

Towards the Development of an Integrated CBT Provision within a Large Organisation Offering Services to People with Mental Health Problems and/or Learning Disabilities

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Abstract

Cognitive Behavioural Therapy (CBT) has become the main psychological treatment provided by the National Health Service (NHS) of the UK. Its position in the NHS has been strengthened by the National Institute for Health and Clinical Excellence (NICE) guidance, which recommends CBT as the psychological treatment of choice for a broad range of psychological and mental health problems. The NICE guidelines also recommend that CBT should be delivered by suitably trained and supervised clinicians. All these recommendations have put considerable pressure on NHS mental health providers to increase access to good quality CBT provision.

This paper will describe how this challenge is being addressed by one such organisation. It will briefly introduce the organisation and provide information on the initial reviews of its CBT provision. It will then describe the model of CBT clinical governance that has been developed, the CBT training schemes available within the organisation and the model of CBT supervision structure that is being implemented. Difficulties and successes of this project will be discussed and illustrated with relevant data.

Keywords: CBT, training, supervision structure, governance

There has been a very significant increase in provision and development of psychological treatments in the last few decades. Nevertheless, the paper by the Department of Health for England entitled "Organising and Delivering Psychological Therapies" (2004) recognises that access to psychological therapies is the main unmet need identified by users of mental health services.

Cognitive behavioural therapy (CBT) is the main psychological treatment recommended and provided by the National Health Service (NHS) in the United

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Kingdom. Its popularity is the result of strong evidence for its effectiveness and efficiency for a wide range of problems and for different groups of service users. This is recognised by National Institute for Health and Clinical Excellence (NICE), which is an *'independent organisation responsible for providing national guidance on promoting good health and preventing and treating ill health'* (NICE, 2009). NICE guidelines recommend CBT more frequently than any other psychological treatment.

NICE guidelines also suggest that the efficiency of CBT is for many mental health problems comparable to pharmacological treatments and that people who use mental health services should therefore be offered a choice between these treatments. However, NICE guidelines also suggest that CBT should only be provided by suitably trained and supervised people.

In order to provide choice and increase access to CBT, there needs to be sufficient capacity for its provision. This implies that there need to be sufficient numbers of appropriately trained therapists who work within a supportive supervision structure. In order to meet this demand CBT is increasingly delivered by a range of mental health professionals including those that have not been traditionally trained in psychological therapies (Department of Health, 2006). This development presents a new challenge for CBT training and supervision.

However, despite the major expansion in psychological therapies in the last few decades and recognition that this expansion needs to continue in the future, a relatively small amount of research and theory development has been published on training and on competences required for such treatments.

Bennett-Levy (2006) provides a review of psychotherapy literature as well as a model of acquisition and refinement of therapist skills. Drawing on previous work in this field, particularly in Binder's (1993, 1999) declarative-procedural model, Bennett-Levy introduces a three-system cognitive model of therapist skill development. He added a 'reflective' system to Binder's 'declarative' and 'procedural' systems. The declarative system refers to acquisition of conceptual (e.g., CBT model for a specific disorder), interpersonal (e.g., collaborative nature of therapeutic relationship) and technical (e.g., how to test thoughts) knowledge. Declarative knowledge may not transfer into practical skills without acquisition of procedural knowledge which is about 'how' and 'when' skill, procedures and rules. In the early stages of therapy skills development the greatest activity is in the declarative and procedural systems, but Bennett-Levy's model suggests that in order to become a competent or expert therapist the activity needs to gradually move towards the reflective system. The reflective system enables individuals to explore and analyse their past therapy experiences and through this enables them to continue to refine their skills. Bennett-Levy sees facilitation of reflection as one of the main tasks for all psychotherapy trainers.

An important question that arises from this model is how these three different types of knowledge can be learned and how the reflective system can be enhanced.

