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Abstract

Background: Whilst the delivery of low-intensity group psychoeducation is a key feature of the early steps of the Improving Access to Psychological Therapies (IAPT) programme, there is little consensus regarding the skills and competencies demanded. **Aims:** To identify the competencies involved in facilitating CBT-based group psychoeducation in order to inform future measure development. **Method:** A Delphi study in which participants (N=36) were relevant IAPT stakeholders and then an expert panel (N=8) review of the competencies identified within the Delphi study to create a shortened, more practical list of competencies. **Results:** After three consultation rounds, consensus was reached on thirty-six competencies. These competencies were assigned to four main categories; group set-up, content, process and closure. A further expert review produced a shortened 16-item set of psychoeducation group facilitation competencies. **Conclusions:** The current study has produced a promising framework for assessing facilitator competency in delivering CBT-based group psychoeducational interventions. Weaknesses in the Delphi approach are noted and directions for future measure development research are identified.

Key Words: psychoeducation, CBT, IAPT, competencies, Delphi, group

Introduction

The Improving Access to Psychological Therapies (IAPT) programme was introduced in the UK in 2008 (Clark, Layard, Smithies, Richards, Suckling & Wright, 2009), with an aim to improve access to evidence-based psychological interventions for patients with common mental health problems (Clark, 2018). IAPT has improved service capacity via a stepped care approach (Robinson, Kellett, King & Keating, 2012). As an index of this capacity, over 1.09 million individuals began treatment and over 582,000 individuals completed a course of treatment across England in IAPT between April 2018 and March 2019 alone (NHS Digital, 2019). Stepped care is an organisational system in which increasingly intensive psychological interventions are delivered sequentially in accordance with patient need and risk (Bower & Gilbody, 2005). Patients are stepped-up when they do not fully benefit from less intensive psychological interventions or according to ongoing risk and need (Boyd, Baker & Reilly, 2019; Green, Barkham, Kellett & Saxon, 2014).

Within stepped care large numbers of patients initially receive low-intensity interventions consisting of guided self-help psychoeducation informed by cognitive behavioural therapy (CBT) principles (Green et al., 2014). Psychoeducation has been shown to be an effective evidence-based psychological intervention (Lukens & McFarlane, 2004). Psychoeducational interventions are delivered via one-to-one guided self-help (e.g. via email, websites, telephone, or in person), computerised CBT and psychoeducational groups (Turpin, 2010). Group psychoeducation is delivered either via didactic or workshop-based formats. Didactic group psychoeducation resembles a taught class rather than traditional group therapy and demands minimal patient disclosure or interaction (White & Keenan, 1990). In contrast, workshop-based group psychoeducation contains patient interaction (e.g. via group exercises,

discussions and role-plays) to supplement the delivery of the psychoeducational materials (Brown, Elliott, Boardman, Ferns & Morrison, 2004).

Didactic or workshop based psychoeducational groups share the 'low-contact/high-volume' philosophy and approach of low-intensity IAPT services (Clark et al., 2009). The most common didactic group psychoeducation delivered in IAPT is *Stress Control* (White & Keenan, 1990). This approach is distinctive in its 'large group' approach enabling groups to be up to N=100 large. This approach has been shown to be organisationally efficient due to high patient-to-practitioner ratios (Kellett, Clarke & Matthews, 2007) and a recent meta-analysis (Dolan, Simmond-Buckley, Kellett, Siddell & Delgadillo, 2020) showed large pre-post treatment reductions, that improvements were maintained at follow-up and that outcomes were equivalent compared to active and passive control groups. However, Delgadillo et al. (2016) found significant outcome variability between *Stress Control* groups, despite it being a manualised and highly structured approach, and hypothesised that this effect was explained by differences in competency between group facilitators.

