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The effectiveness of CBT training on service delivery systems: a benchmarking study

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Abstract. Wales has not adopted the English IAPT system and has no centralized training plan for developing cognitive behavioural therapy (CBT) in Wales. However, Welsh Government policy expresses an ambition to improve access to evidence-based psychological therapies for people in Wales. This study focuses on one Welsh Health Board's plan to improve access to CBT. The study aims to benchmark support for effective delivery of CBT in the Health Board against NICE and Department of Health standards, and to establish whether the Health Board's plan is succeeding in developing staff capability and access to evidence-based CBT. Mental health staff funded by the Health Board to complete accredited training in CBT were asked to complete an online questionnaire asking about their training, accreditation, use of CBT, and experience of workplace support for delivering CBT. The standards were taken from the Department of Health competency framework for CBT, NICE guidelines and BABCP safety and confidentiality criteria. The Health Board performed well across seven standards of workplace support for the delivery of evidence-based CBT. Staff funded to undertake accredited CBT training continued to develop and to use CBT in their everyday clinical practice. The study indicates that the Health Board is succeeding in offering good standards of workplace support for CBT, including access to accredited CBT training. A recommendation is made that this be shared with other Welsh Health Boards and that a comparable study be undertaken within an IAPT service.

Key words: cognitive behaviour therapy, Health Board, staff training, service systems

Introduction

In recent years, considerable advances have been made in improving access to psychological therapies in England (IAPT; Layard and Clark, 2015). Layard and Clark (2015) reviewed evidence showing that mental health difficulties carry a high cost, in both human and economic terms, and that improving access to evidence-based psychological therapies can reduce both of these. Results from IAPT demonstrate that a large workforce, trained in an evidence-based therapy, can improve service user outcomes and reduce health and social care costs (Layard and Clark, 2015; NHS Digital, 2018).

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The Welsh Government has not utilized the same IAPT initiative, but has endorsed the principles of improving access to psychological therapy and increasing staff capability (*Together for Mental Health*, Welsh Assembly Government, 2016). In 2016, the National Psychological Therapies Committee produced guidance for evidence-based treatment of psychological difficulties (Matrics Cymru 2017). The Matrics recommends cognitive behavioural therapy (CBT) for many difficulties, including social anxiety, health anxiety, generalized anxiety, obsessive-compulsive disorder and depression, amongst others (Matrics Cymru 2017). A recent delivery plan for the Matrics (NPTMC, 2018) aspires to 'a position where all services in Wales are able to offer broadly similar, effective and equitable interventions' (NPTMC, 2018, p. 5). However, there is no centralized training plan for developing CBT in Wales, with each Health Board taking their own approach. The diversity and range of psychological therapies that can be offered in each Health Board raises an important question about the standard of training and delivery, which can be offered in each. Within CBT, the importance of staff training to deliver effective CBT is well established (e.g. Westbrook *et al.*, 2008; McManus *et al.*, 2010) with staff who have been trained in CBT more likely to achieve positive outcomes with patients (see review by Rakovshik and McManus, 2010).

All Welsh Health Boards have been required to establish a 'Psychological Therapy Management Committee' (PTMC) to oversee investment in training and evidence-based psychological therapies (Policy Implementation Guidance, 2012). In addition, these Health Boards have been allocated funds from the Welsh Government to spend on improving access to psychological therapies in adult services (National Assembly Wales, 2016). In line with the ambitions of Together for Mental Health (Welsh Assembly Government, 2016) and consistent with evidence on the impact of CBT training (e.g. Rakovshkik and McManus, 2010) the PTMC in this particular Welsh Health Board elected to invest in staff training in CBT (Management Committee Annual Report, undated). The plan for developing CBT included funding mental health staff to take up places on the only British Association for Behavioural and Cognitive Psychotherapies (BABCP)-accredited training programme in Wales: the postgraduate certificate and diploma in CBT at Cardiff University, both accredited at Level 1. At the time of the study a total of 29 staff had taken up places on this training programme: the largest take-up by any Welsh Health Board and an innovative approach within Wales.

Benchmark standards of support for CBT delivery

Standards for effective CBT practice are available from the National Institute of Health and Care Excellence (NICE, 2004, 2005a, 2005b, 2009). These guidelines are based on high quality RCTs for specific 'disorders' (e.g. social phobia, panic, PTSD, depression; Roth and Pilling, 2008; Roth *et al.*, 2010) and recommend specific treatment approaches and modes of delivery. Roth and Pilling (2007) devised a Competency Framework for CBT in order to link policy and guidance such as NICE with 'the treatments actually delivered' (Roth and Pilling, 2007; p. 22). The framework provides detailed standards of core competence for CBT with depression and anxiety disorders, and is published as best practice guidance by the Department of Health (Roth and Pilling, 2007) and endorsed in Wales by the National Psychological Therapies Management Committee, supported by Public Health Wales (2017).

The authors of the competence framework comment that 'It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice'

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(Roth and Pilling, 2007; p. 21) They also suggest the support required includes provision of high quality training addressing all areas on the competency framework, supervision in line with NICE guidance (i.e. provided by a BABCP accredited practitioner); monitoring therapist performance via recording in line with practice on research trials; and enabling practitioners to follow treatment protocols which may require 90 minute sessions or bi-weekly sessions (Roth and Pilling, 2007).

