to the pilot sites (*best practice exemplars*) have been utilised. This 'Source' section therefore provides a concise analysis of evidence relating to the beginnings of the full IAPT roll-out programme across England.

The second element covers literature relating to the '*communication*' (or educative) aspect of the theoretical framework and the final section is a critical

examination of the '*destination*' (or workplace) within the Fixsen *et al* (2005) framework.

2.3. A critical analysis of 'source' literature: the policy context of transfer

The UK Government announced the plans for a large scale implementation of IAPT on World Mental Health Day in October 2007. The plans included an increase in the number of trained IAPT workers to 6,100 by 2014 with the remainder (a total of 8,000) formed by the existing primary care mental health workforce. This was to be achieved from a very low baseline as there were very few psychological therapists in 2007. This represented a sea change in workforce attention and numbers in primary care supporting treatment for people with mental health problems. It was not only a major issue in terms of education provision (where and how to train such individuals) but also a workforce issue (where and how to employ them?).

The roots of this lay in the recommendations by NICE (National Institute for Health and Care Excellence) who had published a number of systematic reviews on effective treatments for depression and anxiety, (NICE 2004a; 2004b). These reviews identified the efficacy of CBT and potential efficacy of other treatment modalities, but also noted that such treatment options were not readily available to the vast majority of people in primary care (NICE 2006). Importantly, the policy agents, who were promoting this agenda, also sought to communicate and convince a wider public on the need for the advancement of psychological therapies in primary care. They published the publication of the Depression Report (Layard *et al* 2006) which was

distributed as a supplement in the Observer newspaper (Sunday 18th June 2006).

At the time of piloting the IAPT programme, there were 154 Primary Care Trusts (PCTs) eligible to test out the assumptions noted above. Two were selected, (both receiving between £1.3 and £1.5 million); Doncaster (South Yorkshire) and Newham (Inner London) to pilot different elements of the 'stepped care' programme (figure 4 page 44). The model offered the NICE approved most effective interventions with a concomitant acknowledgement that the 'stepped care' model should prove to be the most cost effective method of delivery (NICE 2011b; Scoggin *et al* 2003). The stepped care model delineates treatment modalities delivered by differently qualified personnel. Therefore 'Step 2' was treatment delivered by Psychological Wellbeing Practitioners (PWP) and 'Step 3' delivered by High Intensity Improving Access to Psychological Therapy workers (high intensity therapists).

While Stepped Care is said to have a coherence, the optimal system of implementation is unknown (Bower and Gilbody 2005). A reason for this uncertainty can be found in the work of Haaga (2000) who noted that an effective stepped care model must possess two clear principles: firstly it must provide the principle of least burden for the patient, whereby only the required treatment is identified and provided and secondly, it must possess a feedback aspect to allow correction of errors in allocated treatment.

The national guidelines for the management of depression (NICE 2009) provide some context of these challenges. The lack of biological markers for diagnosis in mental health provides a focus on symptom profiles to aid

diagnosis and recommend treatment. However, NICE (2009) states that symptom counts are a poor predictor of severity and should not be used to allocate treatments (as in a 'stepped care' scenario). Consequently, clinical judgement plays a significant role in such decision making in treatment allocation. Kellett and Mathews (2008) have noted that this provides the opportunity for inappropriate treatment allocation resulting in provision of unnecessary treatment and/or ever longer treatment waiting times.

Figure 4. The stepped care approach to treatment for psychological disorder

	Condition	Treatment
Step 3: High Intensity	Depression: Mild-Moderate and Severe	CBT; IPT; behavioural-activation
	Depression: Mild-Moderate	Counselling; couples therapy
	Panic Disorder: Mild-Moderate	CBT
	Generalised Anxiety Disorder (GAD): Mild-Moderate	CBT
	Social Phobia	CBT
	Post-Traumatic Stress Disorder (PTSD)	CBT; Eye movement desensitisation and re-processing (EMDR)
	Obsessive Compulsive Disorder (OCD)	CBT
Step 2: Low Intensity Service	Depression: Mild-Moderate	Computerised CBT (cCBT) guided self-help
	Panic Disorder: Mild-Moderate	cCBT; Guided self-help
	Generalised Anxiety Disorder (GAD): Mild-Moderate	cCBT; Guided self-help; psycho-education groups
	OCD: Mild-Moderate	Guided Self Help
Step 1: Primary care/ IAPT Service	Recognition of the problem	Watchful Waiting

Figure 4 is based on NICE (2011b) Commissioning Guides [CMG41] (Page 11)

The acknowledgement of such uncertainty over the operationalisation of stepped care models saw the testing of alternative approaches. The Doncaster site focused on *low level-high volume* interventions and the Newham pilot tested the assumption that a focus on high level interventions would generate greater policy effects. Clark *et al* (2008) stated that both sites had a history of delivery of psychological treatments for people with depression and anxiety but used these different levels of emphasis. The pilot at Doncaster concentrated on treatments for depression and used low level intervention techniques such as guided self-help and computerised CBT. These were interventions that could be employed by individual PWP's who had received a short training programme in order to demonstrate competence. The main staff group were *case managers* who were individuals from a variety of health backgrounds who received a one week intensive clinical skills training programme, then two terms of one day per week of classroom based training and complimented by one hour per week clinical supervision. The supervision element was provided by a qualified CBT therapist and viewed as critical to maintaining quality control of the treatment process. However, there was little published detail on the supervisory process and this supervision was considered to be an important aspect of the development of a nascent workforce (O'Donovan *et al* 2011).

The treatment model in Doncaster consisted of a prompt response service to any referral and a face to face meeting with a case manager (within 21 days). This face to face meeting enabled an assessment of the presenting problem and a proposed treatment programme. This most often involved telephone

follow-up, referral to more appropriate services or to specialised CBT services if the presenting problem was thought to be sufficiently severe.

The population in Doncaster, who received services, were predominately white British (consistent with the local demography). The Doncaster service used a stepped care approach (figure 4, page 44) where services were concentrated towards the low level interventions (although some high level treatments were available). The Doncaster approach promoted a high throughput model, (treating many people quickly and efficiently). This form of CBT, utilising self-help, and minimal therapist input have been criticised as being less effective than face to face treatment (Hirai and Clum 2006). However there is evidence that highly motivated patients, those who self-refer for treatment are more likely to stay with treatment, but such patients are not usual and so attrition rates for low intensity CBT can be up to 66% (Richards *et al* 2003).

Newham by contrast, provided services for those with depression and all anxiety disorders and delivered to an ethnically diverse population. The Newham site had a greater emphasis on delivering CBT by trained therapists and so delivered a service model based on steps 2 and 3 of the stepped care approach. The Newham treatment process relied less heavily on telephone support and more on formal face to face therapy. There were a larger number of qualified CBT therapists in Newham (10 WTEs compared to 1.5 in Doncaster).

The high intensity CBT of Newham was delivered in keeping with the treatment protocols of the Randomised Control Trials on which the original analysis of IAPT was based (Layard 2004). The underlying assumptions of

CBT have been criticised for that lack of attention placed on understanding the complexity and development of human psychological processes. CBT has a focus on the 'here and now' and consequently takes little account of any possible factors in early development that may account for psychological distress (Wilde-McCormack 2012). Recent studies have also questioned whether the effectiveness of CBT for depression is falling (Johnsen and Friberg 2015). However their conclusions, based on a meta-analysis of reported studies, only used studies that utilised a narrow set of accepted depression measures. Additionally the compared studies were a range of controlled and uncontrolled studies over a long period of time (1977-2014). The development of trial quality over that period was not accounted for in the analysis and many well-known RCTs were omitted as they did not meet the 'accepted depression measure' requirement.

There was information available on the presenting severity data in both sites. In Doncaster 82% scored above the severity cut-off on the clinical measures used in the pilot sites (the Patient Health Questionnaire (PHQ-9) and the Generalised Anxiety Disorder Scale (GAD) and in Newham this was 76%. Those that who were considered severe (with a score of 20+ on the PHQ) this was 34% in Doncaster and 28% in Newham. Assessment of how long people had suffered with a mental health problem (duration of difficulty) was calculated, 33% of people in Doncaster stated they had been unwell for 6 months or less while in Newham this figure was 22%. The people who stated that had been having a mental health difficulty for between 6 months and 2 years, was 33% in Doncaster and 17% in Newham. Lastly, 34% in Doncaster and 61% in Newham complained their problems had been persisting for more

than two years. Therefore, it may be argued that at initial presentation their difficulties were similar, but the Newham cohort experienced a longer period of mental ill-health.

Both services accepted referrals from the traditional routes in primary care (mainly GP and other health care professionals). Both had also developed referral protocols with local employment services and Newham had developed processes to accept 'self-referral', whereby any individual could request a service directly, rather than through a formal service provider (Clark *et al* 2009).

A concern in any assessment of effectiveness centres on how 'improvement' is operationalised by researchers. A reduction in symptoms has been viewed as simplistic as it fails to identify changes (if any) in occupational functioning and environmental changes around the life and social networks of individuals, even with high symptom scores (Davison 2000).

2.3.1. Evaluation of the pilot sites

The economic and equality proposals put forward by Layard (2004) were the focus of the two pilot sites. An observational, prospective cohort study was conducted (Clark *et al* 2009) with the intention of examining patient outcomes from the two different treatment modes. A feature of the evaluation was the use of standardised measures to indicate severity of presenting psychological symptoms and recovery from such difficulties following treatment. The two main scales used were the Patient Health Questionnaire Depression Scale (PHQ-9) (Kroenke *et al* 2001) and the Generalised Anxiety Disorder Scale (GAD) (Spitzer *et al* 2006). The use of such methods has caused debate

within the psychological and sociological literature on the ability to measure constructs such as depression and anxiety (and many other disorders) Mirowsky and Ross (2002).

The measures were administered at each contact session with the therapist, so provided a rich data source from which to examine the presentation of the problems faced by the individuals and whether difficulties (as measured by their assessment scores) improved. From a patient perspective, there was a tension in such an emphasis on session by session data collection, particularly as patients reported feeling 'over assessed' (Department of Health 2007c).

Both sites achieved high levels of pre and post treatment data (99% for Doncaster and 88% for Newham). During the thirteen months of the pilot period, over five and a half thousand people were referred to services with four thousand eight hundred considered to be suitable for treatment and three thousand five hundred people completing treatment. Of this latter number, nearly two thousand received more than one treatment session and provided both pre and post treatment data. The data indicated that over fifty five percent in both sites achieved recovery (assessed as a PHQ score of below 9 and a GAD score of 7 or less). Data were also collected on employment status which indicated that in the Doncaster pilot, 4% of people treated returned to work from statutory sick status, while in Newham this figure was 10% (Clark *et al* 2009). However the issue of site treatment modality was not analysed as Doncaster had an explicit emphasis on high volume low intensity interventions. By contrast Newham had a high intensity low volume model. The role of service modality may be examined by the fact that few patients in

Doncaster were referred to high intensity interventions (Clark *et al* 2009) and similarly in Newham fewer patients were stepped down to lower interventions. This raises the issue of unaccounted false positives (inappropriate stepping up when not required) and false negatives (failure to step down when appropriate). As White (2008) has noted stepped care can only function and be evaluated effectively when there is a clear inter-connectedness of the service which provides practitioners and patients with a range of potential and appropriate treatment options. The pilot sites provide evidence of differing approaches and outcomes but give little overall direction on how a stepped care model might work in primary care.

Preliminary results of the pilot sites appeared to support the contentions of Layard *et al* (2006) that short term psychological intervention can have benefits not only to the individual in terms of recovery, but also in family/carer health gain and employment. Thus, according to the analysis of Layard *et al* (2006) appropriate investment in the development of psychological therapy services will result in a net economic gain for the nation.

Both demonstration sites obtained similar recovery rates, but using different treatment approaches. The communities were different as was the context of treatment therapy; both sites achieved service delivery with short waiting times before receiving an assessment by a therapist. Both services had similarities with the majority of clients unemployed and with more severe difficulties.

To examine the results of the pilot study, Parry *et al* (2011) conducted a 'whole systems' comparison study with matched (non-demonstration) sites. This study suggested that the IAPT programme, across all sites, was

demonstrating effectiveness, and that the low intensity-high throughput model of Doncaster was the most effective. The authors caution though that comparisons were difficult since patients' response rates to requests for data were low (twenty three percent from Newham and fifty four percent from Doncaster). They concluded from their interview data that whilst the IAPT programme has a concept of 'recovery' this is not the one used by patients themselves. The recovery index cut-off score for standard measures, such as the GAD is not uniformly agreed, thus making comparison across services challenging. Additionally the categorisation of presenting common mental disorder was interpreted differently in both sites. This presents a challenge in interpreting data using routine data collection methods as therapists may be idiosyncratic in their approach to such processes.

The conclusion of the study rested on a need to conduct longer term comparative studies to ensure that treatment effects and 'recovery' rates are sustained over time and directly attributable to the IAPT service. They also note the need for IAPT services to develop a strong sense of identity. The two demonstration sites were very different, using different treatment methods for different socio-economic, demographic and geographical contexts, this making direct comparison difficult (Parry *et al* 2011).

A substantial body of literature suggested that a number of people will recover from psychological distress independent of any intervention from a therapist. This is the cited rationale for the therapeutic use of waiting lists and 'watchful waiting' as identified in step 1 of figure 4 (page 44). A meta-analysis from Posternack and Miller (2001) indicated that average recovery rates for people receiving no formal psychological therapy were 20%. The data from the pilot

sites seem to demonstrate a recovery rate well beyond 20% for people with a psychological disorder that had lasted longer than 6 months. The demonstration sites provided data on primary care interventions at low and high intensity and whether the outcomes supported the analysis of Layard on demand and potential economic benefits. The demonstration sites were different in emphasis and attempted to analyse the benefits of such an emphasis on a stepped care model. The emphasis may have provided a confounding variable since a failure to provide the least intensive intervention and the provision of feedback for progress review meant that Haaga's (2000) two key principles were not achieved.

Despite this, there seemed to be some empirical evidence to support the work conducted in Doncaster and Newham. In recognition of this, the Department of Health planned for a full national roll-out of IAPT (Department of Health 2008a). This roll-out did not articulate the provision of prescriptive operational guidelines on the delivery of stepped care in each site but rather left some elements open to local determination and on-going operational support from key leads in the then Strategic Health Authorities (SHAs). The national IAPT team did though impose some controls through the commissioning arrangements. All sites were to be provided on a balance of low and high-intensity therapist numbers on a ratio of 40:60. Implementation of new services and modes of working require careful attention and so the roll-out was set within a primary and secondary NHS service in the midst of significant service transformation which facilitated a range of differing perspectives and decisions on how implementation would happen at a local level (Richards *et al* 2010).

2.4. A critical analysis of the literature relating to ‘Communication’: the educative aspect of ‘transfer’

The communication process was represented in this theoretical model as the aspects directly related to the education/ training programme developed by a national team; delivered by a Higher Education Institution (HEI) and experienced by the High Intensity IAPT trainees. The principal policy intervention, other than enabling the development of services for the IAPT initiative, was the formulation of the training programme. Consequently the training element had a significant status in the policy for improving access to psychological treatments for people in primary care services.

The IAPT programme was designed to equip new workers with the core skills and knowledge needed to deliver Cognitive Behavioural Therapy (CBT) and it therefore was important to scrutinise the training and the nature of its relationship to learning and question whether a skills based training course could sufficiently equip workers in a complex primary care environment. This analysis required reviewing the national IAPT training programme through the prism of adult learning theory.

2.4.1. A review of learning for transfer

The development of the IAPT education programme, like all education programmes, was based on some assumptions about how people learn. In IAPT, assumptions were promoted which related to the concept of *motivation* – policy agents made an assessment of the type of person who they sought to attract to the programme, assuming that the individual would be more

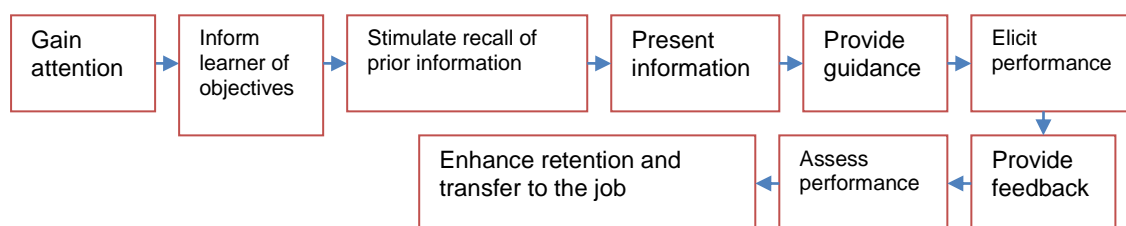
motivated to learn about CBT and likely to want to continue their interest into a work role. The IAPT model promoted experiential learning; making assumptions that the elements of practice and critical reflection were important in the learning process. Additionally the programme was based on an assumption that the development of *competence* formed a meaningful outcome from the *training* process.

Development of educational initiatives such as IAPT did not come value free and so it was apposite to scrutinise these assumptions and assess their central concepts in relation to the theoretical framework adopted in this study.

The IAPT programme course structure was one which followed an instructional design approach (Gagné *et al* 2005); a structured and systematic approach to designing, instructing and delivering learning materials to achieve desired outcomes. Instructional Design (ID) (a model is presented in figure 5) is an approach which is focused on the achievement of outcomes which are set by the educational designers. Gagné *et al* (2005) suggested that while educational programmes vary in their specific details, the same mandatory nine events (in figure 5, page 55) were necessary for the learning process.

The IAPT programme was largely designed externally to the host HEI, with prescribed assumptions about training processes and desired learning outcomes. Whilst the programme allowed some flexibility, the approval of each programme was based on external assessment and evaluation by the British Association of Behavioural and Cognitive Psychotherapy (BABCP) acting on behalf of the Department of Health.

Figure 5. The nine instructional events



(Based on Gagné *et al* 2005 page 30)

The ID approach to learning is a *backwards processing model*, the desired outcomes are identified at the outset and an approach to educational programme design initiated to deliver them. Instructional design can trace its development from pure behaviourist principles to the integration of ‘cognition’ (Case and Bereiter 1984) and in doing so had moved away from an emphasis on responding to stimuli (*behaviourism*) to making meaning from knowledge and adapting to new information (*cognitive*). In this regard both are ‘objectivistic’ in that they view the world as external to the learner.

The IAPT programme used a predetermined goal of educational instruction as it mapped the requirements of the outside world (the health needs of the population and the research evidence) to the learning outcomes for the IAPT student. The structural requirements of CBT for the treatment of anxiety and depression were seen as fixed and the learners were to be instructed to deliver clinical interventions to achieve required clinical outcomes and to be employed in healthcare organisations within a wider primary care infrastructure. The national training programme for IAPT identified a

requirement of 200 hours of teaching and 70 hours of supervision. Additionally there was an emphasis on core skills of CBT along with treatment interventions for both Anxiety Disorder and Depression (Department of Health 2008b).

This approach to ID has increasingly been questioned with authors suggesting a more 'constructivist' approach to educational design (Fletcher 2009). A constructivist approach would offer a fundamentally alternative design of the IAPT programme. Constructivist theory proposed that learners are able to build personal interpretations of the world based on their individual experiences and interactions. Such experiences are in the process of constant change and so an idea that there is a 'correct' meaning in learning cannot be stated, but rather the 'meaning' for a learner, emerges from the contexts in which they find themselves.

Constructivism is based on epistemological assumptions about ways of thinking about knowing and is a philosophical framework rather than a theory of learning (Tobias and Duffy 2009). Knowledge is not an objective reflection of the external environment, but rather knowledge is structured by individuals within their social communities. The learner (in this case the IAPT trainee) would not be considered to be passive but rather an agent engaged in an evolving set of social situations. The trainees would be *creating* meaning rather than *acquiring* it. Such an alternative perspective brings the concept of 'competence' into questions, since this would be viewed as an acquired set of learned knowledge and skills.

The interest in constructivism was linked to the rediscovery of the work of Vygotsky (1978) in educational psychology; from Piaget (see Phillips 2010) in

cognitive and social psychology and the American philosophical pragmatist tradition (Dewey 1938). These approaches rejected the possibility of obtaining a 'true' and 'objective' depersonalised account of the world as experienced through the senses. The real nature of the world was acknowledged but was only known in a personally subjective manner and therefore it was laden with our own interpretive models.

This interpretation pointed to complex models of analysis, as learning cannot be linear, as described by ID protagonists, such as Gagné *et al* (2005), but complex and multi-dimensional (Jorg 2009). The consideration of complex systems entailed a non-linear outlook, where differentiable functions which studied in isolation were considered impossible. The world of connectivity between elements represents our reality. The framework (figure 3, page 25) supported such a complex view, although elements were to some degree bounded and linear (by convenience). The political/policy/educational reality was one where multiple connections and interpretations existed and influenced individual and service practice. The theoretical framework presented a linear feedback process to understanding the development of the IAPT initiative and the transfer process of learning. Throughout such linear processes the external forces were in play and actively influenced the trajectory of the programme. This external *pull* and *push* accounted for the complex nature of the process and it is through this complexity lens that the transfer process was viewed. However, the appropriation by social scientists, of complexity theory (mathematically based as it is) has not met with universal adoption or support (Kirshner and Kellogg 2009). Complexity in healthcare

research is often based on metaphor (Palmberg 2009) but metaphors are not always consistent and have the potential to break down (Von Ghyczy 2003).

Alternative perspectives through which to conceive and explore educative processes such as that of Vygotsky (1978) concerned the ineffectiveness of traditional pedagogical approaches and proposed radical alternatives, based on complex personal interactions and relationships in a highly complex ecology. The link between this radicalism and complexity was understood in relation to the Vygotskian view that learning was conceptualised;

- at the *microgenetic* level; the moment-by-moment processes of change in mental structures as learners conceive and alter new understanding and perspective, and;
- at the *ontogenetic* level; the on-going life span development of the individual (Vygotsky 1978).

This link between the micro and the macro formed the basis on which education theorists fashioned the links to complex systems.

Vygotsky presented three major themes (Palinscar 1998):

1. Individual development as social interaction - the emphasis on development was social and psychological rather than individual. Piaget (see Phillips 2010) considered development to precede learning, whereas Vygotsky (1978) considered the opposite view to be correct. He viewed children (and adults) as primarily social animals and our attention is to our social environment and relationships before attention was given to the issues of formal and personal learning.

2. The role of the 'knowledgeable other' is a theme in which Vygotsky identified an 'other source', with more knowledge and understanding than the student. This relationship was not viewed as hierarchical (teacher–student). The relationship could be between students or between the student and technology.
3. The Zone of Proximal Development (ZPD) represented the distance between the ability of a student to perform a task under supervision and the ability of the student to solve the problem independently.

The above themes were built on a number of principles which included the requirement for teachers and students to adopt unfamiliar roles (the 'teachers' may be other students) and such a free flowing role exchange could facilitate reciprocal learning. The educational setting thus became a community of learners rather than one predicated on an intellectual distance between the teacher and the student. The facilitation of learning allowed the student to extend their knowledge and skills base through attention on the student's motivation to pursue the learning goal.

The idea of education as emancipatory was further explored through the work of Mezirow (1996) who suggested that adult education was emancipatory in that it encouraged reflection and discussion, with the educator being more of a facilitator and maybe even becoming a collaborative learner. This development of a peer relationship rather than a teacher-pupil relationship combined the concept of action learning where the facilitator acted on the peer relationship level.

The issue of participation in research (and more generally) in educational pedagogy opens discourse on the manner and purpose of such participation.

Public involvement in research activity is seen as an essential component of National Institute for Health Research (NIHR). However the nature of participation is a contested construct. From a position of critical theory, participation is promoted as a means to liberation. The challenging of accepted educational and societal norms through reflection, action and directed at transforming historical and coercive relationships (Freire 1972, Giroux 1983). From this perspective, fruitful research in healthcare is only possible when the historical and structural contexts which drive societal process are articulated, reflected upon and understood by all participants.

Such a position is not without its critics as Zorn (2001) describes the critical pedagogy of Giroux (and by implication that of Freire too) as culturally displaced from the everyday perspective of educational participants. In terms not wholly agreeable Zorn (2001) presented an establishment perspective on educational processes. Presenting the norm as purposeful, largely successful and appropriate.

The thesis proposes a participant based approach to data collection and evaluation. Initial discussions on the proposal with IAPT professionals, managers and policy leads cautioned against a drive for full and active participation. At the time of conducting the research, IAPT services were going through a considerable change with significant additional demands being considered in contract re-negotiations. As participation was still considered to be an important principle of the study it was agreed to concentrate time on negotiating entry to the work place and agreeing a process with the workforce on data analysis interpretation and reporting.

The focus on process, as well as content and outcome, within adult learning holds a link to Kolb's (1984) experiential learning cycle, particularly with respect to the often transformative nature of the knowledge that has been gained. The importance of reflection within this context has been stressed by Williamson (1997), who also made the link to Schön's (1983) work on reflection. In particular, Williamson (1997) drew attention to the differences between 'reflection-in-action' and 'reflection-on-action'. The former, taking place whilst something is happening, which resulted in learning that was not remote from the social and cultural context within which the individual had operated. Indeed, past experiences and socialisation resulted in a strong effect on how an individual reflected on the experiences they had (Boud and Walker, 1998). In contrast, Reynolds (2011) has argued that whilst the work of Schön (1983) and Kolb (1984) have been important in furthering the concept of reflection in learning, they have only focused on the individual and see reflection mainly as an element of personal problem solving. So much activity, particularly in health care, was the product of a team endeavour and so a greater focus on the social dimension of transfer of learning was required.

The guidance on IAPT training from the Department of Health (2012a) was explicit in utilising opportunities for experiential learning as a key teaching strategy. As such this formed a direct links to the theory of experiential learning espoused by Rogers and Freiberg (1994). These authors proposed two types of learning; the 'meaningless' and the 'significant'. The former related to the gaining of knowledge while the latter was the learning gained from experience, it was an 'applied' knowledge. For Rogers and Freiberg

(1994); Knowles (1990) and Knowles *et al* (2005) it is the latter which talked directly to the needs of adult learners, as they sought a personal involvement and desired control over their learning.

In the theory proposed by Rogers (1983) experiential learning was directly related to personal change and growth. In line with Rogers' general humanistic perspective, all humans had a natural desire to learn, develop and grow, with the role of formal education to facilitate or enable this drive. In achieving this, educational programmes must combine both intellectual and emotional components of learning and support a positive climate in which learners explored and experienced the sharing and learning from others. In a similar vein to that of Vygotsky (1978) there was a call to ensure that learners were fully engaged in the learning process through their participation and control.

The emerging empirical research appears to support for this process of learner developing insights through reflection. Zull (2002) has promoted a need for a deeper biological understanding of brain processes as learners develop new neural pathways. He used the emerging neuroscience evidence on brain processes and learning to formulate a brain learning cycle (figure 6, page 63) which had a strong evidence to support the learning cycle developed by Kolb (1984). This insight and evidence led to the development of new synthesis of education, biology and cognitive science called Mind Brain and Education (MBE) (Fischer 2009).

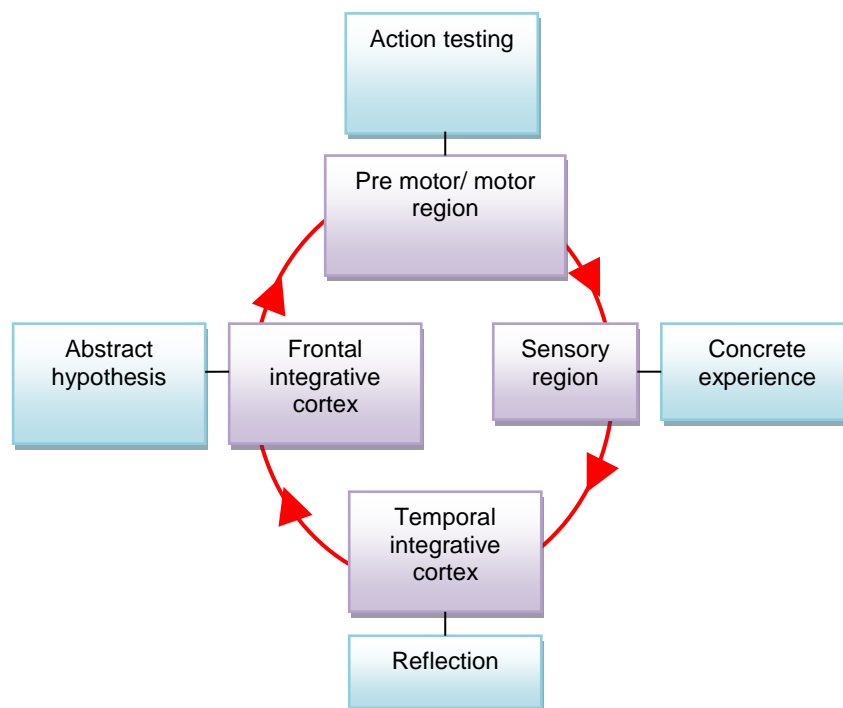
In philosophical terms, the integration of biology (brain processing and neural development) with cognition (individual and social reflection and learning processes) is a feature of the Pragmatist tradition. In this philosophy,

learning, believing and knowing become inextricably a part of *doing* and *feeling*. One of the founders of this pragmatist approach, William James noted;

The great thing then in all education, is to make the nervous system our ally...the more of the details of our daily life we can hand over to effortless custody of automation, the more our higher powers of mind will be set free for their own proper work.

(James 1890 [1950] page 122 Vol 1).

Figure 6. The experiential learning cycle and the regions of the cerebral cortex (after Zull 2002 page 18)



Kolb's cycle of active testing; concrete experience; reflective observation and hypothesis testing (Kolb and Kolb 2005) has synergy with the emerging MBE science and can be integrated into a pragmatist and Vygotskian philosophy. Bringing these themes together challenges traditional relationships inside (and outside) the classroom. The power differentials between agents in the

community of learners constantly shift. In addition to appropriating a Vygotskian perspective to complexity, it was possible to explore how this power shift could be viewed politically. The knowledge economy and the capitalisation of education have placed an emphasis on the provision of knowledge and skills to students in order that they may be prepared for the labour market. The student thus becomes a consumer rather than an individual engaged in a shared community endeavour (Neary and Winn 2009). The IAPT 'trainees' were provided with a programme directly linked to the production of their labour. The national programme was a *training* programme, designed to deliver a set of skills based on a rational analysis of the psychological health needs of the population and the available research evidence which could address the issue.

The thesis identified a tension between a prescriptive cognitive-behavioural model of practice/treatment with the IAPT programme, which was responding to a dynamic and transformative external environment. In maintaining a fidelity to prescriptive CBT treatment modalities, the design of the educational programme was objectivistic and instructional in its scope. However an analysis of the external environment (*the influence*) and the work environment (*the destination*) had the hallmarks of a complex dynamic system. Therefore the relationship between an objectivistic learning programme applied within a context of a complex irregular system was worthy of analysis.

2.4.2. Adult education

The above tension drew a distinction between 'training' and 'learning' in adult education. An aim of this study was to; examine the transfer features that

influence the ability of IAPT practitioners to utilise a competency based educational programme in their practice and this was to be achieved, in part via an examination the personal characteristics of the individual learners and the characteristics of the training programme (Aim 1). In order to achieve this, the relationship of this aim to a number of major education theories required examination.

New ways of working (such as IAPT) and transformational system change required analysis of existing assumptions and values. The tenet of the 'working in new ways' programme related to a critical examination of existing custom and practice before progressing with any alternative models of service delivery. The IAPT programme (like many programmes in health and social care; such as the graduate workers) was predicated on the on-going review and refinement of service models. The programme of development and review of services had a link to the work of Argyris (1997) who proposed 'double loop' learning as a theory of action which related directly to learning about change of the fundamental underlying service values and assumptions. The theory was based on a problem-solving schema, especially those high degree complex service problems. This locus on complexity fitted conceptually with the theoretical framework used in this study. The IAPT programme, both in terms of development of services and the practice of the workforce represented a new way of working in primary care and sat within an external political, social and financial environment which was dynamic and complex in its operation.

Double loop theory was based upon a "theory of action" as promulgated by Argyris and Schön (1996). This action theory sought to explore the reality of

the situation as perceived by the people involved. These were actors or agents who had a significant stake in the social context of the work and learning situation. Any changes in the stated and unstated values, behaviours and roles of leadership were all informed by the actions of the agents involved. The 'double loop' theory identified the dissonance between individuals' espoused views and the "theory-in-use" (what they actually do). This presents a direct link to the work of Fulford *et al* (2012) and the development of Values Based Practice (VBP). Both the theory promoted by Argyris and Schön (1996) and the approach of Fulford *et al* (2012) sought to develop strategies to promote congruence between stated values (*professed values*) and actual behaviour (*operational values*).

Both approaches shared a set of actions to promote learning, most notably the 'public' or team work required to uncover dissonance and the production of new actions which had higher degrees of correlation between values and behaviour. The goals of both approaches centred on increasing effectiveness and a greater acceptance of failure. The approach of Argyris and Schön (1996) has also focused attention on issues of leadership within organisations in the promotion of 'double loop' learning goals.

Thus, the 'prescribed' nature of the IAPT curriculum runs counter to these principles of humanistic higher education.

2.4.3. Developing Self-Efficacy and competence.

The guidance from the Department of Health (2008a) for IAPT identified that experiential learning was a recommended strategy to aid development of

required competences for delivery of CBT practice and achievement of clinical outcomes.

A skills based educational programme such as IAPT was predicated on the ability of novice practitioners of CBT to progress to more expert application over time. The programme sought to develop competence in the treatment of depression and anxiety for those clients who met the stepped care criteria for treatment. Consequently a personal sense of competence in skills performance is necessary and allied to this the confidence that such skills can be achieved (Self-efficacy). The theory of self-efficacy or Social Cognitive Theory (Bandura 1989) proposes that the level of confidence an individual has in their ability to complete a task is related to the effort and performance of a task.

Previous success or failure in a task may influence the level self-efficacy and may be predictive of attention and motivation to task or education completion and thus transfer. Additionally the theory posits that a generalised sense of self-efficacy supports the ability to take learning/skills development in one area and apply it in another (related) one (Bandura 1997). The meta-analysis of Burke and Hutchins (2007) specifically identified Self-efficacy as a key construct in the transfer process, but failed to identify the generality dimension to the theory. They identified a lack of research on the meta-cognitive skills that increase a learner's ability to generalise their learning in novel or dynamic settings. A key study in their analysis was Holladay and Quinones (2003) who attempted to analysis self-efficacy generality behaviours over 'near' and 'far' learning. The authors provided no definition of the near (proximal) and far (distal) learning. Additionally no reliable and valid measures were reported on

the measurement of the self-efficacy construct. The study had an emphasis on goal achievement as a measure of efficacy and this goal orientation was a feature of another paper in the Burke and Hutchins (2007) review

The issue of goal setting in transfer studies was examined by Brown (2005) who used the definition of transfer in this study to examine the impact of goal setting on transfer behaviours. Brown (2005) hypothesised that learners who set short (proximal) and long term (distal) goals would transfer learning better than participants who were encouraged to do their best without setting firm goals (who acted as a control group). The goal achievement and subsequent transfer was considered to be an enhancement of personal self-efficacy. The study was completed on a convenience sample of government employees on a management training programme of four days. A key variable for Brown (2005) was the development of self-awareness in transfer but this as 'developed' via a single days training programme. The study also placed emphasis on student learning, but the major focus of the delivery and analysis focused on training. As has been noted earlier, these are different constructs that require different assessment processes. Transfer was assessed using a number of psychological survey instruments on learning styles, interpersonal relationship building; locus of control and tolerance of ambiguity. No psychometric properties of the reported measures is provided.

All training was provided together and only on completion were groups divided into the three conditions. The specific conditions of their tasks (proximal, distal or control) were provided following training with instructions not to speak with other members about the research study tasks. It is questionable whether the cross fertilisation of task conditions was avoided given that all

participants were in the same employment arenas. Repeat measures were taken six weeks after training completion. In keeping with the definition of transfer the research sought to examine both maintenance of learning (measured through elements of the ambiguity, locus of control scales) and the generalisation of new knowledge to different tasks (measured via a scenario based assessment).

The study retained a 70% response rate at the final stage of data collection (six weeks post training). Results indicated little difference between the groups. The long term goal group (distal goal setting) showed no benefit over any other condition but the distal and proximal group showing a slight improvement over others. There were no data in the study on what these 'goals' consisted of, how they were operationalised in practice or measured (via self-report) as achieved or not. There was no examination of the environmental aspects of training or learning transfer in the study thus excluding an important ecological examination of the transfer climate.

This analysis is important for the study of transfer in IAPT as learners are developing skills in a safe and controlled learning environment before attempting to use them (more generally) in the clinical situation. Therefore the issue of IAPT practitioners being able to generalise their education in the practice setting formed an important aspect of the study of transfer.

The focus on 'competence' as the key determinant of educational attainment within IAPT was an important aspect of debate. A technical aspect of the debate centred on the pace of 'technological' change in NHS practice. Mental health services were less reliant on technological hardware than other aspects of the healthcare system. Nonetheless change in treatment practice

was evident in psychological therapy and it was questionable whether competence, as measured at one point in time, was a meaningful barometer of practitioner behaviour.

This matter of 'competence' had importance in the general debate on the philosophy of education. Like many healthcare programmes, the IAPT education approach could be described as a Front End Model; where a period of formal education was required before the individual was deemed to be qualified. Despite the pervasiveness of this model, additional on-the-job training or Continuous Professional Development (CPD) is required to maintain role performance. The further development of national occupational standards within such a competence based model represented an attempt to specify the range of attributes; required knowledge and key performance skills of the novice practitioner to practice safely. An assumption within the front end model is that formal theories taught during initial education would continue to play a significant role on the individual and on their practice. The model is allied to the instructional design model of Gagné *et al* (2005) (figure 5, page 55) where competence is defined and measured at moments in time, but such competence may well be time limited, making the whole edifice of the competence model, unstable (Berge *et al* 2002).

An important missing element in the competence issue is the social dimension to learning, as competence is viewed as an individual outcome of education. Indeed the integration of 'reflection' also has a strong individualist element to its practice. Psychologically, the Vygotskian and philosophically, the Pragmatist, would counter this view with a focus on the social dimension of learning. The environment of learning is not fixed and nor is the dynamic

social world of the learner. The motivation to engage in social learning has little space in the competence literature, yet it forms a key system in the development of identity to learn, to perform and to engage in effortful control to maintain performance over time, in short, *to transfer learning*.

2.4.4. Motivation

The personal characteristics of the learners were considered to be a critical element in the transfer process, none more so than the motivation of the learner to engage in the learning activity (Vallerand and Ratelle 2002). The research literature on motivation is vast, but as Schunk *et al* (2014) proposed, it can be viewed as following three traditions.

- A *mechanistic* approach – based on a natural science paradigm which sought to measure motivation in terms of changes in behaviour that can be quantified on a continuous scale.
- An *organismic* approach – which suggested that progressive change can be identified but these changes were qualitatively different rather than quantitatively different.
- A *contextual* approach – where motivation change and difference was interactive rather than sequential and often at the behest of historical events.

Motivation is not a unitary concept (Ryan 2012) and contains a number of competing and complimentary theories. A number of theorists consider the field too divergent and lacking a broad consensus (Locke and Latham 2004). Some researchers consider motivation to act as a simple bi-modal linear

relationship between *thought* and *action* – such as the Theory of Planned Behaviour; Ajzen 1991); or a more complex linear process; the trans-theoretical model, called the ‘Stages of Change’ model (Prochaska and DiClemente 1983). The ‘stages of change’ model holds that individuals maintain motivation to move through a set of six stages (*precontemplation; contemplation; preparation; action; maintenance* and *termination*). Critics, such as West (2006) have argued that the theory takes no account of the social dimension within which the individual operates, the stages do not have a clear distinction regarding when they start and finish. Lastly the above two theoretical approaches supported a view that people are logical and coherent in their decision making processes and this is highly questionable (West 2006).

Motivation, is a psychological construct through which the development and delivery of training outcomes are achieved. The theory and application in education programmes such as IAPT, relate strongly to ‘behaviour change’ principles. Trainees had been provided with a rationale and training experience to help them do something/act/behave in ways which they did not previously. How trainees progressed through this process was an important unit of analysis within this thesis. Learning about how trainees had developed knowledge and skill and how they had been used in the practice setting was at the core of ‘transfer of learning’.

Motivation may be perceived as the fuel for personal agency to achieve something new or to maintain a particular set of behaviours. In relation to health care, the vast majority of research conducted on motivation and work has been generated within large corporate organisational settings, with little

empirical research conducted within the public health and social care sector (Wright 2001).

In order to present a coherent overview of the complex theoretical world of motivation, it was preferable to concentrate on a smaller number of the key theories which had generated the greatest research activity, such as the Theory of Self-Regulation (Deci and Ryan 2002) and the Theory of Social Cognition (Bandura 1989) (Michie *et al* 2014). The work of Locke and Latham (2004) while concentrating on 'work motivation' had called for a unified approach to theory and to respond to this call for unification, the 'Prime Theory' of West (2006) was also explored for its resonance within the unification approach to motivation.

The motivation of participants to learn and apply newly acquired skills was considered an important variable in the transfer of learning. The Academic Motivation Scale (AMS) (Vallerand *et al* 1989) is based on the work of motivation theorists, Deci and Ryan (1985; 2000) who proposed a five factor model to conceptualise motivation theory. This included;

1. Amotivation;
2. External regulated motivation'
3. External introjected regulated motivation;
4. External identified regulated motivation and finally
5. Intrinsic motivation

The most simple self regulation description of motivation makes a clear distinction between the 3 principal motivational constructs (Amotivation; Extrinsic and Intrinsic).

Amotivation is the lowest form of motivation where the lack of clarity on why the individual is engaged in an activity is evidenced by their isolation and disinterest in the work. Amotivation is a lack of intentionality on the part of the learner and represents a relative lack of motivation.

To be extrinsically motivated is to be engaged in an activity which is viewed as a 'means to an end'. There is the expectation that on completion of a task, there is some external reward such as a promotion; qualification or greater recognition.

The final construct, intrinsic motivation, is the highest form of self regulation, where an individual is engaged in an activity for his/her own sake and the experience of pleasure in learning that it provides.

The basic motivation model of Deci and Ryan (1985) has undergone some refinement, with elements of extrinsic motivation now called 'Controlled' motivation and intrinsic motivation now referred to as 'Autonomous' motivation. In the development of the AMS, Vallerand *et al* (1989) suggested that intrinsic motivation could be reconceptualised as consisting of three constructs; to know; to experience and to accomplish new behaviours. They have developed a seven factor structure for motivation.

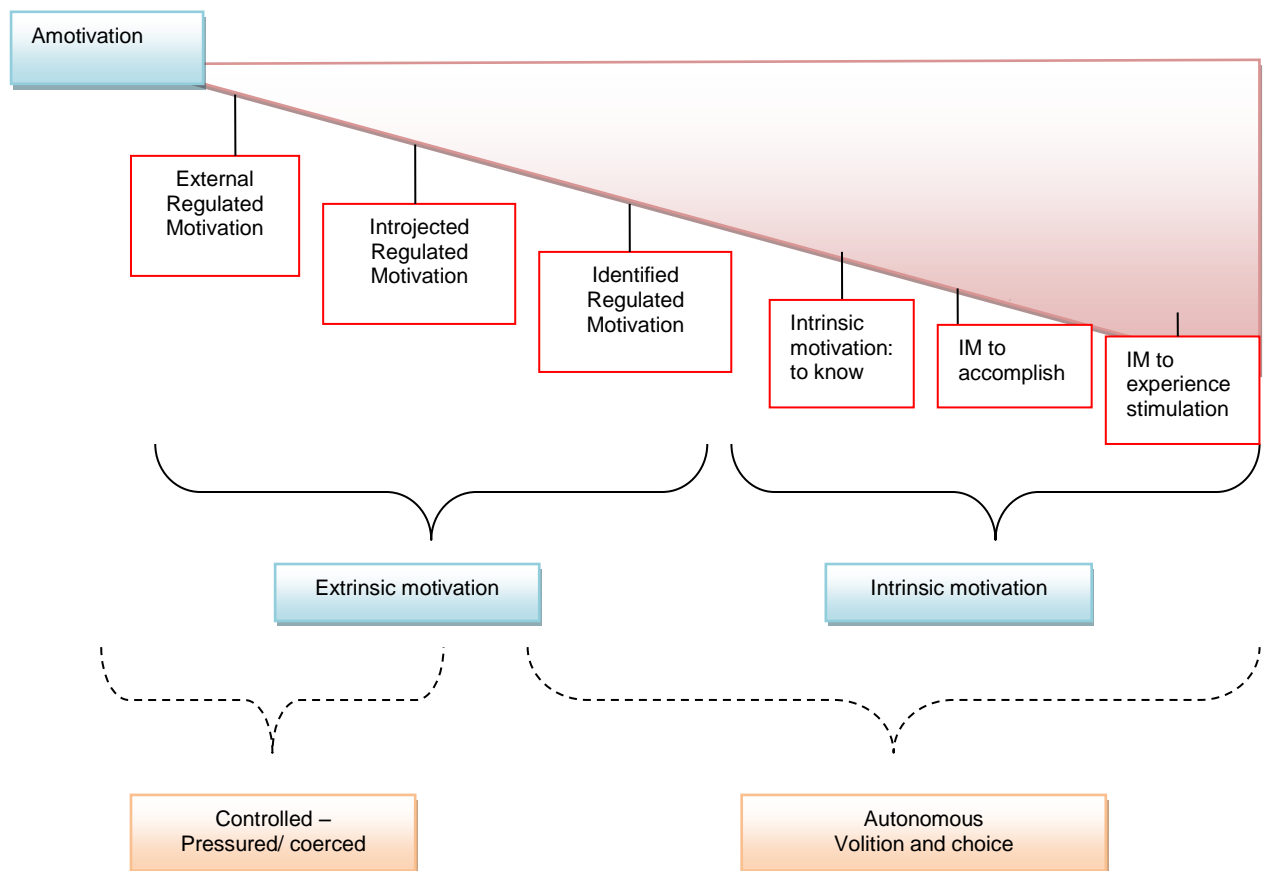
1. Amotivation;
2. External regulated motivation'
3. External introjected regulated motivation;
4. External identified regulated motivation and finally
5. Intrinsic motivation to know
6. Intrinsic motivation to experience new things and stimulation and
7. Intrinsic motivation to accomplish new behaviours

It is proposed that the further along the motivation continuum the person is, the deeper the knowledge and motivation to use new knowledge (see figure 7, page76).

