

## **Children and Young People's Improving Access to Psychological Therapies Programme**

**National Curriculum for Core, Cognitive Behavioural Therapy, Parenting Training (3–10 year olds), Systemic Family Practice, Interpersonal Psychotherapy for Adolescents, Supervision, and Transformational Service Leadership\***

**Version 8**

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## Acronyms

CYP IAPT	<i>Children and Young People's Improving Access to Psychological Therapies</i>
CBT	<i>Cognitive Behavioural Therapy</i>
IPT-A	<i>Interpersonal Psychotherapy for Adolescents</i>
PT	<i>Parenting Training</i>
SFP	<i>Systemic Family Practice</i>

## Acknowledgements

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## 1. Introduction to the Children and Young People’s IAPT Curriculum

The key aim of the project is to transform existing services for children and young people by adopting those elements of the IAPT programme that will help improve outcomes for children and young people, and by providing treatment which is based on best evidence, outcomes focused and client informed.

We will do this by:

- Working in partnership with children and young people to shape their local services and supporting local services participating in the project to do likewise
- Working in partnership with parents and carers to shape their local services
- Supporting local services participating in the project embed parents and carers participation
- Supporting services to develop a culture of reflective practice and accountability
- Improving the workforce through training in best evidence based practice
- Developing mechanisms to deliver frequent/session by session outcome monitoring to help the therapist, service user and where appropriate parent/carer to work together in their session, and to help supervisors support therapists in improving outcomes
- Supporting local areas in improving the infrastructure they use to collect and analyse data to see if children and young people are getting better

For further detail please see: <http://www.iapt.nhs.uk/cyp-iapt/children-and-young-peoples-project/>

### Overview of the Phase II Curriculum

The Phase II curriculum has five main components for therapists and two specialist courses for supervisors and service leads (see table below).

Component	Content
Clinician Component I	Core CYP IAPT Skills
Clinician Component II	Cognitive Behavioural Therapy
Clinician Component III	Parenting Training
Clinician Component IV	Interpersonal Psychotherapy for Adolescents
Clinician Component V	Systemic Family Practice
Component VI	Supervisor’s Unit
Component VII	Transformational Leadership Unit

The course is likely to be provided by, or affiliated to, a university, and run as a one-year full-time course. The current higher education institutions (HEIs) working with the programme have assigned 120 credits to the clinician component and 60 credits to supervisor and transformational leadership units, respectively. The precise organisation of teaching units will be determined by respective learning collaboratives. In the case of the clinical component, elements of the Core CYP IAPT unit may be delivered within the therapy-specific unit – for example, collaborative care is a theme that should run through every aspect of the training, rather than being a discrete section. In essence, learning collaboratives represent a collaboration of clinical services (partnerships) and an HEI. The formation of the collaboratives is beyond the scope of this document. Initially the courses will be annually accredited by appropriate professional associations through agreed processes with the CYP IAPT National Accreditation Council.

## **The therapist postgraduate diploma**

Therapists will undertake the core skills component and either Cognitive Behavioural Therapy, Parenting Training, Interpersonal Psychotherapy for Adolescents **or** Systemic Family Practice. As an indication, we assume that these components have equal weighting of 60 credits per unit (with the exception of IPT-A), although we assume that in terms of clinical load they are comparable. Aspects of the Core module will also be delivered via the therapy-specific module. The postgraduate diploma currently requires 120 credits at M level. Each will have modules/units corresponding to the curriculum structure outlined in this document.

Note: for the postgraduate course for IPT-A the therapist will undertake the core skills component (60 credits) and IPT-A training (credits awarded by the HEI).

## **Service leader and supervisor curriculum**

The service lead and supervisor curriculums outlined below are expected to have module values of 60 credits each or equivalent. Modules and credit ratings can be adapted by institutions and training providers to comply with their academic timetable and can be tailored to suit local needs.

## **Who will be trained?**

There will be three categories of participants:

- Frontline existing CAMHS clinicians with basic competencies (listed online at <http://www.ucl.ac.uk/CORE>). The criteria for being accepted as a trainee include a significant number of the core CAMHS competencies listed in this curriculum and an ability to undertake an academic course to masters level. Trainees without a relevant postgraduate qualification will be asked to demonstrate that they are able to undertake the academic work by HEIs. It will not be specific to any CAMHS professional group. Each clinician is expected to complete Component I (core skills) plus **one** of the other five modality-specific components (e.g. the parent training for conduct disorders option).

- Supervisors (as far as possible from the same services as the clinicians) who are in a position to take on supervision of clinicians attending the course. Supervisors may be those with recognised postgraduate professional training; in order to supervise trainees in modalities, they are to have appropriate qualification in CBT, behaviour therapy, social learning or parenting, systemic family practice, interpersonal psychotherapy, and a minimum supervisory experience of 2 years. In line with the overall objective of improving supervisory practice in CAMHS, Partnerships may wish to send supervisor trainees who do not have modality-specific training. In these cases, acceptance of a non-modality-specific supervisor will be at the discretion of the HEI and will be based on experience and competence to undertake the course. Supervisors without appropriate modality-specific expertise will not be able to supervise on specific modalities and such supervision will need to be provided by a suitable clinical supervisor. The module will be delivered in advance of clinicians beginning their practical training.
- CAMHS leads currently responsible for the organisation of the service participating in the Learning Collaborative. A further module will be available to deliver a transformational leadership curriculum for service leads (who may be clinical or managerial) only, which is to be delivered concurrently with the training of clinicians. Service managers and leaders participating in the programme will be of sufficient status and experience to be able to lead and manage change and support change in other services.

The three categories of participants together make up the change agents within the CAMHS participating in the programme. There will be overlap between the training for each category, and it is expected that HEIs will identify ways to create synergy and reduce inefficiencies, both to maximise course value and to support the creation of an integrated change team.

For all parts of the CYP IAPT training programme there will be (a) face-to-face (direct) teaching and (b) supervised clinical practice **or**, for service leads, programmes around service change. The precise ratio and timetabling of these two forms of learning are left to individual collaboratives. However, CYP IAPT suggests as an indicator that at least half of the training time should be in learning activities with fellow trainees from other services.

The enclosed document offers a framework for training which specifies the aims and general and specific learning outcomes for a series of subject domains which must form part of the CYP IAPT training programme. There is no obligation for collaboratives to adhere rigidly to the detailed structure outlined in this document other than respecting the five distinct components outlined above, and covering **all** the content domains listed below. It is essential that collaboratives can demonstrate **how** they are delivering on the learning outcomes specified in this document. The competencies attained by trainees in teaching programmes are monitored using similar principles to those of the Adult IAPT initiative. The domains below are indicative of the key content areas that



are considered essential to the delivery of the competencies listed under the five clinical component curricula.

CAMHS support diverse populations of children, young people and their families. Children and young people come from a range of backgrounds, lifestyles and cultures, with differing levels of ability, and with differing needs such as language and literacy. The CYP IAPT training will equip CAMHS workers with some of the techniques required to meet the diverse needs of children, young people and families, to ensure services take on board what young people and parent/carers say about what works to improve service delivery on the ground. It is complementary to local training which is provided by host organisations on aspects such as equality, diversity and safeguarding.

The expectation of the programme is that service managers, supervisors and trainees are supported by their host organisation in their continuing professional development (CPD) and service development in this area throughout and after this training.

## **Core skills component domains**

- Collaborative care model
- Young people's and parents' participation
- The CYP IAPT active outcomes framework
- Evidence-based practice/practice-based evidence
- The process of organisational change
- Supporting access, diversity and minimising disadvantage and discrimination
- Fundamentals of therapy adapted to CYP IAPT principles
- Sharing evidence-based practice with children
- Fundamental CBT skills with children
- Fundamental parent training skills
- Fundamental principles of IPT-A
- Fundamental methods of working systemically with families
- Use of supervision
- Shared decision making (children, young people and parents/carers)

## **Cognitive Behavioural Therapy (CBT) treatment for internalising disorders of childhood and adolescence**

- CBT for generalised anxiety disorder
- CBT for obsessive compulsive disorder
- CBT for post-traumatic stress disorder

- CBT for depression
- Group CBT for depression
- CBT for social and other specific phobias
- CBT for separation anxiety disorder
- CBT for panic disorder

### **Parenting training interventions for conduct problems**

- Understanding the causes of conduct problems of childhood
- Parenting from a multicultural Social Learning Theory perspective
- Involving parents/carers in parenting interventions
- User participation and running parenting training groups and individual parent training
- Evidence-based parent group techniques
- Evidence-based individual parent training methods

### **Interpersonal Psychotherapy for Adolescents (IPT-A) treatment for depression**

- Theoretical origins of interpersonal psychotherapy and theories of adolescent development
- IPT assessment – the symptom focus
- IPT assessment – the interpersonal focus
- Formulation and working with IPT focus areas
- Interpersonal role transitions
- Complicated grief
- Interpersonal role disputes
- Interpersonal sensitivity/deficits endings
- Maintenance of IPT-A evidence base and modifications for depressed adolescents
- Translating theory into practice

### **Systemic Family Practice treatment for conduct disorder (over 10s), depression and self-harm, and eating disorders**

- The role of the family and other systems in childhood problems
- A range of evidence-based systemic approaches especially those appropriate for conduct disorder, eating disorder, and depression and self-harm
- Skills in developing an effective and collaborative therapeutic relationship with all family members
- Ethical practice, including the ability to take into account family differences such as culture and religion and consideration of power issues including discrimination and marginalisation

- Methods of gathering formal and informal feedback from all family members and ways of using this to inform ongoing work with families

## **Assessment of trainee therapists**

The assessment of competence will be the responsibility of the HEI(s) leading the Learning Collaborative and other providers of training who are part of the collaborative. How competencies will be tested must be specified, but the curriculum leaves open the method(s) by which Learning Collaboratives achieve this, although clear recommendations are made in this document. However, it is essential that the assessment of competence includes at least these four forms of assessment:

- a) assessment of video-recorded therapy sessions
- b) reports of individual treatments that demonstrate the capacity to make theory–practice links and to integrate outcomes information into their practice
- c) reports on feedback from supervisors and young people and/or parents on their experience of the therapy offered
- d) a summary report of the therapist’s clinical outcomes over the training period.

## **Supervisors’ unit**

This unit is detailed in the main curriculum and includes domains on (a) overall framework of clinical supervision in CAMHS, (b) making analysis of outcomes central to clinical supervision, (c) supervision within the specific modalities covered by CYP IAPT, (d) supervision of cultural awareness, (e) supervisory intervention to address ineffective treatments, and (f) supervision and user participation. As with other units, the supervisors’ unit is assessed by the HEI using video-recorded supervision sessions and robust measures of the outcomes of supervision (e.g. trainee logs of supervisory input). Supervisors who fail this assessment will not participate in the CYP IAPT programme.

## **Leadership unit**

This unit is detailed in the main curriculum and includes domains on (a) national policy perspective relevant to CAMHS, (b) applying outcomes to service planning and organisation, (c) integrating user participation into IAPT service structures, (d) working with commissioners to improve access to National Institute for Health and Clinical Excellence (NICE)-recommended psychological therapies in CAMHS, (e) facilitating outcome evaluation, understanding outcomes and using outcomes-based appraisal systems to improve service effectiveness, and (f) initiating and managing system change. As with other units, the Leadership unit is assessed by the HEI, with leaders providing a report of a management change programme in line with IAPT principles. This report should be supplemented by a video recording of a specific meeting and user feedback on the programme (e.g. as part of a presentation to service users).



## 2. Core competencies for working with children and young people

This version of the core element of the CYP IAPT curriculum is intended for CYP IAPT sites, potential sites, trainees, supervisors and managers to use to understand the aspects that are covered in the core module. The learning objectives of this module are common to all CYP IAPT trainees. HEIs will deliver this module both by interweaving aspects into modality-specific training and by running separate sessions. For example, collaborative practice is essential throughout CYP IAPT, so our expectation is that all therapeutic training will be seen through the prism of how a trainee in a particular modality uses the therapy in collaborative with the child, young person and, where appropriate, family.

### Part A: The key features of CYP IAPT practice

#### A1 Introduction: Expectations for trainees

##### *Key learning outcomes*

- Understanding of the nature of the course and its requirements.
- Knowledge of the close interplay between the services and HEI and the need to follow their host organisation's processes as well as those of the HEI.
- Ability to use the HEI's e-learning system and other resources.

##### *Knowledge*

Knowledge for the course will be provided in the **course handbook**.

##### *Skills*

To negotiate clear arrangements with the personal tutor at the HEI along with arrangements with supervisor in Partnership.

#### A2 What are the core values of CYP IAPT?

##### *Key learning outcomes*

- The rationale for evidence-based approaches to treatment and implementation.
- Understanding of approaches to improving value in health care systems.
- Knowledge of the methods of quality improvement that increase productivity and ensure rapid interventions ('prevention' or 'pre-emptive treatment').
- Acquisition of an intellectual framework for measuring outcomes.

- Understanding and appreciation of how to work in partnership with the child and family<sup>1</sup> contextually, taking into account such factors as culture, personal identities, family dynamics and interfaces with different systems of social life, the presence of difficulties that may create inequality for the child or family developmental stage/level, and communication.

### **Knowledge**

It is assumed that trainees have knowledge of child development and developmental life stages as this is a core competency for working with children and young people.

- The nature of evidence in health care for clinical interventions.
- The framework of risks of disorders and strategies for early intervention.
- Understanding of outcomes that matter to children, young people and families, including the costs of achieving these.
- The collaboratively designed model of service organisation and delivery.
- Placing service users in charge of their own care.
- Supporting shared decision making with the child or young person that involves their parent/carer around the type of treatment received by the child or young person
- Working in partnership with children, young people and, where appropriate, their parents/carers to define goals and outcomes that matter to them both
- Understanding of the process of transformation within CAMHS.
- Basic ideas from implementation science.
- Working to ensure that clinicians meet the standards set by both regulatory and professional bodies.
- Demonstrate knowledge of relevant pharmacological interventions and competence in informing and supporting clients on combined treatment approaches

### **Skills**

- Communication skills with children, young people and families, colleagues, and management in relation to the above.
- Understanding of the legal frameworks around consent, confidentiality, the recording and sharing of information and have the skills and confidence in applying and communicating this to parents and carers
- Listening, appreciating and understanding the parent/carer perspective
- Integrating CYP IAPT models into existing professional expertise.
- Contributing to the development of host bodies as learning organisations.

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<sup>1</sup> In this document the terms 'child' and 'young person' are interchangeable, as are 'family', 'parent' or 'carer'

- Skills to engage children and families in decision making and contributing to service transformation.

### **A3 CYP IAPT collaborative care model (see also goals based practice)**

#### ***Key learning outcomes***

- Knowledge and understanding of the collaborative stance.
- Ability to implement a shared decision-making approach.
- An understanding of the child, young person, family and their thoughts, feelings and motivation, and the full context, taking into account personal identities (race, ethnicity, sexual orientation, disability, gender, age, religion or belief and other equalities issues).

#### ***Knowledge***

- Awareness of the power imbalance of professional–client relationships.
- Integration of the clinician’s expertise with service user expertise.
- Understanding of the evidence base for collaborative practice.
- Understanding of the importance of accurately determining the state of mind of the child, young person or, where appropriate, parent/carer, including cognitive/communication skills, styles, and needs.

#### ***Skills***

- Understand the problem from the often varying perspectives of the child and family.
- Develop an agreed shared understanding of the problem.
- Come up with an intervention plan including explicit intervention goals, in partnership with the client and parent/carer that may need to be responsive to each of their specific needs.
- Work towards creating a shared formulation which takes account of biological, psychological and psychosocial issues between the clinician and the child, young person and parents/carers where appropriate.
- Demonstrate an ability to integrate best clinical evidence with the unique context of the family/young person.
- Highlight the importance of defining the context of each child or young person from a multi-systems perspective including:
  - Ensuring all systems the child/young person is engaged in are considered
  - Ensuring that other potential systems interfaces are also considered, e.g. systems that might help or hinder
  - To thereby support the establishment of multi-dimensional case management and treatment approaches which take full account of all relevant systems

- By interweaving this multi-systems and multidimensional approach within the formulation framework, to establish and evolve a shared narrative and maximise coherence of care
- To ensure in so doing that the clinician is considering all the treatment approaches, including medication and other physiological/physical-based approaches (e.g. exercise) of potential benefit and how such approaches can be integrated in care
- To highlight the risks of 'splitting' and the importance of integration of care.
- Demonstrate the ability to explain best evidence in a way that service users and parents/carers can understand.
- Produce written intervention plans with children, young people and families where appropriate, co-produced and written in everyday, accessible language and other formats to aid communication, which are regularly reviewed and updated to ensure that aims remain relevant, understood and agreed with the young person.
- Develop responsibility for clinical decision making across a range of complexity.

#### **A4 Young people's and parents' participation**

##### ***Key learning outcomes***

- Making a principled commitment to participation.
- Knowing when to adopt each level of participation, from consulting and equal partnership to children and young people and families leading as 'active citizens'.
- Knowing a range of participation models and how to apply them to achieve the best outcomes with young people and their parents/carers
- Taking children and families seriously, treating them with respect, being authentic, hearing and acting upon what children and their parents/carers tell us.
- Addressing specific cultural or environmental needs (e.g. same-sex parents) and having an understanding of these variations.

##### ***Knowledge***

- Familiarity with rights and responsibilities frameworks:
  - UNCRC – history of UNCRC, ratification and adoption by the UK
  - Focus on Article 12: Every child has a right to be able to give their opinion and have their views given due weight in all matters that affect them
  - International perspective/comparison
  - Promoting children's rights.
- Knowledge of the potential stigma of mental health provision (an anti-stigma stance):
  - How children, young people and families experience exclusion and feel stigmatised by mental health problems



- Societal and cultural attitudes, institutional practices that reinforce prejudice, service configurations and individual practice that create stigma
- Effective models to tackle stigma that are relevant to children and young people.
- Knowledge of origins of (young people's) participation and relation to citizenship:
  - Sherry Arnstein, Roger Hart, the ladder of children and young people's participation, young people as citizens
  - Other models of participation, including youth work
  - Hear by Right participation standards and CAMHS version.
- What parents and carers have told us
  - Evidence from qualitative literature on the views of young people and parents
  - International findings (North America, Scandanavia) eg Family Centred Care
  - National literature:
    - Department for Education: Parental Participation within Education
    - DCSF: Participation
    - CHIMAT
    - Carers Trust
  - The impact of targeted groups' and the parent/carer needs including those who have protected characteristics (Equalities Act), additionally Looked After Children and Young Offenders
- What children and young people have told us:
  - International findings (e.g. WHO, UNICEF)
  - National literature – the common themes that have emerged consistently over time
  - Evidence from qualitative literature on the views of young people and parents
  - The impact of discrimination on groups of children/young people e.g. gay and lesbian children, refugees and asylum seeker children, children who are mixed race and children with disabilities.

## **Skills**

- Put values and knowledge into practice:
  - Produce case studies about participation (co-produced by the young person or parent/carer as well as those written by professionals)
  - Develop reflective practice around young people's participation
  - Develop reflective practice around parent/carers participation
  - Be able to work with different age groups around participation
  - Be able to engage with the diversity of children and young people – specific needs of some black and minority ethnic (BME) groups, travellers, lesbian, gay,

- bisexual and transgender (LGBT), refugees and asylum seekers, those with a disability
- Be able to gather and organise a portfolio of participation skills
- Be able to understand the best and current approaches to engaging and working alongside young people and parents/carers, i.e. through digital and social media and creative approaches, as well as in face to face work
- Recognise the challenges and limitations, reflecting on our own cultural values and attitudes.
- Ability to develop participatory practice:
  - Seeking and acting upon children and young people's feedback
  - Seeking and acting upon parents/carers feedback
  - Having a dialogue with children and young people, and/or their advocates and their parents/carers
  - Enabling diverse groups of young people and parents/carers to participate in strategic decision making that is reflective of the local population and minority groups.
  - Supporting children and young people and parents/carers with training and development, peer to peer mentoring, building social capital

## **A5 The CYP IAPT active outcomes framework**

### ***Key learning outcomes***

- Adopting a collaborative approach to evaluating outcomes.
- That clinicians can make decisions with the CYP IAPT framework about the best measures and tools to use for different children, young people and families, and circumstances.
- That clinicians understand the strengths and limitations of different measures and tools and how to use them clinically, including challenges presented by the full range of contexts within which they practise (e.g. learning disabilities).
- That clinicians understand how to interpret data from outcomes measures and service user feedback tools and to understand the limits of any interpretation.
- That clinicians are trained to make use of information from patient-reported outcomes to support their work and their own development, and not purely as performance management tools.
- To use the information from the outcome measures and service user feedback tools to inform and guide therapeutic interventions.
- That clinicians are able to engage children, young people and families where appropriate in the use of outcome measures so that the measures are meaningful and contribute to the overall outcome of the intervention.

- Understanding the importance of personal identities that relate to race, ethnicity, gender, disability, age, sexual orientation, religion or belief that will have an impact in any intervention or outcome measure.

### **Knowledge**

- Knowledge of outcome measures and service user feedback tools commonly used in CAMHS settings, and of their purpose, including:
  - What each measure specifically aims to detect or to measure
  - Measurement development
  - Clinical usefulness of the tool.
- Knowledge relevant to the application of measures, including:
  - Psychometric properties, such as:
    - Scoring and interpretation procedures
    - Reliable change
    - Clinically significant scores
    - Characteristics of the test that may influence its use (e.g. brevity, 'user-friendliness', etc.)
  - Knowledge of procedures for scoring and for interpretation of measures
  - Understanding that some measures can only be administered by suitably qualified individuals, and knowledge of the areas to which this restriction applies
  - Understanding that the measures may not be designed for specific equality groups (e.g. BME, women, LGBT, people with disabilities, religion or belief, or those whose first language is not English) and consideration of how to mitigate any adverse impact, and how to ensure the specific equality groups can still benefit from outcome monitoring
  - Understanding of the use of routine outcome and service user feedback information in active supervision.

### **Skills**

- Ability to introduce the ideas around service user feedback and outcomes to children, young people and carers, in developmentally appropriate language (or other communication techniques to address specific language needs).
- Ability to work collaboratively to choose appropriate feedback and outcomes tools in keeping with the needs and wishes of the child or young person or carer.
- Ability to administer a full set of questionnaires at baseline and a smaller set of questionnaires at each session (appropriate for the person, e.g. a person with learning disabilities).

- Ability to select and administer appropriate questionnaires based on problems identified in the initial session, addressing both symptoms and function, and (as required) completed by multiple informants.
- Ability to integrate the questionnaire results into sessions as part of the process of assessment and intervention, selecting which results should be fed back to clients and how to do this.
- Ability to use the results from questionnaires to help decide when a different approach in therapy, or a different therapist, is needed.
- Ability to present data from questionnaires into supervision and to consider the implications.
- Ability to know when and how to help clients to complete outcome questionnaires where they have difficulty completing them on their own (e.g. due to literacy problems or not speaking English as a first language, visual impairment, learning disabilities).
- Ability to judge when it is appropriate to desist from asking clients to complete a measure (e.g. where the client is expressing reluctance to do so and it is clear that the use of measures needs to be renegotiated with them).
- Ability to engage in active supervision using routine outcomes data and service user feedback and understand how supervisors can use information to guide case supervision.