Acquisition of declarative knowledge relies more on didactic teaching and reading. Procedural knowledge requires more experiential learning. Procedural ability, however, is dependent on interpersonal skills and some researchers (e.g., Dobson & Shaw, 1993) believe that such skills are difficult to change through therapy training. Bennett-Levy, et al., (2001) and Bennett-Levy, Lee, Travers, Pohlman, & Hemernik (2003) provide a more optimistic view, showing that it is possible to enhance such skills through personal experiential work. Other research reported by Bennett-Levy (2006) also suggest that self-referenced learning, for example practicing cognitive behavioural therapy on oneself or reflecting on one's own thought, emotions, and behaviours can also enhance therapist skills. It seems that supervision that provides good opportunities for reflection on clinical work is most helpful in increasing reflective ability (Bolton, 2001).

Bennett-Levy's model leads to a number of interesting questions. If different methods are required for different elements of therapist skills, what is the best combination of these different methods? If different skills develop in different ways and therefore at different rates, how can the discrepancy, be managed? If interpersonal skills are difficult to learn, do we need to be more selective in whom we take for training? If personal experiential work enhances therapist skills, how should this be included in CBT training? If novice and experienced therapists develop their skills differently, what kind of supervision structure is required within organisations that provide therapy?

Bennett-Levy (2006) provides a very helpful model of ever-increasing therapist competences. However, not all CBT interventions require highly competent CBT experts. CBT can be provided at different levels of intensity, requiring different levels of CBT competence. The Roth and Pilling paper (Department of Health - DoH, 2008) which defines different levels of CBT competences is therefore very useful in helping to identify different levels of CBT training. Roth and Pilling identify five CBT competences: generic competences in psychological therapy, for example ability to engage clients required for any psychological intervention; basic CBT competences, for example ability to structure sessions, which are used in most CBT interventions; specific CBT techniques, such as using thought records, that are used in most CBT interventions; problem specific CBT skills; metacompetences which are used by therapists to work across all the above levels and to adapt CBT to the needs of each individual client. Training at different levels of these competences will require different focus on the three different systems of the Bennett-Levy model of therapist skills acquisition.

Information about the Organisation

CBT workforce developments described in this paper relate to a large Mental Health and Learning Disabilities NHS organisation in England, which provides primary, secondary, and tertiary services to a population of about 1.3 million. Service provision is based on the care in the community model resulting in services being provided by numerous (approximately 75) relatively small teams spread across the whole of the covered geographical area. The size of the professionally qualified and unqualified clinical workforce across these teams is around 2800.

The organisation, which will be referred to as the Trust in the rest of this paper, is relatively young. In 2005, three local organisations merged into the current one and within the new organisation, a new Therapies Directorate was created. One of the strategic objectives of the directorate is to increase the number of staff who are able to integrate CBT interventions into their clinical practice, to increase the numbers of accredited CBT practitioners, increase the numbers of CBT trainers and supervisors within the organisation, and thus to increase access to psychological therapies.

CBT Provision Around the Time of the Merger

A number of reviews of CBT provision and CBT knowledge and skills were made. These reviews showed that the quality of CBT provision varied greatly across services. There were pockets of high quality provision as well as pockets of very limited CBT provision. The approach to CBT provision was mainly non-systematic and largely dependent on individual clinicians or managers who had a specific interest in CBT. Most clinicians had done some pre- or post-qualification CBT training but in most cases, the training had been very limited and not targeted. The majority of clinicians providing CBT did not have regular access to CBT supervision. The majority of clinicians who provided CBT provided it at a generic level and were not able to deliver diagnosis specific treatments. There was an even greater shortage of clinicians who were able to provide so-called third wave CBT approaches, such as mindfulness based therapy. However, a significant number of clinicians expressed a desire to improve their CBT knowledge and skills through further training and wished to have access to regular CBT supervision.