Groom and Delgadillo (2010) developed an audit tool to review the standards of CBT delivery in an IAPT service in England. The tool is shown in full in this paper and draws together standards of workplace support for CBT from NICE guidelines (2004, 2005a, 2005b), the Competence Framework for CBT (Roth and Pilling, 2007) and standards of confidentiality and ethical practice from the BABCP Standards of Conduct (2009, 2016). The standards refer to training and development, supervision, ability to carry out treatment outside the office and use internet resources, access to audio/video recording for therapy, ability to use audio/video for supervision and self-reflection, suitability of the clinical environment, and capacity to offer extended or increased frequency of sessions.

In the present study, we used an augmented version of Groom and Delgadillo's (2010) audit tool, with additional questions covering training, accreditation and everyday practice in order to benchmark standards of support for CBT, level of training and accreditation, and use of CBT in routine clinical practice in one Welsh Health Board.

Method

Procedure

Approval for this project was granted by the audit officer in the Health Board. To ensure confidentiality, staff names were anonymized, and the database was password protected (British Psychological Society, 2009). Staff were contacted via telephone and subsequently sent an email with a link to the online survey asking about their CBT training and about standards of support for CBT in their workplace (Bristol Online Survey, BOS). There was an option to 'save for later' and return to compete the questionnaire at a later stage. Staff responses were exported from BOS to an Excel file. Staff names were given a numerical unique identifier, and the Excel file was password protected.

Participants

Participants were mental health staff working in the Health Board. Staff were recruited through opportunity sampling from a database of people who had or were completing CBT training at Cardiff University (PG Certificate/PG Diploma). Twenty-nine staff members were approached and 23 completed the questionnaire. Participants represented a range of professional backgrounds and stages of CBT training (see Table 1).

The questionnaire

Staff were asked whether each standard was applicable to their workplace. The available responses were 'yes', 'somewhat' or 'no' and they were invited to make comments. Staff were also asked for information about their CBT training, accreditation status, and use of CBT in everyday practice.

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Table 1. *Percentage of staff who have completed various stages of CBT training and accreditation*

Question	Percentage (%)
(1) Have you completed the PG certificate, or will you have completed this by next year? (BABCP Level 1)	95.7 ($n = 22$)
(2) Have you completed the CBT diploma, or will you be completed by the next academic year? (BABCP Level 1)	60.9 ($n = 14$)
(3) Have you completed provisional CBT accreditation?	18.2 ($n = 4$)
(4) Have you completed your full CBT accreditation?	4.3 ($n = 1$)
(5) Are you currently working towards your provisional accreditation?	57.1 ($n = 12$)
(6) Were you able to integrate CBT into your everyday practice whilst completing the CBT certificate or diploma?	91.3 ($n = 21$)
(7) Are you currently using CBT in everyday practice?	91.3 ($n = 21$)

Results

CBT training, accreditation and self-reported integration of CBT into everyday practice are shown in Table 1.

In line with the recruitment strategy, 22 of the 23 participants reported that they had completed the PG certificate in CBT or would have done so within the next 12 months, with one participant taking an interruption in studies. Fourteen staff had also completed the PG diploma in CBT and of these, 12 were working towards full accreditation with BABCP and three had already achieved provisional accreditation. The two staff who had completed their PG certificate and diploma but were not working towards their provisional CBT accreditation attributed this to role constraints and an expectation they provide another form of specialist therapy or personal circumstances. The latter was keen to emphasize that this was not due to a lack of support: 'the organisation have been very supportive of staff training . . . , it's mainly been about timing and other factors making it difficult to complete it at the moment' (P21). All except two members of staff reported being able to integrate CBT into their everyday practice during and after competing CBT training at either PG Certificate or PG Diploma level, and a typical comment was: 'The certificate [PG Certificate CBT] has been an excellent vehicle for enhancing skill delivery and improving knowledge base' (P21).

The two staff members who experienced difficulties integrating CBT into their everyday practice described having additional work demands as part of their specialist role ['I am also the lead for another evidence-based practice' (P12)] and pressure to carry out other specialist interventions at the same time ['Having to undertake other psychological interventions such as DBT' (P20)].

Standard 1: training and development

The majority of staff believed that the service was providing appropriate personal development plans related to CBT training (74%, criteria 1a) and monitoring these regularly to ensure that staff were meeting standards (83%, criteria 1b; see Table 2 and Fig. 1). The majority (83%) also reported that the service met criteria 1d – the provision of adequate training approximating NICE guidelines. However, few staff thought the service had a clear policy regarding resources and funds for CPD (1c, 30%).

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Table 2. *Criteria relating to audit Standard 1(training and development)*

Criteria	Description
(1a)	Do you have a Professional Development Plan (PDP) in place that sufficiently identifies CBT specific training priorities for yourself and places these in the context of CBT training needs for the service?
(1b)	Is the PDP monitored and supported in line with trust wide standards? (e.g. one appraisal per year and six monthly reviews).
(1c)	Does the service have a clear policy specifying an allocation of time and resource to spend on CPD activity per week or per month?
(1d)	Bearing in mind practical and realistic limitations on training budgets, have you received adequate training to deliver treatment that closely approximates that of the RCTs in the NICE guidance?