The competency of psychoeducational group delivery is important as this ensures that patients are receiving the best quality treatment possible and facilitates the delivery of evidenced-based psychological interventions (Fairburn & Cooper, 2011). However, Green et al. (2014) previously highlighted that low-intensity CBT interventions had received relatively little research attention in comparison to high-intensity CBT. Therefore, less is known about what constitutes competent and effective low-intensity practice. There are a range of competency measures of high-intensity CBT, including generic (e.g. Cognitive Therapy Scale-Revised (CTS-R); Blackburn et al., 2001) and disorder-specific measures (e.g. Cognitive Therapy Competence Scale for Social Phobia; Clark, von Consbruch, Hinrichs & Stangier, 2006; von Consbruch, Clark & Stangier, 2012). However, the development of valid

and reliable competency measures for low-intensity CBT is currently restricted to 1-2-1 guided self-help (e.g. Kellett et al., 2020).

Group psychoeducation is recommended as an intervention in the National Institute for Health and Care Excellence (NICE) guidelines for common mental health problems (NICE, 2011a, 2011b). This evidence base is specifically limited to group psychoeducation for generalised anxiety disorder (GAD), panic disorder and, under certain limited circumstances, obsessive compulsive disorder (NICE, 2011a). For example, rather than specifying facilitator competencies, the NICE guidelines for GAD specify group contracting and content, such as groups being delivered by trained professionals (ratio 1:12), in a six (2-hour) interactive session format, being CBT-based, use presentations/self-help materials and encouraging experiential learning opportunities via homework. Similarly, the national curriculum for PWP training (Centre for Outcomes Research and Effectiveness, 2015) recognises that PWPs deliver psychoeducational groups, but fails to define any specific competencies. Moreover, the need for identifying group psychoeducation competencies has also been previously identified (Burns, Kellett & Donohoe, 2016).

Therefore, the aim of the current study was to identify by consensus the practitioner-facilitator competencies involved in the delivery of low-intensity CBT-based group psychoeducation by conducting a Delphi study supplemented by expert review. Delphi is a structured, iterative communication research method, originally developed as a means of gathering systematic and interactive forecasts of experts (Dalkey & Helmer, 1963). Use of the Delphi approach is particularly indicated where there is limited research or a lack of clinical clarity and/or consensus (Iqbal & Pipon-Young, 2009) as is the case here. This study also sought to collate by expert review an agreed upon set of group psychoeducational facilitation competencies to inform the development of a future group facilitation competency measure.

Method

Methodology

A Delphi methodology was utilised as this method is commonly utilised to identify quality indicators within healthcare (Boulkedid, Abdoul, Loustau, Sibony & Alberti, 2011), enabling clinical consensus to be formed (Iqbal & Pipon-Young, 2009). Delphi methodology consists of an iterative process which contains of a series of questionnaires or "rounds" that gather information from participants who are experts in their given field (Boulkedid et al., 2011). During the process feedback is given to participants regarding responses in the prior round in order to encourage a consensus of opinion among participants to emerge (Hasson, Keeney & McKenna, 2000). The Delphi methodology was supplemented by an expert panel to refine the list of advocated competencies down to a practical representative 'shortlist'.

Participants

A three-round Delphi study was conducted with qualified IAPT practitioners with experience of facilitating CBT-based group psychoeducational interventions, including both Psychological Wellbeing Practitioners (PWPs) and high-intensity CBT practitioners. The study was conducted between between March and July 2019. Inclusion criteria were; (1) participants needed to be based in England and work within the IAPT programme, (2) participants needed to have experience of facilitating group psychoeducational interventions, and (3) participants had to have a qualification relevant to the facilitation of group psychoeducation (e.g., a LI-CBT postgraduate certificate, high-intensity CBT diploma) in order to demonstrate expertise and relevant knowledge of the area. Participants were recruited using a snowball sampling approach (contacted via professional and academic mailing lists) and via relevant informal Facebook groups for professionals that included

PWPs. Thirty-six participants enrolled in the study, with between 16-23 participants completing each round. Samples of between 10-30 participants are common in Delphi studies (Akins, Tolson, & Cole, 2005), with recommendations for achieving at least 8-15 participants (Hallowell & Gambatese, 2010; Johnson, 1976). Moreover, a sample size of 23 participants has been previously demonstrated to produce reliable and stable responses (Akins et al., 2005).