The AMS contains 28 items (4 items per sub-scale) on a 7 point Likert scale. The scale has been evaluated for its validity by Fairchild *et al* (2005) who suggested the scale had good construct validity with completed data fitting well into the expanded 7 factor model (the AMS distinguishes between the three aspects of intrinsic motivation).

This suggested the link between motivation and educational outcomes is complex, but Guay *et al* (2008) suggested that intrinsic motivation and identified regulation were associated with lower dropout rates of academic courses.

Figure 7. The theory of Self Regulation: the three principal factors of motivation



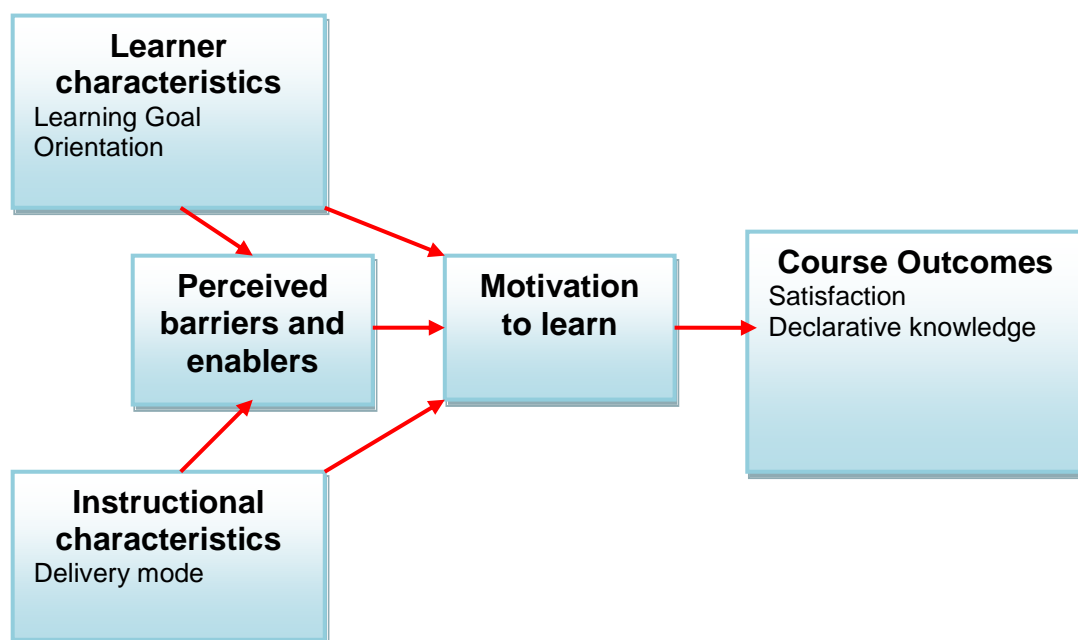
(Based on Vallerand *et al* 1993 and Deci and Ryan 2002 Page 41).

Klein *et al* (2006) proposed a model of motivation (figure 8) which identified the key characteristics of learners/trainees, the work setting and the training programme that were critical features to the impact on practice delivery. The model they presented included a centrality on the motivation to learn. A fundamental question related to whether it was enough to be motivated to learn to guarantee the performance in practice? The training motivation model of Klein *et al* (2006) proposed that motivation to learn had a direct effect on learning outcomes. However whether such learning outcomes,

could be utilised by learners when they returned to their practice settings was not considered and so it remained questionable whether ‘transfer’ was a ‘present’ aspect of the model.

This provides the link to the contextual approach, identified by Schunk *et al* (2014) and the role of interaction and the social dimension of the work and ‘classroom’ settings. The social milieu, according to Schunk *et al* (2014) is a critical modifier in either supporting or inhibiting learners to access, use, maintain and develop their new learning.

Figure 8. The conceptual model associated with Training Motivation Theory



(Based on Klein *et al* 2006 page 668)

In the above model, ‘motivation to learn’, related to desire of the trainee to develop a deeper understanding of the programme content. It was the desire to engage in the activities of learning, with (Klein *et al* 2006) who proposed that *Learning Goal Orientation* had a strong association with motivation to

learn. Klein *et al* (2006) identified high levels of Learning Goal Orientation in trainees were associated with those learners who focused on gaining competence, developing new skills and becoming masterly over their craft. They were individuals who actively sought out challenges and to overcome obstacles. However, there was no evidence that the learning goal of the individual was matched with the training outcome (Klein *et al* 2006). The IAPT trainees were faced with motivational goals at the beginning their training in that all trainees were guaranteed a promotion on completion of the training programme. Such 'hard rewards' could have had a direct or indirect impact on the achievement of learning goals.

A further aspect of the work of Klein *et al* (2006) was the static nature of Learning Goal Orientation (it is either present or not) this bi-modal orientation may present a too simplistic articulation on an individuals' motives for action. Motivational forces may be highly complex and subject to 'threats' in the work setting. Maintaining fidelity to a new set of training skills was challenging in the face of organisational pressures. The study by Gamble (1997) found that despite engaging in a significant (and expensive) skills training programme in mental health, students were unable to maintain their performance when faced with the 'threat' of organisational operational requirements and a lack of formal organisational support. The personal motivation construct may be significant but may also be seen in alliance with ideas of 'identity'. The Prime Theory as proposed by West (2006) suggested that being motivated to maintain an identity is a critical feature in continuing to perform new behaviours. Verplanken and Holland (2002) provided six independent experiment analyses which appeared to provide experimental support for the

centrality of self-identity and personal values in decision making, motivation and behaviour. They demonstrated that the strength of the desire/motivation to act was the critical feature and this goal was more likely to be accomplished if it had a strong values centrality in the self-identity of the individual.

In the meta-analysis of 148 studies, Verplanken and Holland (2002) examined the relationship between motivation and transfer in professional training. In the analysis, motivation was conceptualised over nine dimensions: motivation to learn; motivation to transfer; pre- and post-training self-efficacy; mastery orientation; performance orientation; avoidance; orientation; expectancy and instrumentality.

They noted that correlations were higher when the training focused on declarative and self-regulatory, rather than on procedural knowledge. They also stated that learner-centered, socially supportive environments tended to show positive correlations than did knowledge-centered environments.

The focus of educational interventions was associated with behavioural reinforcement or change, cognitive change and operational opportunity (Michie *et al* 2011). Educational programmes such as the one prescribed for IAPT were intended to deliver behavioural cognitive and attitudinal change. How these constructs were identified and clarified was important, or how else could an educationalist; a practitioner; a manager or even a client know whether such a change has been achieved (Michie *et al* 2011)?

In the examination of learning transfer, this thesis makes a clear link to the concept of behavioural change. Therefore the link between motivation and behaviour change theory was explored. In their analysis of behaviour change

interventions (which include cognitive aspects of development) Abraham and Michie (2008) noted that implementation programmes lacked sufficient detail or clarity on actions thus making replication of studies problematic. They noted interventions such as;

'class discussion', 'counselling sessions' etc. 'such descriptions mask procedurally and theoretically distinct designs and so fail to highlight techniques that may be critical to effectiveness' (Abraham and Michie 2008 page 380).

Analysing educational interventions that were designed to achieve (the target) and how the intervention was implemented (the action) was an important issue for research. The role of motivation as a key component in energising action had a long history in educational psychology research (Graham and Weiner 1996). Motivation theory suggests that this is a personal response to engage, commit and persist at a task. However personal reasons for doing so may rest on a number of complex motivational and social interactions (Vallerand and Ratelle 2002).

While various theories of motivation exist; e.g. *'Self Worth'* Covington (1992) *'Self Efficacy'* (Bandura 1989) *'Self Regulation'* Deci and Ryan (2002) there appeared to be a consensus that *'motivation' per se* was a critical construct in understanding the actions of individuals, their behaviour and cognitive response to development and change (West 2006).

Section 2.5. A critical analysis of the literature relating to ‘Destination’: the workplace aspect of ‘transfer’

The interface between ‘communication’ (the training programme) and ‘destination’ (the work setting) is at the heart of the transfer process. Myles and Milne (2004) consider ‘generalisation’ to be preferable term for transfer. They consider transfer not to be a simple process but one of negotiation in an environment which actively enables transfer of new learning and general application;

‘it has been found repeatedly that the clinical environment to which a trainee returns has an important impact on the transfer of training. When trainees return to work there are a number of constraints that they may encounter that will serve to reduce the transfer of what has been learned’ (Myles and Milne 2004 pg. 178).

This view was supported by Coffield *et al* (2007) who proposed that professionals face competing demands from Government policy, professional and institutional /employer led initiatives and these add to the complex elements that affect the transfer process.

This section of the literature review considered this transition and terrain in the potential transfer process. The issues that link the training and the work setting were examined and a number of key papers on the training of CBT skills, critiqued.

2.5.1. Transfer of learning in the workplace

Transfer of learning occurs when prior-learned knowledge and skills affect the way in which new knowledge and skills are learned and performed. The seminal work of Baldwin and Ford (1988) considered positive *transfer of performance* to be the critical criteria. Any failure of training was only characterised by a lack of positive outcomes in *role* delivery. Transfer, using this approach would minimise the role of humanistic adult learning as a key outcome (Ford and Weissbein 1997).

Ford and Weissbein (1997) noted difficulties with the 'criterion problem' of transfer analysis, which briefly stated was a lack of attention to defining the multi-dimensional nature of the transfer of training; the ability to adequately operationalise what was meant by 'transfer' and the lack of systematic measures with which to monitor and analyse research results.

This focus on performance measures as the key explanatory method for researchers is evident in the work of Cheng and Ho (2001) who stated that greater effort should be made to gain a deeper statistical understanding of the transfer process. However, it is clear that the interplay between trainee personal characteristics, the training programme itself and the context of the work environment would indicate a complex topography where the isolation of distinct variables for independent study would be highly challenging. Alternative methods could provide a vehicle for greater understanding of the transfer process.

To re-emphasise the methodological challenges in thinking purely in quantitative terms for analysis, various types of transfer are identified. Apart from being 'positive' or 'negative', other terminology included '*near*' and '*far*'

transfer. This related to whether the transfer was used in similar or different situations from that of the training programme (Broad and Newstrom, 1992). Foxon (1987) has written about 'horizontal' and 'vertical' transfer, which identified whether the trainee had become adept at utilizing similar or higher skill application from their original training.

2.5.2. Operationalising the transfer of training/learning: what are the criteria?

Examination of the theories of transfer, have in the main, relied on the ability to view and measure transfer as a dependent variable. Work in this area has been prolific within the field of organisational psychology with one framework dominating: Kirkpatrick's (1967) four-level model of training evaluation.

This model was extensively used and developed as a simple articulation of the key components required for efficient evaluation of training interventions (Kirkpatrick 1996). Researchers such as Brooker and Brabban (2004) used elements of the Kirkpatrick model to review the impact of a range of psycho-social intervention training in England.

For the evaluation of training, the model consists of 4 elements:

Reaction to training (level 'a') where evaluation was classed as processes which gauged the learner's initial reaction to the training they had completed.

Changes in Learning (level 'b') articulated a range of evaluation processes aimed at understanding whether or how much the trainees had learned through the training; a change in knowledge level.

Changes in skills or behaviour/performance (level 'c') referred to evaluation processes aimed at charting whether the learners 'work related' behaviour had changed, and,

Changes in results in the organisation/impact (level 'd') identified evaluation which charted changes in the working of an organisation as a response to the training programme.

Kirkpatrick's (1967) levels-based approach proposed that level 'a' (reaction) represented participants' perceptions to the impact of the course. Such data were usually collected immediately after training to ascertain the subjective experience to the training/educational programme. This could include collection of brief questionnaire data or verbal responses for later analysis. Reaction information is simple to collect and analyse and can provide information back to commissioners/managers who had sponsored a programme. This is by far the most pervasive of the evaluation/transfer processes conducted by organisations, mainly due to its simplicity of collection, analysis and reporting.

Despite its pervasiveness, this level of analysis holds some significant weaknesses. Most fundamental is a question of what participants were satisfied or dissatisfied with? - was it the *design* or the *delivery* of the training course? A reaction evaluation will give little or no information about the potential of the programme, or about whether participants could take information and skills and transfer them in their practice.

A satisfied participant *may* be more motivated than a dissatisfied one to consider application of new knowledge or skills. Therefore the link between

'reaction' and 'motivation' may be an important consideration in research design.

Changes in learning (level 'b') in the four levels approach, related to the extent to which there was new or improved knowledge and skill in the participant learner. More detailed post-testing (and logically, some pre-testing too) represented a step wise increase in complexity from the level 'a' approach. This explained why this approach was not routinely conducted in many education/training initiatives. The purpose of this level was to validate the intended learning outcomes and provide evidence of progressive learning on the part of the course participant.

The changes in skills or behaviour/performance element (level 'c') involved the testing of participants' ability, capability or competence to perform new or refreshed skills. A level 'c' behavioural evaluation would test whether participants were able to *use* what they had learned. The focus of this analysis was the consequence of learning and so represented an increase in complexity from previous levels. The focus was on the learner, but not the social context. Therefore a level 'c' analysis would provide little information on enablers or barriers to behavioural implementation of new skills.

The final level (Results - level 'd') represented a comprehensive assessment of the training programme as a whole. It was an assessment of the impact for the organisation, in terms of employee performance and financial improvement of the organisation; the Return on Investment (ROI) (Phillips 1997).

Critics of this approach have questioned whether an emphasis on the 'bottom-line' is a helpful measure of results from a educational programme, with

Kaplan and Norton (2001) suggesting that a 'balanced scorecard' approach with improvement in customer satisfaction providing greater organisational utility.

However there have been attempts to refine the model as the NHS Education for Scotland (2003) suggesting that in the current model, important 'pre-training' organisational and person-centred influences remain unaccounted for.

There have also been some more fundamental critiques of the Kirkpatrick model. Reaction to training is the most frequently used vehicle for evaluation and Holton (1996) has criticised this as being a very low level or negligible indicator of transfer. The four level approach has also been criticised for its lack of utilisation; Bassi and Van Buren (1999) reported that the majority of studies used only 'reaction' and 'learning' indicators (levels 'a' and 'b'). They questioned whether this lack of full utilisation was sufficient to argue whether transfer of learning was taking place. Holton (1996) also criticised the model for its simplicity and argued that it does not describe the full range of factors which either inhibit or facilitate transfer of learning. Others had noted that the linkage between the levels was not clearly articulated and the relationship was not necessarily hierarchical (Alliger *et al* 1997).

The pervasiveness of levels 'a' and 'b' in health service education evaluation could be based on the relative ease by which evaluators could collect the data. To delve deeper into additional levels raised levels of complexity which might be beyond the ability of many organisations.

2.5.3. An examination of training transfer for CBT knowledge and skills

The systematic evaluation of training programmes, particularly those associated with CBT and Psycho-Social Interventions (PSI) has been of long-standing interest to researchers (Myles and Milne 2004). This may be due to the explicit 'Scientist-Practitioner' model which has underpinned these therapeutic approaches (Barlow, Hayes and Nelson 1984) and the advocated clinical techniques such as single-case experimental designs (Hersen and Barlow 1976). A number of studies have been completed in mental health. Brabban and Brooker (2007) completed a review of PSI training, Milne *et al* (2000) studied the transfer of training in CBT and Hughes (2007) reported on an evaluation on the effectiveness of Dual Diagnosis training. These programmes shared a number of components as they were developed using a 'manualised' approach to the delivery of core therapeutic skills. This means the treatment programmes were controlled and therefore training could be delivered in a structured way using a manual as a guide to therapy practice. They also tended to be skills or competency and knowledge based and therefore learning outcomes from training could be tightly controlled and open to scrutiny by structured evaluation. The level of detail in training manuals has been the subject of criticism however, West and Michie (2010) argue that without sufficient detail in training manuals it is impossible to evaluate whether skills have been actually achieved or whether behaviours had changed.

Maunder *et al* (2008) noted that programmes which are purely skills, technique or 'procedural' based tend not to obtain the same transfer results as

those that also concentrate on conceptualising the therapeutic approach and seeing treatment provision within a wider philosophical practice context.

In one study Myles and Milne (2004) sought to examine the utility of a brief (12 week) CBT training programme on the practice of trainee participants. They examined 6 cohorts (totalling 78 active participants) using pre-training measures (3 months prior to training); measures on the first day; measures at the end of the final training day and lastly again at 3 month follow-up. All measures were self-report and administered and analysed by one of the course leaders. The research measures analysed reaction to the training programme, knowledge gain and a self assessment of their ability to transfer their learning. There was a clear link to the levels proposed by Kirkpatrick (1998) in 'reaction' assessment (level 'a'); knowledge gain ['changes in learning'] (level 'b'); and practice 'behaviour' (level 'c'). The authors used a range of approaches to explore these issues including questionnaires, Multiple Choice Questions (MCQs) and Video Assessment Tasks (VAT).

Myles and Milne (2004) sought to examine course relevance (perceived content validity) and barriers to implementation through a 'generalisation' questionnaire (opportunity to use). They reported that institutional constraints were the most significant barrier to implementation, but the authors did not go on to state what these constraints were. They noted that no direct observation of trainee behaviour was used and that data sets were incomplete. There was no attempt to assess whether the training had a direct benefit for patients.

A randomised control trial was conducted by King *et al* (2002) with a sample of 84 GPs using CBT. Patients of the GPs in both arms of the study (the GPs

who received CBT training and those who did not) were monitored to see if they experienced better outcomes following training. The training course was short (two days) and sought to raise awareness of CBT and teach very basic skills that could be used in the consulting room. Training effectiveness was measured using a depression attitude scale and a knowledge of CBT scale developed in a pilot study by the authors. The GPs were taught a range of topics relevant to CBT, such as, the clinical presentation of anxiety and depression; common causes, anti-depressant treatment; CBT theory; assessment of presenting problems; cognitive re-structuring and problem solving techniques.

Following analysis, the researchers could find no evidence of improvement in either of the experimental groups nor any positive impact on patients. They suggested that training transfer is challenging for GPs and teaching CBT cannot be completed in this basic manner.

The above study (King *et al* 2002) made an attempt to monitor improvements in practice, as measured by patient outcomes (positive personal outcomes) and application of knowledge. The complex interaction of possible transfer factors did not feature in the analysis. No attempt was made to explore the level of peer support or whether the GPs felt they had the capacity to transfer new skills.

A recent analysis of the methodological challenges faced by the transfer of CBT into routine practice was produced by Rakovshik and McManus (2010). Issues related to 'therapist competence' were not defined terms and nor were uniform procedures for assessing therapist competence. Therefore, for these authors, training transfer made little sense since there was little in the way of

agreement on what exactly trainees are supposed to transfer. Training transfer therefore made little sense therefore since there was little in the way of agreement on what exactly trainees were supposed to transfer. Training programmes (such as those used for IAPT) were derived from complex training protocols used in RCTs and such packages contain both therapeutic and inert components with limited potential to distinguish between them (Longmore and Worrell 2007).

The 'destination' section of the framework related to the working practices and work environment of IAPT practitioners. It represented the destination point of the skills based educational programme in which they have been engaged. It was in the workplace that practitioners sought to integrate their new knowledge and skills. The workers may be in a position to further develop their identity as IAPT or psychological therapy workers. A common theme in the above review of literature is the relative lack of analysis of the workplace 'destination' and the potential impact on enabling or inhibiting learning transfer. For the analysis of the transfer of learning process, the work environment was subjected to significant external pressures, (the area of 'influence') politically; economically and socially.

The healthcare workplace was a critical aspect of care delivery with a focus on quality of provision. Reviews on the quality of NHS care and IAPT services both in terms of service and workforce provision (Department of Health 2008a; 2008c) had noted the improvements in facilities and practitioner numbers. They also provided an analysis of some less tangible qualitative indicators of quality in the NHS. Patients report feeling like a number rather than a person and care often falls short of feeling personalised, respectful or

dignified. The national reviews (Department of Health 2007c 2008c) proposed development of a personalised NHS where people had their condition explained to them, where they did not feel lost in a system and received high quality 'customer care'. This focus on personalised high quality care might be compromised with the challenges of '*structural*' change (the location of care delivery) and '*process*' issues (how care is delivered). This is addressed with consideration of core quality elements on which the service was founded, such as care and treatment skill delivery; rooted in promotion of dignity and respect; '*the value base*'.

The issue of quality of human care services and societal and technological developments in healthcare is an international one. It had been explored in a systematic review of general practice care on 19 studies over a 30 year period (Wensing *et al* 1998). The review noted that 'humaneness' was the most highly ranked factor of patient priorities in 86% of the studies, followed by competency (64%) involvement/participation in decision making (63%) and time for care (60%). The existence of a pan European group exploring patient evaluations and reaching consistent conclusions on patient dissatisfaction with services, provided an indication that the quality agenda was not unique to the NHS in the UK (Grol *et al* 2000).

The views of personnel in health care services, have been surveyed in relation to quality of care. The Joint Medical Consultative Council and the NHS Confederation reported on the clinical vision of the current NHS reforms (JMCC/NHS Confederation 2007). They suggested practitioners did not necessarily feel extra resources were warranted, but felt frustration in their ability to make reforms a reality. This emphasised the power of external

forces within the theoretical model to influence practitioner behaviour. Health care professionals noted resistance from colleagues in accepting reform along with a management culture which was risk averse, and significant work load pressures on personnel. Such issues made adequate provision for engagement, reflection and acquisition of new skills and attitudes difficult to achieve.

Within the IAPT landscape specifically, government policy developments added to this dynamic work environment. The introduction of the 'Any Qualified Provider' (AQP) (Department of Health 2011c) process into commissioning of services fundamentally changed service provision. The growth of private and not for profit treatment providers increased the range of providers in the primary care mental health market-place. This policy sought to increase choice for service users (including the engagement of private healthcare providers) but may also have created issues for existing IAPT workers in terms of job security. For employing organisations, AQP increased cost and quality pressures (Griffiths *et al* 2013). The Department of Health, which had promoted AQP articulated that the core AQP principle was on quality not price as all providers are paid the same either from a national tariff or by local agreement with commissioners. Reynolds and McKee (2011) noted the new AQP commissioning arrangement had brought significant degrees of complexity to the commissioning process and created a challenge to provider commissioning in a tax based health system (such as the NHS) that has never previously been attempted anywhere in the world;

'One reason why commissioning has not been rolled out elsewhere is that it is difficult to do well; indeed the mixed record of commissioning by PCTs lies behind the enthusiasm among some GPs for an alternative. But will they have the time or the expertise to make this work? Commissioning is potentially very complex, as evidenced by the Department of Health guidance on commissioning roles and responsibilities. If done properly, it requires a combination of skills in assessing needs, designing packages of care, taking an overview of local service provision to ensure that decisions on one service do not undermine the ability to deliver others and evaluating what is delivered. Then follows the process of negotiating contracts that are affordable and deliver what is wanted, monitoring compliance with them, ensuring cash flow and keeping spending within budget' (Reynolds and McKee 2011 page 7).

It should be added that the AQP process would multiply this set of roles and responsibilities by the number of new providers in the market who all required a distinct negotiated contract. The impact of such policy changes to primary care mental health services may challenge the workforce to transfer their learning. The culture of the work setting may prove to be a significant element in the transfer process and this 'culture' would not be immune to the external pull and push aspects of healthcare 'influence'.

This issue of 'culture' is a term often cited as critical in the healthcare environment. In the Mid-Staffordshire NHS inquiry, it was the most often used word in the final review (Francis 2013). However important the 'culture' of an organisation or workplace might be, there is little consensus on the precise meaning of the concept (Scott *et al* 2003). When considering organisational culture, the following assumptions are important:

- History and tradition are important
- Interpretation is critical in understanding the workplace or organisation
- Collective and shared perspectives of group members particularly in relation to workplace practices, and

- Perspectives are subjective and emotional as opposed to rational.

(Alvesson 2013 pg4)

Alvesson (2013) noted that culture is not inside people's heads, but rather '*somewhere between the heads of groups of people where symbols and meanings are publicly expressed*' (Alvesson 2013 page 4).

Various perspectives on workplace 'culture' exist with Davies, Nutley and Mannion (2000) and Leonard, Graham and Bonacum (2004) noting a number of key themes which had resonance on workplace or organisational culture; 'identity' 'leadership and supervision' and 'role performance'.

There were pressures on clinical practice teams as they sought to react positively to organisational demands on service delivery targets and from changes in expectation from service users and their carers. Any sense of hopelessness or failing to meet high expectations may have adversely affected clinical teams and increased the likelihood of 'burn-out' and emerging 'cycle of failure' (Edwards *et al* 2001).

2.5.4. Personal characteristics: identity and burn-out

The concept of 'identity' has multiple perspectives (du Gay, Evans and Redman 2000) and it was unknown in this research, to what degree it had relevance to an IAPT practitioner. The relationship between the IAPT worker identity and their behaviour in transferring training to practice was also previously unanswered. Jenkins (2008) had identified that our self-concept of

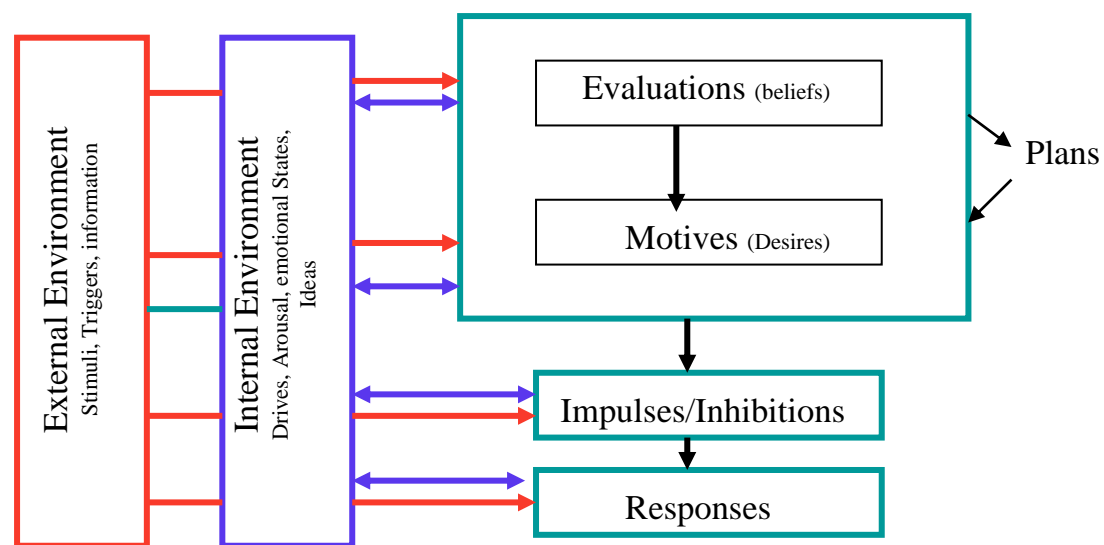
identity was never neutral – it was always in relation to ‘the other’ and it was in that difference that identity mattered to people. Others have argued that the concept of identity was too vague to have any significant meaning and that individual and group identity was not homogenous and shared intentions cannot be defined with precision (Brubaker and Cooper 2000). Within the sociological literature, the social constructionist perspective identified that while there may be difficulties in a precise definition of terms and significant methodological challenges in isolating and researching the concept of ‘identity’, it is a concept that *matters* to people and one against which those who challenge it, have failed to raise an alternative (Jenkins 2008).

Identity is a mental representation of ‘who we are’ and how we describe ourselves. It is not fixed and IAPT workers may possess multiple identities (husband; wife; carer etc.). As West (2006) has noted, the self (and social) identity is related to our motivation, as the stronger our emotional and motivational pull towards our ‘identity’ the stronger the persistence of behaviour which is consistent with it. This idea has been replicated the empirical findings from Verplanken (2004) in a study of the caring behaviours of nurses and the strength of their values to their role.

The model of motivation proposed by West (2006) (figure 9, page 96) promoted the external environment as a significant stimulus to challenge or threaten core identity and associated behaviour. These ‘threats’ come in the form of ‘moment by moment’ challenges which in order to maintain a focus on delivering behaviour which is consistent with a core identity require attention and review (West 2006). IAPT workers may have had an identity as psychological therapists who delivered talking treatment but the internal

(‘*destination*’ in the Fixsen *et al* 2005 model) and the external (‘*influence*’ in the Fixsen *et al* 2005 model) environments presented challenges or threats to this identity, by dint of external and internal political, social and economic pressures.

Figure 9: Human Motivation (Prime Theory) based on West and Brown (2013 page 196)



West (2006) identified PRIME theory as a synthetic theory, in that it is capable of integrating other conceptions of motivational theory, therefore acting as a ‘pegboard’ to which other theory can be incorporated. The PRIME theory proposes that motives are made up of the following interaction;

- a. **Plans:** These are representations of what was hoped to achieve. They provide a structure to our motivations and goals, but plans on their own are insufficient in instigating and maintaining change. Plans need to engage with ‘Motives’ and ‘Evaluations’. This is a dynamic and complex interaction that happens in real time during any encounter and

within the influences of the system (such as figure 3, page 25). The external world in terms of the political, financial and social dimensions can have significant impact on how individuals think about their plans, their future desires for their work and how they evaluate the worth of their activity.

- b. **Responses:** relates to our maintenance of behaviour, either, starting; stopping; modifying or continuing. Responses can be either reflex driven or derived from other elements in the motivational system.
- c. **Impulses:** are linked to 'responses' in that they are consciously experienced as urges to act. Impulses are 'action schemas', a desire to act that may derive from two sources: internal stimuli that signal physiological needs (i.e. hunger), and external stimuli that either offer an amplification of the impulse to act or draw attention away from them.
- d. **Motives:** motives in conscious awareness are viewed as 'wants' 'desires' or 'needs'. Such motives have a degree of valence associated with them in terms of attractiveness of repulsion. The desire to act as a good therapist, to do the best for a patients forms a mental representation of a motive that may drive the behaviour of a worker.
- e. **Evaluations:** evaluations do not have a direct influence on behaviour, only through our motives. The evaluation of being a good therapist would not direct that behaviour on its own, it must be paired with a motivation (motive) to act. Importantly, that motive to act, to fulfil an evaluation, must be sufficiently strong to overcome external influences

which may act as inhibitory forces, such as the area of influence within the theoretical model (Fixsen *et al* 2005).

Utilising West's model (West 2006) education programmes such as the IAPT programme, designed to create behavioural change should:

1. induce a feeling of 'desire' or 'need' to change;
2. create an 'impulse' to initiate change;
3. create a lasting 'commitment' to the change based on the shift in identity, and
4. trigger 'supportive activities' (such as supervision) that can sustain the plan to change and regenerate it when appropriate.

The clinical work environment (*destination*) is full of challenges which may inhibit the transfer process. Therefore supportive processes such as supervision of IAPT practitioners may present a significant factor in maintaining transfer behaviour.

Hoare (2002) identity is a sense of self naming, a sense of who a person is in society. The principles can be applied to professional groups too. Professional identity development occurs over the career of an individual, with its roots in the initial exposure to the socialisation processes of the profession during initial training. The majority of IAPT trainees in this study were previously trained in different professional groups (Nursing, Occupational Therapy, Psychology etc.) and so the issue of primacy of identity was of interest. Parry *et al* (2011) concluded their extensive study of the IAPT demonstration sites with a statement that if IAPT services (and therapists)

were to continue the initial success of the initiative, a stronger sense of identity in primary care would be needed. IAPT teams and individuals were not well knitted in within the service network and this, they concluded, would be detrimental to the service over the longer term.

Bucher and Stelling (1977) identified some key themes in the development of professional identity. They suggest that mastery through being able to perform the professional role; 'role-playing' is a critical aspect, as is the sense of autonomy and responsibility for professional practice. A central function of 'role-play' is the sense that a professional is making a valued contribution to the practice environment. Without a sense of importance, mastery and thus professional identity will be compromised. Finally, the greater the sense of mastery the increased chance that individuals will wish to contribute to the development of the profession through knowledge production.

However, the development of a new and innovative service, in a relatively new location (primary care) provides a situational context where the achievement of professional role identity is threatened. Role conflict and role ambiguity are potential factors which may have an impact on the performance of IAPT therapists and services. The consequences of this include the potential for a reduction in job satisfaction, a sense of demoralisation and job burn-out (Ortquist & Wincent 2006).

In attempting to define burn-out, Maslach et al (1986) identified three core components of burn-out: Emotional Exhaustion (EE), Depersonalisation (DP) and Personal Accomplishment (PA). EE relates to a sense of overwhelming exhaustion caused by the over-use of emotional and physical care giving. DP has a relationship to the feeling of cynicism about aspects of work and finally,

PA is related to a lack of fulfilment about job performance (Maslach et al 1996).

There is a lack of consensus on the mechanism of burn-out, but all models utilise the three elements above though with different relationship hierarchies or interactions (Golembiewski and Munzenrider 1988; Leiter and Maslach 1988; Lee and Ashforth 1993). Despite this, all place Emotional Exhaustion (EE) as the central component (Berry, Barrowclough, and Haddock, 2011).

There remains a challenge to the assumption that caring processes contribute to burn-out with some researchers identifying the positive aspects of caring. Leiter, Bakker and Maslach (2014) identified a number of benefits related to care giving behaviours, such as the opportunity for important and engaging interaction and the positive aspects of learning and developing new knowledge and skills from others.

Despite these differences of emphasis, there is consensus that burn-out has significant consequences for individuals and organisations. Burn-out has important implications for staff, service users and organisations. Schaufeli and Enzmann (1998) were unable to locate a conclusive link between staff burnout and personality characteristics; workload, absenteeism and impact on personal life. More recently though Edwards and Burnard, (2003) and Rose *et al* (2004) identified a relationship between low staff morale and negative responses to service user behaviour.

Professional burn-out was not a major theme of the Human Resource Management (HRM) literature on transfer of learning and this may be a reflection on burn-out as a construct being more associated with formal caring professions (Kilfedder, Power and Wells, 2001). As a consequence HRM,

with its focus in industry may not attend to this issue. Yet a review of the general health literature identified the potential for emotional exhaustion in the development and delivery of new services. Therefore an additional data-base search using the 'Find it at Lincoln' facility was used. This is an amalgamated search engine consisting of the majority of databases held by the library, including CINAHL, Medline, psychINFO, Science Direct and EbscoHOST.

Search terms included 'Burn-out', 'professional', 'IAPT', 'therapy*'. A filter on year of publication was set to 2007 to current 2015, as this was the timescale over which IAPT was in existence. The search provided 85 responses. Books, magazines and theses were removed which resulted in 55 returns. An abstract review was conducted on each of these and duplicates and non-UK literature removed. The final review left eight papers.

Printed copies of these eight papers were obtained and reviewed in more detail. Only one had an explicit research perspective on burnout and IAPT therapists. The study by Steel *et al* (2015) like many studies in the transfer field used a cross-sectional survey design. The study reported sufficient statistical power despite obtaining a return rate of 44%, however the authors included both IAPT therapists and Psychological Wellbeing Practitioners (PWP) within their analysis. These workers had different roles within the stepped care model and as such it might be concluded that they have different exposure to burn-out stressors.

Using three validated measures of work stress (e.g. the Maslach Burnout-Inventory) Steel *et al* (2015) set two hypotheses relating to the level of stress of IAPT workers related to other mental health workers and secondly the level of emotional involvement of therapists with their work. They found high levels

of 'Emotional Exhaustion' but low levels of 'depersonalisation'. The standard model of psychological burn-out (Maslach *et al* 1996) illustrates how a state of depersonalisation is necessary for burn-out to be evident. This depersonalisation is characterised by cynicism and a disengagement from the performance or work tasks. The study is limited further by the lack of attention to the social support available to practitioners (such as supervision) which can act as a mediator in the burn-out process.

Other papers in the search results were theoretical reviews or commentaries on the work of IAPT services (Bhanji, 2011) or opinion pieces drawn from psycho-analytic theory (Rizq 2012).

2.5.5. Leadership and supervision

The delivery of evidence-based practice for the promotion of improved client outcomes was a central feature of the IAPT programme (Clark 2011). The role of clinical supervision within health-care, had an historical link to the quality and governance agenda to promote service user safety and practitioner accountability (Bartle, 2000; Gray, 2001; McKeown and Thompson, 2001).

IAPT practice in primary care, like all healthcare practice, was a synthesis of codes of practice, good practice guidance, personal and professional values and scientific evidence. These competing factors were all set within a complex and challenging policy and commissioning context. Researchers, such as Scaife (2001) and Butterworth and Faugier (1992) noted that a primary function of supervision was ensuring client welfare and the professional and educational development of the supervisee, suggesting that

the educative role of the supervisor was important. This view was not universally shared with others who suggested that supervision should concentrate on the monitoring of performance standards (Bernard and Goodyear 2004).

Milne (2007) suggested 'supervision' had too many competing definitions which all lacked conceptual clarity, thus hampering empirical research and practice. He suggested four essential criteria for clinical supervision a shared understanding that clinical supervision should be *i)* precise; *ii)* specific; *iii)* operational, and *iv)* corroborative. Milne (2007) sought to provide an improved working definition of supervision and in doing so identified the following key themes that characterise the supervisory process;

'a formal relationship process which managed; supported; developed and evaluated the work of colleagues. The objectives were 'normative' (quality control); 'restorative (encouraging emotional processing) and 'formative' (maintaining and facilitating supervisee's competence and capability) (Milne 2007 page 439).

This approach had considerable overlap with the model proposed by Proctor (1994; 1998) and was supported by systematic reviews of the supervision literature (Butterworth *et al* 2008).

2.5.6. Feedback

Within the conceptual framework of this study (figure 2) the issue of 'feedback' occupied a pivotal role. The IAPT programme may have been unique in health service delivery through the requirement of IAPT therapists to obtain outcome measure scores from patients at every treatment session. The requirement followed directly from the pilot programme where the Patient Health Questionnaire Depression Scale (PHQ-9) (Kroenke *et al* 2001) and the

Generalised Anxiety Disorder Scale (GAD-7) (Spitzer *et al* 2006) were utilised.

These data were collected and reported nationally, which constituted a public affirmation of the importance of concern for the programme and associated bureaucracy. This data collection, or feedback loop, enabled the Department of Health (2012b) to produce a detailed report on the first million patients who accessed the IAPT service. In addition, the feedback process was designed to monitor patient satisfaction (via the 'Healthwatch' organisation) and symptom outcomes through analysis of the two clinical scales. The assumption was that unexpected poor treatment outcomes might indicate non-provision of evidence based psychotherapy for the common disorders of anxiety and depression. Collection of routine data also provided the opportunity to monitor the number of people accessing the service. This allowed the Department of Health to conclude that a million people accessed the service, a number which fell short of that expected. A previous target had identified that the IAPT service should be treating over 900,000 people annually and a recovery rate of 50% should be expected.

Clearly a focus on targets added an extra dynamic to the practitioner–patient relationship. The requirement to achieve patient through-put and recovery may form an important element of analysis. What is it to 'recover' through the help of an IAPT service? According to the Department of Health it is to show a significant improvement in symptoms through the appropriate utilisation of stepped care – the right treatment for the right severity of the condition in the right amount of time. People 'moving towards recovery' had been defined:

'the number of people that were above the clinical cut-off before treatment but below following treatment. IAPT looks at change in a person, not just in a

syndrome. For this reason, an individual is defined as a case if (s)he scores above the clinical threshold on depression and/or anxiety at pre-treatment. Recovery occurs if that person subsequently scores below the clinical threshold on depression and anxiety' (Clark and Oates 2014 page 3).

Griffiths and Steen (2013) conducted a detailed examination of the national data set and noted three principle end points in making a judgment of the use of outcome data in IAPT:

- Benchmark A – a proportion of people who had completed IAPT treatment and who 'moved to recover' i.e. their clinical symptom scores fell below 'caseness'. The national data indicated a recovery rate of 44%.
- Benchmark B – a proportion of people moving to recovery who had accessed treatment. Using this figure as the denominator recovery reaches a percentage of 24%. Therefore a significant number of people enter treatment but leave before completion, however, 'completion' is not defined. When is treatment completed? – when an IAPT professional discharges a person from the caseload or when a patient decides they don't want or need the service?
- Benchmark C - a proportion of people moving to recovery who had been referred for treatment – using this measure the recovery rate fell to 12% as it was evident that large numbers of people were referred to services (or referred themselves) but had no subsequent contact.

There was no consensus on what constituted the most accurate figure of recovery within the IAPT programme. This complexity of key performance

indicators of the programme remained an issue for commissioners, managers and practitioners.

2.6. Conclusion to the review of literature

Within this thesis, transfer of learning was an issue situated within the workplace – it can only take place in the work setting - and as such includes both the personal self-reflecting cognitive domain and the social aspect of work, within which a learner is engaged. Understanding this social *culture* was critical to the individual response to learning and also therefore to their transfer behaviours. The work of clinical teams has received considerable attention (Anderson and West 1994; 1998; Bower *et al* 2003) but little research has explored team work in relation to the generation and maintenance of an identity following an educational programme. The relationships within the (IAPT) workforce are viewed as important carriers of a personal/professional identity. Our 'personal' identity is always social' - our personal individual identity is always set within a *dialogue* with an *other* (Jenkins 2008). No one person's identity (no matter how individual) can be divorced from that individual's relationships with other people; we are bound in social relationships. These social relationships are bound up in a complex mix of previous practitioner identity (Counsellor; Nurse; Occupational Therapist; Primary Care Mental Health Worker etc.) and the present workforce role; an IAPT therapist. The methodology for this thesis sought to examine the personal characteristics, such as identity, which may have played an important role in the transfer of learning and whether the identity as an IAPT therapist had been accepted, rejected or reframed.

The introduction, proposed that examining this study through the prism of Implementation Science (IS) offered a rationale for integrating different, but complementary perspectives. Complementary literature sources from a variety of different disciplines were utilised to generate a comprehensive and deep understanding of the subject. Integrating literature and themes from disparate traditions such as organisational psychology, human resource management, sociology and social psychology is an elementary and necessary approach in Implementation Science. This synthesis of common expressions of key factors associated with the transfer of learning formed a key aspect of this study and were used to influence methodological considerations.

The field of implementation science has links, but is different from a range of related fields such as knowledge transfer, and knowledge exchange. The latter usually refer to the processes involved in the engagement of people who use and share knowledge. Implementation science has a stronger structural aspect in the examination of the above but also the factors which heed or inhibit the application of evidence or best practice in healthcare. Implementation Science has a unique position in attempting to examine the uptake of evidence based practice in real world situations. The evidence has often been accumulated in tightly controlled research studies, but the application of such interventions in routine practice is far from straightforward. Learning can take place alongside training (Baldwin and Ford 1988) but the IAPT national training programme was designed to provide a performance output which had a direct impact on practice and a positive return on the investment for the policy implementation team. What had been transferred

and the general process by which this took place, was the focus of this analysis. Transfer of learning must have involved a cognitive process and a desire (volition) to take on new learning and implement it in a practice situation. Some intrapersonal factors that signify each learner as unique, may have been in play on the part of the learners. Some interpersonal factors were also evident, in that the learner must have engaged in some activity with others and thought the learning opportunity was sufficiently important as to seek engagement with the material.

Therefore a literature which explored personal characteristics and the social dynamics of the work and learning setting were considered to be important. An examination of the information on transfer of learning indicated that a simple linear evaluation of education using the stages proposed by Kirkpatrick (1968) would offer little in the way of a new and innovative method. Similarly the systems model proposed by Holton *et al* (2000) while offering a comprehensive overview of the transfer process gave little significant attention to the social domain of the worksetting, nor the external world which may impinge on the transfer process. The theoretical model guided the literature review in order to provide a greater account for these aspects. The issue of motivation was explored in greater depth as a psychological construct. The COM-B analysis of West (2006) identified motivation as a key component of behaviour change (and transfer of learning is about behaviour change). This analysis also focused on the role of 'identity' as a maintaining factor in transfer fidelity, or the continuance of new behaviours, even when faced with challenges or 'threats' to fidelity of identity/transfer. The previous literature review was used to guide decisions about methodology as the study sought to

add a new dimension to the transfer of learning literature in mental health services.

Chapter 3. Methodology and methods

This chapter provides an in-depth analysis of the methodological issues pertinent to this study, including a rationale for the approach taken and a review of complex adaptive systems; case study design and mixed methodology.

Comprehensive and systematic reviews of educational transfer are rarely achieved due, quite probably, to the complex mix of variables inherent in the transfer process (Burke and Hutchins 2007). The theoretical framework (figure 3, page 25) identified that practitioners (and teams/services) may be influenced by external political, social or economic forces. Additionally, individual practitioner characteristics, such as level of motivation, may have significant bearing on the transfer process. Within the work-setting, there may be barriers or enablers (such as levels of management engagement) which inhibit or support the transfer process.

3.1. Methodological considerations

The development of the IAPT initiative focused attention on developing services and a workforce in primary care (where previously none or very few existed). Both these strands of policy programme implementation contained challenges. The IAPT service development required encouragement of potential providers to 'enter the market'. These providers had limited experience of psychological therapy treatment provision in primary care, since

previously no formal service had existed. Additionally service providers were working within a policy context which was not established; given that the IAPT initiative was seeking to create a footprint and establish itself alongside other services.

IAPT services sought to create an entirely new workforce through the establishment of a national training programme. The training programme, delivered by approved HEIs was intended to take trainees from limited knowledge of Cognitive Behaviour Therapy (CBT) to approved practitioner status and working within the new services within one year.

Methodologically this complexity raised issues surrounding the nature of the training programme; the characteristics of the trainees and the practice context in which they sought to operate. The theoretical framework (figure 3) concerned itself with the wider policy and health/social/economic context within which the services and workforce operate. An analysis of the ability of learners to transfer their newly acquired knowledge, skills, attitudes, values and general aptitude could not be divorced from the external context.

To make a contribution to the understanding of these issues, a systematic analysis of the ontological and epistemological underpinnings of the above context was undertaken to determine the methodology for research. The selection of methods and the analytical procedures flowed from this ontological and epistemological discourse.

Epistemological questioning in social research is, in the main, a matter of extolling the virtues of two competing paradigms (interpretive and positivist methodologies). The first, characterised by rich and deep observational data and the latter by numeric and generalisable data. The advocates of positivist

viewpoints look to the success of mathematics in 'explaining' or at least accounting for the work of nature. Galileo announced in 'The Assayer' in 1623, that the book of nature was written in the language of mathematics (Finocchiaro 2008). Galileo pronounced his statement of 'fact'; a statement which at the time was not contested. The removal or almost reduction of 'the human' in the collection and analysis of data meant that mathematics was able to state things in nature as they *really were*. Therefore, the endeavour of the positivist scientific method was to devise methods which described things as they 'are'; to minimise the human, to prize objectivity and introduce rigour to the research approach. Such an approach was penetrative, digging deeper and understanding more, refining the science and understanding as it progressed. The promotion of objectivity was central to the process as the language of science distilled out the subjective experience in search of the 'real'.