Trust's CBT Strategy

It would be unnecessary and unrealistic to expect that all clinicians offering CBT within the Trust should be accredited CBT therapists. As it has been already argued, CBT can be provided at different levels of intensity, which require different levels of complexity. Five year strategy for CBT in the Trust (Shawe-Taylor, 2007) recommended that CBT provision is conceptualised at five different levels:

- Level 1: Use of single CBT techniques, mainly behavioural such as exposure programmes, carried out by clinicians who do not have professional health qualifications. Their work is closely guided and supervised by clinicians who can provide CBT at least at level 2.
- Level 2: Use of a number of basic and specific CBT techniques and principles, which are chosen and applied in an autonomous way by a qualified mental health practitioner with post-qualification CBT training.
- Level 3: Provision of problem specific CBT treatments for different types of disorders.
- Level 4: Provision of individualised CBT treatments for people with co-morbid presentations requiring complex CBT treatments.
- Level 5: Development of new CBT treatment protocols and of new CBT training and supervision programmes.

Fortunately, these five levels can be relatively easily matched with Roth and Pilling (DoH, 2008) CBT competences which were published soon after the above strategy had been written. It seems clear that Level 1 provision requires generic competences; that Level 2 requires basic and specific CBT competences; that Level 3 requires problem specific CBT skills; and that Levels 4 and 5 require metacompetences.

It also seemed clear that comprehensive CBT supervision at all these 5 levels would require strong CBT governance and a comprehensive development of internal CBT training programmes with an integrated supervision structure.

Structure of CBT Governance

A multidisciplinary CBT Strategy Group was formed, the geographical area of the Trust was split into five localities, and CBT leads for each locality were appointed. In addition, CBT leads for different specialisations and different case groups have gradually been added to the group.

The role of the group is to plan, support and oversee CBT developments in the Trust, provide guidance on CBT practice and to lead on the internal CBT training programme. Each locality or speciality CBT lead has an additional responsibility for development and maintenance of appropriate CBT supervision structure within his/her area. The group is chaired by the Trust CBT lead who is responsible for the Trust's CBT strategy and who reports to the Trust's Director of Therapies.

CBT Training in the Trust

Internal courses in CBT had been offered for some years but those courses were relatively short (1 to 5 days) or relatively basic. Training at the level required by the NICE guidelines had been traditionally acquired from external training organisations that provide good quality training, but sending staff to such courses would be costly and it was therefore unlikely that sufficient numbers of clinicians could be trained in this way.

External training courses also find it difficult to address individual training needs that depend on the individual's level of general psychological therapy and academic skills and on the type of service and the care group the individual clinician works with. The consideration of general psychological skills in CBT training has become more important because of the expectation that clinicians who are not traditionally trained in such skills will need to become more involved in direct CBT delivery.

It also seems that individual clinicians who undergo CBT training are too quickly identified as CBT specialists in their services. This puts pressure on them, increases their anxiety, and consequently makes them less able to disseminate their knowledge and skills to their colleagues in the service. They often cope with their anxiety by avoiding CBT work and withdrawing into their pre-training way of working. In order to avoid this happening, a greater consideration needs to be given to the appropriate number of clinicians trained in CBT in any given service. It may often be more appropriate to offer CBT training to teams rather than to individuals. This may enable individual clinicians to support and encourage each other and to develop a culture within the team, which enables good CBT delivery.

It is accepted that Level 4 and Level 5 CBT provision (as defined in the Trust CBT strategy) requires metacompetences (as defined in the Roth and Pilling DoH document) and that development of such competences requires comprehensive training which may best be accessed through external training organisations. However, problem-specific competences, which are required for Level 3 provision, can at least partially be developed through internal training. Internal training programmes can also cover generic psychological competences as well as basic CBT competences and specific CBT techniques.

Based on such thinking, two levels of CBT courses were developed in the Trust, one focussing on training in problem-specific competences and the other focussing on training in basic CBT competences and specific CBT techniques. So far, more attention has been given to the development of the latter group of courses, due to a greater need for internal provision of such courses.

