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GOVERNED PSYCHOLOGICAL THERAPIES: (Psychological Therapies, Low Intensity Interventions and Psychological Well-Being Interventions)

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1 Introduction

This document has been created to provide a governance framework for psychological therapies within Tees, Esk and Wear Valleys NHS Foundation Trust (TEWV) provided by staff from all professions. It outlines the psychological therapies that we have agreed for use within the Trust and the process by which this agreement has been made. The psychological therapies which come within this assurance framework are therefore termed 'Governed Psychological Therapies' (GPT). This document outlines the competencies, training, qualifications, supervision and CPD requirements of staff who use the GPTs within their clinical practice to achieve, develop and maintain their skills.

High standards of psychological therapy provision need to be maintained as increasing numbers of staff practice an increasing number of psychological therapies. Governed Psychological Therapies should only be provided by clinical staff who have received appropriate training, achieved the necessary standards of competence, and who adhere to on-going supervision and continuing professional development (CPD) to maintain skills.

Ensuring that staff providing GPTs meet the training and supervision requirements provides assurance for the Trust of the quality and safety of psychological therapies delivery. The document therefore provides the governance for all TEWV staff, irrespective of profession, who are providing psychological therapies.

Low Intensity Interventions are also described in this document to provide the assurance regarding delivery of these specialised interventions.

The document also includes 'Psychological Well-Being Interventions' (PWBIs) for staff who are using approved materials and under appropriate guidance for our service users, patients and their carers. Guidance is given in this section to ensure that these are offered appropriately and in accordance with the evidence for safe and effective practice.

Where it is possible for other staff to provide principles and techniques under the guidance or supervision of qualified staff, then this is also described in this document.

Information within this document regarding the use of psychological therapies, low intensity interventions and psychological wellbeing interventions within TEWV has been supported and endorsed by both national and local strategies to transform services and improve access to psychological therapies.

This procedure is critical to the delivery of OJTC and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism.

2 Purpose

Following this procedure will help the Trust to:

- Define the main approaches to Governed Psychological Therapy, (the GPTs).
- Define the Low Intensity Interventions that are delivered within the trust.
- Define the Psychological Well-Being Interventions (PWBIs) that are delivered within the trust.
- Outline the process for agreeing that a psychological therapy will be included in the trust provision of psychological intervention, either as a GPT, a PWBI or a Low Intensity Intervention.
- Define the training, supervision and CPD requirements of the above for all clinical staff providing the GPT
- Define the requirements to be able to provide supervision within the above for all clinical staff
- Provide requirements for the audit of provision of the above
- Outline the responsibilities for all clinical staff (all professions) within TEWV to adhere to these guidelines and how to raise concerns appropriately where the guidance is not being met.

3 Who this procedure applies to

This procedure applies to all clinical staff members of all professional groups who are delivering governed psychological therapies and must be adhered to when they are using the relevant activity codes on patient care records.

Psychological Professions staff are to follow the TEWV Psychological Professions CPD strategy document to gain agreement for training and CPD for the GPTs and interventions within this document.

Staff who are not Psychological Professions must follow the guidance for GPTs within this document and are advised to discuss with GPT leads and Psychological Professions Leads prior to accessing training to ensure they are able to meet the training requirements, can access the required supervision as outlined in this document and that the training is appropriate for the clinical service in which they are working. This is to be done in advance of the training. There is limited supervisory capacity within the trust for many of the GPTs and therefore it is essential that this is agreed in advance of any resource commitment to further training.

4 Related documents

Please also note the related document:

- Clinical Supervision Policy
- TEWV Psychological Professions CPD strategy
- TEWV Interpreting and Translation Procedure

5 Core governance requirements for therapy practice

- The principles of clinical governance require that psychological interventions are provided to a standard consistent with current professional perspectives on good standards and competent practice. This is a core ethical requirement and the responsibility of all relevant managers and all individual professionals.
- It requires that basic and subsequent training provides individuals with sufficient skills to practice, and that clinical supervision and CPD maintain and enhance those skills and knowledge and monitor basic levels of safe practice. In addition, it requires that those staff offering clinical supervision also do so within these guidelines.
- In all contexts, professionals are required to make their best judgements about the nature and quality of clinical practice.
- All staff providing a GPT must hold a professional registration with a regulatory body. This must be one of the following: HCPC, NMC, GMC, SW-E, or an organisation which is regulated by the Professional Standards Authority (PSA), such as UKCP or BABCP. If there are any queries, please contact a senior psychologist, or the Chief Psychological Professions Officer.

5.1 Training and Supervision

Staff providing Psychological Interventions must have appropriate:

- **Training:** As defined in this document for each of the interventions. Please note that there are entry requirements for some training, and these are an essential part of the governance.
- **Supervision:** Be receiving clinical supervision that fulfils the requirements of the Trust Supervision Policy, and, in addition, what is described for the psychological intervention in this document. Staff that are required by the Trust to be

accredited/registered with a professional psychotherapy body in order to fulfil the requirements of their role must adhere to the clinical supervision requirements of those organisations.

Where a therapist is qualified in more than one therapy, the expectation is that supervision and CPD will be pro-rata based on the actual work being carried out. So, someone practising CAT and DBT would not access supervision for both therapies at the same rate as someone practising just CAT full time. There must always been an appropriate balance between the amount of supervision and CPD accessed, and the time spent on that therapy with clients. Therefore, consideration must be given within discussion when staff trained in one specialist area would like to train in additional models to ensure that this is for the benefit of developing the service.

5.2 Raising Concerns

If any staff member has any concerns regarding adherence to the guideline in this document or has any other area of concern regarding the provision of psychological interventions, this should be raised with the Psychological Professions lead in the service area, or a more senior psychological professional, or the Chief Psychological Professions Officer.

5.3 Use of codes by staff while undergoing training

While staff are in training for a psychological therapy or as an Applied Psychologist or other professional training, and where this is in line with the guidelines in this document, i.e., that the training will lead to qualification in the intervention, and that they are receiving the appropriate clinical supervision, then they are able to use the code while in training.

5.4 Governance requirements in relation to audit:

- All staff providing psychological therapies are required to record their therapeutic work in adherence to the guidance noted in this document for direct activities. This enables audit processes whereby assurance can be given regarding the safe provision of the psychological therapies.
- An audit programme regarding psychological therapy provision addresses the following areas and is overseen by the GPT steering group, and PPGG (Psychological Professions Governance Group):

- Clinical activity in relation to the Governed Psychological Therapies, Psychological Well-Being Interventions and Low Intensity interventions.
- The services and professions involved in therapy provision.
- The training received by those staff.
- The clinical supervision received by those staff.
- The training received by those staff offering supervision.

6 Consideration regarding provision of Psychological Interventions within TEWV

6.1 The Governed Psychological Therapy (GPT) Steering Group

The GPT steering group is a formal part of the Psychological Professions Governance within TEWV, reporting directly to the PPGG (Psychological Professions Governance Group) to provide assurance regarding the psychological therapies we offer to people who use our service and parents/ carers.

We recognise the benefits of having a broad range of psychological therapies on offer for people who use our services and to encourage a culture of development and innovation within our practice. With new therapeutic approaches becoming available it is therefore essential that appropriate scrutiny is in place.

The GPT steering group provides:

- Scrutiny of the GPTs we offer in terms of evidence base and training requirements to acquire skills to meet the needs of the client groups we work with.
- An alignment of psychological therapy provision to pathways of care.
- Consideration of whether training meets standards/ requirement to meet the psychological therapies job description.
- Upkeep of the GPT document
- Audit, evaluation and effectiveness

Membership of the GPT Steering group is:

Chief Psychological Professions Officer (Chair), Associate Directors of Therapies (if a Psychological Profession), Speciality Psychological Professional Leads, GPT leads, Psychological Therapist lead.

6.2 Acquiring GPT status

To be included in the GPT assurance framework, the considerations outlined in the table below, are brought to the steering group for collective scrutiny and approval. If the steering group agrees, then approval is granted, and this document is updated with the required information. A lead is allocated and invited onto the steering group.

Name of GPT.
Recommended intervention for whom (e.g., NICE guidance, expert consensus, emerging practice)
Entry requirement to training (prior qualifications)
Hours of taught practice. • **Clinical** • **Theory**
Case formulation skills included
Knowledge assessment. **State requirements for assessment against set competencies**
Clinical Practice Requirement
Supervision Requirement
Model Adherence Assessment
Other

7 The Governed Psychological Therapies

7.1 Art Psychotherapy [GPT8]

Description

The terms Art Psychotherapy and Art Therapy are interchangeable – both are protected terms.

Art psychotherapy is a form of psychotherapy that uses art media as its primary mode of expression and communication. Within this context, art is not used as diagnostic tool but as a medium to address emotional issues which may be confusing and distressing.

Art therapists work with children, young people, adults and the elderly. Clients may have a wide range of difficulties, disabilities or diagnoses. These include emotional, behavioural or mental health problems, learning or physical disabilities, life-limiting conditions, neurological conditions and physical illnesses.

Art therapy is provided in groups or individually, depending on clients' needs. It is not a recreational activity or an art lesson, although the sessions can be enjoyable. Clients do not need to have any previous experience or expertise in art.

Although influenced by psychoanalysis, art therapists have been inspired by theories such as attachment-based psychotherapy and have developed a broad range of client-centred approaches such as psycho-educational, mindfulness and mentalisation-based treatments, compassion-focussed and cognitive analytic therapies, and socially engaged practice. Exploring the links between neuroscience and art therapy has also been at the forefront of some of the BAAT's conferences. Importantly, art therapy practice has evolved to reflect the cultural and social diversity of the people who engage in it.

Associated NICE guidance.

- Art Psychotherapy, or the use of art, is cited within the psychological and psychosocial interventions in the following clinical guidelines:
- Psychosis and Schizophrenia for Young People – CG155
- Child Abuse and Neglect – NG76

- Overview | End of life care for infants, children and young people with life-limiting conditions: planning and management | Guidance | NICE (NG61)
- Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE
- Myalgic Encephalomyelitis / Chronic Fatigue Syndrome – NG206
- Overview | Older people: independence and mental wellbeing | Guidance | NICE

Training requirements

An undergraduate degree in Arts then Postgraduate Art Psychotherapies training through an accredited art psychotherapies training institute leading to a Masters Qualification and HCPC registration. Art Psychotherapists are registered with HCPC and- their professional association is the British Association of Art Therapists (www.BAAT.org).

For further information regarding Art Psychotherapy, please visit www.BAAT.org

Supervision Requirements

As required by Trust and BAAT association protocols. 1 hour weekly, fortnightly or at a minimum monthly, depending on experience and the amount of patient/client weekly contact. If working with children, weekly to fortnightly supervision is required, and when working with adults the number of patients/clients seen each week and the patient/client group should be taken into consideration. Supervisors are required to have psychodynamic or compatible training and will have undergone personal therapy as part of their training.

Qualifying as a Supervisor

A short training is provided by the British Association of Art Therapists- 2 day - which helps a practitioner begin to understand the skills needed for supervision. Further and more extensive level 6 qualification are available through BAAT. Providing supervision is something that can be done with two years of full- time practice- gaining qualifications and specific support to provide clinical supervision is preferred.

On-going CPD requirements

In order to remain registered, Art Psychotherapists need to maintain their CPD portfolio and engage in and attend opportunities for the continuation of their development. This portfolio can be audited by HCPC when the professional group comes to that part of the auditing cycle. It is considered that 40 hours of CPD a year for a full-time post is required.

7.2 Attachment-Based Therapy for Children and Young People [GPT13]

Therapy with children and young people based on attachment theory and delivered primarily through parents and carers with an appreciation that the core of the work is helping children feel safe and able to connect with care-givers and have their attachment needs consistently responded to, in order that they no longer need to engage in unhelpful and hard to manage survival behaviours. Approaches include Dyadic Developmental Psychotherapy, Mentalization-based approaches, such as the AMBIT model, Theraplay® and Fillial Therapy, and Life Story Work.

Dyadic Developmental Psychotherapy (DDP) as initially created by Dr Dan Hughes, a Clinical Psychologist in the USA for use in his work with care experienced children and the people and families who support them. DDP is both an attachment-focused family therapy and a practice model for parents and professionals around a child. In DDP therapy parents and carers are supported to more closely attune to their child and deepen their intersubjective connection in order to overcome the isolation of the child's early trauma and repair their capacity to trust and accept co-regulation. Dyadic Developmental Psychotherapy (DDP) is a treatment approach to trauma, particularly Developmental Trauma, neglect, loss and/or other dysregulating experiences and is based on principles derived from attachment theory and research and also incorporates aspects of treatment principles for Post-Traumatic Stress Disorder (PTSD), in particular the value of a coherent narrative through an empathic connection which supports the child to process their affective experiences and responses without blame or shame.

Two parenting support approaches using DDP are well known and have a strong evidence base, namely the 'Foundations for Attachment' and 'Nurturing Attachments', six and 18 week parenting support groups developed by Dr Kim Golding, Consultant Clinical Psychologist, CBE. and colleagues two decades ago.

Supervision

Following Level One and Level Two training the importance of supervision in the model from a Consultant in DDP cannot be overstated in order to embed the model into an individuals practice and ensure model fidelity and coherence. Supervision needs to be from a Consultant in DDP or from an experienced Certified Practitioner who is receiving DDP supervision from a DDP Consultant. Ongoing supervision from a DDP Consultant is a core part of the psychotherapy model.

Training, and CPD

Level one and Level Two trainings are widely available in small in person groups. Training allows people to become familiar with the core aspects of the model, in particular the mnemonic P.A.C.E..

DDP has become synonymous with P.A.C.E., which stands for Playfulness, Acceptance, Curiosity and Empathy, and guides the parent, professional or practitioner in a way of being with the child and their lived experience.

Training in Level One and Level Two allow individuals to use the principles of DDP in their practice. This can be helpful for many in the psychological professions who are working with children and adults with complex trauma, particularly developmental or shame-based trauma, to deepen their relational practice.

Following Level One and Level Two training the importance of supervision in the model from a Consultant in DDP cannot be overstated in order to embed the model into an individuals practice and ensure model fidelity and coherence.

Some people like to use their development in supervision to work through the Practicum, a process of training where DDP practitioners are supported through video-feedback on their work to complete a minimum of ten reviewed videos of them providing DDP. This usually takes at least a year and is always supervised by a Consultant in DDP and ratified (or otherwise) by a second Consultant at the mid-point and the end. Practicum training requires services to recognise the need for professionals to have family cases where they can learn their skills.

Once Certified Practitioners have had time to embed their skills, and while still in receipt of Consultant supervision, they can then explore becoming a consultant in DDP themselves, a process which can also take about a year.

All Consultants in DDP must have supervision from another DDP consultant at least four times per year, and all Certified Practitioners and Consultants must re-certify every three years by submitting evidence of their work to their supervisor.

7.3 Behaviour Therapy [GPT11]

The term 'Behaviour Therapy' refers to:

Behavioural interventions based on the principles of a scientific approach for discovering environmental variables that reliably influence socially significant behaviour and for developing a technology of behaviour change that takes practical advantage of those discoveries. All other forms of behavioural interventions should be coded under cognitive behaviour therapy.

Behavioural therapy approaches utilise behavioural learning theory and social learning theory to inform the management of behavioural disturbance and functional mental health problems. These theories seek to understand how the environment can influence how we learn and therefore learning and behavioural patterns can be modified by altering the environment around us. Behavioural therapy is the 'B' in CBT. For many functional mental health difficulties, the combination of cognitive and behavioural approaches are used but the optimum mix of these is unclear. The uses of behavioural approaches such as exposure therapy have a strong evidence base in their own right in the treatment of many anxiety disorders. Behavioural therapy principles can also be applied in their own right in a number of situations where it is not possible to apply cognitive techniques. For example, in situations where cognitive impairment is present, behavioural techniques may be one of the few therapy options available for depression and anxiety.

Behavioural therapy can also be extremely effective in the management/therapy of behaviours that challenge and may be the therapy of choice in forensic, learning disability, dementia, and neuropsychiatric settings.

Applied Behavioural Analysis is a scientific approach for discovering environmental variables that reliably influence socially significant behaviour and for developing a technology of behaviour change that takes practical advantage of those discoveries. It is a key component of positive behavioural support, which is an evidence-based approach used with people with learning disabilities who display distress in ways that services perceive as challenging. Behaviour Practitioners* conducting functional behaviour assessments and designing function-based interventions must therefore have a qualification in behaviour analysis or PBS appropriate to their role and receive regular supervision.

Supervision

Supervision should be consistent with the Trust Supervision Policy. Behaviour Practitioners specialising in behaviours that challenge must receive supervision from an a more experienced practitioner specialising in ABA/PBS. For Adult Learning Disability (ALD) services supervision arrangements are detailed in the TEWV ALD Behaviour Practitioner framework.

Training

Clinical or Counselling Psychology Doctorate; or Forensic Psychology Stage 2 training leading to HCPC registration.

For Behaviour Practitioners specialising in behaviours that challenge, training requirements are dependent on role and required knowledge, skills, and competencies. Minimum academic level 5 qualification in PBS for Behaviour Practitioners; PG Diploma in PBS or ABA leading to MSc for Advanced Behaviour Practitioners. Behaviour Analyst Certification Board (BACB) certification; UK Society for Behaviour Analysis certification; Practitioners currently in training leading to UK Society for Behaviour Analysis certification. For Adult Learning Disability (ALD) services training/qualification requirements are detailed in the TEWV ALD Behaviour Practitioner framework.

7.4 Cognitive Analytic Therapy (CAT) [GPT6]

Cognitive Analytic Therapy (CAT) is a brief, focussed, integrated psychotherapy and provides a structured, approach to a range of mental health problems in the NHS. CAT integrates cognitive, cognitive behavioural and psychoanalytic approaches, at the level of theory and practice. Its practice emphasises developing a powerful early therapeutic alliance, and the capacity for self-reflection, fostered through the use of collaborative formulatory tools, such as written formulations, and diagrams. Like psychoanalytic psychotherapy, CAT is appropriate for people with primary disturbances and in inter- personal relationships and intra-personal relationships. Like cognitive behaviour therapy, it can be used with people who lack the interest and capacity for self-exploration and self-reflection that may be particularly important for success in psychoanalytic and psychodynamic therapies. CAT has been particularly applied with people where there is some level of 'dissociation' of different states of mind, such as people diagnosed with severe personality disorder.