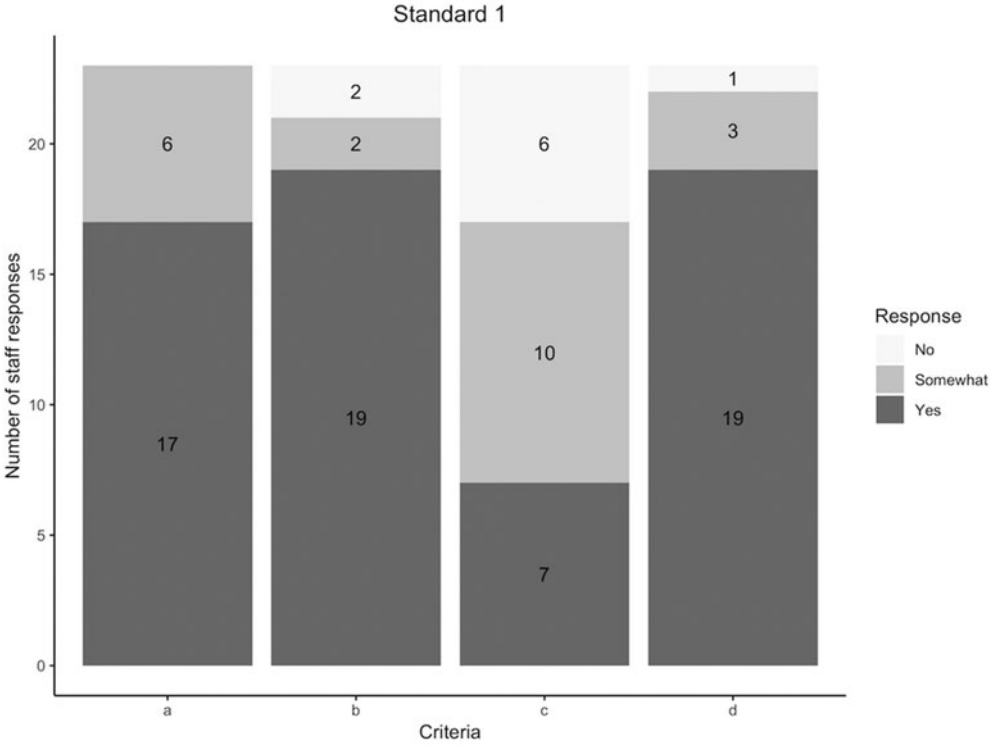

Figure 1. The number of staff who reported that the service met the criteria set in audit Standard 1.

Consistent with the high number of staff who felt that the service was broadly meeting this standard there were some very positive comments: 'The Health Board has been forward thinking and progressive in ensuring well trained and appropriately supervised staff to deliver high quality CBT treatment with excellent outcomes' (P21). However, consistent with the rather lower number of staff (6/23) who felt that there was a clear policy regarding funds for

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Table 3. *Criteria relating to audit Standard 2 (supervision)*

Criteria	Description
(2a)	Is the type of supervision you receive adequate for you to deliver treatment, which closely approximates that of the RCTs in the NICE guidance?
(2b)	Is the quantity (e.g. frequency, duration, enough time to discuss your own cases if supervision is in a group) of your supervision sufficient for you to deliver treatment, which closely approximates that of the RCTs in the NICE guidance?
(2c)	Are the knowledge, skills, and experience of the supervisor well matched to the type of treatment protocols you use?
(2d)	Is your supervisor a BABCP accredited CBT therapist?

