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Transferring Psychological Therapy Education into Practice in the United Kingdom: A Complex Systems Analysis

Ian McGonagle and Christine Jackson

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Abstract

This chapter provides an overview of an aspect of a large research study conducted on the subject of learning transfer from an education institution to a mental health service in the English National Health Service (NHS). From a population of 64 trained staff, nurses and other workers, managers and supervisors were interviewed to gain a detailed understanding of how they sought to maintain and develop the new skills and knowledge they had acquired from an education programme delivered from an approved university provider. A total of 45 interviews were conducted using 1:1 or focus group approaches as part of a larger longitudinal study using a mixed methods design. This chapter provides an overview of the qualitative element of the study. Results indicated that whilst aspects of new learning and skill were maintained, many services were subject to pressure to change from the external political, economic and social environment that influenced the delivery of services such as that provided by the one within this study. This complex interaction between the 'external' and 'internal' healthcare environment is an issue that all educators should acknowledge when developing new and innovative education programmes for nurses and other professionals.

Keywords: policy, education, supervision, mental health, complexity

1. Introduction

This chapter provides an examination of the process associated with learning transfer. This process can be conceptualised as the ability to use what has been learned and to maintain this usage over time. To examine this transfer issue, a large scale study was conducted on a population undertaking a new national education programme to instruct health workers

in treatments of anxiety and depression using psychological therapy. These cohorts of students from the new national education programme were followed up over a 3-year period to explore the process of transferring new learning in practice.

The World Health Organisation (WHO) in 2013 estimated that mental health problems, particularly depression, will be among the greatest health challenges of this century [1]. Mental ill-health presents difficulties not only to the individual but to their entire social network (family, friends, etc.). Additionally, the economic impact, not only to the individual but also to the wider national economy, is significant [2, 3]. Within the United Kingdom, the total economic costs of mental health are estimated to be £25 billion per annum [4, 5].

Prior to a health policy initiative in this area, it was estimated that only 8% of people with a major depressive illness had seen a consultant psychiatrist and only 3% had seen a clinical psychologist [6]. The unaccounted people suffering with depression and anxiety were deemed to be receiving no form of evidence-based psychological therapy at all [2].

To address the issues above, The Department of Health (DH) proposed by the Department of Health (DH) in 2008 to develop a service to educate and train a workforce to offer evidence-based psychological therapy interventions—the improving access to psychological therapy (IAPT) service. The IAPT service, from 2010 offered treatments, primarily cognitive behaviour therapy (CBT) which increased coping abilities, taught self-help approaches and promoted resilience for future mental health challenges. Referral to specialist services (if needed) could be completed simply, efficiently and effectively. Finally, IAPT sought to promote social inclusion and normal life patterns through access to work. This workforce expansion represented a major investment in education and service development. To achieve this, a national skills-based education programme was initiated [7].

This implementation of a new workforce and national education and training programme merited deeper analysis. It is important that services develop an understanding of the implementation and embedding process for service improvement [8]. 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 [9] along with many earlier authors [10–12], key components of transfer were identified such as, the personal characteristics of the trainees, the characteristics of the training programme and the characteristics of the work setting.

To explore this, a series of interviews with practitioners, clinical supervisors, service managers and national policy managers were held. The aim was to obtain a richer and deeper understanding of the process of learning transfer from the national policy to daily practice.

Research on learning transfer models have been primarily linear [10, 13]. This current design articulated a stronger emphasis on a complex systems analysis to understand the transfer process. The study design was a representation of a complex system as it met all relevant criteria:

- A large number of elements are constantly interacting with each other.

- 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.

- 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 [14, 15].

2. Method

The method adopted for this part of the study consisted of single hour long interviews with six IAPT therapists who were graduates of the education programme, three service managers (who were responsible for the day to day operation of the service), four national policy managers (who were instrumental in establishing the IAPT service for the Government of the day) and two clinical supervisors (who were responsible for supporting IAPT therapists to maintain and continually develop, their practice skills). Focus groups were held with thirty other IAPT practitioners, who had not attended the programme under review. Focus groups were used to triangulate data from other sources.

The population consisted of 64 post-graduate students studying on the improving access to psychological therapy (IAPT) course delivered at a Higher Education Institution (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. Permission to approach the students was also sought and granted via the university, health service managers and local research and development ethics committees.

2.1. Approaches to analysis: qualitative data analysis

An interview schedule was developed for this qualitative data element of the design. 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 National Health Service (NHS) region in order to triangulate aspects of the data collected. All individual 1:1 interviews were transcribed verbatim and additional notes kept and developed at the earliest opportunity following the discussion. Focus group data were recorded and transcription notes taken from the recordings. The transcription process utilised the work of Kowal and O'Connell [16] and Roulston [17] in taking a pragmatic approach to transcription, with no detailed textual annotations included. 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 [18]. This process involved: (i) *data reduction*; (ii) *data display* and (iii) *drawing and verification of conclusions*. All interview data were analysed at a single point with the focus group data integrated a later point to help challenge or confirm initial findings. 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 [19].