Recommended treatment for

Adults and Older Adults with Complex Emotional Needs Psychological therapies for severe mental health problems | NHS England | Workforce, training and education

Competencies required to use this code

CAT competence framework UCL ACAT

Training Routes to achieve competencies

2-year CAT Practitioner course which is accredited by Association of Cognitive Analytic Therapy (ACAT).

Training Entry Requirements

A first degree, equivalent qualification, or other evidence of academic capability. Relevant experience of working with people in a mental health setting within therapeutic boundaries, and either a qualification in an NHS recognised core profession (e.g. nursing, applied psychology, medicine, occupational therapy, social work), or evidence and qualification which demonstrates an

equivalent level of competence. It is desirable for applicants to have attended an introduction to CAT workshop or equivalent.

Accreditation

Accreditation as a Practitioner and supervisor is with Association of Cognitive Analytic Therapy (ACAT). Practitioner Course graduates are eligible to apply to do a further two years Psychotherapy Training in CAT (IRRAPT), leading to UKCP registration.

Supervision Requirements

Practitioner Training: weekly supervision with an ACAT accredited CAT supervisor. Group, face to face, supervision is the preferred model. Group capacity is required to provide 15 minutes per case per week.

Accredited CAT Practitioner: a minimum of 1.5 hours per month planned CAT supervision in group or individual supervision with either an ACAT Accredited Supervisor or an ACAT trainee supervisor. The minimum supervision arrangement for CAT Practitioners is peer supervision with other CAT Practitioners eligible for ACAT Practitioner membership. In some circumstances, a combination of peer-supervision with other CAT therapists in consultation with an ACAT accredited supervisor may be acceptable for the maintenance of ACAT CPD. There needs to be a minimum of 1.5 hours per month planned CAT supervision in group or individual supervision. In the case of CAT practitioners in peer supervision, ACAT would consider that the minimum involvement of an ACAT accredited supervisor would be to agree with each supervisee in the group the suitability of their prospective supervision arrangements for the coming year, as part of their annual CPD Personal Development plan, drawn up in accordance with the ACAT CPD policy.

Accredited CAT Supervisor

CPD requirements

CAT Practitioners and ACAT-only Psychotherapists are required to complete 30 hours of CPD every year, 20 hours of which needs to be relevant to their CAT practice and 10 hours of which may be generic.Each full day (e.g. at a training workshop) counts as five hours CPD activity, each half day counts as three hours. The member must demonstrate that their CPD activities are a mixture of activities relevant to current or future practice.

For further information regarding CAT, please visit http://www.acat.me.uk/page/about+cat

7.5 CAT care planning (5 session CAT) [GPT24]

The term CAT care planning (5 session CAT) refers to:

- CAT care planning with client and staff member (usually care co-ordinator) provided by a CAT practitioner or 2nd year Trainee CAT Practitioner

Frequently referred to as “5 session CAT”, this is an approach that involves a CAT practitioner meeting with a client and their care co-ordinator, usually for 5 sessions, to map the formulation of the client’s difficulties (with particular focus on relationships with staff/services) and then this is used to inform/develop the treatment plan. Time is planned before and after the hour with the client (usually half an hour, depending on service setting) for the CAT practitioner and care co-ordinator to meet to reflect upon the session and elicited responses, develop the formulation, support the staff member and inform the treatment plan (ref Carradice, 2013).

Supervision

Supervision requirements for CAT care planning are same as noted above for CAT therapy.

Training

The minimum training required for the therapy to deliver this approach is either an accredited CAT practitioner or a 2nd year trainee CAT practitioner.

CPD requirements

CPD requirements for CAT care planning are same as noted above for CAT therapy.

7.6 Cognitive Behaviour Therapy (CBT) [GPT2]

The cognitive model is based on the theoretical assertion of Beck and others that cognitive processes are central to the psychosocial and emotional functioning of human beings. The way that individuals structure their experiences cognitively is seen as the prime influence on their affect, behaviour and physical reactions. Cognitive theory suggests that psychological disorders are influenced by the meanings that individuals give to events, which are filtered through the framework of core beliefs and assumptions developed through life experience. CBT therapists are interested in the origin of core beliefs, and the individual's appraisal of situations. These can be accessed through their thoughts, images and memories and may become a target for therapeutic change. In addition to the content of cognition, the process of cognition also influences our experience of the world. CBT, or cognitive therapy, is typically offered as an individual psychological intervention on a 1:1 basis. However, it can also be offered using a group format in which more than one client receives the intervention Roth and Pilling Competencies underpin the structure and governance of all CBT Interventions and therapy for full manual and background access information here Roth and Pilling Competencies core competencies are required for all CBT therapy, meta competencies for clinicians working in secondary care settings or specialist services or working with children, young people and their families which are outlined in relation to specific GPT codes later in this document.

Cognitive Behavioural Therapy CORE competencies in CBT.

Generic Therapeutic Competencies

Basic CBT Competencies

Specific Behavioural and Cognitive Therapy Competences

Problem Specific Competencies

Clinicians working in secondary care settings or specialist services need to demonstrate CBT meta competencies.

Clinicians working in CAMHS services need to demonstrate competencies specific to working with children, young people and their families.

Training Requirements

Training Routes:

Two possible training routes. 1 Post Graduate Diploma in CBT, including HIIT, CYPIAPT, SMHP courses. Courses may be accredited level 1, level 2 with BABCP or not accredited.

2. Applied psychology doctorates with substantial training in CBT as part of overall doctorate.

Both routes will have teaching and close supervision and assessment of a clinician's ability to use CBT models to effectively treat anxiety presentations, depression, and PTSD. Trainees at the point of entry to the course must have a core profession or be able to demonstrate an equivalence

knowledge and experience through a Key Skills and Attitudes (KSA) portfolio to be approved by the trust CBT lead and/or the KSA assessor for the host course where available.

Recommended Treatment for:

Depression, Anxiety and PTSD

Evidence Base:

CBT (core competency) is cited within the psychological and psychosocial interventions in the following clinical guidelines.

- Post-Traumatic Stress Disorder (NG116)
- Generalised anxiety disorder and panic disorder in adults management (CG113)
- Depression in Adults: treatment and management (NG222)
- Obsessive Compulsive Disorder and Body Dysmorphic Disorder Treatment (CG31)

Accreditation: Cognitive Behavioural Psychotherapist Accreditation – BABCP

CPD to maintain accreditation and associated competencies: A range of learning and development should be sought, including five reflective statements of CPD events which should include at least six hours of skills development each year.

Supervision requirements:

All supervision arrangements should be agreed with PP lead and CBT lead. Supervision contracts should be reviewed at 6 or 12 monthly intervals.

During training: There may be variance due to course provider. Practitioners should expect to course provided and workplace provided supervision. Workplace supervision provided by BABCP accredited supervisor weekly.

Post training: All staff recording the delivery of CBT need to access supervision with an accredited BABCP clinician. For full time clinical staff 90minutes monthly, including at least one live supervision event per twelve months.

Route to becoming a supervisor:

Accreditation with the BABCP additional supervision focus CPD, minimum of eighteen months practice post accreditation. Supervisors should currently be practicing CBT and providing Cognitive and/or Behavioural therapies as their main (or one of their main) therapeutic models in clinical practice and must be receiving specifically CBT supervision and ongoing CBT CPD.

For further information regarding CBT and BABCP Minimum training standards, please Visit:

- http://www.babcp.com/Public/What- is-CBT.aspx
- Minimum Training Standards (babcp.com)

7.6 Cognitive Behavioural Therapy for Bipolar Disorder [GPT 36] & Group Cognitive Behavioural Therapy for Bipolar Disorder [GPT 40]

Description

Cognitive Behavioural Therapy for Bipolar disorder is a structured, evidence based psychological therapy recommended by NICE as part of a broader, integrated treatment plan. CBT in this context focuses on enhancing mood stability and identifying and modifying unhelpful thinking patterns and behaviours that may contribute to relapse. It is typically delivered during periods of relative mood stability and tailored to support self- management strategies, early warning sign detection and relapse prevention. Effective delivery requires clinicians with specialised training in both CBT and bipolar disorder to ensure fidelity to the model and optimum patient outcomes.

Competencies required:

In addition to CORE competencies in CBT practitioners need to demonstrate both:

Core competencies working with psychosis and bipolar.

Competent using specific CBT evidence-based interventions for bipolar and management of co-existing issues such as depression anxiety, substance misuse

Training Routes:

Those without prior CBT competencies: Complete a two-year CBT Post Graduate Diploma commissioned by Workforce, Training & Education NHS England Psychological therapies for severe mental health problems | NHS England | Workforce, training and education which is designed to meet CBT psychosis and bipolar competencies in year two. Trainees at the point of entry to the course must have a core profession or be able to demonstrate an equivalence knowledge and experience through a Key Skills and Attitudes (KSA) portfolio to be approved by the trust CBT lead and/or the KSA assessor for the host course where available.

Those with prior CBT competencies: Core CBT competencies evidenced through BABCP accreditation achieved following HIT training, CYPIAPT training or a HCPC Registered Applied Psychologist who has already had substantial CBT training as part of their doctorate. Complete a

one year Workforce, Training & Education NHS England commissioned CBT Post Graduate Certificate designed to meet CBT psychosis specific competencies as set our by the frameworks above.

Accreditation: Cognitive Behavioural Psychotherapist Accreditation – BABCP

CPD to maintain accreditation and associated competencies: A range of learning and development, including five reflective statements of CPD events which should include at least six hours of skills development each year.

Supervision requirements:

During training: There may be variance due to course provider however, University supervision, workplace supervision provided by BABCP accredited supervisor year 1. Year 2 workplace supervisor demonstrates above competencies.

Post training: For full time clinical staff 90minutes monthly supervision with an BABCP Accredited supervisor meeting CBTpb competencies as described above.

Route to becoming a supervisor: Demonstrates CBTpb competencies through training as outlined above. Those who have trained as CBT psychotherapist prior to 2020 SMHP training courses has either completed top up or can demonstrate knowledge, skill and practice of related meta competencies through CPD and supervision and has at least eighteen months experience of working with that client group.

Recommended Treatment for: Bipolar Disorder

Associated Guidance:

- Bipolar disorder, psychosis and schizophrenia in young people (QS102)
- Bipolar disorder: assessment and management (CG185)Overview | Bipolar disorder: assessment and management | Guidance | NICE

Training Requirements

Training and supervision sufficient to lead to accreditation as a CBT practitioner with the BABCP plus additional specialist CBTpb training, regular CPD and supervision in CBTpb. Therapist new to CBTpb would be required to complete newly developed National Accredited CBTpb training.

Early cohorts of practitioners involved in developing CBTpb may have undertaken a different route to competence. This might have involved:

- Being a therapist in a CBTpb research trial with supervision from an expert in the field.
- Evidence of attending CBTpb conferences (after receiving generic CBT training), with regular supervision from an expert in the field.

Qualifying as a supervisor

Three years post qualification experience and have attended an appropriate psychological therapies supervisor course. (Supervisors Course, BPS approved DClinPsy Supervisors Course. PG Cert in Clinical Supervision, BABCP registered supervisor optional but not required) CBT practitioner who has additional training, regular CPD and supervision in CBTpb and 2 years + experience working as a CBTpb therapist.

Competencies required to deliver CBTpb supervision can be found Psychological Interventions with People with Psychosis and Bipolar Disorder | UCL Faculty of Brain Sciences

Supervision Requirements

A full-time clinician needs ninety minutes per month (a proportion of this may be delivered in group format) from a BABCP accreditable CBT practitioner who has Competencies required to deliver CBTpb supervision as above.

CPD

For those accredited with the BABCP there is a minimum CPD standard to maintain accreditation which is reviewed on an annual basis.

- Five CPD events
- Minimum of six hours skill practice
- 50 percent of clinical work should be using CBT model.

7.7 Cognitive Behavioural Therapy for Psychosis [GPT 22]

CBTp is an evidence-based psychological intervention recommended by NICE for individuals experiencing psychosis. It is delivered by therapists who have specific competencies for working with psychosis. It is designed to reduce distress, improve functioning, and support recovery by helping individuals understand and manage the thoughts, beliefs, and behaviours associated with their experiences.

CBTp adopts a collaborative and normalising approach, aiming to reduce stigma and validate the lived experience of psychosis. It explores the content of delusions and hallucinations within a structured therapeutic framework, often using models such as the stress-vulnerability framework

Competencies required:

In addition to CORE competencies in CBT practitioners need to demonstrate both:

Core competencies working with psychosis and bipolar.

Competent using specific CBT evidence-based interventions for bipolar and management of co-existing issues such as depression anxiety, substance misuse

Training Routes:

Those without prior CBT competencies: Complete a two-year Complete a one year Workforce, Training & Education NHS England commissioned CBT Post Graduate Certificate which is designed to meet CBT psychosis and bipolar competencies in year two. Trainees at the point of entry to the course must have a core profession or be able to demonstrate an equivalence knowledge and experience through a Key Skills and Attitudes (KSA) portfolio to be approved by the trust CBT lead and/or the KSA assessor for the host course where available.

Those with prior CBT competencies: Core CBT competencies evidenced through BABCP accreditation achieved following HIT training, CYPIAPT training or a HCPC Registered Applied Psychologist who has already had substantial CBT training as part of their doctorate. Complete a one Complete a one year Workforce, Training & Education NHS England commissioned CBT Post Graduate Certificate designed to meet CBT psychosis specific competencies as set our by the frameworks above.

Accreditation: **Cognitive Behavioural Psychotherapist Accreditation – BABCP**

CPD to maintain accreditation and associated competencies: A range of learning and development, including five reflective statements of CPD events which should include at least six

hours of skills development each year. At least one of the five events should be related to psychosis.

Supervision requirements:

During training: There may be variance due to course provider however, University supervision, workplace supervision provided by BABCP accredited supervisor year 1. Year 2 workplace supervisor demonstrates above competencies.

Post training: For full time clinical staff 90minutes monthly supervision with an BABCP Accredited supervisor meeting CBTpb competencies as described above.

Route to becoming a supervisor: Demonstrates CBTpb competencies through training as outlined above. Those who have trained as CBT psychotherapist prior to 2020 SMHP training courses has either completed top up or can demonstrate knowledge, skill and practice of related meta competencies through CPD and supervision and has at least eighteen months experience of working with that client group.

Recommended Treatment for: Psychosis & Schizophrenia

Associated Guidance:

Psychosis and Schizophrenia in adults prevention and management (CG178) Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

Psychosis and Schizophrenia in Adults Nice Guidance Standard (Q580) Overview | Psychosis and schizophrenia in adults | Quality standards | NICE

Psychosis and Schizophrenia in Children and Young People recognition and management (CG155) Overview | Psychosis and schizophrenia in children and young people: recognition and management | Guidance | NICE

7.7 Cognitive Behavioural Therapy for Personality Disorder [GPT 37]

Description

Cognitive Behavioural Therapy for Personality Disorder (CBTpd) is a specialist form of CBT focussing on personality and relational difficulties. It is an individualised formulation driven approach. This approach considers the impact of psychological trauma and neglect on brain function, memory, sense of self, personality and psycho-social development. The approach acknowledges how personality development can be impacted on by of a broad range of adverse experiences in childhood and adulthood, going beyond PTSD. The approach considers techniques and adaptations for working effectively with the consequences of psychological trauma and with personality issues. The focus of interventions may be on increasing those underdeveloped ways of coping, while also reducing those over developed unhelpful ways of coping. CBTpd also has a greater emphasis on working with the core beliefs that drive the way they think, feel and respond to others. CBTpd is be offered on one-to-one basis for minimum of 30 sessions by a therapist with appropriate competences.

Competencies required:

In addition to CORE CBT competencies practitioners working with personality disorder presentations should also demonstrate competencies for working with personality disorders and knowledge and skills in CBT for personality disorder.

Training Routes:

***Those without prior CBT competencies*:** Complete a two-year NHS-E commissioned CBT Post Graduate Diploma which is designed to meet CBT psychosis and bipolar competencies in year two. Trainees at the point of entry to the course must have a core profession or be able to demonstrate an equivalence knowledge and experience through a Key Skills and Attitudes (KSA) portfolio to be approved by the trust CBT lead and/or the KSA assessor for the host course where available.

Those with prior CBT competencies: Core CBT competencies evidenced through BABCP accreditation achieved following HIT training, CYPIAPT training or a HCPC Registered Applied Psychologist who has already had substantial CBT training as part of their doctorate. Complete a one year Workforce, Training & Education NHS England commissioned CBT Post Graduate Certificate designed to meet CBT personality disorder competencies as set out by the frameworks above.

Accreditation: Cognitive Behavioural Psychotherapist Accreditation – BABCP

CPD to maintain accreditation and associated competencies: A range of learning and development, including five reflective statements of CPD events which should include at least six hours of skills development each year. At least one of the five events will be related to CBT for personality disorder.

Supervision requirements:

During training: There may be variance due to course provider University supervision, workplace supervision provided by BABCP accredited supervisor year 1. Year 2 workplace supervisor demonstrates above competencies in CBTpd.

Post training: For full time clinical staff 90minutes monthly supervision with an BABCP Accredited supervisor meeting CBTpd competencies as described above.

Route to becoming a supervisor: Demonstrates CBTpd competencies through training as outlined above. Those who have trained as CBT psychotherapist prior to 2020 SMHP training courses has either completed top up or can demonstrate knowledge, skill and practice of related meta competencies through CPD and supervision and has at least twelve months experience of working with that client group. Supervisors should currently be practicing CBTpd and providing Cognitive and/or Behavioural therapies as their main (or one of their main) therapeutic models in clinical practice and must be receiving specifically CBTpd supervision and ongoing CBT CPD

Recommended Treatment for: Borderline Personality Disorder

Adults and Older Adults with Complex Emotional Needs **Psychological therapies for severe mental health problems | NHS England | Workforce, training and education**

Associated Guidance

- Borderline personality disorder; recognition and management (CG78)
- Personality disorders: borderline and antisocial (QS88)

7.8 Cognitive Behavioural Therapy for Eating Disorders [GPT30] and Group Cognitive Behavioural Therapy for Eating Disorders [GPT41]

The CBT-Ed treatment of eating disorders emphasizes the minimization of negative thoughts about body image and the act of eating and attempts to alter negative and harmful behaviours that are involved in and perpetuate eating disorders. It also encourages the ability to tolerate negative thoughts and feelings as well as the ability to think about food and body perception in a multi-dimensional way. The emphasis is not only placed on altering cognition, but also on tangible practices like making goals and being rewarded for meeting those goals. CBT is a “time-limited and focused approach” which means that it is important for the patients of this type of therapy to have particular issues that they want to address when they begin treatment. CBT has also proven to be one of the most effective treatments for eating disorders. With people who are not significantly underweight, CBT-E generally involves an initial assessment appointment followed by twenty 50-minute treatment sessions over 20 weeks. With people who are underweight treatment needs to be longer, often involving about 40 sessions over 40 weeks. CBT-E is a highly individualised treatment.