Procedure

The study invitation was circulated via email and social media posts and this provided a hyperlink to the Qualtrics questionnaire. This contained the participant information form, consent form, participant demographic form and the first round Delphi questionnaire. All rounds were hosted on Qualtrics and reminder emails were sent out 1 week before rounds 2 and 3 closed. There were three stages to the study; (1) identification of possible group competencies through review of relevant literature, (2) Delphi method, thematic analysis and consolidation with literature-derived items and (3) expert review phase to define a final representative and practical group competency list.

Data analysis strategy

Delphi Phase 1

The first-round questionnaire utilised open questions that asked participants to describe the competencies important in the facilitation of CBT-based group psychoeducational interventions in workshop and didactic formats. Responses were then analysed via thematic analysis in accordance with Joffe's (2011) recommendations. The thematic analysis began by examining the anonymised responses to become familiar with the

data set. Based on this inductive reading of the data set and a priori knowledge of teaching, group psychotherapy, and general group facilitation research, a coding frame which consisted of 27 unique codes was created. These codes were written up alongside examples of data which would be coded within each. This coding frame was then applied to the data set using NVivo 12 (QSR International, 2018). Once the data was categorised within the codes, each code was examined and the themes within the codes were examined and extracted. Each theme constituted a single group psychoeducational competency item. The inter-rater reliability of the coding framework was checked by comparing the coding of two of the authors who each coded the data set using the proposed coding frame. This resulted in a mean Kappa statistic of 0.86 (SD = 0.14) and mean agreement of 99.5% (SD = 0.6%). Any disagreements were resolved by discussion.

The participant-derived competencies were then consolidated with previously extracted literature-derived competencies from teaching, group psychotherapy and general group facilitation contexts, as it was deemed judicious to acknowledge and draw upon pre-existing frameworks in these areas. This recognised approach has been termed a modified Delphi approach and has been recommended to support content and face validity (Hasson & Keeney, 2011). The literature-derived competencies were extracted by the second researcher from a pool of previously published frameworks (Burlingame, Fuhriman & Johnson, 2001; Department for Education (DoE), 2011; Dies, 1994; International Association of Facilitators, 2015; Kellett et al., 2020; National College for School Leadership, 2010; The Health Foundation, 2013; The International Institute for Facilitation, 2003). These literature-derived items were then reviewed by the third and fourth researchers. Items without endorsement from at least one of these researchers were then removed from the list of literature-derived competencies.

Delphi Phase 2

The collated set of literature and participant-derived competencies were then utilised in the second-round questionnaire. Participants rated how important each of the competencies were in the facilitation of CBT-based group psychoeducation. Participants were asked to rate the items on a Likert scale ranging from 1, signalling "not important at all", to 10, signalling "extremely important" and were also provided with a "don't know" option for if they were unsure of how important a competency was in the given context in an effort to increase the validity of participant responses. Participants were also provided with a text box at the end of each Likert scale where they could provide additional qualitative feedback to explain why they gave the competency items their chosen numerical rating.

The median, maximum, and minimum scores and an anonymised summary of the feedback given for each item in round 2 were then fed-back to participants in the third-round questionnaire, in line with recommendations by Boulkedid et al. (2011). Items were not considered for consensus during the second round in order to allow participants to consider alternative points of view in the third round and adjust their ratings accordingly. In the third round, participants rated, using the same Likert scales and qualitative feedback boxes, the importance of the competencies again whilst also considering the median, minimum, and maximum scores and the summaries of participant feedback from round 2. Levels of consensus were then calculated for all items using the participant ratings given in the round 3 questionnaire. Consensus for inclusion was determined a priori as ≥70% of participants giving scores of 8 or above for an item. Consensus for exclusion was pre-determined as ≥70% of participants giving scores of 5 or below for an item.

Expert Review

The expert review was conducted due to crossover between items and in order to derive a more practicable shortened set of competencies which could be used within a practitioner competence measure. Competency items that reached consensus for inclusion

were reviewed and operationalised by the researchers and divided into representative categories and sub-categories. These competencies were then reviewed by eight experts, composed of a mix of senior PWPs, IAPT teachers and an IAPT programme director. These represented regions including Yorkshire (*N*=*5*) and the North West (*N*=3; including Greater Manchester, Lancashire). The experts selected the competency that best encompassed the competencies within that sub-category. The experts were also provided with a text box to provide additional feedback on the identified competency items. Items that were selected by over 50% of experts were selected for inclusion in the final group competency set. In one instance there was a lack of consensus to select a single item within a subgroup, due to a perception that the items were actually distinct competencies. In this case, both items from that subgroup were included in the final shortened list of competencies. Both the full and the shortened, expert-reviewed set of competencies which reached consensus are reported in the results.