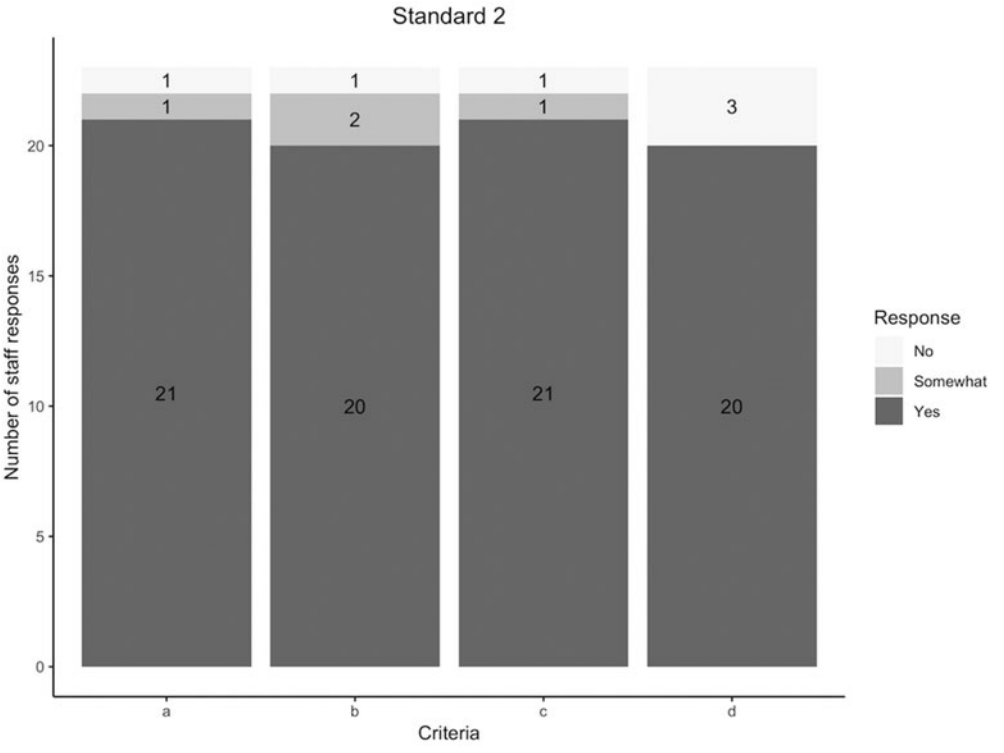

Figure 2. The number of staff who reported the service met the criteria set in audit Standard 2.

CPD, qualitative feedback indicated some confusion: 'Initially I was offered a place but my funding was turned down so I had to reapply' (P16).

Standard 2: supervision

Staff gave a strong endorsement of service support for supervision (criteria 2a, see Table 3 and Fig. 2), with 91% reporting adequate supervision to deliver evidence-based CBT, 87%

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Table 4. *Criteria relating to audit Standard 3 (resources to support clinical supervision and clinical self-reflection)*

Criteria	Description
(3a)	In practice, do you have access to video recording and video play back foruse as part of supervision and/or clinical self-reflection?
(3b)	Are protocols and permissions in place to enable the recording of clinical sessions?
(3c)	Do you have access to a suitable environment for listening/watching recordings of clinical sessions?
(3d)	Is your allocated admin time sufficient to review audio or video material for the purpose of reflection and/or preparation for supervision?

reporting good quality supervision of appropriate frequency, and 91% (criteria 2c) reporting a supervisor equipped with the appropriate skills. Furthermore, staff responses indicated that 87% (criteria 2d) of supervisors were BABCP accredited. Qualitative data confirmed this endorsement: 'The Health Board takes this responsibility seriously and as well as training a number of staff in CBT skills, also provides accredited CBT supervisors' (P21) and 'my supervisor is brilliant' (P16).

A small minority of staff ($n = 2$) reported that standards for supervision were not met. Qualitative feedback showed that this reflected difficulty accessing CBT supervision rather than concern about quality: 'Despite repeated requests I have never received supervision apart from the essential hours required for the CBT certificate' (P9) and 'there was no specialist (in that field) accredited with the BABCP' (P23).

Standard 3: access to audio/video to support supervision and self-reflection

All staff rated the service as at least 'somewhat' able to provide access to audio/video recording equipment for supervision (criteria 3a, see Table 4 and Fig. 3), provide protocols for recording clinical sessions and being able to listen to these in a suitable environment. However, seven staff (criteria 3d) reported that they were not provided with admin time to review these recordings or prepare for supervision, illustrated with comments such as 'Practitioners do not have enough time to prepare/reflect' (P9).

Standard 4: ability to use internet resources and offer treatment outside the office

Eighty-seven per cent of staff believed that the service provided appropriate protocols and permissions to carry out work outside the office (criteria 4a, see Table 5 and Fig. 4), and 78% reported actually being able to treat clients outside of the clinic (criteria 4b). A smaller number (35%, criteria 4c) reported access to appropriate online material required by the treatment protocol, reporting 'intranet not being available in all rooms' (P5) and 'restrictions on certain internet sites' (P11).

Standard 5: capacity to offer extended sessions or increased frequency of sessions

The majority of staff (74%, criteria 5a, see Table 6, and Fig. 5) reported service support to offer 90 minute sessions and more frequent sessions (65%, criteria 5b). One said they were