Competencies required:

In addition to CORE CBT competencies practitioners working with eating disorder presentations need to demonstrate both:

Eating disorder generic competencies

Competencies specific to CBTed.

Training Routes:

Those without prior CBT competencies: Complete a two-year Workforce, Training & Education NHS England commissioned CBT Post Graduate Diploma which is designed to meet CBT for eating disorders competencies in year two. Trainees at the point of entry to the course must have a core profession or be able to demonstrate an equivalence knowledge and experience through a Key Skills and Attitudes (KSA) portfolio to be approved by the trust CBT lead and/or the KSA assessor for the host course where available.

Those with prior CBT competencies: Core CBT competencies evidenced through BABCP accreditation achieved following HIT training, CYPIAPT training or a HCPC Registered Applied Psychologist who has already had substantial CBT training as part of their doctorate. Complete a

one year NHSe commissioned CBT Post Graduate Certificate designed to meet CBT for eating disorder specific competencies as set out by the frameworks above.

Accreditation: Cognitive Behavioural Psychotherapist Accreditation – BABCP

CPD to maintain accreditation and associated competencies: A range of learning and development, including five reflective statements of CPD events which should include at least six hours of skills development each year, at least one of the five events will be related to the CBT for eating disorders.

Supervision requirements:

During training: There may be variance due to course provider. Practitioners should expect to course provided and workplace provided supervision. Workplace supervision provided by BABCP accredited supervisor weekly. Year one workplace supervisors need to demonstrate CBT competencies as outline above. Year 2 workplace supervisor demonstrate competencies for CBT for eating disorder.

Post training: For full time clinical staff 90minutes monthly supervision with an BABCP Accredited supervisor meeting CBTed competencies as described above.

Route to becoming a supervisor: Demonstrates CBTed competencies through training as outlined above. Those who have trained as CBT psychotherapist prior to 2020 SMHP training courses has either completed top up or can demonstrate knowledge, skill and practice of related meta competencies through CPD and supervision and has at least eighteen months experience of working with that client group. Supervisors should currently be practicing CBTed and providing Cognitive and/or Behavioural therapies as their main (or one of their main) therapeutic models in clinical practice and must be receiving specifically CBTed supervision and ongoing CBT CPD

Recommended Treatment for: Anorexia Nervosa, Bulimia and Binge Eating in Children, Young People & Adults

Associated Guidance

- NICE Eating Disorder Quality Standards (QS175)
- NICE Guideline Eating Disorders: recognition and treatment (NG69)

7.9 Child Psychotherapy [GPT14]

Child and Adolescent Psychotherapy is a treatment approach that uses a range of psychoanalytic and developmental therapies to understand the complex emotional lives of children and young people and families. It is based on a psychoanalytic approach, which seeks to look below the surface of human relationships. Child and Adolescent Psychotherapists assess and treat infants, children and young people and work with their parents, families and the networks surrounding them. Therapists are trained to carefully observe a child or young person and respond to what they might he communicating through their behaviour and play. Child and Adolescent Psychotherapists may see children and young people individually, in groups or with other family members. They also apply their framework of thinking to work with parents, families and carers and to training and supporting other professionals who work with children, young people and families to encourage a deeper understanding of the child's perspective.

Supervision

As required by the Trust protocol. British Psychoanalytic Council (BPC) requirement is a minimum of 15 hours a year. BACP require an absolute minimum of one and a half hours a month.

Training

Training courses leading to accreditation by UKCP Psychoanalytic Section; BPC; Institute of Group Analysis; Clinical or Counselling Psychology Doctorate or Forensic Psychology Stage 2 leading to HCPC registration; training courses leading to BACP accreditation; HCPC registered psychotherapists.

7.10 Counselling [GPT3]

The term **'Counselling'** refers:

- Transactional Analysis
- Gestalt psychotherapy
- Humanistic integrative psychotherapies
- Rogerian/person centred counselling and psychotherapy
- All non-directive-based counselling

Transactional Analysis has elements of psychoanalytic, humanist and cognitive approaches. Transactional analysis was developed by Canadian-born US psychiatrist Eric Berne, during the late 1950s. TA is a theory of personality and psychotherapy for personal growth and personal change.

Gestalt therapy is an existential/experiential form of psychotherapy that emphasizes personal responsibility and focuses upon the individual's experience in the present moment, the therapist-client relationship, the environmental and social contexts of a person's life, and the self-regulating adjustments people make as a result of their overall situation.

Supervision

According to trust protocol and as required by UKCP, based on recommendations related to hours of practice.

Training

Training is a minimum of four years through an accredited psychotherapy training institute leading to a Masters qualification; leading to UKCP registration in humanistic/integrative psychotherapists.

Rogerian/person centre counselling and psychotherapy

This form of counselling is based upon the theory that trusts the innate tendency of human beings to find fulfilment of their personal potentials. An important part of this theory is that in a particular psychological environment, the fulfilment of personal potentials includes sociability, the need to be with other human beings and a desire to know and be known by other people. It also includes being open to experience, being trusting and trustworthy, being curious about the world, being creative and compassionate. The psychological environment described by Rogers was one where a person felt free from threat, both physically and psychologically. This environment could be achieved when being in a relationship with a person who was deeply understanding (empathic), accepting (having unconditional positive regard) and genuine (congruent).

Supervision

As required by the Trust protocol. BACP require an absolute minimum of one and a half hours a month.

Training

Training leading to BACP accreditation; Clinical or Counselling Psychology Doctorate, or Forensic Psychology Stage 2 leading to HCPC registration.

7.11 Dialectical Behaviour Therapy [GPT7]

Description

Dialectical Behaviour Therapy is based on a bio-social theory of borderline personality disorder which sees it as a consequence of an emotionally vulnerable individual growing up within a particular set of environmental circumstances referred to as an 'invalidating environment'. Whilst keeping within the overall model other modes of treatment may be added at the discretion of the therapist, providing the targets for that mode are clear and prioritised.

Recommended treatment for: Borderline Personality Disorder

Adults and Older Adults with Complex Emotional Needs Psychological therapies for severe mental health problems | NHS England | Workforce, training and education

Associated Guidance:

- Borderline personality disorder; recognition and management (CG78)
- Personality disorders: borderline and antisocial (QS88)

Competencies required to use this code

DBT Competencies

Training Entry Requirements

Current registration with a core professional body (e.g., NMC) or HCPC Practitioner Psychologist Previous training in another governed and accredited psychological therapy is desirable though not considered essential.

Training

Eligibility for DBT Therapist Training is a current registration with a core professional body (e.g., NMC) or HCPC Psychologist Registration. Previous training in another governed and accredited psychological therapy is desirable though not considered essential.

There are two routes to DBT Therapist Training:

1) Post Graduate Diploma in DBT (PG Dip-DBT)– Currently available through Bangor University. The PG Dip in DBT is accredited by the Society for DBT in the UK and Ireland (SfDBT) as a Level 3 training course. PG Dip graduates who are members of the SfDBT and who complete the first stage of the SfDBT accreditation application will be immediately accredited.

2) Completion of parts 1 & 2 of DBT Intensive Comprehensive Team based training delivered by British Isles DBT Training (BIDBT) aimed at those establishing a DBT programme. This training is divided into two parts. Part 1 (5 days) teaches the theory and the clinical skills necessary to provide DBT. At the end of Part I clinicians are expected to consolidate their learning evidenced through an exam as well as develop a DBT programme in preparation for Part II (5 Days) where they will return to present their work and receive expert consultation.

Accreditation (if applicable) including CPD requirements to maintain accreditation

- PG Dip graduates who are members of the Society for DBT (SfDBT) and who complete the first stage of the SfDBT accreditation application will be immediately accredited.
- For those that have not completed the PG Dip – DBT, DBT Therapists who have completed training with BIDBT at Intensive level and who have been working in DBT for a minimum of 1 year can apply for accreditation through the SfDBT.
- Applicants must be working in a DBT Programme that delivers all functions and modes of DBT for a minimum of 1 day per week. They must attend a DBT consultation team meeting once a week.
- Before applying, applicants must be an ordinary member of the Society for DBT: UK & Ireland Provided that an accredited therapist maintains their yearly CPD requirements (15-hour CPD per year) and remains in good standing with their core profession, accreditation is valid for 10 years.

CPD Requirements: Yearly CPD requirements for all DBT Therapists are to complete 15 hours CPD through attendance at the annual SfDBT Conference and/ or equivalent DBT related workshops and training events

Supervision Requirements

- As a minimum, weekly attendance at a DBT 'Consult' (clinical supervision) group (2 hours each week) with at least one other qualified DBT therapist.
- Additional weekly supervision on individual basis (one hour weekly) with a qualified and experienced DBT therapist for those with less than 3 years' experience. Individual supervision monthly (1- 1.5 hours each month) for those with 3 years plus experience
- For those attending the PGDip, they will need to have attended 20 hours of 1-1 supervision with a trained supervisor outside of the above in order to fulfil the requirements of the course.

DBT Skills Training Group – The group is not a therapeutic group in the traditional sense but is rather focussed on skills acquisition. Code to be used when client is accepted onto the programme as 'skills only', it is **not** to be used with those attending group who are on 'full' programme

Competencies Required

- There **must be at least one facilitator** who has a current registration with a core professional body (e.g., NMC) or HCPC Psychologist Registration. Previous training in another governed and accredited psychological therapy is desirable though not considered essential.
- The DBT Skills Training group facilitated by at least two therapists.
- The primary Facilitator must have completed foundational level training as a minimum.
- The second facilitator must have a minimum of either the British Isles DBT Training 'Essential Skills' (two day) training or the TEWV (three day) DBT skills training.
- All facilitators must attend team consultation each week when they are involved in the DBT - STG.

Training routes and training requirements

- To have completed at a minimum either the British Isles DBT Training 'Essential Skills' (two day) training or the TEWV Introduction to DBT theory and skills Practice training (three days)

Accreditation (if applicable) including CPD requirements to maintain accreditation

Desirable for those eligible to apply for accreditation as above though not essential

Supervision Requirements

As a minimum, weekly attendance at a DBT 'Consult' (clinical supervision) group (2 hours each week) with at least one other qualified DBT therapist.

7.12 Radically Open- Dialectical Behaviour Therapy (RO-DBT) [GPT51]

Code to be used for staff trained in RO-DBT. Section to be reviewed.

7.13 Dialectical Behavioural Therapy skills group intervention [GPT7]

The group is not a therapeutic group in the traditional sense but is rather focussed on skills acquisition. Code to be used when client is accepted onto the programme as 'skills only', it is **not** to be used with those attending group who are on 'full' programme.

Competencies Required

- There **must be at least one facilitator** who has a current registration with a core professional body (e.g., NMC) or HCPC Registered Practitioner Psychologist. Previous training in another governed and accredited psychological therapy is desirable though not considered essential.
- The DBT Skills Training group facilitated by at least two therapists.
- The primary Facilitator must have completed foundational level training as a minimum.
- The second facilitator must have a minimum of either the British Isles DBT Training 'Essential Skills' (two day) training or the TEWV (three day) DBT skills training.

Training routes and training requirements

- To have completed at a minimum either the British Isles DBT Training 'Essential Skills' (two day) training or the TEWV Introduction to DBT theory and skills Practice training (three days)
-

Accreditation (if applicable) including CPD requirements to maintain accreditation

Desirable for those eligible to apply for accreditation as above though not essential

Supervision Requirements

As a minimum, weekly attendance at a DBT 'Consult' (clinical supervision) group (2 hours each week) with at least one other qualified DBT therapist.

7.14 Evidence-based Parent Intervention for Conduct Problems

Description

BABCP identifies Evidence-based Parent Training Practitioners (EBPT) as holding core clinical skills and specialist theoretical knowledge for behavioural difficulties including conduct disorder in children aged 3 to 10 years. They work with both children and their parents to implement NICE recommended individual and group interventions that are based on cognitive social learning theory and draw on attachment theories within a patient child relationship.

Practitioners are trained within a CYP IAPT Parenting programme to assess and understand behavioural difficulties in children who are identified as borderline or within clinical ranges on standardised measures of behaviour: Oppositional defiance disorder, Conduct Disorder or Attention Deficit Hyperactivity Disorder. (NICE 2014).

NICE, recommended evidence-based Parent Training Interventions:

Group Parent Training Programme consisting of:

- Minimum 10 to 16 weeks of 90 - 120-minute sessions with 10 to 12 parents per group and no less than six.
- Delivered by appropriately trained and skilled facilitators who are supervised and access ongoing professional development.
- Based on a social learning model, modelling, rehearsal, and feedback, including relationship enhancement strategies.
- Adhere to developer's model employing all necessary materials to ensure consistent implementation.
- Data of proven effectiveness i.e., RCT or outcome evaluations undertaken independently of programme provider.

Individual Parent Training Programme considered if families are unable to access group programme due to complexities and consist of:

- 8-10 meetings of 60 to 90 minutes duration.

- Delivered by appropriately trained and skilled facilitator who is supervised and access ongoing professional development.
- Based on social learning model, modelling, rehearsal, and feedback, including relationship enhancement strategies
- Adhere to developer's model employing all necessary materials to ensure consistent implementation.

TEWV offer The Incredible Years Programs utilising protocols of minimum 14-week prevention programme or 20–24-week treatment programme for children identified with conduct problems and ADHD.

Associated Guidance:

- NICE-treatment-and-indicated-prevention Conduct/ADHD/behaviour
- Parent Training Programmes management conduct
- BABCP: Apply for EBPT Registration (babcp.com)

Training Requirements (please note these are specified as pre or post 2022)

- Accredited BABCP Postgraduate Certificate /Diploma in Children and Young People's Parent Training for Conduct Problems.
- Approved registered professional qualification and regulatory body or demonstrate completion of EBPT KSA portfolio.
- Minimum training standards for role: Parent Programme Training delivered by BABCP accredited practitioner, Incredible Years Accredited Practitioners, or recognised equivalent for Parent Programme.
- TEWV Recognise: CYP IAPT Postgraduate Certificate/ Diploma in Evidence-Based Psychological Approaches Parent Training Conduct Disorders. (Prior to 2022).
- Approved registered professional qualification and regulatory body or demonstrate completion of EBPT KSA portfolio.
- Additional minimum training standards for role: Parent Programme Training delivered by BABCP Accredited practitioner, Incredible Years Accredited Practitioners.

Accreditation with BABCP

Accredited courses for EBPT practitioner are offered by 3 universities in the UK. Currently BABCP have no current plans to APEL prior uncredited 2023 training. (March 2023)

EBPT practitioners who meet minimum training standards can apply for accreditation with BABCP if:

- Practitioners hold two years' experience in Core Profession (NMC, HCPC, SW-E) meet EBPT Minimum Training Standards, maintain agreed level CPD in Evidence-Based Parent Training, receiving regular EBPT clinical supervision.
- Maintain annual reaccreditation requirements.

Supervision Requirements

Supervision monitors implementation as per model fidelity to achieve expected evidence-based outcomes.

Minimum standards of supervision can be offered by:

- Approved Parent Training clinical supervisor: either Cognitive and/or Behavioural Therapist who meets BABCP criteria for supervision accreditation.
- Accredited Incredible Years supervisor or other evidence-based parenting accredited practitioner. (BABCP 2023)

As a minimum qualified practitioners should receive:

- Weekly peer support recommended for group leaders.
- Group leaders 2 hours per month videotape supervision and feedback with mentor for discussion of patient videos

Qualifying as a Supervisor

- Accredited supervisor within an Evidence-based parent programme, maintaining supervisor requirements.
- Registered EBPT trained therapist, with 3 years post qualification experience and post graduate qualification in supervision.

On-going CPD requirements

Accredited group leaders and supervisors must deliver a group programme minimum every 18 months, attend supervision and partake in video fidelity check with an accredited supervisor. (Incredible Years Program)

- Video supervision of supervision is a requirement of all Accredited supervisors. (Incredible Years Program)
- 5 CPD activities per year (e.g., workshops, lectures and self-directed study, including inhouse CPD).
- Minimum 6 hours skills practice with reflective statement documentation

7.15 Eye Movement Desensitisation Reprocessing (EMDR) Therapy [GPT5]

Description

EMDR was first developed by Dr Francine Shapiro in the 1980's and became widely known through her first Book "EMDR protocols and procedures, 1989". It is an eight-stage therapy that can be used as a stand-alone therapy, or it can be integrated into other models of psychological therapy. Based upon the Adaptive Information Processing Model, with emphasis upon underlying neurological mechanisms, its basic tenant is that bilateral stimulation created usually (though not necessarily) through lateral eye movement, activates the thalamus and amygdala and accelerates information processing of unprocessed trauma-based memories and facilitates their integration with other memory structures. The bilateral stimulation comprises only three of the eight phases (desensitisation, installation, body scan) which involve firstly the paring of negatively held meaning with the desensitisation phase, and positively held meaning with the subsequent reprocessing phase, and then processing any somatically held memory in the body scan phase. History taking, preparation emotional regulation and safety factors are integral to the first three stages prior to the desensitisation and reprocessing stages.

Recommended treatment for

PTSD for children, young people and adults

Associated Guidance Recommendations | Post-traumatic stress disorder | Guidance | NICE

Competencies required to use this code

EMDR competencies UCL HEE

Training Routes to achieve competencies

Training requirements eligibility;

Below is a list of staff who are eligible to train in EMDR:

- Clinical Psychologists & Counselling Psychologists (Registered with HCPC), Educational Psychologists (Registered with HCPC), Forensic Psychologists (Registered with HCPC). Clinical & Counselling Psychologists in their final year of training, are acceptable with a letter of recommendation from their supervisor.

- Psychiatrists MRCPsych or equivalent (including Certificate of Completion of Specialist Training in any psychiatric speciality).
- Registered Mental Health Nurses (NMC) - who have training and a minimum of two years' experience of providing one-to-one psychotherapy, either as part of their professional training or in addition to it.
- Registered Mental Health Social Workers or social workers with experience of working clinically in a mental health setting Have training and a minimum of two years' experience of providing one-to-one psychotherapy, either as part of their professional training or in addition to it.
- BABCP, BACP, UKCP registered practitioners.
- British Psychoanalytic Council (BPC) registered practitioners.
- Association of Child Psychotherapists (ACP) registered practitioners.
- Art Psychotherapists & Occupational therapists that are registered with HCPC and have mental health training, can recognise and assess common mental health problems and have experience of working in a mental health setting. Have training and a minimum of two years' experience of providing one-to-one psychotherapy, either as part of their professional training or in addition to it.