## **A6 Evidence-based practice/practice-based evidence**

### ***Key learning outcomes***

- To know the evidence for common mental health presentations for children, young people and their families.
- To know NICE guidance in relation to all children's and young people's disorders.
- To know the strengths and limitations of practice-based evidence and the available data in relation to this, including evidence regarding the experience of specific equality groups within protected characteristics and those with particular vulnerability such as looked after children.

### ***Knowledge***

- Knowledge of the current status of the evidence for:
  - Depression
  - Anxiety
  - Conduct disorder
  - Attention deficit hyperactivity disorder (ADHD)
  - Eating disorders
  - Self-harm and suicidality
  - Substance use disorders

- Psychosis
- Maltreatment
- Social intervention
- Attachment disorders
- Developmental disorders.
- Awareness of and familiarity with the children and young people's competence frameworks.
- To be mindful of comorbidities and the links between physical health and mental health conditions.

### **Skills**

- Read NICE guidance and draw conclusions about one's own practice.
- Use appropriate websites for gaining up-to-date information on evidence.
- Communicate evidence to colleagues (a summary of the evidence base will be available on the CYP IAPT website).

## **A7 The process of organisational change**

### **Key learning outcomes**

- To understand the role of the individual in facilitating service change and in introducing, promoting, supporting and sharing the CYP IAPT philosophy across the service.
- To explore theories of change, critically appraise barriers to change and explore ways in which service improvements can be facilitated and effectively implemented, including organisational barriers such as institutional discrimination.

### **Knowledge**

- To understand theories of change and to consider the culture, power and politics of leadership, discrimination and organisational change related to the dissemination of evidence-based practice.
- To identify and understand barriers and levers for change at the individual, team and systems organisational level.
- To understand the effects of team and service change on the wider health, social care and educational systems and the third sector.

### **Skills**

- To explore effective ways to influence and support service transformation to achieve more effective, child/young person and parent/carer-focused services.
- Critically examine the role of, and strategies for enhancing, professional influence on an evolving system in order to support service transformation.

- How to view oneself as a change agent who can influence and bring about effective service transformation.
- Supporting services to reflect continuously on how provision fits the characteristics of the population, embedding a culture of participation within the service which addresses any adverse impact for particular groups (e.g. LGBT, BME, disabilities) and how services might need to adapt intervention strategies.
- Using a wider range of community locations such as schools, homes, GP surgeries, places of religious worship, support and advocacy groups.
- Use of technology to provide creative ways of interacting and delivering interventions, e.g. computerised CBT, telephone engagement, text/email reminders, video/facelink appointments – the technology needs to be flexible to address the needs of people with disabilities, language and other communication issues, e.g. deaf children.

## **Part B: The clinical knowledge base for CAMHS**

### **B1 Ensuring the delivery of services that support equality of access, respects diversity and minimises disadvantage or discrimination**

#### ***Key learning objectives***

- To acquire abilities that are in line with good practice, identify and minimise the adverse impact of inequalities in access to CAMHS services for disadvantaged and socially excluded groups (BME, LGBT, children in poverty, gypsies and travellers, those with disabilities and others).
- To optimise the effectiveness of CYP IAPT interventions with disadvantaged groups.
- To minimise, as far as possible, the impact of racism or other forms of discrimination impacting on the mental health of children and their families.

#### ***Knowledge***

- Know about the limitation of current frameworks in meeting the needs of disadvantaged service users.
- Have an understanding of the implications of the Equality Act (2010) and Human Rights Act (1998) for CYP IAPT.
- Know about the interaction of social disadvantage and exclusion and experiences of discrimination as it effects the delivery of CYP IAPT (e.g. the referrals for talking therapies, models of therapy).
- Know about the limitations of the evidence base for diverse communities and seek consultation or other relevant forms of evidence where necessary.
- Know about differences in notions of depression, anxiety and anorexia and how these may be constructed differently in different cultures and communities, including religious explanations.

- Knowledge of the resilience as well as specific vulnerabilities of specific cultural and ethnic groups and communities.

### **Skills**

- Assessment and treatment should involve a consideration of the child in their social, cultural and familial context, including personal identities.
- Ability to work with the young person and family's contextual and cultural explanatory models e.g. the meanings given to symptoms (including traditional models of healing) and expectations of treatment should be explored.
- Ability to recognise, inquire about and address issues associated with racism and other forms of discrimination, including homophobia, sexism and other forms of prejudice.

## **B2 Fundamentals of therapy adapted to CYP IAPT principles**

### **Key learning objectives**

- To (re-)acquire generic CAMHS competencies in the context of the CYP IAPT model.
- To integrate existing knowledge and skills with CYP IAPT principles and practice.

**N.B. This is NOT intended as an alternative CAMHS training but an examination of the impact of changed practice on assumed existing extensive knowledge and skills of CAMHS clinicians.**

### **Knowledge**

- Knowledge of the impact of CYP IAPT principles and practice on:
  - Professional and ethical guidelines
  - Issues of confidentiality, consent and capacity
  - Ability to work with and across agencies
  - The strengths and weaknesses associated with using standardised measures
  - Knowledge of methods using goals in working with children and young people
  - Knowledge of the principles and practice of participation by children in helping systems and schools (e.g. school councils)
  - Understanding of how the therapeutic alliance may be effected by CYP IAPT protocols
  - Understanding of the influence of changes in therapeutic and task alliance in therapeutic outcomes (e.g. rupture–repair, dropout).

### **Skills**

- Incorporation of CYP IAPT practice to elaborate existing skills in:
  - Ability to undertake a comprehensive assessment

- Ability to engage and communicate with children, young people and their families/carers in an appropriate and responsive manner
- Ability to communicate with children and young people of differing ages, developmental levels and backgrounds, including those with disabilities and other communication needs
- Therapeutic alliance
- Endings and service transitions
- Formulation using standardised measures
- Ability to feed back the results of an assessment to children, young people and their family/carers, and to flexibly and responsively agree a treatment plan (e.g. a collaborative approach to the assessment process) that includes consideration of the evidence across all modalities of intervention, including physical and pharmacological, psychological and social spheres
- Ability to undertake a risk assessment and to manage risk, particularly related to confidentiality
- Ability to assess the child/young person's functioning across systems (e.g. the central position of client choice for other statutory services such as education and social services)
- Ability to formulate the child/young person's problem using participatory techniques and standardised measures and outcomes
- Ability to develop shared goals with children, young people and parents
- Ability to involve children, young people and their parents in a review of progress.

### **B3 Shared aspects of evidence-based practice with children**

#### ***Key learning objectives***

- To learn which strategies are common to successful treatment.
- To formulate problems that do not fit expected presentations and outcomes.
- To learn to deal with differences, diversity and deviations from expected presentations.
- To learn to deal with multiple problems and disorders of clinically referred children.
- To learn to adapt interventions for significant contextual problems and family or ecological challenges as revealed in the CYP IAPT complexity measure.
- To learn to adapt new evidence-based practices to existing incompatible organisational infrastructure and predominant clinical protocols.
- To consider the key domains that are associated with improvements in mental health problems in children (e.g. limit setting).

#### ***Knowledge***

- Learn to identify and appropriately apply distinct evidence-based components of treatment and knowledge where treatment components can be applied to problems.



- Learn about decision processes in choosing treatment components based on routine outcomes monitoring.
- Learn about a hierarchy of problems identified in assessment, with due regard to barriers to treatment including cultural and diversity issues.
- Learn about the MacArthur model of modular treatment planning and delivery.
- Knowledge of effective outreach programmes, knowledge and skills of multiagency working and issues that may affect this.

## **Skills**

- Ability to respond to evolving treatment needs within episodes of care as discovered in frequent routine outcomes monitoring.
- Ability to adjust treatment components to life transitions, ages and stages.
- Ability to develop systematic methods for addressing crises and externalising problems interfering with standard course.
- Developing skills in more effective joint agency interventions to supplement evidence-based practice (e.g. harnessing education to support children's needs) and supporting the integration of the work between school and home.
- Clinician to consider and agree who is the best person to work with (e.g., parent, child/young person, both, school, etc.), length of meetings, approach (e.g. verbal vs. visual), in conjunction with the child/young person and parents.
- Adapting evidence-based practices to significant variations in ethnic, language and cultural, family and diversity issues.
- Ability to explain the rationale for and process of the chosen therapy, including the ability to:
  - Explain the model to clients, provide a clear rationale for the treatment offered and describe anticipated outcomes
  - Describe the child/young person's specific problems using the general model.
- Ability to create a shared formulation with the child and parents.
- Ability to explain the likely course and process of treatment offered, including the ability to:
  - Explain the likely course of the intervention (e.g. the anticipated number, frequency and duration of meetings)
  - Outline the collaborative nature of the treatment offered
  - Explain the active process of the treatment offered
  - Provide a rationale for the use of out-of-session tasks.
- Ability to agree the possible role of the parent/carer in the intervention.
- Ability to define the boundaries of confidentiality and information sharing.
- Ability to gain informed consent from children, young people and their parents/carers by:

- Conveying information relevant to decision-making in a form which is age- and/or developmentally appropriate
  - Inviting, and responding to, questions regarding the proposed intervention.
- Ability to involve the child/young person as an active participant in planning all stages of the intervention.
- Ability to develop a collaborative relationship with the child/young person and to convey interest in the child and their ideas.
- Ability to apply developmental knowledge in the intervention.
- Ability to apply knowledge of systemic influences in the intervention, including ability to:
  - Involve relevant members of the child/young person's system in the intervention
  - Identify the concerns and goals of different parties.
- Ability to adapt the treatment offered to the needs and developmental level of the child/young person.
- Ability to make treatment engaging for young person.
- Ability to employ therapeutic skills, including the capacity to:
  - Develop and maintain the therapeutic alliance
  - Convey empathy
  - Employ active listening skills
  - Help the child/young person recognise and articulate different feeling states, moods and states of mind
  - Facilitate the development of new perspectives through questioning and reflection.

## **Part C: Introduction to CYP IAPT modalities of therapy**

A key element of the CYP IAPT programme is to offer training in evidence-based therapies. The therapies selected are those based on best evidence and level of prevalence of presentation. It is essential that CYP IAPT trainees have a basic understanding of the other therapies within the programme. As the elements of the core module can be woven into therapy training, the amount of time spent on this section will vary according to the therapy being taught – for example, CBT trainees will not require separate sessions on the CBT elements described here, as this should be covered in the modality-specific element of their course.

### **C1 Cognitive behaviour therapy for children and young people (CBT-CYP)**

#### ***Key learning objectives***

This teaching session will enable clinicians to understand the key features of CBT for children and young people and to explain CBT to colleagues, young people and families. It is anticipated to last for between 1 and 1.5 days.

## Content

- Suitability for CBT: In CBT, the first step is to evaluate whether or not the conditions are there to implement a CBT intervention with children and young people, and, if not, how to address the barriers. For example, if there is significant parental conflict and the family is in crisis, then it may not be possible to attend sessions regularly or conduct particular systematic exposure exercises.
- Evidence base: Knowledge of the evidence base for CBT, including efficacy and effectiveness. Trainees will be given an overview of the evidence for group-based interventions for anxiety disorders (such as *Coping Cat*) as well as individual-based interventions such as CBT for the specific anxiety disorders in young people. NICE guidance should be used as a basis for the provision of evidence alongside updates from randomised controlled trials that have been conducted in the field since the production of the NICE guidelines.
- Style and structure: Knowledge of the style and structure of CBT, including the number, length and frequency of sessions; extent of parental involvement; and expectations of the young person. An overview of a typical CBT session structure should be provided (brief update including questionnaires, bridge from previous session, setting the agenda, review of homework, discussion of issues on the agenda, setting new homework, summary), and key stylistic features of CBT (summaries and feedback, collaboration, Socratic questioning, use of a shared formulation to guide treatment, a clear focus in each session on the presenting problems and agreed goals).
- Model: Knowledge of A. T. Beck's longitudinal and maintenance model of emotional disorders should be presented, with clarification of when a longitudinal formulation might (occasionally) be used. The difference between automatic thoughts, rules/assumptions, and core beliefs in the treatment of depression should be clarified, with emphasis placed on automatic thoughts and maintaining factors as the principal focus of formulation/intervention. The relationship between A. T. Beck's model and individual disorder-specific models of anxiety disorders should be clarified.
- The premise on which CBT is based should be provided and its basic assumptions described, particularly that (i) it is the interpretation of the event, not the event itself, that determines emotional response; (ii) the role of avoidance and other behaviour in maintaining anxiety in accordance with behavioural theory and therapy; and (iii) symptom improvement results from the identification and reversal of maintaining mechanisms.
- Formulation: Generic CBT formulation skills should be presented, including the hot cross bun (Padesky). The relationship between disorder-specific models and personalised formulations should be described. Trainees should be encouraged to see how such a framework can help them formulate their clients' difficulties.
- Content of intervention: An overview of the generic content of CBT for depression and CBT for anxiety disorders should be provided. This would include (but is not limited to):

- Psycho-education including fight/flight response and cognitive errors
- Identification and challenging of maladaptive cognitions using thought records, positive self-talk and behavioural experiments
- Identification and challenging of maladaptive behaviours using a fear thermometer and graded hierarchies for exposure exercises
- Use of other strategies such as cognitive self-talk and relaxation.
- It should be highlighted that key interventions for specific disorders differ according to the problem, for example re-living for post-traumatic stress disorder (PTSD).
- A brief overview of the differences in CBT therapy with children and young people (including the following):
  - Young people are brought for treatment
  - Engagement issues
  - Motivation Issues
  - Cognitive developmental issues
  - Children are part of wider systems that may need therapist intervention (e.g. carers, school)
  - Parental cognitions.
- Useful information:
  - There is useful information on the nature of CBT on NHS Choices (<http://www.nhs.uk/Conditions/Cognitive-behavioural-therapy/Pages/Introduction.aspx>)
  - <http://www.rcpsych.ac.uk/expertadvice/youthinfo/youngpeople/help/cbt.aspx>

### ***Suggestions for exercises***

- Paired and group exercises can be used to encourage theory–practice links. A minimum of two exercises for a day’s teaching is recommended. Two examples are given below:
  - Trainees are invited to get into pairs (or groups of three if numbers are uneven) and reflect on a client with anxiety or depression with whom they have recently worked. They should reflect on:
    - The evidence base for the intervention they used
    - The style and structure of their intervention
    - The model on which their intervention was based
    - The formulation
    - The content of the intervention
    - The trainee should then reflect on differences between the intervention that they used and a cognitive behavioural intervention. After such reflection in pairs, the pairs should feed back on their reflection to the larger group.
  - Trainees are invited to get into pairs (or groups of three if numbers are uneven) and role play communicating the basic principles of CBT first to a child (aged 9) with separation anxiety and second to an adolescent (aged 15) with depression.

Each role play should last approximately 20 minutes, with one trainee taking the role of the therapist and the other the role of the child/adolescent. Trainees should swap after 20 minutes so that each has a turn in playing the therapist and the young person. At the end of 40 minutes, the entire group should reflect on the role play together as both the therapist and child/adolescent.

## **C2 Parenting programmes**

### ***Key learning objectives***

This teaching session will enable clinicians to understand the key features of parenting training (PT) for conduct disorders and the central concepts of the Social Learning Theory (SLT) model and to understand how these features manifest in both group and individual parenting interventions. At the end of the course the trainees should be able to explain SLT approaches to colleagues and families and should have an understanding of when group or individual-based parenting programmes are indicated. It is anticipated to last for between 1 and 1.5 days.

### ***Skills***

- Evidence base: Knowledge of the evidence base for SLT-based parenting interventions for parents of children with conduct problems aged 3–10 years.
- Trainees will receive an overview of the evidence base for both group and individual-based interventions (and an introduction to a decision-making process for whether a group-based or an individual format is adopted). The importance of early intervention will be included. NICE guidance should be used as a basis for the provision of evidence, alongside updates from randomised controlled trials that have been published since the production of the NICE guidelines. The literature for efficacy and effectiveness should be presented, as well as the moderating factors such as the age of the young person, parental characteristics, comorbidity etc.
- Style and structure: Knowledge of the style and structure of the parenting intervention, including the number, length and frequency of sessions, home visits and the expectations of the parent. An overview of a typical session structure should be provided as well as key stylistic features of the parenting programme, and a clear focus in each session on the presenting problems and agreed goals. Examples of at least one group-based programme should be given and the role of group processes highlighted. An explanation of how individual programmes are structured should be given, and in particular the differences between consultation (carer only) and live (carer plus child) approaches.
- Models: Knowledge of SLT (this will be addressed in full in later lectures for all trainees) and Patterson's coercive cycle. Trainees will learn about the role of parental attention in the reinforcement of children's behaviour. The unifying principles of SLT must be promoted throughout the sessions not prioritising any particular brand of programme or

group over individual approaches. Reference will be made to the basic cognitive behavioural maintenance cycle (thoughts-feeling-behaviour cycle), ensuring trainees understand the role of parental cognition.

- Formulation: An idiosyncratic case example of Patterson's coercive cycle should be described to illustrate the role of positive and negative reinforcement in children's and caregivers' behaviour.
- Content of intervention: An overview of the content of parenting work. The importance of role play throughout the programme should be stressed.

This would include (but is not limited to):

- Assertive outreach work
- Engagement issues and the importance of a non-blaming approach
- Child-focused play
- Specific labelled praise
- Effective limit setting
- Ignoring
- Time out.

### **Exercises**

- Analysing the operant contingencies in case vignettes, to give experience of delineating positive/negative and reinforcing/punishing dimensions in real-life situations. Discuss in small groups and then bring back to the group as a whole.
- Case studies to help trainees formulate cases within an SLT framework in order that they can identify which presentations are most likely to be amenable to an evidence-based parenting programme, the role of safeguarding issues, multiagency working, comorbidity and the possible barriers/treatment moderators that the case study suggests. To experience reframing generic CAMHS descriptions of child and parent behaviour and presentations into SLT-specific language (e.g., specific observable behaviour in the here and now).
- Skills-based role play exercises, for example from skills such as (but not restricted to) identifying and labelling child behaviour in commenting; labelled praise; ignoring specific behaviours; giving clear instructions; examples of consequences, etc.

## **C3 Interpersonal psychotherapy for adolescents (IPT-A)**

### **Key learning objectives**

This half-day module will enable clinicians to understand the key features of IPT-A, and to explain IPT-A to colleagues, young people and families.

## **Content**

- Evidence base: Knowledge of the evidence base for IPT-A, including efficacy, effectiveness, and recent work on moderators of treatment effect, if not covered elsewhere in the core curriculum.
- Structure: Knowledge of the structure of IPT-A, including the number, length, and frequency of sessions; extent of parental involvement; expectations of the young person in IPT-A.
- Model: Knowledge of the basic model and assumptions of IPT-A, including evidence for the key role of interpersonal context in triggering and maintaining depression, and in recovery from depression.
- Content: Knowledge of the content of IPT-A sessions, including the three phases of therapy; use of the interpersonal inventory; the four possible foci; how to derive an interpersonal formulation; introduction to goals and strategies for each focus area.
  - Phases of IPT-A
    - Initial phase, including interpersonal interview and formulation
    - Middle phase, including focus-specific strategies
    - Termination phase
  - Interpersonal inventory
    - Use of closeness circle and network grid
  - Focus areas and treatment strategies
    - Role disputes
    - Role transitions
    - Grief
    - Interpersonal sensitivities
  - Presenting the formulation
    - Case examples to be given

## **Option for group exercises**

- To encourage theory–practice links, a group exercise is suggested.
- Trainees in small groups are invited to recall an adolescent with depression with whom they have recently worked. To consider: how depression was experienced by this young person; what were the main interpersonal issues in the onset and maintenance of depression; what were the vulnerability and protective factors; what is/are the likely focus area(s) (i.e. disputes, transitions, grief, sensitivities).
- Trainees to present a preliminary IPT-A formulation to the rest of the group, modelled on the formulations previously given by the trainer.

## **C4 Systemic family practice (SFP)**

### ***Key learning objectives***

This module will provide clinicians with an introductory understanding of the systemic perspective on families so that they are able to take into account the key role that family relationships play in the lives of troubled children and young people. The focus will be upon helping clinicians improve their ability to work with multiple family members from diverse communities, both conjointly (together) and separately.

It is expected that this aspect of CAMHS practice will cover two days.

### ***Content***

- Knowledge: Family patterns and beliefs; family life cycle; family structure, cohesion, inter-generational scripts, hierarchy and the impact of wider systems on the family including culture. A 'family focus' in which trainees will consider the impact of a problem on the family and the family on the problem. This will also involve brief references to the way family systems may be understood in different ways and problems may be understood from multiple perspectives. This section seeks to give clinicians a language to describe families and family interactions.
- Evidence base: Including an overview of the various evidence-based models such as Functional Family Therapy (FFT), Multisystemic Therapy (MST), Multidimensional Family Therapy (MDFT), etc. The evidence base also includes process research which demonstrates that a split family alliance has an impact on the therapeutic outcome (<http://www.softa-soatif.net> for model for measuring family alliance). Ways of measuring family change (SCORE) also need to be described.
- Theoretical skills: How to construct a number of systemic hypotheses (formulations) and use them to orientate the clinician to the problem and the family.
- Clinical skills: How to engage multiple family members and communicate effectively with them; how to help all family members express their views without restraint and in the spirit of collaborative respect.
- Orientation of systemic family therapy: An overview of the general principles of systemic family therapy, the modules available, and the course and content of evidence-based family therapy.

### ***Whole group exercises***

- The systemic aspects of human interactions can be demonstrated by creating a 'chocolate factory' with the participants: they each chose to take on a role in this factory, making the sounds that their 'machine' might make. The facilitator then removes a couple of 'machines' for 'repair' whilst telling the whole factory that they still have to produce chocolate. This exercise shows how human systems are created, how they adjust to 'problems' and also



how hierarchy, communication, alliances and rivalries become central to the functioning of systems.

- Family processes can be demonstrated by taking the family tree of a real or fictional family. The family tree is drawn up by the facilitator and the group is asked to construct a systemic understanding of the 'problems' family members exhibit (e.g. alcohol misuse, self-harm and suicide). See McGoldrick, M., & Gerson, R. (2008) *Genograms: Assessment and intervention*. New York: Norton.
- Building a family alliance can be explored using the SOFTA web-based resources, which help clinicians practise how to work with multiple family members and address issues such as 'resistant' family members, 'blaming' interactions and divided opinions in families.

### 3. CYP IAPT Cognitive Behavioural Therapy for Anxiety Disorders

#### **Aims**

- To develop critical knowledge of the theoretical and research literature of CBT for anxiety disorders in children and young people.
- To develop practical competency in evidence-based CBT for anxiety disorders in children and young people.