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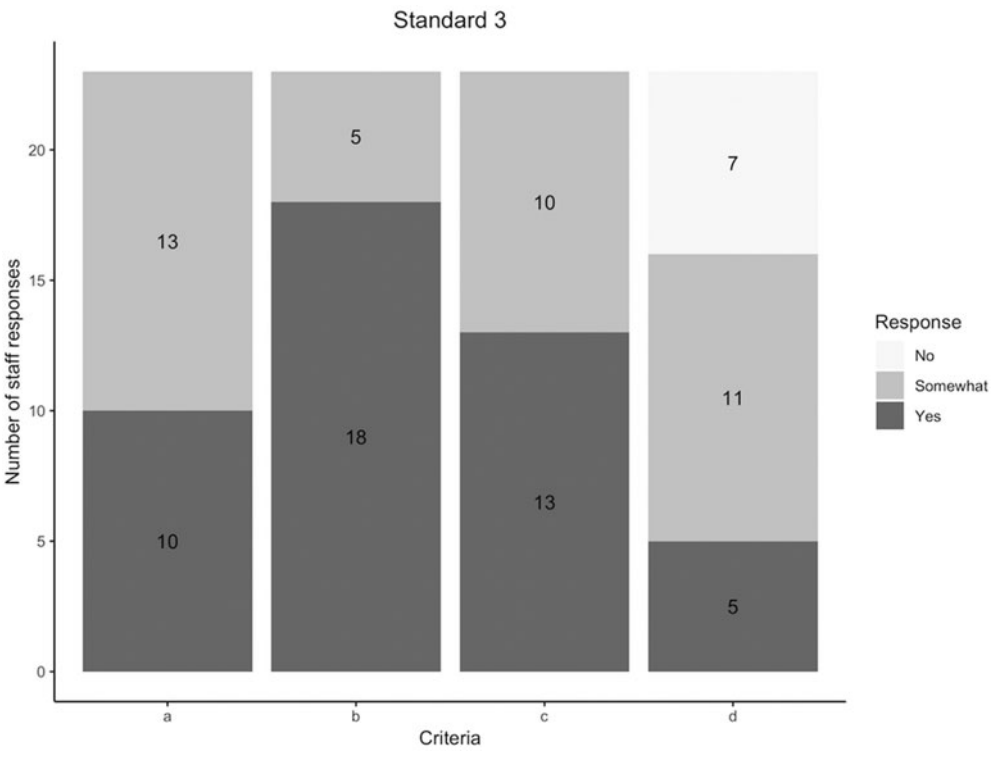

Figure 3. The number of staff who reported that the service met the criteria set in audit Standard 3.

not able to offer 90 minutes sessions and four that they were not able to offer bi-weekly sessions when appropriate.

Standard 6: access to video recording for assessment and treatment

Only eight staff (35%, criteria 6a, see Table 7 and Fig. 6) reported that the service was able to provide access to video recording in the clinic room. Qualitative feedback indicated that equipment was often unavailable ['no video equipment' (P10)], procedures for recording were onerous or unclear ['the procedure for recording and videoing can be very cumbersome' (P1); 'vague policy guidelines' (P10)] and described a need to find creative solutions ['… I used my own iPad and deleted the video recording with client straight after… not ideal' (P16); 'I… encourage client to use own devices' (P10)].

Standard 7: suitability of the clinical environment

All staff indicated that the service was able to provide a suitable clinical environment at least 'somewhat' (criteria 7a:d, see Table 8 and Fig. 7) in relation to a confidential clinic room adequately equipped for therapist and client safety (78%, criteria 7b), with safe access and treatment for clients with disabilities (87%, criteria 7c). All staff reported that the

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Table 5. *Criteria relating to audit Standard 4 (working with real world materials outside the clinic)*

Criteria	Description
(4a)	Are protocols and permissions in place to enable you to treat patients outside the clinic? (e.g. lone working policy, risk management protocol)
(4b)	In practice, are you able to treat clients outside of the clinic as and when required by the treatment protocol?
(4c)	In practice, can you access the internet to use resources such as YouTube and other publicly available material as and when required by the treatment protocol?

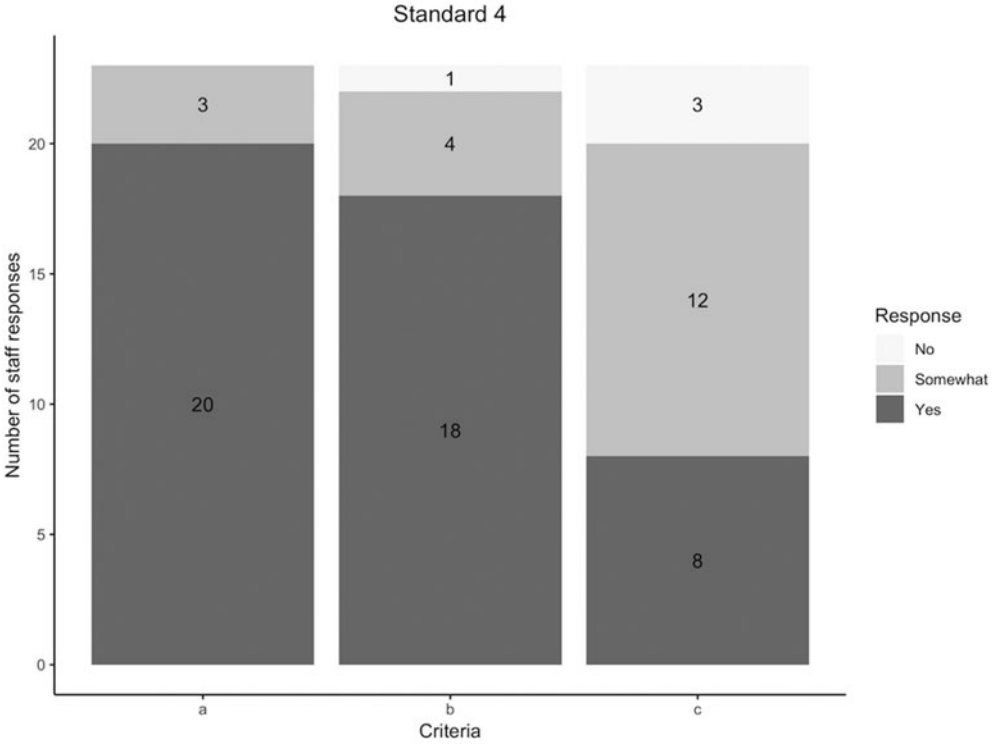

Figure 4. The number of staff who reported that the service met the criteria set in audit Standard 4.