Other researchers have looked to the work of Kuhn (1996) in the structure of scientific revolutions as evidence that the above post-positivist scientific paradigm (in social science at least) had shifted, incorporating methodological considerations that stated that the 'human' element can never be removed or truly minimised from the observation collection and analysis of data. Indeed, to observe data was to influence data.

Other philosophical challenges to the status of the positivist and post positivist scientific method came from Deleuze and Guattari (1987) who argued that when discussing methodological issues we are merely looking through the lens of preference; a 'scientific method' machine and that other equally valid preference lens exist. This stance had opened up a debate, with the work of

Khun (1996) being appropriated by those seeking evidence of an emerging scientific revolution. Khun (1996) did not suggest though that in a scientific revolution previous methods would be made redundant, but rather the acknowledgement of a new and alternative method of researching and seeing the world could also be utilised. Using the analysis of Deleuze and Guattari (1987) an interpretive ontology and epistemology which sought forms of reality in the personal experience of individual actors and their interaction in their temporal space was merely another (and different) 'machine'.

An alternative 'synthetic' perspective on the above discourse, centres on the belief that there is no division between the ontological and epistemological stances, but rather recognition that they are alternative vocabularies to understand and describe our reality.

Philosophically, this position is at the heart of the pragmatist school, initially articulated by Dewey (1930) and James (1947). As Dewey (1930) suggested, we should give up on an idea of progressing towards an end where we can describe reality, but rather (*pragmatically*) acknowledge that a given vocabulary works better than another for a given purpose. Therefore, it is important to ask, what is the appropriate method for scientific research in social sciences? For Rorty (1982) a pragmatist stance takes the researcher 'beyond method' that is, the researcher is free to determine their own questions and the best method available to articulate their intuitions. The researcher is not bound by any external influence or systems of epistemological explanatory power.

The elaborate systems of science are born not of reason but of impulses, at first slight and flickering; impulses to handle, to move about, to hunt, to uncover, to mix things separated and divide things combined, to talk and to listen. Method is their ineffectual organisation into continuous dispositions of

inquiry, development and testing....reason, the rational attitude is the resulting disposition' (Rorty 1982 page 8).

This move towards pragmatism, has drawn theorists to consider whether this middle ground can best be exploited through the utilisation of a 'mixed methods' approach. However the debate on mixed methods is more than just the utilisation of qualitative and quantitative approaches.

3.2. Thesis aims

This thesis used a theoretical framework (figure 3, page 25) as a representation through which the literature and methodology sections were reviewed. The thesis aims were set out on page 13 with the intention of understanding policy development, delivery and transfer of learning. There were interpersonal, intrapersonal and social considerations to consider, giving rise to complex issues in development of an appropriate research design. Consequently it was necessary to ground the thesis within an understanding of how exploring the transfer process as a complex adaptive system may assist in the analysis and interpretation of data. Ideas around complex systems were based on relationships and patterns within and between systems that were constantly adapting within their environment. Holland (1998) noted that more emerges from a system than is originally put in, and demonstrated that systems are more than the sum of their parts. Complex adaptive systems, do not consist of a single complexity theory, but rather a collective of different theories from a range of disciplines who share constructs that possess a conceptual integrity; a complex frame of reference (Begun *et al* 2003). This had considerable overlap with the *Implementation*

Science approach utilised in this thesis as the interdisciplinary concepts formed a unifying element.

3.3. Complexity and complex adaptive systems

Isolating and manipulating particular elements of the 'teaching', 'learning' and 'transfer' processes was fraught with methodological challenges. There were many variables, such as time of day; the location of teaching and the decision on when 'learning' had taken place, which may have affected an individual's preparedness to learn. Each had the potential to influence each other in such a dynamic interacting system. A simple linear path of teaching » learning » transfer could not account for feedback loops from all the participants in the arena. Analysing Considering transfer as pertaining to a system within one wider system challenges the any simple assumptions of policy makers and educationalists that transfer can have an observable cause and effect (Jones 2003).

The theoretical framework (figure 3) was a representation of a complex system as it met all relevant criteria:

- A large number of elements are constantly interacting
- Each part of the system is affected by others, with feedback being a key aspect of its operation
- Small changes in one part of the system have the potential to create large effects in others
- The system is difficult to define or boundary
- The system has a history which helps shape the current behaviour, and

- Elements in the system are not fully aware of the behaviour of other parts of the system and only react to what is known locally (Harkema; 2003; Palmberg 2008)

Complex systems have multiple parts which are never static or fixed and such seek order and operation to offer the greatest utility, '*the principle of efficiency*'. New elements emerge and interact with the system all the time and generate degrees of influence ('*emergent properties*'). These emergent properties can be viewed as external ('*influence*') properties such as the recent development of AQP (see Chapter 2: section 2.5.3.) as a policy drive in primary and secondary health care provision. This policy drive had the potential to have a major influence (emergence) on the work of IAPT services and the practice of IAPT therapists and thus an impact on transfer processes. The issues of connectedness and influence create tension in a system and tension emerges from *divergence*. This is a defining feature of all systems in a complex frame of reference (Mason 2008). In this study, this was non-linearity, 'writ large' as the intrinsic order of a system is inherently unstable. It is dynamic and to a large extent '*self organising*'. The notion that a complex system, such as that described in figure 3 (page 25) can be manipulated by a single research design represents a fundamental and significant methodological challenge.

Systems in a complex world overlap with each other, but share an order of relations. The theoretical model, described in figure 3 was compartmentalised, within distinct boxes, separated as differing elements of the process. However, when framed within a research design on educational

transfer, it is dynamic and was not neatly separated in practice. The IAPT practitioners were individuals, who were parts of learning groups/cohorts, which in turn were part of other cohorts in the learning establishment. Further, they were members of practice teams which were parts of other teams in parts of larger organisations and so on. None of these systems was truly isolated from the other and this expressed the relations any have with each other and defines the '*principle of connection*' in complex systems.

The connection shared by these systems, opened up the opportunity to interact, either directly or indirectly with each other (the *interaction* principle). Connected systems are constantly interacting with each other and each system in a constant state of flux. Due to this dynamic state, the system was subject to the potential for major change (*the principle of multivalence*).

So it was important to question, how a system so dynamic could be 'measured' and could its action be explained? A complex frame of reference approach asserted that measurement was a combination of what is *known* (knowledge about the system) and *ignorance*, what is (currently) unknown. A complex adaptive system can be defined by the limits of understanding on how it operates. In terms of ignorance, it is asserted that little is known on the workplace and personal characteristics that are brought to bear on the transfer process and consequently a measurement approach was required to aid development of greater knowledge. With regard to other elements, such as knowledge gained or psychological constructs as factors within the transfer behaviour, it was necessary to measure the *state* of the system at a moment in time. It was not just about 'end points' but rather at points where the systems underwent transition (Dodder and Dare 2000). Repeated measures

offered the opportunity to isolate the degree of *stasis* and order with the system. A complex frame of reference acknowledged that systems could never be in the same state at two different points of measurement, they would never be identical. However complex theory asserts that there may be sufficient points of measurement in close proximity. The use of repeated measures can unearth relationships of interaction, the *pattern*. Therefore a chosen methodology must be appropriate to support an analysis of 'patterns' (Dodder and Dare 2000).

Objects within the system (variables) share relationships with other objects and can be said to share attributes and properties. An *attribute* is an identifiable characteristic and a *property*; a quantifiable behaviour. Within this study the objects were viewed as the research participants who formed part of a team/learner cohort (*attribute*) and who shared a location and a method of working with their team colleagues (*property*). In this study the property became a product of the interaction between two or more object variables. The behaviour of the individual was based on a relationship and influence of the system (team) in which the individual worked and the systems which influenced it.

3.4. Mixed methods research

Mixed methods have been defined as research conducted by an investigator using both qualitative and quantitative methods within a single study or programme of enquiry (Cresswell and Mertens 2005).

Whilst on the surface, this seems reasonable; to ensure philosophical and epistemological clarity, it is necessary to consider why a researcher would use

two distinct methodologies? What is the relationship between the qualitative and quantitative data that are collected and in what way do they contribute to a greater 'whole'?

A common sense position would consider that collecting quantitative and qualitative data must provide a richer picture of the subject under review, but Denscombe (2008) has suggested that this is not the philosophical meaning of 'pragmatism'. These research approaches have different and opposing world views and traditions. Choosing to join them, *pragmatically* within a single study may offer a degree of completeness to data. However, the action of joining, is not consistent with the pragmatist school of philosophy and will ultimately leave the researcher unable to offer a plausible explanation of their arguments (O'Cathain 2010).

This methodological diversity presented a challenge for mixed methods approaches. The collection of data via different sources from different, or even opposing, epistemological traditions required careful consideration on the part of a mixed methods researcher. Without this, planning the study ran the risk of being made of up two different methodological approaches that held no significant relationship to each other. The synthesis and integration of qualitative and quantitative data within a shared domain had to be evident if the mixed methods approach was to live up to the name as '*the third research paradigm*' (Johnson and Onwuegbuzie 2004 p14). Failure to develop a thoughtful integration would also mean that mixed methods research would not achieve the aim of integrating approaches to create a single study or programme of enquiry (Creswell *et al* 2004). The synthesis of different research epistemologies, ontologies; paradigms of enquiry; foundational

theories and philosophies and methodologies is what typifies the mixed method approach (Sandelowski 2000). Given this, it was clear that a mixed method approach had inherent complexity. The synthesis required attention through the typology of the mixed methods design, if a clear articulation of the relationship between data sources was to be achieved. Creswell and Plano-Clarke (2011) identified key decisions behind the choice of a mixed methods design. Most important was the relationship of the question or aims to the chosen design. The research question for this study asked; what are the characteristics of educational transfer which support delivery of new psychological therapy skills within the IAPT work environment? To answer this question a number of aims were identified. The aims combined personality constructs that were amenable to a degree of repeated measurement. Additionally, the potential design contained a possibility to enter the workspace of IAPT graduates to engage in a shared exploration of unknown/unaccounted aspects of the transfer process. In this regard the mixed methods justifications, proposed by O’Cathain (2010) were utilised to describe the decision to utilise this approach:

Justification 1. *Comprehensiveness*: mixed methods research offered a comprehensive and pragmatic account of complex interactions.

Justification 2. *Confidence*: mixed methods research offered confidence of results based on the triangulation of data from different sources. Quantitative research can offer an account of the structure and qualitative research can offer an account of the processes and patterns inherent in the complex system.

Justification 3. Development / facilitation: mixed methods research offered a guide to the research process as one method may aid development of approaches in another. In this way a qualitative interview method may aid the development of a new survey or questionnaire instrument.

Justification 4. Emancipation: mixed methods research could facilitate marginalised voices to be heard within more traditional research programmes. In this way contested realities (that of national policy leads; local IAPT service managers and practitioners) could form an important basis for data analysis (Dawson and Buchanan 2005).

3.5. Research design

The search for a research design which accommodated the complexity and responded to the notion of 'connectedness' of the factors presented a methodological challenge. The research design process sought an integrated approach that could offer a pragmatic and philosophically coherent solution to these complex design issues. Transfer of learning is a critical and neglected aspect of education provision, yet education and training provision remain a common response to national policy implementation initiatives as a vehicle to promulgate policy into practice – the 'train and hope' method (Drake *et al* 2006).

Funding allocations were made for education and training with the majority aimed at supporting practice and service improvement (Department of Health 2007a). However systematic analysis of the success of training interventions was rarely routinely conducted nor was the exploration of the necessary conditions for successful transfer of learning from the 'classroom' to practice

performance (Holton and Baldwin 2003). The need to develop a deeper understanding of the determinants of transfer of education and training provision that supported NHS policy into practice change and service user experience had never been more pressing.

Previous research noted that the development of skilled practitioners for the delivery of evidenced based interventions appeared to be hampered on two fronts. Firstly, individual services lacked sufficient numbers of such skilled workers for effective supportive growth and secondly, organisational dynamics hinder practitioner ability to implement and maintain innovation in evidenced based interventions (Corrigan *et al* 2001).

Transfer of learning into practice settings is a field of research which had seen growing interest with evidence that sustained long term changes in practice is only achieved following intensive and supportive skills based training (James *et al* 2001).

A pragmatic approach to mixed method research postulated that each avenue of investigation had strengths and weakness. As a consequence, mixed methodology research (such as methods developed from very different epistemological perspectives) was a logical approach.

The research question and aims in this study examined change in knowledge levels and competence (skill) in performing tasks associated with therapeutic activity. This question was amenable to 'behavioural'/quantitative and qualitative measurement. The study participants were members of cohorts, who received a training programme from subject experts. They worked in teams and in environments very different from the environment in which they

learned, and were members of organisations which ‘possessed’ a culture, which influenced practice and utilisation of new knowledge and skill.

The issue of the participants as single entities engaged in an educational exercise and the environments in which they learn and practice were, in some way, connected. This connectivity, recognised that there may be influence in both directions of the process (*to* and *from* the learner participants and *to* and *from* the education providers and team /organisation).

The connectedness of individuals and their environment indicated that isolating either from the other was methodologically unachievable. The issues increased in their complexity when the teaching environment was considered. The participant learner had a greater degree of control over aspects of their practice environment, as they were members of a team, and so had a stake in shaping the culture and working practice of the team. In an educational setting, they had less power and influence, less choice on when study happened and were recipients of a pre-determined curriculum.

The methods chosen for a research study must show the interaction between the various elements of the design, as without the clear interaction the thesis is merely a collection of different methods used independently (O’ Cathain *et al* 2010). This thesis adopted a mixed methods approach using a case study to examine the interrelated aspects of the theoretical framework as it pertained to the transfer of learning. Such a position was justified through the analysis of the place of mixed methodology in the wider theoretical discourse on the ontological and epistemological foundations of research in the social sciences.

In any research endeavour, there was an emergent question to be answered and the optimal method to answer such a question needs to be decided. This statement contained a number of significant assumptions which related directly to the philosophical underpinnings of research design and methodology. Firstly, it must be evident, where the question emerges from and in what way the question is framed? The question (in whatever form) emerges as important enough for the researcher to seek an approach to finding an *answer* or make a contribution to a deeper understanding. However, one needs to ask, why is this question important and by whose criteria is it judged? Similarly the methods chosen to answer the question are identified by the researcher, but again, one must ask, on what basis? (Morgan 2007).

One basis on which a methodological orientation to research pertained to the distinct epistemological system adopted by the researcher was their own personal bias (Morgan 2007). Such personal bias may relate to a post-positivist/realist (quantitative) stance, which stated that there as an approximal external ontological reality to the individual beyond their own conceptual practices. Alternatively, an interpretive belief system may be promulgated which holds true to the notion that reality is wholly constructed by individuals and that an external reality cannot be divorced from the subjective reality of the individual (qualitative; constructivism).

These are opposing perspectives, diametrically different and seemingly unable to accommodate the alternative and integrated world view. Given this, could a mixed methods approach be promoted as methodologically sound? Utilising both qualitative and quantitative approaches as 'the best of both

worlds' falls well short of a coherent metaphysical explanation about the nature of reality and what is 'true' in the world (Evans *et al* 2011).

Yet the growth of mixed methods research designs would indicate that such ontological and epistemological anomalies could indeed be overcome. Returning to the earlier theme of pragmatism as a philosophical perspective, it is proposed that alternative modes of presenting the problems, may result in novel solutions (Hammersley, 2000; Brannen 2005).

The objectives of this study were framed around the collection of survey and interview data. These data were to be collected at different points within the overall design and so the timing of data mixing was an important consideration. In order to avoid any possible bias, a decision was taken to analyse the data as a single entity. The quantitative data were collected and stored securely and left unanalysed. Qualitative interviews with managers and national policy leads were conducted and analysed before the individual questionnaire data were analysed. Data from the questionnaire could then be reflected into the individual interviews with IAPT graduates. In this regard the design used in this study was a modified embedded mixed methods design (Creswell & Plano-Clarke 2011).

3.5.1. Case study design

The 'case study' is a 'definitional morass', with multiple meanings (Gerring 2007 pg 17). Gerring (2007) noted that a feature of all case study research is the focus on a single bounded unit of analysis. This study focused on a national policy leads for IAPT and a single cohort of IAPT practitioners in their work setting within an English region. It explored their ability to transfer new

knowledge and skills into the practice environment. It was an attempt to study one single cohort of IAPT practitioners and through robust research processes provide data and results which may have generalisation across the IAPT service. In that regard, the study met the case study definitional requirements of Gerring (2007).

To counter any confusion of definition, Yin (2003) articulated the key applications of a case study approach, when a researcher wished to:

1. explain the presumed causal link in real-life interventions that are too complex for the survey or experimental strategies;
2. describe an intervention and real-life context in which it occurred;
3. illustrate certain topics within an evaluation;
4. explore the situations in which there is no clear, single set of outcomes;
and
5. conduct a meta-evaluation (an evaluation of an evaluation)

(Yin 2003 pg 15).

As noted above, a 'case study' has the potential to mean different things and consequently it is necessary to be clear about the type of case study employed. Within a coherent research programme there is a need for consistency between the question being posed and the aims and objectives of the research methods employed. To achieve this consistency, the three principal theorists on Case Study research were analysed (Yin 2003; Merriam 1998 and Stake 1995).

While all three share a 'constructivist' perspective, it is Yin (2003) that has a strong emphasis on combining both qualitative and quantitative data within a

case study. Stake (1995) and Merriam (1998) have a much stronger emphasis on case study as a qualitative research enterprise. The philosophy of pragmatism has guided this research and in doing so it is not methodological considerations that have primacy but the question under consideration.

This programme of study met the first above criteria, in that it explained the presumed link between motivation, skills and knowledge development with the workplace. The researcher had no control over either the course content or the workplace characteristics and there was no attempt to manipulate these. Other alternative approaches such as an experimental methodology would require some degree of control over at least one of these variables and a single survey method would be unable to capture the characteristics of the cases (individuals, courses and work settings) under discussion.

A criticism of case study design is that they are only as good as the theoretical model which guides them and it is not uncommon to find the theoretical model is unidentified (Anderson *et al* 2005). Additionally, Anderson *et al* (2005) argue that any theoretical model for health care case study design, should be congruent with the health care setting within which it is set.

This research utilised a multiple case study design as described by Yin (2003) where a sample of individual trainees; clinical teams and the key policy agents formed the units of analysis. A limitation of this case study approach was the newness of the IAPT programme, and so proved difficult to be assured of the representativeness of the other IAPT teams in IAPT primary care mental health services. A detailed analysis of their characteristics assisted in

postulating an argument for the generalisability of the findings. The longitudinal element also contributed to the robustness of the design.

An additional consideration for utilising a case study approach, related to the relative instability of teams and organisations in the NHS. Public service in the UK was actively involved in the drive to increase efficiency, effectiveness and modernisation. This being so, it ensured that any attempt to 'control' important variables was outside the capability of the researcher. A case study approach supported flexibility of data collection and so was suitable to the topography of public service research. Case study design provided the opportunity to engage in a detailed analysis of the context of education and development to increase proficiency in care delivery. Not only the context, but some relationships between variables on enablers and barriers to practice transfer could be observed.

Case study design was open to criticism, most notably relating to issues of reliability and generalisability. It is usual in case study approaches to concentrate and explore in-depth, a single (or small number) of cases. This concentration on small numbers makes the challenge of generalisability important. Is it possible to make assertions about other (similar, but not the same) units of analysis and draw conclusions about other settings? Critics feel that case study approaches only have utility as an 'exploratory' tool, that is they can unearth important relationship issues through detailed analysis, require other carefully controlled studies to determine the explanation of the relationships (Merriam 2009).

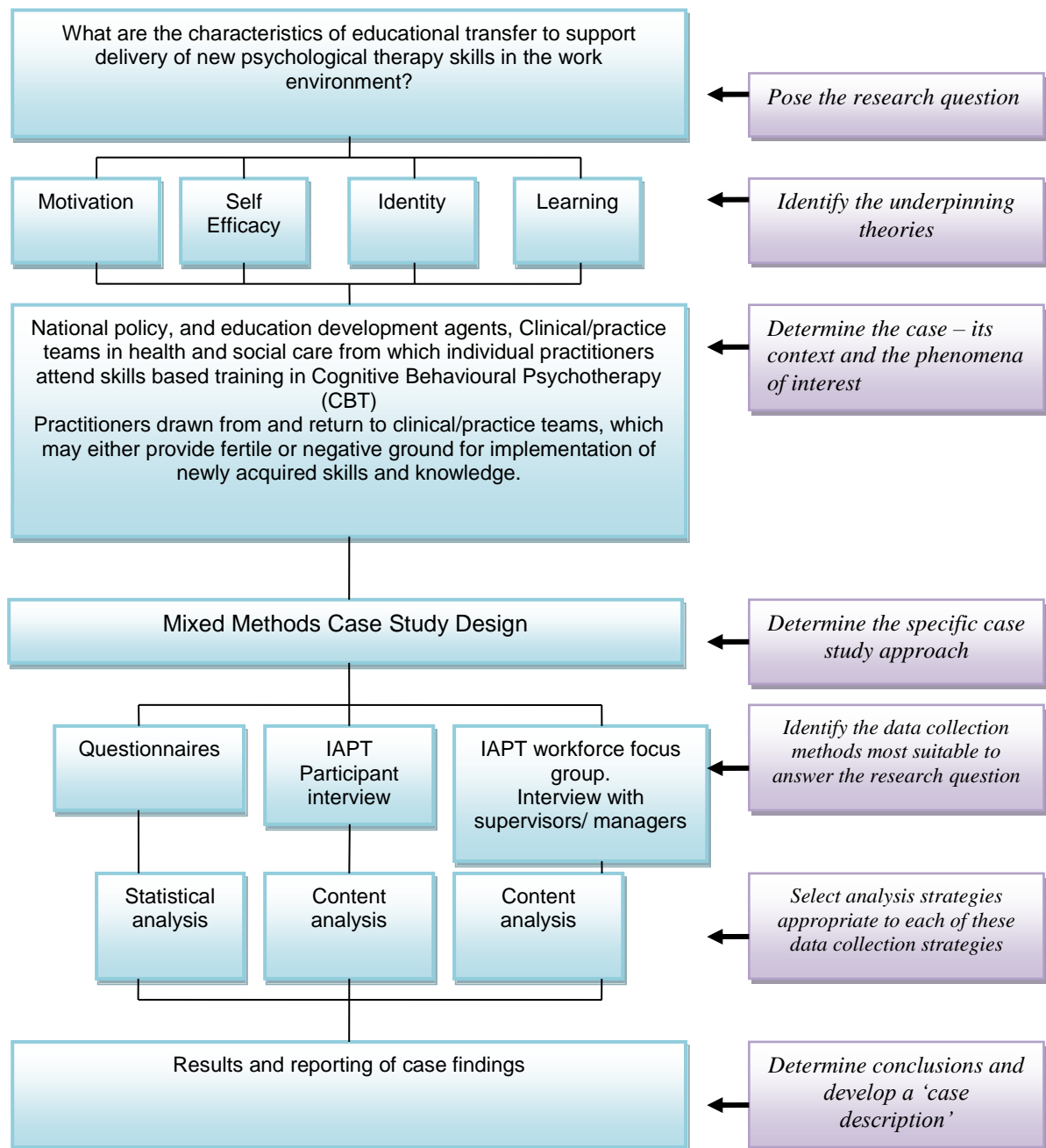
3.5.2. The stages of case study research: developing methods

Yin (2003) has proposed that effective case study research should progress along six defined stages:

1. Determination and definition of the research question or propositions
2. Selection of cases and method of data collection
3. Preparation for data collection
4. Data collection
5. Analysis and evaluation of data
6. Reporting of case findings

Each of these are discussed within this review of research methodology. Rosenberg and Yates (2007) suggest that a schematic representation of the case study approach adds clarity to complex research programmes, and use a visual 'map' of the inter-related elements gives structure to the case study process. Additionally a visual representation can aid illustration of the key concepts, theories and procedural steps. Figure 10 (page 129) provides just such a visual map of the research design used in this study.

Figure 10: The case study design planning process with ‘design steps’ (based on Rosenberg and Yates 2007 page 449).



The six stages of the case study design above, offered a comprehensive pathway through the research process. In the figure above the first five stages are examined in this methodology section. The final stage ‘Results

and reporting of case findings' are presented in the 'Results' (Chapter 4) and 'Discussion' (Chapter 5) sections.

The *first* stated aim was 'to examine the transfer features that influence the ability of IAPT practitioners to utilise a competency based educational programme in their practice'.

3.5.3. Validity and reliability in case study design

In using Yin (2003) as the guide to case study construction it is important to identify some key elements in this approach (which are less evident in other theorists e.g. Stake 1995 and Merriam 1998). The issue of the quality of the design is determined through attention to validity and reliability at every stage of the process. The instruments of measurement were therefore chosen to reflect the key data being sought. Attention was placed on obtaining key informants and using methods of data collection and promoting reflexivity on the part of the researcher. There were challenges to the consistency of reliability and validity and these are discussed in the limitations section of the thesis.

The objectives associated with this aim were to conduct a survey of personal attributes, knowledge and skills of IAPT workers and also a series of interviews to examine these issues, within the work setting. The survey questionnaires were designed specifically to explore key personal characteristics aspects of the transfer process and reflect the themes or variables identified via the systematic review of the transfer literature by Burke and Hutchins (2007).

This part of the study was a longitudinal examination of the students prior to training; immediately at training completion and follow-up when fully returned to their clinical practice. The study analysed the link between the stated aims and expectations of policy developers and the experience of policy implementation agents (practitioners) in delivery of their practice.

The above aim developed the ideas around transfer of learning and focused on the destination of applying learning in practice (the situated learning). This aim covered information relating to the transfer of learning and the personal and social characteristics of this process. It also sought to analyse the work of IAPT therapists, their sense of identity and the parity with the original aims of the IAPT policy agents. The sphere of 'Influence' was considered to be an important element in the daily work environment for IAPT workers, their managers and other stakeholders.

3.6. Methods

The research question and associated aims indicated that a mixed methods approach had utility, but the design of a coherent study was still required. Bryman (2006) provided an analysis of the process of mixed methods integration. This included the level of *interaction*; the *priority* given to the qualitative and quantitative strands; the *timing* of the strands and the *procedures for mixing* the strands.

The level of *interaction* or relationship between the data approaches was considered by Greene (2007) to be the most important element in a mixed methods design. The interaction can be independent (the two elements are kept separate in the study) but are drawn together when analysing results and

drawing conclusions. Alternatively the two elements are interactive and this can happen at any point in the research process. In this thesis, the two elements were kept separate and were analysed together only when all data were gathered.

In terms of *priority*, this may be explicit or implicit in the design, where one element has priority over the other or both are given equal weighting. Within this study both elements were seen to be of equal weight. It was important to gather personal characteristic data and to examine changes in level of knowledge and confidence in CBT through the questionnaire study. It was equally important to work collaboratively with practitioners in obtaining a deeper understanding of what these characteristics bring to the transfer process and to assess the effect of external processes on the ability of workers to utilise what they learn.

The temporal relationship in terms of *timing* of data collection presented significant challenges (see 'Limitations' section in chapter 6). The longitudinal and sequential nature of the design indicated that sufficient time would be required to IAPT workers to settle back into the work role following completion of training before undertaking the qualitative data collection process. In this way, the data collection process would allow a 'near' and 'far' analysis of learning transfer (Cree and MaCaulay 2000).

3.6.1. Questionnaire and interview development

To answer this first stage of the six stages in the case study design process required the identification of questions or issues of relevance. A number of key personal psychological constructs were considered to be important within

the sphere of 'personal characteristics' of Burke and Hutchins (2007) and were reflected in figure 8 (page 77).

These personal characteristics were the role of individual motivation to learn and to use new knowledge and related characteristics of intervention readiness to use, job attitudes and work burnout in learning transfer. The Kite Foundation (2012) identified motivation as one of the principal constructs in the transfer process. In their analysis, the role of the workplace in supporting and maintaining motivation was largely absent (Kite Foundation 2012). The issue of work place stress has also been noted as a key construct, particularly in the NHS. The NHS Staff Survey in 2008 identified that 28% of NHS staff reported illness as a result of stressful work environments. However, from 2012 the level of self reported stress related illness was 38% and had remained at this level on each subsequent annual survey (NHS England 2014). This rise in stress amongst healthcare providers had been mirrored in the Labour Market Survey (Health and Safety Executive 2013) which reported that people working in health and social care experience much higher levels of stress than the average member of the UK workforce (2.2% compared with 1.4%). The stress levels amongst health and social care providers displayed an upward trend (Health and Safety Executive 2013).

To explore these issues some previously validated scales were utilised in this study:

- The Academic Motivation Scale;
- The Generalised Self Efficacy Scale;
- The Minnesota Job Satisfaction Scale and
- The Human Services Survey

(Section 3.10 provides an overview of the scales and appendix 1 for a full set of questionnaires used in this study).

It was also considered important to gather data on the knowledge gain in the IAPT education cohort and their ability to transfer knowledge and skills. Therefore, these elements of the survey were designed to examine participants engagement in the learning programme. A measure of knowledge development was used as a 'proxy' for level of educational engagement. The survey also sought to identify the reaction of the IAPT participants to the training programme and whether they considered the content and experience to have some clinical utility to the requirements of their practice. To examine these issues, some previously validated scales were utilised;

- Cognitive Behavioural Therapy Knowledge Quiz (CBTKQ) was used as a repeat measure.
- The Transfer Acceptability Rating Scale and
- The Self Rating Scale of the Generalisability of Training

In addition to the survey, interviews with key stakeholders in IAPT transfer process were conducted (IAPT participants; managers; supervisors and other IAPT workers).

Studies that have examined the transfer of learning had rarely explored the application of learning in the practice work setting and the social context of the transfer process. Still less attention has been paid to the external political, economic and psycho-social environment and its role in the transfer process (Ford *et al* 2011; Hurtado, *et al* 2012). Conducting this aspect of the study presented an opportunity to offer a unique perspective on the transfer process

and add a depth of understanding on the factors that inhibit or promote effective educational transfer.

Four principal qualitative approaches were adopted;

- interviews with a subset of the IAPT graduate participants from a single organisation in the English region under review.
- interviews with their clinical supervisors.
- interviews with managers of the service and,
- two focus groups of the IAPT workforce who were not part of the graduate participant group, and a group from a different English region. This second group was utilised to verify or challenge emerging findings and facilitated an understanding on the generalisability of the results.

3.7. Participatory approaches

The process of adopting a methodological approach must account for the range of methods available to a researcher when gathering data within a placement setting. The choice of design must offer a consistency with the concern to build a rich and clear picture within an overall case study approach utilising complimentary mixed methods.

The gold standard of research methodology promotes objective and impartial evidence based assessment of phenomena, but as has been stated by Chouinard (2013) such an approach to research data gathering ran the risk of;

(falling) 'short of capturing the range of local views, contextualised meanings and culturally relevant perspectives' (Chouinard 2013 page 238).

The methodological stance adopted in the qualitative, interview driven, aspect of the study was one which extolled the virtues of illuminating the dynamic social experience of learning (Vygotsky 1978). In order to expose this aspect of learning, it was necessary to work collaboratively with research participants in this emerging understanding. A participative enquiry approach was employed to analyse the factors associated with the work environments that may enable or inhibit transfer.

This participatory approach was justified on the basis that researching 'at a distance' from participants is morally questionable as the process of 'objectification' places a privilege on the position, knowledge and understanding of the researcher. This is neither democratic nor emancipatory and disenfranchise the participants of a stake in the research. Philosophically, the study had a social constructivist stance promoting inclusion of multiple participants in knowledge production. Inclusion without participation is not inclusion and nor is it effective consultation. Additionally, the thesis promoted a pragmatic philosophical position, one which valued the practical orientation of the work and the mode by which practical results could be achieved. Meaningful inclusion on the part of participants could lead to better decision making and enhance personal, team and organisational learning.

An inclusive methodological position presented challenges in its application in ensuring effective involvement and representation of diverse opinion. How

were decisions about when best to stop collecting data made? How were relationships managed between the researcher, the participants and organisational management? What were the issues associated with managing conflict and organisational problems that may result from the research process? These issues receive attention in the section on 'ethical considerations' (section 3.13).

The aims and research design include working in a participatory manner with the respondents who accepted an invitation to take part in this study; a description of the sample participants is given below.

3.8. Description of the sample for Aims 1 and 2

For Aim 1, the sample (at times 1, 2 and 3) consisted of sixty four post graduate students studying on the Improving Access to Psychological Therapy (IAPT) course delivered at a HEI approved by the national policy team. The course was a full time, skills based, CBT training course run over a period of a single year. The participants were individuals who had demonstrated sufficient skills and experience of psychological therapy to merit a place on the programme. The HEI which was delivering this IAPT curriculum was approached for permission to seek consent of the student group. On granting of this permission the students were invited to take part via an email from the course leader prior to commencing the programme.

A subset of the IAPT graduates, from a single IAPT service provider in the region were followed up back in clinical practice following completion of the IAPT education programme. Again permission to approach the students was sought via the service managers and local ethics committee.

For Aim 2, the sample were drawn from members of the national workforce programme for IAPT. This was a relatively small working group of national policy leads and policy implementation managers. They were approached via email and through letters of introduction and invited to participate.

3.9. The administration of questionnaires

The administration of questionnaires was planned to obtain repeat measures over three different time periods (see table 2) (time 1 - prior to the commencement of CBT skills based training at a university). The second data set were collected at completion of training at the university (approximately 1 year later). Both these data sets were collected in person at the HEI on the first day of training (time 1) and during the least week of training (time 2). The final collection (for time 3) was a postal process approximately 18 months after time 2. To increase return rates an electronic version of the questionnaires was also developed through the 'Survey monkey' tool and emailed to participants who had failed to return paper questionnaires. The rationale for the time series data collection was to establish a baseline at time 1. This was before any of the participants had started any formal study. While participants may have had different exposure to psychological therapy the baseline provided data before formal training and education had begun. The second data set was collected immediately at post training, again providing for a comparison for when the cohort had completed the same programme.

The third data set was collected following dispersal of the group back to their work settings. The 18 month time period, post training was to examine a long term trend in transfer practice.

Table 2: The administration of measures for the study

Time line	Time 1	Time 2	Time 3
	Pre-training	Immediately post training	18 months post time 2
Participant Groups	IAPT Trainees Group (n= 64)	IAPT Trainees Group (n= 62)	IAPT Trainees Group (n= 57)
Measures:	Minnesota Job Satisfaction Scale	Minnesota Job Satisfaction Scale	Minnesota Job Satisfaction Scale
	Self Efficacy Scale	Self Efficacy Scale	Self Efficacy Scale
	HSS - Burnout Inventory		HSS - Burnout Inventory
	Academic Motivation Scale (AMS)	Academic Motivation Scale (AMS)	
	CBT Knowledge Quiz	CBT Knowledge Quiz	CBT Knowledge Quiz
		Measure of Training Generalisation Scale (MOG)	Measure of Training Generalisation Scale (MOG)
			Training Acceptability Rating Scale (TARS)

3.10. Measures and scales.

The scales that were used to examine the factors associated with ‘Aim 1’ of this thesis are described in detail below:

3.10.1. CBT Knowledge Quiz (CBTKQ)

This scale was originally developed by Myles and Milne (2004) and is still in the process of psychometric development. The version used in this study was

the 26 item version; a multiple choice scale with responses made from a choice of four options.

The scale was designed to generate evaluation evidence for the development of knowledge about CBT. The questions are about knowledge of CBT principles, terminology and concepts and scenario based questions which test application of theoretical components of standard CBT procedures.

Participants in this study completed this scale at three time periods; time 1 (prior to training); time 2 (immediately post training completion) and time 3 (at 18 month follow-up after completion of training). Each question has one correct response.

3.10.2. Maslach Burn-out Inventory (Human Services Survey [HSS])

This scale was developed by Maslach *et al* (1996) to measure stress and burn-out in human services. It is a 22 item questionnaire with response options on a 6 point scale. This is made up of three sub scales covering:

- a) Emotional Exhaustion (EE);
- b) De-personalisation (Dp) and
- c) Reduced Personal Accomplishments (PA).

The subscales are scored in the following manner:

Participants who score high on both subscales (a) and (b) [scoring 21 or more and 8 or more] respectively and who score low on subscale (c) [scoring 28 or less] are said to be in 'burn-out'.

This burnout inventory has been used in many studies (Poghosyan *et al* 2009; Iwanicki, *et al* 1981 Schaufeli *et al* 2001; Hughes 2007) and has generated a

number of normative scores including those for mental health workers (table 3).

Table 3: Maslach burnout inventory normative scores for Mental Health workers.

<i>Subscales</i>	Low	Average	High
Emotional Exhaustion	≤13	14.20	≥21
Depersonalisation	≤4	5.7	≥8
Reduced Personal Accomplishment	≥40	33.29	≤28

3.10.3. The Academic Motivation Scale (AMS)

The motivation of participants to learn and apply newly acquired skills was considered an important variable in the transfer of learning. The Academic Motivation Scale (AMS) (Vallerand *et al* 1989) is based on the work of motivation theorists, Deci and Ryan (1985; 2000)

This suggested the link between motivation and educational outcomes is complex, but Guay *et al* (2008) suggested that intrinsic motivation and identified regulation were associated with lower dropout rates of academic courses.

Vallerand *et al* (1993) reported good internal consistency with the AMS, with Cronbach's Alpha scores ranging from .83 - .86 across the subscales, except subscale 4, 'Identified regulation' which had a score of .62. Additionally, test-retest reliability over a one month period ranged from .71 to .83.

3.10.4. Minnesota Job Satisfaction Scale

This instrument is designed to examine an employee's general job satisfaction. The scale is available in two forms; the long version and the short version. The short version, used in this study, consisted of 20 items which were a close fit to the key variables from the longer version. Factor analysis studies show that the short version is able to generate 3 results: intrinsic satisfaction; extrinsic satisfaction and an assessment of general satisfaction.

- Intrinsic satisfaction (IS) is made up of 12 items.
- Extrinsic satisfaction (ES) is made of 6 items, and
- General satisfaction (GS) is made up of all 20 items.

The scale is based on a belief that greater job satisfaction is associated with lower staff turnover and a greater job contribution. A plus 75 percentile score is associated with high job satisfaction while a minus 25 percentile score is associated with low satisfaction. The authors indicated that normative data is the best benchmark to use when interpreting results from the scale. There are limited number of professions/work groups who have been used to generate normative data. There were no normative scores for health workers within the published literature on the scale.

3.10.5. General Self Efficacy Scale (GSE)

The English version of the GSE was developed by Schwarzer and Jerusalem (1995) and consists of ten items which assess an individuals' general sense of ability to cope with stressful life events. It is recommended that the ten

items are randomly mixed with a larger pool of questions which use the same four point response format. In this study, a 16 item scale was constructed (containing six redundant items; Questions 1, 2, 3, 6, 9 and 10).

The scale was scored by calculating a sum of all items to gain a composite score within a range of 10 – 40. The higher the score, the greater the sense of self efficacy. Reliability studies indicate a range of scores (Cronbach's Alpha) .76 to .90, suggesting that repeated scores were consistent over time.

3.10.6. Training Acceptability Rating Scale (TARS)

The TARS was developed by Milne and Noone (1996) and was a development of an earlier instrument on acceptability of behaviour therapy techniques (the Acceptability Rating Scale) by Davis *et al* (1989). The first part of the scale was a six point bi-polar Likert response ranging from Strongly Disagree [scoring 1] to Strongly Agree [scoring 6]. The first six items of the TARS were direct reflections of the earlier acceptability scale and cover items surrounding the dimensions of acceptability, these are;

- General acceptability (this approach would be appropriate to a variety of staff);
- Effectiveness (the training would be beneficial to staff);
- Negative side effects (the training will result in disruption or harm to clients);
- Appropriateness (most staff would not accept that the training provided an appropriate approach to client care);
- Consistency (the training was consistent with common sense and good practice in helping staff work effectively); and

- Social validity (in an overall, general sense, most staff would approve of training in this method (e.g. would recommend it to others)).

The second part of the scale consisted of nine questions exploring impressions of the teaching process and outcomes of training (how well the training was completed and whether it was helpful). Each item had a four point response on a likert scale from 'not at all' [scoring 0] to 'a great deal' [scoring 3].

This provided a minimum score of 6 and a maximum score of 63. The TARS had reported good test-retest validity ($r=0.83$) and internal consistency (0.99) and acceptable construct and concurrent validity (Milne *et al* 2000).

The scale was designed to explore a participants' reaction to the training programme. In this regard it can be viewed as meeting the requirements of the first level of the Kirkpatrick (1967) four level analysis of transfer of training. Participants in this study completed this scale only once, at time 2 (immediately post training).

3.10.7. Measure of Generalisability (MOG)

The self report MOG (Milne *et al* 2000) covered five areas: experience; generalisation; areas of functioning, support and participation and confidence and competence. It was originally designed for studies of CBT in Psycho-Social Interventions (PSI) and so (minimal) description alteration was made to the scale to reflect the interest in CBT within this study.

- Section (a) of the MOG had eight items and examined the practical experience of practitioners in utilising core CBT skills in everyday practice;

- Section (b) covered 'generalisation' with three items that examined the frequency with which the respondents utilised new skills in practice;
- Section (c) focused on the area of functioning with three items on the impact that new skills had on the practice of respondents and their ability as therapists;
- Section (d) contained eight items; examined the support and participation of respondents in continuous development of their new practice skills; and the final,
- Section (e) with three items, examined the feelings of competence and confidence that practitioners had following the skills based training programme.

3.11. Approaches to analysis: Aim 1: Quantitative data analysis

The quantitative aspect of longitudinal time series utilised a number of statistical approaches. In the first instance, using descriptive statistics, the sample in this study was compared with the data available on the national IAPT workforce profile using descriptive statistics. The Academic Motivation Scale (AMS) was only collected during the period of academic involvement (prior to training and immediately post training) and so a paired *t-test* was calculated.

For analysis of the Minnesota Job Satisfaction Scale, scores were summed and compared with reference to the normative group most closely associated with the sample under review. On the General Self-Efficacy scale, the redundant items are removed and scores were summed and compared over the time period. The burnout inventory (Human Services Survey) the three

factors were scored by the sum of the total scores in the factor. High score in Emotional Exhaustion (EE) and De-personalisation (Dp) are associated with 'burnout'. High scores in Personal Accomplishment (PA) are associated with less burnout.

The CBT Knowledge Quiz data were calculated by obtaining the mean scores over the three time periods. The Measure of Generalisation scale (MOG) was used over two time periods and so a paired t-test was calculated. The Training Acceptability Rating Scale (TARS) data were collected on a single time period (time 2) and so scores were calculated by using the sum of the scores; the higher the score the greater the endorsement of the training programme

3.11.1. Approaches to analysis: Aim 1: Qualitative data analysis

Different approaches were taken for the different sets of qualitative data. Interviews and focus groups were held with IAPT practitioners, including one focus group of the wider IAPT team from the same organisation (i.e. those IAPT practitioners who were not in the original trainee cohort) and one with IAPT practitioners from a separate English region in order to triangulate aspects of the data collected. The workforce team data yielded detailed information from participants. Therefore a method was required for managing such data. All interview work was transcribed verbatim or where this was not possible detailed notes kept and developed at the earliest opportunity following the discussion. The transcription process utilised the work of Kowell & O'Connell (2014) and Roulston (2014) in taking a pragmatic approach to transcription. Verbal annotations were to be kept in the transcript but a

detailed annotation system was not utilised for the purposes of simplicity and readability. This aim of simplicity was carefully considered and so recorded interviews were repeatedly listened to ensure the transcriptions retained not only the documented words, but also the spirit of the conversation. Qualitative content analysis used the three stage method for data analysis (Miles, Huberman and Saldana 2013). This process involved (i) *data reduction*; (ii) *data display* and (iii) *drawing and verification of conclusions*. These processes were achieved by a close reading of the textual material and operating a reflective attention to material even after conclusions had been drawn. It involved a questioning approach to reflect and analyse the nuances in data to verify that conclusions drawn were robust and demonstrable. The emerging themes were developed and refined throughout the process. This process enabled the research data to be interrogated from different perspectives as new ideas were promoted and challenged depending on whether the data existed to support their inclusion. The approach was a dynamic and creative process which enabled other lines of enquiry to be explored.

Conceptually the data analysis approach reflected the examination of patterns in the data, seeking examples with a strong 'fit' with others. The examination of coherence and clustering data aimed to provide a plausible narrative of the data. The narrative could be jarring, but by recognising that dissonant perspectives expressed by participants could also generate important themes worthy of closer examination (Miles and Huberman 1994). The relation between variables expressed as either consensus and dissensus were potential areas for the examination of new understanding.

3.12. Approaches to analysis: Aim 2: Qualitative data analysis

In keeping with the stated objective, the work of policy developers/agents was reviewed through the in-depth interviews around their perspectives on the status of the IAPT policy. The above aim and objective related to the 'source' aspect of the theoretical framework. They included an understanding of the importance of the environmental 'Influence' within which this policy initiative was set.

The numbers of these policy agents were known to be quite small so choosing an appropriate method of data collection required the individual participants to reflect on the process of development and their aims for the policy. It was considered appropriate to provide as much opportunity for reflection as possible and so an unstructured interview was utilised. Again, the model of content analysis identified by Miles and Huberman (1994) was adopted.

Using five of the six stages in the case study design process (page 128) the first stage required a question of relevance that explored the historical sequence of events and interactions which formed the source of the national IAPT policy.

In order to meet the second stage 'select the cases' and 'method of data collection', it was evident that the principal source of information were the key policy development agents who within the sphere of influence (the *economic*, *political* and *social* realms) initiated the cross-government discussions and promoted the arguments to help fund pilot studies that examined the feasibility and achievement of outcomes.

The third stage was the preparation requirements for data collection. To achieve this, key known individuals were contacted about the study and their consent for participation was requested. Using a snowball sampling technique, other potential participants were identified and letters of introduction were sent from these initial respondents. The sample in this element, were all high profile (and busy) leaders in mental health services. This approach to sampling was used as it was considered to be the most likely to initiate a response. 'Snowballing' has limitations in that it cannot be representative and individuals may influence nominations (Bowling 2014).

The fourth stage related to the data collection processes and this was completed by a digital recording of the interview, in which individuals were asked an opening question "*Can you tell me what you hoped to achieve in the development of the national IAPT policy?*" This opening question was used to allow as much freedom as possible to the participant in answering the question. Too many prepared questions could have given rise to the possibility of the research being 'directed', when it was important to generate free data as determined by the participants. They were given the opportunity to decide what they felt was important in the process of IAPT development. All participants were involved in the IAPT development and so took the opportunity to talk about a range of issues, pertinent to policy development and programme initiation and as such, the interview process generated a significant amount of data.