#### **Scope**

Workshops in the module will cover the evidence base for CBT, assessment and treatment strategies for anxiety disorders in children and young people. They will cover anxiety disorders generally, and the specific anxiety disorders: separation anxiety disorder, specific phobia, panic disorder, social phobia, obsessive compulsive disorder (OCD), PTSD and generalised anxiety disorder (GAD). Body dysmorphic disorder, which is covered in the same NICE guidance as OCD, may also be included. Adjustment disorder with anxiety, in the context of stressors, may also be included.

The evidence base for CBT for children and young people with anxiety disorders refers to both anxiety disorders generally and to specific anxiety disorders. NICE guidance for anxiety disorders is for specific disorders. There is guidance for GAD and panic disorder (CG22, updated by CG113), for PTSD (CG26), and for OCD and body dysmorphic disorder (CG31). CBT is strongly recommended in each of these disorders, in forms varying between conditions. The first of these guidelines does not include children and young people; the second and third of these guidelines covers the age range including childhood and adolescence. Therefore, while there are NICE recommendations for CBT for children and young people with OCD and PTSD, there are none for GAD and panic disorder for this age group. Nor is there yet NICE guidance on the other anxiety disorders as they present in childhood, young people, or in adults. The most substantial evidence base for CBT for GAD, separation anxiety and social phobia in children and young people comes from trials of the *Coping Cat* manual (Kendall & Hedtke, 2006) and related manuals, with samples of children and young people with one or more varied diagnoses of anxiety disorders.

#### **General learning outcomes**

This module will provide opportunities for trainees to develop and demonstrate knowledge, understanding and competency in the following:

- A critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of anxiety disorders in children and young people.
- A critical understanding of clinical research literature on CBT for anxiety disorders in children and young people (clinical trials and outcome studies).

- Assessing whether a child or young person with an anxiety disorder is suitable for CBT.
- Explaining the principles and general procedures of CBT for anxiety disorders to children, young people and parents/guardians responsible for informed consent to treatment.
- Demonstrating evidence of understanding the points of view of children, young people, and parents/guardians responsible for informed consent to treatment, regarding anxiety problems in the child or young person and how they impact on their lives; and an understanding of how these points of view may vary with the age of the child or young person.
- Constructing maintenance and developmental conceptualisations of cases of anxiety disorders in children and young people.
- Demonstrating evidence of understanding the factors relevant to whether and to what extent parents/guardians are involved in treatment sessions (such as whether they are responsible for informed consent, wishes of the family members, whether parental behaviour may be involved in maintenance cycles, and whether parental assistance in therapy or homework may be helpful).
- Developing CBT treatment plans for a range of anxiety disorders in children and young people.
- Demonstrating evidence of critical evaluation of theoretical evidence-based interventions integrated within, and guiding, therapy with anxiety disorders in children and young people.
- Collaboratively deriving an anxiety model with a client.
- Ability to work with children and young people to elicit and evaluate key cognitions and images in anxiety disorders.
- Constructing, carrying out and evaluating exposure exercises and behavioural experiments.
- Capacity for self-direction in tackling and solving basic therapeutic problems with anxiety disorders in children and young people.
- Working with comorbidity and other complexities in presenting problems with support of appropriate supervisor.
- Ability to deal with ending therapy and planning for long-term maintenance of gains with evidence of relapse prevention plan.
- Begin practising as 'scientist practitioners', continuing to advance their knowledge and understanding to develop new skills in working with anxiety problems in children and young people.
- Insightful knowledge of CBT and an ability to identify their own values and beliefs in working with anxiety and the applicability of CBT to their own lives.
- Making best use of supervision for anxiety disorders on the course and evidence of making use of, and continuing to learn from, ongoing CPD.

- Ability to sensitively adapt CBT for anxiety disorders to ensure equitable access, taking into account the age of the child or young person, and cultural and social differences and values among the children, young people and their parents/guardians.
- Using clinical measurement with specific anxiety disorders to monitor CBT process and outcome.

## CBT competencies for specific anxiety disorders

Apart from the general competencies required to provide CBT for children and young people with anxiety disorders noted above, there are specific evidence-based competencies required for specific types of anxiety problem. NICE guidance covers some but not all of the anxiety disorders. There is an evidence base from trials of CBT with samples of children and young people with varied diagnoses of anxiety disorders. In addition, there are well-designed trials of CBT for specific anxiety disorders in children and adolescents not covered by NICE guidance to date. Within this complex and evolving evidence base, the curriculum is not prescriptive about which of the evidence-based CBT competencies, with their associated models, should be taught. There is in any case, as would be expected, substantial overlap between the evidence-based CBT approaches.

The following sources should be consulted as a guide to the evidence-based CBT competencies and their associated models for specific anxiety disorders:

PTSD	NICE CG26; Roth, Calder, & Pilling, 2011
OCD	NICE CG31; Roth, Calder, & Pilling, 2011
GAD	Kendall & Hedtke, 2006 a, b For older adolescents, consult NICE CG22 and CG113 for adults
Panic disorder	For older adolescents, consult NICE CG22 and CG113 for adults. There is little evidence base for CBT for panic disorder in children and younger adolescents
Social phobia	Kendall & Hedtke, 2006 a, b; Albano & DiBartolo, 2007; Spence, 1995
Separation anxiety disorder	Kendall & Hedtke, 2006 a, b
Specific phobia	Kendall & Hedtke, 2006, a, b. Also see below.

Below is an illustrative example of competencies relevant for CBT for one of the anxiety disorders, specific phobia, adapted from the IAPT Curriculum for High Intensity therapists (for adults).

## **CBT for specific phobia**

### ***Demonstrate competency in:***

- A critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of a specific phobia in children and young people.
- A critical understanding of the current, evidence-based pharmacological and psychological treatment for specific phobia in children and young people.
- A critical understanding of the relations between normative developmental fears of childhood and specific phobias.
- Assessing specific phobia to determine specific symptoms, severity and impact on daily life and previous treatment.
- Identifying triggers, patterns of avoidance, and safety-seeking behaviours.
- Deriving a shared understanding of the cognitive behavioural conceptualisation of specific phobia and delivering a rationale for treatment with a child or young person using a recent example.
- The use of standard and idiosyncratic measures to evaluate outcome of CBT for specific phobia.
- Identifying the role of cognitions in maintaining the phobia and generating an alternative perspective through discussion techniques, cognitive restructuring and behavioural experiments.
- Drawing up a graded hierarchy to guide exposure interventions.
- Carrying out exposure using the key principles of graded, repeated, focused and prolonged; working with difficulties competently as they arise.
- Modelling non-phobic behaviour.
- Deriving, conducting and evaluating behavioural experiments in and out of sessions.
- Deriving related specific homework tasks and evaluating these in the next session.
- Ending therapy; deriving a relapse prevention plan utilising an idiosyncratic blueprint of therapy and planning for long-term maintenance of gains.

## 4. CYP IAPT Cognitive Behavioural Therapy for Depression

### ***Aims***

The course will have a cognitive behavioural theoretical base with preference for approaches with the soundest evidence and where cognitive and behavioural techniques are integrated in therapy. In addition to providing practical, intensive and detailed skills training to facilitate skill development to a defined standard of competency, the course will aim to increase trainees' knowledge base of theory and research in CBT for depression, and to promote a critical approach to the subject. It will aim to equip trainees to become skilled and creative independent CBT practitioners.

The course will provide opportunities for trainees to develop and demonstrate knowledge, understanding and skills in the following areas:

- To develop practical competency in CBT for depression in young people.
- To develop practical competency in working collaboratively with parents and educational services as part of routine treatment of depression in young people.
- To be able to adapt CBT interventions for younger children presenting with depression
- To develop critical knowledge of the theoretical and research literature relating to CBT and other psychological therapies for depression in children and young people.

### ***General learning outcomes***

At the end of the course trainees will be able to:

- Construct maintenance and developmental CBT conceptualisations for depression in children and young people.
- Include in the conceptualisation child/young person developmental aspects and family life cycle and dynamics as appropriate.
- Develop CBT specific treatment plans based on the conceptualisation.
- Practise CBT with children and young people with depression systematically, creatively and with good clinical outcome.
- Deal with complex issues arising in CBT practice.
- Take personal responsibility for clinical decision making in straightforward and more complex situations.
- Demonstrate self-direction and originality in tackling and solving therapeutic problems.
- Practise as 'scientist practitioners', advancing their knowledge and understanding and developing new skills to a high level.
- Demonstrate a systematic knowledge of the principles of CBT application in children and young people and the evidence base for the application of CBT techniques.
- Demonstrate a systematic knowledge of CBT and depression.
- Demonstrate a critical understanding of the theoretical and research evidence for cognitive behaviour models and an ability to evaluate the evidence.

- Demonstrate an ability to sensitively adapt CBT and ensure equitable access, taking into account cultural and social differences and values.

The NICE guideline on depression in children and young people (CG28, 2005) concluded that a number of psychological treatments were helpful as a first line of treatment. Evidence from RCTs was limited for all types of psychological treatments, and although CBT had the widest range of research evidence the results from studies on CBT were mixed. Overall, there is not sufficient evidence to suggest that CBT is clearly superior to a number of other psychological treatments such as interpersonal psychotherapy (IPT), psychotherapy or family therapy. Research findings since 2007 have not radically altered the evidence base used by the NICE guidance group. The ongoing large RCT in the UK (the IMPACT study) comparing CBT, child psychotherapy and psychiatric management will add significantly to our knowledge of the effectiveness of these three treatments with clinically referred children and young people.

For the treatment of depression, CYP IAPT workers will be trained in the NICE guidance (CG28) including, for example, recognising the need for psychiatric review and consideration of medication as an adjunct to psychological therapy. Within this framework, CYP IAPT workers will be trained to deliver CBT for children and young people. The course will be predominantly focused on depression in adolescence, as it is much more common in adolescents than younger children. CYP IAPT workers will need to be able to adapt the approach to younger children and this will be considered in a specific part of the module.

Courses for CYP IAPT therapists will aim to provide a post-qualification training in evidence-based CBT for children and young people with depression. The training should ensure that all trainees reach a level of competence that would enable them to obtain the outcomes reported in the relevant NICE guideline for depression. It will also be necessary for trainees to be familiar with the management of conditions that are commonly comorbid with depression (such as anxiety and conduct problems).

All competencies outlined in this document, both general and specific, are integral to the CBT competency framework. Supervision will be delivered in line with the supervision competency framework and according to the IAPT Good Practice Guide on Supervision (<http://www.iapt.nhs.uk/workforce/supervisors>). Each module also contains general and specific learning outcomes. It is anticipated that the learning outcomes and competencies will accumulate as trainees progress through the modules.

For more information on competencies, please refer to Roth and Pilling (2007): [http://www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm)

## **CBT for depression**

This module will develop skills in CBT for depression to an advanced level, improving proficiency in the fundamental techniques of CBT, and developing competency in the specialist techniques used in the treatment of depression. Specific cognitive and behavioural models of depression, empirical evidence, and assessment and specialist cognitive and behavioural treatment strategies will be covered in workshops.

The clinical workshops will provide trainees with a strong foundation in the evidence base for CBT with depression, and address the most up-to-date research methods.

The curriculum will comprise the following:

- Phenomenology, diagnostic classification and epidemiological characteristics of depression.
- Common factors linked to predisposition and precipitation, course and outcome of depression.
- Current evidence-based pharmacological and psychological treatments for depression, to include the role of combined treatment.
- Current evidence-based NICE guidance on pharmacological and alternative psychological treatments for depression.
- Theory and development of cognitive and behavioural models for depression.
- Assessment and formulation of CBT with depression, including specific associated problems, taking into account child/young person developmental aspects, the parenting history, the child's educational history and current level of engagement, the quality of parent-child relationships, the family life cycle and current peer relationships as appropriate.
- Risk assessment, risk management, suicide risk, mental state examination, personal and medical history.
- Application and suitability for CBT with depression (to include contra-indications such as substance misuse) and awareness of referral pathways for unsuitable cases.
- Role of comorbid disorders such as anxiety, PTSD and substance abuse.
- Clinical process for CBT with depression using a cognitive or behavioural activation model (formulation, rationale, active treatment, relapse prevention).
- Clinical process for CBT with chronic, recurrent depression.
- Use of standard and idiosyncratic clinical measures to monitor CBT process and outcome in depression.
- The role of the therapeutic relationship in CBT with depression.
- Relapse prevention.
- Linking theory with practice, clinical trials and outcome studies.
- Application of theory to practice in individual cases.



- Theories and experimental studies of process in depression.
- Development of therapeutic competency in the application of cognitive and behavioural interventions with depression.
- Experiential learning illustrating how both cognitive and behavioural strategies with depression can be applied to trainees' own experiences.
- Values, culture and social differences (access, ethical, professional and cultural considerations).
- Effective use of supervision to help trainees fully consider developmental and systemic aspects of the young person's presentation and context, and to identify own values and beliefs in working with people with depression to enhance and regulate good practice.

### ***General learning outcomes***

This module will provide an opportunity for trainees to develop and demonstrate competency in:

- A critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of depressive disorders.
- Assessing patients with depression, taking into account developmental and familial factors, clinical manifestations, comorbidity, past history, present life situation, course and outcome of depression in suitability for CBT.
- Assessing risk factors associated with depression and the integration of risk management within treatment plans.
- Ability to assess suicidal risk and self-harming behaviours and implement practical strategies for managing suicidality and self-harm.
- Prioritising problem areas, problem solving and identifying solutions.
- Constructing both cognitive and behavioural development and maintenance formulations in cases of depression.
- Using a collaborative stance, developing a shared formulation which is preferably inclusive of the views of the young person and the parents/carers.
- Developing cognitive and behavioural treatment plans for depression, including specifying the type of role expected of parents/carers.
- Ability to critically evaluate a range of evidence-based interventions in depression.
- Deriving cognitive or behavioural models with clients, taking into account individual needs and preferences.
- Working with comorbid presentations of depression and taking personal responsibility for clinical decision making in complex and unpredictable situations.
- Demonstrating self-direction and originality in tackling and solving therapeutic problems with depression, including use of client support networks.
- Ability to deal with ending therapy and planning for long-term maintenance of gains with evidence of a relapse prevention plan.

- Beginning to practise as ‘scientist practitioners’, continuing to advance their knowledge and understanding to develop new skills with depression to a high level.
- Demonstrating insightful knowledge of CBT and an ability to identify own values and beliefs in working with depression and the application of CBT to their own lives.
- Making best use of supervision with depressive disorders on the course and evidence of making use of and continuing to learn from ongoing CPD.
- Ability to sensitively adapt CBT for depression according to developmental factors, and ensure equitable access of CBT taking into account cultural and social differences and values.
- Demonstrating a working knowledge of the principles and practice, and competency in delivering high-intensity psychological therapy for depression within a stepped care system.

### ***Cognitive therapy for depression***

Demonstrate competency in:

- Adopting a collaborative stance, developing a shared formulation with the young person and the parents.
- Consistent with the young person’s right to confidentiality and wishes, enabling parents to contribute to the intervention plan.
- Providing parents and young person with appropriate psycho-educational material about the nature of depression and its treatment.
- Applying the cognitive triad (self, others and future) with depression.
- Conceptualising common processing biases such as arbitrary inference and selective abstraction.
- Working with severe depression, in working initially on behavioural rather than cognitive approaches in the early phase of therapy.
- Monitoring and scheduling activity, rating mastery and pleasure.
- Awareness of the client’s idiosyncratic depressive beliefs, maintenance factors and coping strategies.
- Delivering a rationale for treatment using a recent example that was arrived at collaboratively.
- Defining the role of cognitions and the concept of negative automatic thoughts and images.
- Ability to identify depressive rumination and to make links with this and under-activity.
- Ability to identify the different forms of common cognitive information biases or ‘cognitive distortions’ used to support the client’s thinking.
- Enabling a client to successfully re-appraise their own thoughts using the diary methods as agreed with the young person.
- Helping the client to find alternatives by examining the accuracy of specific thoughts, working with themes of guilt and self-blame.

- Identifying and working to effect change with underlying assumptions using a range of specific change techniques such as pie charts, advantages and disadvantages, continuums.
- Ability to identify and implement strategies working with depressive rumination on a process and content level.
- Constructing and carrying out behavioural experiments both in and out of session to modify the client's assumptions.
- Identifying core beliefs using downward arrow techniques, looking for common themes and using cognitive techniques to re-evaluate core beliefs and strengthen new beliefs.
- Constructing appropriate homework tasks using a rationale and anticipating difficulties.
- Constructing an idiosyncratic relapse prevention plan or 'blueprint' of therapy to maintain and consolidate gains and identify future stressors.

### ***Behavioural activation for depression***

Demonstrate competency in:

- Knowledge of the behavioural activation model, behavioural theory and the role of behaviour in the development and maintenance of depression.
- Working collaboratively with a client, developing a functional analysis (linking antecedents, behaviours and consequences) and focusing on contingencies that are maintaining the depression.
- Explaining the rationale for a focus on behavioural activation and socialising the client to the model.
- Helping the client to engage in activities despite feeling low or lacking in motivation, particularly with respect to schooling or college.
- Recognising the importance of peer relationships during adolescence and actively supporting positive peer group contact and friendships.
- Identify secondary coping behaviours (such as avoidance, inactivity or rumination).
- Enabling the client to focus on external environmental cues (act from outside in rather than inside out).
- Helping clients to use activity charts, rate mastery and pleasure, and monitor patterns of avoidance.
- Developing manageable short-term goals and re-establishing routine.
- Using distraction from unpleasant event or 'behavioural stopping'.
- Developing a functional analysis of triggers for rumination and alternative activity-focused strategies.
- Constructing appropriate homework tasks using a rationale and anticipating difficulties.
- Constructing an idiosyncratic relapse prevention plan or 'blueprint' of therapy to maintain and consolidate gains and identify future stressors.

## 5. CYP IAPT Parenting Training for Conduct Problems in Children aged 3–10 years

### **Aims**

- To develop practical competency in evidence-based PT for conduct problems in children aged 3–10.
- To develop critical knowledge of the theoretical and research literature of PT for conduct problems in children aged 3–10.

### **Scope**

Workshops in the module will cover the evidence base for PT, assessment and treatment strategies for conduct problems in children using both individual and group approaches. They will cover the main presentations of conduct problems, including proactive and reactive aggression, bullying, antisocial behaviour confined to the home context or pervasive (e.g. also expressed at school), comorbid conditions such as ADHD, callous-unemotional traits, learning disabilities, emotional dysregulation, etc. The module will also cover the main presentations, assessment and treatment of parenting difficulties in terms of the immediate parent–child relationship, including child attachment, and the wider contextual factors that impede parenting ability, such as parental depression, substance misuse, domestic violence, life events and daily hassles, and parental learning disabilities. The focus at this stage is on children aged 3–10 years but interventions for children aged 10 years and above may be considered at a later point in the programme.

All parenting trainees must provide group work for 14 weeks, a minimum of 21 days' work including set up and running groups.

The evidence base for PT for conduct problems in children is extensive. It includes the 2005 NICE Health Technology Assessment for Parent Training and Education for Childhood Conduct Disorders. A full NICE guideline on conduct disorder across the age range to 18 years is in preparation.

Training should be in models of parenting training where at least four conditions apply;

1. There is good evidence from randomised controlled trials that the model of parenting treatment is effective in addressing conduct problems in children and young people.
2. The programme is well described in a manual which forms an adequate basis for training.
3. There is an adequate and appropriate means for assessing the extent to which observed clinical practice conforms to the manual in terms of a) adherence and b) competence.
4. There is an appropriate and adequate means for assessing the outcomes of individual interventions.

## ***Key learning outcomes***

This module will provide opportunities for trainees to develop and demonstrate knowledge, understanding and competency in the following:

- A critical understanding of:
  - The principles of Social Learning Theory (SLT)
  - The aetiology, phenomenology, diagnostic classifications and epidemiological characteristics of conduct problems in children, e.g. ADHD, oppositional defiant disorder (ODD), conduct disorder (CD)
  - The aetiology and phenomenology of parenting styles and how they relate to conduct problems in children
  - Knowledge of cognitive and behavioural principles, including ABC (antecedent-behaviour-consequent) analysis, detailed behavioural descriptions of behavioural problems and analysis of operant rewards, including parental attention for antisocial behaviour
  - The clinical research literature on PT for conduct problems in children (clinical trials and outcome studies), including predictors, moderators, and mediators of treatment
  - Systemic factors influencing parenting and conduct disorder in children, for example peers, school and community risk and resilience factors
  - Knowledge of how to successfully engage parents and children
  - Knowledge of implementation science, including which factors lead to better outcomes (e.g. therapist skill, agency readiness and commitment).
- Competency in assessing:
  - The extent of the child's conduct problems, including the presence of comorbid conditions, especially ADHD, autistic traits, callous-unemotional traits, generalised learning disability, anxiety and depression, and other current difficulties; the impact of symptoms on functioning (e.g. on family life, school attendance and attainment, and relationships with peers), any significant life events and family and relationship problems, etc.
  - The quality of parenting: engagement, warmth, stimulation, sensitive responding, encouragement and praise, disciplinary strategies and supervision.
  - Understanding of different types of maltreatment (neglect, physical, emotional, sexual abuse), including prevalence, presentation, and assessment. When to refer to children's social care; legal duties of practitioner in relation to safeguarding
  - The inter-parental relationship, including domestic violence
  - Parental mental health, including depression, drug misuse, generalised learning disability, other conditions, predicaments or beliefs that inhibit parenting capacity; parental beliefs about the child, feelings towards him/her

- Assessing risk to the child of physical, sexual, emotional abuse and neglect; risks posed by the child to self and others
  - Suitability for group vs. individual PT or another modality of treatment. Trainees must assess and select suitable attendees for the group(s) that they deliver as part of the course training. It is not acceptable for trainees to inherit a group set up by a colleague.
  - Formal and informal support systems available to parent or carer and child
  - Each of the above considerations to be informed by assessment using multiple informants (parent, child, teacher, other professionals).
- 
- Ability to engage with parents in both group and individual settings by showing an understanding of their viewpoint; ability to form a working alliance and set up agreed joint goals for treatment.
  - Ability to identify the role of setting and prior events in triggering, and consequent events in maintaining the conduct problems, and to explain this model to parents and generate an understanding in parents of this process through exploration of their beliefs, discussion techniques, cognitive restructuring and behavioural experiments.
  - Ability to provide a rationale for the use of homework which explains that home activities are a way of trying out ideas and practising new skills in the normal home/school environment.
  - Ability to create a verbal and diagrammatic formulation in collaboration with the parents and child/young person.
  - Ability to structure sessions individually according to progress, or according to the group programme; ability to know how and when to catch up or go slower by reviewing progress.
  - Ability to run sessions that go through stages including play, praise and rewards, ignoring, limit setting and logical consequences for non-compliance, time-out.
  - Ability to tailor the level of parent/carer involvement in sessions in line with the formulation of the specific problems which the parents face and the relationship between the child/young person and parent/carer.
  - Ability to help identify improvements by working with the parent to compare their current behaviour and link it to the child's.
  - Ability to identify any remaining difficulties and to consider how the parent could use techniques they have learned in therapy if problems re-emerge.
  - Ability to run parent groups successfully:
    - Treat each group member in a positive manner consistent with SLT
    - Set group rules on confidentiality
    - Identify and manage group members who say too much or too little/fail to take part in sessions

- Keep sessions running to time
- Ability to plan and enact role plays (both to enable parents to show what is happening at home, and to learn new methods of relating with their children) using a number of group participants
- Skill in knowing when to be directive and teach vs. when to allow the group to generate solutions
- Obtain positive ratings from group participants (average within 80% of programme median)
- Ability to use video or audiotaped examples successfully (for programmes that use them)
- Ability to draw out core principles seen in a vignette, allowing parents to speak first and give their views, relating content to parents' own predicaments
- Ability to assess which clients are likely to do better with an individual approach, thus, knowledge of the pros and cons of an individual approach, including parental shyness, severity of parental problems making joining with a group or going at group pace difficult, ability to attend at group times and cost-effectiveness
- Ability to re-assess families that are failing to progress, and manage appropriately, including: noting signs of failure to progress; analysis of whether this is due to lack of parental change or child insensitivity to change; if parent, is it proximal failure to understand what to do, or interference at home (by partner, mental health problems, etc.); if child, assess for conflicting management from other parent, reconsider abuse, learning disability, autistic spectrum disorder, ADHD, callous-unemotional traits, etc.
- Ability and confidence to follow up parents who do not attend or engage with groups and to develop appropriate strategies for re-engaging parents or offering appropriate alternatives.
- Demonstrate self-direction and originality in tackling and solving basic therapeutic problems with parents of children with conduct problems, including recognising the need for and enacting a re-assessment when therapy is failing to progress.
- Ability to work individually with parents or carers, including in home-based settings, and to develop appropriate assessment and treatment plans for families.