Training

Training consists of four spaced parts over a total of seven days, that lays new skills and knowledge over existing skills and knowledge, and which is supported through ongoing supervision. Following training, which normally takes a year or more to complete, the individual may then work towards Practitioner Accreditation. The accreditation standards require a minimum number of cases and clinical and supervisory hours and direct observation under the supervision of an EMDR accredited Consultant. Accreditation is renewable every five years. EMDR Europe is the accrediting body for EMDR that sets rigorous standards of training for EMDR Practitioners, Consultants and Trainers. In the UK, membership to EMDR (UK & Ireland) is required. There are a small number of training organisations across UK that are approved to train under EMDR Europe standards.

There are also training requirements for EMDR with children and adolescents. Those working with children and adolescents using EMDR must have completed an EMDR Europe accredited child training, Level 1. Prior to this training, they must also have as a minimum, completed a generic EMDR Europe Accredited Level I or Parts I & II.
There is a new NHS-E EMDR training which provides 10 training days over 18 months.

Supervision requirements

It is recommended that the supervision of those undergoing training through parts 1 – 4 should be supervised by an accredited practitioner. Those who have completed training and who are working

towards Practitioner accreditation must be supervised by an EMDR Consultant. Those who are accredited practitioners may be supervised by their peer EMDR accredited Practitioners. However, it is noted that due to limited access to EMDR Consultants due to small numbers, there may also be limited access to accredited Practitioners coming through. Therefore, there may need to be a transition period whereby supervision may be provided by experienced EMDR practitioners who have not yet completed but are working towards accreditation.
EMDR practitioners working with children and young people should be receiving regular supervision from an EMDR Europe accredited Consultant with experience in using EMDR with Children and Adolescents. EMDR Consultants should receive supervision from another EMDR consultant with relevant expertise for their area of speciality.
Accreditation as an EMDR practitioner takes a minimum of one year post EMDR basic training, a minimum of 25 cases, a minimum of 50 EMDR sessions and at least 20 hours of Consultant supervision along with observed practice and completion of competency criteria.

Qualifying as a supervisor

The criteria for accreditation as a Consultant and Supervisor are set out by EMDR UK and includes attendance at a 4 day consultant training, a minimum number of years (3) as an accredited practitioner before being able to apply for Consultant accreditation along with a minimum number of EMDR sessions (400), minimum number of patients (75) in addition to observation of supervision and practice and completion of competency criteria and a number of CPD points.
Whilst accredited practitioners can supervise, the supervision they provide does not count towards their supervisee's own accreditation requirements.

Ongoing CPD requirements

EMDR UK specify a minimum number of CPD points that Practitioners and Consultants must attain during the 5-year registration period along with attendance at the EMDR UK national conference during the registration period.

7.16 Family, Systemic and Couple Therapies

Therapy Overview and Evidence Base

The development of family therapy was based on the idea that the behaviour of individuals and their families was influenced and maintained by the way other individuals and systems interact with, and around them. This way of working now relates to a wide range of models, approaches and family interventions based on systemic theory and is used within child, adult and older peoples' mental health services across clinical pathways. Specific family therapies also integrate other psychological theories and therapies within the treatment. Therapeutic work is undertaken with individuals, couples or families and may also include consultation to wider networks such as other professionals working with the individual or the family.

Systemic family therapy has been an influential psychological approach for over 50 years and is offered to a range of client groups within mental healthcare including children and adolescents, working age adults, older people and learning disabilities. There is a clear evidence base for both its efficacy and effectiveness in the treatment of many mental health problems (e.g., Stratton, 2016) and systemic family therapy is recommended within many NICE clinical guidelines and is embedded within a range of clinical pathways within the Trust.

7.17 Systemic Family Therapy (GPT 20)

Systemic Family Therapy is a way of working with people with problems that embraces work with smaller systems (including individual and family work) and bigger systems than the family. Systemic and family therapists understand individual problems by considering the relevance of family relationships and the impact of the wider social and economic context on people's lives, their wellbeing and their mental health. Therapy aims to identify and explore patterns of beliefs and behaviour in roles and relationships and therapists actively intervene to enable people to decide where change would be desirable and to facilitate the process of establishing new, more fulfilling and useful patterns. In Systemic Family Therapy the therapist clarifies the concerns that brought the family into treatment and provides a series of reframing statements designed to optimise engagement in therapy and identification of dysfunctional behaviour patterns.

Systemic Family Therapists have a range of interventions open to them in working with the family to co-create change in family behaviours or beliefs. Systemic Family Therapy grew from the recognition that the symptoms of an individual family member are likely to be an essential component of a complex interacting system and the meanings that the family create. Systemic

Family therapists often work with reflecting teams using live consultation or as sole practitioners using retrospective consultation. The therapist, assisted by ideas from the team, helps the family to re-story the difficulties in ways that no longer push people into entrenched positions but leave them better able to choose a more acceptable life.

Supervision Requirements

The clinical supervision of systemic family psychotherapists should be provided by an AFT Approved Supervisor. Where this is not possible supervision should be provided by an experienced Systemic Family Therapist who has been registered with UKCP for at least 3 years. The AFT requirement for the first 3 years post-qualification is a minimum 18 hours per year of clinical supervision and at least 12 of these hours should be individual supervision. The remaining 6 hours can include live team supervision or group supervision. After 3 years of post-qualified practice the requirement is a minimum of 12 hours per year.

Training Requirements

Training leading to UKCP accreditation as a Systemic Family Therapist – Masters in Systemic Family Therapy.

Ongoing CPD requirements

Once qualified as a systemic family therapist, ongoing membership of the Association for Family Therapy and Systemic Practice (AFT) is recommended in order to practice systemic family therapy. Therapists should ensure level of competence through continuing professional development to meet required standards for AFT membership and accreditation with the UKCP as a systemic family therapist.

Qualifying as a Supervisor

To qualify as a systemic supervisor requites completion of an AFT accredited training course in systemic supervision, teaching and training.

Further Information

For further information regarding family therapy and systemic practice:
https://www.aft.org.uk/page/whatisfamilytherapy

7.18 CYP-IAPT Systemic Family Practice (GPT 26)

CYP-IAPT Systemic family practice is based on the same theoretical and evidence base as systemic family psychotherapy but denotes an intermediate level of systemic.

training. Systemic family practitioners support family members to explore difficult thoughts and feelings safely and help them to understand each other's experiences and views. Systemic family practice has been developed specifically for treating children and young people with conduct disorder, depression, self-harm and eating disorders.

Systemic family practitioners have been trained through CYP-IAPT.

Supervision Requirements

The AFT requirement for CYP-IAPT Systemic Family Practitioners is a minimum of 1.5 hours of clinical supervision per month (18 per year) from an approved systemic supervisor or experienced UKCP registered systemic family psychotherapist. A minimum of 12 of these hours should be individual supervision and the remainder can be group supervision.

Training Requirements

AFT accredited CYP-IAPT Systemic Family Practice training course (Postgraduate Diploma).

7.17 Family and Couples Therapy (GPT 9)

Family therapy is also delivered at an intermediate level by systemic practitioners that have completed either an AFT accredited intermediate level training course or specialist systemic training within their core clinical training such as doctoral training in clinical psychology.

Supervision Requirements

Intermediate level systemic practitioners require 1.5 hours of supervision per month (18 per year) from an approved systemic supervisor or experienced UKCP registered systemic family psychotherapist. A minimum of 12 of these hours should be individual supervision and the remainder can be group supervision.

Training Requirements

Intermediate level training course in Family Therapy and Systemic Practice (Postgraduate Certificate); Doctorate in Clinical Psychology that has included specialist systemic training.

7.18 Behavioural Family Therapy (GPT 12)

This form of family therapy is a practical, skills based, intervention with the aim of increasing shared understanding and improving communication and problem solving within a family. It was developed for families were a member experiences psychosis. NICE recommends that family intervention, of a BFT form, is offered to 100% of people experiencing psychosis and bipolar disorder as it is effective in reducing family stress and reducing relapse rates in those experiencing psychosis. It also can have applicability for other presentations e.g., long term physical conditions. The approach includes psychoeducational, relapse planning and communication and problem-solving skills. Treatment plans are devised collaboratively with the family and service user who should be present if at all practical. It is delivered by either one or two trained therapists and includes any person who the service user identifies as part of their family unit. BFT is and usually delivered within the family home. It should be offered for a minimum of 10 sessions. BFT is not the same as “Carer-focused education and support”, another NICE recommended intervention which, as its name suggests, is focused particularly on the needs of carers.

Supervision

2 hours group supervision per month delivered by a supervisor who has completed recognised BFT supervisors training.

Training

Completion of 5-day Behavioural Family Therapy Training Course

7.19 Family Based Therapy for Eating Disorders (GPT 28)

This form of family therapy is practical skills-based intervention with the aim of increasing the shared understanding and improving communication and management of a young person with an eating disorder within a family. It has been developed for families where a young family member experiences a significant eating disorder (Anorexia Nervosa or Bulimia Nervosa). NICE recommends this family-based intervention, of a BFT form (BFT; FT-AN; FT-BN), is offered to 100% of families as a first line approach for the treatment and support of children and young people experiencing a significant eating disorder. This family-based treatment approach for anorexia nervosa is an outpatient intervention and consists of three distinct phases: (1) weight restoration (2) transitioning the control of eating back to the young person from the parent/carers (3) wider adolescent issues.

The approach includes psychoeducational information, communication styles, and problem solving and relapse prevention skills. Treatment plans are devised collaboratively with the family, initially particularly with parents/carers, with the young person present. Parents/carers are supported to provide the care and communication approaches required for weight restoration for their child with the eating disorder.

Supervision Requirements

Group or individual supervision delivered by a supervisor who is a systemic practitioner or family therapist (and who has FBT training) once per month.

Training Requirements

Completion of 1–5-day Family-Based Treatment (FBT) Training Course.

7.20 Family interventions for Psychosis (GPT 31) and Bipolar Disorder (GPT 38)

This form of family intervention has general competencies aligned to the Roth and Pilling psychosis and bipolar competency framework. It is practical skills-based intervention with the aim of sharing understanding, improving communication and problem solving. The approach also has a focus on carer support (but is not the same as carer- focused education and support). The NICE guidelines recommend that anyone with psychosis and bipolar disorder who are living or in close contact with their family should be offered family interventions. It is delivered generally by two trained therapists. If the trained therapist does not hold a core profession there must be another staff member included in the work who does hold a core profession. The sessions can include any person who the service user identifies as part of their family/support unit. It is preferable for the service user to be part of the family work sessions but not essential.

The competencies are the same for both interventions, please determine code use on basis of presentation that is being treated i.e. Bipolar Disorder or Psychosis.

Recommended treatment for

Adults and young people with Psychosis and Bipolar Disorder

Associated Guidance

Bipolar disorder: assessment and management (CG185) Overview | Bipolar disorder: assessment and management | Guidance | NICE

Bipolar disorder, psychosis and schizophrenia in young people (QS102)

Psychosis and Schizophrenia in adults prevention and management (CG178) Overview | Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

Psychosis and Schizophrenia in Adults Nice Guidance Standard (Q580) Overview | Psychosis and schizophrenia in adults | Quality standards | NICE

Psychosis and Schizophrenia in Children and Young People recognition and management (CG155) Overview | Psychosis and schizophrenia in children and young people: recognition and management | Guidance | NICE

Competencies required to use this code

Family Interventions described in: Psychological Interventions with People with Psychosis and Bipolar Disorder | UCL Faculty of Brain Sciences

Training Routes to achieve competencies

A Family Interventions Training Programme delivering National FI Curriculum National Family Interventions Curriculum. 10 days training plus 12 months supervised practice.

Training Entry Requirements

Individuals with a Core Mental Health Professional Qualification. Other clinical and peer support staff with experience of working with psychosis and bipolar disorder can attend and become co-therapists.

Accreditation

None currently

Supervision Requirements

Supervision is given individually or to groups by a supervisor who has completed A Family Interventions Training Programme delivering National FI Curriculum National Family Interventions Curriculum and who has also had at least a year's practice of delivering FI or in some cases a practitioner trained to at least intermediate level systemic family therapy (a systemic practitioner) and has some supervisory experience. Supervision is required to be undertaken for a minimum of one hour per month when actively providing family intervention therapy sessions.

7.21 Group Psychotherapy [GPT 18]

Group Analytic Psychotherapy/ Larger Psychotherapeutic Groups is a specific form of psychotherapy 'of the individual in the group, by the group, including its conductor'. The same small group (six to eight people) meet weekly over a period of time with a Group Conductor/Psychotherapist. Group Analysis utilises psychoanalytic principles and an understanding of unconscious group processes and social psychology to provide the individual with an opportunity to share the experience of psychotherapy with fellow members as well as the psychotherapist. Through the interactions which occur in the group, members are able to explore and understand difficulties in relationships and the conscious and unconscious origins in the past and the present of symptoms and psychological disturbance.

Groups for children and adolescents generally need more structure than is the case in adult groups. In child settings, parent groups and mother and father groups have been used to change problematic personality and relationship difficulties in relation to other group members, other adults and the children and families of group members using the group as a medium to identify and work on these engrained personality characteristics. Multi-family groups have also been used to work on whole family difficulties.

Supervision

As required by the Trust protocol. British Psychoanalytic Council (BPC) requirement is a minimum of 15 hours a year. BACP require an absolute minimum of one and a half hours a month.

Training

Training courses leading to accreditation by UKCP Psychoanalytic Section; BPC; Institute of Group Analysis; Clinical or Counselling Psychology Doctorate or Forensic Psychology Stage 2 leading to HCPC registration; training courses leading to BACP accreditation; HCPC registered psychotherapists. Those practicing group psychotherapy should be accredited Psychodynamic and Psychoanalytic Psychotherapists, Group Analytic Psychotherapists, Child & Adolescent Psychotherapists; HCPC registered Clinical, Counselling or Forensic Psychologists; BACP accredited counsellors and psychotherapists. Psychodynamic psychotherapy will only be offered by a psychodynamic or psychoanalytically trained clinician, with a recognised qualification as above.

7.22 Humanistic Psychotherapy [GPT17]

Humanistic/Rogerian counselling relies on the nature of the therapeutic relationship and the capacity of empathic listening to provide those human experiences that are necessary for people to grow and develop, and for their sense of a valued self to become stronger. As such change takes place defences may be reduced, self-esteem and confidence may increase, and people may be able to discover and develop their own capacity to live with their life contexts in different ways. The principles of humanistic counselling and therapy are recognised as an essential part of all therapeutic approaches and thus make a contribution to all therapies.

Humanistic psychotherapies such as Transactional Analysis (TA) and Gestalt have developed, breaking away from their psychoanalytic routes and influenced by humanistic philosophies. Many have developed into an integrative framework in practice.

Supervision

According to trust protocol and as required by UKCP, based on recommendations related to hours of practice.

Training

Minimum of four years training through an accredited psychotherapy training institute leading to a Masters qualification; leading to UKCP registration.

7.23 Integrated Psychological Therapy [GPT15]

The term **'Integrated Psychological Therapy'** refers to:

- The form of therapy in which evidence based psychological knowledge is used to build a shared understanding (with the patient) of psychological phenomena.

The term "integrated" implies that at least one evidence based psychological theory or model will be used in the formulation and in any intervention plan. The theories or models used might be taken directly from psychology (e.g., attachment theory, social learning theory, or attribution theory), or from the applied psychology of psychological therapies (e.g., negative automatic thoughts from CBT, snags and traps from CAT, transference from psychodynamic psychotherapy, or systematic desensitisation and from behavioural therapy).

The choice of which theories or models are used to formulate phenomena is based on their explanatory power. Explanatory power can be regarded as a factor of theories' or models' ability to explain the observed phenomena, and the extent to which these theories or models can be integrated with a person's models of their experience.

Supervision

For qualified practitioners' supervision required at least monthly from an HCPC registered practitioner psychologist.

Training

HCPC registered practitioner psychologist.

7.24 Interpersonal Psychotherapy (IPT) [GPT1]

Interpersonal Psychotherapy (IPT) and Interpersonal Counselling (IPC) [GPT required]

Interpersonal psychotherapy (IPT) is a time-limited therapy which focuses on current relationships and life events, not past ones, and on interpersonal processes rather than intra-psychic ones. It focusses on difficulties arising in the daily experience of maintaining relationships and resolving difficulties whilst suffering an episode of psychological distress. It is being developed on an ongoing basis and there are now protocols for its use with PTSD, bipolar disorder, eating disorders and also across the lifespans. IPT is a therapy which can be used by registered healthcare professionals who have completed an IPTUK recognised IPT Practitioner qualification.

IPC is also time limited and focussed on current interpersonal situations linked with distress but is a shorter model and for use by non-professionally registered staff such as support workers, assistant psychologist and mental health wellbeing practitioners and information is available by request from IPT lead.

The main tasks within therapy are to help patients to learn to link their mood with their relationships/life events and to recognise that, by appropriately addressing these they may improve both their relationships and reduce symptoms of psychological distress. Patient and therapist agree to work on a particular relationship/life event based focal area which precipitated and maintains the current episode of psychological distress. This is chosen out of role transitions/adjustments (e.g., retirement, adjustment to health problem, new role as parent, redundancy), relationship disputes or conflicts (e.g., marital difficulties, dealing with work relationships), grief/bereavement or interpersonal sensitivity (lack of people skills or repeating unhelpful patterns in relationships often originating from childhood difficulties).

The focus of the therapy sessions is, largely to aid understanding of recent events in interpersonal/relationship terms, and to explore alternative ways of handling these situations. It is important that patients apply the content of therapy sessions, and this may be achieved through tasks.

There are two main models of IPT – IPT (for those older than 16-18 years old) and IPT-A (for those aged 13-18 years old). IPT takes place over sixteen sessions (IPT-A = 12 sessions), running up to four to six months. These sessions are split into four sessions of a detailed assessment, eight sessions of working on the chosen focal area (IPT-A =5 sessions), and four sessions (IPT-A 3 sessions) of consolidation and ending. IPC is a 6-7 session protocol with one assessment and ending sessions and 4-5 middle sessions.