The fifth stage was the analysis and evaluation of data, which was completed via content analysis (Miles and Huberman 1994). Qualitative data in the form of spoken words is open to interpretation by the researcher. This study used

a pragmatic and social constructivist 'footprint' as a foundation to the collection and analysis of data. As with data in aim 1, an attempt was made to minimise the potential for misinterpretation. To this end, all data that were intended as evidence of results were sent back to the originator. They were asked to approve inclusion and to accept or reject the interpretation by the researcher.

Data were subjected to thematic analysis which is considered to be an accessible and theoretically flexible approach to qualitative data analysis (Braun and Clarke 2006; Silverman 2014). The decisions a researcher makes about methods of qualitative analysis are important aspects of the articulation of results. Whilst there are a range of qualitative data approaches (Green and Thorogood 2014) they all share the generation of 'themes' as a core endeavour (Holloway and Todres 2003).

In identifying themes, it was necessary to offer a clear articulation of the process of analysis since this supported clarity of approach and facilitates others to replicate the research process. Themes do not emerge within an epistemological vacuum; the researcher played an active role in the process of deciding what is important in the data. Being transparent about the process of thematic identification and promoting a reflexive account of the values and opinions of the researcher, enables other reviewers of the research to assess the completeness of the process.

The research design accentuated the identification of 'patterns' within the transfer process, which are often the tacit but critical elements which play an important role in the complex interaction between organisational structures and process (Plsek 2001). A limited structure to the interview process

facilitated participants to illustrate their unique world view on the development and delivery of IAPT and as such this '*emic*' approach was different from that adopted from grounded theory (Glaser and Strauss 1967). The researcher was well versed in the topography of IAPT having been tangentially involved in elements of the initial national programme. This required a degree of self reflexivity when asking questions or following up on lines of enquiry and also when analysing data. It was necessary to ensure that the data spoke for itself, that it provided some insight into the process of policy development and the proposals for transfer of learning into a work-setting.

The interview data were analysed using the following process:

- a. **Data familiarisation:** all collected data both in recorded and note form, were reviewed (listening and reading) on a regular basis. General notes were made on the content of the material.
- b. **Transcription:** over time all recorded data were transcribed onto a word processing package (see appendix 6). Attention was paid to punctuation but inflections and other slight emphasis behaviours (coughs etc.) were not recorded in the transcript. The data were transcribed as faithfully as possible to ensure that it was an honest and accurate reflection of the content provided by the participant.
- c. **Generation of initial codes:** data were reviewed on an on-going basis. A reflexive approach was adopted and research supervision was used as a means of challenging and confirming emerging themes. Data were gathered into meaningful collections of generally similar areas of interest (Miles and Huberman 1994).

Initial codes were identified for repeated areas of discussion and again a reflexive approach to the data was used. The number of repeated discussion points was not the sole determinant of whether an item reached influence to be coded. Illumination of key points was viewed as the principal determinant in moving from the data set into a potential thematic category.

- d. **Identification of themes** (first cut): A list of codes were identified and reviewed from the data. A number of visual data maps were drawn and reviewed on an iterative basis to help question and identify the emerging data themes. Candidate themes and sub-themes were identified through this procedure.
- e. **Thematic review**: The data were reviewed again to ensure that the themes identified were 'true' to the data provided by the key informants. Attention was paid to whether the themes had some degree of consistency, were illuminative and justifiable as an accurate representation of the data.
- f. **Naming and defining**: following this process, themes were named and where required attention was paid to definition and refinement. The named themes were considered to be important and relational to each other. The themes had something interesting to say about the policy development and programme implementation process for IAPT and something important to say about the process to support the transfer process within IAPT.

The fact that the data were generated from a single question made the researcher feel assured that the themes emerged from the data and

were not a paraphrase of themes already known prior to data collection.

3.13. Ethical considerations

Ethical approval for the study was first obtained from the University of Lincoln Ethical Committee 2008.

The Higher Education Institution which delivered the IAPT programme was approached for permission to approach the students. A series of telephone calls were made to the chair of the Ethics committee and paperwork describing the study provided. Through 'Chairs Action', approval was permitted to collect data for the initial phase of the study (the quantitative data process at time 1). There is a limitation relating to the administration of the questionnaires at time 2 and time 3. The original consent to collect data identified the time sequence and assumed consent for questionnaire completion even after finishing the IAPT training programme [appendix 3]. At this point the graduates were fully back in their employing organisations. All managers of IAPT services in the region were kept informed of data collection plans and processes before time 1 and during the stages of the study. However formal ethical approval processes from NHS R&D were not obtained until the workplace analysis at time 3.

At time 3 assurances were provided and the necessary consent information provided by the appropriate NHS R and D committee [appendix 2].

3.13.1. Data protection and governance

Rigorous processes were employed to ensure protection of data which were applied and consistent with the University of Lincoln policy on research (<http://secretariat.blogs.lincoln.ac.uk/academic-policies-2/>).

All IAPT participants and organisations were allocated a unique code known only to the researcher and available only to the study supervisor. These data were kept in a locked cupboard in the office of the researcher. The codes were used to ensure that participants could be tracked and compared over the three time periods of the study. Administration of questionnaires over the three time periods was collected by paper and pen methods and these data too were stored in a secure locked cabinet with access only open to the researcher and the supervisor. The only deviation from this process was in an attempt to increase response rates at time 3 an electronic version of the scales was developed through the 'Survey Monkey' website. This raises issues of data security and ownership as 'Survey Monkey' are a private company based in the United States of America. However 'Survey Monkey' have a policy statement on data security compliance which is consistent with the requirements of the European Union regulations on data protection and security (<https://www.surveymonkey.com/mp/policy/privacy-policy/>).

The ethics of entering and leaving the work environment needed to be considered. The chosen method was an approach which sought to work collaboratively with research participants in examining the transfer issues in clinical practice. The existence of possible transfer enablers or barriers to the transfer of learning process was not known. Where there were enablers that appeared to work well, it was assumed that the researcher and the

participants may discover these and support their continued use. However the issue of barriers to the transfer process present the researcher with a different dilemma. What were the researcher and the participants to do with barriers that may have been uncovered? The prospect of examining an issue, identifying its existence and then leaving it unresolved was inconsistent with the aims and methodological stance of this thesis.

The ethics of conducting an incomplete or unproductive study was considered. To ensure that the study was to achieve the stated aims, a small scale pilot study was completed. The questionnaires and interview protocol were completed by two IAPT therapists who were geographically unrelated to the study site. Completion times and acceptability of the scales and the focus of the interview were tested to confirm the research process.

In agreement with IAPT managers of the service, any potential challenging organisational barriers to transfer (over and above their usual managerial organisational responsibilities) were considered for a response. It was agreed that post analysis, the researcher, if required would re-enter the work environment and assist with possible solutions to organisational barriers to transfer implementation. In discussion with IAPT service managers the Soft Systems Methodology (SSM) (Checkland and Scholes 1990; 1999) was agreed as an appropriate staff development methodology should additional work be required.

Chapter 4. Results

All data were analysed with reference to the 'mixed methods' requirements of the study. Comprehensive and mutually coherent data sets to provide a fuller picture of the process of transfer from the classroom to the work-setting were collected. The mixed methods approach requires a seam of consistency as each element of the data set must make a contribution to the overall transfer 'picture' (Cresswell and Plano-Clark 2011). Without methodological consistency there was no philosophical basis on which to build a mixed method approach to this case study analysis.

The approach to reporting a mixed methods design was a key consideration in the overall design. Solutions to complex questions on presentation of the results were therefore required to respond to this issue. O'Cathain *et al* (2010) provided a number of analyses and reporting strategies available to mixed methods study data.

A mixed-methods matrix (O'Cathain 2010) which follows the principles of a meta-matrix (Miles and Huberman 1994; Bernard and Ryan 2010) was developed (appendix 5) to illustrate the integrative nature of the analysis. The transcribed and recorded data were read and reviewed many times and annotated (see appendix 6). A careful reflexive approach was adopted to form a picture of the experience of the respondents. As themes emerged from the data, via initial coding and recoding (Saldaña 2013) and they were entered into the table (appendix 5) and re-analysed until separation of the key themes emerged and the data saturation noted in the data collection process was evident within the collated results (Baker and Edwards 2012).

Unexpected findings or extreme results were prioritised in exploring whether the study was generating new insights into the transfer of learning. The following presentation of results therefore includes predetermined themes based on the original literature review (motivation; burnout; competence and confidence) and unexpected findings (support; feedback; the level of tension/external pressure and transfer of education to practice in the real world).

In terms of the qualitative analysis the issues of reflexivity and possible bias on the part of the researcher and a potential social desirability bias on the part of the respondents were considered (Van de Mortell 2008). The theoretical framework (figure 3, page 25) identified the potential for external influencing factors to have a significant impact on the work of IAPT practitioners. The sequence of data gathering had the potential to influence the analysis and construction of themes. Ideas and themes may emerge from the reviewed literature and data could be mined with the intention of specifically searching for such themes within the analysis. To counter these elements, a reflexive, analytic approach and participant inclusion were used to actively minimise bias in this potential area of influence. Taking steps to enable the participants to verify data, through the development of on-going relationships and communication relating to data and interpretation were used to monitor and minimise possible aspects of influence and bias.

The aim of data analysis in qualitative research is to reach data saturation where no new information appears to be emerging from the collected and collated data. The process of reading, re-reading and interpretation was an ongoing one until over time, the data revealed no new themes. It remains an

aspect of debate at which point saturation is reached. When asked how many interviews was sufficient in qualitative research Becker (2012) stated *'The only possible answer is to have enough interviews to say what you think is true and not to say things you don't have that number for. The kinds of things you might want to say take a lot of forms and so require varying numbers of interviews'*. (Becker 2012 page 15).

4.1. Demographic analysis of the initial IAPT workforce.

Case study methodology has utility if it is possible to draw parallels between the sample group and the wider population of interest (Gerring 2007). In order to understand the extent to which data generated from this study were generalisable, the sample was compared with the known features of the national IAPT workforce.

Demographic data were obtained from the IAPT cohort at the *time one* element of the survey (prior to commencement of the education programme). These were then compared with national data on IAPT therapists.

The available data from the national IAPT programme indicated that the IAPT workforce was made up of practitioners with a wide range of disciplines. This made it difficult to categorise the workers in order to be able to contrast and compare their similarities and differences.

As a consequence, demographic information were based on a sparse data set, but did give the best estimate on the differences and similarities between this case study cohort and the original national group of IAPT trainees.

The data are presented in table 4 below. A difference in the raw scores between the two groups was identified in psychology graduates. In the

national cohort at the start of IAPT, graduates trained in psychology accounted for 15% of the group, while in this study the same group accounted for only 3%.

Chi-square tests were completed to examine whether the observed differences were of statistical significance. As the psychology group was a smaller number in the study group, they were included in the 'other' profession category for statistical techniques.

Table 4. Chi-Squared test on two groups of High Intensity trainees on a range of demographic indices.

	HI Sample	National group	National proportion	Chi-Square
Counsellors	11	40	9.5	0.236842
Nurses	33	95	23	4.347826
Other**	19	126	30.5	4.336066
Totals:	63	261	63	8.920734
			$p=$	0.012
Female	43	209	50	1.099677
Male	20	52	13	4.419856
Totals:	63	261	63	5.519533
			$p=$	0.019
20 – 29	5	54	13	4.952472
30 – 39	19	76	18	0.023399
40 – 49	25	79	19	1.844734
50 – 59	13	40	10	1.158744
60+	0	5	1	1.206897
No response	1	7	2	0.281492
Totals:	63	261	63	9.467738
			$p=$	0.0918
Asian/British Asian	6	12	3	3.336426
Black/ Black British	1	7	2	0.280882
Chinese /Other	1	2	0	0.555071
Mixed	4	5	1	6.470742
White British	48	226	55	0.780036
No response	2	5	1	0.522335
Totals:	62	257	62	11.93951
			$p=$	0.035626

*'Other' in the national data set represents an amalgamation of Graduate Mental Health Workers, CBT therapists (core profession unspecified), psychotherapists and individuals whose profession is not known. In the 'Transfer of Training' data set, 'other' relates to generic counsellors and those with no core profession.

**'Other' in the HI sample also includes psychology graduates. ($p=\alpha$ 0.05).

The evidence in table 4 shows there was no equality between the sample and the national cohorts on a measure of profession. Therefore it was concluded that in terms of professional background, the two groups were statistically different.

The collated national IAPT data showed that 80% of the initial IAPT trainees were female, and 68% in this study. The results in table 4 indicate that the gender patterns between the two groups, with the sample in this study were statistically significant different than the first national cohort (at $p=\alpha$ 0.05).

There were also national data available on the age of the original national cohort and this was used to examine the two groups. The results from the Chi-square test allowed for a marginal acceptance that the two groups had a statistical similarity when age range is considered.

The national data also provided some information on the ethnic mix of the first national cohort. The identification of ethnicity was different from the one used in this study. This thesis used the accepted categorisation of ethnicity advocated by the Civil Service (HM Government 2012c). The national data did not use the same categorisation preferring instead to capture a broader categorisation of ethnicity (there is no easily identifiable place for anyone who is white European in the national data). Therefore regional data were recalculated to make a best guess and so 'white European' was grouped under 'white British' in the ethnic mix. The results from the chi-square test in table 4 indicate that the two groups were statistically significantly different.

Importantly ethnicity is important for IAPT (and all psychological therapy) as it is well documented that people from Black and Minority Ethnic (BME) groups are less likely to be offered or accept psychological therapy (National Institute for Mental Health in England 2003; Department of Health 2003b; 2004d). The need for culturally sensitive psychological therapy should not be minimised (IAPT 2009) and it had been advocated that training places should be offered to reflect the cultural and ethnic mix of the local populations (IAPT 2009). How this is to be achieved without clear data collection and workforce planning protocols in such a culturally and ethnic workforce mix remains open to question.

The national data were incomplete on the IAPT workforce and the national workforce profiling team at Health Education England had acknowledged this (Health Education England 2013). As a consequence the conclusions drawn from this comparison exercise, for generalisation purposes, should be treated with caution.

4.2. IAPT workforce interviews and focus groups

Interviews were held with managers, supervisors and practitioners. Recordings were made and transcripts of individual and group work collated and notes taken in the field by the researcher. In interview settings, where recording was not possible (such as the focus groups) extensive field notes were made.

Managers of IAPT service indicated that gathering of IAPT therapists for a dedicated focus group was unfeasible given the workload pressures and commitment already given to face to face interviews. Permission was provided to make use of the scheduled team meetings to gather data. IAPT therapists from the cohort were not present at the sessions. The timing, constituency and venue for focus groups were not in control of the researcher, with both meetings scheduled for large rooms with long tables. The first focus group consisted of 16 therapists and the second 14 therapists. The testing of recording quality resulted in partial data and consequently a decision to utilise extensive field notes was made. Both focus groups were preceded by a short presentation on the research and its history. In each focus group an engaging discussion took place amongst the members, and this made the recording (in writing) of quotes achievable. The researcher was also required to make a

'real time' judgments on the relative importance of issues raised and whether worthy of recording.

Individual interviews were held with three managers associated with IAPT. With one manager, the discussions were held over a period of two separate occasions, and were opportunistic. Due to the constraints associated with this process, it was decided not to tape record these meetings but rather to maintain a diary with notes made during the interviews and immediately after. The interviews were designed to provide an overview of the IAPT policy implementation and the transfer of the content of the educational programme into practice. The challenges associated with delivery of a national policy in a dynamic healthcare environment was also a key feature of the interviews. Formal interviews were possible with two service managers and these data were recorded and transcribed. These interviews took place at a time and location convenient to the interviewee and lasted, in total between forty five minutes and one and a half hours.

A series of in-depth interviews were also held with the IAPT cohort members who were the focus of this study. All interviews were held at a place and time most suitable to the practitioners. Interviews lasted between one hour and one and a quarter hour. There were 6 interviews conducted with IAPT cohort practitioners.

The national curriculum for IAPT identified a minimum of 70 hours of clinical supervision within the training (DH 2008a; Turpin and Wheeler 2011) and post qualification on-going clinical supervision is a requirement registration as an accredited CBT therapist (BABCP 2013). The systematic review of evidence for transfer of learning identified little empirical support for the role of

supervision in the transfer process. The model of Baldwin and Ford (1988) (figure 1, page 17) and the work of Holton, Bates and Ruona (2000) specifically identify a role for supervisory processes in education transfer. Given the importance placed on clinical supervision within the curriculum, data on supervision were considered. In order to explore this in detail, two in-depth interviews were held with IAPT supervisors. As previously, the interviews were held at a location and time of the supervisors' preference. Both interviews lasted about one hour.

In summary, for this part of the initial aim of the study there were two large focus groups of IAPT workers; three interviews with service managers; six interviews with IAPT graduates and two interviews with IAPT supervisors.

This formed an examination of the process and aims for the IAPT policy and sought to understand from the opinion of policy developers whether these had been, or were being, met.

4.3. Research themes

The research themes follow the mixed methods process which guided the research from the outset. In illustrating the themes all data have been combined to provide a comprehensive and coherent analysis of data. This process involved an approach to cross-case analysis as a means of identifying the factors that may contribute to the case study under review and the research question. It represented an attempt on the part of the researcher to understand the discrete relationships that may have existed among the data. The process relied on a cognitive engagement and reflexive approach to rich variety of data. The data were mined with a view to generate linkages,

patterns and differences. The purpose was to generate themes which formed an accurate and truthful interpretation of the IAPT workforce in their attempts transfer learning in practice.

4.3.1. Theme: Confidence and capability in transferring learning

The training programme for IAPT was based on a competency model as influenced by Roth and Pilling (2007) although the concept of competency had yet to be adequately defined or measured (Sharpless and Barber 2009). Most often it was related to therapist self-reported increase in confidence and their belief in achieving treatment outcomes. Additionally the importance of independent assessment of CBT therapist competence had been a feature of treatment protocols (Sholomskas *et al* 2005). To examine the competence and confidence of the IAPT cohort in this study, the follow-up period was a minimum of eighteen months post completion of the course. The rationale was that newly qualified or novice therapists had been found to be overly optimistic in their self-report abilities of practice competence and ability to transfer new knowledge (Brosnan, Reynolds and Moore 2008). The longer follow up period was to facilitate a more considered reflexive account of therapist behaviour, competence and a comprehensive understanding of the factors that influence practice performance.

An aspect of competence is knowledge and to explore this, a survey measures of competence (the CBTKQ) was used. The questionnaire was administered on three occasions (prior to training beginning [baseline]; at the end of training and at eighteen month follow-up). Table 5 summarises the results from this data.

Table 5. CBT Knowledge Quiz: between difference in groups analysis

Time	N	Score/26	Mean Score	SE		
Time 1	63		15			
CBT prior training and supervision		27	16	.556		
Non supervision group		36	13	.664		
Missing		0			$t(61)=-2.966$	$p=.001$
Time 2	40		17.5			
CBT prior training and supervision		19	13.68	1.428		
Non supervision group		21	8.17	1.638		
Missing		23			$t(61)=-5.054$	$p=.013$
Time 3	24		18.5			
CBT prior training and supervision		15	14.71	2.142		
Non supervision group		21	13.79	2.350		
Missing		39			$t(61)=.913$	$p=.775$

(p =alpha 0.05)

At follow-up the knowledge base for core CBT practice showed some negligible improvement over time, from a mean average of 15 to 17.5 correct responses. There were six participants (out of twenty four) whose scores declined at time three.

Data were further scrutinised to examine whether there was a between group difference in the data. It was hypothesised that there may be a difference between IAPT therapists who had experienced training and supervision for CBT practice and those that had no CBT supervision. To examine any potential differences an independent sample *t-test* was conducted. The results in table 5 indicated who at time 1 the null hypothesis of no difference was rejected. The CBT supervision group was found to score significantly higher on the CBTKQ than the not CBT supervised group. At time two, there was still a slight significant difference between the two groups, with the

supervision group once again scoring higher on the scale. At time three the null hypothesis could not be rejected as the two groups had become equivalent over time.

The low mean scores on the CBTKQ of the non CBT supervised group were interesting. One possible explanation is that the scale makes use of three clinical scenarios through which to test CBT theoretical knowledge. Having previous exposure to clinical supervision for CBT may have provided an advantage to the higher scoring group.

The issue of competence of therapists required attention as the national programme of education was based on a set of competences derived from a major 'delphi' exercise (Roth and Pilling 2007). One of the national policy leads spoke at length about this issue, including the challenges of implementation:

'So that's when they went back to the research trials, they found the manuals and they extracted the competences from what people did as described in the manuals. ...and so they then established expert reference groups of the great and the good and they did contact [REDACTED] and he commented on their work and so it was a very international and high quality debate' ... 'um it wasn't a rational sequence of 'well here are the competence frameworks now let's develop the curriculum associated with them.... Part of that was just 'when are we getting the money?..oh my God it's in 3 months-time, we better get cracking' it was that sort of thing' (IAPT policy lead: individual interview).

The national education programme was therefore identified as a potential source of shared competences for all IAPT therapists in England. But the matter of this national benchmark for comparative training was identified as an issue as one education reviewer remarked.

'I have reviewed a number of national training programmes and I can tell you they are absolutely not the same, they are really varied'. (IAPT Therapist: focus group)

For some interviewees the training programme and subsequent practice exposure had helped them view their skills more critically. One interviewee, despite having a long history of working as a professional in mental health services identified how the programme had helped them develop a deeper understanding of their skills and deficits;

Oh I thought it was a really good course, I thought..although they were nerve wracking...the supervision we did that was rated, just watching myself on video was really uncomfortable, but it taught me a lot about myself and what I needed to improve on. The supervision within the university was really good, very challenging, which was good' (IAPT Therapist: individual interview).

One manager was in no doubt that the impact of the training and education increased level of skill they had witnessed. However, the sub-text of the quote indicated a slightly reductive approach to treatment, as the IAPT workers in their view had become competent at one thing; assessment. It is questionable whether that is sufficient to motivate a workforce to continuous improvement.

'They (the IAPT workers) can see quite a few patients quickly and discharge them, because that is all they do. They see patients, treat and discharge, so they are becoming quite expert. That's why I think we can operate successfully at the lower 'dose' than you see in the research trials' (IAPT manager: individual interview).

The issue of fidelity to a treatment model was a concern of the policy implementation leads. They promoted a programme based entirely on the CBT interventions which had an evidence base for depression and anxiety. However, it was evident that practitioners were less keen to offer what they saw as rigid and prescriptive interventions. This may have reflected a change in the client group, so interventions for anxiety and depression were under utilised and it may also reflect the sense of developing expertise of IAPT

practitioners. The 'Novice to Expert' model (Benner 1994) may be a reflection on this sense of developing expertise that supports a more fluid interpretation on how to gain an effective treatment outcome. The work of Foxon (1987) on 'vertical' transfer may also be evident here, where original skill or competence is refined and applied creatively:

'I started doing CBT, 'cos that's what we were trained to do but now I'm much more integrative y'know, I use other techniques that I knew before the training, I use whatever will help the client' (IAPT Therapist: individual interview).

Policy managers remained fundamentally exercised at the prospect of a loss of treatment fidelity. The competence based education programme was derived from treatment manuals from RCTs. Any deviation from this was viewed as a threat to the effectiveness of IAPT interventions. However some policy leads saw this shift as inevitable:

'I think that is a massive assumption and really is pretty naive. To think that the motivational drivers for ordinary people in the NHS are gonna be the same as those who want to go and work in a high end research clinic is just so stupid, It is just so so stupid' (IAPT policy lead: individual interview).

The issue of competence was also explored using aspects of the Measure of Generalisability Scale (MOG). The scale was administered on two occasions, immediately after training completion (time 2) and at least at eighteen months follow-up (time 3). The MOG contains three items directly relevant to the matter of therapist competence and sense of confidence. At initial return of the MOG, data were received from thirty eight respondents, while at the second data collection point this had declined to twenty four. Thus a matched pair *t-test* for related samples was conducted on the twenty four participants with end of training and eighteen month follow up being the two data points. Table 6 provides the results of the recorded data.

Table 6. Measure of Generalisability: competence and confidence sub-scale

Time	N	Mean Score	SE		
Time 2	38	12	.289		
Time 3	24	8.6	.458		
				$t(24)=-3.4$	$p=.000$

On average, the reporting of feeling confident and competent using CBT yielded a significant result (at $p=\alpha 0.05$). At first testing (immediately post training) respondents reported a high degree of confidence but this confidence had dropped statistically significantly at eighteen month follow-up. The importance of confidence was a feature of the interviews with practitioners which followed completion of the quantitative data collection process.

In addition to the Measure of Generalisability scale, the Training Acceptability Rating Scale (TARS) (Milne and Noone 1996) was also utilised. The TARS has two subscales; the first examines the perceived *content* of the training programme; was it acceptable? was it effective in what it set out to do?; was it helpful to the learner?; was the content appropriate? Was it delivered in a consistent manner? and was the content socially valid to the learner. The scale has a 1-6 response range, with 1 equaling a strong disagreement with the statement and score of 6 equaling a strong agreement. The highest score available on this subscale is 36 and the minimum score is 6.

The scale was utilised as a measure on the assumption that a training programme which had good socially valued content that was delivered in a consistent manner would have a bearing on the confidence and competence of practitioner educational transfer to the work setting.

The TARS was administered only once (at the end of training) with a total number of forty responses to the TARS from IAPT therapists. Respondents reported a mean average score of 20 (SE=.5, SD=3.3 Min score=13; max score=31) on the sub-scale with the median scores for the quartile ranges were quartile 25=18; quartile 50=20 and quartile 75=22.

Table 7 provides a detailed breakdown of the TARS questions.

Table 7. TARS: detailed analysis of the competence subscale

Time	N	Mean Score
Time 2	40	
The education programme was....		
Acceptable		3.8
Effective		4.0
Helpful		2.4
Appropriate		2.7
Consistent		3.9
Socially valid		3.9

The two lower mean scores in table 7 ‘helpful’ and ‘appropriate’ may be explained by the negative phrasing of the questions on the scale; ‘helpful’= ‘The training will result in disruption or harm to patients’ and ‘appropriateness’ = ‘Most staff would not accept that the training provided an appropriate approach to client care’. Therefore a lower mean score would indicate that in general the respondents thought the training was unlikely to cause any harm and that it was acceptable treatment of which their colleagues would approve.

The issue of competence and confidence was of paramount interest to clinical supervisors too;

I think it's probably.....an analogy would be driving.. you can drive when you learn, but you are not used to all circumstances...you should come out of the training knowing what guidelines, processes and treatments are there for people with particular problems. The complexity comes in when people don't fit into those categories, so when you are working in a clinic you might know what to do for a particular problem but you mightn't know what problem to address and you might not know how to engage somebody...it's that sort of thinking through the whole person's problems and that sort of idiosyncratic thing that you see in primary care where a lot of psychological distress is caused by environmental factorshow do you distinguish between managing the person's problem as in terms of their clinical condition against a background situational circumstances that might not be changeable, it might not be in that persons' ability to change,...(IAPT supervisor: individual interview).

This theme was recognised by one of the national policy leads, who noted the limitations of a focus on competency, particularly when associated with an assumption that such competences were held by certain professions;

'...and I discovered that they were selecting for CBT competence, so you see what you are getting is a continual privileging and a narrowness, it is a very binocular vision of saying this is what we are doing based on the science. But they have not got the experience; they may be competent but have not come across the complexity. So it's the same thing again, we train people for a particular purpose, but how does that reflect the reality, the complexity of the setting' (IAPT policy lead: individual interview).

But with experience came a different mind-set and ability and one of the clinical supervisors returned to the theme of competency as driving a car;

'Going back to the driving analogy, they are probably worse drivers, but they have more confidence...so they are probably less likely to have an accident, but they are probably not as modality specific as they were, so I think it's a constant battle to keep people focused on the principles of whatever therapy they have chosen to go down the path of. It's that philosophical principle thing is oh so difficult to keep people on' (IAPT supervisor: individual interview).

The importance of confidence and competence within all data was a prominent theme. The policy leads promoted competence above confidence,

which may reflect their focus on policy and the development of an education programme to support new workers and services. The IAPT therapists, supervisors and managers had a stronger reflection on the importance of feeling confident when engaged in direct therapy. This confidence was allied, but distinct from the feelings of 'therapeutic drift' (see section 4.3.7) where their ability to respond to problems in therapy raised doubts on the limitations of the ability to transfer key skills from training to practice.

4.3.2. Motivation: Identity

A relationship existed in the psychological literature between competence, or the desire for competence, and 'motivation' (Deci and Ryan 2002). Within the data an attribute that many responders identified was the need to exhibit motivation to work as a High Intensity IAPT therapist. As indicated within the literature review, there were many theories which are utilised to explain motivation. The PRIME theory of West (2006) and West and Brown (2013) placed a primacy on 'identity' as a key feature of motivation to continue to engage in an activity, despite many external 'threats'.

An example of an external threat was promulgated by one of the national policy leads, who identified the potential for IAPT to become a transitory initiative (like many other new workforce roles identified in the introduction to this thesis). This respondent considered the importance of developing and maintaining an IAPT identity for the workforce as critical in enabling them to remain within services and develop their practice further. Without such an identity and the associated emphasis on transfer in practice, the policy might fade.

I have come to see professional identity as hugely powerful, hugely powerful. I think it amazing that we have managed to retain the term High Intensity therapist. I imagine this may change over time. When there is no longer the IAPT programme and the mainstreaming process begins, this may well change. I think you'll find people migrating back to whatever they have originally been, I don't know, but I think it is probably true' (IAPT policy lead: individual interview).

The statistical element of motivation was examined through completion of the Academic Motivation Scale (AMS) (Vallerand *et al* 1989). The scale was completed on two separate occasions (prior to IAPT training and on completion of training (1 year later). A paired-sample *t-test* was completed on the data and in the first instance a simple three way motivation construct was used (Amotivation; Intrinsic Motivation and Extrinsic Motivation). The reason for this decision was based on the sample size over the two assessment periods. There were sixty three responses at the first data collection point and forty at time 2. Consequently, detailed examination of the seven factor model proposed by Vallerand and Ratelle (2002) could not be tested with any statistical rigour.

Specifically, the data were tested to identify any difference between IAPT practitioners who had identified as having previous CBT experience and those that had come from a different psychological therapy background (e.g. counselling). The 'Intrinsic motivation' scores were tested at the beginning of the training programme, to examine differences between these two groups; to examine whether those who had a previous CBT experience were more motivated to engage with the training. A paired sample *t-test* was conducted to examine any differences between these two groups. The results of this process are presented in table 8.

Table 8. Academic Motivation Scale paired t-test

Time	N	Mean Score	SE		
Time 1: intrinsic motivation	63				
CBT prior training		48.0	3.7		
No CBT experience group		50.1	4.1		
				$t(31)=-2.10$	$p=0.708$
Time 2: intrinsic motivation	40				
CBT prior training		50.5	3.6		
No CBT experience group		51.4	4.1		
				$t(31)=0.16$	$p=0.87$
Time 1: Extrinsic motivation	63				
CBT prior training		47.4	3.3		
No CBT experience group		54.6	4.3		
				$t(27)=1.32$	$p=0.19$
Time 2: Extrinsic motivation	40				
CBT prior training		48.7	3.4		
No CBT experience group		53.6	3.8		
				$t(31)=0.98$	$p=0.33$
Time 1: intrinsic motivation	63				
CBT prior supervision		41.9	4.0		
No CBT supervision		55.0	3.5		
				$t(36)=2.46$	$p=0.019$
Time 2: intrinsic motivation	40				
CBT prior supervision		46.3	3.4		
No CBT supervision		57.3	3.6		
				$t(37)=2.74$	$p=0.009$
Time 1: Extrinsic motivation	63				
CBT prior supervision		44.5	3.4		
No CBT supervision		54.9	3.4		
				$t(36)=2.03$	$p=0.05$
Time 2: Extrinsic motivation	40				
CBT prior supervision		42.6	3.4		
No CBT supervision		57.4	3.2		
				$t(37)=3.20$	$p=0.03$

($p=\alpha$ 0.05)

Results for the intrinsic subscale indicated that at time 1, the null hypothesis of no significant differences between IAPT therapists who had previously studied CBT and those that had no previous knowledge could be accepted. At time two, (the completion of training) the null hypothesis again was accepted as once again there was no statistically significant difference between the two groups.

This picture was mirrored in the results of the sub-scale to examine the levels of extrinsic motivation in the two groups. The null hypothesis was accepted as no statistically significant difference was calculated.

In the collection of demographic data, the IAPT therapists in training were also asked to identify whether they had received CBT supervision previously. It was based on the premise that receipt of CBT clinical supervision was an indication of an *applied* interest in CBT practice. That is, this sub-group had not just studied some CBT theory, but had used it in their clinical practice previously and had been supervised in their clinical application.

To examine the relationship between these two groups (CBT prior supervision and non CBT supervision) the intrinsic motivation sub-scale was re-calculated at the beginning of training. The null hypothesis was accepted as no statistically significant difference was evident.

At immediately post training the two group scores were examined with the supervision group and this time the null hypothesis was rejected as a clear difference emerged. This statistically significant difference was also evident on the extrinsic motivation scale as both at prior to training and immediately on training completion the prior supervision group was statistically different and the null hypothesis was rejected.

There was evidence from results in qualitative data of a long held desire of this group to work for a therapist qualification for many years;

'I had a long interest in Behaviour Therapy...so I had a sense that I had been living and breathing this stuff for a long time. So I did some basic training in CBT a long time ago, it was hard academic work, which I struggled with. So I was quite frustrated for a long time, trying to find opportunities to do some additional training' (IAPT therapist: individual interview).

Another respondent identified a long term frustration in obtaining funding to obtain a higher level qualification and long-term supervision to become a Cognitive Behaviour Therapist.

'so I got a supervision contract with [REDACTED] And then I applied to do the MSc in CBT and got funding for the first year (the PG certificate) but then funding was withdrawn for the last two years with the change-over in managers, ...but anyway I stopped at that point. It was all completely changed then...but anyway I finished the certificate, but then was in effect practising as a CBT therapist within the CMHT' (IAPT therapist; individual interview)

The issue of motivation was related to the construct of identity within PRIME theory (West and Brown 2013). Therefore attention was placed on analysing data to explore a narrative around a developing/developed self-perception as a CBT therapist following a period of study. Clearly for some respondents the external organisational pressures were always a feature of their realisation as CBT therapists;

'I am only interested in providing a service to the person in front of me, but it is difficult, there is so much pressure to discharge people, the bean counting gets you down' (IAPT therapist: focus group respondent).

There is no way you can be motivated to get some rewards, because there are none..no recognition, no promotion..you can only be motivated by wanting to do your best'...

'..Or you just get burned out!' (IAPT therapist: response from focus group member).

'Of course there is tension, our values as therapists are at odds with the managers and the political environment, we know there is the threat to the NHS, so as a therapist you feel quite isolated, there is no shared identity or shared value set, I have no idea what others think because we don't have the opportunity to meet and discuss' (IAPT therapist; individual interview).

The tension of different value sets and the implication of the development of a shared identity and coherent service provision was not just an issue for therapists and managers;

'One of the risks, I believe, that the Treasury identified about implementation of the programme was about deep rifts between different schools of psychological therapies and that is why the New Savoy Partnership emerged which was trying to get a whole range of people involved' (IAPT policy lead: individual interview).

Some practitioners identified solutions to the challenges they faced from the internal and external pressures that affected their work. Strongly linked to the concept of motivation and transfer, these practitioners seemed to develop a resistive stance to the accepted norms or a sense of compromise between what they thought they were as therapists and what they were expected to do.

This thing about 'I can only give 6 sessions' or whatever is all in our heads..it's not true..what can the manager's really do?..we tell ourselves these lies all the time' (IAPT therapist: individual interview)

No..I thought it would be more Cognitive Behaviour Therapy.. and I make a distinction..I work as a Cognitive Behaviour Therapist but I don't do Cognitive Behaviour Therapy with all my patients, I just don't. I can't square that and say that I do. There are some patients on my list, I would say two in every ten, where I do CBT, where it feels structured, where it feels like there is some progression, some therapeutic relationship. Other patients, I think I'm utilising CBT but I'm not doing actual therapy with them. I'm told that I am, but I don't think I am. If you see somebody for three sessions and you've normalised their symptoms and you've given them some techniques, I feel uncomfortable about them saying 'I've had Cognitive Behaviour Therapy' because you've had some therapeutic input which has been helpful, but to call it CBT is to misrepresent what my idea of CBT is. Maybe it's my idea of what it is, is wrong and I need to change that but...maybe that's just the way it has to be.

(IAPT therapist: individual interview)

For a clinical supervisor the issue of being motivated and retaining fidelity and an identity to a model of working was paramount in transferring new skills and obtaining positive outcomes for patients.

'If you have got someone who buys into what they are doing it is so much better...I was talking with one of my colleagues, one of my supervisees and reviewing her audio tapes...and I told her she does it so much better than I do, she thought I was being facetious...I wasn't...because she believes it more than I do, she wholeheartedly buys into the model of low self-esteem, and that's fine...I don't and therefore I'm not as good and sometimes explaining having a belief in something is really important, being able to sell it. It's about the skills and developing them, it's about that desire to want to work in this field' (IAPT supervisor: individual interview).

There was clearly a link to competence and capability in the above quote, but the critical aspect was reflected in the consistency of purpose in selling a way of working to people who seek help with their problems. The motivation to stay true to a treatment model and an identity as a CBT therapist was exemplified when the supervisor earlier in the interview noted that treatment is difficult, and that often a patient will seek to avoid some of the more challenging aspects of therapy. Without a certainty in a therapist identity and the theoretical model, it becomes easy for the therapist to opt-out of the difficult treatment too and collude with the patient;

'sometimes therapy is painful for the patient and can make them feel worse,..so having support when doing that difficult work is important. There is the potential to move into offering supportive,....because for the patients some of the treatment is so difficult..and it's difficult for the therapist, it's about holding the line, particularly in primary care, where you're working on your own for a lot of the time, so it's that about sticking with the process making sure we are doing CBT even if the client might want something different' (IAPT supervisor: individual interview).

The role of identity as a supportive process to aid a sense of surety of purpose and to facilitate the coherent and consistent application of key agreed skills and competences was considered important. The national policy leads,

made clear statements about, IAPT being an opportunity to develop a new workforce and to protect its emerging identity.

'I think we had in mind from quite early on, they would be part of a new profession. We'd have to have our own concept of accreditation and so on...because that is one of the peculiar things of IAPT, it has developed in such a way that there isn't a professional association for it and that's why it is peculiarly important to maintain the central structure because that's where its identity is coming from' (IAPT policy lead: Individual interview).

The transfer of learning for an (emerging) profession might be predicated on a consistent and coherent application of a body of knowledge. This would seem to be a challenge for the IAPT programme of which national policy leads were well aware.

4.3.3. Tension and external pressures

The data on identity raised a number of examples where the emerging identity and application/transfer of new skills was threatened by tensions. These challenges were faced by practitioners, policy leads, supervisors and managers and formed a significant theme in all the analysis. The external world was seen as the principal reason for challenges in transfer behaviour. Training programmes were seen to be important and facilitating some room to consider therapy skills and the most appropriate approach to treatment for particular conditions. The 'real world' environment was seen as the antithesis of this. It was viewed as high pressure, time limited and replete with many quotes relating to health care provision as 'factory' analogies.

'Tension is the best way to describe it..between activity, getting people seen and quality, the giving of enough treatment. They have a lot to do, taking measures, giving treatment, quickly and getting feedback data. The focus on achieving recovery rates is immense. Do I think they were trained for this...no? I am not sure you could possibly train people for this..not sure they would accept it' (IAPT supervisor: individual interview).

As if to exemplify the dynamic nature of health and social care provision, managers indicated the threats to service delivery related to external national policy. Such policy application was viewed as having significant unintended consequences for new services like IAPT in primary care;

'The reality is that AQP ('Any Qualified Provider') has changed the work so much. We are in competition with other providers and they might well be working in the same surgeries (General Practice). For patients'..I don't know whether they know the difference really, but the focus is on making the service pay. We just can't afford to have patients be in treatment for too long...you commented on the aims of IAPT about equality of access and help for hard to reach groups..we really struggle to find time for that, 'cos that would take time and resources and they are things we don't have, it's a capacity issue, simple as that' (IAPT manager: individual interview).

'AQP demands that the service gets expanded, if a patient wants a service it has to change..you are kind of driven to meeting needs of GPs and patients wherever they are...we used to just be located in 2 areas (of the county) and now we are everywhere..it increases our costs..does it make us better, better quality service..I don't know' (IAPT manager: individual interview).

This perspective was shared from the perspective of individual therapists, who spoke openly about the changes that related policy such as AQP had on their practice;

'The whole picture has changed,..not much in the way of collaboration now..I mean the voluntary sector has diminished, there is hardly any meaningful service left, certainly nothing you could rely on, 'cos of budget cuts and the like. And secondary care ...I don't think they have anything like the pressures we have' (IAPT therapist: individual interview).

The issue of contact with clients was a common theme and particularly the number of sessions required to obtain a positive change in a person's mental health. The original analysis for IAPT recommended a minimum treatment period of 12 sessions (the 'therapeutic dose'). Within IAPT services at the time of analysis, a maximum of 6-8 sessions was not unusual.

'It's tension..productivity verses quality and that's it, that's what we balance all the time'. (IAPT Therapist: focus group).

'This is a social policy of getting the absolute most out of something for minimal cost and it is having an effect. Look at the issues with incapacity benefit. We are operating a 'dose related' model like they do in the US (United States)'. (IAPT therapist; focus group).

Respondents identified that some of the challenges emerged from less direct routes than new national policy, such as AQP. The role of commissioners and the requirements of Clinical Commissioning Groups (CCGs) were often reported. It would seem evident from the respondents that the rationale for changes requested by CCG commissioners was not clearly communicated;

The people we treat have changed and that means the workers have to change...they weren't trained for the people they see now..much more complex. Commissioners identify groups no one is seeing and say 'can you do that now' and staff were not trained for that' (IAPT therapist: individual interview).

'How do you retain your best staff, they can get jobs at a range of providers as let's face it we ain't exactly falling over ourselves with trained therapists..we have to open the workforce pool a bit 'cos we have to respond to changing demands of commissioners and we have many more counsellors now, not trained in IAPT but have some CBT' (IAPT manager: individual interview).

And commissioners would come in and say, we want this or that and they were another group who were just not involved and so would make commissioning decisions that would go against some of the implementation decisions that needed to be made' (IAPT policy lead: individual interview).

A major theme, which was often referred to by all participants concerned the use of an 'evidence base' to guide development of the programme, the training initiative and the work of IAPT practitioners. Utilising available research evidence (particularly for CBT) was seen by all as a defining feature of the IAPT initiative.

'...the debate between a high volume model and one which promoted, let's just get more CBT therapists in primary care. The one thing they didn't do was to consider a theoretical model and to use that theoretical model to drive change and they didn't do that. They just said we are gonna train a load of people and these people are gonna see patients and that's it. I mean we see difference in implementation models, difference in patient experience and that's been the case from the beginning' (IAPT policy lead: individual interview).

The work of Bochel and Duncan (2007) identified that research informed policy rather than dictated it. However, the issue of what constitutes research and whose 'voice' is seen as persuasive to policy makers requires attention. Additionally, and as identified in the theoretical framework for this study, the external (political, social and economic) influences on policy decision making and implementation were profound. The initiation of the IAPT policy was not seen as a singular scientific process, with many competing perspectives on workforce planning. There was a link to the concept of identity and the role of core professional qualification and the impact on becoming a CBT therapist who could transfer new skills into IAPT practice;

'anyway there was quite a lot of argy bargy about "counsellors, they're hopeless" there was a lot of playing out of prejudices. There was also some..work around training nurses and implementation of practice and how difficult it was to achieve real change, Now (a person's) view on this was 'well this is hopeless, there is no point in training these people'. Now that gives us a problem here, because what is unique about IAPT is that you have brought people in with different professional backgrounds, and the data is there but what we haven't done is see if there are any qualitative differences in people who have these different professional backgrounds' (IAPT policy lead: individual interview).

The role of the evidence base for practice was a strong feature of the IAPT initiative. In the original submissions to HM Treasury, emphasis was placed on RCT evidence in supporting the primacy of CBT in IAPT. It is noted that the failure to implement research trial interventions is at the heart of the implementation science agenda. The complex interactions (as within this study) present significant implementation challenges to services in the utilisation of evidence in practice. However, there was evidence of different perspectives on whether such a primacy was sustainable beyond well controlled clinical trials;

'The science on which research trials are based are 'if then' causal models they are purely linear, people are selected, they take out the complex, they take out people who are different. That's fine if you just accept it for what it is. I think it's natural, people want simplicity, that want to say, yes this is how it is!, y'know 'we want to sort out our priorities'... you can see it, that's why you do it, but then if you think is that all there is, well no, that is not all there is, so you know you need to think about complex systems' (IAPT policy lead: individual interview).

A very different interpretation was offered by another respondent;

'What you hear is that people say the people in clinical trials are so highly selected that they are not from the real world, it's just not true. The eligibility criteria does not say 'is this person complex'? 'yes' well 'not eligible'. People are coming into trials with all sorts of stuff and it's one of those amazing myths that clinicians use to excuse the fact that they don't appear to get the same outcomes. What they don't understand is there is a whole host of people in clinical trials who don't do well' (IAPT policy lead: individual interview).

The external pressures were also evident for policy leads, as the theme of tension was evident in their responses. A number of respondents identified that policy implementation was highly challenging as the 'whole system' worked against an evidence based application of practice;

'The programme as it was originally conceptualised was about getting CBT into the NHS in more than a half-hearted way, so umm the original concept "let's just get a load of CBT therapists trained". ..But it largely hinged on what your definition of CBT was. Some might argue that the original conceptualisation for CBT in primary care was somewhat naive. The problem had been articulated very clearly, y'know here was a NICE guideline that works, but we don't do it. I mean you would not tolerate such a circumstance in diabetes, heart disease or cancer. Treatments work they get recommended and they get done. That may be our fantasy about how things get done, but in mental health it seems as though there is a different rule book which is we recommend them, but they don't get done. So we thought the identification of the issue was absolutely spot-on and the solution 'get CBT out there' is a great idea' (IAPT policy: individual interview).

There were many examples of where policy leads identified the shortfall in their initial implementation aims. Whilst on the whole it was clear that many aspects of the policy had been achieved, it had been done so at some cost to compromise and relinquishing control;

'What we thought the training and service as not only in parallel but intimately related and if we had not been able to developed the services that implemented to

evidenced based the ultimate object is not to train people but to have services. Actually I suppose you could say the training in some senses has probably been more successful than the services' (IAPT policy lead: individual interview).