The evidence-based CBT competencies, and their associated models, for specific conduct disorders may be found in the following:

- NICE guidance on parent training for conduct disorders (TA201, 2006)
- The competence framework developed by Roth, Calder, and Pilling (2011): [http://www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm)
- NICE clinical guidance for conduct disorders (CG158, 2013)

### **Assessment of trainees**

- All trainees will be assessed on individual as well as group work.
- Trainees will be assessed on three cases working individually with parents who are not part of a group, including work with the parent, and with the parent and child. Parent and child work to be evidence-based.
- Trainees will be assessed on three cases working individually with parents identified from the group, including work with parent, and with the parent and child
- It is recommended that trainees are assessed on one individual and one whole group video recording.

### **Key texts**

For individual work:

- Zisser, A., & Eyberg, S. (2010). Parent-child interaction therapy. In J. Weisz & A. Kazdin (Eds.), *Evidence-based psychotherapies* (2nd edn., pp. 179-193). New York: Guilford Press.
- Kazdin, A. (2010). Problem-solving skills training and parent management training for oppositional defiant disorder and conduct disorder. In J. Weisz & A. Kazdin (Eds.), *Evidence-based psychotherapies* (2nd edn., pp. 211-226). New York: Guilford Press.
- McMahon, R., & Forehand, R. (2003). *Helping the noncompliant child*. New York: Guilford Press.
- Barkley, R. (1997). *Defiant children* (2nd edn.). New York: Guilford Press.

For group work:

- Webster-Stratton, C., & Reid, J. (2010). The Incredible Years parents, teachers and children training series. In J. Weisz & A. Kazdin (Eds.), *Evidence-based psychotherapies* (2nd edn., pp. 211-226). New York: Guilford Press.
- Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The Triple P-Positive Parenting Program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology*, 68, 624-640.

General review:

- Scott, S. (2008). Parenting programs. In M. Rutter, D. Bishop, D. Pine, S. Scott, J. Stevenson, E. Taylor & A. Thapar (Eds.), *Rutter's child and adolescent psychiatry* (5th edn.). Oxford: Blackwell.

### **Format**

This will be based on:



- A taught course
  - A mixture of lectures, workshops and seminars, including active elements such as role play
  - Attendance at an accredited training for an approved evidence-based parenting programme (e.g. Incredible Years or Triple P; each of these takes approximately 3 days).
- Clinical practice
  - If possible, it is desirable that two groups be undertaken by each trainee, but we recognise that under some circumstances it may not be possible. Undertaking supervised practice with one group is essential for the clinical practice training. Keeping the membership of the group at a high and constant level is part of the demonstration of trainee competence.
  - Seeing at least six individual cases for 6–12 sessions, to include home visits.
- Supervision of clinical practice
  - Trainees will keep video or audio recordings of all clinical sessions, which they will show at supervision, where they will be expected to practise new skills.
  - They will receive weekly individual personal supervision, which will focus on their implementation of the chosen intervention model.

The precise format will be at the discretion of the programme, but IAPT will specify a minimum number of supervised cases, length of supervision sessions, number of people within supervision groups, the number of tapes to be passed, and may in future recommend particular assessment methods and rating scales.

## **6. CYP IAPT Interpersonal Psychotherapy for Adolescents for Depression**

This document sets out the overall aims of the national curriculum for CYP IAPT Interpersonal Psychotherapy for Depression in Adolescents (IPT-A). Trainees will complete this 60-credit module in conjunction with the Core CYP IAPT curriculum (60 credits).

The course will have an integrated theoretical base, reflecting the integration of medical and interpersonal models of depression. In addition to providing practical, intensive and detailed skills training to a defined standard of competence, the course will aim to increase trainees' knowledge base of theory and research in IPT-A, and to promote a critical approach to the subject. This course will further introduce students to theories of adolescents' psychological development (social, emotional, moral) and differing perspectives within that. The course will invite students to apply developmental theory to case examples thus encouraging critical reflection on the utility of such models to enhance the application of IPT-A in this population. It will aim to equip trainees to become skilled and creative independent IPT-A practitioners, in accordance with IPT-UK accreditation guidelines, and to contribute to the development of IPT-A.

### ***Aims***

The course will provide opportunities for trainees to develop and demonstrate knowledge, understanding and skills as follows:

- To develop practical skills in delivering IPT-A for depression.
- To develop practical competency in working collaboratively with parents and educational services as part of routine treatment of depression in young people
- To develop practice skills in conceptualizing and formulating from an interpersonal perspective and to develop a critical understanding of the parameters of such an approach
- To develop critical knowledge of the theoretical origins and research literature relating to IPT-A for depression.
- To develop critical awareness of theories of adolescent development and to critically evaluate the utility of such models to enhance current practice.

### ***Scope***

The evidence base for IPT-A relates to its use as a treatment for depression in adolescents and as a preventative intervention for young people at risk of developing depression. Workshops in the module will cover an overview of IPT-A; the application of CYP IAPT core skills in IPT-A; the

theoretical origins and evidence base for IPT and IPT-A specifically; collaborative case formulation and working with IPT-A focus areas; IPT-A assessment strategies with symptom focus; IPT-A assessment strategies with an interpersonal focus; working with parents and education providers; strategies for working with Interpersonal Role Transitions, Complicated Grief, Interpersonal Role Disputes and Interpersonal Sensitivity/Deficits; strategies for working with ending and preparing maintenance and relapse prevention plans; modifications for adolescent depression; working with affect; working with communication; child development theories, mentalization skills in IPT-A and advanced practice skills.

### ***Structure of training***

The IPT-A practitioner training course is delivered over fifteen teaching days. The first five days, which focus on the core model, are delivered consecutively and the remaining ten days, which focus on theories of child and adolescent development, Mentalization skills in IPT-A and advanced practice skills training are scheduled at monthly intervals. It is essential that these training days are conducted with explicit reference to the core skills and principles of CYP IAPT and the application of these skills in the IPT-A framework is explicitly examined and promoted.

Following completion of the initial five days of training trainees begin casework with adolescents with depression using IPT-A. NICE guidelines recommend IPT-A for adolescents with moderate to severe depression. Trainees attend weekly supervision for the duration of the casework. Trainees submit a minimum of three recorded therapy sessions for evaluation per case. Trainees complete a detailed competency-based self-assessment prior to submitting recordings, using the IPT Rating Scale, and receive written feedback on the same competency assessment form following the supervisor's or external rater's review of the recording. Trainees submit a written or oral case report with a reflective statement following completion of each case.

### ***Method of training***

The course will employ a mix of didactic teaching, large and small group discussions, extensive use of case discussions and role play, recorded materials and interactive role plays by course tutors, directed reading and review of resources and direct participation and input from young people. The advance practice training days will make extensive use of video recordings of the student's own practice in skills focused workshops.

IPT-A training must be conducted by IPTUK accredited trainers or IPT supervisors under supervision of an IPTUK accredited trainer.

### ***Learning objectives***

Knowledge and Understanding

- Demonstrate a full, critical and integrated understanding of the developmental and psychological theories and principles that underlie effective IPT interventions as these are applied to depression in adolescence.
- Demonstrate critical understanding of the theoretical and research evidence for IPT for depression and an ability to evaluate the empirical evidence for the effectiveness of IPT-A with adolescents with depression.
- Demonstrate knowledge and understanding of the role of the evidence base in shaping an individual treatment programme.
- Demonstrate critical knowledge of interpersonal and social models of change as they apply to children and adolescents, including principles of assessment and diagnosis.
- Demonstrate critical understanding of normal and atypical cognitive, social, and emotional development, and the links among these.
- Demonstrate a critical understanding of the principles of Mentalization as these apply to adolescents and interventions for depression in adolescence.
- Critique and evaluate the principles of developmental theory as they apply to clinical practice.
- Demonstrate knowledge and critical understanding of the phenomenology, diagnostic classification and epidemiological characteristics of depressive disorders and competence in effectively communicating this information to the client.
- Demonstrate knowledge of relevant pharmacological interventions and competence in informing and supporting clients on combined treatment approaches
- Demonstrate knowledge and understanding of the relevance of wider family context and competency to engage the family in the treatment.
- Demonstrate knowledge and understanding of the interpersonal vulnerability and protective factors associated with adolescent depression.

#### Practical and specific skills

- Demonstrate competence in practising IPT-A with depression systematically, creatively and with good clinical outcomes
- Demonstrate competence in promoting and supporting the young person's active participation in shaping and determining the course of therapy.
- Demonstrate competence in working collaboratively with parents and educational services as part of routine treatment of depression in young people.
- Demonstrate competence in developing a constructive therapeutic relationship with the client and their family unit and using this to model collaborative communication and facilitate adaptive interpersonal exchanges
- Demonstrated competence in conducting a collaborative diagnostic assessment, taking into account clinical manifestations, past history, present life situation, course and outcome of depression and suitability for IPT-A
- Demonstrate competence in conducting risk assessment and management in taking a history of depressive disorders and co-morbid diagnoses

- Demonstrate competence in assessing for the suitability of IPT-A and identifying contra-indications
- Demonstrate competence in the use of CYP IAPT process and disorder specific clinical outcome measures.
- Demonstrate competence in conducting a timeline assessment of depressive symptoms in the interpersonal context
- Demonstrate competence in engaging the client in identifying early targets for symptom and interpersonal change and opportunities to engage social support.
- Demonstrate competence in translating depressive symptoms into the interpersonal context.
- Demonstrate competence in using the interpersonal inventory to identify which interpersonal difficulties are linked with the current symptoms of depression and to help the client feel understood by summarising the salient interpersonal events linked to the onset and maintenance of symptoms
- Demonstrate competence in actively engaging the client in responding to the formulation, to clarify any misunderstandings or disagreements with the formulation and where there are several potential foci, to support the client in identifying the most pressing concern that has the greatest impact on their interpersonal functioning and symptoms.
- Demonstrate competence in collaborating with the client and their family to identify primary and achievable goals related to the agreed focal area that will direct the individual work within the focal area.
- Demonstrate competence in conducting a weekly symptoms review with the client which integrates self monitoring and use of standardised CYP IAPT outcome measures
- Demonstrate competence in helping the client to maintain attention on the agreed focal area and its link to symptoms
- Demonstrate competence in the flexible selection and application of focus specific and generic strategies to address current symptomatic and interpersonal distress and move towards resolution.
- Demonstrate competence in balancing attention to historical material and a here and now interpersonal focus.
- Demonstrate competence in working constructively and purposefully with intense affect
- Demonstrate competence in the detailed reconstruction of interpersonal exchanges and collaboratively developing more adaptive communication strategies.
- Demonstrate competence in balancing explicit attention to the therapeutic relationship and an external interpersonal focus.
- Demonstrate competence in allowing adequate preparation for ending therapy to enable accurate evaluation and consolidation of gains, and preparation for independent practice.
- Demonstrate competence in collaborating to produce a relapse prevention plan, including medication where necessary, that actively involves the available interpersonal and professional networks.

Overarching meta-competency framework for CYP IAPT can be found at:

[http://www.ucl.ac.uk/clinical-psychology/CORE/child-adolescent-competences/CAMHS%20Competences%20Framework\\_V1%20\(2\).pdf](http://www.ucl.ac.uk/clinical-psychology/CORE/child-adolescent-competences/CAMHS%20Competences%20Framework_V1%20(2).pdf)

### **Key Texts**

IPT-A for depression

- Mufson, L., Pollack Dorta, K. Moreau, D. Weissman, M.M. (2004) Interpersonal Psychotherapy for Depressed Adolescent (2nd Ed). Guilford Press, New York.

IPT-A for depression

- Markowitz, J.C. & Weissman M.M & Klerman G.L. (2000) Comprehensive Guide to Interpersonal Psychotherapy. Basic Books, New York.(Pubs)
- Markowitz, J.C. & Weissman M.M. (Eds) (2012) Casebook of Interpersonal Psychotherapy. Oxford University Press, New York. (Pubs)
- Law, R (2013) Defeating Depression: How to use the people in your life to open the door to recovery. Constable and Robinson, London (Pubs)

### **Assessment strategies:**

Knowledge will be assessed through a daily knowledge test during the first five training days. Participants must achieve a mean score of 60% over the five days.

Trainees are required to complete four twelve-session cases using IPT-A under weekly supervision. At least ten sessions must be completed and demonstrate evidence of work in the three phases of IPT-A in each case.

Knowledge will be assessed in one case conceptualization, including literature review, (4000 words), one case study (2000 words), one oral presentation of a whole session with accompanying reflective analyses and linked recording (1000 words) and two oral cases presentations with accompanying reflective analyses (2000 words). Each case report must focus on a different IPT-A case.

Knowledge will also be formatively assessed by means of self-assessment, using the IPT competencies self-assessment tool. This is completed following the initial five training days, at the mid point of supervised casework and on completion of the supervised casework.

IPT-A practice will be formatively assessed on the four IPT-A cases using the IPT rating form. Trainees complete a self-assessment and receive competency-based feedback on at least twelve recordings across the four cases. These assessments will not directly contribute to the PGDip award but will count towards accreditation with IPTUK on completing training.

## 7. CYP IAPT Systemic Family Practice and Basic Skills

### *Introduction*

Work with families is a significant component of treatment in CAMHS and other child-focused mental health settings. There is growing evidence for positive outcomes from family interventions. In addition, work with families often accompanies other interventions and can make an important contribution to the development and maintenance of the therapeutic alliance. It can also support adherence to other interventions. Many mental health professionals currently work with families as part of their professional role and this curriculum provides evidence-based training to support that work. Systemic family therapy provides the key theoretical frame that informs clinical practice with families, although many clinicians working with families will not be trained to a qualifying family therapy level. Within multidisciplinary teams qualified family therapists have an important role not only to offer highly skilled therapeutic work with families but also to provide consultation and supervision to colleagues with less training in systemic practice <sup>2</sup>

This document sets out the overall aims of the CYP IAPT curriculum for systemic practice with families. This curriculum comprises a basic systemic module (30 credits) and specialist systemic modules for depression and self-harm (15 credits), conduct disorder (15 credits), and eating disorders (30 credits). It is expected that trainees will complete the basic systemic module and two single 15-credit specialist modules or one double (30-credit) specialist module, giving a total of 60 credits.

In total, trainees within CYP IAPT will complete a 120-credit course by completing the core CYP IAPT curriculum (60 credits) and basic and specialist systemic curricula (60 credits).

### *Entry requirements*

1. A training in a mental health-related profession (e.g. psychology, nursing, social work, occupational therapy, speech and language therapy, special needs teaching, psychiatry, other psychotherapy, counselling).
2. Two years' experience of working within a professional setting concerned with the mental health of children and young people.
3. Some experience of working with families.

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<sup>2</sup>Note on terminology: In this document we use the terms Systemic Family Therapy (SFT) and Systemic Family Practice (SFP) to differentiate between the work of clinicians trained to qualifying level and those trained to an intermediate level. While we recognise that in clinical practice the distinction between providing SFT and SFP is by no means absolute, it is important as a way of underscoring the difference in the levels of theoretical knowledge and specialist skill that qualified family therapists bring to the multidisciplinary team



There are specific entry requirements for the Eating Disorders module. Please refer to the description of that module for details.

Professionals who have completed an AFT accredited intermediate course in systemic practice with families will usually be required to take the specialist modules and core CYP IAPT Curriculum.

### ***Teaching and learning strategies***

Teaching will combine didactic teaching, small group work, role play and observation of therapy. There will be an emphasis on relating learning to clinical practice.

### ***Trainers and supervisors***

All trainers should be registered or eligible for registration with UKCP as Systemic Family Therapists and should have knowledge and experience of the topic being taught.

The quality of supervision is a key factor in ensuring high-quality learning. Supervision of clinical work should, wherever possible, be carried out by AFT-registered Systemic Supervisors or those who meet the competencies required for registration (i.e. eligible for registration.). AFT will provide guidance on those competencies and the processes for achieving registration through an APEL route.

It is recognised that in some areas there may be a limited resource of specialist Systemic Supervisors and in this situation the best available Systemic Supervisors should be used. This should be considered a temporary measure for the first 2 years, with efforts made to increase the pool of fully qualified supervisors. At a minimum, any supervisor would need to have completed a qualifying training in Systemic Family Therapy, have a minimum of 3 years' post-qualifying experience, and have gained previous experience of supervising systemic practice within a CAMHS setting.

### ***Specialist modules***

Currently there are three specialist modules. Two of these (Self-Harm/Depression and Conduct Disorder) are single specialist modules (15 credits each). The Eating Disorder module is a double module (30 credits). Trainees will be required to complete the basic module and either two single modules or one double module.

### ***Supervision and clinical work***

In the basic module and specialist modules there will be specific requirements for clinical work. This will be supervised on a weekly basis by AFT-accredited supervisors (see above). The supervision will be mainly group supervision with no more than six trainees in a group and will last for a minimum total of 2.5 hours per week. Some supervision can also be done on an individual

basis. It is highly recommended that some live supervision is included as this is considered of particular value in helping students acquire clinical skills.

Trainees will be expected to complete a clinical log and reflective learning diary and use a self-report measure to reflect on their sessions and do a self assessment of clinical competencies. It is recommended that the Systemic Session Rating Scale is used at some point (s) as a formative assessment tool. If used in the final assessment it should be used together with other evidence drawn from a range of sources. In total, across all the modules (60 credits) they will be required to complete a minimum of 60 hours of clinical work, divided in the following way:

Module	Number of hours of clinical work	Number of cases
Basic	12	2 cases
Depression and Self-Harm	24	3 cases (1 to conclusion)
Conduct Disorder	24	3 (1 to conclusion)
Eating Disorder	48	3 cases (1 to conclusion)

Please refer to the specialist modules for more detail about clinical work requirements

### ***Assessment strategy***

All trainees are required to complete a learning portfolio, which is continued throughout the basic and specialist modules. At a minimum this should contain a log of clinical hours with learning points, a reflective diary and copies of self assessments of clinical competencies.

Assessment of the log should take account of

1. Completion
2. Reflective learning capacity

### 3. Evidence of taking charge of own learning

A self-evaluation measure of systemic competencies should be completed at agreed points during the course (formative assessment).

A reflective self-evaluation should be completed following clinical sessions and used in supervision (formative assessment).

At the end of the basic module there will be an assessed 4000-word case study of a piece of work reflecting the learning outcomes of the module. (summative assessment).

At the end of each of the specialist modules there will be an assessed 5000-word case study reflecting the learning outcomes of the modules.

Please note that this is the minimum level of assessment required.

#### Assessment of Clinical Work

1. Reports from all clinical supervisors indicating whether or not a student has reached a satisfactory level of competence. This assessment should be based on required clinical competencies.
2. An overall clinical mark based on clinical competencies using the following evidence
  1. Supervisors reports
  2. Formal rating of a recorded clinical session ( for example using the Systemic Session Rating Scale). The final mark for this should take into account the student's reflections on the session.
  3. Evidence from the student's portfolio of learning.

## Module 1: Basic skills

### *Aims*

- To develop practical competency in evidence-based methods of Systemic Family Therapy (SFT) addressing common mental health problems in childhood and adolescence.
- To understand and apply the theories underpinning SFT.
- To develop critical knowledge of the theoretical and research literature relating to SFT.
- To develop an understanding of the links between systemic theory and practice and other therapeutic approaches.
- To develop the ability to integrate the core principles of SFT into systemic practice with Families (SFP), formulate a treatment plan, carry out systemic interventions and manage therapeutic endings.

- To develop the ability to integrate the core principles of SFT with appropriate specific evidence-based systemic practice models.

### **Scope**

Workshops in the module will cover the basic knowledge and clinical skills for delivering systemic work with children, young people and their families that will serve as the foundation of specific evidence-based techniques, intervention and treatment models. Successful SFP requires that the core foundation of SFT thinking and practice forms the foundation of any specific evidence-based practice. Integral to all teaching will be a knowledge and appreciation of diverse family forms, the importance of culture and the influence of wider systems. It is recognised that the focus for intervention may vary considerably and include different family members and other carers. Specific knowledge and skills with respect to specific disorders or problems will be covered in subsequent modules.

**Note:** The curriculum authors have written this basic module (30 credits) plus 2 x 15-credit specialist modules (or 1 x 30-credit specialist module) so that they also meet the requirements for intermediate-level training in Family Therapy (AFT). The CYP IAPT SFP training is a route into year 3 of the four-year Systemic Family Therapy Training (accredited by the Association for Family Therapy). Information on ways of completing the training can be found on the AFT website: <http://www.aft.org.uk>

### **General learning outcomes**

On completion of the module trainees should be able to:

- Structure and pace sessions in a way that provides a safe, containing, therapeutic environment for all family members, especially children, young people and other vulnerable family members.
- Work collaboratively with family members, including the identification of overall goals and the agreed focus for each session.
- Include progress reviews using agreed measures and in-session review.
- Develop and maintain the therapeutic alliance with each family member, grasping their world view and using warmth, humour, empathy and positive feedback appropriately
- Make a formulation of the family and its relationship to the presenting problem, reviewing this throughout the work, and recognising the limitations of the approach and referring on appropriately.
- Help family members to recognise and articulate different feeling states, moods and states of mind, and articulate how these are manifested and understood within the family.
- Map trans-generational family relationships using questioning, genograms and other maps.