Results

Of the 36 participants who completed the consent form, 23 (63.9%) completed the first round, 22 (61.1%) completed the second and 16 (44.4%) completed the third Delphi round. Thirty participants were PWPs (83.33%), N=4 (11.11%) were IAPT PWP course leads or trainers and N=2 (5.55%) were high-intensity CBT therapists with experience of facilitating group psychoeducation. Of the 36 participants, 29 (80.6%) that took part in at least one round, as participants were allowed to participate in later rounds, even when they had not participated in earlier rounds. Within the complete responses received, the "don't know" option was selected fifteen times in the second round, with 12 of these "don't know" responses being submitted by the same participant, and four times in the third round, with all four of these responses being submitted by the same participant. Therefore, in practice the

"don't know" response was largely redundant due to only a very small minority of participants utilising it. Table 1 reports the demographic data of participants who took part in any of the three rounds where this information was available. The thematic analysis from round one yielded 67 competencies and a further 51 literature-derived competencies were extracted. When the literature-derived and participant-derived competencies were consolidated to eliminate duplicate competencies, this resulted in 64 unique competencies being derived.

- *Insert Table 1 here* -

In total, 36 (56.3%) of the 64 competencies reached consensus for inclusion (≥70% of participants scored 8 or above) and these are reported in Table 2. The competencies were conceptualised under 4 main categories; *group process, group content, group set-up and group conclusion.* Twenty-four of the items that reached consensus were related to the *group process* category and covered facilitator organisation, interpersonal skills, management of group dynamics and disclosures, professional conduct, participant engagement, risk management, feedback and facilitator development, and responses to group members. A further 6 items were contained in the *group content* category, with particular reference to the facilitator's knowledge, utilisation, and communication of CBT-based psychoeducational concepts, and their adherence to the intervention. Finally, *set up* and *conclusion* categories were also identified containing 4 and 2 competencies, respectively. The *group set up* category pertained to establishing boundaries, roles, rules, and guidelines with the group participants and outlining the agenda for sessions. The *group conclusion* category involved the appropriate creation, exploration and setting of homework tasks.

- *Insert Table 2 here* -

Following expert review, 16 competencies were included in the shortened set of group psychoeducation facilitation competencies. In total, consensus around a single item (i.e. at least 50% of experts preferred a single competency item) was reached in 14 of the 15 subgroups of competencies. The subgroup in which no item gathered sufficient consensus was regarding the group conclusion competencies. One expert (#3) noted that *"many of the competencies I have ticked do expand on the broader concepts and give examples, but without doing so fully enough to encompass all of the other competencies in that subgroup."* It may be that the absence of a competency item that clearly encompassed the other items led to a divergence of opinion in this subgroup, indicating more than one unique competency and thereby preventing consensus from being reached. Moreover, on the basis of expert feedback, items 1 and 4 in the *set-up* category were combined together in the shortened, expert-review list. An expert highlighted that whilst item 1 sufficiently encompassed item 3 it did not cover item 4, therefore the aforementioned changes were made.

- *Insert Table 3 here* -

Discussion

The findings of this Delphi study have produced a focussed list of competencies that are relevant to the facilitation of CBT-based group psychoeducational interventions, constituting an initial step to meet the call for research development in this area (Burns et al., 2016). These items were derived from the consensus opinion of a panel of participants who had good experience of facilitating or teaching group psychoeducation. In total, 36 competencies were included in the extended list and 16 in the shortened expert-reviewed list. These items could form the basis for the development of a competency measure for use across didactic and workshop-based psychoeducational groups. It is worth noting that many of the competencies that were identified already existed within related teaching, group

psychotherapy and group facilitation competency frameworks, but had never been appropriately integrated for use with CBT-based group psychoeducation. In the sections that follow, the identified group psychoeducation competencies and their congruence with existing related frameworks, measures and empirical research will be discussed.