All CBT courses in the Trust aim to develop knowledge as well as skills. All candidates for the courses have their individual training needs assessed through interviews. Whenever possible clinicians working within similar services or care groups are grouped together, so that the necessary specificity of CBT delivery can

be arranged. While regular supervision is offered as part of all the courses, all trainees are strongly encouraged to start arranging their post-training CBT supervision well in advance.

Different Types of Courses

We have been running a regular annual programme of two courses, one at each of the training levels defined in the previous section. Both courses are run one day a week for a period of ten weeks. Training days are divided into teaching, skills training and practicing and small group supervision. Each trainee is required to do CBT work with one client during the duration of the course and regularly presents recordings of their sessions in supervision. The courses do not require any written assignments but those training in problem specific CBT skills are required to present a written or diagrammatic formulation of their client's situation in supervision. The content of the problem-specific courses is determined on the basis of the trainees and their service needs.

In addition, Praxis CBT courses are regularly offered to the teams. The Praxis CBT package, which was developed, by North Tyneside and Northumberland Mental Health NHS Trust (Myles, 2003) is highly interactive and can be accessed online or through a well designed CD-ROM. It is most suitable for training in basic and specific CBT competences. Following Praxis guidelines, we developed our own Praxis training programme which runs over 20 weeks and involves whole day fortnightly sessions that are divided between workshop type of training and small group supervision. Trainees are again expected to do CBT work with one client for the duration of the courses and to record their CBT sessions. In addition, they are expected to do homework agreed at the end of each training session and based on the Praxis package. Each trainee is given a Praxis CD-ROM for the duration of the courses. As indicated above, Praxis courses tend to be offered on a team basis and whenever possible facilitated by local clinicians.

As part of a pilot study (de la Fosse, 2009), we recently also offered a basic and specific competences course which was based on problem based learning; CBT knowledge and skills were acquired through learning on cases that trainees brought to the training sessions.

The training outcomes data shows that participants in this process increased their CBT knowledge less than participants in the group, which received more classical training, based on teaching, workshops, and supervision. However, increase in the use of CBT techniques in therapy was the same for both groups. This was just a small pilot study, but it would be worth repeating this study on a larger scale because problem-based learning may be more suitable for some trainees, particularly those who find more formal learning difficult.

In addition, more specific CBT training programmes are being developed. So far, a local Dialectical Behavioural Therapy (DBT) course and a CBT course for people working with children and young people have been delivered.

All trainers and supervisors of these courses are experienced CBT practitioners; the British Association accredits some of them for Behavioural and Cognitive Psychotherapies while others are likely to be eligible for such accreditation.

METHOD

Training Outcomes

Sixteen different CBT courses have been delivered since 2005. Three of these covered problem-specific competences while 13 covered basic and specific CBT competences. In the latter group, there were five courses, which were based on a more standard training model with teaching, workshop, and supervision components, five Praxis courses; one problem based learning course, one course for clinicians working with children and young people and one DBT course. Altogether 163 clinicians completed the courses making an average of 10.2 participants per course.

Measures

The outcome measures for the different CBT courses were unified in 2007. Three separate questionnaires are used for this purpose. *The Course Evaluation Questionnaire (CEQ)*, which is completed by each participant at the end of the course, assesses the quality of the course in terms of its content and teaching. The other two questionnaires are administered at the beginning and at the end of the course.

The CBT Knowledge Questionnaire (CBTKQ) is based on questions included in the Praxis training package and is aimed at assessing CBT knowledge. It has 39 multiple choice questions, with each question being scored 1 if correct and 0 if incorrect.

It was more difficult to find a measure of CBT skills that can be applied regularly on a pre- and post-training basis. A new questionnaire *Assessment of Usage of CBT Techniques (AUCBTT)* was developed for this purpose. Participants are asked to estimate the frequency of their usage of 10 different CBT techniques (goal setting, agenda setting, activity scheduling, Socratic questioning, graded exposure, role-play, behavioural experiments, cognitive rehearsal) on a 6-point scale, ranging from 0 for never to 5 daily.