'It is impossible to implement something like IAPT in the NHS, because there is always someone in authority who wants to bastardise it, because they don't want to pay for it...there's no respect for research evidence at all' (IAPT manager: individual interview).

The external (political) environment was a feature of every interview. The policy leads had their set of perspectives on the goals of the whole programme and its implementation. There did appear to be a consensus that while policy formulation was challenging but achievable, the implementation proved a challenge given a lack of infrastructure to support the process;

'Implementation is so hard, these new workforce programmes because we kind of know what will work but you can't control it, people use their freedom to tweak elements of the programme locally that it becomes almost unrecognisable in the end. I think the days of command and control work from the centre is long gone now, not sure we could get it back' (IAPT policy lead: individual interview).

'What were the barriers and facilitators, what work needs to be done in order to normalise evidence based medicine or whatever. We never did it and that comes, partly comes from the fact that we did not have organisational psychologists and I don't think anyone understood this. It was more of, 'it is a manualised treatment, train people to give manualised treatments and we'll get manualised treatment outcomes'. I think there was a massive blind spot and what they thought the NHS is and what it really is. Honestly there wasn't an implementation programme, the various regional leads were not given the tools to implement it. I mean it was really just organising all the training tenders, getting all that sorted and that was a big job for them' (IAPT policy lead: individual interview).

The policy leads all confirmed that the education arm of the implementation programme was the main aspect of policy over which they had some control. There was a desire for a consistent approach to implementation that proved elusive from the very beginning, causing tension about retaining a fidelity to the aims of the programme:

'universities were asked to put forward their curriculum based on the materials given them. So again it was highly articulated about what we wanted, they had to come in and show what they were going to do...and it was only when we were going through that and they had started to run courses that we thought we ought to have an accreditation process' (IAPT policy lead: individual interview).

'We were right to be that suspicious because a number of universities failed their accreditation, but even with national training curriculum and supportive materials some people still wanted to do their own thing and didn't meet the national learning needs. I saw the fact that there was no learning blueprint for this job and we'd shown without the learning blueprint people will go off and do their own thing. We needed that direction and as publicly funded workers this is what should do, to point out the evidence base and argue for implementation of it' (IAPT policy lead: individual interview).

Even when a policy lead identified that IAPT was actually quite a prescriptive programme, with a *prescribed* training programme and a *prescribed* set of outcome measures based on the delivery of a CBT psychological treatment model;

'The only way I think IAPT has been successful because it has had the implementation arm under control...and if you think how prescribed it is, however, you can go ten different services and they all work slightly differently. Some of them are only CBT and some have, well a variety of different therapists and 30% of the workforce are counsellors' (IAPT policy lead: individual interview).

The political nature of the external environment was crystallised in statements from policy leads which caused considerable concern for the future of a credible IAPT programme;

'I think what is definitely coming into play is the policy around Any Qualified Provider (AQP) and because of the cuts, the need to save £20billion etc. we are certainly seeing examples of wildly inappropriate contracts. I heard about one where Low Intensity interventions was limited to two sessions and I think High Intensity to seven or five....a ridiculously low figure. I mean it's just nonsense. Because again I think you are in danger of throwing the baby out with the bath water' (IAPT policy lead: individual interview).

There were also a number of known workforce pressures in evidence within the implementation programme, particularly in understanding where the new workforce would come from;

'But it's been I think would be fair to say that education providers and services have really struggled to recruit' (IAPT policy lead: individual interview).

██████████ really wanted to recruit clinical psychology and their argument was there was a recession on the horizon and there was cutbacks in NHS spending going on at the same time and the other professions were beginning to see a rise in unemployment in graduates and they were expecting the same in clinical psychology and wouldn't it be great if they could train for another year. Surprise, surprise the unemployment in psychology did not happen and not many doctoral graduates were that impressed by the prospect of another year of training, so it was a hard offer to make (IAPT policy lead: individual interview).

In addition to the above qualitative data, the Minnesota Job Satisfaction Scale was used as a proxy measure to explore the 'tension and external pressures' aspect of the study. The scale is made up of an intrinsic satisfaction; extrinsic satisfaction and an overall satisfaction scale. The measure was administered on three occasions during the study, at pre-training, immediately post training and at eighteen months post training. Table 9 provides a breakdown of the results from the administration of this questionnaire.

Table 9. The Minnesota Job Satisfaction Scale over three time periods

Time	N	Mean Score	SE	Median	SD	N in lower quartile	N in upper quartile
Time 1: General satisfaction	63	66.65	1.386	69	11.05	16	22
Time 2: General satisfaction	38	69.76	1.781	70.5	10.98	9	10
Time 3 general satisfaction	27	71.30	1.492	72	7.755	7	7

A score in the 75 percentile quartile was considered to be indicative of a well satisfied workforce. The mean general satisfaction scale remained stable

over the three data collection points. The data indicated a consensus across the 3 time periods on each measure of satisfaction (intrinsic; being satisfied and enjoying work for its own sake; extrinsic; satisfied for the rewards work can bring and general satisfaction; an amalgamation of the two subscales).

Therefore despite many external pressures there was no evidence to indicate any significant job dissatisfaction amongst the IAPT therapists.

This was not to say that IAPT practice was not without emotional costs with a number of therapists identifying a sense of exhaustion an often referenced issue within the interview data.

Oh I don't know, I feel knackered...I am going through the very tired, weary burnt-out stages myself but it's not burnt-out but that very weary stage and again I take this into account with..when the patients in the real world they have all these kinds of things that I have..things that go off. When they are unmotivated I suppose my motivation is a bit flatter at the moment' (IAPT therapist: individual interview).

'Well there are two things really. It is a really fantastic job where there are times when I think, I can't do this I'm really crap at it and there are other times when you think, y'know what it's going really well and that person has got a lot out of seeing me.... I am absolutely certain you cannot sustain this, at the end of the week I am absolutely shattered' (IAPT therapist; individual interview).

The Maslach Burn-out Scale (Maslach *et al* 1996) included subscales covering 'emotional exhaustion' (EE); 'de-personalisation' (Dp) and 'reduced personal accomplishments' (rPA). While the scale itself identified a cohort of people who did not meet the threshold for 'burn-out', it was evident from many respondents that a sense of exhaustion was reported. Data in table 10 provide the results of the burn-out inventory with total and percentage scores.

Table 10: Maslach Burn-out Inventory scores based on normative sample distributions

Construct	Sample size	Low Scores	Mean average scores	High scores
EE time 1	62*	11 (18%)	17 (27%)	35 (55%)
EE time 3	27	3 (11%)	9 (33%)	15 (56%)
Dp time 1	62*	40 (65%)	10 (16%)	12 (19%)
Dp time 3	27	14 (52%)	8 (30%)	5 (18%)
rPA time 1	62*	11 (18%)	42 (68%)	9 (14%)
rPA time 3	27	7 (26%)	17 (63%)	3 (11%)

*There was a single incomplete questionnaire page from a participant in time 1

For 'burn-out' to be present, the authors of the scale (Maslach *et al* 1996) state that respondents must score high on both subscales (EE and Dp) and low on the personal accomplishment sub-scale. The scores (as a percentage) remained quite constant over the period of analysis – time one data were collected prior to the commencement of training and time three data collected eighteen months after training had been completed. Only three individuals met all the above requirements for burnout at time one and only two participants met the threshold at time three. Therefore, as a group, the participants could not be classed as 'burnt-out' in terms of this scale. The Emotional Exhaustion (EE) scores though did require closer examination as this sub-scale alone had been cited as having the strongest predictive power (Aiken *et al* 2002) although the large study by Poghosyan *et al* (2009) indicated that all three factors were required to be present and correlated significantly with each other. Taris *et al* (2005) proposed that factors of the scale should be seen as a development process in that feeling emotionally exhausted over time, may lead to feelings of de-personalisation and then reduced personal accomplishment.

The Emotional Exhaustion (EE) subscale (while not indicative of 'burn-out' as a construct) did identify high scores at both time 1 (at the beginning of training) and time 3 (eighteen months after training was completed). This indicated the reflections of IAPT practitioners and the management of high pressure, high volume service delivery processes.

The interview data generated many examples of participants explicitly citing a feeling of exhaustion, stating that the job was emotionally draining. There were explicit implications for their transfer behaviour, as time to reflect, study and practice therapy as they had been taught were often compromised;

'I don't recall the last time I went back and referred back to a manual, preparation for a patient is not what is expected of us now. If you're lucky you might get ten minutes, but that is just refreshing yourself on what you did last time, there is no way there is any time to engage in treatment planning in advance of the person turning up. Even your DNA (Did Not Attend) time is taken up with admin, and there is enough of it but I dunno, you think yes I should look at that manual on social anxiety, but so knackered most of the time, it just gets done' (IAPT therapist; individual interview).

'The way it is organised is that, because I work in these clinics, when I have rooms available, I have to book people back to back, so I don't, so they're literally booked in on the hour, so if you assume each patient is going to get 45 minutes of that hour, it sometimes overruns, but there are times when I am saying goodbye to one patient as you follow them and bring in another one through the door and that is very different to how we were taught to work. We were taught to have time to digest what the patient said; write some notes reflect on it; plan for the next patient session and that is just not the case' (IAPT therapist; individual interview).

;.and to engage in confrontational difficult therapy; addressing people's difficult emotional problems by ploughing through them is hard work and one of the big problems that therapists have in primary care is that sense of isolation. They don't work in departments with other CBT therapists, for a lot of their working life they are on their own' (IAPT supervisor: individual interview).

The time to consider the integration of skills to practice; the process of transfer, was not a significant feature of the interview data with policy leads. Yet for other respondents, the focus on targets for client contact and recovery was seen as the main issue about service delivery. It was considered to be

the main agenda item at the expense of quality and practitioner development. These targets were the subject of local negotiation and funding arrangements with commissioners. As a consequence the contact and recovery targets formed an important strand of the tension expressed by managers and IAPT therapists.

A number of therapists had utilised a personal therapy approach to making the psychological adjustments to managing this tension and external pressure.

(in trying to meet targets) they should take in their own therapy, it is people's own perfectionism in trying to meet the standard and if the standard is unrealistic, you are setting yourself up to fail. So when I have taken the pressure off myself, I just do what I can, so I have in my mind the target and if I can get them in I will and if I can't, I can't....so you haven't got control over the buses running late and patients coming in 40 minutes late and you can't see them..and you..babies being sick, child minders being sick, y'know you have no control so that's all you can do. You take control of what you can, which is offering the appointments and the rest is up to the patients in their world. I suppose it is separating myself off, y'know, they are not an extension of me'. (IAPT therapist: individual interview).

For some respondents the overriding emotion was frustration and anger at what they saw as an over reliance on data to demonstrate the worth of treatment in psychological therapy;

'What can they do if I don't hit the targets, I mean seriously, what can they do. As long as I am trying my best that's all that matters. I control what I can and what I can't I don't and I tell the others to do the same' (IAPT therapist: focus group).

'I do what I can, my managers know this. I tell people around me not to buy into this crap about targets. What can they really do? It is not as though they are going to sack us all is it?' (IAPT practitioner: focus group).

There were no data in the survey which indicated a cohort of practitioners suffering with burn-out, but the interview data and survey 'burn-out' subscale did point to a highly challenging work environment and concomitant elevated stress levels.

4.3.4. Feedback

The process of feedback was identified in the literature review as a feature of complex adaptive systems. Consequently, adopting a complex frame of reference in this thesis, the issue of feedback in the transfer of knowledge and skills was considered worthy of analysis. During interviews and focus groups, the introduction of feedback systems into the conversation was followed up with additional exploratory questions. One of the key aspects of this study of transfer of education in IAPT is its unique status in terms of policy feedback processes. The national approach in IAPT was to collect data on every treatment session in the service. Such data collection processes were viewed with differing perspectives from all participants, with no particular group valuing them above any other. There was a more positive slant given to data collection about treatment progress by the policy leads who identified its benefit:

'one of the very big debates around IAPT, one of its strengths I think is, was umm 'How are we going to measure it? What are the outcome measures going to be? And in the end, for better or worse, they ended up with PHQ-9 and GAD' (IAPT policy lead: individual interview).

For this respondent, the focus on outcome measures as a means of demonstrating the worth of the programme was seen as an absolute strength:

'Our tools for recovery are pretty blunt really, the PHQ-9 and GAD don't really tell you much but we have to use them..not sure what is better, but I know there are different approaches to how the form gets filled in and how and when it should be completed..it isn't consistent and we have no capacity to make sure it is done just in one way'. (IAPT manager: individual interview).

The limitations of the nationally approved monitoring scales found resonance with an IAPT supervisor who identified a series of challenges with the

commissioning arrangements for IAPT at DH and CCG levels. Services were paid on assessments that progress to treatment (of at least two sessions).

The contract arrangements for IAPT services were largely monitored via the data set that were returned to commissioners and DH on a monthly basis:

'Obviously over simplified objectives within IAPT..I am not saying I've got any answers, but it's certainly an oversimplification...an example of that is that many of our patients wouldn't score on the rating scales, because they are highly avoidant, they are probably the ones most in need of Cognitive Behaviour Therapy er..and most dysfunctional but they just don't score on symptom scores because they don't confront their anxiety or distress. So that's a practical evidence that our objectives are not focused enough on patient need' (IAPT Supervisor: individual interview).

Despite this, the DH was in a position through central reporting mechanisms to conduct trend analysis on the output of therapy (DH 2012b). The caution with which such data processes should be treated was noted by a number of respondents, as there were potential failings in the national implementation programme, when the monitoring (or lack of monitoring) of data sets was the principal quality indicator:

'Who was ever monitoring, I don't think it was ever monitored. Genuinely...I have worked with and trained a whole host of people from a vast area and honestly some of the stories they tell of their clinical procedures ..I mean it makes me think, this is not what I sat in those committees to decide. What do you mean you are only giving people a small number of sessions? I mean everyone gets a group...this is not evidence based, it's just amazing' (IAPT policy lead: individual interview).

The IAPT implementation programme may have been unique in national policy implementation terms in relation to the emphasis on session by session recording and reporting of patient response to treatment. This feedback loop provided patients; practitioners; managers; supervisors; services, employers; CCG commissioners and the DH with accurate and timely data on service performance. The theoretical model (figures 2 and 3, pages 23 and 25)

identified feedback as a critical aspect of a complex adaptive system, and it was clearly evident within the IAPT service.

'that this routine outcome monitoring could be a useful help for the therapist, but actually conducting therapy week by week but also could be thought of as a sort of challenge to the therapist in terms of whether it really was achieving the kind of standards because it is quotes 'objectively' measured. Sort of we know from trials what can be done and that what a professional person would be trying to achieve' (IAPT policy lead: individual interview).

However not every therapist saw the process as uniformly positive as there were concerns that outcome data were the main source of intelligence on therapist ability and concern that feedback was directly related to services being re-commissioned.

'there is a pressure on us to discharge so many patients each month, that's part of our individual targets each month as therapists. If we don't do that then um.. it has been insinuated that could have a bearing on our future employment, it genuinely has, so it's not really a negotiable thing, you do it, you get on with it. You find yourself in a sticky situation when people scrutinise..and it's often..your told it's the people...it's not just the managers, it's their managers and their managers who are looking at these individualised figures, so all the information is there, so 'be careful, they are looking at you' and that draconian environment does leave you feeling.. not that you're looking over your shoulder, not like some paranoid therapist, but you just...you're more aware that actually, yeah you want to get this patient well and you want to engage with them but also you've got to get them out the other end pretty quick and that's in the back of your mind, so there is a time issue which forces you to be, maybe a bit more mechanistic' (IAPT therapist: individual interview).

The above quote did illustrate the tension that many therapists identified in managing service needs such as data collection and maintaining a focus on transferring skills and developing their own practice.

The theoretical model (figure 3, page 25) identified a feedback loop in the communication process (HEI education provider in this instance). However it was of note that a number of respondents considered the HEIs to be an absent part of the process when it came to receiving information on the

demands of service delivery. This in turn was reflected in what they viewed as a training model which did not prepare for the realities of practice.

'...the training was helpful, not always good, but I did learn quite a bit, but really it is nothing like the work we do. The pressure is academic, I suppose that's the way it is designed, but it does not prepare you for what you actually have to do...I don't think they (the HEI) have too much contact with services really, so they can't know what it's like' (IAPT focus group).

'We were able to put on additional training, things that were not covered on the course, these were things they practitioners needed but they didn't get.. I have to say it was slightly disjointed.. I could see what kind of level the people were at when they left the course so we were able to put in place some kind of additional...sort of following on from the course. I think they benefitted enormously from that because I think there is a lot of developments in CBT that weren't covered on..particularly on the IAPT course, so we did these after..sort of after the main training had finished' (IAPT manager; individual interview).

Feedback of change in patient problem scores was clearly a helpful (for the most part) process in supporting evidence based therapy. It was a process that guided caseload management but also was seen as inhibitory for supporting development of practice. There were clear links to interference with transfer processes when the need for contract commissioning and national reporting data took primacy in IAPT practice.

4.3.5. Support and supervision

The provision of supervision was another recurring theme in the focus groups and interviews with IAPT practitioners. There was a relationship to the 'feedback' theme (section 4.4.4) as supervision was a process aimed at providing the supervisee with the opportunity to engage in some form of learning or reflection on practice. In this mode, supervision could be viewed as having a principal role in supporting the transfer process within the work-setting. The interview data provided a range of opinion and experience on the IAPT supervisory process.

Some respondents identified supervision as a management tool used to support service demands rather than individual learning and development:

'the supervision we had during training was really good, but it falls away when you qualify, it is such an opportunity that we don't utilise as it's all managerially led and about numbers rather than anything else' (IAPT therapist: individual interview).

We use supervision to monitor work but because we have to make the service pay, we have to be dispersed, so getting people to travel for supervision is hard..they haven't the time and we haven't the time..I don't believe this is factored in when the policy wonks decide on tariffs'. (IAPT manager: individual interview).

The views of the policy leads varied too on the process of supervision and support:

I think a model of supervision which is driven by the needs of the therapist rather than the needs of the patient is the wrong way round and we need to stand up and say that..but it's my firm, firm belief that we have evidence that good supervision improves patients outcomes...but the sort of supervision that improves patients outcomes wasn't that, "how are you feeling today? What do you want to talk about?" type of supervision, it was 'how many patients have you got what are their scores? What are you doing with this person? Y'know 'what's your problem statement? It's a very different model and I would liked to have seen that more firmly..um institutionalised...or normalised if you like, in the High Intensity (programme)' (IAPT policy lead: individual interview).

Implementation of supervision for some participants was viewed as a 'cultural' problem in regard to professional acceptance and history of supervision:

'yes that's right, the model assumes they will go back and lead and be change agents and we know it doesn't work like that. It's a bit like the [redacted] programme in psycho-social interventions. I mean (named person) has trained what 1500 people and what evidence is there? They were saying things like people did not turn up for supervision and I do think it is important and I do think there is a difference in professions in that point because psychologists and social workers have a tradition in their training as seeing supervision as essential' (IAPT policy lead: individual interview).

This issue was reinforced by another policy lead when reflecting on the role of clinical supervision in IAPT:

'I don't think nurses have got it. It's not been part of their history and because they are the biggest workforce I think that is one of the fundamental problems' (IAPT policy lead: individual interview).

The issue of supervision as a process to support implementation was the most significant clinically related theme in the interviews. Supervision was viewed as a checking mechanism that management could use or a self-driving clinical quality monitoring tool:

'The real strength also is the supervision component both in the training and in practice and that's got to be a key issue. I suppose that if you have a training model in mind and you are expecting that an individual will go and implement and the context doesn't matter because you have transformed the person. Now I think that has been a model and we know it doesn't work'. (IAPT policy lead: individual interview)

'Supervision is one of the principal predictive factors (in improvement of patients). Our model of supervision is a different model, it's a kind of case management supervision.It's a data driven supervision rather than a personal supervision, ..the problem is that people see this as 'management' supervision which has a lower value set in the minds of professionals, but....it's really important;' how many patients you seeing?' 'how are they doing?' 'how many people had four sessions, how many had eight?' 'What are their scores looking like' it is really important stuff as it tells you about how someone is managing their workload and how patients are responding (IAPT policy lead: individual interview).

The link between caseload management and clinical supervision formed one of the most nuanced elements of data interpretation. For one of the policy leads the distinction was clear, caseload management was a process by which caseload numbers were discussed, but clinical supervision was a professionally challenging process aimed at developing practice:

'So what became evident early...was that you had to differentiate clinical supervision from caseload management. The High Intensity therapists on the whole got clinical supervision, obviously they got management supervision, how many cases are you seeing etc....there is a tendency for people to be selective about who they bring to supervision and not always for the right reasons. So they don't always bring the people they are having problems with because they don't want to expose themselves' (IAPT policy lead: individual interview).

Statistically, the issue of such support was measured using the 'support and participation' subscale of the Measure of Generalisability (MOG). The subscale measures the level of formal and informal support and participation

in support type activity (Attending CBT workshops/conferences etc.) respondents have been engaged in over a previous three month period.

The results of a paired samples *t*-test are provided in table 11.

Table 11. Measure of Generalisability: support and participation subscale

Time	N	Mean Score	SE		
Time 2	38	29.7	.95		
Time 3	24	27.2	.88		
				$t(22)=2.970$	$p=.007$

Results indicate that the null hypothesis can be rejected as CBT practitioners were engaged in less formal and informal support following the completion of their education and the return to the work environment.

This might be explained by the changes in supervisory structures that therapists mentioned. In interview and focus group, a number of IAPT therapists identified that the distinction between caseload management and supervision was increasingly unclear. They stated that originally, clinical supervision was given greater prominence in their working plan, but as client contact pressures had increased, supervision had been reduced:

‘Supervision is just so..well important I guess. It just feels like we are getting instructions now rather than our development. It can be weeks before you get to see anyone now..not good enough’ (IAPT therapist: focus group).

‘..That’s true..caseloads are all that really matter now, things have changed a lot in the last year or so’ (IAPT therapist: focus group).

‘I mean what I miss from supervision is ‘how I am’ at uni some of the supervision was about how we felt, how therapy made you feel as a therapist, what was your reaction? And that was invaluable, for me, to just work that through, cos how I’m feeling with the patient can be quite informative in terms of what the issues are, what would be a good thing to do at that point and I miss that. It sometimes feels like, present a case, right here’s what you should do, next one...a bit factory like’ (IAPT therapist: individual interview).

Clinical supervisors provided an important insight into the process of supervision within IAPT. They reflected comments made by managers that the IAPT business model is such that organisations are always financially vulnerable:

'To tell you the truth I'm not sure we're affordable, if we weren't part of [REDACTED] [REDACTED] we'd be gone. They can absorb some of our central costs. If we were on our own like [REDACTED] and [REDACTED] we would run a very different service. I hate to say it but some of our 'softer' decisions and some support would have to go' (IAPT manager: individual interview).

The IAPT therapists were cognisant of these issues and noted increasing pressures meant that supervision was seen as vulnerable when efficiencies were required:

'I enjoy supervision, but..I find there isn't much continuity. When I was training I got a lot of supervision, quite regularly and I know that's not sustainable...but now because it's once a month, it doesn't feel like it has that continuity and so often it is like, there is a patient I really want to talk about, but it's three or four weeks before I can talk about it and by that time the issue has died down or gone away cos I've seen the patient, I've worked through it, I've had to sort it the best way I can in the absence of talking about it' (IAPT therapist: individual interview).

The importance of being able to 'talk it through' was emphasised by a clinical supervisor:

'We examine risks of therapy versus not therapy, supporting people taking positive risks with clients if the outcome is potentially rewarding,..I guess that one of the things about clinical supervision is to try and get people to work on clinical problems where the client is working where there is a chance of success, so often you see clinicians discharge people who have that opportunity and keep hold of patients who have no chance of getting better because of compliance and motivations issues. There is a tendency to do this the wrong way round, again it is this desire to get people better, some sort of egotism on the part of the therapist, they come out of training thinking they are some kind of omnipotent therapist who can cure everyone, so the feelings the therapist has about therapy are important in identifying... so ok how do you feel about failure? how do you feel about not being able to move forward with this? to get them to look at their own particular way of working, responding to their own emotions. I suppose this comes a bit close to the psychodynamic theories of transference and counter transference where emotions of the therapist can sometimes lead them down a bit of a blind alley' (IAPT supervisor: individual interview).

The support for IAPT therapists formed a very strong theme within the data, possibly due to the high pressure high volume treatment model. The service was new in primary care and far from established. The workforce was new and other policy (such as AQP) had challenged the service further. Supervision was seen as a place to continue to develop as therapists, but was increasingly under threat as service efficiencies became continual demands.

4.3.6. Transfer of education to practice in the real world

The transfer of learning acquired or confirmed in educational settings and transferring them to the work setting was at the heart of this thesis. The 'real world' application had links to the themes of 'tension and external environment' and 'supervision and support'. There was a clear distinction drawn by many practitioners (but to a much lesser extent acknowledged in the interviews with policy leads) between the world of education and the 'real world' of practice. Respondents repeatedly used the phrase 'real world' to describe practice how it *actually is* rather than how it is perceived within the world of academia or the world of policy development:

'I suppose when the university is teaching people certain techniques, they are, quite rightly, saying, these are the rules, this is how to do it. But it is that experience of having to adapt things to the real world ..I mean they have these DVD's of the patients, you know these beautiful examples. You don't see the videos of the people who are climbing the walls before they have even start talking to you' (IAPT therapist: Individual interview).

'One of the other issues we've come up against quite recently actually, is ...for me there is a preciousness about High Intensity. What you've got is these people believing they are trained to the same standard as though they are trained by one of the world experts, there is a kind of 'entitlement schema' that develops that says 'I'm special, I'm not supposed to do this' and I don't think that is very helpful. Because in the realities of the real world they are often called upon to do other things and they don't like it much and they feel anxious about it, because they don't feel well equipped' (IAPT policy lead: individual interview)

This distinction was noted by some policy leads but the dissonance between what was considered good practice and what was evident in the 'real world' was not viewed as a unimportant theory-policy gap. One of the respondents spoke candidly about the challenges for policy leads:

'The distinctive thing about IAPT was that it was highly principled, it was about delivering evidenced based interventions, properly and coherently. It's about having properly trained and competent staff to do that,...that had been trained to do it. It's about routine outcome monitoring and regular supervision and that's what, if you like, makes an IAPT service. And those principles derive, I would argue, from RCT's. It's all about efficacy of clinical trials, I mean what is in an RCT, you select good therapists, you train them in them and you give them good supervision and you pay attention to measuring outcomes. So it's about translating that into a service. So it was about service transformation but mainly about increasing the workforce, I think we have found it really difficult with the NHS changes. There was a focus on localised planning and so IAPT money was disappearing in the PCT baselines all over the place, so it's been really difficult to drive the programme, although it has been driven because of the publication of outcomes' (IAPT policy lead: individual interview).

There were clear differences of opinion within the policy leads group on the extent of the impact of the IAPT policy. Implementation was viewed by some to be a matter of service development and education and training:

██████████ view was that this programme was entirely about education and training, that was their take on it and you will see if you read early stuff on that that this is an education and training programme. Now, my view was that this is absolutely not about an education and training programme, because what you were trying to do was implement something completely different in practice, and what worried me from the outset was that this work was being done in a sort of bubble and was thinking 'how the hell is that going to play out locally?' because you have got different starting points. So there has been tension from the outset on this'. (IAPT policy lead: individual interview)

The change in primary care service landscape was not lost on the policy leads and the real world challenges of implementation and the ability to transfer new knowledge and skills. It was also a feature of this conversation where the respondent was aware of the fragility of new healthcare service provision and the challenge of establishing a new service and workforce.

'What we thought the training and service as not only in parallel but intimately related and if we had not been able to developed the services that implemented to evidenced based the ultimate object is not to train people but to have services. Actually I suppose you could say the training in some senses has probably been more successful than the services....but I have never much heard of much criticism of any of the training programmes this may partly because they were all essentially inspected by [REDACTED] and [REDACTED];...whereas we know the service development has been very uneven and um..to some extent as so far it has become problematic with the re-organisation of the health service commissioning and the number of structures changed so if you ask why the numbers have fallen the trainees have not come forward because they were not confident that services would continue to expand'. (IAPT policy lead: individual interview).

The role of the education programme and the reaction of the IAPT cohort to its provision was explored through the utilisation of the TARS sub-scale on impressions of the teaching/educative process. The 9 item subscale was scored on a 0-3 response option, where 0= not at all and 3= a great deal. Therefore the scale has a maximum score of 27 and a minimum score of 0. The higher the score, the greater the positive self-report impressions of the education programme.

Taking the 'impressions of the education process' sub-scale as a whole, the scores from thirty nine respondents were $M=16$, $SE=.72$, $SD=4.5$. The minimum score=7; the maximum score=25. Overall, the respondents appeared generally satisfied with the education programme.

The scale could be sub-divided again with the first four questions relating to the impressions of the respondent on whether the education programme had a beneficial impact on them as a practitioner, 'the training was helpful', 'increased my confidence' etc. Results from this cut of the four items sub-scale indicted whether the education programme;

- a) *improved understanding*: $M=1.9$, $SE=.109$, min score =1 max score =3
- b) *helped develop work related skills*: $M=1.8$, $SE=.116$, min score =1 max score =3

- c) *increased confidence*: $M=1.6$, $SE=.125$, min score =0 max score =3
- d) *enabled transfer to the workplace*: $M=2.3$, $SE=.105$, min score =1 max score =3

The practical nature of the education programme for IAPT, it being highly skills orientated, may have helped IAPT practitioners consider the transfer process to be desirable and possible.

The second sub-division of the scale concerned the impressions of the respondents on the quality of the education team and the curriculum, 'they were competent', 'motivated', the content was 'appropriate' and 'satisfactory'.

It was surmised that if the IAPT practitioners were satisfied by the training programme and felt increased confidence, this would aid transfer into the work-setting.

From this cut-off point, results from the four items sub-scale indicated whether the education programme;

- a) had a competent education leader: $M=1.9$, $SE=.123$, min score =0 max score =3
- b) promoted satisfaction with the education: $M=1.5$, $SE=.124$, min score=0; max score=3
- c) covered the key topics sufficiently: $M=1.5$, $SE=.123$, min score=0; max score=3
- d) the education leaders related to the group effectively: $M=1.7$, $SE=.090$, min score=1; max score=3
- e) the education leaders motivating: $M=1.6$, $SE=.106$, min score=0; max score=3

The results of this sub-scale indicate slightly less satisfaction with the education programme.

In examining the TARS scale in its entirety, the authors, Milne and Noone (1996) identify that the acceptability of a training programme can be reviewed with reference to the total scores across all subscales. They identify a potential range of scores from a minimum of 6 to a maximum of 63 with a higher score representing a greater satisfaction with the education programme.

The total scores for the TARS were a mean average of 36.4, SE=1.1, SD=7.04, min score=23; max score 49. The median quartiles were; quartile 25=31; quartile 50=37 and quartile 75=41. This indicates a general, but not total satisfaction with the education programme.

The IAPT graduates had given a positive response to the transfer aspect of the education in the results from the TARS. This issue of transfer from training to the 'real world' or the sphere of influence was an often cited aspect of the interview dialogue. The simple linear development of services and training was not reflected in practice. This simplicity of implementation was viewed as something alien to mental health services, something services had historically failed to develop:

'..but the factory model, no, cos that's what it is. Like I said, you can go through periods where you feel like really tired out, empathy fatigued and it's the pot luck of what you're getting through the door. You can't plan or balance your caseload because you'll get pockets of loads of trauma or pockets of loads of health anxiety at the same time and in an ideal world you'd have a mixture of stuff to keep you interested and stimulated but sometimes it gets really boring when every session you're having the same conversation' (IAPT therapist: individual interview).

A policy lead identified that even the education programme would not prove to be an easy win for the policy implementation team, both in terms of the performance of HEIs and the challenges of the programme:

'...what they wanted was to achieve the same results you got in clinical trials. So it was if we train literally now, thousands of people in the NHS to use the same protocols that had been tested and delivered these fantastic and excellent clinical trials we are more likely to get those results that the clinical trials got, much more likely to achieve that rather than say 'Oh this is a generic CBT course. So rather than go with those generic courses they went specifically for a focus on anxiety and depression, because their view was that the existing courses weren't honing down on those evidence based protocols. (IAPT policy lead; individual interview).

In statistical terms the Measure of Generalisability (MOG) was utilised to explore the issue of educational transfer in practice. The 'Area of Functioning' subscale examined the working model of the IAPT practitioners and how productive and effective they considered themselves to be.

The average results of the paired *t*-test recorded no significant difference between the measures over the two time periods. Data from the analysis of the Measure of Generalisability 'Area of Functioning' subscale are provided in table 12.

Table 12: Measure of Generalisability: area of functioning subscale

Time	N	Mean Score	SE		
Time 2	38	8.76	.50		
Time 3	24	9.16	.628		
				$t(24)=-.480$	$p=.635$

Therefore the null hypothesis was accepted that there was no difference in how effective practitioners felt themselves to be over time.

4.3.7. Therapeutic drift

Therapeutic drift was explicitly and implicitly stated in the majority of interviews. It was conceptualised by IAPT practitioners as the moving away from the set approach that was taught on the programme within the HEI. The concern was whether therapeutic drift was a relaxation of skills or an example of the development of higher order skills. The interviews with policy leads identified that the national competences (from which the national minimum benchmarks for training were derived) were based on treatment manuals from Randomised Controlled Trials treatment protocols. A concern for the expert who aided development of such protocols was the difference between what RCT protocols stated was the best practice and their own personal practice.

This was also a key feature of interviews with IAPT practitioners who identified their practice had moved beyond that of their initial training. All practitioners noted that the transfer of learning had progressed beyond the expectations of training and concern was expressed whether they were still holding a fidelity to their initial training or whether they had drifted away:

'Well...I think there is a balance to be struck, as you grow in confidence, you begin to relax in how you deliver things. In some regards it has freed me up to be less mechanistic in how you deliver things..the course was delivered in a very strict, almost protocol approach, I mean, 'this is the way of doing this intervention and you must do it in this way' and almost like..you must use these words as you do it. So you were training to pass an exam..it's like learning to drive you pass the exam and you learn to drive after. So there is a degree to which I have moved..as I have grown in confidence, I have moved away from that kind of mechanistic approach, like having to do things in a set order. I like to think that allows me to work quite idiosyncratically with the patient, but I am also aware, that I can hide behind that and it really is just a bit of therapeutic drift, where you are just kidding yourself that this is good idiosyncratic practice when actually you are just becoming a bit woolly and a bit lazy. I think for me it is that balance I hope it is the former' (IAPT therapist: individual interview).

The reasons for this were varied, but many participants identified the challenges of the external environment as a principal influencing factor. The

issues of (performance) targets and structural elements of service provision appeared to impinge on how respondents saw their ability to maintain fidelity to a mode of treatment such as CBT:

'so any planning I do would be on a separate day and that isn't always the best way of working. So it can feel, if I'm honest, There is a plan in there somewhere but most of the time...I wouldn't say I'm winging it, but there is an element of winging it and there's an element of it being more fluid and there are benefits and costs to that. And the risk is that therapy drift again, if you don't work to a clear plan, are you going to get anywhere with that patient? (IAPT therapist: individual interview).

For managers though, there appeared to be less emphasis placed on the issue of therapeutic drift. There was a clear emphasis placed on activity as a key output of therapist work:

'I can't deny the through-put agenda isn't a massive one for us...we work hard to ensure the workforce are well supported to be as good as they can be..to see as many as possible without compromising quality..can't always say we achieve that though. (IAPT service manager: individual interview).

The MOG sub-scale on 'Generalisability' was used to examine the frequency with which IAPT therapist respondents considered themselves to be actively using core CBT techniques in their practice. Results from this data are presented in table 13.

Table 13. Measure of Generalisability: Generalisability sub-scale.

Time	N	Mean Score	SE		
Time 2	38	8.72	3.3		
Time 3	25	12.2	2.10		
				$t(24)=-3.4$	$p=.000$

The results indicate that the null hypothesis; that participants were not using more CBT as they progressed in practice following training was rejected. These scores indicate a stronger utilisation of CBT practice principles as the

measure questions whether such skills infiltrated other aspects of practice. It was possible to view 'drift' as a positive experience as core skills become accepted ways of working in any situation, regardless of task or client.

The issue of drift was also identified by the supervisors, who were clear on the need for supervision to protect the skills that the IAPT therapists had and continued to develop:

'The change, I think in terms of when people first qualify, is that they are probably at their most skilled at that point than they will probably ever be in their careers, er, umm I guess the clinical supervision then..moves to try and keep them, in terms of at that modality level...that focused modality, to try to prevent the sort of drift that is common in therapists...erm, particularly therapists who have had previous clinical practice, worked as nurses, counsellors, which the majority of them had done. So there's still a skills gap, erm.. a clinical experience gap if you like. They've not seen all conditions, they've not worked with everybody erm.,with particular problems. So there's some, I suppose development of knowledge and experience, but trying to not let them drift in to getting into non-CBT ways of working is a big part of what clinical supervision is about' (IAPT supervisor: individual interview).

'Clinical practice in itself makes you drift...the pressures on the work, the not being able to reflect enough on the work, the throughput and also the persons prior experience...I guess there is the potential for the person with previous experience to drift back, particularly if clinical supervision is not focused, people do drift' (IAPT supervisor; individual interview).

The argument in IAPT is that we are able to demonstrate the competences, this is what it is and in supervision, you look at what you are doing, you look back at the literature and then you can be very clear about how far you are deviating from this, so ██████████ for example, having looked at his own practice said, having looked at all this, he realised he was deviating and all the academics would say 'that was wrong' so deviation is a bad thing, it is wrong, we need to keep to the purity and clarity of what the research says..the word of God..!' (IAPT policy lead: individual interview).

4.4. Conclusion

The study produced an extensive amount of data which required careful analysis in order to explore the emergent themes. Previous research on the educational transfer process (Burke and Hutchins 2007) had identified a number of themes which were found to facilitate transfer; motivation and skills

training and such themes also emerged in this study. The theoretical framework of Fixsen *et al* (2005) (figure 2, page 23) was used to examine transfer using a dynamic complex frame of reference and such a theoretical framework had not been used on educational transfer previously.

The complex frame used to understand the inter-relationships between the various variables was used to synthesise the data; to construct a narrative that provided a structured analysis of the evidence on key factors that inhibited or facilitated educational transfer in primary care mental health services. The mixed methods design was utilised to provide a rich and comprehensive picture of transfer issues from different perspectives.

The results of this study identified a number of inter-connected themes. IAPT therapists, supervisors and managers articulated a picture of psychological therapy in primary care which was challenging and susceptible to changes in policy direction and practice imperatives driven by CCG commissioning intentions. The core target client group; those people with low to moderate level anxiety and/or depression had been integrated into treatment groups with people with additional and sometimes multiple social and health needs. The prescribed feedback process, via the in-treatment measures and reporting added a bureaucracy to the care process that received mixed support. Some therapists maintained that in-treatment measures such as the PHQ-9 and GAD had therapeutic merit. Others maintained the primary utility of the feedback process was through CCGs to hold therapists and services to account and seek more activity from the workforce. It was undeniable that the feedback data on recovery and treatment activity for IAPT made it one of the

few policy initiatives and services in the NHS with such a contemporaneous data source on patient access, therapy process and treatment outcome.

The caseload management procedures to support the feedback of data also generated mixed responses. The IAPT policy team identified that caseload management was essential for effective management of services and such a view was echoed by service managers. It was suggested that close management of caseloads enabled detailed conversations with service commissioners about service design and delivery. IAPT therapists presented a picture of caseload management with a different emphasis on the feedback process. They reported positive reflections on maintaining a focus on patient selection and treatment outcomes. Over time, such processes had less emphasis on training fidelity and moved to emphasise treatment duration and patient throughput. This change in emphasis was also evidence in the reported stress associated with the perceived alteration of the feedback process. There were frequent uses of words “exhaustion” and “burn-out” and some responses where individuals reported actively refusing to engage in the caseload management process.

Data illustrated an emphasis on the desire of all respondents in clinical roles to offer effective psychological treatment and so motivation was a prominent theme. However prominence was not given to the mental representation of an identity as an IAPT therapist. The COM-B approach of West (2006) towards behaviour (such as transfer behaviour) identified the need to have the capability (C); the opportunity (O) and the motivation (M) to direct behaviour. According to West (2006) the maintenance of a strong and resilient identity was critical for behaviour (such as transfer behaviour) to be maintained.

There was evidence that all elements of the COM-B process were utilised by IAPT therapists except that of a robust identity. All those interviewed called themselves CBT therapists, there were few examples of a coherent articulation of a mental representation of such a role. A number of therapists doubted whether they were faithful to the CBT approach and whether they were provided with as many opportunities to fully practice their skills. The results indicted a link to the concept of therapeutic drift, which again was a sentiment expressed by a number of therapists. Both therapists and supervisors noted concerns that the education programme for IAPT emphasised treatment interventions for anxiety and depression derived from clinical research trials. Many responded with an acknowledgement they were practicing a hybrid approach, instilling a sense of uncertainty of either drifting from CBT orthodoxy or developing deeper CBT skills based on the core principles gained from the original training programme. Therapists and supervisors were engaged in a trade-off between practicing with fidelity to the CBT model or developing a deeper sense of confidence and capability in responding to a complex client group. This fidelity drift/confidence dissonance was set within a clearly expressed awareness of the political, social and economic forces at play.

The frequent response from interviewees was that training and its transfer had to be adapted to the 'real world' setting. The education programme within the HEI was viewed as a place to learn and practice core skills in a safe and 'unreal' setting. Exposure to actual practice of IAPT was seen very differently, where concerns of therapist isolation and autonomous decision making were stressors. The theoretical model of Fixsen *et al* (2005) provided a feedback

process to the 'communication' source, which in this study was considered to be the HEI education providers. They were the prime source of IAPT therapy practice, as supported through the national curriculum and the views of policy leads. The results gave little indication of the existence of a formal feedback loop to HEIs from either the policy centre (*the source*) or from IAPT services (*the destination*). The national accreditation process was provided by an external partner (the BABCP).

The work of Burke and Hutchins (2007) was used to guide the research around topics with little or no empirical evidence for their role in the transfer of learning, such as the role of 'supportive supervision' falling into this category. In this thesis, a meta-theme that seemed to unite all others was the role of clinical supervision in supporting educational transfer in IAPT. The importance of supervision was mentioned in every interview and it was possible to deduce a role of structured clinical supervision playing an important role in responding to the challenges and opportunities identified in the qualitative and quantitative data.

Chapter 5: Discussion

The introduction to this thesis identified the transfer model of Baldwin and Ford (1988) as a seminal conceptual model of learning transfer. In addition, the review of literature identified a number of personal constructs (motivation etc.) which were viewed as important in transfer ability. Both within the HRM and mental health literature, there has been a relative dearth of attention paid to the ecological factors of transfer in the workplace. The research which has been conducted, most notably in the Psycho-Social Interventions training transfer literature, has not, in the main, considered the wider dimensions of transfer in the NHS. This thesis identified a theoretical framework placing transfer within the domain of complex adaptive systems and suggested that transfer components could be re-considered using such a perspective. The results in the previous chapter identified that emergent properties in this complex system had important levels of influence on the ability of practitioners to transfer new knowledge and skills. The research question was posed which sought to examine the characteristics of transfer in the IAPT workplace. Therefore a deeper understanding of the interaction of the results in the complex world of clinical practice in the NHS was required in order to offer a meaningful contribution to the debate on how to support and promote quality of care provision and also obtain the best return on the financial investment in education in the NHS. This study used IAPT as a case study example, but many parallels may be drawn with the wider debate on transfer of learning in the NHS and Social Care.

This thesis contributed to new knowledge through a detailed analysis of the environmental barriers and enablers for education transfer in the NHS.

Additionally, it examined the personal characteristics of this transfer process through a 'behaviour change' model. Psychological themes relating to 'identity' as a factor in learning transfer have never previously been considered. The challenging role of different forms of supervision as support systems for maintenance of identity and transfer was also novel.

Following a mixed methods approach, the results were presented as an amalgam of the various strands of the data sources to provide a synthesis of the results *in toto*. This discussion chapter takes the results and considers their meaning within the transfer of learning process. In addition the IAPT policy will be critically reviewed to illustrate the challenges and opportunities for learning transfer within a politicised and policy driven healthcare education provision. This will be achieved through a reflection on the framework of Fixsen *et al* (2005) which guided the research process (see figure 2, page 23). The IAPT policy, indeed any health or social policy was not self-executing, as it passed through stages of implementation and interpretation. The ultimate users, using Lipsky's term 'street level bureaucrats' (Lipsky 2010) had considerable influence and power on how (or if) they drove the implementation. The examination of transfer behaviour set within the work context was a unique aspect of research in this area.

The utilisation of a complex frame of reference had the potential to reinforce an internal inconsistency in this discussion on 'meaning making' from the results. Learning was conceptualised as complex; it was not a linear model of learning transmission where a study was completed/evaluated and learning was transmitted to readers or an audience and new learning utilised. Instead, learning in the conceptual framework of this thesis, posited that a dynamic

and complex set of social, political and other interactions were at play. Transfer of learning was not a single and individual cognitive act, but rather a complex interaction of 'context, environment and individual processes'. The complex world exists within the context of this study and the construction of 'meaning' or 'sensemaking' from these results (Brown *et al* 2014).

The IAPT graduates in this study, like many students completing education and training in the NHS, were engaged in the delivery of 'results' driven by national policy. These policy initiatives invariably focused on efficiency and effectiveness within a results orientated culture in public services. The IAPT practitioners, managers and policy leads, consistently reverted back to the themes of throughput; recovery rates and targets. In this study, IAPT practitioners were provided with an education programme to support a change in their practice - to do something they were not previously doing. New services that were previously unavailable within primary care, were commissioned to provide psychological therapy to patients. New rules of competition changed, enabling more private providers to enter the market, so adding a greater plurality to service provision and so the landscape of primary care changed too - along with many of the inter-connected relationships between participants in the service delivery and commissioning worlds. In such a landscape, it was doubtful whether learning could ever be viewed as linear.

The pathway of policy initiatives to service delivery represented a convoluted process involving many stages, personalities and perspectives. The Implementation Science (IS) literature identified that contextual features have a profound impact on the ability of policy ideas to fulfil their goals (Health

Foundation 2011; Health Foundation 2013; Bate 2014). Indeed Bate (2014) suggested these contextual features were evident by their repeated omission in studies on organisations and their practices. Based on the review of literature these contextual omissions were true where the transfer of learning is concerned. Results from this study supported the fundamental challenge of the assumption that simple linear application of policy into practice or successful implementation of practice is simply a matter of 'transfer' (Greenhalgh *et al* 2005).