The identified *group set-up* competencies emphasised the importance of establishing an effective start to psychoeducational groups and introducing an associated group session structure to manage and contain expectations and anxieties. This included outlining the patient's role, group rules and the content and agenda of sessions. This structured treatment approach reflects the general group psychoeducational approach (Delgadillo et al., 2016). Group psychoeducation delivered within the IAPT programme consists of a pre-determined number of sessions (6 is indicated in NICE (2011a)), that each cover distinct and pre-determined topics and associated guidance on coping skills (White & Keenan, 1990). Communicating the appropriate patient role is important given the differences between didactic and workshop-based formats. Beck (2011) suggested that agreeing expectations enables patients to feel more contained and comfortable and gain more from sessions and Yalom and Leszcz (2005) noted that addressing patients' misconceptions was vital. However, it should be noted that a prior review examining the relationship between setting patient role expectations and treatment outcomes yielded ambiguous results (Arnkoff, Glass & Shapiro, 2002).

The identified *group content* competencies revolved around clear knowledge and utilisation of psychoeducational concepts and materials. This stresses the importance of facilitators possessing sound declarative knowledge of psychoeducational materials and associated CBT theory. This content theme perhaps has most in common with the guidance regarding the manner in which psychoeducational groups should be run as reported in the IAPT Manual (National Collaborating Centre for Mental Health, 2018) and NICE guidelines

(NICE, 2011a, 2011b). Clearly, the competent running of a psychoeducational group rests on the declarative knowledge of mechanisms of the disorder being treated and how the change methods taught in the group act on these mechanisms. Green et al. (2014) has previously indicated that more clinically effective PWPs have a better declarative knowledge of the low-intensity treatment protocols. Clearly, the change methods presented and practiced in the groups need to be well integrated into the structure of the groups (Lukens & McFarlane, 2004). Therefore, it follows that any self-help materials used via presentations, workbooks, worksheets and handouts are clear, easy to understand and written at the national reading age (Bennett-Levy, Richards & Farrand, 2010). Moreover, case examples should be multi-culturally sensitive and appropriate. The identified competencies also covered the importance of communicating the CBT-based psychoeducational material in a manner which is engaging, accessible, and accurate. This has much in common with the interpersonal effectiveness item of the CTS-R (Blackburn et al., 2001), but reconsidered at a group level of delivery.

Several *process* competencies (items 1 and 3) pertained to the organisational and time management skills of group facilitators. Given the limited number of sessions and structured nature of group psychoeducation (White & Keenan, 1990), it follows that these competencies are essential to ensure that all relevant psychoeducational materials are covered and that sessions are well paced. Additionally, one competency (item 2) highlighted the role of facilitator presentation skills. This is also congruent with the format of group psychoeducation (Brown et al., 2004) and is consistent with NICE (2011a) guidelines suggesting that psychoeducational groups should contain clear presentations of key materials. Three process competencies (items 19 to 21) emphasised the importance of facilitators responding effectively to feedback and being able to assess strengths and weaknesses in their own low-intensity practice. These competencies are consistent with the literature which

emphasises the importance of reflective practice (Bennet-Levy, 2006; Bennett-Levy, Thwaites, Chaddock & Davis, 2009).

Within the *process* competencies there was also an emphasis on facilitating change. Items 9 to 11 emphasised the role of the group facilitator in supporting, encouraging, and guiding patients in the effort to change. Good psychoeducation needs to have a clear emphasis on change (Pilling, Cape, Newman & Hardy, 2015, appendix 9). However, there was also a focus in the current study on placing appropriate responsibility and autonomy on the patient in enabling change. This is consistent with the PWP role which is defined as that of a self-help coach rather than a traditional psychotherapist (NHS, 2010). These distinctions between low- and high-intensity CBT also reflect the fact that the competencies identified clearly map onto facilitator and teacher competency frameworks (DoE, 2011; National College for School Leadership, 2010; The International Institute for Facilitation, 2003).