RESULTS

Participants who have attended the courses (62 of them) have been asked to complete all the above questionnaires pre and post training. Data on 49 participants who completed one of the basic and specific competences courses is available so far.

The difference between the pre- and post-scores was statistically analysed using the sign test. This is a non-parametric test that was chosen as it makes weaker distributional assumptions about the data, which in our case does not have a normal distribution. Nonetheless in Table 1 the means are presented in order to illustrate the differences between pre- and post-training scores.

We first consider the difference between pre- and post- CBTKQ scores (Table 1). All the trainees increased their CBTKQ score post-training, a statistically significant change (sign test, $p < .01$).

Table 1. Comparison of pre-training and post-training CBT knowledge and usage of CBT techniques

	Scale range	Pre-training		Post-training		Sign test
		Range	Mean	Range	Mean	P
CBT knowledge (CBTKQ)	0 - 39	10 - 27	21.00	20 - 38	29.25	< .01
Usage of CBT techniques (AUCBTT)	0 - 50	0 - 37	19.60	16 - 42	26.90	< .01

We now turn to the difference between pre- and post- AUCBTT scores (Table 1). Two trainees' post-training score was lower than the pre-training score, but for the rest the score was higher, giving an overall change that is statistically significant (sign test; $p < .01$).

The participants were generally positive about the course content, teaching, and supervision. A course evaluation questionnaire asked participants to assess the 'content of the teaching sessions', 'style of teaching' and 'quality of supervision' with a range of scores: 1 (very poor), 2 (poor), 3 (fair), 4 (good) and 5 (very good). Apart from one respondent who rated 'style of teaching' as fair, all of the scores were either good or very good (Table 2).

Table 2. Course evaluation

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Content of the teaching sessions	4.76
Style of teaching	4.53
Quality of supervision	4.76

In summary, the results of these three evaluation measures suggest that the trainees found the courses useful and that the courses helped to increase their CBT knowledge and usage of CBT techniques.

DISCUSSION

The range of CBTKQ suggests that some trainees started the course with a high level of CBT knowledge and the range of scores on the AUCBTT may similarly suggest that some trainees already used many CBT techniques before starting the training.

However, it is accepted that while CBTKQ may be a satisfactory measure of CBT knowledge there are a number of problems with AUCBTT. Firstly, the scores are based on self-assessment and are therefore not objective. Secondly, the frequency of usage of a certain CBT technique does not necessarily say much about the more important question of the quality of its application. Thirdly, using all CBT techniques all of the time is neither realistic nor appropriate. While some of them may indeed need to be used all the time, others can be used only occasionally. The questionnaire does not discriminate between these different techniques. There was an awareness of all these three difficulties with AUCBTT before the measures were taken, but the questionnaire was nevertheless used because no other appropriate screening measure of CBT skills was available to us.

There is, however, a further difficulty with AUCBTT, which came to light only after its regular usage. The two trainees whose pre-training scores were higher than the post-training ones illustrate this difficulty. Interview with these two trainees showed that pre-training they did not understand what different CBT techniques were and therefore scored themselves inappropriately. Clearly, greater care should have been taken to explain the assessed techniques before giving out the questionnaire.

All the above post-training measures were taken immediately after the end of the courses. However, it would be even more interesting to know to what extent the newly developed knowledge and skills are maintained over time. We have begun to collect six monthly follow-up data but this is not yet available for analysis.

Conclusions

It seems that some important steps have been made so far but that much more work needs to be done in order to achieve high quality CBT at all levels of its provision. While we need to continue with the current strategy, we also need to attend to some additional tasks.

We have experimented with different types of training models and have, not surprisingly discovered that there is not one that suits all clinicians. It seems that it is important that careful attention is given to the membership of training groups so that those with similar learning needs and training styles are pulled together and the training model is adjusted for them. This can be improved through an appropriate selection interview. We have also discovered that selection interviews increase motivation for training and reduce the number of initial drop-outs.