This discussion offers a synthesis of the study, integrating the literature and results of the gathered and reported data to formulate a deeper and richer understanding of the transfer process in education within a health (and social) care context.

The IAPT programme was an ambitious attempt to not only meet a significant under resourced health need in the population, it proffered a view that not only was offering psychological therapy a moral imperative (equality of access) it was also an effective intervention for the nation state (economics of ill health). The IAPT initiative sought to develop a new service in primary care, an area of NHS provision where mental health service delivery had not been a prominent feature. Services in primary care or any care service are made up of people (a workforce) who are (in policy terms) required to perform distinct performance roles to deliver policy aims. The IAPT programme was predicated on the development and delivery (primarily through training) of this new workforce.

The theoretical framework identified five core components of implementation (a *source*; a *destination*; a *communication* process; a *feedback* process and an *influence*). These have been discussed in both the literature review and the results. The framework also identifies three implementation outcomes;

1. Changes in adult professional behaviour (knowledge and skills of practitioners and other key partners)
2. Changes in organisational structures and cultures (formal and informal) to support the change
3. Changes in relationships with consumers, stakeholders and system partners

These outcomes of implementation form a contextual framework upon which the discussion on the findings of this study was developed. The Fixsen framework (Fixsen *et al* 2005) is a determinant model (Nilsen 2015) and as such makes no attempt to offer a detailed examination of the processes involved within the interconnected relationships hypothesised by the model. Utilising the results of this study, this thesis offers insights into these possible relationship processes. Therefore these will be overlaid on the guiding theoretical framework. To achieve this, the model of West (2006) was utilised as a method of identifying the elements related to personal characteristics and their applicability in the transfer behaviour of IAPT workers. To identify the broader systemic and organisational elements of transfer processes, the approach of Grol and Wensing (2013) was used.

Many implementation of change models exist Pettigrew *et al* (1992) Øvretveit (1999); and Greenhalgh *et al* (2005) have tended to share a number of common elements. These frameworks and models had been used extensively within the Implementation Science literature (Stetter *et al* 2009; Butler 2003; Demens 2007; Dawson & Buchanan 2005). The approach developed by Grol and Wensing (2013) shared many features of frameworks for organisational change, identified by Pettigrew (1987). He noted that the contextual drivers for change were a mixture of internal/organisational features (the issues an organisation has some control over) and the external/systemic features (over which an organisation has little control). These Implementation Science approaches are highly consistent with each other and possess the ability to be analysed side by side.

5.1. Developing a proposal for change

The '*development of the proposal for change*' of Grol and Wensing (2013) was an area of analysis in this study which drew a rich data picture. All participants in the study gave commentary on the quality and coherence of the policy approach. There was uniform agreement that the policy provided a logical and coherent argument for the IAPT intervention. All participants viewed the need to offer psychological help to people in distress as a sensible aim of health and social care providers. Undoubtedly all respondents had a vested interest in this position, since their national profile or actual daily work was based on this belief. There was less uniformity on the central rationale of the IAPT initiative. Not everyone placed an emphasis on the moral argument, that psychological help should be available to people who previously had

been (partially, if not wholly) excluded from evidenced based talking treatments in primary care. IAPT therapists provided data indicating a shared perception of the service being driven primarily by economic arguments; suggesting this was the most pressing issue in the sustainability and continuity of the IAPT programme. However for others, such as the policy leads, the proposal for change was no longer the focus. Instead data pointed to a group who remained focused on new service development and the building of infrastructure and methods of evidence, to enable the service to survive. The policy leads did note the original arguments of the IAPT initiative, but they had moved on to concerns of implementation and sustainability. The challenge of developing a new service was a critical, but not always explicitly mentioned. Statements were made both by policy leads and therapists reflecting the vulnerability of the IAPT initiative. Policy leads were more explicit in their statements that developing new services presented a significant policy challenge. Initiatives were subject to re-organisation and reconceptualisation by government departments and unrelated policy, such as AQP, could de-stabilise such new service provision. IAPT therapists were more circumspect in their comments, noting they felt their practice and outputs were under scrutiny by managers, commissioners and others.

The results indicated a service which was driven by central programme aims of through-put and a construct of 'recovery' whereby a patient is deemed to have recovered if they score below the clinical threshold on the clinical indicators (PHQ-9 and the GAD). Some researchers had sought to develop a concept of 'reliable recovery' (Gyani *et al* 2013).

The analysis rested on the consideration in the minds and practice of IAPT workers in understanding the emotional requirements to support motivation to transfer knowledge and skills in a healthcare environment where the economic consideration was perceived as having primacy.

The issue of predictability, in terms of system outcomes and the behaviour of people (workforce) was not clear. The appropriation of a complexity frame of reference as an explanatory approach in social science was an attempt to understand the dynamic and interdisciplinary structures in play when considering the implementation of practice change at this level (Byrne 1998; Byrne and Callaghan 2013).

Developing a successful proposal for service change was predicated on achieving a sense of shared perspective and aim. Data from this study indicated that there was uniformity on the proposal. The need to develop a mental health primary care service drew considerable support across all the policy leads.

The development of a new service required an interlinking of all elements of the development infrastructure. Results from the data reflected the view that policy leads had little contact with the 'front line'. They repeated that a new service and new workers were viewed as central to the IAPT initiative and so their sense of belonging was viewed as critical. Despite this, there appeared few systematic processes of means to gather such intelligence. The double loop learning of Argyris (1997) was noted in the literature review as a process of communication loops that gathered data and monitored values in the workplace. The re-organisation of the NHS through the NHS and Social Care Act, HM Government (2012a) stripped the Strategic Health Authorities (SHAs)

from the organisational pyramid. This layer, while raising concerns from some policy leads on their implementation skills, might be viewed as a key conduit from communication between the front line therapists and managers to those funneling throughput and recovery data.

5.2. Analysis of actual performance targets for change

The policy problem was clearly identified following the analysis completed by Layard *et al* (2004) and a behavioural target clearly established. There were significant numbers of people suffering with anxiety and depression and there was a lack of a service to treat them in primary care. A known set of evidence based interventions (CBT) were available that suggested treating people would have positive effects for the individual but potentially also, for the national economy. So in terms of behavioural change strategy, the significant increase in the availability of CBT for depression in primary care had a clear target in mind. The analysis completed after the first three years identified the expectation to generate net savings of £300million by 2015. These were savings to the exchequer through people moving off sickness benefits and savings to employers in the reduced payments of statutory sick pay. The drive to help people recover and 'get (back to) work' formed an implicit aspect of IAPT data, particularly from policy leads, even those who had also expressed moral argument that people deserved access to treatment. The scenario existed whereby the Treasury had provided the money and the duty of IAPT was to repay the investment. The equity of access argument had fallen off the list of outcomes with the focus centrally located on financial gains to the economy. However many therapists and supervisors placed greater

emphasis on 'helping people' as an end in itself. They were more focused on the problems people were facing and supporting the incorporation of treatment strategies to overcome disabling aspects of psychological distress. There may be an inevitable tension when the drive, from a central policy perspective was to achieve outcomes.

However the qualitative data also indicated that the focus on anxiety and depression had shifted and those who presented for treatment had a more challenging set of complex mental and physical health issues. As a consequence, such a shift may have had a profound impact on the way in which psychological therapy in primary care was viewed by the Treasury, CCG commissioners; managers; supervisors and therapists.

Behavioural distinctions between the IAPT workers on their perception of them as workers, (their identity); their work patterns (normative practice) and expectations of each other (shared norms). In keeping with the theory of Values Based Practice (Fulford *et al* 2012) exposing the values which underpin practice to public debate can expose very different value positions. It is only when such values are exposed that practitioners can begin the process of negotiation towards a more shared articulation of values in practice. The question arises on how participants begin this process of shared perceptions for practice? The question was more pressing since the performance targets remained the same but practice of IAPT in this study showed signs of drift. Manojlovich *et al* (2015) proposed a reassessment of communication theory within an implementation science framework. In broad terms they identified two paradigms of communication between healthcare participants; those that were *transactional*; focused on the transfer of

information and those communications that were *transformational*; with a focus on *change* as a result of the communication. Their analysis indicated communication strategies that were fraught with many challenges in seeking a shared perception and understanding. This analysis represented a sociological perspective that proposed that communication was socially constructed, that actors (and groups) created a social reality based on their dynamic interactions with others.

Within these data, a principled means of communication between managers and IAPT therapists was via caseload supervision and the process of clinical supervision between therapists and supervisors. The results indicated a somewhat didactic arrangement for caseload management and a reflective, personal growth model for clinical supervision. In this way both the paradigms of Manojlovich *et al* (2015) were apparent. Caseload management was perceived by all participants as management process which ultimately reflected the desire to retain a service by demonstrating acceptable (to commissioners and CCGs) throughput and recovery. This represented a communication feedback process which was a major theme of all the results. The communication processes around throughput and recovery were viewed negatively by IAPT therapists as they represented a process over which they had no influence and was a 'must do'. There was no opportunity to engage in a transformative dialogue with managers, commissioners (CCGs) and the Department of Health and to share perspectives on the positive and negative elements of implementation of IAPT. The transfer of learning process for IAPT therapists represented a desire to move beyond the 'must do', although

it was a dilemma, since they understood their future role was predicated on achievement of policy aims.

This thesis introduced the widely held perception in the HRM literature that only 10% - 20% of what was learned was transferred into practice (Aik and Tway 2006). Data from this study indicated that this might be better conceived as practitioners use whatever works for them and that possibly they find only 20% useful or applicable. Additionally, it was clear that the external environment had such a profound influence that the ability to transfer was not what a therapist would actually use from the education programme, but rather whether they were able to adapt that learning in a rapidly changing environment. Transfer, when considering the performance indicators in practice, had a significant relationship to the culture of the workplace.

Manley *et al* (2011) had articulated a number of enabling factors which, they argued, played a significant role in the implementation of a positive adaptive workplace culture, one which actively supported the adoption of new training practices, even in complex organisational systems.

They suggested that the following framework elements are required of clinical practice teams:

- Explicitly stated core values of the team
- The development of a team culture where adoption and practice of the shared core values is supported
- Implementation of shared values/vision through transformational leadership and skilled facilitation

- Team members who develop and model cooperative working practices and who display a willingness to implement change as new knowledge is generated.

These are themes that were evident in the research with IAPT practitioners as a team level, the micro-system which reflected the micro-culture of Manley *et al* (2011).

This thesis utilised a 'complexity' motif as a means of describing the work setting, but complexity is not a unifying concept. Using the work of Manley *et al* (2011) such a framework would support delivery of transformative health care. However, others have questioned whether this belief could be sustained. An 'enactivist' stance such as that advanced by Niessen *et al* (2008) suggested that an alternative definition of complexity would indicate that the control by workers, over micro-system elements as described in the above framework could not be achieved. There was the possibility to seek an influence within the system, but 'control' is beyond the purview of any researcher/manager/clinician. Instead it is the moment by moment interactional dynamics of the actors which should be the focus of attention. From this perspective, the idea that any learning in one workplace setting can be implemented wholesale in another micro-system was flawed.

5.3. Problem analysis of target group and setting

In any research there is the challenge of describing a realistic picture of the situation. As such, the framework schematic (figure 2, page 23) and the various figures used in this thesis represent only fragments of a reality that cannot be adequately articulated.

The target group in this analysis were IAPT therapists and the problem analysis consisted of developing and transferring evidence based CBT skills into new services in primary care. This thesis was primarily concerned with this issue.

The 'workforce' itself as a concept, was a feature of respondents. The IAPT therapists were made up of a range of different disciplines with different training histories. Some were 'professionally qualified' such as nurses, occupational therapists etc. while others were graduates in psychology or counsellors who may not have had such a foundation in healthcare education. Workforce planning has long been a problem for services as forecasting future healthcare need is an imprecise science (Addicott *et al* 2015). Planning must take account of changing demand with an ageing population, differing health outcomes and the uncertain effects of an external environment, be that social, political or economic. The IAPT programme faced the dilemma of developing a workforce in a period of rapid expansion and as one respondent pointed out, this workforce needed to gain an identity equally rapidly. The only way this could be assured was to retain a strong central control through the collation of therapy data. Identity though was a multi-faceted concept. Data illustrated a workforce of therapists who leant heavily on previous career professions (nursing, OT) whilst still viewing themselves as Cognitive Behaviour Therapists. Others were very precious about being therapists and were concerned that service models often hindered the true (as they saw it) application of their CBT practice. They were very concerned to make the distinction that clients had received a service, but they had not received CBT.

Policy leads saw an opportunity to develop a new workforce based not on core professions but on newer therapists entering the workforce, which was a feature of the Doncaster pilot programme for IAPT. However, others considered that other professions were more able to make a contribution, as in the Newham pilot.

The idea of 'an IAPT therapist' was therefore not a unifying term, but rather an umbrella term that covered a wide range of people from different backgrounds. Data from supervisors, indicated that some therapists trained to deliver Cognitive Behavioural Therapy do so begrudgingly. Consequently the notion of a shared identity would seem to be elusive given that CBT is not a model of service delivery, but rather a model of therapy (Gilbert 2009). A workforce of CBT therapists with a shared CBT identity might not be possible since CBT as a term covers a wide range of therapeutic approaches.

The model of West (2006) proposes that is the strength of an 'identity' which is the principal factor in behavioural change resilience. This view was supported through the empirical work of Verplanken (2004). The IAPT service, is subject to significant organisational and operational pressures. The results from this study suggest that there is uncertainty on the 'IAPT identity'. In such an environment a lack of professional coherence on role performance may account for therapeutic and policy drift.

Policy leads returned to the theme of workforce numbers, understandably, the focus was on service development and filling training places. But psychological processes of 'belonging' and as sense of 'community' may be as equally important aspects of workforce development, which remain unaccounted.

The supportive organisational culture was dialectic between the views of managers of the service and practitioners. West *et al* (2014) have identified that a supportive culture should be the basis of sustainability of implementation goals. Fixsen *et al* (2005) indicate that such sustainability is also a process of responding to external forces whilst retaining the original programme aims. This is the critical aspect of transfer of learning as the external ecology of healthcare alters the process of fidelity to the components of education and training.

5.4. Development and selection of strategies and measures to change practice

The implementation of IAPT was predicated on behavioural change in individuals and services. It involved the education of individuals the setting up of new services and locating them in a new clinical mental health primary care environment. The science of implementation was designed to offer some insights into these processes as the list of failed implementation programmes is long (Health Foundation 2013).

The behavioural impact of the individual within the team may be profound. The IAPT education programme was designed to contribute to a new worker delivering evidence based practice to people who had little access to such help previously, a situation that had a costly economic impact on the nation. Based on information from key informants, the IAPT implementation plan consisted of developing a national training programme; the allocation of finances to primary care services to develop new teams and the implementation of a national reporting programme based on collection and

analysis of in-treatment measures (PHQ-9 and GAD); more latterly the national team developed some competences for the delivery of supervision.

The results both from policy leads and from service supervisors and managers indicated that a focus on the competence of this new workforce of IAPT therapists was a key concern.

The issue of competence was an important feature of both the qualitative and quantitative data, with IAPT therapists reinforcing the need to feel confident and competent in their work. The finding of a mismatch between what IAPT therapists were trained to do (treat people with anxiety and depression) and what they found themselves doing was a self-reported concern for them. It remained unclear whether the development of practice in 'the real world' represented natural development based on increased experience and exposure in the clinical setting. The alternative view was promulgated that it may have represented a drift in therapeutic orientation despite the efforts of clinical supervisors to maintain fidelity.

The IAPT therapists were judged to be competent on completion of their year long, skills based education, in the assessment and treatment of anxiety and depression. Data from both therapists and supervisors indicated that the 'real' clinical world was one where complexity was the norm. There was a greater emphasis placed on clinical isolation and the need to make judgements without reference to clinical supervisors, other therapists or managers. Therapists spoke openly about the loneliness and stress associated with the role and the disconnection between their competence and their capability. For some therapists this dissonance was an inevitable consequence of their development and generated a desire to become more integrative in their

therapeutic approach. For others, and certainly the supervisors, this was a concern of therapeutic drift and posed a threat to the goals of the IAPT programme. The development of integrative therapists was considered by supervisors and managers to be a retrograde step back to when GPs employed generic counsellors in their teams. The policy leads had been advocates of IAPT as the provision of evidence based psychological therapy based broadly on a CBT model. It was the defining feature of IAPT and was predicated on consistent and competent provision of therapy. Data from this study indicated delivery of therapy which was highly patient focused and flexible. The requirement of a competent IAPT workforce which could transfer a narrow CBT training into a complex and dynamic healthcare delivery environment was central to this thesis. It remained questionable whether CBT could be viewed as a service model given the breadth of therapeutic orientation under the CBT banner.

A deeper analysis of the issues of implementation indicate that a Capability, Opportunity, Motivation – Behaviour (COM-B) analysis (West 2006) provided a system for analysing behaviour in the context. Namely, individuals (in this case - IAPT practitioners) require the capability and the opportunity to perform their tasks, but most importantly they require the motivation to initiate the behaviour change and focus on the target behaviour. Without this level of motivation, competing behaviours would deflect a person away from the target requirements. This study identified the profound impact of team processes and the potential of team culture to impact on personal motivation. Motivation formed an important psychological construct in care giving; care eliciting and

attachment are as applicable to a workforce as they are to individuals (Gilbert and Bailey 2000).

The focus on behaviour change is also a focus on individual change. Training programmes are by their nature mostly concerned with the individual, their learning needs and learning strategies to achieve their goal. However, the social environment as noted in the results section has a considerable influence on the personal. Vygotsky (1978) argued that learning was a social endeavour. Reviewing the analysis of the findings, the implementation strategy was not sufficiently comprehensive or synergistic. The training programme and service development were seen as the most important strands of implementation (get them trained and give them a place to work) instilling hope that in this new environment and following a period of intensive training, the individuals, working as teams, would behave differently. The desire for a different way of working is evident from the training programme curriculum, which was comprehensive and required an accreditation process as a means of quality control. If training was not the most significant implementation initiative, it would have been possible to develop new services and employ the large number of psychological therapists and provide 'on the job training' and this was certainly a theme expressed by a number of the IAPT therapists. Behaviour change on this scale required a coordinated set of interventions, which may have been broader than the ones identified in this study.

The transformative nature of clinical supervision was highly valued by both supervisors and supervisees. It was seen as a place of learning and critical self-reflection, where the interpersonal relationship between participants was

considered a significant professional and personal development process. The subject of clinical supervision was viewed as a difficult but important process in developing an identity and the skills as an IAPT therapist. Despite considerable support for the process there were concerns from managers of services that it was “expensive” and “vulnerable” when efficiencies were required. New “more efficient”, though not necessarily more effective, ways of completing BABCP supervision requirements were often the subject of managerial discussion.

5.5. Development, testing and execution of implementation plan

Allied to this issue of support in the organisation is the matter of ‘managerial and clinical relations’. The data identified differences in opinion on what support should be available; what was available and how participants explained any distortion between the two. There were many examples of respondents who identified views on preferred models of clinical managerial support via supervision models, most particularly the role of caseload management.

The IAPT programme had benefitted from extensive pilot programmes in Newham and Doncaster, although these were two different models of psychological treatment, delivered by differently qualified sets of workers. The stepped care model (figure 4, page 44) was an illustration of how different treatment models were related. These data pointed to a complex picture where the steps were not so easily differentiated and health and social care commissioning decisions, forced by the external economic situation, had re-fashioned the treatment landscape leaving practitioners unsure of best service

provision for clients. Many IAPT practitioners identified IAPT as often the only source of support for vulnerable people which added to the challenges regarding treatment decision making.

Data indicated that the education programme received considerable attention from policy leads, although there was some disagreement on the primacy of education over the service development arm of the implementation process.

Data indicated that attempts were made to develop a national competence based curriculum. However there was considerable evidence that curricula bore little resemblance to the realities of practice and the cited need for a national consensus programme of education was questioned by participants.

Additionally the dissensus between curricula and the required work of IAPT therapists formed a major element of these data. A problem analysis perspective suggests that policy leads faced a dilemma in continued development of IAPT services. The national curriculum was focused on developing skills and knowledge using a competency based framework to support practitioners to treat people with anxiety and depression. Data from IAPT therapists showed that the programme had great utility, particularly around the delivery of clinical supervision. Supervision was often referred to as 'challenging' 'difficult' and 'uncomfortable' with a strong emphasis on facilitating higher levels of skill in the therapist. This focus and interest in supervision continued into the work-setting where additional challenges of client complexity and practitioner isolation were important. However supervision was a process which was viewed as under threat due to the drive for ever greater efficiency. The focus for managers was finding supervisory processes which met BABCP requirements for supervision (90 minutes per

month) without losing 'valuable' treatment time. This clearly fed into the emotional exhaustion that all IAPT therapists spoke about and the frustration they felt about the danger of becoming a process led service rather than a quality led one.

Clearly, re-thinking curricula and pedagogical processes is an important starting point. An IAPT curriculum which promoted an Instructional Design perspective (the training is designed, delivered and assessed) (Gagne *et al* 2005) may at best be offering a disservice to IAPT students and at worse preparing them for competence they do not actually possess when faced with 'real world' problems such as complex case presentations and therapist isolation. The evidence based nature of CBT and its empirical roots may drive curriculum developers to consider education delivery as a structured process which allows for structured problem presentation and structured assessment and feedback. CBT education for IAPT in this model bore the hallmarks of a 'well-structured problem', even within a complex frame (Kirschner and van Merriënboer 2008). However, it was these data which presented CBT in real world practice as an 'ill-structured problem' (Spiro and DeSchryver 2009) which required a fundamental examination of curriculum and pedagogy to support IAPT therapists and their transfer behaviours. There was much less certainty on what constituted 'the answer' to therapy problems, which patients to treat, for how long with how much purity to a treatment model? The curriculum may be well articulated but the pedagogical stance of the tutor should reflect the complexity of the work environment (Byrne 2014).

Grol and Wensing (2013) identified a relationship between the simplicity and clarity of the goals and priorities with the key figures leading the change and the cooperation within the interagency network. This tripartite relationship could be conceived as one between policy leads; service providers (including practitioners) and education providers. The theme that emerged strongly from these data was the distinction between the curriculum as it was taught (theoretical) and as it was experienced '*in the real world*'. In this way, it is possible to reconstruct the work of Roth *et al* (2000) and their identification of a distinction between the *theoretical* and the *enacted* curriculum, and stated that both are necessary in order to make educational endeavours work. The work of Roth *et al* (2000) was limited to the distinction between the curriculum as experienced or enacted in the classroom. The transfer of learning in professional practice, by necessity entails the development of the curriculum or learning outcomes beyond the classroom and directly into practice. Therefore the enacted element consisted of a dialogue and relationship between these different agencies. This dialogue - or lack of it - between the policy leads in developing a theoretical (competency based) education programme, the educators who delivered it and participants and service leads who enacted an alternative version was a critical aspect of the transfer debate.

The curriculum as developed by policy leads could be considered to be an *adopted curriculum*, being one which identified the key concepts and competencies considered to be relevant to the delivery of effective CBT. The competences were developed through a large scale iterative process with world experts and close examination of clinical trial training manuals.

However, as Michie, Van Strallen and West (2011) identified, a clear articulation on the processes of how competences were delivered were often missing from documents and therefore any replication presented significant challenges. Despite this, the national curriculum did exist (Department of Health 2008b) but seemingly with no consensus on how it should be delivered. This indicated that the goals and priorities of the policy (at a curriculum level) were not clear or simple. There were many responses from the policy leads that identified the challenges of implementation, particularly in the negotiated roles of support services throughout the country. Therefore while there may have been a degree of consensus with the group of policy leads, the further removed key sources of support the greater the potential for variation in implementation practice. Certainly for one of the policy leads there was criticism that implementation processes could have been developed more carefully with the acknowledgement that opportunities and barriers could have been given more account.

The perceived simplicity of the goals was also evident in the overriding concern for competency based learning outcomes. Clearly, for NHS policy makers, who used education as a principal element of implementation, having a *technical* perspective on education had its function. Developing competence through the repeated demonstration of techniques provided a degree of certainty that core elements of the policy could be delivered. However, this did not account for the *process* of learning, or the actual implementation of policy in practice. The technical policy driven perspective had a focus on the adopted curriculum but not the one enacted in practice.

Within the IAPT programme there was an attempt to move beyond competence and consider the process of implementation. The national curriculum was based on a set of core values (the Ten Essential Shared Capabilities) which were intended to encourage the incorporation of the difference of values in the applications of technical skills (McGonagle 2009; McGonagle *et al* 2015). The results data indicated that no practitioner knew about such an initiative nor could explain in what way it entered the curriculum. For a number of the policy leads too, the focus on values came a distant second to the assurances of technical competence in CBT. The data demonstrated IAPT practice that was beyond the technical delivery of CBT and more akin to the Deweyian conception of 'intelligent action' (Wraga 2013). The practitioner was supported and expected to make a difference in the practice context and able to make sensitive judgments 'in the moment'. The conundrum, from a policy perspective, was ensuring that free reign to make 'in the moment' decisions allowed for the possibility of drift from the policy aims. A number of respondents articulated a view, that it was very easy for IAPT services to lose their way and fill the void left by the diminishment of other services in primary and secondary care. Competence may be ontologically significant, in policy terms; a shared world view can be described in practical rather than conceptual terms. The evidence from this study identified that in epistemological terms the situation was less clear. Mulcahy (2000) identified competence not to be an event but rather as a process (as a practitioner *becomes* competent); competence is something a practitioner does.

There was synergy in this aspect of debate on the competency – capability dichotomy in IAPT practice (this debate was not unique to IAPT) with PRIME theory advanced by West (2006). This theory was introduced in the literature review which explored aspects of behaviour change. It was a theory which promoted a view that human motivation to change or maintain behaviour was an interacting system of plans; responses; impulses; motives and evaluations. The interacting complex nature of this system means that behaviour change or maintenance is inherently chaotic as the moment by moment nature of external and internal stimuli has the ability to dominate wants and needs. These stimuli may support behaviour or may come in the form of ‘threats’; having the potential to destabilise the system. Within this thesis, the role maintenance of behaviour was a key aspect of the policy drive for IAPT. IAPT practitioners, in the main, were trained in CBT with the expectation, from policy leads, educators and managers, that they would deliver CBT as directed within the research protocols and competence frameworks which informed the curriculum. The data indicated that no practitioners and supervisors did this. They were unable or unwilling to maintain a strict fidelity to the training programme. There were many accounts given where the provision of IAPT practice deviated quite markedly from the requirements of the training and curriculum. The reasons for this plurality of provision were accounted for in various ways. A consistent theme was the ‘needs of the patient’, as practitioners identified a growing confidence in their ability and the tension of having to treat people within a specific time frame (usually 6 sessions of 45-50 minutes each). Therefore procedural practice of assessment; formulation; treatment and review were amended as the

situation arose. Some respondents felt the client group was different to that they had been trained to treat and many commented many patients had complex social situations as well as psychological distress and often the social elements (financial; housing problems etc.) took precedence over any psychological intervention. Other respondents proffered a view that the disinvestment in a range of services from both health and social care commissioning had resulted in IAPT being one of the few services to which a GP could make a mental health referral. The IAPT service could be characterised as one in which the tension between what should be delivered and what was actually provided was consistent. All respondents understood that offering a service to people who were not suitable for CBT treatment, those with pressing social concerns, meant that they were potentially diminishing their service efficacy. It could be this tension was at the heart of the different perspectives between various policy leads when they discussed patients who presented with complex problems.

Gros and Wensing (2013) emphasised the political, social and strategic nature of change and innovation. This sphere of influence was a central concern in this thesis, as it was a feature of transfer that was overlooked. This perspective might be best viewed in terms of the impact such areas of influence had on the inner workings of the organisation. These contextual features could be viewed through an examination of the hard measures of structures and procedures adopted for the provision and support of IAPT practice. Alongside this, harder to measure and looser constructs such as 'culture' and 'climate' were also considered. These variables were critical in understanding how an organisation responds to innovation and change as

they played a significant role in how IAPT practitioners practiced their role, formulated their identity and maintained their practice in the delivery of IAPT.

The study setting, for the main qualitative study, was similar to other providers in the region but not exclusively so. There also existed a number of small primary care and private providers offering services under AQP arrangements. The organisation (within the IAPT service) had a small management and supervisor team and a workforce geographically spread and over a large area. The vast majority of IAPT practitioners operated out of GP surgeries usually meeting up with other colleagues once or twice a month for supervision and organisation 'team' meetings. So while departmental units were relatively small (little or no hierarchy) the distribution of IAPT workers presented structural complexity.

The leadership members (within the IAPT service) were strong advocates for the approach to the above service design. This was viewed as the most cost effective means of covering services costs within the available contract. Data from these IAPT service managers indicated that financial margins were so tight that there was a feeling of organisational disenchantment with the IAPT project.

The framework used in this thesis, (Fixsen *et al* 2005) identified that there should be a clear implementation outcome around:

- Changes in relationships with consumers, stakeholders and system partners

There was a dynamic between the external influencing forces on the service and the internal moderators elements that sought to maintain fidelity to service aims. The external elements had a dynamic relationship with the

inner, internal aspects of the service. The goals of IAPT, as set by the national team and policy, which were interpreted by local GCGs through their commissioning arrangements, before being implemented by services such as the one under consideration. The mode of implementation was further interpreted by individual practitioners. A central theme of the study was the tension all aspects of the service felt in negotiating these critical aspects of implementation. This negotiation was through encounters with formal service data – patient data scores – and was used extensively as a means of monitoring service utilisation and to a lesser degree ‘quality’. The use of ‘softer’ aspects of the service was also evident, as many respondents talked about the importance of the culture and a supportive environment, despite many existing pressures.

The supportive environment clearly related to the culture within the organisation, but a distinction must be drawn between a culture of support and a culture which promoted innovation. Innovative practice was associated with new practices, risk taking, failure and radical thinking. The IAPT programme had a focus on change and the establishment of a new service (Perrin 2002). The management approach was focused on maintaining parameters on service delivery in keeping with the required outputs of a contract with CCG commissioners. While a number of respondents identified that they had been supported to extend their practice (e.g. developing specialist knowledge and skill in EMDR) such innovation was limited to added value to an existing clinical contract. Anderson and West (1998) conducted large scale studies in the process of developing a team climate inventory. In doing so, they considered four factors to be important in a positive team

climate: *vision; participative safety; task orientation and support for innovation.*

Data from this study provided support for 'participative safety' and 'task orientation' in IAPT, but there was little data that indicated a coherent vision for the service, nor innovation. IAPT practitioners were supportive of their managers, stating that they gave as much freedom and flexibility as was possible, but the emphasis was on survival and reaching monthly and year end targets. There were no data which indicated that clinical managers had a vision for the IAPT service as so much direction was at the behest of local CCGs. The focus was on delivery of recovery rates and meeting the wishes of GPs and commissioners.

The changing dynamic relationship though implementation may be viewed through an analysis of the construct of 'power'. In a complex adaptive system, power sits within the '*patterns*' in the system. Such patterns were (by the nature of complex systems) unpredictable but had a pervasive impact on the working of the system as a whole. Data emerged from this study strongly supporting a view that power was expressed in many different ways and in an unpredictable fashion. The external aspect of influence was seen to play a major role in setting the scene for behaviour and expectations of key stakeholders. For some respondents, particularly the policy leads, power was expressed in delivery of the agreed outcomes with central government. The power to impose a session by session reporting structure was seen as essential in maintaining fidelity to the programme outputs, but potentially also an unnecessary bureaucratic burden that added little value about the quality and true outputs gained from psychological therapy in primary care. Power differentials were also identified by IAPT therapists, when they noted that

more work would be required on a patient group due to a decision made by a commissioning CCG. However this power was not always seen as oppressive. In keeping with Lipsky's (2010) analysis of the 'street level' power of workers in policy implementation, some IAPT therapists reported a refusal to play what they saw as a bureaucratic game.

5.6. Integration of changes into routine care

This thesis used a complexity frame of reference to guide the research process. It was questionable whether a theory of complexity in relation to the social sciences was unrealistic. A theory, by definition, means a set of rules that are amenable to testing and retesting. Controlling and accounting for the influence of variables is sometimes impossible in social science research. Rather in the social sciences, the call on complexity is based more on an ontological desire; it is a way of helping explaining the world and the research situation under scrutiny. The theoretical framework (figure 2, page 23) was used extensively as a reference point to articulate the complex basis that policy implementation such as IAPT was founded. Most significantly, the issue of training transfer sat at the centre of this system. Typically transfer of training evaluations within the in-service healthcare provision were surface level reviews, seeking data on contentment on the part of learners of the training delivered. Within the HEI sector, there was a greater attention on an additional understanding of knowledge development. With specific programmes such as IAPT where an assessment of clinical skills was necessary, there was a concomitant accent on ensuring core skills were evident.

However this still left the complex interaction of the work-setting and 'external' environment unattended. Within a complex social system such as health and social care, such inattention cannot help explain the issue of training/learning transfer. Evidently from the data collected and presented, there was a distinct difference between what people were 'trained' to do and what people learned to manage in the practice setting.

The questionnaire data indicated a growth in knowledge about CBT, practitioners became more certain consistently over time in their answers, but critical issues of motivation and burnout required attention.

The motivation of IAPT participants was of particular interest, as it was posited that motivation maybe the most critical psychological construct when considering the transfer of learning. Like so much under review, the response to 'change' was a recurring theme. Transferring knowledge, skills and attitudes was a response to 'change' – stopping doing one thing and doing something else instead. Utilising West's theory of change (West 2006) the relationship between opportunity, competence and motivation in cementing new behaviours/skills was evident. Underlying this development of 'the new' was a foundation built on an identity as an IAPT worker.

The culture of a work setting played a major role in facilitating or inhibiting innovation and change in practice. This was certainly true when considering the transfer of learning. Denison (1996) considered culture to be the deeply embedded values and assumptions in an organisation, but as this study demonstrated the idea that there are a set of uniformly held values and assumptions is contested. The exploration of values as a factor in the development of a shared identity was a central aspect of the study.

Such a position had been echoed by Manley *et al* (2011) who proposed workplace characteristics as being multiple sub-cultures (idiocultures) which interact with broader organisational cultures. The respondents described very different approaches taken by different IAPT practitioners. The consensus view was that while each individual considered themselves to be an IAPT therapist, they were unable to describe a shared IAPT identity. The behaviour of IAPT therapists was subject to a number of internal and external factors (management demands and commissioner/GP expectation). The client group had changed, so while IAPT graduates were trained to treat people (primarily with anxiety and depression) they were now expected to offer evidence based treatment to a wide range of disorders with a greater severity of symptoms and disorders.

This would seem to challenge theories such as that of 'planned behaviour' (Fishbein and Ajzen 1975). The theory (Ajzen 1988) proposed that behavioural action was guided by a personal reflection on own views; a consideration of the views of important others and an assessment of personal capacity/capability to act. It was questionable about a clear understanding on who are 'important others'? and clearly the 'external' social environment had a significant impact on how these individuals saw their role and felt able to act. Issues of individual capability were challenged. Such personal challenges to competence/capability are significant to the original aims of the IAPT initiators who sought to promote a new workforce competent to deliver evidence based interventions. It may be suggested as one of the interviewees in the policy study indicated that it is possible to move beyond competence and into expert practice, not unlike the healthcare novice to expert model proposed by Benner

(1984). The social representations of IAPT workers form a critical discourse in articulating the work of the IAPT workers and the ability to transfer what has been learned.

This study examined the ability of IAPT practitioners to transfer skills gained in their training to the practice arena. Despite concern that training could be highly variable, the consensus was that supervision was the most challenging element of the educational programme. The exposure IAPT practitioners experienced of their emergent skills to public examination (supervisors and co-students) was consistently identified as the most anxiety provoking and also most helpful aspect of the programme. Undoubtedly, supervision remained the cornerstone of transfer issues for IAPT. All respondents identified increased ability, confidence and skill following completion of their education. The role of clinical supervisors was seen as a significant variable in that transfer process. The continuity of supervision between education and practice was seen as critical in navigating the changing landscape of education (characterised as slow and deliberate, careful and safe) to practice (characterised as frantic; isolated; time limited; complex and chaotic). Whilst clinical supervision was not the same as in education it was viewed by all participants as the principal vehicle of continued professional development of IAPT therapists.

The theoretical framework of Fixsen *et al* (2005) identified that implementation should have the following outcomes;

- Changes in adult professional behaviour (knowledge and skills of practitioners and other key partners)

- Changes in organisational structures and cultures (formal and informal) to support the change

Similarly, Vygotsky (1978) identified a major theme around the importance of the role of the 'knowledgeable other'. The work with the 'knowledgeable other' (supervisor?) was not a hierarchical relationship for Vygotsky, but one based on mutuality in developing knowledge and skills.

The competences identified for CBT supervision provide a comprehensive checklist of supervisory practice (Roth and Piling 2007a - appendix 4 'map' of the competences). A number of key generic competences were identified in the data and a number received little or no attention in either the focus groups or the individual interviews. There was no mention of supervisors using educational theory to guide their practice, and some evidence of practitioners indicating that time pressures meant that clinical supervision has become less of an opportunity to reflect and learn and more of an occasion where they were told what to do, rather than explore how they could deliver optimal treatment options.

There was concern that the supervisory alliance was at risk due to the changing external demands on IAPT services. Individual supervision was slowly moving towards group supervision as a means of seeing more people over a shorter period of time. Without doubt all the clinical participants in this study could see the difficulties this posed for the on-going development of the services and the challenges for clinical and managerial relationships. The issue of personal exhaustion was a common thread and the unique opportunity of supervision to facilitate high order Cognitive Behaviour Therapy skills was

felt to be diminishing. The focus on targets and recovery rates through supervision undoubtedly helped realise those ambitions. The utility of supervision as a personal development process may be minimised. Some saw supervision as an important and valued process. Clearly there were differences in how supervision was implemented and understood by participants. This reflected the tension on the subject evident in the analysis of policy leads and senior managers in the study. For some the issues of supervision was an important procedure to help effect the development of practitioners, while others focused on the evidence base, stating that only caseload management could be supported as (in the view of one individual) it was the only one with sufficient empirical evidence. Milne (2007) had argued for a stronger definition of supervision, stating that common conceptions of the process failed empirical tests of precision; specification; operationalisation and corroboration. To this end, he developed the following empirically testable definition:

The formal provision, by approved supervisors, of a relation-based education and training that is work focused and manages, supports, develops, and evaluates the work of a colleague/s. It therefore differs from related activities, such as mentoring and therapy, by incorporating an evaluative component and by being obligatory. The main methods that supervisors use are corrective feedback on the supervisees' performance, teaching and collaborative goal-setting. The objectives of supervision are 'normative' (e.g. case management and quality control issues); 'restorative' (encouraging emotional experiencing and processing); and 'formative' (maintaining and facilitating the supervisee's competence, capability and general functioning).
(Milne 2009 page 439)

This definition reinforced the tripartite model developed by Proctor in 1981 (see Cutcliffe *et al* 2001) of Formative, Normative and Restorative supervision

(see table 14 for a description) which provides a well-recognised overview of the supervision process.

The definition above, identified supervision to be provided by 'approved' supervisors indicating the criticality of the process. For this to be effective there must be a standard of competence/capability against which all supervisors might be measured. The issue of the development of professional identity; the articulation of service and professional norms were important aspects to consider Scaife (2009). This thesis identified practitioner burn-out as an important construct to consider. The use of psychological measures indicated an absence of burn-out, but in the interview process, it was evident that stress levels were high. The practice of supervision within IAPT may play a role in maintaining the workforce. The results indicated the utility of 'letting off steam' and managing stress levels, supporting the assertion for Edwards *et al* (2006) that supervision has a significant role in supporting the workforce.

Within the data, there emerged a challenge in developing a delivery of supervision that met the definitional requirements. The evidence was that much valued individual supervisory processes were changing to group methods. The often cited reason was one of time management, as the time saved from individual supervision provided more opportunity to treat more patients and achieve more targets. The service demands were considerable in IAPT, and monthly individual hourly supervision was seen as a luxury services could no longer afford. The caseload management supervision was also noted to be changing in responding to the same service demands. The educational aspect (the 'knowledgable other') of caseload supervision

identified so clearly in the data was being replaced by service demands for target achievement only. The tension was evident in meeting national patient targets for service provision and recovery and practitioner development. Caseload supervision was utilised as a means of ensuring IAPT provision was for patients who matched the research evidence profile. Patients who were most likely to benefit were identified and others either discharged or never accepted into the service. This caused concern for therapists as conducting the *same* therapy on the *same* patients was identified as ‘boring’ and did not engender sufficient interest in personal development. This presented a balancing act in meeting national targets for positive treatment outcome for patients and engaging the workforce in the development of their skills.

In addition there was concern from supervisors that even though the BABCP had mandated at least 90 minutes per month for IAPT supervision, there was no mandate on the quality of that supervision, nor a robust process for ensuring the skills of the supervisor.

Table 14: Proctors tripartite model of supervision

Element of supervision	Description
Restorative	The offering of psychological support to help mitigate the challenges and stresses of work in.
Normative	A focus on accountability in practice, ethical and legal considerations and fostering compliance with service procedures and goals.
Formative	The focus on learning; skills; development and identity. The organisation has a responsibility in supporting the supervisee in this element.

(Source: Cutcliffe *et al* 2001 page25)

5.7. (Continuous) evaluation and (where necessary) adapting plan: Feedback

The feedback process provided IAPT patients, therapists, managers and commissioners with a vast data repository. It provided the leaders of the service with the means by which to monitor practitioner data on session by session client progress; recovery rates and discharge figures. While there was evidence of approval of the principle of data collection, there were alternative perspectives on the utility of the data and how they were actually used in practice. The policy leads felt the session by session data were a hall-mark of the IAPT policy and provided an opportunity to give a central national team at the Department of Health a comprehensive analysis of the policy progress, almost in real time. It might well have been that IAPT was unique (within health and social care) in the ability to do this. Additionally there were expressed views that such data were the bedrock of supportive empirical caseload management supervision. The view from practitioners was the opposite of this, in that they expressed a consistent view that data were used within caseload management as a monitoring tool and not a learning tool. When caseload management was referred to as a learning opportunity, it was in reference to early learning about the process of therapy, beyond this, the data were seen less of a 'carrot' and more of a 'stick'. There were examples given of how supervisors had helped practitioners understand their reaction to waiting lists and how to develop strategies to manage this. However, the clarity of the message from practitioners that data were used as evidence of how to do more in less time was striking. The tripartite tension arising from such comprehensive data, between patient improvement,

national reporting and therapist development was at the heart of the IAPT transfer initiative. The balancing of these competing demands represents an additional challenge to the relationship between clinicians and managers.

How the data were used was of central concern, as from a staff support perspective there was emphasis placed on therapist development. Routine patient data were utilised in caseload management to identify blocks (discharge rates) or problems (recovery rates) but rarely mentioned as a tool for clinical supervision. It was left to the therapist to decide which patients were discussed in supervision (which runs counter to the requirements set out by the national team (Turpin and Wheeler 2011)). There was concern from therapists that if they only discussed patients with whom they were struggling it would give the impression of a lack of competence and so patient selection needed to be handled sensitively.

Feedback, by way of patient report data on progress was not uniformly distrusted or seen without utility. The IAPT policy programme may be unique in its collection of robust data that were utilised in the clinical cycle, the commissioning cycle and within central government. The respondents considered that the data had some use to someone (not always them, or their patients) and therefore was seen as having merit. The managers and supervisors—particularly those engaged in case management, found the data beneficial in identification of emerging trends and pre-empting commissioner concerns regarding throughput or recovery rates. This formal explicit knowledge creation may be seen in the context of the analysis of Dopson *et al* (2002) who identified that formally available explicit data to support evidence in practice presents a number of implementation hurdles. The analysis of

Dopson *et al* (2002) is identified in the left hand column of the following table and data on explicit knowledge creation from this study are included in the right hand column.

Table 15: Feedback comparison between Dopson *et al* (2002) and this study.

<p>Strength of evidence does not drive diffusion.</p>	<p>The IAPT national reporting programme (IAPT 2011) provided a comprehensive account of the requirements and process of data collection. It also provided research data to illustrate the utility of the chosen approach to data collection on a session by session basis. Despite this, data in this study replicated the findings of Dopson <i>et al</i> (2002) that a sound rationale on its own did not guarantee that practitioners would adopt the initiative willingly or unquestioningly.</p>
<p>Evidence is socially constructed.</p>	<p>The issue of what constituted ‘evidence’ or good practice took place within an intellectually competitive environment. In this study, where many IAPT practitioners questioned the validity and utility of measures they considered to be ‘blunt’. Alternative approaches were postulated, although none that would be so readily amenable to local, regional and national collection and comparison.</p>
<p>Evidence is differentially available to different groups within the organisation.</p>	<p>This was a finding not replicated in this study. All clinical data were available to all practitioners across the service, allowing them to compare their performance (in terms of contacts and recovery rates) against others in their team. While a number of practitioners raised concerns about the development of a ‘competitive culture’ with this process, there were no profound objections to this process. The fact that data were not shared between all organisations (only commissioners received a breakdown of each service) only added to the cynicism expressed by some practitioners that there was a strong external competitive environment and they were engaged (unwittingly) in a privatisation agenda of NHS services.</p>
<p>Evidence is differentially valued by different groups within the organisation.</p>	<p>This finding of Dopson <i>et al</i> (2002) was also found in this study, where practitioners based in inner city or deprived areas valued data collection less than some of their colleagues. Statements and objections were raised that the data on its own, and the conclusions drawn, did not tell the full story of the complex levels of need in the local community.</p>

<p>Boundaries between different professional groups inhibit transfer of evidence.</p>	<p>Again, there was evidence to support this assertion, in that a number of pro-CBT therapists identified data and measures as an important (if sometimes challenging) bureaucracy in monitoring patient improvement. Such an empirical perspective is very much part of the CBT tradition. However, a number of respondents in focus groups and interview from a stronger counselling background had less warmth to the data collection protocols. Ultimately, data collection was seen as mandatory by the national IAPT team and so there was no evidence of active processes of inhibiting feedback collection.</p>
<p>Networks within professions enhance the transfer of evidence.</p>	<p>Somewhat allied to the above point was that data collected in this study indicated that those networks of practitioners with a stronger collaborative empiricist perspective or identity were stronger advocates of data collection processes.</p>
<p>Research evidence competes with, and is seen as different from other forms of evidence.</p>	<p>The issue of what counts as 'quality' was a strong theme of the interview data. Many practitioners had concerns that other forms of patient report data were not given the same degree of attention and therefore practitioner performance and results of therapy was an incomplete picture of true IAPT practice. There were often comments about the complex nature of the patients' difficulties which current data collection systems could not collect.</p>
<p>Environmental context influences the rate and extent of evidence transfer.</p>	<p>The mandatory nature of the data collection process was a clearly established principle of IAPT. This context set the tone for much of the service and was well understood by practitioners prior to entering the service. While the data was collected, it was clear that the messages given to patients about the importance of the measures varied considerably.</p>
<p>Opinion leaders have a powerful influence on the adoption and dissemination of evidence</p>	<p>This was not a significant finding in this study. It may have been the relative isolation and independent nature of IAPT practice in this setting which resulted in respondents citing their own perspective on knowledge creation and utility rather than some other leader.</p>

5.8. Conclusion

Whilst the rationale for the IAPT initiative was uniformly welcomed by respondents, the application was less coherently articulated. The therapists, when faced with the complexity of real world practice, found a simple and linear transfer approach incompatible. The question raised from this study, surrounded the clarity of the concept of transfer. Taking a reductive position, the IAPT practitioners identified elements of their training that they still used but uniformly noted that much of their education was not utilised as there was a significant disparity between what they had been taught to do and what therapy they now provided. In that particular frame, it is clear that the transfer behaviours would be relatively low.