- Understand the history of the presenting problem in relation to significant family events, family relationships, and the impact of the problem on the family.
- Demonstrate active listening skills and curiosity and facilitate the development of new perspectives through techniques including questioning, reflection, reframing, externalising and scaling.
- Encourage family members to identify their own strengths and resources (including problem-solving skills) and use them more effectively.
- Actively track and work with behavioural processes and problematic communication patterns within the session.
- Explore constraints, such as language, beliefs, narratives, wider social discourses and interactions, and how these affect the ability of families and family members to find new ways forward.
- Use non-verbal and child-focused activities, especially in communicating with children at an appropriate developmental level.
- Manage endings effectively, including collaborative decision making about timing and reviewing of the work with the family.
- Understand and manage ethical issues relating to systemic practice with families, including consideration of the impact of personal and professional issues on the work.

The evidence-based SFP learning outcomes and competencies have been based on the following:

- The competence framework developed by Roth, Calder, and Pilling (2011): [http://www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm)
- The 'Blue Book' training standards of the Association for Family Therapy ([www.aft.org.uk](http://www.aft.org.uk))
- Leeds Manual
- Tavistock Clinic Childhood Depression Manual
- Diamond Manual for Attachment Based Family Therapy for Depressed Adolescents
- SHIFT (Self Harm Intervention Family Therapy) manual
- FFT Manual
- Maudsley Child and Adolescents Eating Disorders Service model and Family Therapy Training Manual

The competencies for SFP are based on the competencies for SFT but represent a less advanced level of practice. The competencies are mapped out in more detail below.

### **Competencies for SFP**

- Knowledge of the core principles and components of SFT, including knowledge of the evidence base of SFT for children, adolescents and their families.

- Ability to explain the rationale for and the process of SFP to all family members in developmentally appropriate ways.
- Ability to undertake a systemic assessment taking into account the problems and the context in which they present, as well as the process of referral and the opportunity to involve the wider system.
- Ability to take into account culture throughout the therapy process, together with factors such as class, gender, ethnicity, disability and other issues of inequality affecting the family.
- Ability to locate the child/young person and the presenting problem within the wider system (family, social community settings, personal networks, cultural and wider socio-political environment).
- Ability to develop a shared formulation with the family and its individual members.
- Ability to explain and review the likely course and process of SFP, continuously and throughout the therapeutic process, including the ability to:
  - Be as clear as possible about the likely course of the intervention (e.g. the anticipated number, frequency and duration of meetings)
  - Convey the nature of the collaborative and transparent work of SFP
  - Be open about the different roles and positions the therapist might take
  - Elicit feedback from family members to inform about their different understandings and preferences
  - Provide a rationale for the use of interventions, including out-of-session tasks.
- Ability to discuss flexibly the possible roles of family members and, where appropriate, the wider network, in the therapeutic process.
- Ability to structure all sessions, in a way that is appropriate for all family members.
- Ability to employ therapeutic skills, including the capacity to develop the therapeutic alliance with each family member.
- Ability to encourage family members to use their own resources and employ problem-solving skills.
- Ability to define the boundaries of confidentiality.
- Ability to use warmth and humour appropriately.
- Ability to use a range of techniques to explore meanings, behaviour, emotions and relationships and their interconnections.
- Ability to observe within the session interactions and process, between family members and family members and therapist.
- Ability to monitor and reflect on the therapist's own internal processes and responses to the family.
- Ability to actively track and work with behavioural processes and problematic communication patterns within the session.
- Ability to highlight and enhance family members' strengths and resources and help them to identify ways in which they can utilise these to address problems.

- Ability to remain curious about differences in culture, beliefs and values, as well as the family members' current life circumstances and significant events, and take this into account in the work.
- Ability to discuss how trans-generational patterns may affect current family life and relationships.
- Ability to use expertise whilst aware of its limitations in relation to particular families. To do this in a way that takes account of the power differentials and potential for undermining.
- Ability to map the effects of the presenting problem on the family and wider system.
- Ability to explore constraints, such as language, beliefs, narratives, wider social discourses and interactions, and how these affect the ability of families and family members to find new ways forward.
- Ability to manage endings.
- Ability to manage complex ethical issues as they arise in work with families.

### ***Structure of the module***

This module is run over 8 days and trainees will be required to complete this module before taking the specialist modules. It is expected that this module would be run during the first term and a half of the course.

- Unit 1: 1 day

Basic systemic theories relating to evidence-based practice and rationale for meeting with the family.

- Unit 2: 1 day

Engagement with families and family members with special reference to issues of power and taking account of culture and other difference. Forming a collaborative and non-blaming relationship.

- Unit 3: 1 day

Further systemic theories informing evidence-based practice. Narrative ideas, social constructionism and brief solution-focused approaches with some basic interventions.

- Unit 4: 1 day

Family formulation and assessment. Using a range of perspectives and dimensions of family life. Focus on a range of questioning techniques and ways in which they can be applied in work with families.

- Unit 5: 1 day

Convening and managing a session with family members. Having difficult conversations and managing conflict and differing agendas.

- Unit 6: 1 day

Working with communication and behavioural patterns. Using concepts of family structure and organisation to understand family relationships and intervening directly in family process.

- Unit 7: 1 day

Further interventions, including externalising, building on positives, encouraging resilience and helping promote empathy, reflection and problem solving.

- Unit 8: 1 day

Putting it all together. Focus on theory to practice.

### ***Clinical supervision***

- Each trainee will have clinical supervision weekly in a group of no more than four, with occasional individual sessions in place of the group sessions.
- Before each session, the trainee will complete a self-assessment form to be referred to in supervision. They will receive written feedback following supervision, which will be included in the portfolio together with a brief reflection on the comments.
- Recorded material from at least two cases should be included at some point during the supervision sessions.
- At the end of the course when clinical work has been completed, the supervisor will be asked to complete a proforma assessment form and indicate whether or not a trainee has reached a satisfactory level of clinical practice.

### ***Assessment strategy***

- Completion of a Learning Portfolio. This should contain:
  - Clinical log and learning points
  - Reflective diary
  - Copies of self-assessments re systemic learning
- Supervisor's report showing satisfactory standard of clinical work
- 4000-word case study (minimum)

The assessments should together measure the learning outcomes for the course.

This assessment strategy represents the minimum required.



## **8. CYP IAPT Systemic Family Practice for Depression and Self-Harm**

### ***Introduction***

This module constitutes a specialist module of 15 credits. It will sit alongside the other specialist modules (Eating Disorders and Conduct Disorder). It will be delivered alongside the Core IAPT and once the Basic SFP module has been completed. The module draws upon a number of relevant manuals, including Tavistock Childhood Depression, Diamond Attachment Based Family Therapy for Depressed Adolescents, and Self harm Intervention Family Therapy (SHIFT). This will be a 6-day module.

### ***Aims***

The course will have a Systemic Family Therapy (SFT) theoretical base with preference for approaches with the soundest evidence. In addition to providing practical, intensive and detailed skills training to facilitate skill development to a defined standard of competency, the module will aim to increase trainees' knowledge base of both theory and research in depression and self-harm, and to promote a critical approach to the subject. It will aim to equip trainees with skills and competence in this area of work.

The module will provide opportunities for trainees to develop and demonstrate knowledge, understanding and skills in the following areas:

- Critical knowledge of the theoretical and research literature relating to psychological therapies for depression and self-harm in children and young people.
- Practical competency in SFT for depression and self-harm in young people.
- Ability to use this approach alongside other approaches within CYP IAPT competencies and apply routine measures.
- Ability to apply this approach to diverse family forms.

### ***Trainers and supervisors***

Trainers delivering this module must be registered systemic family psychotherapists and have significant experience in both teaching and supervising clinical practice within the NHS. In addition, trainers must have a secure knowledge in the core approaches that make up this module.

The quality of supervision is a key factor in ensuring high-quality learning. Supervision of clinical work should, wherever possible, be carried out by AFT registered Systemic Supervisors or those who meet the competencies required for registration (eligible for registration). AFT will provide guidance on those competencies and the processes for achieving registration through an APEL route.

It is recognised that in some areas there may be a limited resource of specialist Systemic Supervisors and in this situation the best available Systemic Supervisors should be used. This should be considered a temporary measure for the first 2 years with efforts made to increase the pool of fully qualified supervisors. At a minimum, any supervisor would need to have completed a qualifying training in SFT, have a minimum of 3 years' post-qualifying experience and have gained previous experience of supervising systemic practice within a CAMHS setting.

Practitioners coming on to this module must have satisfactorily completed the Basic SFP module

This curriculum sits alongside other CYP IAPT curricula. It will consist of 12 units.

### ***Key texts***

- NICE guidelines for childhood/adolescent depression
- Tavistock Clinic Childhood Depression Manual
- Diamond Manual for Attachment Based Family Therapy for Depressed Adolescents
- SHIFT (Self Harm Intervention Family Therapy) manual
- Systemic Competencies Framework

### ***SFT and systemic practice for depression/self-harm***

SFT has been demonstrated to be an effective intervention for child and adolescent depression and self-harm (Trowell et al., 2007; Diamond et al., 2010), based on research of childhood depression, attachment-based family therapy for depressed adolescents, and the current SHIFT trial involving self-harm. SFT approaches are recommended by NICE (CG28, 2005). This module draws from the manuals from these trials. The focus of the module is to adapt these approaches for family systemic practitioners.

### ***General learning outcomes for systemic practice for depression and self-harm***

At the end of the course trainees will be able to demonstrate:

- Critical understanding of the phenomenology, diagnostic classifications, epidemiological characteristics and clinical research literature of self-harm and depression in children and adolescents. Ability to assess the suitability of a young person or adolescent and their significant network for systemic practice and an ability to articulate the indications and contra-indications for treatment and explain the principles and procedures of systemic practice to children, adolescents, their families and others who may be responsible for informed consent.
- Understanding of the points of view and experiences of children, adolescents and their families or carers in relation to self-harm and depression and how it impacts them as individuals and as a family.

- Ability to conduct a systemic assessment in relation to presentations of self-harm and depression, and make a systemic hypothesis and formulation of the case including a relational, interactional and contextual conceptualisation, and the identification of the restraints and resilience factors of all participants.
- Understanding of factors which contribute to the consideration of who is included in the relevant 'system' to be worked with; including carers, absent parent, extended family or other professionals or school representatives.
- Ability to adapt systemic practice so that it is accessible and responsive to children, adolescents and families with different social identities, cultures, needs and abilities.
- Ability to collaboratively construct a treatment plan with the child or adolescent and their family or carer; including consideration of risk and safety.
- Ability to work with comorbidity and other complexities in presenting problems with support of appropriate supervisor.
- Ability to plan the ending of the therapeutic support and enhancement of therapeutic gains.
- Ability to be self-reflexive in relation to own personal and professional responses to the issues around self-harm and depression.
- Ability to make use of supervision for self-harm and depression.
- Ability to use clinical measurement to monitor systemic family sessions and clinical progress.
- Knowledge of the limit of own capacity and when necessary to refer to more skilled colleagues (such as qualified systemic psychotherapists or other therapists or disciplines).
- Critical understanding of clinical research literature on SFT for self-harm and depression (clinical trials and outcome studies).

The competencies for SFP are based on the competencies for SFT but represent a less advanced level of practice. The competencies are mapped out in more detail below.

### ***SFP competencies for self-harm and depression***

Following successful completion of this module, systemic practitioners should be able to demonstrate the following competencies:

- Ability to apply understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of self-harm and in children and young people to formulation and treatment planning. This will include potential hereditary and genetic predispositions to mental health vulnerability and family environmental contributions.
- Ability to consider risk and protective factors in relation to self-harm and depression in children, young people and their families and wider contexts, and address this in the work.

- Ability to develop a critical understanding of the current evidence-based pharmacological and psychological treatments for self-harm and depression and be able to use this to plan the work.
- Ability to use direct and indirect methods to enhance engagement and alliance development with the child, young person and family members, including the ability to work with different ages, abilities and differences in culture, class, race and gender.
- Ability to work from a stance of cautious optimism and curiosity, offering a non-blaming approach
- Ability to apply child and adolescent psychosocial developmental theory and family life cycle theory in the assessment and formulation of the presentation of self-harm and depression. This includes knowledge and attention to general resilience factors and the identification of specific individual and family strengths and resources
- Ability to consider the context of the referral from the perspective of the young person, family and professionals involved and to convey this in the work
- Capacity to understand and address peer group relationships and relationships at school as an important aspect of the context of children and young people.
- Ability to address self-harm as a coping mechanism and to work jointly with the young person's and parent's goals in relation to this.
- Ability to evaluate the level of risk due to self-harm, suicidality and depression, which includes an understanding of both the young person and the capacity of participants in the system to respond effectively.
- Capacity to create and implement a safety plan as part of the relational and communication process between adults and young person and negotiate the appropriate level of parental protectiveness and young person's autonomy in relation to increased or decreased level of risk.
- Ability to work systemically with children and young people prescribed medication, and with the professionals prescribing.
- Capacity to actively intervene to create a safe environment for the therapy, including interrupting or taking breaks in the management of high levels of conflict.
- Capacity to consider safeguarding issues and make a referral as appropriate.
- Ability to manage a referral and work with CAMHS policy in such a way that maximises the potential for safety (in the first instance) and resumption of family work after a crisis by effective systemic coordination between professionals and family.
- Ability to conceptualise the self-harm and depression in terms of both individual meaning to the young person/adolescent and the family and other relevant systems (e.g. school) and as communication across systems. Ability to understand the importance of social media to young people and include it in the work. Included in this is the cultural meaning of self-harm and depression, taking into account languages/cultures where there is no definition of mental illness and depression, and assumptions of best response.

- Ability to demonstrate an understanding of the patterns of self-harming behaviour, the form(s) it has taken, the intentions of the young person, the interactional sequences, physical responses and the meanings. Central patterns include those of the management of strong emotions (anger or numbness) between the young person and the body (self-harm) and between the young person and significant relationships and to help the young person and family members to manage these emotions.
- Understanding of the patterns of depression, the severity, duration and interactional sequences and meanings for all participants.
- Capacity to facilitate the capacity of the family to see the individual's self-harm and depression in the broader context of significant relationships. To map the family history and genogram where appropriate, paying careful attention to timing and potential emotional impact.
- Ability to identify and map problem-solving attempts by all participants, noting those that have been helpful and unhelpful, and helping the family to develop the positive experience.
- Ability to facilitate the capacity for communication and, where necessary, to represent the voice of the young person/adolescent in discussions especially about problematic relationships.
- Ability to enhance the parents' capacity for understanding the young person's communication by discussing the meaning of behaviour and supporting age-appropriate concerns through discussion.
- Capacity to actively support the development of new positive meanings and patterns as they emerge in therapy, highlighting small positive changes and looking for further detail to support their maintenance and progression. Ability to help individuals and the family to re-story behaviours.
- Ability to actively support the realignment of positive emotional attachments within the family.
- Ability to facilitate family conversations in joint sessions but, when required, negotiate parallel individual sessions with the young person or the adults as a means of enhancing appropriate communication and mutual understanding or as a response to concerns of risk and safety.
- Ability to consider own personal and professional responses to the issue of self-harm and depression and how that may constrain or support the work with clients, including the capacity to identify potentially problematic responses and discuss them in supervision.
- Ability to intervene in ways that use general systemic skills: systemic hypothesising, systemic questions (circular, narrative, solution focused), use of self in session and action techniques (enactments, sculpting, drawing and play).

### ***Structure of training***

The SFP practitioner training course is delivered over 6 days, consisting of 2-day block/single day/2-day block/single day (the last day is at the end of the course to reflect on all the clinical experience). The training covers all of the specific competencies for systemic practice for self-harm and depression and the current evidence base.

Prior to attending the course trainees use a self-assessment measure to identify their general competencies and the systemic practice-specific competencies they bring to the training. This exercise is repeated after the training in order to monitor the acquisition of specific SFT/SFP competencies.

Casework relating to this module should begin following the first 2 days of the specialist training

Trainees attend weekly supervision for the duration of the casework. Trainees complete a self-assessment following each systemic practice session and use this as a basis for clinical reflection and supervision. Trainees submit a minimum of three recorded systemic practice sessions to the supervisor for evaluation per case.

Prior to submitting filmed recordings of their clinical sessions (three per case), trainees complete a competency-based self-assessment.

The teaching will include didactic teaching, large and small group discussion, case discussion and role play, and DVD material for observation.

### ***Supervised clinical work***

A minimum of three cases, one seen to a planned ending, and a minimum of 24 hours of face-to-face practice will be completed under supervision (please see above for details of appropriate supervisors). Self-assessment measures and outcome will be regularly reviewed.

Clinical supervision will be conducted weekly for 2.5 hours in a group setting with a maximum of four trainees. Some of these supervision sessions will be held individually and some live supervision is recommended if feasible. At their group supervision trainees will present filmed extracts (DVD) of their clinical sessions.

After each session the trainee will complete a self-assessment form to be referred to in supervision. They will receive written feedback following supervision, which will be included in their portfolio together with a brief reflection on the comments.

Recorded material from at least three sessions per case should be included in the supervision sessions.

## ***Summary of the units***

The 6-day course is broken down into 12 units. Each unit is half a day.

- Unit 1: Introduction to aetiology, diagnostic categories and evidence self-harm and depression in children and young people. Consideration of overlap and distinctions. Review theoretical foundations and development of SFP in relation to self-harm and depression.
- Unit 2: Development of a systemic assessment for self-harm and depression. Treatment goals and planning endings. Relational risk assessment and systemic understanding of the professional safety and safeguarding system. Consideration of the importance of the way in which the meanings of the self-harm/depression, its assumed origin and the possible responses are explored, including different cultural meanings.
- Unit 3: Child developmental issues in relation to depression and self-harm. Working with cognitive and emotional differences between younger children, younger adolescents and older adolescents in relation to depression and self-harm. Systemic engagement and alliance-building techniques.
- Unit 4: Systemic engagement with parents in relation to depression and self-harm. Balancing individual and family sessions. Consideration of how self-harm can be experienced as a family crisis and also an individual coping mechanism.
- Unit 5: Systemic formulation. Contextualisation of the depression/self-harm to enable the family to view this in a broader context, including the use of social media. Comorbidity. Exploration of the mutual influence of depression/the self-harming response and patterns of interaction and how this gives new meanings. How self-harm has become a means of communicating and constrains alternative responses. Exploration of potential resources for change.
- Unit 6: Systemic attention to behaviour, pattern, beliefs and language. Techniques and strategies to help the adolescent reduce the frequency and severity of self-harm and attend to how a shared meaning of therapy process and goals emerges through discussion. Working from a stance of cautious optimism and curiosity and offering a non-blaming approach.
- Unit 7: Systemic skills – use of questions. Evoking non-blaming descriptions, inviting self-reflection by the family on their patterns, developing new accounts.
- Unit 8: Systemic work with difference. Attending to the real and constructed differences of culture, race, gender, sexuality, ability and class. Attending to differences between individuals.
- Unit 9: Systemic skills – use of action techniques. Intervening to directly change patterns or sequences of behaviours.
- Unit 10: Systemic skills in relation to emotions, expressed and unexpressed. Exploration of difficulty regulating emotions. Moving from a sense of anger and resentment to an appreciation of caring elements. Encouraging a greater awareness of emotions as well as understanding of what others may experience.

- Unit 11: Systemic use of self and supervision. Staying aware of one's own processes as self-harm and depression can raise strong emotions. Identifying own beliefs and assumptions about depression and self-harm and how these may influence interactions with the child and family. The use of sessional outcome as feedback for the clinical work and for supervision.
- Unit 12: Reflection of clinical work and competencies. Reflective overview of learning points. Reflections on the use of outcome measures.

### **Entry criteria**

Trainees will have to be undertaking the Core CYP IAPT module and have completed the Basic SFP module (see Basic SFP module for entry requirements) and be able to complete the required clinical work.

### **Summative assessment**

- Clinical hours: Completed
- Completed portfolio demonstrating reflective learning and ability to take charge of own learning. Trainees will be expected to complete a separate section of their learning portfolio logging their clinical hours and learning points for each session. In addition, they should complete a reflective learning diary weekly during the time of this module. It should include supervision feedback forms.
- At the end of the module they should complete a 5000-word case study of work they have done with a family containing a child or adolescent with depression or self-harm.
- Supervision report: The supervisor has confirmed that the trainee has reached the required level of clinical competence.

### **References for depression/self-harm module**

- Byng-Hall, J., Campbell, D., & Papadopoulos, R. (1996) *Systems Integrative Family Therapy (SIFT): Manual for The Cross National Outcome Study Comparing Individual Psychodynamic Psychotherapy and Family Therapy. Unpublished manual: Tavistock Clinic, London.*
- Diamond, G. S., Wintersteen, M. B., Brown, G. K., Diamond, G. M., Gallop, R., Shelef, K., & Levy, S. (2010). Attachment-based family therapy for adolescents with suicidal ideation: A randomized controlled trial. *Journal of the American Academy of Child and Adolescent Psychiatry, 49*, 122-131.
- Trowell, J., Joffe, I., Campbell, J., Clemente, C., Almqvist, F., Soininen, M., Koskenranta-Aalto, U., Weintraub, S., Kolaitis, G., Tomaras, V., Anastasopoulos, D., Grayson, K., Barnes, J., & Tsiantis, J. (2007). Childhood depression: A place for psychotherapy. An outcome study comparing individual psychodynamic psychotherapy and family therapy. *European Child & Adolescent Psychiatry, 16*, 157-167.



- National Institute for Health and Clinical Excellence (2005) *Depression in children and young people: identification and management in primary, community and secondary care*. GG28. London: National Institute for Health and Clinical Excellence. (<http://publications.nice.org.uk/depression-in-children-and-young-people-cg28>)
- National Institute for Health and Clinical Excellence (2011) *Self-harm: Longer-term management*. CG133. London: National Institute for Health and Clinical Excellence. (<http://publications.nice.org.uk/self-harm-longer-term-management-cg133/guidance>)

## 9. CYP IAPT Systemic Family Practice for Conduct Disorder

### ***Introduction***

This module constitutes a specialist module of 15 credits. It will sit alongside the other specialist systemic modules (Eating Disorders and Self-Harm/Depression). It can only be taken once the Core IAPT and Basic SFP modules have been completed. The module draws upon a number of relevant approaches including Functional Family Therapy (FFT) (Sexton, 2011; Sexton & Alexander, 2004). This will be a 6-day module.

### ***Aims***

- To develop a critical knowledge of the theoretical and research literature of the SFT approach to conduct disorders in children and adolescents.
- To develop practical competency in an evidence-based systemic approach for conduct disorders in children and adolescents.
- To develop the ability to use this approach alongside other approaches within CYP IAPT competencies and apply routine measures.
- To be able to apply this approach to diverse family forms.

### ***Trainers and supervisors***

Trainers delivering this module must be registered systemic family psychotherapists and have significant experience in both teaching and supervising clinical practice within the NHS. In addition, trainers must have a secure knowledge in the core approaches that make up this module (FFT).