IPT accreditation standards/training & eligibility for training

Current standards & eligibility for training can be found here:
https://www.iptuk.net
(NB IPC training is open to non-registered clinical staff)

Supervision Requirements

The clinical supervision of IPT therapists should be provided by an IPTUK Approved Supervisor initially, or where this is not possible supervision should be provided by an experienced IPT practitioner through peer supervision. This should take place as a minimum of monthly and could be individual or group supervision.

Training Requirements

Training leading to IPTUK accreditation as IPC or IPT practitioner.

Ongoing CPD requirements

Once qualified as a systemic family therapist, ongoing membership of IPT UK is recommended, a minimum of two IPT cases per year and attendance at one IPT CPD event (practitioners) or two events (supervisors).

Qualifying as a Supervisor

Training leading to IPTUK accreditation as IPC or IPT supervisor.

7.25 Mentalisation based Treatment [GPT21]

Mentalizing refers to our ability to attend to mental states in ourselves and in others, as we attempt to understand our own actions and those of others on the basis of intentional mental states. If we are mentalizing successfully, we are able to understand what is going on in our own minds and in the minds of other people, and realise how this is affecting the emotions, thoughts and actions of ourselves and others. A focus on this very human activity as a therapeutic intervention forms the core of mentalisation based treatment. However, some people find it more difficult to mentalize in certain contexts, than others. MBT is particularly useful for people experiencing long – term difficulties in relationships and for people who experience intense emotional distress that can be overwhelming.

MBT can be delivered as a stand-alone intervention or combination of:

- A Psycho-Educational Introductory Group (MBT – I) of 90-minute sessions for 12 weeks
- 1:1 therapy format for 60-minute sessions as a longer-term therapy
- Mentalisation based Group Therapy (MBT-G) of 90-minute group sessions for 9 months or longer.

Further information available at Quality Manual for MBT

Recommended Treatment for: Adults with Borderline Personality Disorder

Overview | Borderline personality disorder: recognition and management | Guidance | NICE

Overview | Personality disorders: borderline and antisocial | Quality standards | NICE

Adults and Older Adults with Complex Emotional Needs Psychological therapies for severe mental health problems | NHS England | Workforce, training and education

Competencies Required to Deliver MBT

Personality_Core_competencies_for_work_with_people_with_personality_disorder.pdf

Training route to achieve these competencies

There are 3 components to MBT practitioner training:

1. MBT Basic Training (3 live instructor led training days, and 12 hours of self-guided online training).
2. Supervision of clinical practice with an MBT Supervisor.

3. MBT Practitioner Training (two live instructor led training days and 4 hours of online learning).

Requirements

- Four individual patients or two groups or two individual patients and one MBT-G group must be treated using MBT as the primary intervention for a minimum of 24 sessions each (as part of an MBT treatment of 12 - 18 months duration*) to embed basic and practitioner skills.

- Patients (minimum of 2 or 1 group) should have complex emotional and interpersonal problems associated with developmental trauma.

- Delivery of MBTi does not count as a clinical case and is an additional requirement MBT Practitioner Status Pack 3 .

- Participation in or working knowledge of MBT-Introductory group or Socialisation to MBT model in individual sessions

- A reflective written statement must be produced on completion of each case.

- A satisfactory supervisor's report must also be provided.

- Evidence of continuing professional education in MBT, e.g. case presentation and discussion, conferences, workshops, e-learning as outlined in the MBT Quality Manual.

Clinicians who are not yet able to deliver a full MBT group and individual programme, may work with patients with complex emotional and interpersonal problems on a 1:1 basis to learn and demonstrate their competency in MBT interventions for individual MBT. This can only take place in health services where there is written consent from the clinical service manager and the patients in treatment. Levels of MBT Practitioner Status On successful completion of the MBT training and development programme, people who worked with individuals or group only, will receive a certificate stating that they have demonstrated competence in the delivery of MBT with individuals or group - MBT Practitioner (individual) or MBT Practitioner (Group). People who work with both individual and group, on successful completion of the training trajectory will receive a certificate stating that have demonstrated competence in the full delivery of MBT - MBT Practitioner (individual and group)

Training Entry Requirements

Core Mental Health Professional Qualification BABCP | British Association for Behavioural & Cognitive Psychotherapies > Accreditation > Cognitive Behavioural Psychotherapist Accreditation > Core Professions > Core Professions list and criteria AND evidence of the generic 'personality disorder' psychological therapy competences **Personality_Core_competencies_for_work_with_people_with_personality_disorder.pdf**

Courses will carefully assess that all 'personality disorder' psychotherapy foundational competences are in place before learners join MBT specific training.

Accreditation

MBT Practitioners are accredited by the Anna Freud Centre and eligible for entry onto the British Psychoanalytical Council (BPC) roster.

Accreditation requires:

1. Completion of the MBT Basic and Practitioner Training courses.
2. Four individual patients or two groups, or two individual groups and 1 MBT – G group. Patients (minimum of two or one group).
3. Participation in or working knowledge of an MBT Introduction group (MBT-I).
4. Supervision of the cases with an Accredited Supervisor: A minimum of three 15-minute video recording of sections from different sessions of treatment will be submitted to the Supervisor for formal review with reference to the MBT adherence scale Microsoft Word - Adherence_Scale_August_2020.docx (d1uw1dikibnh8j.cloudfront.net) and MBT competencies https://www.ucl.ac.uk/clinical-psychology/competency-maps/pd-map.html
5. A reflective written statement must be produced for each case.
6. A satisfactory Supervisors report.
7. Evidence of CPD in MBT e.g., case discussion and presentation, conferences, workshops, e-learning.

Supervision Requirements

In training:

Pre-accreditation practitioners: A minimum of 22 hours of group supervision take place across a 12-month period for those working towards accreditation. This supervision should be with an accredited MBT Supervisor. Supervision sessions should be twice monthly for 1 hour. At least 4 hours of supervision for each case.

Post- accreditation practitioners: Once accredited it is recommended for MBT Practitioners to have monthly supervision from an MBT accredited Supervisor

CPD

CPD can include case discussion and presentations, conferences, workshops, e-learning. MBT Supervisors must attend one CPD event a year e.g., conference, workshop or course.

Training/Accreditation to become an MBT Supervisor

The timescale from MBT accreditation to MBT supervisor is a minimum of 3 years MBT practice combined with MBT Supervisor training provided by The Anna Freud Centre. Mentalization-Based Treatment - Adults | Anna Freud

7.26 Structured Clinical Management (GPT 47- will change to PWBI)

Description

Structured Clinical Management (SCM) is an evidence-based approach to help general mental health professionals deliver a reliable, consistent and coordinated approach to care, for people with Complex Emotional Needs (CEN). This may include problems with managing emotions, moods, triggers of distress, impulsivity and interpersonal situations that make them feel vulnerable or sensitive, such as feeling rejected / being alone.

It is an attachment-based approach with an emphasis on 'good team working' and developing good therapeutic relationships. The approach offers guidance on how to improve patient-led assessments, interventions and endings throughout a person's journey in mental health services, including a focus on safety and risk. Psychological intervention is interwoven into the clinical approach in both a one-to-one and group-based format. This covers aspects of relationships, understanding trauma, emotions and impulsivity with an emphasis on problem-solving.

SCM has been found to be as effective as other specialist treatments such as Dialectical Behavioural Therapy (DBT) and Mentalisation-Based Treatment (MBT). Emotion and mood regulation, managing urges, interpersonal problems and quality of life all improve with SCM treatment, and are usually maintained over time.

Associated Guidance

Borderline personality disorder: recognition and management

Overview | Personality disorders: borderline and antisocial | Quality standards | NICE

Psychological Interventions with People with Personality Disorder | UCL Psychology and Language Sciences - UCL – University College London

Bateman A, Krawitz R (2013). Borderline Personality Disorder: An evidence-based guide for generalist mental health professionals. *Oxford University Press: Oxford*

Competencies required

To attain SCM Practitioner Status, trainees will need to demonstrate competencies as set out by the Health Education England (HEE) National Curriculum (**Report template).** This includes competencies in assessment, crisis planning, 'discussing the diagnoses' and formulation. Additionally, trainees will be required to deliver each of the 4 modules of SCM (Problem solving,

Emotion management, Impulsivity, Interpersonal function) within a group-based format. Trainees are to attend monthly external supervision (60-90 minutes) and SCM peer supervision.

Training Requirements

The course is suitable for all mental health professionals currently working with patients who have Complex Emotional Needs. No specialist or high-level psychological treatment skills are required to attend the course. Practitioners can apply from Band 5 upwards and do not need a core profession.

Training

Trainees are to complete a 12-month course with the Anna Freud Centre. The SCM Basic Training consists of 18 hours of instructor-led content over 3 days, and 21 hours of self-guided content plus 12 months of organisational implementation supervision. Applicants must be able to commit to the above training requirements with an agreement from their line manager. A job plan will be required to allow the trainee to fulfil the hours and competencies required for the course.

Supervision requirements

During training: Trainees will be offered 12 monthly external supervision sessions. Trainees must attend a minimum of 9 out of 12 group supervision sessions and present clinical work at a minimum of 5 sessions including the submission of videos and audios of clinical practice. At the end of training trainees are to submit a clinical logbook, plus additional evidence of clinical practice to successfully reach practitioner status. This will be reviewed and signed off by their external supervisor and approved by Anna Freud.

Post Training: Monthly supervision to be offered 60min monthly supervision by an SCM Supervisor (internal to the Trust) to maintain the competencies / practice above. To attend monthly peer supervision with SCM practitioners.

Ongoing CPD requirements

Practitioners are to commit to attending ongoing CPD events in relation to SCM, including supervision, conferences & workshops.

Qualifying to be a supervisor

The supervisor training programme is a 2-month course built around three 1-day workshops. The programme contains workshops on theoretical and clinical skills in relation to supervision,

including knowledge, facts, theories, approaches to problems and solutions, plus learning through reflection.

There are two components to the training:
1. SCM training (3 days of live, instructor-led training and 3 hours of self-guided online training);
2. Supervision of group supervision with an SCM Trainer and observation of trainee clinical supervision in the workplace ('supervision of supervision') (4 hours).

Who can apply? Applicants must:

1. Have worked in and/or set up an SCM programme that meets ***OR*** is working towards criterion in SCM Implementation Checklist
2. Have a supervisory role within their work as evidenced in their current Job Plan
3. Show evidence of continuing education in treatment of personality disorder through attendance at additional training/learning events annually
4. Have completed all components of SCM intervention trajectory from Assessment to Formulation to Groups and Individual sessions under expert supervision (supervision individually or in group supervision)
5. Mental health professional registered with a professional organisation or recognised mental health professional employed and professionally accountable in an NHS Hospital Trust
6. Agree to supervise 2 supervision groups each year for the HEE-funded SCM training programme.
7. Have availability and commitment to complete the 2-month programme

7.27 Specialist supportive clinical management (GPT 44 will change to PWBI)

SSCM utilises clinical management skills, a sustained focus on improving eating disorder symptoms, and supportive therapy techniques to guide people towards meeting their own treatment goals. There is an additional focus not just on a client's symptoms, but on improving their enjoyment and quality of life alongside their eating disorder symptoms. SSCM is a much more flexible approach than many of the other structured skills-based approaches offered for anorexia. Within each session, core symptoms and progress towards treatment goals are reviewed, however other than that the content of each session is dictated by the needs, feelings and desires of the client; the therapist contributes less of their own agenda. SSCM is not based on a detailed psychological formulation or model, but uses a very practical, gentle and supportive approach. The role of the therapist is seen as being merely to facilitate, support and encourage the client to use skills and strengths that they already have, to move towards treatment goals. In this sense SSCM builds on a client's pre-existing strengths rather than providing clients with a new set of skills. The content of treatment is completely unique to each client and will be a combination of the client's knowledge about what might work for them, and the clinician's knowledge about what might help someone to recover from an eating disorder.

Further information on training competencies and supervision to follow.

7.28 Mindfulness Based Cognitive Therapy for depression [GPT16]

Description

Mindfulness-Based Cognitive Therapy (MBCT) combines intensive training in mindfulness meditation with elements of Cognitive Behavioural Therapy. It is delivered in a group format over a period of about two months in a course of eight 2-hour sessions and one longer session. The course includes extensive daily 'home practice' for participants to engage with between sessions. MBCT was designed as a relapse prevention intervention for people who experience repeated episodes of depression but is now used more broadly than this.

The British Association of Mindfulness Based Approaches (BAMBA) accredits organisations (including TEWV) that deliver training and publishes good practice guidance. All therapists delivering MBCT within TEWV should be compliant with the good practice guidelines.

The TEWV team has close links with and follows the standards set by the Oxford Mindfulness Foundation takes the lead nationally and internationally in MBCT training, research and programme development.

Competence is assessed by trained assessors using a structured assessment tool, the Mindfulness Based Interventions: Teaching Assessment Criteria MBI:TAC). The TEWV team includes trained assessors. All therapists in TEWV that are delivering MBCT should be assessed as (at least) 'competent' on the MBI:TAC.

Associated NICE guidance

Depression in adults: treatment and management (2022) www.nice.org.uk/guidance/ng222

- As a relapse prevention intervention.
- As a treatment option in the first-line treatment for less severe depression.

Mental wellbeing at work (2022) www.nice.org.uk/guidance/ng212

- NICE recommends the provision of mindfulness for employees to support their wellbeing and mental health.

Training requirements

BAMBA accredits organisations (including TEWV) that deliver training. Training pathways last a minimum of 12 months. Pre-requisites for training include the following: personal experience of the course as a participant; in-depth personal experience of all the MBCT practices; an appropriate

professional clinical training. TEWV is the North of England site for an ongoing national programme of HEE-funded training of Talking Therapies HIT staff.

Supervision Requirements

BAMBA's good practice guidelines include requirements for regular supervision with a trained MBCT supervisor and includes the opportunity to reflect on MBCT courses being delivered and the therapist's own mindfulness practice.

Qualifying as a Supervisor

The Mindfulness Network describes a supervision training pathway Fulfilling the prerequisites and a 3-day supervision training is required for the first level of training. BAMBA publishes good practice guidance for mindfulness supervision.

Ongoing CPD requirements

BAMBA's good practice guidelines include the following requirements: a daily personal mindfulness practice; attendance at an annual silent retreat of at least 5 days duration; ongoing contacts with other MBCT therapists as a means to share experiences and learn collaboratively; a commitment to further training.

7.29 Phased Trauma Therapy for complex trauma (GPT27)

Description

Phased Trauma Therapy for complex trauma forms part of the 'Trauma Informed Services: Clinical Link Pathway'. It is beyond the scope of this document to review complex trauma, its development and symptoms. Please see the Trauma Informed Services for further information regarding these issues and how best to support an individual experiencing complex trauma. ICD 11 differentiates between 'simple' PTSD and 'complex' PTSD with the latter referring to trauma that tends to have occurred in the context of relationships, over a prolonged period of time, for example: childhood sexual, physical or emotional abuse, domestic abuse, sexual abuse in adulthood, chronic life-threatening illness, experiences of war, torture or trafficking and military trauma (NHS Scotland National Trauma Training Programme). As well as the triad of symptoms consistent with simple PTSD (re-experiencing; ongoing distress; avoidance) there are additional complexities associated with CPTSD i.e., a negative self-concept; persistent problems with affect regulation; and difficulties with trust and intimacy in relationships. There is a considerable overlap in symptomatology of CPTSD with other diagnostic labels such as EUPD.

Additionally, most individuals with Dissociative Disorders such as DID have CPTSD because of the trauma that has caused their condition was interpersonal, chronic, severe, started in childhood and had a significant developmental impact. Dissociative Disorders present with tertiary structural dissociation of personality compared to CPTSD that is characterised by primary and or secondary structural dissociation (van der Hart, Nijenhuis, & Steele, 2006). DID is currently recognised in ICD-11 (code: 6864) and DSM-5 (APA, 2022). Within ICD-11, a distinction between partial DID (a non-dominant state is making occasional and transience appearance e.g. when self-harming only) and full DID (substantial episodes of amnesia are typically present at some point during the course of the disorder disorder) exists. The current standard care with regards to the treatment of CPTSD and DDs such as DID (ISSTD, 2019; Herman, 2022; Blue Knot Foundation, 2019, 2020; UKPTS, 2017) recommends a three-phase approach to recovery which may be applied to any therapy model, when therapy is being considered. In clinical practice, the phased treatment model is not applied in a strict linear model but rather takes the form of a spiral in which attention to tasks belonging to the various phases alternate (Courtois, 1996). Treatment choices should be based on a comprehensive, collaborative, trauma-informed assessment, and formulation of need.

Phased Trauma Therapy for CPTSD and Dissociative Disorders (DD) involves three stages (Herman, 2022):

Phase one - Stabilisation:

This phase is a CORE task of mental health services and may be necessary at least to some degree over the whole period of care but is essential to establish at the outset. This phase involves a collaborative trauma-informed formulation, improving symptom management, self-

soothing and addressing current life stressors to achieve safety and stability in the present. It includes empowering and offering choice to the client, to enable them to have more understanding and control over their day to day lives. Phase one goals are likely to include personal safety, genuine self-care, and healthy emotion regulation skills.

For patients with DID, severity, complexity and whether they can meaningfully engage in phased treatment work plays a role. For instance, Horevitz & Loewenstein (1994) divided DID individuals into three subgroups that reflect the important differences in treatment complexity and prognosis: 1) high functioning DID clients; 2) complicated DID clients with comorbid conditions e.g. EUPD, ASD, ADHD and 3) enmeshed individuals, who are the most recalcitrant to treatment and who tend to remain enmeshed in abusive relationships, have a dissociative lifestyle and actively participate in self-destructive and or antisocial behaviours and habits. For the second & third subgroups, treatment focusing on stabilisation and symptom reduction may be the only feasible option and this may often be done by psychological professionals supporting the multidisciplinary context of care rather than offering therapy.

When the diagnosis of DID is clear and shared with clients, treatment is geared at stabilisation and symptom reduction, including containment of traumatic memories if they appear. It is recommended to consider the following interventions (see van de hart & Boon, 1997, Steele et al, 2017): boundaries of the relationship (e.g. contact, duration of therapy, breaks), psycho-education with regard to dissociation and DID as a survival strategies (e.g. structural dissociation model), develop positive relationship will all parts geared with compassion and speak 'their language', teach them how differentiate adult parts from child parts, teach them how to regulate parts and invite them to be more present, acknowledge identities and memories they may hold but not invite detailed exploration of traumatic memories until the individual is resourced and agreed with the whole person, develop a protocol for crisis management, understand and identify phobia of dissociative identities, phobia of emotion, phobia of traumatic memories, teach cooperation between various identities (in particular those which are unaware of traumatic past and function mainly in daily life), and general supportive interventions.