A substantial number of *process* competencies (items 4-8 and 14-18) related to the utilisation of interpersonal skills (e.g. warmth, empathy, confidence) and processes (e.g. managing group dynamics, emotional expression, and their impact). Facilitating an effective group atmosphere is thought to contribute to improved group cohesion in group psychotherapy (Burlingame, Fuhriman & Johnson, 2002), which is associated with improved treatment outcomes (Burlingame, McClendon & Alonso, 2011; Norcross & Lambert, 2018). Regardless of intensity of intervention, CBT needs to be delivered in the context of sound interpersonal effectiveness skills (Blackburn et al., 2001). Interventions that contribute to an improved emotional climate include expressing warmth and empathy and modelling an accepting, non-judgemental and non-evaluative stance (Burlingame et al., 2002). During more interactive (i.e. workshop-based) interventions, practitioners understanding and appropriately managing intragroup and intrapersonal exchanges comes to the fore (Burlingame et al., 2002). Moreover, if group facilitators can enable a sense of relatedness

between patients then this can also reduce dropout from psychoeducation (Firth, Delgadillo, Kellett & Lucock, 2019), despite previous research suggesting normalisation is easily achieved during large group psychoeducational interventions by merely attending the intervention (Kellett et al., 2007). Competencies related to risk management (item 13) and maintaining a professional demeanour (items 22-24) were also identified. This is congruent with guidelines which suggest that the appropriate management of risk is a vital competency for any mental health practitioner (Department of Health, 2009). Similarly, the importance of maintaining a professional demeanour has been noted across psychotherapies, regardless of intensity, as poorly managed boundaries undermine interventions and harm patients (Pope & Keith-Spiegel, 2008).

The *group conclusion* competencies referred to the development, setting, and exploration of homework with patients. Group psychoeducation participants that engage with homework more often tend to attain better treatment outcomes (Joice & Mercer, 2010). Therefore, this highlights the importance of facilitators adequately setting homework at the end of groups as a routine aspect of group psychoeducation. This also connects to the NICE (2011a) guidelines for group psychoeducation that stress the role of between-session experiential learning via clear homework exercises. During psychoeducational groups, then the homework in early sessions will be based more in enabling better recognition of problematic patterns (e.g. via completion of mood diaries for example), with later homework more emphasising change (e.g. behavioural activation in the face of low mood).

This Delphi study had a number of methodological limitations worthy of note. Due to the high level of commitment required to take part in a Delphi study, this likely introduced selection bias (Iqbal & Pipon-Young, 2009). Therefore, it is possible that a different panel could reach different conclusions or identify additional items (Iqbal & Pipon-Young, 2009). The primary study weakness was the attrition rates between rounds 2 and 3, which may have

introduced attrition bias into the findings from round 3. Our final study sample of 16-23 participants per round is considered to be adequate to produce reliable and stable results (Akins et al., 2005; Hallowell & Gambatese, 2010; Johnson, 1976), but it was broadly on the lower end compared with some studies (Akins et al., 2005). Therefore, this could be considered a limitation of our study. Some competencies may also subsequently prove difficult to operationalise in an observational competency measure (Fairburn & Cooper, 2011). Finally, the use of an expert panel could be seen as a potential source of bias and future research might benefit from supplementary approaches such as framework analysis.

To conclude, this study has taken the first steps to identifying a potential framework for assessing competence in facilitating CBT-based group psychoeducational interventions. Although we acknowledge limitations with this study, we believe that this framework could provide a foundation to developing and testing a competency measure in future. Future research directions include refining the framework further in order to address limitations, piloting a corresponding competency measure in collaboration with key stakeholders, and testing its psychometric validity and reliability. A primary reliability test will be intra-class correlations (ICCs) between expert raters of facilitator group psychoeducational competency (Kanada et al., 2015). If successfully translated into a valid and reliable competency measure, these items could thereby provide a framework within which competence in facilitating CBT-based group psychoeducational interventions can be measured. The availability of such a measure of would also create the possibility of then integrating assessment of group psychoeducational competencies into the PWP training course curriculum. A validated measure could also allow researchers to better assess competency of delivery in any evaluation of group-based psychoeducation, therefore supporting the internal reliability of future clinical research trials. The importance of such a measure is supported by the large

numbers of patients being treated in psychoeducational groups who need to be better served with appropriate clinical governance methods and structures.