The quality of supervision is a key factor in ensuring high-quality learning. Supervision of clinical work should, wherever possible, be carried out by AFT registered Systemic Supervisors or those who meet the competencies required for registration (eligible for registration). AFT will provide guidance on those competencies and the processes for achieving registration through an Apel route.

It is recognised that in some areas there may be a limited resource of specialist Systemic Supervisors and in this situation the best available Systemic Supervisors should be used. This should be considered a temporary measure for the first 2 years, with efforts made to increase the pool of fully qualified supervisors. At a minimum, any supervisor would need to have completed a qualifying training in SFT, have a minimum of 3 years' post-qualifying experience and have gained previous experience of supervising systemic practice within a CAMHS setting.

Practitioners coming on to this module must have completed the Basic SFP module satisfactorily.

This curriculum sits alongside other CYP IAPT curricula. It will consist of five units.

### **Key texts**

- Henggeler, S., Schoenwald, S., Borduin, C., Rowland, M., & Cunningham, P. (2009) *Multisystemic therapy for antisocial behaviour in children and adolescents*. New York: Guilford Press.
- Sexton, T. (2011) *Functional family therapy in clinical practice*. New York: Routledge.

### **SFT for conduct disorders**

Systemic Family Therapy (SFT) has been demonstrated to be an effective intervention for child and adolescent conduct disorders (Woolfenden et al., 2007; Sexton and Turner, 2010; Henggeler & Sheidow, 2012). Various SFT approaches are recommended by NICE (2013). These include FFT and MST, and a number of trials are currently being undertaken in the UK to determine the efficacy of these approaches in the UK. Traditionally these approaches are time-limited and intensive. This module draws from these approaches but does not seek to replicate the 'model specific' aspects of them. The focus of the module is to adapt the core approaches for an entry-level training that is specific to the CAMHS population of families and practitioners.

The emerging evidence for Parenting Training (see section 3) and Family Therapy suggest significant overlap between treatments to be recommended for both these groups (NICE, 2013; Fonagy, P. et al.). Group Parent Training is recommended as the first line intervention which is likely to be effective for most cases with children under 10 years of age. In some contexts, particularly in families facing multiple adversities and for children with severe conduct problems, individual behavioural management of children by parents under supervision of a clinician is recommended in NICE guidance (Eyberg, S. M., et al, (2001).

Children and young people aged 11 or older present with conduct problems that are harder to treat without also considering family issues that may have interfered with the appropriate management of the young person's behaviour (Alexander, J., et. al). NICE guidance supported by substantial clinical evidence still accumulating, identifies family based interventions, particularly functional family therapy, as an effective mode of therapy in many cases where conduct problems are relatively severe and well established. Evidence concerning young people who have already offended or had several warnings, have been excluded from school on a long term basis, meet full criteria for conduct disorder in addition to ADHD with long histories of conduct difficulties may be challenging to manage in the context of functional family therapy. In these cases multi systemic therapy (Henggeler, S., et.al, 2009) is probably the treatment of choice for families.

### **Aims of module**

To enable trainees to:

- Demonstrate an understanding of the theoretical principles of SFT as it is applied to conduct disorders.

- Demonstrate a critical understanding of the research and theoretical evidence for systemic family therapy for conduct disorders.
- Apply systemic practice through comprehensive and systematic treatment to young people with conduct disorders in a way that results in good clinical outcomes, including:
  - Engaging and motivating young people and families
  - Building pro-social, family-based behavioural skills that fit the family and alleviate the presenting problems
  - Generalise treatment and prevent subsequent relapse
  - Manage complex clinical situations whilst retaining a relational SFP focus
  - Identify the relational processes that maintain or precipitate conduct disorders
  - Demonstrate the ability to apply relational formulation in conduct disorders
  - Be able to create shared relational treatment goals with families
  - Monitor progress to agreed goals collaboratively
  - Demonstrate cultural competence in SFP for conduct disorders (including the use of interpreters)
  - Develop conflict resolution skills including de-escalation and recognising unhelpful interactional patterns
  - Maintain a strengths perspective rather than a pathologising one.

### ***Key learning outcomes***

- Demonstrate knowledge, understanding and critical awareness of the theoretical foundations of and research evidence for systemic family therapy approaches to conduct disorders.
- Develop the ability to practise systemically, moving from early to middle and final stages of treatment.
- Understand conduct disorder within a relational framework, including trans-generational influences.
- Formulate this understanding into a coherent description of the behaviour, including the importance of current living context, and make a coherent systemic assessment which is shared with the family.
- Understand how to engage and maintain a therapeutic alliance with young people with conduct disorder and their families.
- Understand how to reduce 'within family blame' and work collaboratively to create common treatment goals involving all family members.
- Understand how to increase motivation for engaging in systemic practice for conduct disorders.
- Understand the range of methods and techniques used in systemic practice for conduct disorders; adapt them to fit individual families, taking account of diversity.
- Understanding the role of behaviour change skills in the treatment of conduct disorder.

- Understand how to support change, maintain and generalise treatment gains so that families can manage future difficulties
- Know how to gather and monitor the process and progress with a range of SFT and CYP IAPT measures and gather client feedback, integrating it with the treatment.
- Be able to recognise the limits of personal competence and effectiveness of the model and seek advice on appropriate referral.

The competencies for SFP are based on the competencies for systemic family therapy but represent a less advanced level of practice. Below the competencies are mapped out in more detail.

- Knowledge of systemic family therapy in relation to conduct disorders.
- Knowledge of systemic principles of the systemic family therapy approach to conduct disorders.
- Ability to be critical and creative about practising systemically with conduct disorders.
- Knowledge of the core and common changes mechanisms of evidence-based family treatment.
- Ability to implement systemic practice in treatment of conduct disorders.
- Competence in systemic assessment of conduct disorders.
- Ability to construct a relational formulation of conduct disorder.
- Ability to develop a therapeutic alliance in systemic practice with conduct disorders.
- Ability to collaborate with the family on treatment goals arising from the formulation.
- Ability to work with families on specific behaviour changes, helping them generalise those changes and embedding these in family interactional patterns.
- Ability to identify large systems issues that may challenge families' ability to maintain change through relapse prevention.
- Ability to collaboratively construct relapse prevention strategies with the family.
- Ability to include all other relevant systems in the maintenance of symptom improvement.
- Ability to use family-focused motivational interventions in systemic practice with conduct disorders.
- Ability to reduce the blame and negativity within families.
- Competence in the use of various systemic family therapy techniques, interventions and treatment models in the treatment of conduct disorders.
- Capability to adapt the intervention flexibly to match to and individualise the treatment to the individual family.
- Ability to adapt common treatment interventions and techniques to fit with the cultural, contextual, individual family relational system using the cultural competency framework.

### **Summary of units (6 days in total)**

- Unit 1: SFT evidence-based approaches for child and adolescent conduct disorders (1 day).
- Unit 2: Founding principles of SFT: relationally focused, systemic assessment, attempted solutions, case formulation, trans-generational influences and importance of current context (1 day).
- Unit 3: Building alliance in conduct disorders: engagement and motivation, setting achievable goals (1 day).
- Unit 4: Skills in systemic practice for conduct disorders: reframing, intensification, unbalancing, mapping circular interactions, problem solving, enactment, encouraging empathy and strategies for creating a 'safe base' within the family (2 days)
- Unit 5: Measuring treatment progress, supporting behaviour change and preventing relapse, generalisation (1 day).

### **Unit 1: SFT evidence-based approaches for child and adolescent conduct disorders (1 day)**

This unit will place both the core systemic family therapy principles and specific treatment intervention approaches within the systemic ideas of family life cycle and family transitions, with reference to diversity and wider systemic influences. It will introduce the evidence base for the range of systemic family therapy approaches to conduct disorder. Finally, it will describe the various evidence-based approaches and seek to elicit commonalities between them. These will focus on the relational and systemic formulations, systemic treatment, and outcomes of conduct disorders.

#### **Learning outcomes**

- Demonstrate knowledge, understanding and critical awareness of the theoretical foundations of systemic family therapy approaches to conduct disorders.
- Demonstrate knowledge, understanding and critical awareness of the various different systemic family therapy approaches to conduct disorder.
- Demonstrate knowledge and critical awareness of the research evidence for the systemic family therapy approach to conduct disorders.
- Demonstrate how systemic theory and understanding of family processes relate to conduct disorder.
- Develop the ability to conduct systemic practice in a systemic manner, moving from early to middle and final stages of treatment

#### **Competencies**

- Knowledge of systemic family therapy in relation to conduct disorders

- Knowledge of systemic principles of the systemic family therapy approach to conduct disorders
- Ability to be critical and creative about applying systemic practice in conduct disorders
- Knowledge of the core and common changes mechanisms of evidence-based family treatment.
- Ability to implement systemic practice in treatment of conduct disorders.

### ***Learning and teaching strategy***

Teaching will be via lectures, discussions, guided reading, video observation, and case presentations. Reading will be specified in advance.

## **Unit 2: Founding principles: systemic assessment and relationally focused intervention (1 day)**

This unit will elaborate upon the commonalities of the SFP approaches to conduct disorder, including the therapeutic alliance (reference to split alliance research), undertaking a systemic assessment and constructing a collaborative formulation/hypothesis. Many approaches also focus on attempted relational solutions and seek to address these.

### ***Learning outcomes***

- Understand conduct disorder within a relational framework, including trans-generational influences.
- Formulate this understanding into a coherent description of the behaviour, including the importance of current living context.
- Understand the principles of systemic assessment.
- Be able to formulate and share this formulation/ hypothesis as a set of working goals with families.
- Understand the role of alliance in systemic practice.

### ***Competencies***

- Competence in systemic assessment of conduct disorders.
- Ability to construct a relational formulation of conduct disorder.
- Ability to develop a therapeutic systemically based alliance.
- Ability to collaborate on treatment goals arising from the formulation.

### ***Teaching and learning strategy***

Teaching will be via lectures, discussions and case presentations. Learning within clinical practice will be highlighted.

### **Unit 3: Engaging and motivating children, young people, their families, and other significant members of the professional or personal network of the youth (1 day)**

This unit will focus on the systemic family therapy approaches to developing engagement, motivation and therapeutic alliance when working with young people and families with conduct disorders. The emphasis is based on the role of respect and clarity of purpose in treatment. The therapeutic alliance with systemic family therapy conduct disorder treatment rests on reducing 'within family blame and negativity' to create family focused achievable goals. This will require understanding of systemic motivational skills:

- Engaging and motivating young people and families by building family-focused treatment goals.
- Engaging and motivating young people and families through reducing 'within family blame and negativity'.
- Building therapeutic alliance with families and children and young people with conduct disorders.
- Collaboratively building family-focused, common and shared obtainable and lasting treatment goals.

#### ***Learning outcomes***

- Understanding of how to engage young people and families.
- Understanding of how to reduce 'within family blame' to create common treatment goals.
- Demonstrate the ability to engage family members in family based treatment of conduct disorders.
- Understanding of how to increase motivation in systemic practice for conduct disorders.
- Demonstrate the ability to develop family-focused and meaningful treatment goals that involve all family members in systemic practice for conduct disorders.

#### ***Competencies***

- Be able to use systemic family therapy engagement strategies.
- Be able to engage all significant family members in systemic practice for conduct disorders.
- Be able to use family-focused motivational interventions in systemic practice.
- Be able to reduce the blame and negativity within families.
- Be able to create family focused treatment goals in collaboration with all family members.



### ***Teaching and learning strategy***

Although there will be some lectures and discussions, this unit marks the transition of the module into a more active role play and experiential process. Trainees will be expected to practise their skills and demonstrate their competency in the classroom.

### **Unit 4: Intervention strategies, skills and treatment protocols in systemic family therapy for conduct disorders (including reframing, intensification, unbalancing, mapping circular interactions, problem solving, communication improvement, conflict management and relapse prevention and enactment, etc.) (2 days)**

This unit will demonstrate the range of techniques and methods used by the systemic family therapy approaches to conduct disorder. It will enumerate the methods recommended in the approaches and trainees will practise these in live role plays in the classroom. Each technique will be described, its historical origins explained and then examples shown.

### ***Learning objectives***

- Understand the range of methods and techniques used in systemic practice for conduct disorders.
- Understand how to fit these methods/techniques to individual families.
- Demonstrate ability to integrate these skills into a systematic treatment of young people with conduct disorders.
- Demonstrate ability to use these skills flexibly and creatively with respect to specific families and taking diversity into account.

### ***Competencies***

- Competence in systemic assessment of conduct disorders.
- Ability to construct a relational formulation of conduct disorder.
- Ability to develop a therapeutic systemically based alliance.
- Ability to collaborate on treatment goals arising from the formulation.
- Competence in the use of various techniques, interventions and treatment models while intervening in the treatment of conduct disorders.
- Capability of adapting the intervention flexibly to match to and individualise the treatment to the individual family.
- Ability to adapt common treatment interventions and techniques to fit with the cultural, contextual, individual family relational system using the cultural competency framework

### ***Teaching and learning strategy***

Teaching will be via experiential role play with some exposition of the rationale for particular techniques in particular situations.

## **Unit 5: Supporting behaviour, generalising and maintaining change and monitoring outcome (1 day)**

All systemic practice interventions in this area are designed to lessen conduct disorder symptoms. The primary focus therefore is to generalise changes to other family problems, support those changes over time, and maintain changes in the future. All the techniques adopted in unit 4 are therefore also relevant to enabling the family to alter behaviour and consolidate change. This unit concentrates upon this phase of treatment.

### ***Learning outcomes***

- Understanding the role of behaviour change skills in the treatment of conduct disorder.
- Understanding how to support change, maintain and generalise treatment gains so that families can manage future difficulties.
- Know how to gather and monitor the process and progress with a range of systemic family therapy and relevant measures offered through CYP IAPT list of outcome measures
- Understand how to integrate aspects of different CYP IAPT approaches within the treatment of conduct disorders (especially in the case of trauma).
- Understand how to use client feedback from systematic measures in treatment of SFP conduct disorders.

### ***Competencies***

- Ability to work with families on specific behaviour changes, helping them generalise those changes and embedding these in family interactional patterns.
- Ability to identify large systems issues that may challenge families' ability to maintain change through relapse prevention.
- Ability to collaboratively construct relapse prevention strategies with the family.
- Ability to include all other relevant systems in the maintenance of symptom improvement.

### ***Teaching and learning strategy***

Teaching will be via presentations and discussions. Live supervision will determine learning.

### ***General teaching and learning strategy for the module***

This will utilise a range of methods with an emphasis on role play and application of learning to case material. Trainees will be encouraged to bring their own examples of practice. Reading will be provided before each unit.

### ***Supervised clinical practice***

This will be carried out concurrently.

Supervision will be carried out in small groups of four with one supervisor. There should be the opportunity for occasional individual meetings, which will replace the group meetings. The supervision should include therapist self-rating scales to be used within the supervision process.

Trainees are required to carry out work with a minimum of three cases which include a child or young person with conduct disorder and overall complete a minimum of 24 hours of clinical practice.

### ***Assessment***

- Trainees will be expected to complete a separate section of their learning portfolio logging their clinical hours and learning points for each session. In addition, they should complete a reflective learning diary weekly during the time of this module.
- At the end of the module they should complete a case study (5000-words) of work they have done with a family containing a child or young person with conduct disorder as a minimum.

This should demonstrate the learning outcomes for the module.

### ***Required clinical hours***

Minimum of 3 cases: One seen to a planned ending

Minimum of 24 sessions in total

### ***Clinical supervision***

Each trainee will have clinical supervision weekly in a group of no more than four with occasional individual sessions in place of the group sessions. Before each session the trainee will complete a self-assessment form to be referred to in supervision. They will receive written feedback following supervision, which will be included in the portfolio together with a brief reflection on the comments. Recorded (audio or video/DVD) material from at least three cases should be included at some point during the supervision sessions.

At the end of the course when clinical work has been completed the supervisor will be asked to complete a proforma assessment form and indicate the progress and status of the trainee.

### **Summary of summative assessment**

- Clinical hours: Completed.
- Learning portfolio: Completed and demonstrating reflective learning in a way that includes log of clinical hours and learning points, reflective diary and supervision feedback forms.
- Supervision report: meets clinical competency criteria (marked and graded).
- Case study of 5000 words (minimum).

### **References for conduct disorder module**

- Henggeler, S., & Sheidow, A. (2012). Empirically supported family-based treatments for conduct disorder and delinquency in adolescents. *Journal of Marital and Family Therapy*, 38, 30-58.
- Sexton, T., & Alexander, J. (2003). Functional family therapy: A mature clinical model for working with at-risk adolescents and their families. In T. L. Sexton, G. R. Weeks & M. S. Robbins (Eds.), *Handbook of Family Therapy* (pp. 371-400). New York, NY: Brunner-Routledge
- Sexton, T. & Turner, C. W. (2010). The effectiveness of Functional Family Therapy for youth with behavioral problems in a community practice setting. *Journal of Family Psychology*, 24, 339-348.
- Woolfenden, S., Williams, K. J., & Peat, J. (2001) Family and parenting interventions in children and adolescents with conduct disorder and delinquency aged 10-17. *Cochrane Database of Systematic Reviews* Art. No.: CD003015. doi: 003010.001002/14651858.CD14003015

## 10. CYP IAPT Systemic Family Practice for Eating Disorders

### ***Introduction***

This 12-day module constitutes a specialist module of 30 credits and will normally be taken once the Core CYP IAPT and Basic SFP module have been completed. The specific training in the systemic treatment for eating disorders will be provided as a specialist module for sites that are offering a specialist eating disorders service and will run in parallel with the other problem-specific systemic training modules (depression/self-harm and conduct disorder) offered to other CYP IAPT trainees. The systemic eating disorders curriculum aims to train individuals who will contribute to the development of specialist community-based multidisciplinary eating disorders teams that will be able to deliver the highly skilled expert interventions that are needed to achieve the desired outcomes. There are specific entry requirements for this module described later.

### ***Summary of aims***

- To develop critical knowledge of the theoretical and research literature of evidence-based treatments for eating disorders in children and adolescents.
- To develop an expert level of knowledge of eating disorders, including knowledge of epidemiology, physiological effects of malnutrition, the physical and medical risks of starvation, and knowledge of nutrition, to be able to manage severely malnourished individuals.
- To develop practical competencies to deliver effective family-based treatments for eating disorders in children and young people as part of an integrated specialist outpatient multidisciplinary eating disorders team.
- To ensure that clinical practice is in accordance with local and national CYP IAPT service policy, including the need to work appropriately with difference, apply the approach to diverse family forms and to routinely monitor clinical outcomes.

### ***Trainers and supervisors***

Trainers responsible for delivering this module should be registered or eligible for registration with UKCP as Systemic Family Therapists and have significant experience in both teaching and supervising clinical practice within the NHS. In addition, all trainers must have sound specialist knowledge of eating disorders and an understanding of the core approaches that make up this module. Some components of the teaching may be delivered by trainers who may not be systemic family therapists but have other relevant specialist expertise in treating child and adolescent eating disorders (e.g. medical or CBT for eating disorders).

The quality of supervision is a key factor in ensuring high-quality learning. Supervision of clinical work should, wherever possible, be carried out by AFT registered Systemic Supervisors or those who meet the competencies required for registration (eligible for registration.). AFT will provide

guidance on those competencies and the processes for achieving registration through an Apel route.

It is recognised that in some areas there may be a limited resource of specialist Systemic Supervisors and in this situation the best available Systemic Supervisors should be used. This should be considered a temporary measure for the first 2 years, with efforts made to increase the pool of fully qualified supervisors. At a minimum, any supervisor would need to have completed a qualifying training in SFT, have a minimum of 3 years' post-qualifying experience and have gained previous experience of supervising systemic practice within a CAMHS setting.

Practitioners coming on to this module must have completed the Basic SFP module satisfactorily.

### **Key texts**

- Eisler, I., Lock, J., & Le Grange, D. (2010). Family-based treatments for adolescent anorexia nervosa. In C. Grilo & J. Mitchell (Eds.), *The treatment of eating disorders*. New York: Guilford Press.
- Simic, M. & Eisler, I. (2012). Family and multifamily therapy. In J. Fox & K. Goss (Eds.), *Eating and its disorders*. Oxford, Willey-Blackwell
- Eisler, I., Simic, M., et al. (2012). Maudsley Child and Adolescents Eating Disorders Service model and treatment manual for single and multifamily therapy for adolescent anorexia nervosa. Unpublished treatment manual. South London and Maudsley NHS Foundation Trust

### **SFP and systemic practice for child and adolescent eating disorders**

The research literature concerning the treatment of child and adolescent eating disorders includes both evidence concerning the efficacy of SFP (e.g. NICE 2004 and more recent studies, e.g. Eisler et al., 2007; Schmidt et al., 2007; Le Grange et al., 2007; Lock et al., 2010) and recent evidence about the key role of service context (House et al., 2012) which shows that the most effective way of providing clinically effective and cost-effective treatment for young people with an eating disorder is through specialist, easily accessible services that are able to deliver highly skilled evidence-based outpatient treatment with minimal need for inpatient care. A key principle informing this specialist curriculum is that while individuals undertaking the training are expected to gain the required level of knowledge and skill (and will be assessed on that basis individually), the desired treatment and health economic outcomes will be best delivered in the context of an integrated specialist multidisciplinary team. The curriculum addresses this by including modules on multidisciplinary aspects of assessment and treatment and differentiating between levels of knowledge and skill required for each team member and levels of knowledge and skill required to be held within the team as a whole but not necessarily by each team member.

### ***CYP IAPT curriculum for systemic work with families for the treatment of eating disorders in young people***

The training described here is to be provided as part of the broader CYP IAPT training, which includes the Core CYP IAPT training modules and Basic SFP training. The specific training in SFP for eating disorders will be provided as a specialist module for sites that are offering a specialist eating disorders service. The training will be team based with trainees from up to five teams joining in a training group, requiring a minimum of three members of each of the eating disorders teams to attend the course. For the multi-family therapy component of the module, the remaining members of the participating teams will also be invited to take part, to enhance team building and enable teams as a whole to deliver multi-family therapy as part of their service specification.

While specific learning outcomes are defined for individual CYP IAPT trainees undertaking this module, there is an expectation that the delivery of the specific evidence-based treatments will be integral to a specialist service configuration. The multidisciplinary aspects of the teams are described in more detail in the specific entry requirements for this module. In general it is understood that for the effective functioning of the team as a whole, additional skills and expertise is required over and above those that are the subject of this training and will be held only by some members of the team (e.g. medical knowledge of eating disorders and the effects of malnutrition or highly specialist family therapy skills needed to provide within team supervision, consultation or co-working when needed).

The curriculum of this module does not aim to cover in detail the very specific highly specialist areas, such as medical management, but teams requiring additional input on e.g. medical aspects will be able to access additional teaching or consultation if they require this. It is also expected that services accessing this training will generally have or will be in the process of developing posts that will assume pre-existing levels of training, e.g. medical or family therapy training that will complement the skills and competencies that the CYP IAPT trainees will bring back to the teams from their training. As family-based therapies are the key evidence-based treatments for eating disorders, it is expected that teams will generally have one or more fully trained family therapists in post and it is expected that they will provide the ongoing supervision in the teams and should ideally take part in the CYP IAPT supervision training at the earliest possible time.