Fisher (2017) identifies that the most important goals of the stabilisation phase, in dissociation informed therapy, is for the therapist to support the most functional part (ANP), while holding in mind that this adult is influenced emotionally and physiologically by trauma related parts, to be invited to become more curious to understand the whole system of parts, promote acquisition of new, healthy self-regulatory skills for soothing, calming or energizing them, and foster a greater capacity for internal connectedness, for "association" instead of dissociation.

All eligible clinical staff who have attended an introductory training (e.g., ESTD UK Foundations online Course available within TEWV) and have appropriate supervision, will be able to deliver the phase of stabilisation and or support other mental health professionals to deliver dissociation informed care.

Phase two - Trauma-focused work to process traumatic memories:

This phase may be periodic but clustered in the middle phase of the treatment when the client is sufficiently able to address the memories without being overwhelmed. There will be collaborative discussion with the client about their goals and targets for re-processing and may draw on different governed psychological therapies with a proven evidence base to meet the client's goals (e.g., TF-CBT; EMDR), adapted for age and the client's specific needs. Herman describes this phase as involving "remembrance and mourning" i.e., working through the painful memories and the impact that they have had on the person's life.

In clients with DD, including DID, there may be a need before starting to address the traumatic memories, for the memories to be available within the shared consciousness between different identities through collaborative negotiation. Psychological professionals and other eligible clinical staff, with additional training in trauma focused therapies such as EMDR, TF-CBT or other relevant models may be able to deliver phase 2 work, while receiving appropriate supervision. It is important to note that phase 2 work requires careful planning, negotiation, and adaption of trauma focused therapies when working with DDs. The overall aim of phase 2 is the transformation of dissociative traumatic memories into auto-biographical-narrative memories of the traumas (van de hart & Boon, 2017). The outcome of successful transformation is that dissociation is reduced, and clients (including dissociative parts) overcome phobia of traumatic memories while revising trauma related beliefs and narratives. Phase 2 is not indicated for every DID client. Decision to proceed with phase 2 work should be taken in collaboration with all parts, and with appropriate supervision. This is more relevant to DID clients with severe comorbidities and/ or history of organised or ritual abuse.

Phase three - Reconnection and rehabilitation:

This phase of therapy involves re- establishing social and cultural bonds and building on treatment gains to enable the client to develop greater personal and interpersonal functioning. This phase increases towards the end of care and begins only after the impact of the trauma and the potential outcomes of therapy are understood.

The timescale for all three phases of therapy will vary considerably, depending on the age of the client, the nature of their trauma and their progress within therapy. In some cases, phase 1 may be sufficient to achieve the client's therapy goals, however, there is evidence that phase-based therapy which includes phase 2 (the trauma-focused work) is more effective than stabilisation alone (Willis, Dowling & O'Reilly, 2023).

In relation to DID clients, during the third phase, the focus is personality reintegration and rehabilitation. Often integration is referring to personalities having better co- consciousness (rather than fusion of personalities, which may also occur), and phobias of dissociation, phobia of normal life, phobia of traumatic memories and phobia of attachments are all overcome and or significantly reduced. In phase 3, the work may alternate with elements of phase 1 and phase 2 such as guiding clients with further co consciousness and integration of the personality, while revising

trauma related beliefs and identifying present motivations and coping strategies (refer to relevant guidance documents such as ISTSS, 2019).

Associated NICE Guidance/ Evidence based

Blue Knot Foundation (2019) *Practice Guidelines for Clinical Treatment of Complex Trauma*. http://www.blueknot.org.au/

Blue Knot Foundation (2020) *Practice Guidelines for Identifying and Treating Complex Trauma-Related Dissociation*. http://www.blueknot.org.au/

Courtois, C. A. (1996). Informed clinical practice and the delayed memory controversy. In K. Pezdek & W. P. Banks (Eds.), *The recovered memory/false memory debate* (pp. 355–370). Academic Press.

Corrigan, J. P., Fitzpatrick, M., Hanna, D., & Dyer, K. F. (2020). Evaluating the effectiveness of phase-oriented treatment models for PTSD—A meta-analysis. Traumatology.

Fisher, J. (2017) *Healing the Fragmented Selves of Trauma Survivors: Overcoming Self-Alienation*. Routledge: New York & London.

Horevitz, R. & Loewenstein, R.J (1994). The rational Treatment of Multiple Personality disorders In S. J. Lynn, I. Kirsch, & J. W. Rhue (Eds.), *Casebook of clinical hypnosis* (pp. 193–222). APA.

Herman, JL (2022). Trauma and Recovery: The Aftermath of Violence – From Domestic Abuse to Political Terror. Little Brown: London.

Kaiser, AP et al. (2019). Posttraumatic Stress Disorder in Older Adults: A Conceptual Review. Clinical Gerontology, 42(4): 359–376.

Willis, Dowling & O'Reilly (2023) Stabilisation and Phase-Orientated Psychological Treatment for Posttraumatic Stress Disorder: A Systematic Review and Meta-analysis - ScienceDirect European Journal of Trauma and Dissociation, 7 (1) 100311.

Phase-based approaches for treating complex trauma: a critical evaluation and case for implementation in the Australian context: Australian Psychologist: Vol 56, No 6 (tandfonline.com).

van der Hart, O., Nijenhuis, E. R. S., & Steele, K. (2006). The haunted self: Structural dissociation and the treatment of chronic traumatization. New York: Norton

World Health Organization. ICD-11 (https://icd.who.int; accessed 5 April 2024).

American Psychiatric Association. Dissociative Disorders. In: American Psychiatric Association (APA). Diagnostic and statistical manual of mental disorders, Fifth Edition, Text Revision (DSM-5-TR). APA: Washington, 2022

Overview | Post-traumatic stress disorder | Guidance | NICE

UKPTS Guideline on Complex PTSD - UKPTS

International Society for Traumatic Stress Studies (2019) *ISTSS Guidelines Position Paper on Complex PTSD in Adults*. ISTSS. ISTSS_CPTSD-Position-Paper-(Adults)_FNL.pdf.aspx

International Society for Traumatic Stress Studies (2019) *ISTSS Guidelines Position Paper on Complex PTSD in Children and Adolescents*. ISTSS. ISTSS_CPTSD-Position-Paper-(Child_Adol)_FNL.pdf.aspx

Training Requirements

Therapists need to have a core training as a HCPC registered Applied Psychologist or psychological therapist with an approved regulatory body, and also be able to demonstrate:

- That they have recognised post qualification CPD in at least one therapy relating to trauma focused therapy.
- If working with Dissociative Disorders, they have had specialised foundation training in working with DD including DID (e.g. ESTD UK Foundation Course currently available in TEWV)
- That they have had training or access to appropriate supervision which can support the appropriate use of GPT models with clients with a complex trauma history.
- That they can show they have regular clinical supervision from someone with knowledge of complex trauma and experience in working with complex PTSD and Dissociation.
- Psychological Professionals such as MHWP, CWP, PWP, EMHP, Assistant Psychologist or Higher Assistant Psychologist, trainee applied psychologist may also use this code to capture clinical activity in Phase 1 (stabilisation) when offering trauma stabilisation psychological wellbeing intervention while under the supervision and

oversight of a registered Applied psychologist or Psychological Therapist who fulfils the above criteria .

Supervision requirements

Regular supervision by a professional who is experienced in working with complex trauma and/or DD is essential for the wellbeing of the client and therapist. Therapists should adhere to their professional and model-specific requirements in terms of supervision.

With service users with DD that have complex abusive history arising within the context of organised or ritual abuse and evidence of mind control, it is wise to seek further professional advice on treatment by an expert and/or access further training as this population is likely to be more complex to work with due to traumatic transference and risks.

It is also important to consider the potential for vicarious traumatisation, services should encourage the following to reduce a therapist's risk of this: Recognition of the early warning signs of traumatisation, regular supervision, peer support, team support, containing management support, including self-care groups within the workplace, limits on exposure to traumatic material, balancing of caseloads, balancing days and scheduling of breaks, and having a good work-life balance.

Qualifying as a supervisor

This will vary depending on the qualifications of the therapist and the model(s) being used in therapy. Only those with the appropriate qualifications and required competencies will be able to supervise the phased trauma therapies. Please refer to the appropriate accrediting body.

Ongoing CPD requirements

It is expected that all therapists delivering phased therapy for complex trauma and DD will maintain their therapeutic skills and engage in regular CPD, in line with the requirements from their regulatory and/or accrediting body and this will be supported by the Trust through the appraisal process.

7.29 (a) The Flash Technique (Rapid Trauma Processing Intervention) - (No Code Currently)

Description:

The Flash Technique is not a GPT, however, refers to:

A specific technique for rapid trauma processing developed by Phil Mansfield (2016). This technique was originally designed to support stabilisation within the preparation phase of EMDR. However, it has now developed its own evidence base as an intervention to reduce the distress associated with traumatic memories.

This technique is distinct in that service users do not need to talk, think, or feel the emotions linked to distressing/traumatic memories. This makes this technique a safe, effective, and accessible intervention for clients. This makes Flash safe to use with limited adverse experiences in use, as it is less likely to trigger internal defences and dissociative responses.

Flash can also be used in multiple settings (Online, individual, group).

The Flash technique can be used as a standalone intervention or within specific trauma focused psychotherapies (EMDR, CBT) as an aide to trauma processing.

GPT Coding:

Currently there is not a specific code for recording when the flash technique is being used. It is therefore recommended that one is sought. Until there is a separate code, the Phased Trauma Therapy for Complex Trauma code is to be used.

Recommended Intervention for whom

The Flash Technique has been shown to be effective in PTSD and Complex trauma processing as well as Anxiety, OCD and Depression. Further research available at www.flashtechnique.com

It is specifically targeted at desensitising traumatic memories safely and effectively.

Entry requirements for Training

- Experience in working with people who have experienced trauma and associated symptomatology.
- Knowledge of limitations of working with trauma

- Knowledge and experience of trauma stabilisation practices (for example, calm place, grounding skills).

Training:

- Theory and practice are taught within the training which is a 3-hour webinar
- Following initial training an advanced training for a further day of training can be accessed.

Clinical Practice Requirement:

As a Trust we are agreeing to ensure the governed use of this technique. The following entry requirements for use of the Flash Technique in practice within the organisation are required:

Qualifications:

- Clinical or Counselling Psychology Doctorate; or Forensic Psychology Stage 2 training leading to HCPC registration.

Or

- A Governed Psychological therapy training.

And

1) Evidenced experience of working with trauma related symptomology within a therapeutic framework.
2) Currently under the supervision of a Psychological Professional.

For Registered professionals (Nurses, social workers, OT's and any other registered professional) who are not psychological professionals, and any un-registered professional, training should only be considered and offered in agreement with the Flash Technique lead and the Local Psychological Professional Lead to ensure the training is in the practitioners scope of practice.

The following criteria and scope of practice should also be met:

Foundations to training and practice:

- Have knowledge of the fundamental aspects of trauma symptomology
- Have experience of working effectively with trauma stabilisation and psychoeducation approaches around trauma, and trauma related dissociation.

Training:

- Have completed the Flash Technique training in its entirety and have a valid certificate of completion of training.

Application for those not trained in a GPT for PTSD/ Complex PTSD:

- To be used for single trauma events where a clear trauma symptomology is present.
- Fixed application with sets administered being specific (e.g. 3 sets).
- Use of the Flash Technique as intervention to reduce the distress of obvious intrusive trauma memories,
- Limited case conceptualisation and troubleshooting will occur.
- The goal is to engage in trauma stabilisation and not to aim for fully processing of SUD's to 0/10
- Must have agreement and supervision in place with a Qualified Psychologist or Psychological Therapist

Practice:

- To increase fidelity, at least 3 (or more based on agreed competence with supervisor) observed practices will be expected post training with a flash trained clinical supervisor who is also trained as a psychological therapist or applied psychologist.
- Receive ongoing supervision within the flash supervision network while practising the flash technique.

Supervision Requirements for all:

- All clinicians meeting the above knowledge, training, and competency for the use of the Flash Technique, **must**, access Flash Supervision as part of ongoing clinical development and practice.
- The minimum requirement expectation is that 2 flash focused supervision sessions a year are attended (at least one every 6 months).
- If not attending supervision either with a Flash experienced psychological therapist, an EMDR trained therapist or within the supervision network the clinician should **not** practise the technique.
- All supervision received should be recorded in line with Trust policy.

7.30 Play Therapy [GPT10]

The term 'Play Therapy' refers to:

- Formal non-directive play therapy and will exclude the use of play techniques and informal play experiences. Other frameworks such as CBT may be used alongside non-directive play therapy.

Play is the natural and primary way children communicate their feelings, learn, and make sense of their world. Play therapy utilises this process. During therapy children can explore emotions, thoughts and life experiences by being allowed freedom of expression in a safe and trusting environment.

Play Therapy is defined as:

"*Play Therapy is the dynamic process between child and play therapist in which the child explores at his or her own pace and with his or her own agenda those issues past current, conscious unconscious that are affecting the child's life in the present. The child's inner resources are enabled by the therapeutic process to bring about change. Play therapy is child centred in which play is the primary medium and speech the secondary medium*" (British Association of Play Therapists, 2005).

Supervision

As required by trust protocol. British Association of Play Therapists requirement is 12 hours per year at regular intervals and 24 hours per year for play therapists with less than 2 years' experience by a supervisor approved by the British Association of Play Therapists.

Training

Courses accredited by the British Association of Play Therapists are Post Graduate Diploma (2-year part time course) and M.A. (1 year part time course) in play therapy, Trainees hold a first qualification in either nursing, teaching, social work, occupational therapy and have extensive experience of working with children. Personal therapy and supervised practice are essential elements of the training.

7.31 Psychodynamic Psychotherapy [GPT4]

The term **'Psychodynamic Psychotherapy'** refers to:

- Psychodynamic Therapy
- Psychoanalytic Therapy
- Parent-infant psychotherapy

Psychodynamic Psychotherapy

This therapeutic approach draws on the core psychodynamic/psychoanalytic concepts of unconscious conflict, defences, hidden feelings and unhelpful repeated patterns in relationships to enable changes in the ways in which people experience themselves and others, and the ways they behave in their relationships with other people. It recognises the origins of psychological problems within early developmental experiences and links the impact and ongoing psychological consequences of those experiences with current life contexts and relationships. A safe, empathic and boundaried relationship between therapist and client enables emotional experience and its meaning to be revisited and experienced more fully and to be experienced as heard and understood by another person. At the same time the client's patterns of experience and behaviour in relation to other people can be explored and understood. These combined processes can change the functioning of defences and alter the ways in which an individual sees themselves, and the ways they are then able to behave in relation to others. Psychodynamic

therapy, including the recent DIT (Dynamic Interpersonal Therapy) adaptation, is usually relatively brief. Its principles can be helpful within very brief contexts of up to 10 sessions and can also be valuably used in therapy contexts of up to a year or more.

Psychoanalytic Psychotherapy

This therapeutic approach draws on psychodynamic/psychoanalytic concepts in more depth compared with psychodynamic psychotherapy. In comparison with psychodynamic therapy, it allows more opportunity for client defences and relationship patterns to be revealed and relived in the relationship with the therapist, which can lead to important developmental changes within the client. These processes can free up natural development, and help people to understand and resolve repeated problems, by increasing awareness of their problems, and of their inner world and its influence on behaviour and relationships. Therapy aims to reduce symptoms, promote

understanding and alleviate distress by helping individuals explore their underlying, often unconscious causes of difficulties within the context of the therapeutic relationship.

The duration of psychoanalytic psychotherapy will depend upon the severity, depth (age and development stage at which trauma or disturbance occurred), and how extensive is the nature of the psychological disturbance. It can be provided on a once-weekly basis or on a more intensive basis, up to three sessions weekly.

This therapy is indicated for patients whose difficulties may have multiple problematic and traumatic origins, be particularly complex and often not amenable to other interventions. The psychic depth at which the therapy works can, over time, enable deeply entrenched psychological difficulties to be resolved. It requires, therefore, a capacity to tolerate a process which at times can be deeply emotionally painful, in the interest of long-term emotional gains. Clients can include the most disturbed patients.

Parent-infant psychotherapy

This is based on psychoanalytic and psychodynamic theory and understanding as well as developmental psychology. It is applied to parents and infants in distress. The therapy explores the link between the parents' experience of being parented and their current difficulty in the relationship between them and their infant. This is often a brief model of therapy of five sessions over a period of time.

Supervision

As required by the Trust protocol. British Psychoanalytic Council (BPC) requirement is a minimum of 15 hours a year. BACP require an absolute minimum of one and a half hours a month.

Training

Training courses leading to accreditation by UKCP Psychoanalytic Section; BPC; Institute of Group Analysis; Clinical or Counselling Psychology Doctorate or Forensic Psychology Stage 2 leading to HCPC registration; training courses leading to BACP accreditation; HCPC registered psychotherapists.

For further information regarding Psychodynamic Psychotherapy, please see:
What is psychotherapy? Whatis psychoanalytic psychotherapy? (bpc.org.uk)

7.32 Schema Therapy [GPT34]

Description

The term 'Schema Therapy' refers to:

An intervention of formal schema therapy completed by an accredited schema therapist who meets the criteria for membership of the International Society of Schema Therapy (ISST) as an accredited schema therapist or an advanced accredited schema therapist. Founded in 2008, the ISST is the member organisation committed to the principles and practice of schema therapy.

Schema Therapy was initially developed by Jeffrey Young (1990) and stems from a Cognitive Behavioural Therapy (CBT) approach. It is based upon a unifying theory and a structured and systematic approach. It is an integrative treatment and therefore overlaps with other psychotherapeutic models such as cognitive, object relation theory, but there is no total overlap. The model can be summarised as the etiology of psychopathology in the form of maladaptive schema development when normal healthy developmental needs of childhood are not met. Schemas are constructs that include beliefs about ourselves, the world and others which result from an interaction between unmet core childhood needs, innate temperament and early environment. Schema activation results in intense states, described as schema modes. These modes can occur when schemas are activated and are the focus of the therapy. The key goals are to help change dysfunctional life patterns and develop ways of meeting core needs in adaptive ways by changing schemas and modes.