service provided a room 'fit for purpose' although the number rating this item as a 'yes' was rather lower. Feedback indicated variability across different bases ['some bases are better than others' (P1)], some missing equipment ['we are still waiting on white boards' (P16); 'computers installed into some of the rooms' (P16)] and some concerns about sound proofing ['Both (locations) have issues with sound … so not fully confidential' (P7)].

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Table 6. *Criteria relating to audit Standard 5 (extended sessions or increased frequency of sessions)*

Criteria	Description
(5a)	In practice, are you able to offer extended sessions of up to 90 minutes when appropriate?
(5b)	In practice, are you able to offer bi-weekly appointments when appropriate?

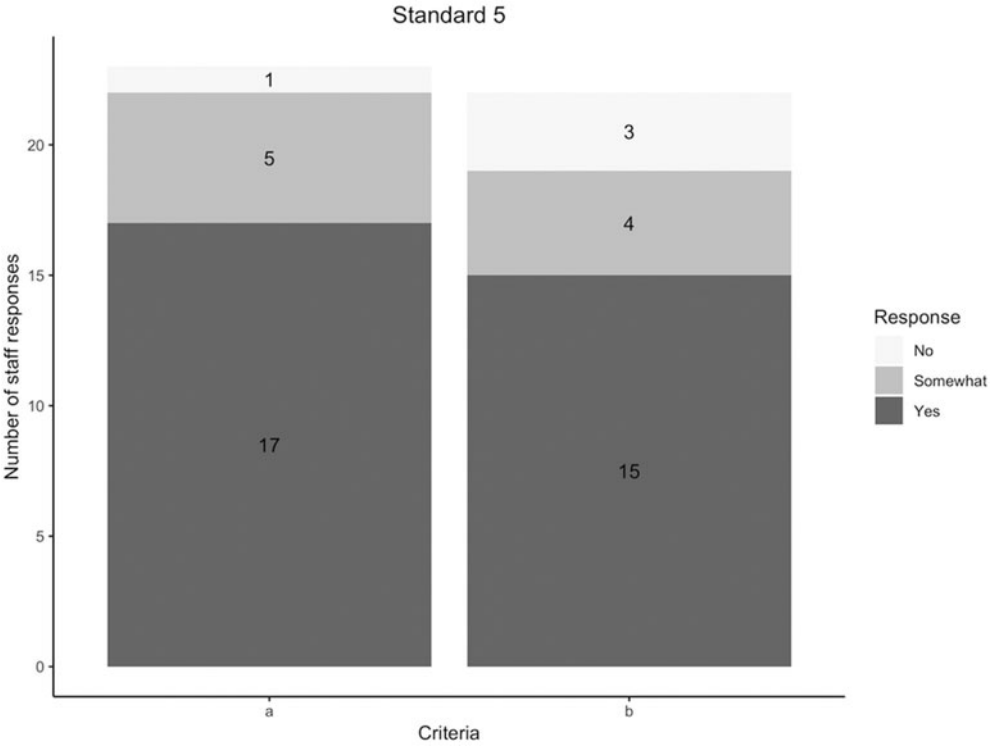

Figure 5. The number of staff who reported that the service met the criteria set in audit Standard 5.

Discussion

The results of the current audit provide an insight into levels of training, accreditation and use of CBT among those staff who have received a training investment from the Health Board. In addition, staff views of standards of support for CBT in the Health Board provide a means of benchmarking the service against NICE and DoH standards. There is as yet no other time point or service to compare with the standard in this Health Board.

Training, accreditation and use of CBT in everyday practice

Our results indicate a progression through staff completing the postgraduate certificate in CBT, the postgraduate diploma in CBT, working for provisional accreditation and achieving full accreditation. As we would expect from a development plan there were more staff at the

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Table 7. *Criteria relating to audit Standard 6(extended sessions or increased frequency of sessions)*

Criteria	Description
(6a)	In practice, do you have access to video recording and video play back for the use in your clinic room?