The training will combine general teaching about eating disorders, their assessment and management with clinical practice and skills-based workshops and multidisciplinary team development work. While the central part of the treatment approach is based on manualised SFT approaches, there is evidence that for some young people (e.g. those with bulimia nervosa or with comorbid anxiety or OCD), CBT interventions should also be included in the overall treatment, and the training programme will address this.

### ***Entry requirements specific to the eating disorders module***

In addition to the individual general entry requirements for CYP IAPT SFP training, there are service level entry requirements for those taking this module. These additional requirements are based on the evidence that the service context plays a key role in determining the best clinical and health economic outcomes for the widest range of young people suffering from an eating disorder. This includes findings that in areas where there is direct access to specialist outpatient services, identification of young people who require treatment was 2–3 times higher than in areas with no specialist provisions; that rates of admission to hospital are at least 2–3 times higher in non-specialist than specialist services; and that continuity of care in specialist outpatient services is high, whereas for those treated for an eating disorder in generic CAMHS as many as 80% are eventually referred for treatment elsewhere. This evidence indicates that the usual stepped care model, in which initial treatment is provided in generic CAMHS, is ineffective (due to low level of eating disorders expertise), costly (due to high rates of hospital admissions) and viewed negatively by families (due to poor continuity of care and limited expertise).

The additional requirements for this module are:

1. Trainees will be members of an existing or developing specialist outpatient Child and Adolescent Eating Disorders Service (CAEDS). Composition of individual CAEDS teams is likely to vary, but based on the Royal College of Psychiatry (2012) report on eating disorders services the expectation is that they will:
  - a) have a minimum of 50 new eating disorders referrals per year to allow a sufficient throughput to develop high levels of eating disorders expertise and justify staff levels to provide a stable multidisciplinary service
  - b) be multidisciplinary and include both medical and non-medical staff who have significant experience of treating eating disorders
  - c) be members of a team with the necessary expertise to deliver recommended treatments for adolescents – i.e. psychological therapy, assessment of physical risk and family interventions addressing the eating disorder (NICE, 2004)
  - d) have the resources required to offer routine outpatient treatment.
2. To meet the above requirement, normally services need to cover a wide geographical area, with a minimum population of 500,000. Individual CAEDS teams are often set up as discrete specialist teams or sometimes as virtual teams working across several boroughs or districts with a central base and a network connected with individual CAMHS teams. They should have a minimum of five staff with protected time to work with children and young people with eating disorders.

### ***Detailed description of aims***

- To develop critical knowledge of the theoretical and research literature of evidence-based treatments for eating disorders in children and adolescents in general and specifically eating disorders-focused family therapy for young people with anorexia



nervosa, multi-family therapy for anorexia nervosa, and systemic CBT and other family-based treatments for bulimia nervosa.

- To develop an expert level of knowledge of eating disorders, including knowledge of epidemiology, physiological effects of malnutrition, the physical and medical risks of starvation, and knowledge of nutrition, to be able to manage severely malnourished individuals. While it is expected that the level of knowledge of these areas will vary across the specialist multidisciplinary team, all members of the team will be expected to have sufficient knowledge of the above to incorporate them into their practice and know when they need to involve other members of the team to manage specific cases in a safe way.
- To develop practical competencies to deliver effective single-family and multi-family treatments for eating disorders in children and young people as part of an integrated specialist outpatient multidisciplinary eating disorders team and to develop an ability to use these alongside of other evidence-based treatments.
- To ensure that clinical practice is in accordance with local and national CYP IAPT service policy, including the need to work appropriately with difference, apply the approach to diverse family forms and to routinely monitor clinical outcomes and make use of these in clinical practice.

### **Scope**

Workshops will cover the evidence base of treatment outcome studies for eating disorders, multidisciplinary assessment and treatment strategies. They will cover different presentations, relevance of comorbid conditions such as depression, anxiety and OCD, the role of temperamental and personality factors that may act as risk or predisposing factors, and the social and cultural factors that shape the presentation of eating disorders.

### **Learning outcomes**

- Critical understanding of the phenomenology, diagnostic classification, epidemiology and research literature of eating disorders in young people including the relevance of comorbid conditions, personality, culture, physiology and management of malnutrition.
- Competency in assessing whether a young person and their family are suitable for single or multi-family therapy and knowledge of contraindications.
- Ability to explain the principles and process of family and multi-family therapy to young people and their carers.
- Demonstrate an understanding of the different points of view and experiences of children, young people and their families in relation to eating disorders and how it impacts them as individuals and as a family.
- Understand and recognise the different levels and different ways of expression of motivation to change by young people and their families.

- Understand and recognise different attachment patterns within the family (including attachment between children and parents and other parental figures as well as parents' own attachment patterns) and the impact this may have on the development of the therapeutic alliance.
- Engage all family members, including reluctant young people, in the treatment process.
- Conduct a systemic assessment in relation to the presentation of an eating disorder.
- Develop a working systemic hypothesis and formulation of the case, including a relational, interactional and contextual conceptualisation and identification of the restraints and resilience factors of all participants.
- Show an appreciation of factors which contribute to the consideration of who is included in the relevant 'system' to be worked with; including absent parent, siblings, extended family or other professionals.
- Collaboratively construct a treatment plan with the young person and their family while taking into consideration issues of risk and safety and different levels of (overt) motivation to change among different family members and in a way that is accessible and responsive to young people and families with different social identities, cultures, needs and abilities.
- Plan and manage the ending of the process of therapy.
- Capacity for self-direction in engaging with and creatively responding to basic therapeutic problems, capacity to effectively use supervision and know the limit of own capacity and when necessary consult with other team members or refer to other colleagues.
- Ability to be self-reflexive in relation to one's own personal and professional responses to the issues around eating disorders and related issues such as depression, self-harm, or violence.
- Begin practising as a 'scientist practitioner' and continue to advance both individual knowledge and contribute to the shared team knowledge and understanding of eating disorders and their treatment in children and young people.
- Demonstrate ability to use routine clinical measurement to monitor treatment progress.

The competencies for SPF are based on the competencies for SFT but represent a less advanced level of practice. Below the competencies are mapped out in more detail.

### ***Specific competencies in relation to single family therapy for anorexia nervosa***

Ability to:

- Assess together with medical members of the multidisciplinary team the suitability and safety of providing outpatient treatment.

- Use knowledge about eating disorders and the effects of starvation to externalise and reframe the young person's problem and to create a safe base for engaging the family in treatment.
- Engage the young person in treatment even though they may express reluctance to share the goal of gaining weight.
- Engage the family around the task of managing the young person's eating and other eating disorders symptoms.
- Convene and manage a therapeutic family meal.
- Monitor together with the family the process of weight gain and discuss relevant nutritional information.
- Adapt the focused eating disorder interventions in the treatment manual and flexibly match them to the specific needs of the individual family, taking in to account the nature of family relationships, the level of motivation of the young person and the level of physical risk and severity of malnutrition.
- Adapt the specific manualised interventions to fit the social and cultural context of individual families.
- Address areas of family functioning that may have become ineffective and potentially part of the maintenance of the eating disorder.
- Manage the transition between different phases of treatment, including handing back control over eating to the young person.
- Explore issues of independence, adolescent identity and self-esteem that have been affected by the eating disorder.
- Explore the needs of siblings, parents and the family as a whole that have been unmet while the eating disorder dominated family life.
- Discuss and manage the process of ending treatment in a timely manner and in a way that meets the needs of individual family members.

### ***Specific competencies in relation to multi-family therapy for anorexia nervosa***

Ability to:

- Convene a multi-family group drawing on the families' shared experiences of living with eating disorder problems that impact the whole family.
- Support and encourage families to share experiences in a way that fosters a sense of hope and maximises family strengths and resilience.
- Use expert knowledge about eating disorders in a way that promotes open and collaborative conversations with families.
- Convene and manage therapeutic multi-family meals and create opportunities to maximise learning from the meal situation, ensuring that both parents' and young peoples' voices are heard.

- Maintain a strong focus on parents managing their child's eating problem in the early stages of the multi-family group while encouraging the young people to have a strong and distinctive voice in how this affects them.
- Use action and creative techniques such as role plays, multi-family sculpts, drawing, collages, etc. with both young people and adults.
- Be playful and use humour appropriately to encourage open communication and self-reflection within the group.
- Use the group to generate new ideas and problem solve difficulties encountered by individual families.

### ***Specific competencies in relation to systemic CBT for bulimia nervosa***

Ability to:

- Explore motivation to change in the young person and negotiate safe ways of managing eating disorder behaviours.
- Explore and agree with the family ways in which the family can best provide support for the young person to change their eating behaviours.
- Ensure that early changes provide stepping stones for further change and re-evaluation of treatment targets.
- Explain the cognitive behavioural model of bulimia nervosa using family systems conceptualisations.
- Develop a shared formulation that draws both on the cognitive behavioural model of bulimia nervosa and on a systemic understanding of the family context.
- Explore both with the young person and with the family as a whole how emotions and feelings are expressed, what meanings are attached to them, and how they become interconnected with eating disorder behaviours.
- Facilitate the learning of distress tolerance and emotional regulation skills either individually by the young person or, where appropriate, in a family context.
- Manage and contain at times high levels of emotions and hostility that are frequently associated with bulimic behaviours.
- Assess and manage risk associated with weight loss and/or bulimic behaviours as well as risk of self-harm.
- Facilitate the capacity of the family to view the young person's problematic eating behaviours as attempted solutions to other problems they experience and the potential connections with the relational context in which this occurs.

## ***Structure of training***

The specialised team training for SFP for eating disorders is delivered over a total of 12 days:

- 1-day introductory block on general knowledge of eating disorders  
This will be largely didactic but will include work to map relevant individual skills and knowledge and initial team building exercises.
- 3-day block on single eating disorders focused family therapy  
This will be conducted through a mixture of didactic teaching, small group exercises and skills role plays. The block will include modules on engaging the whole family and developing a systemic formulation; the use of information giving as part of the process of engagement and the creation of a safe base for treatment and its role in externalising the problem; conducting of a therapeutic family meal; reframing the meaning of parental control of eating and exploring disabling beliefs about the impossibility of parental action; exploring issues of individual and family development, cultural, social and inter-generational contexts; handing back control to the young person and exploring the impact on relationships within the family and between family and therapist.
- 4 day block on multi-family therapy for anorexia nervosa (it is expected that in addition to the CYP IAPT trainees taking this module, other members of their team, including senior staff, will take part in this block)  
This will build on the general theoretical principles and skills developed in the previous block; there will be didactic teaching about the principles of multi-family work and there will be a strong experiential component to develop practical skills in working with multi-family-groups, including: convening multi-family groups; using the group to problem solve and enhance a sense of competence; exploration of motivation; multi-family meals; strengthening the voice of the young people. A key part of this phase of the training is also team building and multidisciplinary working.
- 2-day block on working with adolescent bulimia nervosa  
This will include didactic and experiential teaching on the specific differences commonly found in engaging and ongoing work with young people and their families around bulimia nervosa; developing alternative treatment plans that combine individual and family meetings; systemic CBT principles of working with adolescent bulimia nervosa; and principles of multi-family work with this group.
- 2-day follow-up (to include extended team members)  
This will include case consultation and problem-solving difficult cases; exploring endings and handing back to families in both single-family and multi-family settings; and small group discussions about future team developments and consultations around setting up and running multi-family groups.

## **Assessment**

- Completion of clinical hours
- Trainees will be expected to complete a separate section of their learning portfolio logging their clinical hours and learning points for each session. In addition, they should complete a reflective learning diary weekly during the time of this module.
- At the end of the module they should complete a 5000-word case study of work they have done with a family containing a child or young person with an eating disorder as a minimum.
- Supervision report: The supervisor has confirmed that the trainee has reached the required level of clinical competence.

This should demonstrate the following learning outcomes:

- Knowledge and critical awareness of the research evidence for the SFP approach to eating disorders.
- Understanding of the relationship between systemic theory family processes and eating disorders.
- Ability to conduct SFP in a systemic manner, moving from early to middle and final stages of treatment.
- Understanding of eating disorders within a relational framework including trans-generational influences.
- Ability to formulate this understanding into a coherent description of the behaviour including the importance of current living context.
- Understanding of the principles of systemic assessment.
- Ability to formulate and share this formulation/hypothesis as a set of working goals with families.
- Understanding of how to engage young people and other family members.
- Ability to demonstrate the skill to engage family members in family-based treatment of eating disorders, including young people with ambivalent motivation to change.
- Understanding of how to increase motivation in SFP for eating disorders.
- Ability to develop family-focused and meaningful treatment goals that involve all family members in SFP for eating disorders.
- Understanding of the range of methods and techniques used in SFP for eating disorders.
- Understanding how to fit these methods/techniques to specific families.
- Ability to use these skills flexibly and creatively with respect to specific families and taking diversity into account.
- Understanding the role of behaviour change in the treatment of eating disorders.
- Understanding how to support change, maintain and generalise treatment gains so that families can manage future difficulties that occur outside of intervention setting.

- Knowledge of how to gather and monitor the process and progress of a range of SFP and CYP IAPT measures.
- Understanding of how to integrate aspects of different CYP IAPT approaches within the treatment of eating disorders.
- Understanding of how to use feedback from measures in treatment of SFP conduct disorders.

### ***Required clinical hours***

Minimum of three cases: one seen to a planned ending

Minimum of 48 sessions in total

### ***Clinical supervision***

Each trainee will have clinical supervision weekly in a group of no more than four with occasional individual sessions in place of the group sessions.

Before each session the trainee will complete a self-assessment form to be referred to in supervision. They will receive written feedback following supervision, which will be included in the portfolio together with a brief reflection on the comments.

Recorded material from at least three cases should be included at some point during the supervision sessions

### ***Summary of summative assessment***

- Clinical hours: Completed.
- Learning portfolio: Completed and demonstrating reflective learning and ability to take charge of own learning. Must include a log of clinical hours and learning points, reflective diary, supervision feedback forms.
- Supervision report.
- Case study of 5000 words (minimum).

### ***References for eating disorders module***

- Eisler, I., Simic, M., Russell, G. F. M., & Dare, C. (2007). Family therapy for adolescent anorexia nervosa: A five year follow-up study of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry*, 48, 552-560.
- Le Grange, D., Crosby, R. D., Rathouz, P. J., & Leventhal, B. L. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. *Archives of General Psychiatry*, 64, 1049-1056.

- House, J., Schmidt, U., Craig, M., Landau, S., Simic, M., Nicholls, D., Hugo, P., Berelowitz, M., & Eisler, I. (2012). Comparison of specialist and non-specialist care pathways for adolescents with anorexia nervosa and related eating disorders. *International Journal of Eating Disorders*, 45, 949-956.
- Lock, J., Le Grange, D., Agras, W. S., Moye, A., Bryson, S. W., & Boil, J. (2010). Randomized clinical trial comparing family-based treatment with adolescent-focused individual therapy for adolescents with anorexia nervosa. *Archives of General Psychiatry*, 67, 1025-1032.
- National Institute for Health and Clinical Excellence. (2004). *Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders*. (CG9). London: National Institute for Health and Clinical Excellence. <http://publications.nice.org.uk/eating-disorders-cg9>
- Royal College of Psychiatry. (2012). Eating disorders in the UK: Service distribution, service development and training. <http://www.rcpsych.ac.uk/files/pdfversion/CR170.pdf>
- Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., Winn, S., Robinson, P., Murphy, R., Keville, S., Johnson-Sabine, E., Jenkins, M., Frost, S., Dodge, L., Berelowitz, M., & Eisler, I. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry*, 164, 591-598.



## **11. CYP IAPT Enhanced Evidence Based Practice (EEBP) Curriculum for Child and Adolescent Mental Health Practitioners**

### ***Introduction***

This curriculum has been developed as part of the Child and Young People Improving Access to Psychological Therapies programme (CYP IAPT). The EEIP curriculum complements existing CYP IAPT curricula in specialist psychological therapies (CBT, Systemic Family Practice, Interpersonal Therapy for Adolescents, and Parent Training for Conduct Problems.) It focuses on enhancing skills in assessment; delivering brief, low intensity, evidence based interventions and in the core competencies required to work with children and young people.

### ***Rationale for the EEIP curriculum***

Children and young people can access Child and Adolescent Mental Health services in a variety of settings. The arrangement of CAMHs in England and Wales varies greatly but typically children and young people can be seen in a range of community settings as well as in the specialist NHS services. The aim of CYP IAPT is to ensure that CAMHs, wherever delivered, offer safe and effective treatment that is designed around the wishes and needs of children and their families. CAMHs must meet the needs of a diverse population. Not all young people, children or their families want, or need, formal psychological therapies. Brief evidence-based interventions can provide short-term focused support for common difficulties such anxiety and depression. If these are delivered promptly and skilfully, they can prevent the development of long-term difficulties, disability and distress.

In addition to intervention skills in specific, brief, evidence-based interventions the curriculum will highlight core skills required for working with children, young people and families. These include working across agencies, developing a shared understanding with the family, using supervision and consultation, engaging different family members and working through parents. These skills enhance the capacity of health care professionals working with children and ensure that their competencies are put to the most efficacious use possible.

The EEIP curriculum is designed to be suitable for staff working across different organisations that offer child and adolescent mental health services. It is suitable for staff whose role includes brief interventions for children, adolescents and families and who already have basic clinical competencies.

During the period of training students will be required to hold a caseload, to be receiving regular clinical supervision, to be able to video record their sessions with children and families, and to use the battery of CYP IAPT routine outcome measures. Students should be working in services that have access to colleagues in specialist CAMHs for consultation and where they can refer children and young people for specialist multidisciplinary care as necessary.

### ***Learning outcomes***

At the end of the EEIP programme, successful students will:

- Understand the core components of a successful CYP IAPT programme
- Demonstrate how these core components are incorporated into their work with children, young people and families
- Conduct a comprehensive assessment of a child/young person/family considering elements of risk, development and mental health diagnosis
- Carry out brief evidence based interventions for anxiety disorders and depression in children and young people
- Use clinical supervision and demonstrate evidence of self-reflection in relation to their clinical work

### ***Learning methods***

The EEIP curriculum uses a range of teaching methods including e-learning, problem sets and supervised clinical practice in the workplace and workshops, skills practice and classroom learning at university. It focuses on the development of core skills and is assessed largely through the assessment of direct clinical work. The clinical skills taught are suitable for delivery in a range of settings including the voluntary sector, social and educational settings and the NHS.

Over the course of the programme students will spend 15 days attending workshops, skills classes and other activities at a university base. They will spend an additional 10 days in workplace based learning. This will consist of group work with other students employed in the same or a neighbouring organization and work place supervision. Students will also be expected to study in their own time in order to complete assignments, prepare for clinical sessions and supervision and read relevant background material.

The period of study will be equivalent to an academic year.

### ***Qualifications and entry level***

The Enhanced Evidence Informed Practice curriculum is equivalent to 60 credits and will be delivered across an academic year. It is open to staff with graduate level qualification and staff who do not have graduate qualifications. Staff may be awarded with a post graduate certificate in Enhanced Evidence Informed Practice or a graduate certificate in Enhanced Evidence Informed Practice depending on their qualifications at entry.

### ***Purpose***

The purpose of the Enhanced Evidence Informed Practice Curriculum is to support existing CAMHs, whether in the statutory or voluntary sector, to provide care and treatment to children, young people and families that is:

- Based on a collaborative, comprehensive assessment
- Evidence based
- Guided by the feedback from monitoring outcomes and goals as a matter of routine in sessions and in supervision
- Delivered in partnership with young clients and their families
- Supported through a facilitative supervisory system
- Facilitate working across agencies

The course is aimed at staff with existing core competencies in working with children, young people and families where the child or young person has emotional or psychological problems. For services operating Agenda for Change banding, the staff grade would be Band 5 or 6. For services not operating agenda for change, staff need to have core competencies and experience of working with children young people and families – this is not a training course for staff starting from scratch who wish to become mental health practitioners. This would suit counsellors, social workers, school nurses where there is significant time spent on mental health direct work, parenting workers or family support workers. Throughout this document we refer to trainees on the EEIP programme as CAMHs practitioners, but this refers to individuals engaged in part or whole of their time in dealing with issues of mental health in children and young people and is not considered to imply either professional or organisational affiliation.

The academic level set is graduate or post graduate certificate level, so staff must be able to undertake formal learning and have their practice scrutinised and assessed. The training providers delivering this course may wish to interview candidates in collaboration with provider organisations to establish their suitability both academically and to demonstrate competencies are present.

Staff embarking on the course must be:

- Working directly with children, young people or families delivering interventions for their emotional or psychological difficulties as their main job
- In a position to use the newly acquired skills in their day to day routine work with children and young people
- Committed to continuing their personal professional development and to using the skills and outcome framework during and after the course is finished
- Prepared to invest time in study and reflection
- Are able and willing to access regular supervision
- Are happy to join partnership learning sets for service based learning activities

Services wishing to send staff on the course must:

- Ensure that appropriate supervision, leadership and resources are in place for the local learning sets that support two fifths of the training
- Ensure that supervision throughout the course is provided by appropriately qualified staff, and that supervision continues after the course is over to help practitioners embed their new skills (the expected qualifications of the supervisor are outlined in module one)

- Ensure that staff can video record their sessions and review videos with supervisors and university staff
- Ensure that the staff embarking on the course are given protected time for study and skills development

The delivery of this curriculum must be:

- Within the overall delivery of the full CYP IAPT curriculum - providers must also provide the post graduate diplomas, certificate level supervision and transformational leadership to support CAMHs partnerships to develop the appropriate environment for staff undergoing this course
- Facilitated fully by the HEI. The HEI must work closely with partnerships in selection of candidates and designing and setting up the guided learning sets, including being available on the day remotely to assist with queries regarding course content

## **Course Content**

**Induction Day:** Course overview including introduction to core values, registration, library, allocation of study advisor, use of equipment.

## **Module 1: Core Skills Module**

### ***Scope***

This module includes the fundamental elements of safe and effective working with children, young people and families. It provides an introduction to the CYP IAPT programme and shows how the EEIP training course links with other elements of the CYP IAPT programme. The curriculum builds on trainees' existing clinical skills and knowledge of working within CAMHs.

A notional structure for the 5 days of teaching is shown below with possible MindEd e-learning sessions to support learning. NB: there is discretion here for HEIs to select sessions that are most appropriate for their students and discretion over how the days are allocated to workplace learning and HEI based learning.

### ***Aims***

The aims of the module are to engage clinicians with the core principles of CYP IAPT and to equip them with essential skills necessary to enhance their clinical work with children, young people and parents. This module will underpin modules 2 (assessment) and 3 (interventions).