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Conflict of Interest

Louise Noble, Nick Firth, Stephen Kellett, and Jaime Delgadillo have no conflicts of interest with respect to this publication.

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Ethical Statements

The authors have abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS. Ethical approval for the study was granted from the University of Sheffield Research Ethics Committee (#024005) and the study was pre-registered using AsPredicted (#21318).

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	Delphi Participants (N = 28)
Age	
Mean (SD)	34 (8.3)
Gender	
Male	8
Female	20
Years of Experience	
Mean (SD)	7.2 (7.6)
Role	
Trainee PWP	2
PWP	13
Senior PWP	7
IAPT Course Lead/Trainer/Director	4
Other	2
Highest Qualification	
Bachelor's Degree	1
Postgraduate Certificate	20
Master's Degree	4
Doctorate	3
Disorders Participants Have Experience of Working With	27
Generalised Anxiety Disorder	27
Depression	21
Phobias	21

Obsessive Compulsive Disorder	23
Panic Disorder	5
Health Anxiety	10
Other	

Table 1: Demographic data of Delphi study participants. *Note.* Of the 29 individuals who took part in at least one round of the Delphi study, one did not complete the demographic questionnaire, hence demographic data was only available for 28 participants.

CBT-Based Group Psychoeducational Intervention Competencies	Level of consensus (% of participants who rated 8 or higher)
Set-Up	
1. Set boundaries, procedural guidelines, group rules, process norms, and participant responsibilities (i.e. Regarding participation and what is expected of participants) (D&W)	87.5
2. Utilise and communicate a clear agenda, structure and learning objectives for each session (D&W)	75
3. Establish guidelines regarding confidentiality (W)	75
4. Outline the purpose of the group (W)	75
Content	
1. Present materials in an engaging and enthusiastic manner in order to maintain engagement of participants (e.g. Be enthusiastic, break up content using different modes of delivery such as video, presentations, and written material, bring content alive with examples) (D)	93.8
2. Utilise examples given by participants to benefit of the group by relating them back to the psychoeducational material (D&W)	75
3. Clear and accurate communication of psychoeducational concepts (e.g. Utilising appropriate metaphors and relatable/relevant examples, simplifying complex topics/ideas, jargon-free, variety of materials) (D&W)	81.3
4. Provide and clarify a meaningful rationale for treatment, reviewing as necessary	87.5
5. Demonstrate/possess knowledge of psychoeducational materials and CBT theory, rationale, interventions and change processes (D&W)	87.5
6. Adhere to principles of intervention (D&W)	93.8
Process	
1. Good organisation and administrative skills (e.g. Prepared for sessions, appropriate resources at hand, knowledge of attendees) (D&W)	75
2. Good presentation skills (e.g. Confidence, projection and intonation, not just reading off slides, familiar with slides, not repetitive, logical flow) (D&W)	93.8

3.	Demonstrate time management skills (i.e. Makes effective use of time, ensures group stays on track to cover everything on agenda) (D&W)	87.5
4.	Utilise appropriate non-verbal cues (e.g. Eye contact, calm, confident and relaxed body language) (D&W)	75
5.	Utilisation of interpersonal skills (e.g. Warmth, patience, empathy, active listening, assertiveness, appropriate humour) (D&W)	81.3
6.	Maintain an objective, non-defensive, and non-judgemental stance (D&W)	81.3
7.	Project confidence in own skills and ability to lead the group (D&W)	81.3
8.	Work equally, supportively, and co-operatively with co-facilitators (D&W)	81.3
9.	Support and encourage behaviour change (D&W)	100
10.	Encourage participants to take a responsible and conscientious attitude to their own work and study (D&W)	75
11.	Create and maintain a stimulating and productive environment in which participants are engaged with interactions that stay focused on achieving the goal (D&W)	81.3
12.	Able to effectively answer questions and challenges posed by group members regarding psychoeducational material and address misunderstandings (D&W)	93.8
13.	Utilise appropriate risk management plan (D&W)	93.8
14.	Manage and resolve disruptions and inappropriate behaviour appropriately and in accordance with agreed rules (i.e. Utilising containment skills, sensitively closing inappropriate discussions, diffusing conflicts between participants) (D&W)	87.5
15.	Demonstrate an awareness of and appropriately manage group dynamics (i.e. Prevent individuals from dominating the conversation, aware of the impact of an individuals' behaviour on the group and acting in accordance, encourage quieter members to contribute) (D&W)	75
16.	Manage the disclosure of personal experiences and emotions sensitively (W)	75
17.	Value each individual and ensure everyone has equal access to resources within the group (D&W)	81.3
18.	Encourage positive regard for the experience and perception of all participants (D&W)	87.5
19.	Take responsibility for improving facilitation through appropriate professional development, and responding to advice and feedback from colleagues (D&W)	75