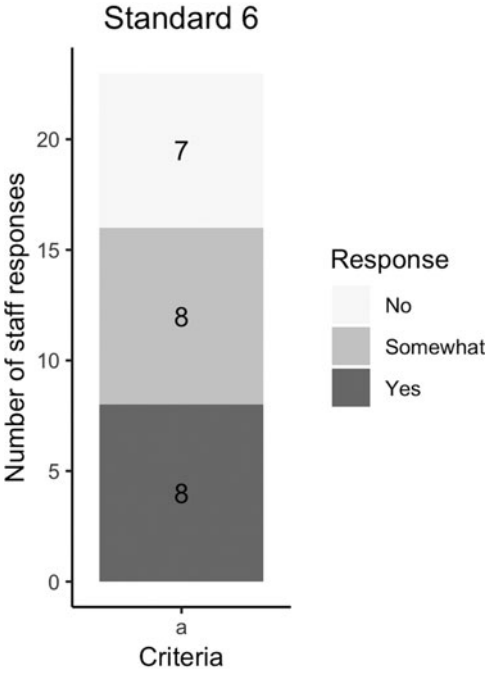

Figure 6. The number of staff who reported that the service met the criteria set in audit Standard 6.

early stages of this process and fewer at the end. The Health Board seems to be succeeding in increasing staff capability and improving access to evidence-based psychological therapy in line with Welsh Government policy (Welsh Assembly Government, 2012, 2016). The vast majority of staff reported that they continue to use CBT in their everyday practice, indicative of the service having a return on their investment (Layard and Clark, 2015; National Assembly Wales, 2016).

Standards of workplace support for delivering effective CBT

Most staff answered 'yes' to a question asking if they have a professional development plan that identifies training priorities, and the majority said this was reviewed. Nineteen of the 23 members of staff felt that they had received adequate training to deliver treatment that closely approximates that of the RCTs in NICE guidance ('bearing in mind practical and realistic limits on training budgets'). This suggests that staff feel that the Cardiff CBT programmes are succeeding in developing their capability and positive comments were offered concerning the

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Table 8. *Criteria relating to audit Standard 7 (suitability of clinical environment)*

Criteria	Description
(7a)	Confidentiality: does the clinic room that you use allow communication to remain confidential?
(7b)	Safety: is the clinic room that you use set out in such a way that reasonably ensures the safety of the therapist and client? (e.g. consider emergency exits, availability of panic alarms, any safeguards to deal with violent incidents, etc.)
(7c)	Accessibility: does the clinic room that you use allow the safe and appropriate treatment of clients with any disabilities?
(7d)	Is the clinic room that you use 'fit for purpose' as described above? (e.g. consider fittings, furniture, equipment, etc.)

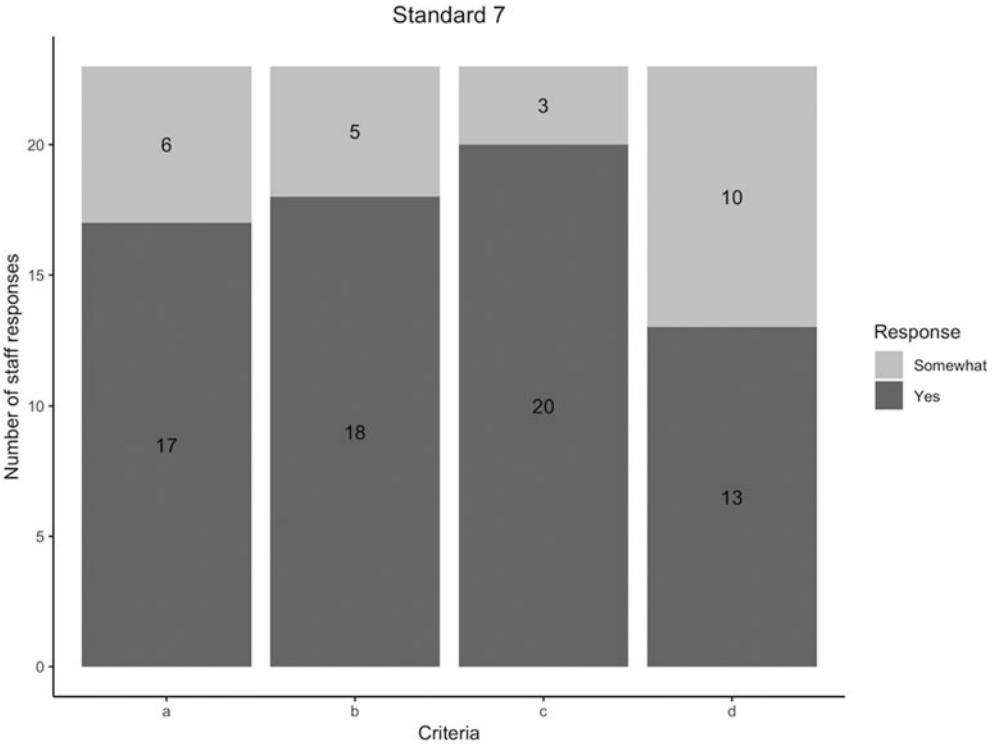

Figure 7. The number of staff who reported the service met the criteria set in audit Standard 7.

training programmes. However, only a minority (7 out of 23) said 'yes' to the Health Board having a clear CPD policy specifying time and resources. Also some staff reported difficulties obtaining funding for the next stage of training (certificate, diploma or further CPD to achieve accreditation). This suggests that although the workforce plan is generally succeeding, staff would appreciate greater transparency and a clear model of progression.