Associated NICE Guidance and other evidence base

- NICE guidelines (CG 78) Borderline Personality Disorder

Recommended Treatment for: **Adults and Older Adults with Complex Emotional Needs**
Psychological therapies for severe mental health problems | NHS England | Workforce, training and education

- Samantha A. Masley, David T. Gillanders, Susan G. Simpson & Morag A. Taylor (2011): A Systematic Review of the Evidence Base for Schema Therapy, Cognitive Behaviour Therapy, A systematic review of the evidence base for Schema Therapy - PubMed (nih.gov)

Training Requirements

Both standard and advanced accreditation is available. Competence for accreditation is assessed by trained independent assessors using the Schema Therapy Competency Rating Scale (STCRS). There are minimum scores required to be able to achieve accreditation.

See Training requirements document here:

2021 ISST CERTIFICATION REQUIREMENTS (INDIV) V.2.0 (2).pdf (schematherapysociety.org)

Supervision Requirements (for accreditation)

Supervision to be provided by an ISST approved accredited supervisor: minimum of 15 hours of supervision required for role plays and 20 supervision sessions (50-60mins in duration) for standard accreditation and 40 hours of supervision for advanced accreditation. Duration of supervision must be for a minimum of a year and a maximum of 3 years to achieve accreditation.

Qualifying as a supervisor

An ISST Certified Supervisor is entitled to:

- provide supervision in schema therapy to trainees preparing to apply for ISST certification as well as to other certified schema therapists. This ISST certified supervision counts towards the supervision hours that trainees need in order to apply for certification as a schema therapist. It also counts towards ISST Continuing Education Credits.

Application requirements for ISST certification as a supervisor. Applicants for certification as a Schema Therapy Supervisor must provide documented evidence of all of the following:

- having engaged in at least 2 years of Schema Therapy clinical work after the date of achieving Advanced Certification.
- having provided schema therapy to at least four clients for six months or more duration (at least 20 sessions each); of these, two must have a diagnosis of a personality disorder (or severe personality disorder traits). Adaptation of this requirement for Schema Therapy for Children and Adolescents, Schema Therapy for Couples, and Group Schema Therapy will be determined by the respective Training and Certification Committees and published in due course.
- having completed the ISST 12-hour Supervisor Skills Development (SSD) workshop webinars. You are eligible to take the workshop once you will have two years post advanced accreditation by the END of the workshop.
- Post completing the SSD the Supervisor candidate is able to begin certification supervision for a maximum of TWO supervisees. During this time the Supervisor Candidate is required to:
    - Have regular supervision of their supervision by a certified supervisor – trainer, for every 2-3 supervision sessions provided. This needs to total a minimum of SIX HOURS of supervised practice.
    - Use the STSVRS to discuss supervision experience.

- It is recommended that supervisors are to use this supervisor evaluation form to assist in the delivery of supervision and evaluate its effectiveness.

Ongoing CPD requirements

The ISST has a continuing education policy, this is outlined below:

- To maintain Schema Therapy Certification, Schema Therapists are required to:
  - Maintain their membership of the ISST and pay their annual dues on time.
  - Participate in 12 hours of Schema Therapy Continuing Education (CE) during any 2-year period.

- The 12 CE hours can be made up of any combination of the following:
  - Attending workshops on Schema Therapy topics presented by ISST Certified Trainers.
  - Attending individual Schema Therapy Supervision with an ISST certified trainer (50 minutes for 1 CE hour).
  - Attending Schema Therapy Group Supervision with an ISST certified trainer with the hours credited being determined by the same formula used for Standard or Advanced Certification.
  - Giving a formal presentation to a Special Interest Group (SIG) or Group Supervision. This presentation equals 1 Continuing Education hour. Not more than 3 such hours can count in any 2-year period and each presentation must be attested by a letter from the supervisor or SIG leader.
  - In the case of certified trainers, giving advanced training workshops on an aspect of the application of schema therapy (giving basic training workshops does not count for this).
- This CE requirement will apply from 1st January 2020 for those who are already Certified as schema therapists at the Standard or Advanced level.
- From January 2021, certified members will be asked to provide a summary of their CE activities during the previous year (and, from 2022, during the previous two years) when they apply for renewal of their ISST membership and make their annual dues payment.
- When a member becomes certified, the CE requirement will apply from January 1st of the year following the one in which they achieve certification.
- Honorary Life Members of the ISST are exempt from these CE requirements.

Further info about all of the above can be found at https://schematherapysociety.org/

7.33 Transference focused psychotherapy (TFP) GPT45

Transference-Focused Psychotherapy (TFP) is a form of psychoanalytic psychotherapy. It was specifically developed to help people who experience difficulties associated with their personality or personal functioning. The overall aim of TFP is for people to resolve these issues by achieving a better level of overall functioning, by improving relationships and by gaining a better ability to work and to enjoy life. TFP has a long history and grew out of many years of practical experience of providing psychotherapy to people with complex psychological difficulties. Transference-focused psychotherapy (TFP) is a psychoanalytically oriented modality predominantly working with relationships. TFP is an evidence-based psychodynamic psychotherapy developed by Otto Kernberg and colleagues at the Personality Disorders Institute in New York, for patients with a personality disorder such as borderline and narcissistic personality disorders. Therapy is once or twice a week, face-to-face, and preceded by a detailed assessment and diagnosis, and the negotiation of a therapeutic contract. The minimum course of therapy is one year.

Recommended treatment for: **Adults and Older Adults with Complex Emotional Needs**
Psychological therapies for severe mental health problems | NHS England | Workforce, training and education

Training: The training involves attending 42 hours of teaching of the TFP curriculum and two years of supervised practice, followed by an examination. Teacher-supervisors are examined at a higher level. Both levels of training are certified with the International Society of TFP.

7.30 Maudsley model of anorexia nervosa treatment for adults (MANTRA) [GPT43]

Description:
MANTRA is a specialist integrative therapy that has been developed specifically for the treatment of anorexia nervosa. MANTRA consists of seven core modules conducted over 20-40 sessions. MANTRA aims to address the cognitive, emotional, relational and biological factors which tend to maintain anorexia nervosa by working out what keeps people stuck in their anorexia, and gradually helping them to find alternative and more adaptive ways of coping. This might include: developing motivation to change and recover; improving food intake and nutrition; addressing interpersonal difficulties; developing more helpful styles of thinking; learning new ways of managing emotions; and developing a sense of identity that is separate to anorexia nervosa.

Recommended treatment for: Anorexia Nervosa
Associated Guidance: Eating disorders: recognition and treatment NICE guideline:NG69 2020
Overview | Eating disorders: recognition and treatment | Guidance | NICE

Competencies required to use this code:
Core Competencies for Eating Disorder as set out in Psychological interventions for Eating Disorders: A Psychological framework PLUS

5 days of teaching plus assessment days and supervised practice of MANTRA training delivered by The Maudsley Model of Anorexia Nervosa Treatment for Adults (MANTRA) Training Programme

Training Entry Requirements:
Trainees should be AFC band 6 or above working in specialist adult or all-age eating disorder services, have at least one year's experience of working with eating disorders, and be able to evidence core competences for psychological interventions for individuals with eating disorders covering generic
Therapeutic competences and assessment and formulation competences specified in the Roth & Pilling competency framework.

Supervision Requirements: A minimum of one hour per month of
MANTRA-specific supervision from an experienced MANTRA practitioner.

Accreditation: None currently

7.31 Eating Disorder Focused Focal Psychodynamic Psychotherapy – FPT AN [GPT29]

Description:

Focal Psychodynamic Therapy for Anorexia Nervosa (FPT-AN) is a manualised type of time limited psychodynamic psychotherapy developed by a group of professionals with clinical and research experience. The efficacy and safety of FPT for anorexia nervosa was assessed in the Anorexia Nervosa Treatment of Outpatients (ANTOP) study along with E-CBT (Enhanced Cognitive Behaviour Therapy, versus optimised treatment as usual. The study was funded by the German National Ministry of Education and Research (20067-2013).
ANTOP Study The ANTOP study: focal psychodynamic psychotherapy, cognitive-behavioural therapy, and treatment-as-usual in outpatients with anorexia nervosa - a randomized controlled trial - PMC

Competencies required to use this code: Core Competencies for Eating Disorder as set out in Psychological interventions for Eating Disorders: A Psychological framework

PLUS

Training and Accreditation:

Even though it appears that the model is closely related or heavily relying on psychodynamic theory there are no accredited training courses or any specific information regarding overall training requirements, including training route, commitment, and curriculum. The same applies to Supervision training and requirements.

In some relevant literature there is a reference to the use of the Operationalised Psychodynamic Diagnosis (OPD) tool as integral part of the therapy and the need for someone to be trained and certified to use:

Anorexia Nervosa: Focal Psychodynamic Psychotherapy. H. C.Friederich, B. Wild, S. Zipfel, H. Schauenburg, W. Herzog, 2019, Hogrefe Publishing GmbH - Anorexia Nervosa - 2019 - Focal Psychodynamic Psychotherapy – Hogrefe - Online testing, psychometric test & training providers

UCL Competencies for Focal Psychodynamic Therapy for Anorexia Nervosa 5 Focal psychodynamic therapy for anorexia nervosa PDF.pdf

NICE Guidelines (2017): Recommendations | Eating disorders: recognition and treatment | Guidance | NICE

FPT for adults with anorexia nervosa should:

- typically consist of up to 40 sessions over 40 weeks
- make a patient-centred focal hypothesis that is specific to the individual and addresses:
    - what the symptoms mean to the person
    - how the symptoms affect the person
    - how the symptoms influence the person's relationships with others and with the therapist
- in the first phase, focus on developing the therapeutic alliance between the therapist and person with anorexia nervosa, addressing pro-anorexic behaviour and ego-syntonic beliefs (beliefs, values and feelings consistent with the person's sense of self) and building self-esteem
- in the second phase, focus on relevant relationships with other people and how these affect eating behaviour
- in the final phase, focus on transferring the therapy experience to situations in everyday life and address any concerns the person has about what will happen when treatment ends.

7.32 Interpersonal and Social Rhythm Therapy (IPSRT) for Bipolar Disorder [GPT42]

Background:

Interpersonal and Social Rhythm Therapy (IPSRT) is an adaptation of Interpersonal Psychotherapy (IPT) for depression, a time-limited treatment that focuses on the bidirectional relationship between mood and life events. IPT also emphasizes strategies to improve social support and relationships. For more information about IPT, please visit the website of the International Society of Interpersonal Psychotherapy (ISIPT).
Social Rhythm Therapy (SRT) was added to IPT to form IPSRT. The SRT component came from clinical experience and research showing a connection between daily routines and mood. A growing body of evidence shows that disturbances in circadian rhythms, the approximately 24-hour biologic processes that control many aspects of physiology, contribute to risk for mood disorders. These intertwined research-based threads contributed to the evolution of IPSRT.
IPSRT is typically administered in four stages. The acute phase of treatment lasts about 20 weeks, with an option for maintenance treatment afterwards. Throughout IPSRT, therapists use tracking tools to monitor and modify patients' rhythms and relationships. These tracking tools include the Interpersonal Inventory and Social Rhythm Metric, which are available to registered site users.

Training Route:

Obtain qualification as an IPT Practitioner first and then undertake further training for IPT for Bipolar
IPT UK Training: Interpersonal Psychotherapy Training (IPT) | Anna Freud
IPT Practitioner Training - IPT UK

Training Commitment

Qualify as an IPT Practitioner: Six-day accredited with IPTUK course of didactic sessions, small and large group work, and clinical role-play. Followed by 4 supervised cases each run for 16 sessions (unless they are CAMHS cases, in which case it is 12 sessions).
THEN you can train in IPSRT

IPSRT Training UK:

Information can be found on the IPT UK website under training: "Other Courses / IPT for Bipolar"
Other Courses - IPT UK / IPT for Bipolar - IPT UK

Who can undertake this training (IPT)?

Individuals who have a mental health qualification and at least 2 years post qualification experience of providing psychological therapy for people with mental health problems. Those who have completed 2 years full time training in delivering psychological therapies e.g. final year clinical psychology trainees, are also welcome to apply. Individuals with a core Mental Health Professional Qualification or equivalent.

IPT Accreditation: Interpersonal Psychotherapy Training (IPT) | Anna Freud / IPT Practitioner Training - IPT UK

Course accredited by **IPTUK** and International Society of Interpersonal Psychotherapy **ISIPT** Therapist Added Qualifications (AQ) Certification–IPSRT | International Society of Interpersonal Psychotherapy - ISIPT

Practitioners must have the following credentials to deliver this therapy:
Specific IPT/ Interpersonal and Social Rhythm Therapy (IPSRT) for Bipolar Disorder as set out here by UCL: Bipolar IPT-Social Rythm Therapy web version.pdf
Those wishing to become IPT practitioners are required to undertake supervision with an IPTUK accredited Supervisor.

7.33 Video Interactive Guidance (VIG) [GPT29]

Description

VIG is an intervention where the client is guided to reflect on video clips of their own successful interactions. The process begins by helping the family or professional to negotiate their own goals and asking them what they would like to change. Adult-child interactions are then filmed and edited, to produce a short film that focuses on what is working well.

This is followed by a shared review session of the video, where the family and professional review and micro-analysis successful moments, particularly those when the adult has responded in an attuned way to the child's action or initiative using a combination of non-verbal and verbal responses. They reflect collaboratively on what they are doing that is contributing towards the achievement of their goals, celebrate success and then make further goals for change. These reflections move very quickly from analysis of the behaviour to the exploration of feelings, thoughts, wishes and intentions.

Guiders are supervised in their own practice through the analysis of themselves in filmed interaction. Film is gathered of shared review with clients, and these are used in supervision, to focus and build on micro-moments of attuned interaction, particularly those where they activate the client to make initiatives, then receive the client fully and respond with ideas that can be understood and used to promote positive change.

Patient leaflet can be found here: T:\Patient and Carer Information\Trustwide\AMH Trustwide information

Evidence Base

The UK Association of Video Interaction Guidance (AVIGuk) was set up in 2012 to provide more direction and leadership. This body regulates standards and has the most up to date guidance on the intervention: www.videointeractionguidance.net

VIG has a growing and evolving evidence base including;

- Overview | Children's attachment: attachment in children and young people who are adopted from care, in care or at high risk of going into care | Guidance | NICE NICE26
    - Cochrane Review (2019) endorses video feedback interventions to enhance sensitivity in parents of children at risk of poor attachment (November 2019 Cochrane Review) Video feedback for parental sensitivity and attachment security in children under five years - O'Hara, L - 2019 | Cochrane Library

Training

Training consists of an Initial 2-day Training Course which provides the background to VIG and orientates participants towards the underlying value system and how this affects practice.

To be accredited, trainees are expected to work with a minimum of 6 clients and to undertake 18 cycles of VIG (a cycle consists of taking a film and doing a shared review of the clips with the client). Each trainee normally requires 15 hours individual supervision with an accredited VIG supervisor to become accredited as a VIG practitioner with AVIGuk.

There is a further midpoint training day halfway through the clinical supervisory process. The successful candidate will subsequently be registered with AVIGuk as an accredited practitioner and may practice independently. There is a requirement that you have at least 2 InterVision's whilst training as a practitioner. InterVision is peer supervision in which video is shown and reviewed.

Supervision

Whilst in training practitioners are required to have supervision from an accredited VIG supervisor. Once practitioners are accredited, they can then engage in peer supervision with other accredited VIG practitioners. All practitioners currently practising VIG are expected to engage in InterVision and AVIGuk strongly recommends practitioners having at least 6 InterVision sessions per year (showing videos of their work) and/or 6 individual supervision hours per year.

Qualifying as a Supervisor

An AVIGuk supervisor is required for clinicians to progress to be accredited as a VIG Practitioner, Advance Practitioner and Supervisor.

Ongoing CPD requirements

Once accredited there is a requirement for VIG practitioners to participate in CPD, retain a log as outlined by AVIGuk and attend InterVision supervision as outlined above.

8. Low Intensity Interventions

8.27 Low Intensity Cognitive Behaviour Therapy (LI-CBT) [awaiting code]

Description

As with CBT, LI-CBT is based on the cognitive model but targets those presenting with mild to moderate low mood/depression and anxiety disorders where assessment indicates a more parsimonious intervention is likely to be effective. Similarly, LI-CBT shares the theoretical underpinnings described for CBT, but LI-CBT aims to deliver evidence-based intervention in the most effective and least burdensome way as recommended by national guidelines for best practice e.g., NICE. Within the stepped care model of psychological therapy LI-CBT is considered most appropriate at step 2 (or getting help within the Thrive model).

Typically, LI-CBT is aimed at treating mild to moderate presentations of common mental health disorders such as: Generalised Anxiety Disorder, Panic Disorder, Separation Anxiety Disorder, Obsessive Compulsive Disorder, Social Anxiety Disorder/Social Phobia, Low Mood/Depression, Specific Phobia and Low Self-Esteem. Treatment normally involves fewer sessions of shorter duration (e.g., 30 minutes), compared to High Intensity CBT. Delivery modes can include face to face, telephone/video therapy, computerised CBT, pure/guided self-help, psychoeducational class and therapeutic groups e.g., Parent-Led CBT.

Associated Guidance

Children and Young People Wellbeing Practitioner (CWP) National Implementation Guide (in Press).

BABCP: Apply for PWP Registration (babcp.com) CWP Registration (babcp.com)

BPS: Psychological Wellbeing Practitioner (PWP) | BPS
Also see condition specific NICE guidelines for anxiety and mood disorders.

Training

Training- for specific up to date guidance please check CWP Registration (babcp.com)

BPS Accredited BABCP Post-Graduate Diploma/Certificate in LICBT (or Health Education England (HEE) Quality Assured CWP Training Course prior to January 2023).

BPS Accredited BABCP Post-Graduate Diploma in HICBT with specialist training in the LICBT approach (Health Education England (HEE) Quality Assured CWP Training Course prior to January 2023).

Supervision

Requirements for specific up to date guidance please check CWP Registration (babcp.com)

As a minimum qualified LICBT practitioners should receive 1-hour individual Case Management Supervision every fortnight (or 2 x 30 minutes a week).

Clinical Skills Supervision should remain as 1 hour once a fortnight for the first six months post qualification. As a minimum CSS should be offered for 1 hour every month after this.

Live supervision: 4 episodes of live supervision per annum. requirements to be confirmed.