20. Evaluate and respond effectively to group feedback (D&W)	75
21. Demonstrate awareness/accurate self-assessment of own strengths and weaknesses (D&W)	73.3
22. Demonstrate emotional self-control (D&W)	73.3
23. Model professional boundaries and ethics (D&W)	86.7
24. Act with integrity (D&W)	93.8
Conclusion	
1. Develop and set clear and relevant homework tasks/out-of-session activities to consolidate and extend participants' acquired knowledge and understanding. (D&W)	93.8
2. Explore how homework/out-of-session activities will be completed with the group and any barriers to completion. (D&W)	87.5

Table 2: Practitioner competencies for the facilitation of CBT-based group psychoeducational interventions which reached consensus and their respective levels of consensus. *Note.* Letters in parentheses after each competency indicate the type of group psychoeducational intervention they are endorsed for. D = Didactic, W = workshop.

Shortened, Expert-Reviewed CBT-Based Group Psychoeducational Intervention Competencies

Set-Up
Set boundaries, procedural guidelines, group rules, process norms, and participant responsibilities (i.e. Regarding participation and what is expected of participants) and outline group purpose (D&W)
Utilise and communicate a clear agenda, structure and learning objectives for each session (D&W)
Content
Present materials in an engaging and enthusiastic manner in order to maintain engagement of participants (e.g. Be enthusiastic, break up content using different modes of delivery such as video, presentations, and written material, bring content alive with examples) (D)
Clear and accurate communication of psychoeducational concepts (e.g. Utilising appropriate metaphors and relatable/relevant examples, simplifying complex topics/ideas, jargon-free, variety of materials) (D&W)
Demonstrate/possess knowledge of psychoeducational materials and CBT theory, rationale, interventions, and change processes (D&W)
Process
Good organisation and administrative skills (e.g. Prepared for sessions, appropriate resources at hand, knowledge of attendees) (D&W)
Good presentation skills (e.g. Confidence, projection and intonation, not just reading off slides, familiar with slides, not repetitive, logical flow) (D&W)
Utilisation of interpersonal skills (e.g. Warmth, patience, empathy, active listening, assertiveness, appropriate humour) (D&W)
Support and encourage behaviour change (D&W)
Able to effectively answer questions and challenges posed by group members regarding psychoeducational material and address misunderstandings (D&W)
Appropriate approach to risk management issues which may arise (D&W)
Demonstrate an awareness of and appropriately manage group dynamics (i.e. Prevent individuals from dominating the conversation, aware of the impact of an individuals' behaviour on the group and acting in accordance, encourage quieter members to contribute) (D&W)
Demonstrate awareness/accurate self-assessment of own strengths and weaknesses (D&W)
Model professional boundaries and ethics (D&W)

Conclusion
Develop and set clear and relevant homework tasks/out-of-session activities to consolidate and extend participants' acquired knowledge and understanding. (D&W)
Explore how homework will be completed with the group and any barriers to completion (D&W)

Table 3: Shortened, expert-reviewed list of practitioner competencies for the facilitation of CBT-based group psychoeducational interventions. *Note.* Letters in parentheses after each competency indicate the type of group psychoeducational intervention they are endorsed for. D = Didactic, W = workshop.