This thesis used a complex frame of reference through which to examine the role of IAPT therapists in primary mental healthcare services. A mixed method case study was utilised to reflect the dynamic interplay between the various interacting elements associated with learning transfer. The political social and economic factors were found to have a profound effect not only on service configuration but also the transfer activity of IAPT therapists. Therapists reported being capable meant being able to do something therapeutic with whatever patient, with whatever condition, walked through the door. There were service boundaries, but all therapists and supervisors reported a picture of IAPT services increasingly providing support, especially social care support, for client groups outside the original and narrow description of the stepped care model (figure 4, page 44).

For policy leads, the process of transfer was viewed as complicated, but ultimately linear. Services were developed a national training programme was

provided; people learned the skills of CBT for depression and anxiety and then implemented them in practice. This was supported by feedback processes such as a contractual requirement for clinical and caseload supervision and the reporting of regular in-treatment measurement of patient progress. Such support processes would ensure fidelity to the treatment model and evidence of progress toward meeting policy objectives.

Data from IAPT therapists, managers and supervisors provided a more complex picture (and the distinction between complicated and complex was important). The IAPT workforce was engaged in a process of managing competing demands and dynamic relationships from a variety of stakeholders. All these change factors were identified in the implementation outcomes of the theoretical model by Fixsen *et al* (2005). However the changes the workforce identified were not settled nor viewed as positive. The changes, in practitioner knowledge and skills; in organisational structures and in stakeholder relationships were in a state of flux. This may have been a result of the relative infancy of the service and IAPT role in primary care. Alternatively it may have been the result of uncontrollable external political, economic and social forces, the sphere of 'influence' and its effect on the transfer process.

In transfer of learning, the data pointed to the dissonance identified by the theory of action by Argyris and Schön (1998). The complicated process of learning transfer articulated by policy leads, was very different from the 'theory in use' identified by the IAPT workforce.

One important transfer process, identified by all respondents, was the provision of supervision (both caseload and clinical supervision). This

process was seen as highly developmental and crucial to maintaining fidelity to treatment approaches (the provision of evidence based CBT for depression and anxiety). It was the process that challenged therapists and was identified as the most beneficial method of developing personal skills and knowledge.

However the application of that education with the support of effective clinical supervision provided IAPT therapists with a confidence in their ability and a burgeoning sense of expertise. This reflected the conceptual process of vertical transfer (Foxon 1987) where education was reframed and utilised to solve problems at a higher skill level. The role of clinical supervision in supporting transfer; providing feedback to therapists; developing a sense of identity and maintaining fidelity to broad policy aims should not be underestimated.

The issue of identity of the IAPT workforce was not an overly strong theme in the data, yet according to the COM-B behaviour change system identified by West (2006) it was a process which was critical to effective and sustained change or education transfer. This thesis used a theoretical framework for understanding policy and practice improvement (Fixsen *et al* 2005) which had the construct of 'change' over three dimensions as the key outcomes. Educational transfer was about change and so such a framework provided an approach that guided the research process. Therefore sustaining behaviour change, in the face of significant external pressures or threats (such as the sphere of *influence*) according to West (2006) required a strong sense of identity, based on a clear belief and attachment to the goals of IAPT therapy to resist or manage such external pressures. There were links to the supervisory process in the data as it provided the opportunity for IAPT

therapists to engage in a collaborative discussion on service and treatment goals for patients.

However such an important process was continually under threat from aspects of *influence* and was being reduced to less of an educational and transfer mechanism to one which supported the factory analogies offered by many respondents. Managers identified the external commissioning requirements and sought ways to balance competing demands and maintain financial viability. IAPT was conceived as a treatment service before the economic down-turn in 2008-09 and the associated consequences to the broad landscape of health and social care. The stepped care model was medical in its description and provided no analysis of the associated social care needs that may be associated with mental health conditions.

The introduction to this thesis identified that many new roles in mental health services had failed to be sustained over the short or medium term. While no comprehensive analysis of the reasons for new role failure existed, it was possible that a significant reason for workforce failure was an inability to prove effectiveness in terms of tangible patient outcomes and the inability to develop a sufficiently strong identity. Clearly IAPT was a workforce implementation initiative which was strong in this area.

Chapter 6. Conclusion, limitations and recommendations

The thesis took a longitudinal approach to the study of transfer of learning in a health care setting. The majority of literature examined transfer as a process that related to the responsibility of the individual learner. The social dimension as articulated by Dewey (1938) and Vygotsky (1978) was largely absent. In adding to the body of knowledge this study used a complex frame of reference and identified that the transfer process took place within a dynamic work setting. The theoretical framework of Fixsen *et al* (2005) identified, the 'source' of policy implementation was an articulation by policy leads of how the IAPT programme might operate in 'the real world'. However, as identified by one policy lead there was no attempt to consider an implementation model for IAPT. During the early life of the implementation process key support structures emerged (CCGs) or were dissolved (SHAs). Other policy approaches emerged and were implemented (AQP) and had the potential to have a profound influence on the delivery of IAPT, as was originally intended and the transfer behaviour of IAPT therapists in their work setting. Therefore, this workplace sat within an external area of influence being subjected to economic, social and political forces that influenced to work of the learners in this study. Taking such a dynamic complex systems approach was unusual in transfer studies and had not previously been undertaken in research related to the process of transfer in the education for Improving Access to Psychological Therapy.

The research question sought an investigation to the characteristics of educational transfer within the IAPT work environment. To achieve this two aims and related objectives were identified (see page 12).

The theoretical model provided a useful description of the macro enablers and barriers to transfer of education to practice, but lacked the ability to enhance understanding of the *process* of transfer. In order to examine transfer in this way, the approach of Grol and Wensing (2013) was used to present the results of implementation and transfer. The process model was used to offer a practical guide to a system which was viewed as complex and dynamic. Conceptualising and presenting this study raised concerns that a linear approach was layered on a theoretical framework which was presented as, incontrovertibly, non-linear. The approach of Grol and Wensing (2013) also contains elements of dynamic feedback, but these were intended to be examined as a 'how-to' guide to implementation and so focused on the *meso level* (organisational) of understanding of transfer. The process of research in examining transfer still required an individual level of analysis, as the *macro* and *meso* had been accounted. To develop a *micro* level understanding of transfer, the theory of West (2006) was utilised to provide a deeper explanation of how transfer might be explained on a personal level, particularly in relation to the important psychological construct of motivation.

The study focused on the issue of transfer of learning which has a particular resonance in IAPT as education was one of the principal goals of policy implementation. The standard model for transfer identified between 10% and 20% return on the education provided (Aik and Tway 2005). Whilst this figure is contested (Ford *et al* 2011) in the NHS, with an annual education budget of nearly £5 billion, any improvement on such a return would be important.

The thesis was influenced by an examination of transfer literature which sought to identify the key variables associated with the issues related to

transfer. A number of survey instruments were identified through a review of the literature and these were administered over three time periods (prior to education; on completion of education and at eighteen month follow up). In addition a series of interviews and focus groups were conducted to gather a deeper understanding on the issues of transfer from the perspective of IAPT policy leads, IAPT therapists, their managers and clinical supervisors.

6.1. Limitations of the study

A study which utilised a complex framework such as Fixsen *et al* (2005) (figure 2 and 3, pages 23 and 25) were replete with potential and actual limitations. The explanatory power regarding the inter-relationships within a dynamic system presented a challenge to the research. The transfer of learning in such a system could not be easily and directly articulated. Instead, it was argued, an incremental approach would illuminate the factors associated with the transfer of learning. The work of Burke and Hutchins (2007) was used as basis on which to limit the number of possible variables considered to have an impact on transfer behaviour. It is possible that one of the 'discounted' variables had an (unrecorded) impact on the transfer behaviour of IAPT therapists in this study.

The decisions regarding research focus represented a limiting factor in any research design, particularly one which sought to examine data through a complex frame of reference. Consequently the breadth of the reference field may have sacrificed elements of depth. One of the most fundamental design decisions was to concentrate on IAPT therapists and policy leads at the expense of the key stakeholders in the IAPT transfer; the people who use the

service. The lack of a patient voice and the experience of receiving IAPT services may be viewed as a challenge to the results and discussion of this thesis. Assumptions on quality and outcomes have been presented but are uncontested against the experience of people who use services. The issues of marginalised voices and contested realities had been raised in this study and the lack of service user representation in the data is one of the hallmarks of this unrepresented voice (Abma and Widdershoven 2005).

Another limitation of the thesis was the uncontrolled nature of a pre and post training research design. The internal validity of the study was limited, as a comparator reference group had not been used and therefore it was impossible to identify the veracity of these findings with another group of IAPT therapists. An attempt was made to verify the findings through a single focus group of IAPT therapists from another English region. This presents a major limitation in the lack of representative voice of IAPT therapists may limit the applicability of the findings. A larger comprehensive sample of IAPT therapists would have supported stronger conclusions.

There was a significant reduction in the follow-up aspects of the research design. Attempts were made to increase the response rate through the use of an on-line questionnaire process. Requests were made to seek time three responses but to little effect. The length of follow-up (18 months) was chosen to ensure IAPT therapists could reflect on the transfer process. However such a long follow-up period may have been a major factor in the response rate.

While Implementation Science (IS) is promoted as a key reference point for this study, the thesis lacks an economic evaluation; an evaluation which is an

important element in IS research. Implementation programmes in public services such as IAPT in the NHS did not happen within a financial vacuum. Whilst some policy leads and IAPT therapists identified the moral arguments for the existence of psychological therapy in primary care, there was unequivocal acknowledgement that the financial return on investment formed a major drive for the programme.

On a practical level, the research process suffered from a number of potential limitations. One of the most obvious related to the inclusion of national policy leads as a key reference point in anchoring the research data. These individuals were well known national figures in the IAPT programme and obtaining time and opportunity in their schedule proved very difficult. The respondents had a vested interest in IAPT in that they played significant roles in developing and implementing the national policy. Consequently it could be questioned whether they were able to have a dispassionate and objective assessment of the 'source' process. The IAPT programme represented a significant shift in mental health policy. The provision of IAPT was based on both economic arguments and clinical evidence; that IAPT was based on the delivery of evidence based practice and could deliver NICE approved psychological therapy for anxiety and depression (Clark *et al* 2009). The rationale for this policy implementation was twofold; the aim to decrease the prevalence of mental illness in primary care populations and secondly the economic gains associated with increased productivity, employment and a reduction in welfare payments. Such gains formed the cost-benefit analysis by the Treasury in releasing the finances to initiate and sustain the programme (Layard *et al* 2007; Radhakrishnan *et al* 2013). A national policy

development of such a magnitude may have influenced responses to questions within the interview.

Other limitations related to the methods of data collection. Primarily the focus groups were based on detailed field notes rather than recorded transcripts. In the facilitation of discussion, key data may have been missed despite attempts to be reflexive in action (Giddens 1979). Despite this there remains the possibility that key avenues of research were not recorded and followed.

The practical and situational issues identified at the beginning of this chapter may have distorted the research results. At the start of this research there was a very different topography to the health and social care landscape. IAPT was initiated and implemented prior to the health and social care reforms of the Health and Social Care Act (2012) (HM Government 2012a). Consequently, there were a number of Strategic Health Authorities in existence, with IAPT leads at the beginning, but replaced over time with Clinical Commissioning Groups (CCGs) and lead commissioners. The introduction of the AQP policy added another level of complexity to the IAPT process. Where AQP was introduced (it was in the research site of this study) all providers were required to re-tender for the contracts to deliver psychological therapy in primary care. The policy also allowed a number of new providers to enter the market place. At this time all support for this research project effectively stopped and the process of data collection was placed on hold while organisations went through a major re-tendering exercise. This was no small endeavour as each organisation had significant start-up and capital costs associated with IAPT contracts. It was an illustration of the power of an external area of influence on the delivery of

health care and by association, the ability of IAPT therapists to put their education into practice.

This thesis used a theoretical framework to examine the relationships between parts of the healthcare system associated with IAPT implementation and transfer of education into practice. Nilsen (2015) identified that there were no shortages of such frameworks and they were often untested and lacking clarity on how they can advance understanding of implementation (and transfer) issues. Frameworks such as the one used in this study have little explanatory power as they are used only as a means of illustrating the (hypothesised but untested) relationship of empirical phenomena. The Fixsen *et al* (2005) framework, was described by Nilsen (2015) as a 'determinant framework' in that it hypothesises outcomes based on the interaction between barriers and enablers in practice (independent variables) on the impact of implementation (dependent variables). In using such a framework in transfer of learning, there was no attempt to offer a causal explanation of how change in practice, or transfer of learning, took place. The framework used in this study made no attempt to describe the relevance of the implementation on end users (in this case IAPT therapists and services). The sequence of relationships was hypothesised (but common across many implementation frameworks) and as such represented an area for future research (Nilsen 2015). The framework was used to examine elements of the transfer process (from policy identification to transfer in the work-setting) in a compartmentalised and linear fashion. However the thesis identified that such relationships between elements of the framework (the source; the communication link and the destination within an area of influence) could only

be viewed as a dynamically inter-connected set of relationships with dynamic feedback loops. Such dynamic interaction presented a barrier to research description or analysis.

The elements of the framework which were subject to survey were garnered from a literature review and influenced by the meta-analysis of Burke and Hutchins (2007). The aspect of bias on the part of the researcher must be a factor in consideration of limitations of the research particularly in relation to the process of choosing survey instrument selection.

The issue of personal bias on the part of the researcher is a critical consideration within this thesis. The researcher was associated with the very early development of IAPT. A number of key national figures were associates of the researcher during this period. Adopting a reflexive approach to data collection and analysis was essential. This critical self-reflection was a fundamental process conducted by the researcher. All findings and assumptions were subject to on-going examination to ensure that any bias was identified and eliminated.

6.2. Summary of findings, synthesis and contribution to new knowledge

The results indicated that transfer was a challenging process for IAPT therapists and their services. National training programmes focused on the development of core skills which bore little resemblance to the practice of IAPT therapists. Policy development and practice implementation existed within a highly dynamic sphere of influence. The national curriculum and education programmes did not appear to reflect the reality of IAPT practice. There was an argument that curriculum for novice workers could only deliver

core training skills to ensure a baseline of clinical competence from which future practice development could spring. In supporting such development, the role that supervision played was a significant part in maintaining a focus on transfer. The importance of supervision was a theme expressed by every respondent and IAPT was a policy initiative (which had also formalised supervision in the delivery plan). The focus on the evidence base for delivery of NICE guidelines at a policy level identified the role of CBT within IAPT. This CBT based approach had an impact on the findings of this study. The minimum training and supervision standards of the British Association of Behavioural and Cognitive Psychotherapies (BABCP) were incorporated into the national IAPT delivery plan. As a consequence all IAPT therapists had to receive at least ninety minutes of supervision per month. The BABCP also attempted to monitor the quality of supervision and practice through confirmation of practice processes for re-accreditation as a CBT therapist. However, data indicated that this supervision was viewed as variable with a greater or lesser intention to focus on fidelity to CBT principles in IAPT. The provision of supervision had a relationship to the theme of 'feedback' since it was viewed as a reflective process giving IAPT practitioners the opportunity to examine their work and continue the process of educational transfer. The caseload management supervision also provided direct feedback to therapists in the form of data on delivery and recovery targets. The delivery targets formed an element of feedback in contributing the theme of tension. This tension was significant in data as practitioners, supervisors and managers sought to deliver IAPT contracts to commissioners whilst also maintaining service relationships with GPs and other key stakeholders. The provision of

feedback through sessional data in the form of standard outcome measures gave IAPT a process for centralised strategic monitoring at the DH and close operational monitoring by CCGs. The theoretical model identified the importance of feedback but it was evident that education providers were not well connected in the important feedback system for IAPT. The policy leads identified that IAPT was centred on two strands; service development and education and training with the latter being identified as more successful than the former. The basis though of IAPT was consistent, that it should deliver evidence based CBT therapy for anxiety and depression. However, services have developed in such a way as to move well beyond this, often as the behest of CCG commissioners.

Transfer was not talked about in explicit terms by respondents, who focused on the demands of their therapy role and the support they required. Some IAPT respondents talked about developing an identity as CBT therapists but were concerned that service development threatened their ability to fulfil it. Concern was raised that the 'real world' of practice was so different from that of academia that CBT skills were being eroded and less relevant to changing or complex client groups. At the heart of this was a contradiction in IAPT in that CBT was not a model of service delivery but a treatment model. The focus on CBT in the education programme and the identity of therapists related to a form of therapy. Indeed CBT was not a single therapy but a psychotherapeutic approach that incorporated a number of other, cognitively based, treatment approaches.

The transfer of education to practice entailed a significant element of change, the change of practice to incorporate new learning or new skills. Behavioural

and/or cognitive change theory was not a feature of the transfer of learning literature, yet was a critical element of the process. This thesis sought to integrate change and consider how it might play a significant role in the practice of IAPT workers. The theory of West (2006) was introduced, particularly the focus on capability; opportunity and motivation (COM-B) processes that influence behaviour. The therapists in this study identified significant opportunities to develop their practice and were motivated to do so. However the motivation was tempered with concerns that IAPT processes contained a strong management approach, given the scrutiny of the programme. The ability to produce significant feedback data may well be the factor that facilitates such scrutiny. Therefore motivation, which was the most important element in the COM-B change theory and was the psychological process that appeared most tentative in the data. IAPT therapists talked about a sense of exhaustion caused by the contract demands and made many references to factory analogies. In such a situation the motivation to engage in transfer behaviours was limited.

6.3. Recommendations

Transfer of learning is a dynamic process that takes place within the context of a complex sphere of external (social, political and economic) influences. As such a linear evaluation model gives little indication on the factors that enable or inhibit transfer. Evaluation of educational transfer must account for the pervasive impact of the external environment and internal work processes in healthcare practice.

The role of clinical and workload supervision was the overarching theme in this research. The supervisory processes displayed a clear relationship to a positive response to all the other themes and so may be classed as a meta-theme. As an enabler of transfer of learning from the classroom to the practice setting, supervision played an important role in supporting novice IAPT therapists make the transition from the protected learning environment within a HEI to the confusing, messy and isolated world of routine IAPT clinical practice. Supervision had an important role in building confidence and capability in IAPT therapists as well as challenging 'inappropriate' therapeutic drift.

Clearly for policy implementation and Continuous Professional Development (CPD) supervision was an important process, given that it was a contractual requirement of all HEIs and services. However, data indicated that external policy and productivity pressures caused respondents to report the vulnerability of effective supervisory processes. Data showed a relaxation of the contractual requirements. The implications of this for transfer and fidelity to policy goals are unknown, but based on data in this study it is proposed that it represented a retrograde step. There were many examples of new roles and new ways of working cited in the literature which were no longer supported. Either these roles were not needed in the first place, hence their removal or they were not well supported and adopted and so 'withered on the vine'. The relaxation of requirements for the support of these roles may well have been one of the reasons for their eventual reduction and dissolution. There was a debate within IAPT about a relaxation of the requirements of PWP's to conduct elements of the stepped care model (figure 4, page 44).

This along with a relaxation for supervision may be an initial step which may challenge the fundamental basis on which the service was initiated.

Recommendation 1: For educational providers and policy leads to develop a new curriculum for complexity as a post IAPT registration programme. Such an educational development would contextualise the 'real world' of IAPT delivery in a primary care setting.

The requirement to build on the core skills of CBT for anxiety and depression was a strong theme in this research. The feedback processes which were quite robust between services and central policy managers were largely absent to educational providers. This created the opportunity for a disconnection between the curriculum and the reality of isolated and often unsupported practice. Developing stronger links between service and education providers will enable a dialogue which accurately reflects current IAPT practice.

The thesis identified that theoretical approaches to behaviour change can be integrated into an understanding of the transfer process from the education to the clinical setting. The emphasis in this thesis on the role of behaviour change in educational transfer represents an innovative approach to this literature. This thesis identified behaviour change as a key feature of transfer of learning and one that was explicitly absent from many studies on the subject. There was considerable interest in the mechanisms of behaviour change (Michie *et al* 2014) but educational initiatives such as the one in this study were not a significant feature of the debate. A deeper understanding of

how change theory could be incorporated into educational programme development and future transfer studies is needed.

Recommendation 2: The role of supervision as an agent of behaviour change requires attention. In achieving this, there is a need to develop a new supervision model which utilises a COM-B (West and Brown 2013) as a synthetic and integrative approach to behaviour change theory.

Feedback processes were somewhat unique in IAPT. Many agencies were provided with important information about service development and the practice of trained IAPT therapists. The feedback procedures allowed for identification of practice challenges and were cited as information that provided important learning opportunities. However despite some awareness that in-treatment measures had clinical utility, these processes were seen by IAPT practitioners as overly bureaucratic and focused on financial goals rather than therapy goals.

Recommendation 3: For policy leads, commissioners, HEI and IAPT service managers to revisit the purpose of feedback processes within IAPT. Therapists often viewed in-treatment measures as overly bureaucratic and supervisors viewed them as sometimes not clinically sensitive.

The identity of IAPT therapists was a challenge in the transfer process. Policy leads thought that a unified sense of being an IAPT worker would stem from the central control of the service. However policy changes from central

government introduced a range of local flexibility which meant that IAPT services were at the behest of newly established CCGs and where applicable the AQP programme. The dynamic healthcare environment and frequent policy initiative processes means that IAPT services may not remain a high priority commissioned service over the medium and long term. Other initiatives may usurp their status. Consequently it was important to understand what will enable the IAPT footprint to be maintained in primary care for the benefit of the large numbers of people who were deemed to require psychological help and who were not receiving a service previously. An aspect of the positioning for a distinct IAPT approach to psychological therapy in primary care is that of a developing IAPT identity. There are forums for psychological therapy at a national level: the BABCP and the New Savoy Partnership both hold national conferences each year but these are aimed at a broad range of psychological therapists in a variety of services. There is no setting dedicated to IAPT therapists and to their development of evidence based psychological therapy in primary care.

Recommendation 4: For IAPT therapists and national policy leads to consider supporting a dedicated forum for IAPT therapists to review, challenge and develop IAPT practice.

The transfer of learning was a complex process made more so by awareness that learning may take place over short (near) or long (far) timescale.

Research studies need to account not only for this, but also the potential for 'vertical' transfer too. The 10%-20% transfer rate, much referenced in HRM

literature may be a statistical fallacy. In this study, the IAPT therapists identified only a fraction of their core education they then used after establishing themselves in the work setting. Taking a longitudinal approach to data collection helped identify that only important training elements were used to increase confidence and capability in managing a complex and challenging work setting. While there were concerns that this development of practice may have been a feature of therapeutic drift, it was still a belief in practice development based on core skills provided in their education. Clearly clinical supervision was seen as an important, but vulnerable response to ensuring continual transfer over the longer term.

This thesis identified that new roles in mental health services have previously been developed but have not been sustained over the short or medium term. IAPT is a service that has proven efficacy in terms of patient activity and recovery rates. There will always be the opportunity or even necessity to adapt over time. However such adaptations can only be achieved if the role is sustained over time. The above recommendations, based on the findings from this research provide the infrastructure to best achieve this.

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Appendix 1

Demographic data

1. ID Number

2.. Date of Questionnaire completion ___/___/_____

3. Gender:

Female [] (0)

Male [] (1)

4. Age Range

20 - 25 [] (1)

25 - 30 [] (2)

30- 35 [] (3)

35 - 40 [] (4)

40 - 45 [] (5)

45- 50 [] (6)

50 - 55 [] (7)

55- 60 [] (8)

60+ [] (9)

5. Your area of Work (*please tick*)

[] (1)

[] (2)

[] (3)

[] (4)

[] (5)

[] (6)

[] (7)

Other [] (8) Please state

6. What is your healthcare background?

- Qualified Occupational Therapist [] (1)
- Registered Nurse (please specify branch) [] (2)
- Qualified Psychologist (please specify branch) [] (3)
- Qualified Medical Doctor [] (4)
- Other Allied Health Professional (please specify) [] (5)
- Qualified Counsellor [] (6)
- No professional healthcare qualification [] (7)

7. Ethnic Origin (Please circle)

White British		Pakistani	
Asian, Asian British		Chinese	
Indian		Black, Black British	
Irish		Caribbean	
Bangladeshi		Other Black background – please write in below	
Other white background, Please write in below			
		Other Ethnic Background	
Mixed - Please write in below		Other Asian background –Please write in below	
African		Tick here if not known	

8. Your highest level of education? (please note the highest only)

- PhD [] (1)
- Masters [] (2)
- PG Dip [] (3)
- PG Cert. [] (4)
- Degree [] (5)
- Diploma [] (6)
- Certificate [] (7)
- None [] (0)

9. Have you studied Cognitive Behavioural Therapy prior to this course?

Yes [] (1)

No [] (0)

10. If yes, please give details on the type of course(s), length of time , whether it was accredited by a professional/organisational body, whether it was 'in-house' training or provided by an accredited training provider (e.g. university)

11. Have you received on-going CBT supervision from an accredited CBT supervisor?

Yes [] (1)

No [] (0)

Thank you

About the questionnaires

The following pages contain a number of questionnaires which have some variations on the scoring requirements. It is therefore very important that you read the instructions for each questionnaire and respond accordingly.

Try not to deliberate on your answers, your initial responses will be sufficient

Transfer Study (AMS-C 28)

Why do you attend this training programme course ?

Using the scale below, indicate to what extent each of the following items presently corresponds to one of the reasons why you attend this course.

Does not correspond at all	Corresponds a little	Corresponds moderately	Corresponds a lot	Corresponds exactly		
1	2	3	4	5	6	7

WHY DO YOU ATTEND THIS COURSE ?

- | | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. Because this course will provide me with the foundation
To find a high-paying job later on. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 2. Because I experience pleasure and satisfaction
while learning new things. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 3. Because I think that this course will help me
better prepare for the career I have chosen. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 4. For the intense feelings I experience when I am
communicating my own ideas to others. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |
| 5. Honestly, I don't know; I really feel that I am wasting
my time in this course. | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

6. For the pleasure I experience while surpassing myself in my studies.	1	2	3	4	5	6	7
7. To prove to myself that I am capable of completing a course of this type	1	2	3	4	5	6	7
8. In order to obtain a more prestigious job later on.	1	2	3	4	5	6	7
9. For the pleasure I experience when I discover new things never seen before.	1	2	3	4	5	6	7
10. Because eventually it will enable me to seek the job in a field that I like.	1	2	3	4	5	6	7
11. For the pleasure that I experience when I read interesting ideas/authors.	1	2	3	4	5	6	7
12. I once had good reasons for attending this course; however, now I wonder whether I should continue.	1	2	3	4	5	6	7
13. For the pleasure that I experience while I am surpassing myself in one of my personal accomplishments.	1	2	3	4	5	6	7
14. Because of the fact that when I succeed in this course I feel important.	1	2	3	4	5	6	7
15. Because I want to have "the good life" later on.	1	2	3	4	5	6	7
16. For the pleasure that I experience in broadening my knowledge about subjects which appeal to me.	1	2	3	4	5	6	7
17. Because this will help me make a better choice regarding my career orientation.	1	2	3	4	5	6	7

18. For the pleasure that I experience when I feel completely absorbed by what people have written.	1	2	3	4	5	6	7
19. I can't see why I go to this courses and frankly, I couldn't care less.	1	2	3	4	5	6	7
20. For the satisfaction I feel when I am in the process of accomplishing difficult academic activities.	1	2	3	4	5	6	7
21. To show myself that I am an intelligent person.	1	2	3	4	5	6	7
22. In order to have a better salary later on.	1	2	3	4	5	6	7
23. Because my studies allow me to continue to learn about many things that interest me.	1	2	3	4	5	6	7
24. Because I believe that these years of education will improve my competence as a worker.	1	2	3	4	5	6	7
25. For the "high" feeling that I experience while reading about various interesting subjects.	1	2	3	4	5	6	7
26. I don't know; I can't understand what I am doing on this course.	1	2	3	4	5	6	7
27. Because this course allows me to experience a personal satisfaction in my quest for excellence in my studies.	1	2	3	4	5	6	7
28. Because I want to show myself that I can succeed in my studies.	1	2	3	4	5	6	7

Transfer Study
Cognitive Behavioural Therapy Knowledge Quiz
(CBT-KQ)

No.

Date:

INSTRUCTION:

Read each question carefully and select only one answer from the 4 options. Indicate your choice by circling A, B, C or D. **Please note there is only one correct answer. If you circle more than one answer for a question then no marks will be given.**

1. Cognitive Behavioural Therapy is best defined as:

- a) A systematic approach that focuses on the connection between a patients' symptoms and current interpersonal problems.
- b) An approach that views thoughts and feelings as by-products of behaviour.
- c) A self help model that enables the patient to learn how to use positive thinking.
- d) A short term, structured problem-solving form of psychotherapy.

2. In Cognitive Therapy, which of the following is usually the earliest stage in treating severe depression?

- a) To identify negative automatic thoughts and begin evaluating them.
- b) Encouraging the patient to talk about their previous life experiences.
- c) The monitoring and planning of daily activities.
- d) To recognise thinking errors and modify conditional beliefs.

3. Which one of the following could NOT be classed as a maintaining factor in an anxiety disorder?

- a) Controlled breathing.
- b) Distraction.
- c) Habituation.
- d) Relaxation.

4. **Negative automatic thoughts are usually best identified by:**
- a) First establishing the schemas and conditional beliefs that influence them.
 - b) Introducing the patient to the notion of thinking errors as early as possible in therapy.
 - c) Exploring specific instances where an emotional change has occurred.
 - d) Exploring rationally with the patient his/her typical way of thinking about the world.
5. **What is currently the main behavioural technique used to treat phobic anxiety?**
- a) Systematic Desensitisation
 - b) Covert sensitisation
 - c) Behavioural experiments
 - d) Graded exposure
6. **The basic idea underpinning 'instrumental learning' or 'operant conditioning' is that:**
- a) A behaviour will increase through repeated pairings with another stimulus.
 - b) Learning is consistently strengthened by frequent pairings.
 - c) A response is altered in probability by its consequences.
 - d) Positive and negative reinforcement will reduce the frequency of a behaviour.
7. **Which of the following is the central feature in the cognitive model of panic disorder?**
- a) The presence of recurrent unexpected panic attacks followed by persistent concern about having another panic attack.
 - b) Avoidance of situations associated with panic attacks and the use of safety behaviours.
 - c) A discrete period of intense fear or discomfort in which a number of symptoms occur including palpitations, sweating, shaking and feeling dizzy.
 - d) Catastrophic misinterpretation of physical or mental symptoms.
8. **Schemas are best described as:**

- a) Underlying beliefs which the individual can identify as being unhelpful.
- b) Negative cognitions about the self that are triggered instantly by distressing events.
- c) Unhelpful ways of perceiving situations that help to maintain problems such as depression and anxiety.
- d) Strongly held unconditional beliefs that are thought to develop through early experience.

9. **Mr. White suffers flashbacks of an incident when he was the victim of a personal assault. He also avoids any reminders of the incident and is in an almost perpetual state of high physiological and mental arousal. Which of the following approaches is most likely to help him manage the symptoms?**

- a) Progressive deep muscle relaxation and imaginal exposure.
- b) Prolonged exposure in imagination to his memories of the incident.
- c) Thought stopping for the flashbacks and distraction for the anxiety.
- d) Exposure to reminders of the incident and controlled breathing.

10. **The 'Downward Arrow' is a cognitive technique most frequently used to reveal:**

- a) Conditional beliefs.
- b) Type I thinking errors.
- c) Negative automatic thoughts.
- d) Dysfunctional thinking styles.

11. **In cognitive models of anxiety, safety behaviours are seen as preventing:**

- a) The patient from learning new and more adaptive ways of behaving in specific situations.
- b) The accessing of conditional beliefs and schemas, through reducing anxiety.
- c) Exposure to the feared consequence and, therefore, inhibit habituation.
- d) The disconfirmation of the thoughts or beliefs that are maintaining the problem.

12. **'Graded Exposure' should be:**

- a) Brief and repeated.
- b) Prolonged and modelled.
- c) Prolonged and repeated.
- d) Brief and attention focused.

13. **The initial focus of CBT is most commonly on:**

- a) Maintaining factors to a patient's problem.
- b) Precipitating factors to a patient's problem.
- c) Predisposing factors to a patient's problem.
- d) Activating factors to a patient's problem.

14. **In the work of A.T. Beck the 'cognitive triad' relates to:**

- a) Antecedents, beliefs and consequences.
- b) The view one holds of one's self, world and future.
- c) Thoughts, feelings and behaviours.
- d) Thoughts, conditional beliefs and schemas.

15. **In CBT the therapeutic relationship is vital in:**

- a) Allowing emotional processing of faulty thinking patterns.
- b) Enabling early challenging of underlying beliefs.
- c) Allowing a collaborative process of therapy to be developed.
- d) Enabling the patient to establish appropriate safety behaviours.

16. Habituation refers to:

- a) The psychological processes maintaining anxiety.
- b) The waning of a response such as anxiety.
- c) The positive reinforcement of unwanted behaviours.
- d) The generalisation of feared stimuli in phobic anxiety.

17. Phobias of natural objects and situations are more commonly reported than phobias related to man-made items. This may be explained by:

- a) Preparedness.
- b) Operant conditioning.
- c) Stimulus generalisation.
- d) Classical conditioning.

18. Which of the following is the most effective way to overcome agoraphobia?

- a) Leave the feared situation and practice relaxation and then re-enter it.
- b) Graded exposure to feared situations and symptoms.
- c) Use of positive self-talk and distraction when in anxiety provoking situations.
- d) Breathing into a paper bag to raise CO² levels in the blood stream.

19. A 'negative automatic thought' is best described as:

- a) A thought or image, which spontaneously enters a person's mind and is negative in content.
- b) A volitional thought, which comes into a person's mind and has a negative content.
- c) An illogical or irrational thought that affects a person's emotions.
- d) An involuntary and repetitive thought extremely common in depression.

20. A depressed patient has not completed his activity diary because he didn't do all the things that were planned in the last session 'so there was no point in writing it down'. This type of thinking is an example of:

- a) Dichotomous thinking.
- b) Minimisation.
- c) Catastrophising.
- d) Selective abstraction.

21. If a behaviour is negatively reinforced it will:

- a) Initially increase in frequency but will eventually become extinguished.
- b) Stop almost immediately.
- c) Decrease in frequency.
- d) Increase in frequency.

22. What does the 'Socratic Questioning style' refer to?

- a) A process of guiding the patient to uncover their thoughts and feelings, evaluate them, and to arrive at alternative interpretations and solutions.
- b) A process in which the patient uses a series of questions given to assist them in evaluating their negative thinking while completing behavioural experiments.
- c) A process in which a direct form of questioning is used to lead the therapist and patient to the identification and evaluating of schemas.
- d) A process in which questions are used that are designed to bring the therapist and patient to a new level of understanding of behaviours maintaining the problem.

23. Activity Scheduling is commonly used in Cognitive Therapy to tackle:

- a) Catastrophising and poor concentration.
- b) Inactivity and procrastination.
- c) Poor concentration and physical tension.
- d) Panic attacks and avoidance.

24. Conditional beliefs are best described as:

- a) Absolute beliefs about self, others and the world.
- b) Cross-situational beliefs that guide behaviour and expectations.
- c) Distorted beliefs that lead to negative emotional states.
- d) Unhelpful and maladaptive core beliefs not articulated consciously.

25. Mrs. Smith is a 35 year-old mother of two. She reports repeated intrusive thoughts about harm coming to her children as a result of cancer. She responds to these thoughts by trying to replace them with a 'good thought' or by imagining harm coming to someone other than her children. Treatment should involve the following:

- a) Exposure to thoughts of harm coming to her children through illness, response prevention to the use of replacement thoughts.
- b) Exposure to doctor's surgeries and hospitals, response prevention to thoughts of harm coming to her children.
- c) Information about the likelihood of childhood cancers, cognitive restructuring regarding the thoughts of harm.
- d) Exposure to information regarding illness, reassurance that her thoughts will not come true.

26. Graded task assignment is best described as:

- a) The allocation of activities according to specific mood states.
- b) The breaking down of activities into small manageable steps.
- c) The process of step-by-step exposure practice for phobic anxiety.
- d) All of the above.

Transfer Study

MEASURE OF GENERALISATION (MoG)

SELF RATING OF CBT PRACTICE

DATE:

This form is intended to obtain an estimate of your use of CBT skills and concepts in your current practice.

A. EXPERIENCE

The following items refer to your practical experience in CBT. For each item please answer by circling the number of your answer on the scale below:

- 5 = extensive application of these concepts in practice
- 4 = frequently use these concepts in practice
- 3 = sometimes use these concepts in practice
- 2 = rarely use these concepts in practice
- 1 = never use these concepts in practice

I currently.....		<u>Circle one answer</u>				
1. Refer to the cognitive behavioural model in my clinical practice.	5	4	3	2	1	
2. Use a cognitive behavioural formulation.	5	4	3	2	1	
3. Use validated measures	5	4	3	2	1	
4. Use behavioural techniques.	5	4	3	2	1	
5. Use cognitive techniques.	5	4	3	2	1	
6. Identify underlying core beliefs using cognitive strategies.	5	4	3	2	1	
7. Use a set session structure including agenda setting and homework.	5	4	3	2	1	
8. Use relapse prevention strategies.	5	4	3	2	1	

Use any others, please list:

- a)
- b)
- c)

B. GENERALISATION

This next set of questions refer to the frequency with which you have generalised the above methods. Once more, please use a 1-5 scale to rate the degree of generalisation that has taken place:

- 1 = not generalised CBT concepts at all in this respect
- 2 = rarely generalised (i.e. 1-2 occasions)
- 3 = sometimes generalised (i.e. 3-4 occasions)
- 4 = frequently generalised (i.e. 5-6 occasions)
- 5 = extensively generalised (i.e. on more than 6 occasions)

For example, if you have tried to make sense of a colleagues health on one occasion by means of the CBT model, you would circle 2 for question 9.

To what extent.....

Circle one answer

9. Do you use CBT principles with people other than in your clinical practice.

Please state which people (e.g., other staff; family member):

5 4 3 2 1

a)

b)

c)

10. Do you use CBT principles to tackle problems outside your clinical practice. (e.g. time management; goal setting). Please state what areas tackled, again listing up to three:

5 4 3 2 1

a)

b)

c)

11. Have you developed individualised methods of assessment or therapy based on CBT principles.

5 4 3 2 1

a)

b)

c)

C. AREAS OF FUNCTIONING

To what extent has your current model of working had an impact on the following.

- 1 = no impact at all
- 2 = rarely had any impact (i.e., 1-2 occasions)
- 3 = sometimes had an impact (i.e., 3-4 occasions)
- 4 = frequently had an impact (i.e., 5-6 occasions)
- 5 = extensively had impact (i.e., on more than 6 occasions)

Circle one answer

12. Productivity at work (e.g. efficiency).	5	4	3	2	1
13. Your sickness absenteeism (e.g. time away from work for health or other reasons)	5	4	3	2	1
14. Your clinical effectiveness (e.g. ability to resolve client problems)	5	4	3	2	1

D. SUPPORT AND PARTICIPATION

Next please tick all those activities in which you have been involved over the past three months.

- 5 = extensively been involved in this activity (i.e., 16 occasions or more)
- 4 = frequently been involved in this activity (i.e., 10-15 occasions)
- 3 = sometimes been involved in this activity (i.e., 4-9 occasions)
- 2 = rarely been involved in this activity (i.e., 1-3 occasions)
- 1 = not been involved in this activity

a) Attending supervision groups	5	4	3	2	1
b) Contact with other course members	5	4	3	2	1
c) Contact with tutors	5	4	3	2	1
d) Contact with Cognitive Behavioural Therapist	5	4	3	2	1
e) Staff meetings	5	4	3	2	1
f) Supervision	5	4	3	2	1
g) Reading CBT books/journals.	5	4	3	2	1
h) Attending CBT workshops/conferences.	5	4	3	2	1
i) Any others? Please specify here:-					
j)					
k)					
l)					

Of these, which have been the most helpful to your use of CBT methods?

Most helpful:

Second most helpful:

Third most helpful:

E. COMPETENCE AND CONFIDENCE

The following items refer to your competence and confidence in using CBT. For each item please answer by circling a number on the scale below:

- 5 = always
- 4 = frequently
- 3 = sometimes
- 2 = occasionally
- 1 = not at all

15. I feel confident using CBT techniques.	5	4	3	2	1
16. When using CBT techniques, I feel I am currently competent.	5	4	3	2	1
17. I am interested in gaining further knowledge about CBT models and techniques	5	4	3	2	1

If you would like to offer any comments, either on the ratings that you have made or of a more general kind, please do so here:

.....

.....

.....

.....

Once again, many thanks for your co-operation.

Generalised S.E Scale

Transfer study

Please read through the following statements and rate the one on the scale provided, which most accurately describes your views. To mark your score please colour in the

circle ● If you make a mistake place an **X** through the circle and mark another one.

		1=Not true at all	2 = Hardly True	3 =Moderately True	4 = Exactly True
1	I actively seek out intellectual challenges	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2	Sometimes I feel overwhelmed by the size of the tasks I face	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3	Achieving my set goals is my main priority	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4	I can always manage to solve difficult problems if I try hard enough.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5	If someone opposes me, I can find the means and ways to get what I want.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6	I am not swayed from my task by external events	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7	It is easy for me to stick to my aims and accomplish my goals.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8	I am confident that I could deal efficiently with unexpected events.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9	I often rely on the help of others when solving problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10	I look carefully for resources that can help me accomplish a task	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11	Thanks to my resourcefulness, I know how to handle unforeseen situations.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12	I can solve most problems if I invest the necessary effort.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13	I can remain calm when facing difficulties because I can rely on my coping abilities.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14	When I am confronted with a problem, I can usually find several solutions.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15	If I am in trouble, I can usually think of a solution.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16	I can usually handle whatever comes my way.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Transfer Study

HUMAN SERVICES SURVEY

The purpose of this questionnaire is to discover how persons in the human services or helping professions view their jobs and the people with whom they work closely. It uses the term **recipients** to refer to the people for whom you provide your service, care, or treatment.

When answering this questionnaire please think of these people as recipients of the service you provide, even though you may use another term in your work.

On the next page are 22 statements of job-related feelings. Please read each statement carefully and decide if you ever feel this way **about your job**.

If you have **never** had this feeling, circle the **0**. If you **have** had this feeling, indicate **how often** you feel it by circling the number from 1 to 6 that best describes how frequently you feel that way. The answer key is shown below:

Never	A few times a year	Once a month	A few times a month	Once a week	A few times a week	Every day
0	1	2	3	4	5	6

For example, in response to the statement “I feel depressed at work”:

- If you never feel depressed at work, you would circle the number **0**.
- If you rarely feel depressed at work (a few times a year or less), you would circle the number **1**.
- If your feelings of depression are fairly frequent (a few times a week, but not daily), you would circle the **5**.

	STATEMENTS	Never	A few times a year	Once a month	A few times a month	Once a week	A few times a week	Every day
1	I feel emotionally drained from my work.	0	1	2	3	4	5	6
2	I feel used up at the end of the day.	0	1	2	3	4	5	6
3	I feel fatigued when I get up in the morning and have to face another day on the job.	0	1	2	3	4	5	6
4	I can easily understand how my recipients feel about things.	0	1	2	3	4	5	6
5	I feel I treat some recipients as if they were impersonal objects.	0	1	2	3	4	5	6
6	Working with people all day really is a strain for me.	0	1	2	3	4	5	6
7	I deal very effectively with the problems of my recipients.	0	1	2	3	4	5	6
8	I feel burned out from my work.	0	1	2	3	4	5	6
9	I feel I'm positively influencing other people's lives through my work.	0	1	2	3	4	5	6
10	I've become more callous towards people since I took this job.	0	1	2	3	4	5	6
11	I worry that this job is hardening me emotionally.	0	1	2	3	4	5	6
12	I feel very energetic.	0	1	2	3	4	5	6
13	I feel frustrated by my job.	0	1	2	3	4	5	6
14	I feel I'm working too hard on my job.	0	1	2	3	4	5	6
15	I don't really care what happened to some recipients.	0	1	2	3	4	5	6
16	Working with people directly puts too much stress on me.	0	1	2	3	4	5	6
17	I can easily create a relaxed atmosphere with my recipients.	0	1	2	3	4	5	6
18	I feel exhilarated after working closely with my recipients.	0	1	2	3	4	5	6
19	I have accomplished many worthwhile things in this job.	0	1	2	3	4	5	6
20	I feel like I'm at the end of my rope.	0	1	2	3	4	5	6
21	In my work I deal with emotional problems very calmly.	0	1	2	3	4	5	6
22	I feel recipients blame me for some of their problems.	0	1	2	3	4	5	6

Transfer study

MINNESOTA SATISFACTION SCALE

The items in this scale refer to aspects of your work which may be a source of satisfaction or dissatisfaction to you.

For each item, please indicate the extent to which you feel satisfied or dissatisfied with that aspect of your work by placing a ring around the appropriate number.