Qualifying as a Supervisor- for specific up to date guidance please check CWP Registration (babcp.com)

Clinical Skills Supervision should be provided by a practitioner who is appropriately qualified and experienced in LICBT or HICBT approaches. Supervisors must also be currently practicing and utilising CBT or LICBT (i.e., be an BABCP accredited/accreditable CBT practitioner or a BABCP/Registered CWP/SWP/EHMP). All supervisors should have attended the CWP/EMHP supervisor (PG Certificate or CPD) or Senior Wellbeing Practitioner (SWP) G/PG Diploma training programme, provided by one of the nationally commissioned training providers. If supervisors have not completed this training, they must have at least two years' experience of providing supervision to CWPs and have completed a supervisors competency assessment framework with a senior accredited practitioner/CYP-IAPT LICBT trainer on a HEE approved programme. For most recent guidance see the BABCP website CWP Registration (babcp.com)

CPD- for specific up to date guidance please check CWP Registration (babcp.com)

5 CPD activities per year (e.g., workshops, lectures and self-directed study, including inhouse CPD).

Minimum of 6 hours skills practice.

8.28 Behavioural Activation (BA) [awaiting code]

Description

BA as a stand-alone treatment evolved from activity scheduling which was originally developed by Beck (1979) as a component of Cognitive Therapy for Depression.

It should be recognised that BA is a distinct therapy in its own right with a robust evidence base across age ranges (Ekers et al., 2011; Richards et al. 2016; Tindall et al. 2017). It differs significantly from activity scheduling which is viewed as a change method/technique rather than a stand-alone therapy/treatment. Hence, BA as a therapy contains the assessment, intervention and relapse prevention stages of therapy. It also requires comprehensive training and supervision in order to be delivered to a competent level.

BA as an evidence-based therapy is based on the behavioural model of depression (Martell et al. 1996) and aims to:

- To increase contact with diverse and stable sources of positive reinforcement and create life with meaning a purpose.
- To develop a broader and more flexible repertoire of behaviours than has developed in depression.
- Encourage the individual to do more of what matters, to get more out of life which is in turn antidepressant.

BA is exclusively aimed at treating Low Mood/Depression across the age ranges. There are a number of different BA protocols ranging from 20-24 session Martell model BA (Martell et al., 2022) to more contemporary Values-based BA for adults and adolescents (Lejuez et al., 2011; Pass et al., 2018;2022). As such BA falls under umbrella of CBT and training in these approaches are part of the curriculum for LICBT and HICBT training.

Associated Guidance

NICE (2022). Depression in adults: treatment and management. NICE guideline (NG222).

www.nice.org.uk/guidance/ng222

NICE (2019). Depression in children and young people: identification and management, NICE guideline (NG134). www.nice.org/guidance/ng134

Training Requirements

Post-Graduate Diploma/Certificate in LICBT.

Post-Graduate Diploma in HICBT.

Clinical or Counselling Psychology Doctorate; or Forensic Psychology Stage 2 training leading to HCPC registration with specialist training in BA.

Certificate in Behavioural Activation training provided by an approved trainer and approved by the CBT/BA lead in TEWV.

Supervision Requirements

If intervention is being delivered by accredited or registered HICBT or LICBT therapist, then please refer to standard CBT and LICBT supervision requirements. Please note that not all supervision content highlighted above needs to be on BA, but BA should receive regular discussion as needed.

If BA is being delivered by a practitioner who has only completed specialist training in BA, the supervision should be delivered by a qualified supervisor and the amount should be determined by that supervisor and be a minimum of 1 hour per month.

Qualifying as a Supervisor

Supervision should be provided by a HCPC registered practitioner psychologist (with additional LICBT training if supervising LI approaches), BABCP accredited CBT therapist or a LI-CBT trained therapist, with 3 years post qualification experience and a post graduate qualification in supervision.

9. Psychological wellbeing interventions (PWBIs)

There are many ways to use psychological knowledge to help people reduce their feelings of distress, to change behaviour, or improve wellbeing.

There are some interventions have been developed and described in ways that have enabled them to be disseminated and researched and can therefore be described in detail to help us be more effective and safer when working with people who are in distress.

The Trust calls these PWBIs and has given them Paris codes so help guide staff to deliver these interventions in line with best practice guidance.

9.27 Activity scheduling (previously BA PWB16)

This change technique is about supporting a service user to recognise the relationship between avoidance and negative reinforcement and engagement in activity and positive reinforcement. Activity Scheduling supports a service user to introduce small changes where they will schedule daily activity encompassing value, pleasure and mastery. The level of activity will be built up gradually allowing the service user to work towards achieving their goals. Activity scheduling is different to Behavioural Activation which is a Governed Psychological Therapy requiring specific training and supervision.

9.28 Managing emotions PWB20

Managing emotions is about: supporting service users to help them understand the meaning and purpose of emotions, discussing helpful models that describe emotions, learning how to identify emotions in themselves and others (in the body, in thoughts, and through behaviours), and learning skills to tolerate, learn from, and manage emotions. The aim is to help the service user to notice, tolerate, and express their emotions in ways that don't get in the way of recovery, or cause harm to themselves or others. Recommended materials available within specialties which are overseen by the Psychological Professions leads.

9.29 Sleep interventions PWB27

Sleep interventions are used when the service user has difficulty in getting to sleep, difficulty staying asleep, early wakening, or non-restorative sleep despite adequate time and opportunity to sleep. Sleep interventions should be used when these patterns of sleep result in distress and/or impaired daytime functioning, such as poor concentration, low mood, daytime tiredness and reduced ability to access coping skills. Interventions can include sleep hygiene (including

education), exercise, stimulus-control therapy, sleep restriction activities, relaxation training or paradoxical intention.

9.30 Hearing Voices and unusual experiences PWB21

These are interventions aimed at helping the service user to cope better with their experiences so that they are able to achieve personal recovery aspirations and meaningful goals. Validating the service user's experiences and helping them to feel okay about talking about their voices or unusual experiences is the first key step. Normalising, and coping strategies are essential activities that help the service user to make sense of their experiences and promote psychological wellbeing. Whatever someone believes about their experiences, the most important thing is to help the person find ways of dealing with their belief and finding some sense of power, control and hope within it.

9.31 Psychoeducation PWB22

Psycho-education refers to an educational approach to recovery in mental health. It complements other clinical interventions. Psychoeducation involves providing information to service users experiencing mental health problems to enable them to understand their individual difficulties and take steps to manage aspects of their difficulties themselves. Psychoeducation also involves signposting service users to other sources of support and activities that can assist them in managing their well-being.

9.32 Positive Behavioural Support PWB28

Positive Behavioural Support (PBS) provides a values-based framework that seeks to understand the context and meaning of behaviour in order to inform the development of supportive environments and skills that can enhance a person's quality of life. It is a person-centred approach, which focuses in a planned way on understanding why, when and how behaviours happen and what purposes they serve for the individual. It is offered in a therapeutic atmosphere of compassionate care and support that inevitably requires positive changes in how services work to support the person.

9.33 Reminiscence/ life history work PWB7

This is the shared gathering and discussion of personally relevant information about a service and his/her lives in order to communicate with and better understand the person, enable cognitive stimulation, stimulate memories and enhance self-worth. Individual discussion about the service user's life, group reminiscence sessions, developing a memory box, creating life story books, using digital life story programmes such as 'My Life', presenting audio/visual materials, such as films/music, and discussing memories of these, developing a visual collage of meaningful images/objects. Reminiscence/Life History is used principally with service users who have difficulties with cognition in order to enable communication.

9.34 Graded Exposure Activities PWB23

Graded exposure activities involve a service user staying in a feared situation in a planned way to reduce anxiety caused by that feared situation. The service user does this in collaboration with another lead clinician who will have agreed the activities within the therapeutic sessions such as for trauma or phobias. Graded exposure work requires careful planning and regular review.

9.35 Motivational Interviewing PWB24

Motivational interviewing can be a distinct intervention or part of a conversation that involves listening and helping the service user to explore the idea of change in relation to a particular behaviour or behaviours. It is based on the understanding that people need to feel confident before trying to change, and that uncertainty is normal. A number of approaches are used to facilitate this process: For example, asking open-ended questions, listening reflectively and prompting self-motivational statements. It is usually provided formally on a 1:1 basis over several sessions.

9.36 Cognitive Stimulation Therapy PWB6

Cognitive Stimulation Therapy is a brief group treatment for people with mild to moderate dementia. It is based on ideas from of reality orientation and cognitive stimulation. A one-to-one personalised version of CST has also been developed. Sessions follow similar themes and ideas to group CST. Family, carers, or health staff can offer them. Health staff delivering this intervention will have a good understanding of dementia.

9.37 Peer Support PWB25

This is a specific code only to be used by individuals employed in the organisation as Peer Support Workers. Peer Support is at its simplest the process of individuals with lived experience of mental distress connecting with and supporting each other. To be considered Peer Support this has to be values based, being founded on; empathy, trust, mutuality and reciprocity, equality and a non-judgemental attitude. Peer support should be trauma informed.

9.38 Relational Interventions PWB26

This intervention is about interacting with a service user in a planned (or strategic) way so that person experiences a particular aspect of human relationships. For example, during and after contact with the member of staff, the service user might experience compassion, or feel that they have been related to as a competent adult, or that their emotions have been taken seriously, or that they are being held in mind between appointments. Relational interventions are relevant to any / all contact with a service user (including by phone). Relational interventions can be used in a planned way by the whole clinical team, based on the services user's individual formulation, or just by one member of the team. These interventions often happen alongside doing other things (e.g., whilst drawing up a staying well plan or dealing with a crisis) and influence the way these other things are done. Relational interventions need to be individualised for each service user. They are based on the psychological formulation and are specific to that person. They are more specific to a particular person than our normal therapeutic compassion and collaboration skills.

9.39 Guided Self Help for Eating Disorder PWB29

Please note this is for Eating Disorders Use Only

Guided self-help for eating disorders is based on a version of cognitive behaviour therapy that has been adapted to help people experiencing eating difficulties (CBT-E). This intervention usually involves the service user working through a book or booklet between regularly planned meetings with a worker. The book or booklet used will be based on the specific eating problem identified or the closest match if the service user's difficulties overlap between different eating problems. Examples of specific eating problems include Anorexia Nervosa, Bulimia Nervosa and Binge Eating Disorder.

9.40 Self Help [Code Required]

Self-help can be delivered on an independent basis or working alongside a clinician. This intervention usually involves the service user working through a book, booklet or online resources

between regularly planned meetings with a practitioner. The self-help materials used will be evidence-based packages with robust research support.

9.41 Computerised Therapeutic Interventions [Code Required]

Can be delivered on an independent basis or working alongside a clinician. This intervention usually involves the service user working through a computerised therapeutic programme that does not fall under the bracket of GPT. The programme used will be an evidence-based package with robust research support and offered according to approved service procedures. Supervision for computerised therapeutic interventions should be delivered by someone already trained in the computerised package.

9.42 Trauma Stabilisation [Code Required]

Trauma stabilisation is often seen as one of the first stages in the treatment of trauma across the age ranges. Trauma stabilisation might include psychoeducation using agreed materials, building support networks and ensuring a stable and safe environment. Trauma Stabilisation should always be delivered under the supervision of a professional appropriately qualified to deliver one of the evidence-based treatments. See entries for TF-CBT, EMDR and Phased Trauma Therapy for Complex Trauma.

9.43 Mindfulness [Code Required]

Introducing service-users to the perspectives and practices of mindfulness can support them in developing important skills and attitudes which support psychological wellbeing. Clinicians using this approach with service-users should have significant personal experience of mindfulness practice that they can draw upon when working in this way. The TEWV mindfulness team runs regular courses for staff – these are a good way to develop a personal practice as well as a theoretical understanding. The mindfulness team also runs 'Using mindfulness in clinical practice' workshops for graduates of 8-week courses. These workshops focus on how best to introduce mindfulness into clinical practice in a safe and trauma-sensitive way. This code refers to the use of mindfulness as a psychological wellbeing intervention in therapeutic work with individuals (or sometime families). There is a different code for Mindfulness Based Cognitive Therapy (MBCT), which is a governed psychological therapy delivered in a group format. MBCT is described elsewhere in this document.

9.44 Parent Infant Relationship PWB31

This code is used when the focus of the work is on interventions to develop and support the parent-infant relationship. Training courses that practitioners base this work upon might include Baby Massage, Baby Yoga, Hypnobirthing, the Solihull Approach, Compassion Focused work that includes the baby, DBT informed work including the baby, Neonatal behavioural assessment scale; neonatal observation scale; Watch, Wait and Wonder or Mellow Parenting courses. Practitioners may also provide psychoeducation about the parent – infant relationship and how to promote the development of this.

10. How this procedure will be implemented

- This procedure will be available on the trust intranet and can be accessed by any member of staff.
- Psychological Professions leads and team and service managers will disseminate this procedure to all Trust employees accompanied by a trust wide briefing.
- Any concerns raised about current practice that does not adhere to the procedure will be managed in a supportive manner.
- The approach described within this procedure has been in place in the trust for several years therefore this should not cause significant change to practice.

10.27 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Communication to be shared with all staff via Psychological Professions leads and team and service managers to all staff.	For all staff to ensure they are providing appropriate and safe patient care. For all staff to access the required training, supervision and CPD to sustain their practice.	By September 2025	CPPO and Psychological Professions Leadership.	Through feedback, minutes of relevant meetings and audit of activity codes.

11. How the implementation of this procedure will be monitored

Number	Auditable Standard/Key	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented and

	Performance Indicators		monitored; (this will usually be via the relevant Governance Group).
1	Activity codes	Frequency = every 24 months Method = via report from IIC Responsible = CPPO	Ownership by the Psychological Professions Governance Group (PPGG) and shared with the Care Groups via the Psychological Professions leads.
2	Activity codes that mention GPT in some format other than those stated in this procedure document.	Frequency = initial audit required Method = via report from IIC Responsible = CPPO	Ownership by the PPGG and shared with the Care Groups via the Psychological Professions leads.

12. References

See each section for relevant references

13. Document control (external)

To be recorded on the policy register by Policy Coordinator

Required information type	Information
Date of approval	26 August 2025
Next review date	26 August 2028
This document replaces	CLIN-0035-002-v1 GPT Framework Procedure
This document was approved by	Psychological Professions Governance Group (PPGG)
This document was approved	26 August 2025
This document was ratified by	n/a
This document was ratified	n/a
An equality analysis was completed on this policy on	26 August 2025
Document type	Private
FOI Clause (Private documents only)	n/a

Change record

Version	Date	Amendment details	Status
v1.1	26 Aug 2025	Full review with minor changes as detailed below. P4 added into related document section; Interpreting and Translation Procedure. P6 additional statement added regarding applicability of document for psychological professions and staff who are not in a psychological profession P7 section 5.1 Additional statement regarding regulatory requirements (inclusion of PSA regulated bodies).	Published

		P7 section 5.1 Additional statement regarding entry requirements to training P14 updated section on Attachment therapy for CYP. Pages 21,24,28,29,31, CBT codes changed to match the SNOMED codes required to flow to the MHSDS to provide evidence for transformation of services for SMH. P38 Placeholder for new code for RO-DBT P60 Phased trauma section updated to reflect current understanding of trauma, dissociation and dissociative identity disorder and updated practice guidelines. P65 Flash (rapid processing) section added and linked to the above, phased trauma section. P68 section on Structured Clinical Management added to this document to formalise governance for services who are using this existing intervention.	

Appendix 1 - Equality Impact Assessment Screening Form

Please note: The Equality Impact Assessment Policy and Equality Impact Assessment Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Director of Therapies
Title	Governed Psychological Therapies
Type	Procedure/guidance
Geographical area covered	Trust-wide
Aims and objectives	To provide an assurance framework for the governed psychological therapies provided within TEWV
Start date of Equality Analysis Screening	April 2025
End date of Equality Analysis Screening	26 August 2025

Section 2	Impacts
Who does the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?	Service users who are offered psychological therapies, and staff who are providing psychological therapies. Provides assurance for the trust regarding safe and effective care.
Will the Policy, Procedure, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups? Are there any Human Rights implications?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO** • **Sex** (Men and women) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual, Heterosexual, Pansexual and Asexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women / people who are breastfeeding, women / people accessing perinatal services, women / people on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families) **NO** • **Human Rights Implications NO** (Human Rights - easy read)
Describe any negative impacts / Human Rights Implications	None anticipated
Describe any positive impacts / Human Rights Implications	More people will access evidence based interventions.

Section 3	Research and involvement
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	Best practice guidance have been referenced including peer reviewed research and NICE guidelines.
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	No
If you answered Yes above, describe the engagement and involvement that has taken place	
If you answered No above, describe future plans that you may have to engage and involve people from different groups	We will include live experience staff, service users and carers in the governance process.

Section 4	Training needs
As part of this equality impact assessment have any training needs/service needs been identified?	No
Describe any training needs for Trust staff	
Describe any training needs for patients	
Describe any training needs for contractors or other outside agencies	

Check the information you have provided and ensure additional evidence can be provided if asked.

Appendix 2 – Approval checklist

To be completed by lead and attached to any document which guides practice when submitted to the appropriate committee/group for consideration and approval.

Title of document being reviewed:	Yes / No / Not applicable	Comments
1. Title		
Is the title clear and unambiguous?	Y	
Is it clear whether the document is a guideline, policy, protocol or standard?	Y	
2. Rationale		
Are reasons for development of the document stated?	Y	
3. Development Process		
Are people involved in the development identified?	Y	
Has relevant expertise has been sought/used?	Y	
Is there evidence of consultation with stakeholders and users?	Y	
Have any related documents or documents that are impacted by this change been identified and updated?	Y	
4. Content		
Is the objective of the document clear?	Y	
Is the target population clear and unambiguous?	Y	
Are the intended outcomes described?	Y	
Are the statements clear and unambiguous?	Y	
5. Evidence Base		
Is the type of evidence to support the document identified explicitly?	Y	
Are key references cited?	Y	

Are supporting documents referenced?	Y	
6. Training		
Have training needs been considered?	Y	
Are training needs included in the document?	Y	
7. Implementation and monitoring		
Does the document identify how it will be implemented and monitored?	Y	
8. Equality analysis		
Has an equality analysis been completed for the document?	Y	
Have Equality and Diversity reviewed and approved the equality analysis?	Y	29 Aug 2025 lc
9. Approval		
Does the document identify which committee/group will approve it?	Y	
10. Publication		
Has the policy been reviewed for harm?	Y	
Does the document identify whether it is private or public?	Y	
If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	n/a	
11. Accessibility (See intranet accessibility page for more information)		
Have you run the Microsoft Word Accessibility Checker? (Under the review tab, 'check accessibility'. You must remove all errors)	Y	
Do all pictures and tables have meaningful alternative text?	Y	
Do all hyperlinks have a meaningful description? (do not use something generic like 'click here')	y	