As expected, courses that have been delivered within teams have generated more enthusiasm for training and post-training CBT work and continued supervision. However, it is still unclear if this really translates into a greater long-term increase in CBT provision and quality within those teams.

While it seems clear that regular recording of CBT sessions enhances skills acquisition in more advanced CBT learners, this may have the opposite effect on those who are more or less CBT beginners and are training at lower levels of competence. Such clinicians are usually not used to recording their clinical work and therefore find recording very anxiety provoking. This tends to lead to different kind of avoidances. Such clinicians often benefit more from role-playing in supervision than from trying to use CBT with their clients. This suggests that other experiential learning, such as self-referenced learning recommended by Bennett-Levy (2006) should also be included in future training.

However, when trainees are ready to start using CBT with real clients it seems important that they do so with clients from their own service and do not go searching for an "ideal CBT client" from other services. Our experience suggests that in the latter case clinicians find it much more difficult to transfer their newly acquired CBT skills into their everyday practice.

It has also been observed that the level of general psychological skills and motivation for CBT training has changed over the last few years. In the first wave of training, trainees tended to be highly interested in CBT and usually had a history of training in psychological therapies even if their original professional training did not include much of such training. More recent groups have often been motivated to do CBT training for different reasons. One example of such a motivation may be the general trend, which requires greater integration of CBT techniques, and principles in most provided treatments or simply anxiety about their positions and jobs. Their post-qualification career direction and training did often not suggest strong interest in psychological treatments. Such trainees often require slower and more basic training and therefore some adjustment of their training programme. On

the other hand, is it possibly the case that some clinicians may find it too difficult to train as psychological therapists as Dobson and Shaw (1993) seem to imply? If this is indeed the case, we need to refine our training selection strategy and procedures.

It may also be worth pointing out that any training puts demands on the trainees and for a period shifts some resources from the service. It is therefore extremely important that any training programme fits with the organisation's strategy and that therefore service managers are supportive of it. Without such support, trainees are put under too much pressure, can only partially apply themselves to the course, and therefore are more likely to drop out altogether.

While it seems clear that CBT training in the Trust is needed and is desired by managers and many clinicians, it is not yet clear how useful the current training programme is. The training outcome measures show increased CBT knowledge and usage of CBT techniques post-training but not enough is known about how this translates into long-term improvement in clinical work.

We need to develop better assessment tools and procedures for measuring training outcomes and for measuring the quality of CBT that is being provided. Without improvement in this area, we will continue to be uncertain about the quality of our CBT provision and the usefulness of our training. The use of treatment outcome measures can clearly be helpful in some cases but may be misleading when CBT approaches are integrated with other treatments provided by either the same or more clinicians.

We had been fully aware that training course is just the first step in developing skills and that without further regular supervision there is little point in attending training, but we had not fully appreciated the difficulties associated with trying to address this. Due to such difficulties, we have now started to require that anyone attending any of our CBT courses make arrangements for further supervision before starting the course. However, this is a touch requirement because in spite of the best efforts of the CBT Leads to develop good supervision structures within their areas, there is often a lack of appropriately trained supervisors and regular movement of staff makes developed supervision arrangements unstable.

Our training focus so far has been on lower CBT competency levels but we now also need to start giving more support to those clinicians who want to develop high levels of CBT competences and become CBT accredited therapists, teachers and supervisors. We also need to start attending more to the supervision needs of highly competent CBT practitioners. We need to develop more peer supervision groups that will facilitate reflection and enable such therapists to continue to refine their skills as suggested by Bennett-Levy (2006). Shortage of appropriate supervisors has already been identified above but without a sufficient number of such therapists, we will also not be able to fulfil the requirement of the NICE guidelines. However, once such therapists have been trained they need to be motivated to stay within the organisation. We therefore need to develop a good career structure for CBT therapists in order to make them want to stay.

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