	STATEMENTS	very dissatisfied	dissatisfied	neutral	satisfied	very satisfied
1	My pay and the amount of work I do.	1	2	3	4	5
2	The chances for promotion in this job.	1	2	3	4	5
3	The praise I get for doing a good job.	1	2	3	4	5
4	The way care policies are put into practice.	1	2	3	4	5
5	The working conditions.	1	2	3	4	5
6	The way my employers handle their workers.	1	2	3	4	5
7	The competence of my supervisor in making decisions.	1	2	3	4	5
8	The freedom to use my own judgement.	1	2	3	4	5
9	The chances to tell people what to do.	1	2	3	4	5
10	The chance to try my own methods of doing the job.	1	2	3	4	5
11	The way my co-workers get along with each other.	1	2	3	4	5
12	The chance to work alone on the job.	1	2	3	4	5
13	The way my job provides for steady employment.	1	2	3	4	5
14	The chance to be "somebody in the community".	1	2	3	4	5
15	The chance to do different things from time to time.	1	2	3	4	5
16	The feeling of accomplishment I get from the job.	1	2	3	4	5
17	Being able to keep busy all the time.	1	2	3	4	5
18	Being able to do things that don't go against my conscience.	1	2	3	4	5
19	The chance to do something that makes use of my conscience.	1	2	3	4	5
20	The chance to do things for other people.	1	2	3	4	5

The next 12 questions focus on your impressions of the teaching process and outcomes, i.e. how competently you think the training was conducted and whether it was helpful or not. For each question please circle the statement that best expresses your opinion.

PLEASE CIRCLE ONE ANSWER

7. Did the Workshop/training improve your understanding?

Not at all A little Quite a lot A great deal

8. Did the workshop/training help you develop work related skills?

Not at all A little Quite a lot A great deal

9. Has the workshop/training made you more confident?

Not at all A little Quite a lot A great deal

10. Did you expect to make use of what you learned in the training in your workplace?

Not at all A little Quite a lot A great deal

11. How competent was the training leader?

Not at all A little Quite a lot A great deal

12. In an overall, general sense, how satisfied are you with the training?

Not at all A little Quite a lot A great deal

13. Did the training cover the topics it set out to cover?

Not at all A little Quite a lot A great deal

14. Did the training leaders relate to the group effectively?

Not at all A little Quite a lot A great deal

15. Were the leaders motivating?

Not at all A little Quite a lot A great deal

16. What was most the helpful part of the training for you personally?

.....
.....
.....
.....

17. What changes, if any, would you recommend? (e.g. to the content of the teaching)

.....
.....
.....
.....

18. Please make any other comments that you would like to offer.

.....
.....
.....
.....

Appendix 2

Ethical Approval Form: Human Research Projects

Please word-process this form, handwritten applications will not be accepted



This form must be completed for each piece of research activity whether conducted by academic staff, research staff, graduate students or undergraduates. The completed form must be approved by the designated authority within the Faculty.

Please complete all sections. If a section is not applicable, write N/A.

1 Name of Applicant	Ian McGonagle	
	Department:	Faculty:
	CCAWI	Health and Life Sciences
2 Position in the University	Seconded to CCAWI from Derbyshire Mental Health NHS Services.	
3 Role in relation to this research	I am the National Lead for implementation of the National Institute for Mental Health in England (NIMHE) Ten Essential Shared Capabilities	
4 Brief statement of main Research Question	What are the conditions required to support effective transfer of learning around the ESC from 'classroom' settings to mental health practice.	
5 Brief Description of Project	Transfer of learning is a critical and neglected aspect of education provision in mental health. The NHS spends in the region of £4.3 billion on education and training with the majority of this allocation aimed at supporting practice and service improvement for people who use health services (Department of Health 2007). However systematic analysis of the success of such training interventions is rarely routinely performed. There is a continuous need to explore what are the necessary conditions for successful transfer of learning from the 'classroom' to practice performance (Holton & Baldwin 2003)	
	Approximate Start Date:	Approximate End Date:
	July 2007	August 2011
6 Name of Principal Investigator or Supervisor	Dr Chris Jackson	
	Email address: cjackson@lincoln.ac.uk	Telephone: 01623 819155
7 Names of other researchers or student investigators involved	1. 2. 3. 4.	
8 Location(s) at which project is to be carried out	Within 3 skills based courses in mental health delivered by the University of Lincoln	

9 Statement of the ethical issues involved and how they are to be addressed –including a risk assessment of the project based on the vulnerability of participants, the extent to which it is likely to be harmful and whether there will be significant discomfort.

(This will normally cover such issues as whether the risks/adverse effects associated with the project have been dealt with and whether the benefits of research outweigh the risks)

The study is predicated on receiving informed consent from the participants involved. In order to obtain such consent, the participants will be assured of the nature of the study. This information will be provided in a variety of ways, verbally and written, and available at all times via a web-site link. The information will be written in a language which is easily understood by all stakeholders (research participants, facilitators and practice supervisors).

The sample will be drawn from the main non-medical professions in mental health (Nursing, Social Work and Occupational Therapy) usually from the local in mental health trust. These participants are key partners in the development and delivery of the research programme and as such will wish to be satisfied that secure protocols exist and are implemented which ensure the confidentiality of the collected and collated data.

The practice teams, from which the participants are drawn, are seen as a critical element in describing and understanding the 'cases' within this study. Multiple measures will be used in order to accurately describe the practice setting. A 'triangulated' approach to data collection is being proposed through contact with managers and supervisors, it is essential to ensure ownership of this process is shared with research participants, as much as possible within the parameters of this study. The issues of confidentiality noted above will need to assured.

A pilot study will be completed in order to test out the issues noted above and to determine the feasibility of the protocols, procedures and measurement instruments in this design.

All participants have the right to information about this study in order to make informed choices about their inclusion. In addition to the actions noted above, all participants will have the right to withdraw at any point of the study with no reprisal. This option will be consistently communicated in seeking consent and on-going consent.

Ethical Approval From Other Bodies

10 Does this research require the approval of an external body ?

Yes **No**

If "Yes", please state which body:-

NHS Partner Ethics committees

11 Has ethical approval already been obtained from that body ?

Yes **-Please append documentary evidence to this form.**

No

If "No", please state why not:-

The stage of the research procedures are not completed sufficiently to be ready for full ethical approval

Please note that any such approvals must be obtained and documented before the project begins.

APPLICANT SIGNATURE

I hereby request ethical approval for the research as described above.
I certify that I have read the University's ETHICAL PRINCIPLES FOR CONDUCTING RESEARCH WITH HUMANS AND OTHER ANIMALS.



7th May 2007

Applicant Signature

Date

Ian McGonagle

PRINT NAME

FOR COMPLETION BY THE CHAIR OF THE FACULTY RESEARCH COMMITTEE

Please select ONE of A, B, C or D below:

A. The Faculty Research Committee gives ethical approval to this research.

B. The Faculty Research Committee gives conditional ethical approval to this research.

12 Please state the condition (inc. date by which condition must be satisfied if applicable)

C. The Faculty Research Committee can not give ethical approval to this research but refers the application to the University Research Ethics Committee for higher level consideration.

13 Please state the reason

D. The Faculty Research Committee can not give ethical approval to this research and recommends that the research should not proceed.

14 Please state the reason

Signature of Chair of Faculty Research Committee

Chair of Faculty Research Committee

Date

Appendix 3

Dear (insert name)

RE: PhD studies on the 'Transfer of Learning from 'the 'Classroom' to the Practice Setting'

I am a PhD student at the University of Lincoln working on a project with the above title. While working with the National Institute for mental Health in England (NIMHE) I was heavily involved in the National Workforce Programme, and am bringing that experience to bear on the context of my PhD.

My research focuses on new ways of working and new roles and consequently am interested to explore an educational programme which chimes with this direction. Therefore this is a formal approach to request a meeting to discuss access to your High Intensity CBT course, which forms part of the Improving Access to Psychological Therapy (IAPT) initiative.

The programme of studies seeks to explore three related domains: the design of the course; the knowledge & skills gained by the students and the climate of the practice team that HI workers are using their newly acquired knowledge and skills.

Naturally, your organisations role within the IAPT programmes resonates with the (insert here) aspect of the study. I would therefore appreciate the opportunity to come and meet with you in the very near future, with a view to obtaining agreement to approach potential participants to seek consent to collect the necessary data.

Due to the nature of the IAPT development process, I know you understand that there is a short window available between contracts being awarded, and students accessing the course to begin their training. The design relies on collection of pre-training data and therefore, as you can appreciate, there is a degree of urgency required in your consideration and response.

The research programme has been approved by the University of Lincoln ethical procedures, with regard to design and procedures for maintaining security and confidentiality of collected data.

I look forward to hearing from you

Best wishes

Ian McGonagle
Principal Lecturer
Centre for Clinical & Academic Workforce Innovation
University of Lincoln

27/05/2014

Ian McGonagle
School of Health and Social care
Room 2213 (2nd Floor)
Bridge House
Brayford Pool campus
Lincoln
LN6 7TS

Dear Ian,

I am writing to inform you that [REDACTED] Clinical Research Committee has reviewed and granted NHS permission for the following study:

Title:	The transfer of learning in High Intensity IAPT training
REC Ref:	N/A
Area:	Practitioners and their managers in IAPT services
Research Activity at site	Phase 2: unstructured interviews and focus group activity
Recruitment target	As agreed with local collaborator [REDACTED]
Start date: 27/05/2014	End date: 31/08/2014

As part of our monitoring requirements, we will ask you for a progress report six months after the start of your study, and every six months as applicable. We will also ask you for a short summary of your research findings once the study is complete to assist in the dissemination process within the Trust.

You can now proceed with your study in accordance with the agreed protocol and the Research Governance Framework. Please notify us immediately of any adverse events or changes to the protocol.

If you require any further information please do not hesitate to contact me.

Yours sincerely

XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
Research and Clinical Audit Manager

XXXXXXXXXXXXXXXXXXXX and the Clinical Research Committee



January 2013

Dear colleague

Re: The transfer of learning in High Intensity IAPT training

Thank you for agreeing to take part in an interview, the content of which is relevant to the above study. This study is part of my PhD studies at the University of Lincoln.

This letter provides information about the studies and a consent form. Please note that you can withdraw your agreement at any time.

Thank you once again for your interest

Ian McGonagle

Principal Lecturer and PhD student

School of Health and Social Care

University of Lincoln



Information relating to the Transfer of Learning Study in High Intensity IAPT

I would very much appreciate your interest in the above study as I believe your involvement will add greatly to our understanding of the process of implementation of policy and the conditions necessary to support effective implementation of new learning in clinical practice.

Before you decide about whether to be involved or not, it is important you have a broader overview of the issues under review. Please take your time in reading this information before completing (if you wish) the attached 'Consent Form'.

Purpose

This part of the study is concerned with understanding the process of policy formation and the timeline of decision making in turning policy ideas into activity. You have been selected because you have been identified as a person who was involved in either;

- a) Being directly involved in the development of the Improving Access to Psychological Therapy policy
- b) Helping the development of support infrastructure to aid implementation of the policy
- c) Helping in the educational, workforce or organisational components of the IAPT policy initiatives or
- d) All of the above

Please note; it is entirely up to you whether you wish to take part in the study. If you require additional information about the study, please contact myself, Ian McGonagle (imcgonagle@lincoln.ac.uk) or phone Ian on 07887651492.

If you do decide, you will be asked to sign the consent form (a copy of which is attached to this information). You can choose to withdraw your interest and or consent at any time and no reason will be sought for your decision.

What is involved?

Ian McGonagle will contact you to arrange a mutually convenient date, time and location to meet. This meeting will take the form of an unstructured interview about your involvement in the development and/or implementations of the national IAPT programme.

Ideally, I would like to digitally record this interview, but this need not be the case if you decide against recording. In this event I will make detailed notes of the conversation. This recording (along

with others will be stored securely away in locked cabinets. No formal identification of your participation will be used on the electronic or paper data.

The interview will centre on your recollections of the development and implementation of the national IAPT programme from inception to the current date. This part of the study is intended to gain a detailed understanding of the decision making around policy formulation and implementation in order to better understand the key processes seen as critical to getting IAPT off the ground and into services.

This data will be added to other data from a cohort of IAPT High Intensity students/practitioners to gain a deeper understanding of how a policy is developed and implemented; how the workforce is identified, educated and supported in practice. Additionally I intend to understand the relationship between the initial aims of the policy and its current implementation in practice.

If you would like to talk to someone else about this study or to make a complaint about any aspect of the study please do not hesitate to contact:

Dr Christine Jackson (Principal Research Fellow)

School of Health and Social Care, Bridge House (3rd Floor)

Brayford Pool Campus, University of Lincoln, LN6 7TS

cjackson@lincoln.ac.uk

What happens to the data?

The data (if recorded) will be transcribed by myself. It will be analysed for items which appear to be significant in the understanding of the issues identified above with the intention of placing them within the body of my final PhD dissertation. The data themes and direct quotes will be isolated and placed into a report table. This table will then be sent to yourself for your review. The purpose of this is twofold;

- a) To ensure that you agree you cannot be identified from the data and quotes provided and
- b) To ensure you are happy that your quote can be used

If you do not agree to the information being used in my final dissertation, the quote will be removed and not used.

Thank you once again for your interest

Yours faithfully



Ian McGonagle

Consent form

Interview for the Transfer of Learning study – High Intensity IAPT

Name of Researcher: Ian McGonagle

Please initial each box

1. I confirm that I have read the information leaflet about this study and I am content that I understand the purpose and my involvement in the study.
2. I confirm that I have been provided with information about how I can seek additional information and to clarify the purpose and requirements of my involvement.
3. I confirm that my involvement is completely voluntary and that I can withdraw my involvement at any time without the need to offer a reason.
4. I understand that all data relating to my involvement, (information sheets, consent forms, digital and paper recorded data) will be kept locked in a secure filing cabinet in accordance with the University of Lincoln ethical code for research.
5. I understand and agree that any data presented in the final dissertation will be anonymised and that my approval will be sought prior to any publication.
6. I consent to the interview being recorded digitally.
7. I agree to take part in the above study.

Name

Date

Signature

Name of researcher: Ian McGonagle

Date:

Signature:



On completion: 1 copy to participant and 1 copy to secure research file



January 2013

Dear colleague

Re: The transfer of learning in High Intensity IAPT training

Thank you for agreeing to take part in an interview, the content of which is relevant to the above study. This study is part of my PhD studies at the University of Lincoln.

This letter provides information about the studies and a consent form. Please note that you can withdraw your agreement at any time.

Thank you once again for your interest

Ian McGonagle

Principal Lecturer and PhD student

School of Health and Social Care

University of Lincoln



Information relating to the Transfer of Learning Study in High Intensity IAPT

I would very much appreciate your interest in the above study as I believe your involvement will add greatly to our understanding of the process of implementation of policy and the conditions necessary to support effective implementation of new learning in clinical practice.

Before you decide about whether to be involved or not, it is important you have a broader overview of the issues under review. Please take your time in reading this information before completing (if you wish) the attached 'Consent Form'.

Purpose

This part of the study is concerned with the factors which influence the transfer of the learning from your IAPT training programme to the workplace. The purpose of this phase of the study is to negotiate and agree through discussion and observation, the key organisational and NHS national factors which either enable or inhibit your ability to 'transfer' your skills and knowledge as an IAPT practitioner.

Please note; it is entirely up to you whether you wish to take part in the study. If you require additional information about the study, please contact myself, Ian McGonagle (imcgonagle@lincoln.ac.uk) or phone Ian on 07887651492.

If you do decide, you will be asked to sign the consent form (a copy of which is attached to this information). You can choose to withdraw your interest and or consent at any time and no reason will be sought for your decision.

What is involved?

Ian McGonagle will contact you to arrange a mutually convenient date, time to meet and discuss the study (preferably in a team meeting with other participants). Data collection will take the form of unstructured interviews and focus group activity about your how you approach your work as an IAPT practitioner. It is essential to agree a mutually appropriate process to data collection to ensure you are not adversely affected from completing your work.

Ideally, I would like to digitally record these interviews and discussions, but this need not be the case if you decide against recording. In this event I will make detailed notes of the conversations. This recording (along with others will be stored securely away in locked cabinets. No formal identification of your participation will be used on the electronic or paper data.

All collected data will be reviewed with you (individually and in group settings) to ensure that an accurate picture and interpretation of the data has taken place. This data will be added to other data from IAPT High Intensity students/practitioners to gain a deeper understanding of how a policy is developed and implemented; how the workforce is identified, educated and supported in practice.

If you would like to talk to someone else about this study or to make a complaint about any aspect of the study please do not hesitate to contact:

Dr Christine Jackson (Principal Research Fellow)

School of Health and Social Care, Bridge House (3rd Floor)

Brayford Pool Campus, University of Lincoln, LN6 7TS

cjackson@lincoln.ac.uk

What happens to the data?

The data (if recorded) will be transcribed by myself. It will be analysed for items which appear to be significant in the understanding of the issues identified above with the intention of placing them within the body of my final PhD dissertation. The data themes and direct quotes will be isolated and placed into a report table. This table will then be sent to yourself for your review. The purpose of this is twofold;

- a) To ensure that you agree you cannot be identified from the data and quotes provided and
- b) To ensure you are happy that your quote can be used

If you do not agree to the information being used in my final dissertation, the quote will be removed and not used.

Thank you once again for your interest

Yours faithfully



Ian McGonagle

Consent form

Interview for the Transfer of Learning study – High Intensity IAPT

Name of Researcher: Ian McGonagle

Please initial each box

1. I confirm that I have read the information leaflet about this study and I am content that I understand the purpose and my involvement in the study.
2. I confirm that I have been provided with information about how I can seek additional information and to clarify the purpose and requirements of my involvement.
3. I confirm that my involvement is completely voluntary and that I can withdraw my involvement at any time without the need to offer a reason.
4. I understand that all data relating to my involvement, (information sheets, consent forms, digital and paper recorded data) will be kept locked in a secure filing cabinet in accordance with the University of Lincoln ethical code for research.
5. I understand and agree that any data presented in the final dissertation will be anonymised and that my approval will be sought prior to any publication.
6. I consent to the interview being recorded digitally.
7. I agree to take part in the above study.

Name

Date

Signature

Name of researcher: Ian McGonagle

Date:

Signature:



On completion: 1 copy to participant and 1 copy to secure research file

Consent form

Interview for the Transfer of Learning study – High Intensity IAPT

Name of Researcher: Ian McGonagle

Please initial each box

1. I confirm that I have read the information leaflet about this study and I am content that I understand the purpose and my involvement in the study.
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7. I agree to take part in the above study.

Name

Date

Signature

Name of researcher: Ian McGonagle

Date:

Signature:



On completion: 1 copy to participant and 1 copy to secure research file

Appendix 4

Generic therapeutic capabilities/competences

Knowledge and understanding of health problems

Knowledge and ability to operate within ethical guidelines

Ability to engage patients

Ability to foster and maintain a therapeutic alliance

Ability to undertake generic assessment with a relevant history and possible interventions

Ability to deal with emotional content of treatment

Basic Nursing capabilities/competences

Promote health

Promote growth

Promote development

Prevent illness

Prevent disease

Prevent injury

Minimise illness & suffering

Prevent disability

Enable understanding & Coping with disease

Enable understanding of treatment & its consequences

A focus on the whole person

Accountable practitioner

Specific nursing capabilities/competences

Empowering people

Identification of nursing need

Helping people maintain, achieve or recovery independence

Deliver personal care

Offer personal physical and psychological support

Advise & educate

Manage care & the care environment

Develop policy

Problem/service specific competences



Meta competences

Capacity to use clinical judgement

Helping

Enabling

Problem solving

Recovery orientated

Practice orientated

Health orientated

Person centred

Appendix 5

Appendix: Mixed methods thematic analysis matrix for complete data set

Theme: short description	Theme: Tension/external pressure	Theme: Motivation: Identity	Theme: competence and confidence in transferring learning.	Theme: Feedback	Theme: Support and supervision	Theme: Transfer of education to practice in the 'real' world	Theme: Therapeutic drift/policy drift
Scales and sub-scales which illustrate the theme	HSS data: not evident in cohort data EE sub-scale from Maslach Burnout Inventory Minnesota job satisfaction scale	AMS data	includes CBTKQ; MOG competence and confidence data; TARS subscale and SE Scale	MOG Experience subscale	MOG: support and participation subscale	MOG; Areas of functioning TARS: Appropriateness subscale	MOG: Generalisation sub-scale
Theme detailed description	The experience of external political, social or financial pressures on the delivery system. These pressures and tensions are experienced as outside the control of the respondents in the study. Leading to the experience of emotional exhaustion and detachment from the work role	The drive to perform based on a clear sense of identity of CBT therapists. An identity which is robust and resistant to external threats to performance of the role.	The personal sense of therapists that they are able to feel secure in their practice and can manage difficult situations in practice	The processes, both formal and informal which aid development of service delivery.	The processes, both formal and informal that aid development of IAPT therapist practice.	The experience of challenge the IAPT therapist to adapt 'trained for' skills against complex adaptive application skills	The experience of drifting from core training skills in the adaptation process in practice. A loss of confidence in identity and role performance.
Inclusion criteria	To be included in this theme the data must include clear statements from respondents on their knowledge and experience of external pressures which may either	To be included in this theme the data must clearly relate to the emotional drive for effective CBT treatment, an indication of personal investment in the	To be included in this theme the data must relate to the requirement and ability to feel confident and competent in treatment delivery skills	To be included in this theme the data must relate to the process of obtaining or receiving feedback on the quality and outcomes of service delivery	To be included in this theme the data must relate to the process of support and supervision in all its forms within the service	To be included in this theme the data must illustrate the tension and opportunities inherent in transferring knowledge and skills from	To be included in this theme the data must represent clear statements or data which indicate concern that core training skills derived directly from the training

	enhance of challenge the IAPT service.	role				education to the practice arena	programme are being used more flexibly.
Exclusion criteria	If the data relates general work/performance challenges, particularly those over which some control is exerted.	If the data relates to the importance of the CBT role but the emotional content and motivational drive is absent from the text or data.	If the data does not provide a commentary of the competence and capability of the IAPT therapist in practice.	If the data relates to general feedback but does not focus on the service development.	If the data relates to general and unspecific support structures, rather than formally established processes within the service or policy.	If the data does not provide a commentary on the transfer process.	If the data relates to information would indicate a normal and to be expected development of skill following the completion of training.
Typical exemplars	'You seem to get pulled in all sorts of directions.. who knows who's really in charge?						
Atypical exemplars	'I think that if you look at some of the voluntary sector services that we use, you can see now that they are developing waiting lists and so it is sometimes quicker to see us than them, now in my experience this is new'						

Appendix 6

1 Interview no 3

2 Thank you seeing me... it is very kind of you. My first question relates to your professional
3 background, can you tell me about your career before your current post?

4 So..I worked previously, before I joined IAPT, as er...a primary care mental health worker, so the
5 stuff that predates that is probably not important as it was not healthcare related, working in a shop
6 etc.. but I did get my undergraduate degree in psychology..my dad is a clinical psychologist, so if I
7 did think I was going to work in an area related to psychology then I guess it was always going to be
8 more related to clinical work. So I did the graduate programme and got the certificate in post
9 graduate mental health and then practiced as a mental health worker offering guided self help for
10 people with mild mental health needs, anxiety and depressive disorders.

Commented [IM1]: Previous experience in CBT?

Commented [IM2]: Environment?

Commented [IM3]: Experience

11 Ok. We might come back to this issue later, now can I ask you about the IAPT training course and
12 your reflections on what was good and what you think was of little benefit.

13 Of the IAPT course? I personally found that there was quite a bit of variability in how valuable I
14 found the taught sessions to be, depending on who was doing the teaching. There were a couple of
15 tutors who I..I thought they really knew what they were talking about and it was obvious they had a
16 wealth of experience and others who either, um..lacked the experience who were just not great at
17 presenting information, so it was slide based stuff, just reading what was on the slide and you end
18 up feeling like well if you are just going to read it you could have just e-mailed it me and save me the
19 journey coming in here. So there was a bit of variability...um there were specific techniques that
20 were taught on the course like hyperventilation and provocation that I still use...um downward
21 arrow techniques that sort of thing. They are the sort of things I would use and still draw on some of
22 the books and the course material to refresh myself – how you should be doing it.

Commented [IM4]: Course dissatisfaction – transfer issue?

Commented [I5]: Indicating a dissonance?
'should'

23 When you say 'How you should be doing it', can you expand on this?

24 Well...I think there is a balance to be struck, as you grow in confidence, you begin to relax in how
25 you deliver things. In some regards it has freed me up to be less mechanistic in how you deliver
26 things..the course was delivered in a very strict, almost protocol approach, I mean, 'this is the way of
27 doing this intervention and you must do it in this way' and almost like..you must use these words as
28 you do it. So you were training to pass an exam..it's like learning to drive you pass the exam and you
29 learn to drive after. So there is a degree to which I have moved..as I have grown in confidence, I
30 have moved away from that kind of mechanistic approach, like having to do things in a set order. I
31 like to think that allows me to work quite idiosyncratically with the patient, but I am also aware, that
32 I can hide behind that and it really is just a bit of therapeutic drift, where you are just kidding
33 yourself that this is good idiosyncratic practice when actually you are just becoming a bit woolly and
34 a bit lazy. I think for me it is that balance I hope it is the former....

Commented [I6]: Confidence – how does this happen?

Commented [I7]: mechanistic

Commented [I8]: Approach to teaching?

Commented [IM9]: Training to pass an exam – focus of
education?

Commented [I10]: 'Having' and now 'choosing'?

Commented [I11]: Self aware about drift

Commented [IM12]: Therapeutic dilemma – drift?

35 Were there any elements of the training that you have never returned to?

36 Umm...as in specific techniques or..more broadly?

37 Either really

38 I think there is one aspect of the course I did not enjoy, there was too much self directed learning,
39 going and finding out for yourself. I understand the reasons for it, but I think there was too many
40 times when I think things were not prepared in advance and so we were sent off to the library. I
41 think the things like role play, the things we all cringe at and don't like doing are probably the most
42 valuable and video-taped sessions were things that I didn't particularly like doing, but I learned the
43 most from. So in terms of watching yourself back, looking at your own body language, I can vividly
44 remember one examples when a patient had become visibly distressed and you could see in my
45 body language that I was uncomfortable with their distress and I hadn't clocked it at all, because it
46 was ..oh God, that's not good and I was sort of recoiling from them...so it was really helpful to reflect
47 on that and to try to work to change that for subsequent patients. So the stuff like that, that
48 everyone groans at ..that was probably the most helpful.

Commented [IM13]: Course dissatisfaction

Commented [IM14]: Learning -as feeling uncomfortable

Commented [IM15]: Pain? Uncomfortable, support to overcome this?

Commented [I16]: Reflection on personal behaviours

49 One of the things I have felt, and I have discussed this with a lot of colleagues and we all seem to feel
50 the same and that is, you are trained to be a Cognitive Behaviour Therapist and it often comes down
51 to time, the amount of time you have got to spend with a patient – you are having to condense
52 down interventions or therapy with a patient because of time constraints. So that doesn't mean
53 that you would do the interventions badly, but it means you would be selective over the
54 interventions which you would choose. So..so I guess if you had free reign to work with that
55 individual for as many months as you needed so you might systematically work through a number of
56 the issues that are entwined or interlinked. In IAPT we don't have the luxury, you have to pick, it's
57 more of 'look these are the things we are going to work on and the other stuff, maybe you'll have to
58 come back for further episodes of care further down the line, if that's appropriate because in the
59 time frame you can't do everything. So I favour pick one thing and try to do it well than sort of cover
60 everything and do it all badly.

Commented [I17]: Shared perceptions?

Commented [I18]: Time – org. barriers? System barriers

Commented [I19]: choosing

61 So that's skilled then in the identification of what's the target, what's the thing to work on. Is that a
62 skill you've developed or did the course give you that do you think?

63 It is kind of alluded to on the course, but it did not teach me that. I think in CBT in general you would
64 do problems and targets with the patient and you would look at condensing down what are the
65 main problems and you would probably agree with the patient what you are going to work on and in
66 what order, so I suppose it's only an extension of that but it's trying to ..it's trying..the skills I
67 suppose lies in trying to arrive at a consensus with the patient, but you are steering them to the
68 issues that in your clinical judgment are going to be the ones that are going to be most helpful to
69 work on.

Commented [IM20]: Course limitations-'learning on the job'

Commented [I21]: Shared decision making? Balance between collaboration and professional direction – The principles of CBT are collaborative though – so does the system challenges, time etc..offer a challenge to the CBT approach?

70 You mentioned the word 'confidence' earlier and I wonder if that is tied up here?

71 I think as I have grown in confidence I have felt more able to do the guiding, to look at the problems
72 they don't want to look at. I think the way that I am supervised is based on that issue of finding the
73 issues that are going to be most helpful in the time available you've got and sometimes it involves
74 not approaching issues and not sharing that information with the client, which is kind of
75 interesting..so I am thinking well who do I share with and who do I not share, if anyone at all! So
76 whether that would be any different in a non-IAPT setting I can't say because I've never worked
77 beyond this kind of work. I don't know how much of this is the constraints of IAPT or....

Commented [IM22]: Confidence growth in practice - transfer

Commented [I23]: Guiding /steering the discussion – persuading.

Commented [IM24]: Confidence linked to supervision?

Commented [I25]: Confidence but also non-sharing – professional judgement

78 I think the issue of exploring people's core beliefs and having the time and opportunity to really look
79 at that and for some patients it is relevant and we do have enough time and space to do that, but for
80 a lot of them we don't have the time and I think for a lot of them it comes down to...at uni we were
81 taught that it is really important to use not just a generic formulation, like a five areas model, but a
82 problem specific formulation and I think I have moved away from that a bit and so there are some
83 patients where we will have a problem specific formulation so we will come to a model of OCD or
84 whatever and we will map it out, we will draw it out and then there are others where I don't do that.
85 No why I don't do that is an interesting question: is it because I don't feel there isn't enough time,
86 that the constraints in IAPT dictate this or is it that therapeutic drift and I have become lazy. I don't
87 know why some and not others..if it was just laziness I wouldn't do it with anyone, so I think it comes
88 down to whether I think it is going to be meaningful to the patient, have I got the time to do this?
89 Have I got time to make it meaningful?

Commented [IM26]: Drift, but why? Confidence?

Commented [IM27]: Personal concern, transfer, keeping on the right track? How?

Commented [I28]: Confidence in own clinical judgement..

90 How do you make that decision?

91 Um....some of this comes down to..and I hate this term, but it comes down to whether the patient is
92 psychologically minded, if they have a degree of insight into their problem and they seem fairly
93 clued-up about the processes then it feels more relevant to share the problem specific model with
94 them..um.. if they're struggling to do the basics, like making the distinction between a thought and a
95 feeling then I think well this is just going to confuse matters more if I present..try to present, a
96 complicated model..so some of it's down to actually how clued-up I think the patient is.

Commented [IM29]: Clinical judgement

97 Ok..well you mentioned earlier the issue of supervision and one area I would like to look at is the
98 support you are given in implementation of IAPT, can you say something about this?

99 I actually feel.. I know from other services, that this service is one of the best in terms of
100 support..valuing the staff and trying to marry up the demands of IAPT with the needs of patients and
101 the therapists and clinicians. I do feel well supported but I feel that one of the problems is that we
102 are perpetually fire-fighting so there'll be an issue of spiralling waiting lists and so then it's a case of
103 quickly doing something to try and tackle that, but it does feel that a lot of the time all we are doing
104 is responding to the latest thing that has been issued, the latest tick-box type thing...you know..

Commented [I30]: Complex matrix

Commented [I31]: Meeting needs in a pressure environment

105 'we'll get a bit more payment if we say what the problem is for the patients' so you'll get an email
106 that says, 'quick go through all the patients that you have recently discharged and say what the
107 problem is and tick this box, 'cos we'll get an extra bit of money for it. Umm and you think what is

Commented [IM32]: Organisational constraints

108 this all about and then you realise this is the game we're in, this is the landscape we're in..our
109 competitors will be doing that and if we don't well we won't fare so well as a service. But it often
110 feels as though we are just jumping through the next set of hoops. So in the context of that which

Commented [I33]: Awareness of external pressures.

111 can be quite frustrating and quite stressful, then well I do feel quite well supported. I have
112 supervision, once a month at the moment, I have a team leader who does case management with
113 me, managing the number of cases on my list. There is a good ethos in the team and I do feel we are
114 a team which I think is important, so I do feel supported, umm but I do feel ok for a time and then at
115 times something will happen and my stress levels will spike and that's not because I have done
116 anything different, it's just there is a lot more referrals or they have moved someone out of a
117 surgery to cover someone else and then there are ramifications.

Commented [I34]: Support, supervision and Case management.

Commented [I35]:

Commented [I36]: Team support

Commented [IM37]: External environment pressures

118 You talked about supervision and caseload management and the distinction between the two. What
119 are your views on the value of these two aspects of support?

120 Supervision tends to be more around taking an individual case maybe one that you are struggling
121 with and talking that through with someone and getting some pointers on how you might move
122 forwards erm..so a narrower focus whereas case management is broader so it is less concerned with
123 individual cases it is more about how many are on your list and have you hit your targets? It's
124 increasingly become about looking on the computer, this sort of matrix they've got showing how
125 many you've seen each week, how many you've discharged and this is increasingly the focus. It will
126 say what you have done and it is a matter then of 'well done' or 'We'll work to support you meet
127 your targets!' which basically means you need to do something to meet your targets. So I look
128 forward much more to supervision than case management because supervision feels helpful in
129 terms of my clinical practice. Case management feels like..umm..I have to work very hard not to be
130 constantly on the defensive, it feels like...its a bit..um.. yeah..um less supportive and more 'have you
131 been doing what we need you to be doing' it's often frustrating for me umm because..um if I
132 haven't updated everything on to [named reporting system] on time then it under-reports what I've
133 done...it looks like I haven't done as much as I know I've done which is frustrating, but that's about
134 me working smarter I guess. So there are elements when I've reflected on... I remember in the early
135 days, over a year ago, there was an issue of me feeling personally responsible for people that were
136 on my waiting list, as so over booking, so there was a problem of me over booking patients and I was
137 stressed out my mind, so I wasn't hitting any of my targets because I wasn't doing any of the admin
138 'cos I was booking in 35.. y'know, 35 patients a week and only supposed to book in 25 or whatever it
139 was. And that was interesting to reflect on why are you doing that, is that because you feel
140 responsible, do you need to work on that, so you can detach yourself healthily from these lists,
141 because this is the services problem not your individual problem....and the case load manager at the
142 time helped me with that and I found that really quite useful, so that was about learning, so I can't
143 be completely damning of the whole process, but it has felt more like in recent times that it has
144 been less about that and more about,..er..like..er an opportunity to look at my performance figures
145 and to er..say yes carry on as you are or..or you need to start booking more people in or you need to
146 discharge more people. So there's been elements of it being learning but er...um....a lot of it has
147 been a bit of a tick box exercise really.

148 Can you put the change in Caseload management down to anything?

149 Erm..well..there's always pressure at this time of year, as we end the financial year, so there is
150 always a pressure at this time of year to make sure we get as much done as we can to try and hit our
151 targets, and I think we all collectively feel that pressure actually, cos I think it drip feeds down to
152 us...as we approach mark it is 'please don't take annual leave' or we get an email at Christmas
153 saying, take all your leave now cos we'll need all hands on deck in the run up to March. And funnily
154 caseload supervision feels more relaxed after then, it feels more.... more about me and less about
155 ..um.. I don't know whether this is perception on my part or if there is a genuine difference, that I
156 feel more stressed as the year goes on cos I know I'm going to be scrutinised and I interpret things
157 that way or there really is a shift in the way things get done..I don't know...sorry this has been so
158 waffled...but there have been elements of learning and been helpful, but more often than not, it has
159 felt like an exercise in making sure I am hitting my targets rather than anything else. Maybe that's
160 what caseload management is supposed to be, I don't know but it feels more like. 'this is what
161 you've done, now how can you pull your socks up and see more'. So that's why I say I come in to try
162 and not be defensive and there is almost a sense that I have to do that which tells you something.

Commented [I138]: Experience of caseload supervision – a learning experience?

Commented [IM39]: Evaluative difference between CS and CM -feedback

Commented [I140]: Caseload supervision purpose ?

Commented [IM41]: Personal accountability/responsibility

Commented [IM42]: Personal responsibility support?

Commented [I143]: Caseload management as a learning tool – system driver for this though? Waiting lists and targets?

Commented [I144]: Tick box comes up a lot

Commented [I145]: Awareness of external pressures

Commented [I146]: Shared cultural experience.

Commented [I147]: Support as scrutiny

Commented [I148]: Focus of caseload support?

163 Can you tell me then about what you think about Clinical Supervision?

164 I enjoy supervision, but..I find there isn't much continuity. When I was training I got a lot of
165 supervision, quite regularly and I know that's not sustainable cos you'd end with a service where
166 staff were just supervising staff and no one would be seeing anyone. But you could talk through
167 patients and come back to patients you had already talked about and that was really helpful, but
168 now because it's once a month, it doesn't feel like it has that continuity and so often it is like, there
169 is a patient I really want to talk about, but it's three or four weeks before I can talk about it and by
170 that time the issue has died down or gone away cos I've seen the patient, I've worked through it, I've
171 had to sort it the best way I can in the absence of talking about it, or I have some informal peer..chat
172 through with others. I tend to do that quite a lot a bit more than I ever did to plug the gaps of the
173 supervision not being so..er..regular. And I don't have the luxury of being too choosy about who I
174 talk to... often er..I'm in clinic four days a week and I come here (the office base) for evening clinics a
175 couple of times and it is really whoever is around. So I might bend their ear for a few minutes, so
176 not too selective and sometimes it does not have to be a step three worker, you'd assume it would
177 be another CBT therapist, but I'll often chat to the Step Two workers who are in the building just to
178 run something by them to see what their take might be...or the cleaner or anyone! Cos you can go
179 for days without seeing anyone apart from patients.

180 The way it is organised is that, because I work in these clinics, when I have rooms available, I have to
181 book people back to back, so I don't, so they're literally booked in on the hour, so if you assume
182 each patient is going to get 45 minutes of that hour, it sometimes overruns, but there are times
183 when I am saying goodbye to one patient as you follow them and bring in another one through the
184 door and that is very different to how we were taught to work. We were taught to have time to
185 digest what the patient said; write some notes reflect on it; plan for the next patient session and
186 that is just not the case, so any planning I do would be on a separate day and that isn't always the
187 best way of working. So it can feel, if I'm honest, There is a plan in there somewhere but most of the
188 time...I wouldn't say I'm winging it, but there is an element of winging it and there's an element of it
189 being more fluid and there are benefits and costs to that. And the risk is that therapy drift again, if
190 you don't work to a clear plan, are you going to get anywhere with that patient? I mean what I miss
191 from supervision is 'how I am' at uni some of the supervision was about how we felt, how therapy
192 made you feel as a therapist, what was your reaction? And that was invaluable, for me, to just work
193 that through, cos how I'm feeling with the patient can be quite informative in terms of what the
194 issues are, what would be a good thing to do at that point and I miss that. It sometimes feels like,
195 present a case, right here's what you should do, next one.. a bit factory like. I remember at uni one
196 of the supervisors was like which are the patients you really aren't enjoying working with? Which
197 are the ones when you open your diary and you groan 'Oh not them again' and they're the ones we
198 need to talk about, all the other ones are probably...we don't need to talk about so much and I
199 found that really helpful as well. Now during supervision, you are given the freedom to pick the
200 cases and so...erm.. sometimes I pick the patients where I have got no idea where I'm going with
201 them, it doesn't feel like I'm doing any meaningful work with them..help! and I dunno, maybe it's a
202 pride thing but I sometimes feel I have to temper that with a patients where things are good, so it's
203 not all bad, I am doing some good work. I don't know if it just me, but at uni it felt that everything
204 was slowed down. 'how do we understand this patient, where're they coming from?' you know, a
205 formulation, 'how are they in session , how are they coping, how are you feeling about them?' and
206 that is just not the approach we now take. I don't know if that's just the way you do the training, it's

Commented [I49]: Distinction between training environment and 'real' world?

Commented [I50]: Team support?

Commented [IM51]: The real world of practice

Commented [IM52]: Real world of practice-culture shock?

Commented [I53]: Difference between training and 'real' world environment.

Commented [I54]: Restorative aspect of supervision

Commented [IM55]: This whole section – much more emotional not so articulate!

Commented [IM56]: Challenge in supervision

Commented [IM57]:

Commented [I58]: Difference between training and work environment.

207 important to reflect on these things and it becomes a bit more steam-lined. It's a bite more like
208 present a case, here's some pointers...next one. It's a bit more like...it's a bit like everything in
209 IAPT...it's a bit more.....factory like.

Commented [I59]: Difference between training and work environments

210 If I asked you to try and explain why it is different in practice than it was in training, what would you
211 say?

212 Umm..time pressure is one thing, so I think we are all conscious of the number of sessions we've got,
213 even though we have an upper limit of twenty, we work to an average of between eight and ten, I
214 do feel like everything is about getting...the number of discharges, it....there is a pressure on us to
215 discharge so many patients each month, that's part of our individual targets each month as
216 therapists. If we don't do that then um.. it has been insinuated that could have a bearing on our
217 future employment, it genuinely has, so it's not really a negotiable thing, you do it, you get on with
218 it. You find yourself in a sticky situation when people scrutinise..and it's often..your told it's the
219 people...it's not just the managers, it's their managers and their managers who are looking at these
220 individualised figures, so all the information is there, so 'be careful, they are looking at you' and that
221 draconian environment does leave you feeling.. not that you're looking over your shoulder, not like
222 some paranoid therapist, but you just...you're more aware that actually, yeah you want to get this
223 patient well and you want to engage with them but also you've got to get them out the other end
224 pretty quick and that's in the back of your mind, so there is a time issue which forces you to be,

Commented [I60]: Shared view?

225 maybe a bit more mechanistic..or..umm I think there's a time issue, I think there is a complexity
226 issue, so who are we supposed to take on.. I felt at university there was more of a focus on ...the
227 onus on ..taking on more complex cases, but now, there is a almost a sense of are..will they show
228 recovery? And if no then are they who we should be taking on? I don't suppose there is anything
229 wrong with that, we are in a stepped care model, so more complex cases should go to secondary
230 care. The more complex cases are the ones I like; they are the ones where it feels I am doing what I
231 am supposed to be doing and the everyday anxiety and depression, which is the remit of IAPT, but it
232 can get boring, so it's good to have a few complex cases just to make it a bit more interesting as a
233 therapist, cos you can up feeling, as a therapist that just..it can feel 'samey', you're seeing the same
234 patient just with a different face. And so to have a bit more complex stuff and liven it up a bit more
235 to remind you... about your skills. I mean I get the argument that you should be aware of your
236 limitations and you shouldn't open up stuff if you are not going to be there to see it through at least,
237 you could do more harm than good. I get that, but I think it is possible to do some meaningful pieces
238 of work with individuals that are more complex. You might not address every issue, but you might
239 do something that is helpful and meaningful to them, that doesn't massively increase the risk or
240 open stuff up. But that requires a degree of skill to work out who that's going to be applicable to
241 and how to manage that. I think as you grow in confidence, and I don't mean this in an arrogant
242 way, but I think you get a 'felt sense', a gut feeling, that someone is going to engage with you and
243 whether it feels appropriate to go with that and I know that is hard to quantify that feeling, but I
244 think you do get it with some patients where you feel 'actually on face value you're probably too
245 complex within a strict interpretation of the IAPT remit, however, I've sat with you for an hour and
246 we could have a few sessions just to look at this issue'. Umm I had a patient a couple of years ago
247 who was a patient who had been in and out of secondary services for years, clearly not for us, I
248 assessed him and I just felt for one of his issues there was something I could do . Now I don't know
249 where he is now, but after a few sessions he said it had been helpful to him, he'd got some
250 strategies to help him with his difficulties which he'd not had before. You could see value in that, I

Commented [I61]: Understanding on how external environment impinges on practice

Commented [I62]: Confidence – developing skills and expertise?

251 think, but it would be a case of..on paper he would not have been a case for IAPT. So I think there is
252 a lot of trust in our service, they do trust our clinical judgement so it isn't so draconian that they say,
253 right we're taking this decision out of your hands, it's often framed in terms of 'what do you think?'
254 and to my supervisors credit it's always left with me to make that decision and it's always negotiable
255 and I feel that If I assessed a patient and I think I can do some meaningful work then nine times out
256 of ten she would support me, that's not me being manipulative, but she would trust my judgement,
257 so that feels good. But I have to frame it in such a way that it is to do a distinct piece of work, there
258 would be concern if they were getting the full twenty sessions. There is the risk of working outside
259 IAPT, in IAPT and that could be problematic and too frustrating.

Commented [I63]: Support and recognition of level of skill.

260 Does that rest on you knowing what IAPT is?

261 Yes it does, I think I know what IAPT is but I know that differs from colleagues in other services and
262 even people in our service. Sometimes decisions are made and I think, 'well I would have seen
263 them, I would have assessed them' or 'I wouldn't have taken them on' so even within our team the
264 conception of what IAPT is varies. I think if you were to be so to the letter of the law you would end
265 up not assessing 50% of the referrals we get, genuinely, 50%, you can always find a reason to say,
266 this person is not suitable for IAPT, but I think we approach it, 'how are they appropriate for IAPT?'
267 which I think is a really good think and I know there are other services who adopt the other strategy,
268 cherry picking. You just don't know whether it is a legitimate clinical reason or an economic reason,
269 you just don't know.

Commented [I64]: Different perspectives on focus for IAPT.

Commented [I65]: Focus on IAPT and differences in approach.

270 Can I ask you about the feedback measures and their clinical utility?

271 For some patients I think there is some utility as it is a good way of showing how they are progressing,
272 for some patients less so. Some complain about completing them and they usually are the ones who
273 get no benefit out of going through the scores with them. It does feel a bit heavy on measures, I
274 mean every session and so...yeah...I ..um I feel that is more about economics, sort of performance
275 management rather than actually what's best for the patient. This feels like its lots of data that
276 people can look at, it's cynical but that's how it feels. The use of measures is good, but if I had free
277 reign I would use them on everyone at every session.

278 Finally, just reflecting on your practice, is this how you felt IAPT would be when you started the
279 course?

280 No..I thought it would be more Cognitive Behaviour Therapy.. and I make a distinction..I work as a
281 Cognitive Behaviour Therapist but I don't do Cognitive Behaviour Therapy with all my patients, I just
282 don't. I can't square that and say that I do. There are some patients on my list, I would say two in
283 every ten, where I do CBT, where it feels structured, where it feels like there is some progression,
284 some therapeutic relationship. Other patients, I think I'm utilising CBT but I'm not doing actual
285 therapy with them. I'm told that I am, but I don't think I am. If you see somebody for three sessions
286 and you've normalised their symptoms and you've given them some techniques, I feel
287 uncomfortable about them saying 'I've had Cognitive Behaviour Therapy' because you've had some
288 therapeutic input which has been helpful, but to call it CBT is to misrepresent what my idea of CBT is.
289 Maybe it's my idea of what it is, is wrong and I need to change that but...maybe that's just the way it
290 has to be.

Commented [I66]: Difference between training and work environment.

291 *End of interview*