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 [20]. The relation between variables expressed as either consensus or dissensus was potential area for the examination of new understanding.

The transcribed and recorded data were read and reviewed many times and annotated. A 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 [19] and they were entered into an analysis table and reanalysed until separation of the key themes emerged and the data saturation was evident [21].

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 [22].

3. Results

Unexpected findings or extreme results were prioritised for exploration as to whether the study was generating new insights into the transfer of learning. The process of theme development was based on a close reading and re-reading of the transcribed material and a reflexive approach to the research aim. Through this process, a number of themes emerged were considered to have a significant role in the transfer process. All interviews produced a wealth of material and many quotes were gathered which crystallised the emerging themes.

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 [23], although the concept of competency had yet to be adequately defined or measured [24]. Most often it was related to therapist self-reported increase in confidence and their belief in achieving treatment outcomes.

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. They saw themselves developing new skills and being able to deliver them meaningfully in practice. The process of development was supported through critical evaluation of their skills through the use of video recording of their current competence and capability:

'Just watching myself on video was really uncomfortable, but it taught me a lot about myself and what I needed to improve on'. (IAPT Therapist: individual interview).

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, you mightn't know what problem to address and you might not know how to engage somebody' (IAPT supervisor: individual interview).

3.2. Motivation: identity

A relationship existed in the psychological literature between competence, or the desire for competence, and 'motivation' [25]. Within the data an attribute that many responders identified was the need to exhibit motivation to work as a high intensity IAPT therapist.

Respondents considered the importance of developing and maintaining an IAPT identity for the workforce as critical in enabling them to remain within services and remain motivated to develop their practice further. Professional identity and the associated emphasis on personal motivation were critical issues within the transfer process. However, within such a complex clinical environment, significant challenges were identified.

'I have come to see professional identity as hugely powerful'. (IAPT policy lead: individual interview).

'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).

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.

'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'. (IAPT therapist: individual interview).

The role of identity as a supportive process to aid a sense of certainty 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. 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.

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 managers, supervisors and service managers and formed a significant theme in all the analysis. The external wider clinical environment was seen as the principal reason for challenges in transfer behaviour. Clinical practice was viewed as high pressure, time limited and replete with many quotes relating to healthcare provision as challenging.

'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… 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).

The external pressures were also evident for policy managers, 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'. (IAPT policy: individual interview).

There were many examples of where respondents identified the shortfall in their initial implementation aims. While 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:

'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. 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'. (IAPT policy lead: individual interview).

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.

'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 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.

3.4. Support and supervision

The provision of supervision was another recurring theme in the focus groups and interviews with IAPT practitioners. Supervision was viewed as 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 the principal role in supporting the transfer process within the work-setting.

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).

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'. (IAPT policy lead: individual interview).

In interview and focus group, a number of IAPT therapists stated that originally, clinical supervision was given greater prominence in their working plan, but as workload 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).

3.5. 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 study. 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'. (IAPT therapist: 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,… and that's what, if you like, makes an IAPT service'. (IAPT policy lead: individual interview).

The 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.

3.6. 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. The concern was whether therapeutic drift was a relaxation of skills or an example of the development of higher order skills.

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. I 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' (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 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'. (IAPT supervisor: individual interview).

4. Discussion and conclusion

The study produced an extensive amount of data which required careful analysis in order to explore the emergent themes. The complex frame used to understand the inter-relationships between the various variables that were 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 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. The core target client group; those people with anxiety and/or depression had been integrated into treatment groups with people with additional and sometimes multiple social and health needs.

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. The change model of West and Brown [26] towards behaviour (such as transfer behaviour) identified the need to have the capability or skills to change; the opportunity to change behaviour and the motivation to do so to direct behaviour. According to reference [26], 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 capability, opportunity and motivation process were utilised by IAPT therapists. 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 practising 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 education institution 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 work of Burke and Hutchins [9] was used to guide the research around topics with little or no empirical evidence for their role in the transfer of learning. In this study, clinical supervision emerged as a meta-theme that seemed to unite all others 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.

This study provided an insight into the complexity associated with the process of learning transfer in the English NHS. Healthcare is a dynamic and politicised agenda with many competing demands impinging on the day to day work of nurses and other practitioners. It is important that education developers, teachers and service managers have a deeper appreciation of the complex and challenging practice environment that students are working when considering the transfer of learning.

Author details

Ian McGonagle* and Christine Jackson

Address all correspondence to: imcgonagle@lincoln.ac.uk

School of Health and Social Care, University of Lincoln, Lincoln, UK

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