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The majority (20–21 out of 23) of staff were very positive about their CBT supervision. This supervision was determined to be to be the right type of supervision for delivering NICE recommended CBT, of sufficient quantity, offered by a BABCP accredited practitioner supervisor with CBT knowledge, skill and experience. Staff may have been referring to supervision provided by the CBT programmes as well as 'in-house' supervision, but in either case it indicates success for the Health Board. However, three members of staff said they did not have access to a BABCP accredited supervisor in line with NICE recommendations for the delivery of CBT.

All staff reported that the service was at least 'somewhat' able to provide recording equipment for supervision, and thought there were protocols for recording sessions and a suitable environment for listening to these. This positive feedback indicates that the Health Board is able to facilitate staff use of recordings in supervision in line with NICE and DoH recommendations. However, some staff reported that they did not have time to listen to recordings.

The majority of staff thought policies and protocols were in place to offer treatment outside the office (e.g. behavioural experiments, site visits) but some staff did not feel able to carry this out practice. Comments from staff suggest that this may be due to the protocols and policies being onerous, and a lack of equipment may also have played a part. In terms of being able to use appropriate internet resources only eight out of 23 said 'yes', and staff comments suggest this is partly due to a lack of resources and partly to Health Board IT restrictions on access to websites such as YouTube.

All but one member of staff reported being able to offer 90 minute sessions, suggesting that this has become an accepted part of CBT practice in the Health Board. Most (19 out of 23) also felt they could offer bi-weekly sessions as recommended, for example, for depression.

Seven members of staff responded with a 'no' to a question asking whether they have access to video equipment for therapy. The lack of access to video equipment for all staff is a cause for concern, as staff are treating disorders, such as social anxiety, which have a clear treatment protocol requiring the use of video. Some staff mentioned using solutions which included using their own equipment and commented that this was 'not ideal', which implies it may be causing them some anxiety.

All staff rated items related to the suitability of the clinical environment as at least 'somewhat' met. However, their comments suggested variability between clinical bases, a lack of some basic equipment (e.g. white boards) and some concerns about confidentiality due to rooms being insufficiently sound proof.

Significance of the overall findings

Although the results of this study have highlighted some areas for improvement, the overall picture suggests that the Health Board is succeeding well in supporting CBT in the workplace. It is worth noting that this Welsh Health Board has been compared against national standards for the UK, and is still performing very well across all standards. Unfortunately, an English service with comparable data were unwilling to share their results to allow a comparison.

Of note, our questionnaire was a self-report measure, which may be subject to social desirability effects (van de Mortel, 2008), and thus our results may reflect slightly inflated estimates of standards. However, asking for staff views allowed us to collect insightful and constructive critical comments from those who know the service well.

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Recommendations

Overall, the Health Board is succeeding in offering a high level of support for the delivery of evidence-based CBT, as assessed against standards from NICE and the Department of Health. A comparable study carried out with an English service would provide an interesting comparison. Staff funded to undertake accredited CBT training continue to develop and to use CBT in their clinical practice. The Welsh Government ambitions to develop staff capability and provide effective, evidence-based psychological therapy for people in Wales (Welsh Assembly Government, 2012, 2016) are being enacted by the Health Board. The Health Board are recommended to share their development plan through the National Psychological Therapies Committee which 'welcomes reports of innovative approaches for consideration and dissemination of best practice across all areas of Wales' (NPMTC, 2018, p. 5).

Main points

(1) This benchmarking study provides evidence for a promising service delivery model for CBT for devolved nations such as Wales.
(2) Wales has not adopted the English IAPT system and each Welsh Health Board is developing its own approach to improving access to psychological therapies.
(3) The Health Board in this study aimed to develop access to effective CBT by taking up places on the only BABCP accredited programme in Wales.
(4) Staff funded to undertake accredited CBT training continued to develop and to use CBT in their everyday clinical practice and the Health Board performed well across seven standards of workplace support for the delivery of evidence-based CBT.
(5) The authors recommend that this be shared with other Welsh Health Boards and that a comparable study be undertaken within an IAPT service.

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Ethical statements

All authors have abided by the Ethical Principles of Psychologists and Code of Conduct. Audit approval for this benchmarking study was granted by the audit officer in the Welsh Health Board. As this study was deemed to be an audit/service evaluation, ethical approval from the Trust was not necessary – as decided by the Welsh audit officer.

Conflicts of interest

L. Hadden and M. Groom have no conflicts of interest with respect to this publication. However, L. Waddington is involved as one of the instructors on the Cardiff CBT training course, which could potentially provide a conflict of interest. Nevertheless, this was mitigated

through L. Hadden, who has no direct links to the CBT training course (trainee clinical psychologist) conducting the benchmarking study and analysing the data.

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Recommended follow-up reading

Jenkins H, Waddington L, Thomas N, Hare J (2018). Trainees' experience of cognitive behavioural therapy training: a mixed methods systematic review. *the Cognitive Behaviour Therapist* **11**, e2, 1–22. doi: 10.1017/S1754470X17000253

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Learning objectives

(1) To understand the service delivery systems for psychological therapy in Wales compared with England.
(2) To understand the need for a homogeneous approach to psychological therapy delivery in Wales, in line with Government recommendations.
(3) To understand that a staff training investment can streamline service delivery systems when compared with the gold standard of care in England.