## ***Learning outcomes***

At the end of module 1 trainees will:

- Engage and involve children, young people and parents in a way that maximises their collaboration and engagement in mental health services
- Understand and convey the core principles of CYP IAPT and the active outcomes frames and use of routine outcome measures
- Support access to child and adolescent mental health services to the whole population and minimise disadvantage and discrimination
- Be able to explain the key principles of core, evidence-based therapies
- Use self reflection and supervision to enhance their clinical work
- Knowledge of commonly used medication their effects and possible complications

## ***Core competencies***

These pre-existing knowledge based competencies will be assessed at the start of the programme.

At the end of the module trainees will demonstrate a number of core competencies:

- Understand how evidence informs clinical practice in Child and Adolescent Mental Health services
- Ability to use and explain the use of a range of routine outcome measures with children, young people and parents
- Effective use of video recording to reflect on own clinical practice, bring to supervision, and enhance safe and effective work
- Effective communication with children, young people and parents
- Understand the perspective of the child, young person and their parents and develop a shared understanding of any difficulties
- Collaboratively develop a course of action with which the child, young person and family are fully engaged
- Reflect on own learning and clinical skills, prepare for and use supervision to enhance own learning and clinical outcomes for the child, young person and family
- Understanding the procedures required to obtain appropriate consent
- Skills required for shared decision making that ensures clinicians work with parents/carers and young people in a fully collaborative manner

## ***Learning and teaching strategy***

The module uses a combination of e-learning, group work around problem sets, supervised clinical practice and classroom based learning at the HEI. Following an induction day at the beginning of the programme (not a formal teaching day) the module will be delivered over five days. 4 days will be delivered in the workplace and 1 day will be delivered at the HEI.

E-learning from the MindEd e-portal will be used to deliver key elements of the core curriculum. This has been developed specifically to support the CYP IAPT curriculum and can be accessed

freely anywhere (including internationally). E-learning content will be supported by learning sets provided by the HEI and completed with other trainees, at the workplace. The learning sets will be based on clinical material. They will use the principles of problem based learning to engage trainees and to facilitate and promote theory practice links.

Each workplace organisation will identify a co-ordinator for a group of trainees. The co-ordinator will have completed a CYP IAPT postgraduate diploma or certificate if it is a supervisor, be using the core skills of CYP IAPT in their work, and be able to support trainees in developing the core skills. Workplace co-ordinators will organise and facilitate group work and problem based learning, including the necessary resources (e.g. study space, access to e-learning) and support trainees' use of the e-learning materials. Workplace co-ordinators will liaise with academic staff at the HEI and monitor progress of trainees in their workplace learning.

### ***Assessment strategy***

Assessment will be through a combination of:

- Supervisor assessment of clinical competences
- Clinical portfolio
- Short answer or multiple choice questions completed under examination conditions

### ***Duration***

The Core Skills module normally involves at least 5 days of teaching, 1 at the HEI site and 4 in the workplace. Students will also be expected to dedicate considerable private study time (about 5 days) to complete the portfolio and prepare for and reflect on supervision.

### ***Course Outline***

Day 1: Core values of CYP IAPT, introduction to the Collaborative Care model, ensuring equality of access to CAMHS

MindEd sessions:

- Introduction to CYP IAPT
- Collaborative Care
- Equality of Access

Day 2: CYP IAPT routine outcome monitoring, legal frameworks, consent, confidentiality and ethical practice

MindEd sessions:

- Confidentiality, consent & ethics
- Assessing and managing risk

- The active outcomes framework
- The Children Act (MindEd core, 410-055)
- The Mental Health Act (MindEd core, 410-056)

Day 3: Young people's and parents' participation, stigma, working with diversity

MindEd sessions:

- Making participation meaningful
- Stigma and mental health provision
- Culture, beliefs and mental health (MindEd core – 410-051)

Day 4: Introduction to CYP IAPT modalities of therapy (1/4 day on each)

MindEd sessions:

- Introductory sessions to each of the modalities (Systemic Family Practice, Interpersonal Psychotherapy for Adolescents, Cognitive Behaviour Therapy, Parent Training for behaviour problems)

Day 5: Introduction to Evidence-Based Practice, how to get the best out of supervision

MindEd sessions

- Introduction to Evidence Based Practice
- Supervising practice (MindEd core curriculum 410-069)

## **Module 2 – Engagement and Assessment**

### ***Aims***

Child and adolescent mental health practitioners assess children, young people and families with a range of mental health problems. This assessment must reflect the child and their family's perspective and must be conducted with the child and family's needs paramount. The assessment should reflect a shared understanding of the child or young person's current difficulties and inform how decisions are made with the family about the best next steps for the child and the family. Possible next steps include giving advice and psycho-education, referral to another agency, care within the multidisciplinary CAMHS team (e.g. for medication or formal psychological therapy) or a low intensity intervention (e.g. guided self-help, brief behavioural activation) delivered by the practitioner themselves.

The CAMHS practitioner must be able to undertake a child-centred interview which identifies the child's current difficulties, their goals and those of their family/parents, their strengths and resources and any risk to self or others. They need to understand the child in the context of their family, culture, wider social environment, developmental stage and temperament. They need to engage the child or young person and their carer(s) and other family members and to establish therapeutic alliances. They need to gather appropriate information from different sources, be able

to make sense of this and with the family develop a shared understanding. They also need to understand how the child's difficulties fit within a diagnostic framework, identify other physical, developmental or psychological difficulties (e.g. epilepsy, autistic spectrum disorders, attachment history) and know what evidence-based interventions are likely to be appropriate.

This module will equip CAMHs practitioners with a good understanding of the incidence, prevalence and presentation of common mental health problems and evidenced-based treatment choices. Skills teaching will develop core competencies in active listening, engagement, alliance building, patient-centred information gathering, information giving and shared decision-making.

### ***Learning outcomes***

At the end of the module trainees will;

- Demonstrate core engagement skills (i.e. listening, reflection, alliance building, active questioning, sense checking, and empathy)
- Using a range of methods (e.g. interview, questionnaire, observation) to conduct comprehensive, structured assessments with children, adolescents and parents which consider multiple historical, family and contextual factors
- Develop a shared understanding with the child/young person and their family which highlights key factors, identifies goals and outlines the next steps
- Draw on knowledge of diagnoses and evidence-based practice to help the family make a decision about appropriate interventions
- Make informed assessments concerning risk in relation to children and young people

### ***Core competencies***

At the end of the module trainees will be able to:

- Assess any current risk to the child or young person, or of the child or young person to others and take appropriate actions
- Understand and use current diagnostic frameworks relevant to child and adolescent mental health problems
- Use routine outcome measures (in conjunction with other information gathered) to assess the child's current difficulties and subsequently track change over time
- Use observational methods, questionnaires, and interviews with the family to develop a shared understanding of their current difficulties
- Carry out a basic functional analysis of a child's presenting difficulties
- With the family, develop a treatment plan based on the assessment

### ***Learning and teaching strategy***

Skills-based competencies will be learned through a combination of clinical simulation in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be



learned through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Knowledge will also be supplemented through e-learning sessions available on the MindEd e-portal. There are 6 timetabled teaching days. It is anticipated that 5 days will be delivered at the HEI in a combination of workshops, skills classes, and lectures and that 1 day will be delivered at the workplace using learning sets in groups. Students will also be expected to work independently between formal teaching sessions.

E-learning sessions to support classroom or workplace learning, or for use in private study could include:

- The therapeutic alliance
- Conducting a developmental assessment
- Overview of diagnostic assessment
- Assessing and managing risk

### ***Assessment strategy***

This module will be assessed by:

- 1 x video recording of an assessment session accompanied by a 1k reflective analysis
- A Clinical Outcomes Portfolio with competences signed off by the service supervisor and submitted by the student to the university to include direct observation of each of the treatment strategies taught, whether through video recording or live supervision - all must reach 50% minimum to be deemed competent.

### ***Duration***

5 days classroom based (at the HEI) learning, 1 day workplace learning plus private study. The training days at the HEI may follow the proposed structure below:

Day 1: Core assessment skills, engagement of children, adolescents and families

Day 2: Risk assessment \*, using supervision

Day 3: Basic diagnostic framework for children and adolescents\*, eliciting the child's perspective

Day 4: Functional analysis; using ROMs in assessment; goal setting; shared understanding

Day 5: Treatment planning, signposting and shared decision making

## **Module 3 – Evidence informed interventions**

### ***Aims***

The aims of the module are to equip students with essential skills necessary to provide an evidenced informed intervention based on the young person's presentation.

This module includes the fundamental elements of providing evidence informed interventions for mild presentations of anxiety and depression, when working with children, young people and their families. The curriculum builds on students' existing clinical skills and knowledge of working within comprehensive CAMHs and the successful completion of the core and engagement and assessment modules 1 and 2 of the EEIP course.

This module will be delivered over 14 days: 9 days of classroom based teaching at the HEI and 5 days in learning sets in the student's service. A notional structure and order for the HEI based days of teaching is shown below with (MindEd e-learning sessions may also be used to support learning). Appropriate e-learning sessions will be selected as an adjunct to learning.

### ***Learning outcomes***

**At the end of the module trainees will demonstrate knowledge and skills in:**

- **Working with parents:** Understand how to successfully engage parents in developing shared understandings of difficulties. To enable parents to support interventions with young people that are informed by social learning perspectives.
- **Working with Anxiety:** demonstrate a critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of anxiety disorders in children and young people; a critical understanding of clinical research literature on exposure for anxiety disorders in children and young people (clinical trials and outcome studies); understand how to sensitively adapt Behaviour Therapy for anxiety disorders to ensure equitable access, taking into account the age of the child or young person, and cultural and social differences and values among the children, young people and their parents/guardians
- **Behavioural Activation:** A critical understanding of the phenomenology, diagnostic classifications and epidemiological characteristics of depression. Demonstrate a working knowledge of the behavioural activation model, behavioural theory and the role of behaviour in the development and maintenance of depression.
- **Managing Worry:** An ability to draw on knowledge of the main components of an evidence based intervention for working with worry which may include: progressive muscle relaxation; cognitive restructuring, imagery exposure and in-vivo exposure
- **Lifestyle Management:** demonstrate understanding and delivery of healthy lifestyle packages and interventions (e.g., sleep hygiene)
- **Guided Self Help:** To understand the rationale and process of delivery of guided self-help. To understand the use of appropriate self-help materials and support the client in the use of relevant and effective materials.

- **Supervision:** Understand how to best use supervision and outcome measurement and feedback to support the implementation of collaborative, evidence based interventions with young people and their families.
- **Relapse Prevention:** Demonstrate knowledge and understanding of the importance of adequate preparation for ending therapy, to allow accurate evaluation and consolidation of gains, and preparation for independent practice. Demonstrate knowledge and understanding of the potential for recurrence of depression and anxiety symptoms after ending and competence in collaborating to produce a relapse prevention plan, including medication where necessary, that actively involves the available interpersonal and professional networks.

### ***Core competencies***

At the end of the module trainees will be able to:

- Demonstrate the ability to develop a shared understanding of the presenting issues with the child, young person or family they are working with within a systemic context
- Support parents/carers, where appropriate, to engage with the intervention and to use strategies (e.g., positive reinforcement) to support the child/young person
- Understand which treatment approach to use with each presentation or to be able to signpost to an appropriate treatment modality
- Demonstrate the ability to use guided self-help with fidelity
- Use supervision effectively, including the use of routine outcome measures to guide intervention.
- Understand and effectively use evidence based interventions for mild anxiety and depression
- Demonstrate the ability to plan for the ending of therapy and to collaboratively construct relapse prevention strategies

### ***Teaching and Learning strategy***

Competencies will be predominantly acquired through skills based learning. The module therefore uses a combination of classroom based learning at the HEI, incorporating video and role play, group work with problem based learning sets, supervised clinical practice and e-learning from the MindEd portal to augment learning.

E-learning from the MindEd e-portal will be used to deliver key elements of the core curriculum. This has been developed specifically to support the CYP IAPT curriculum and can be accessed freely anywhere (including internationally).

E-learning content will be supported by learning sets provided by the HEI and completed with other trainees, at the workplace. The learning sets will be based on clinical material. They will use the principles of problem based learning to engage trainees and to facilitate and promote theory practice links.

Each workplace organisation, in collaboration with the HEI, will identify a co-ordinator for a group of trainees. Ideally, the co-ordinator will have completed a CYP IAPT postgraduate diploma or certificate

and be using the core skills of CYP IAPT in their work and be able to support trainees in developing the core skills and competencies. Workplace co-ordinators will organise and facilitate group work and problem based learning, including the necessary resources (e.g. study space, access to e-learning) and support trainees' use of the e-learning materials. Workplace co-ordinators will liaise with academic staff at the HEI and monitor progress of trainees in their workplace learning.

Students will be required to provide therapeutic interventions to children and young people with mild presentations of anxiety and depression. This work will be video recorded and supervised by a service supervisor who has completed the Postgraduate Certificate in Supervisory Skills or the 5 day outreach CYP IAPT supervision course. Students will keep a professional and reflective portfolio demonstrating assessments, interventions, supervision and reflective practice. Clinical work will be verified by supervisor sign off in the professional portfolio and clinical competence will be assessed by the service supervisor and a video recording of an intervention session submitted to the HEI. Service supervisors will also be required to write a supervisor report for the portfolio.

### ***Assessment strategy***

Assessment will be assessed by:

- 1 x video recording of an intervention session demonstrating clinical competence.
- Supervisor assessment of clinical competences
- Professional and reflective treatment portfolio
- Short answer questions completed under examination conditions

### ***Duration***

This module involves 14 days of teaching, 9 which are classroom based (at the HEI), 9 in the workplace and private study. A proposed structure of the 9 days at the HEI is below:

- Day 1: Working with parents, using positive reinforcement / social learning theory (child in context)
- Day 2: Promoting healthy lifestyles
- Day 3: Working with young people with anxiety, working with avoidance using exposure
- Day 4: Behavioural Activation for mild depression
- Day 5: Managing worry
- Day 6: Supporting guided self-help. Using supervision to aid interventions.
- Day 7: Relapse prevention, endings and therapeutic process. Clinical Skills supervision
- Day 8: Clinical skills supervision

- Day 9: Clinical Skills supervision. Competency Assessment

### ***Supervision and Supervisor Training***

The clinical work of the practitioners will be supervised by staff that have either completed the PG Certificate in Supervising Evidenced Based Psychological Therapies course or the five day outreach generic supervisor training course at one of the CYP IAPT training providers. This will ensure that they have developed knowledge of and competency in the Roth and Pilling generic supervision competencies

(<http://www.ucl.ac.uk/clinicalpsychology/CORE/supervisionframework.htm>) and how to embed the core CYP IAPT principles into their supervision practice. They should also have working knowledge of the interventions the practitioners will be implementing (or evidence how they will gain this knowledge).

In addition, supervisors will be required to attend two further days of supervisor training at the beginning of the practitioner's course. These training days will develop their skills in providing case management and clinical skills supervision to support the practitioners' delivery of the evidenced based interventions within the EEIP curriculum.

More specifically, Supervisors will be trained in providing two main forms of supervision; Clinical Case Management Supervision and Clinical Supervision. Clinical Case Management Supervision will be the principal means of ensuring treatment fidelity, good case management and clinical governance. Clinical Supervision will be the method by which skills development and support is ensured. During the EEIP training, supervisors will also have to support practitioners in developing and demonstrating competencies in core CYP IAPT principles, assessment and delivering interventions. It will be the supervisors' responsibility to assess trainees' achievement of these competencies.

Some supervision may also be provided to the practitioners by the HEI to support the development of skills within the training programme and to familiarise the practitioners with the process and content of supervision to support their work in services. This, in conjunction with the supervisor training, will allow for sustainable practices in relation to supervision being developed and embedded into services.

## 12. Curriculum for Supervisor Training

60 Credits

### **Aims**

- To incorporate CYP IAPT principles into supervisory practice, developing supervisors who can assist in the overall service transformation of services participating in the programme.
- To develop competency in supervising IAPT in the evidence-based interventions set out in the CYP IAPT treatment curriculum.
- To enable supervisors to have critical knowledge of the theoretical, research and implementation literature that underpins the supervision of trainees on the CYP IAPT programme.
- To enable supervisors to develop sustainable skills in supervising CYP IAPT in order to drive ongoing development of quality-driven, outcomes-informed services.

### **Scope**

The role of the supervisor within CYP IAPT is pivotal. Supervisors form part of the team of change agents alongside their service management and therapy trainee colleagues.

High-quality supervision of trainee therapists is key to ensuring the successful delivery and sustainability of the CYP IAPT programme. The following curriculum for CYP IAPT supervisors is intended to be read alongside the revised IAPT Supervision Guidance developed for the Adult IAPT programme (Turpin & Wheeler, 2011; <http://www.iapt.nhs.uk/silo/files/iapt-supervision-guidance-revised-march-2011.pdf>)

This guidance outlines clear expectations and requirements for supervisors. These will also be adopted by the CYP IAPT programme, along with clear information and guidance to assist in recruiting appropriate supervisors. Many of its themes are expanded upon in the following curriculum, with a particular focus on meeting the objectives of the CYP IAPT programme.

In the first three years of operation (2011–12 to 2013–14), the CYP IAPT programme is focused on training high-intensity therapists, and therefore the current curriculum focuses on developing supervisor graduate skills to meet the standards required at this level.

### **Positioning of this course within the overall Children and Young People's IAPT Curriculum**

The training of supervisors complements and overlaps with that of trainees and service leads. In some aspects of the curriculum, HEIs may wish to train supervisors alongside service leads and/or

therapists, both because the training can be appropriately shared and to support the team of service lead, supervisor and therapists working together as change agents. There will be parts of the course that are relevant to supervisors alone and these should be delivered accordingly.

### ***Experience/competencies***

The CYP IAPT programme regards the provision of excellent supervision as key to the long-term sustainability of a reflective and learning culture within CAMHS. The addition of further modalities and drive to improve access to training amongst supervisors in the statutory and voluntary sector has led in 2012–13 to the identification of elements within the supervisors' curriculum which are core to all supervisors, whatever modality they are trained in, and modality-specific supervisory skills to equip supervisors to supervise in CBT, Parenting Training (PT), IPT-A or SFP.

It is the experience of existing collaboratives that not all those who wish to come on the supervisors' course can also deliver modality-specific training because supervisors may not have the modality-specific skills. For this reason, the supervisors' curriculum specifies different areas to be covered depending on whether or not the supervisors have the existing competency to supervise for specific modalities. If supervisors do not have modality-specific skills, they can supervise to general IAPT principles but modality-specific supervision of trainees will need to be provided by an appropriate modality-trained supervisor.

### ***For modality-specific CBT or PT***

In line with recommendations outlined by Turpin and Wheeler (2011), supervisor trainees will have the following level of experience:

- A recognised postgraduate professional training or equivalent professional experience at senior level.
- A recognised postgraduate qualification in CBT, Behaviour Therapy, Social Learning, or Parenting – with eligibility for/actual accreditation.
- A minimum of 2 years' post-qualification supervisory experience in the area undertaken in the relevant modality.
- A minimum of 4 years' experience in CAMHS.
- Supervisors are required to adhere to the BABCP Standards of Conduct, Performance and Ethics in the Practice of Behavioural and Cognitive Psychotherapies.

### ***For modality-specific IPT-A***

- IPTUK or equivalent practitioner accreditation in IPT or IPT-A.
- A minimum of 2 years' post-qualification supervisory experience in either CAMHS or IPT.
- For non-CAMHS specialists, top-up training in delivering IPT supervision in a CAMHS setting.

### ***For modality-specific SFP***

- AFT-registered Systemic Supervisors or those who meet the competencies required for registration and are eligible for registration. (AFT will provide processes for achieving registration through an Apel route and will normally supervise those training in SFP).
- In areas with limited resource of registered Systemic Supervisors, supervisors would need to have completed a qualifying training in Systemic Family Therapy (SFT), have a minimum of 3 years' post-qualifying experience and have gained previous experience of supervising systemic practice within a CAMHS setting.
- Supervisors are expected to adhere to the UKCP Code of Conduct and Ethics and AFT Supervisors Code of Ethics.

### ***For non-modality-specific supervision***

- A recognised postgraduate professional training or equivalent professional experience at senior level.
- A minimum of 2 years' supervisory experience in CAMHS post-qualification.
- A minimum of 4 years' experience in CAMHS
- Supervisors are required to adhere to the BABCP Standards of Conduct, Performance and Ethics in the Practice of Behavioural and Cognitive Psychotherapies.

### ***General learning outcomes***

At the end of the course supervisor graduates will:

- Understand the aims, objectives and structure of the CYP IAPT programme
- Understand the importance of supervision as a key clinical activity within the CYP IAPT programme.
- Understand the importance of the supervisor as a change agent offering leadership and support to colleagues during the service transformation process.
- Be aware of the models of supervision applied within CYP IAPT programme services
- Be able to describe the supervision competencies outlined by Roth and Pilling (2007), published at: [http://www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm).
- Demonstrate practical understanding in the application of clinical supervision competencies.

### ***Course structure***

While knowledge, facts, theories, and approaches to problems and solutions will be taught, an equal weighting will be given in the course to learning through reflection on the process of supervision itself, underpinned by a peer support and coaching/mentoring process.



Success of the trainees on the course will be assessed on the basis of the peer support/mentoring process, ongoing supervisor log and 360-degree evaluation.

It is expected that this curriculum will be delivered using a mixed format of didactic teaching and experiential/reflective sessions. Trainees will be developing CYP IAPT-specific supervisory skills with the support of the course leads, experts and their own peers.

The aim will be for this course to be front loaded. An indicative structure might be 6 days in the first term, followed by up to 6 further days over the following two terms. The first 6 days will be more didactic, with the latter 6 days being focused on reflective, group-based practice. The course will include video supervision of trainees' practice.

It is expected that a 'Community of Children and Young People's IAPT supervisors' will evolve, which will become a growing resource to facilitate change in children and young people's mental health care across a wider region beyond a given CAMHS district, and this will provide further support into the future for the sustainability of the CYP IAPT programme.

## **Description of individual modules and specific learning outcomes**

The following module descriptors outline the content of the first 6 taught days for CYP IAPT supervisors. Each module should contain a combination of direct teaching, discussion, group work and experiential learning.

### ***Understanding CYP IAPT***

The aim of this session is to introduce the rationale for the CYP IAPT programme to transform CAMHS by exploring the origins of the IAPT programme, and the national and political context for CAMHS. This session may be delivered to trainee supervisors in conjunction with trainee therapists and service managers.

Supervisors will develop knowledge of:

- The core concepts of IAPT, with a brief history of the Adult IAPT programme, including policy drivers for mental health, models of stepped care and outcome-based delivery.
- The core components of the CYP IAPT programme, with clear reference to the current context for CAMHS, in terms of demand and capacity, and range of existing service delivery models.
- The timeline for key policy drivers shaping the development of CYP IAPT, including the CAMHS Review, NICE guidelines, and *No Health without Mental Health*.

- The rationale for the IAPT Curriculum, and development of the programme around evidence-based interventions for anxiety (CBT) and depression (CBT, SFP, IPT-A), alongside parent training.
- The model of delivery for CYP IAPT and expectations around service change and outcomes monitoring embedded in the CYP IAPT programme.
- How CYP IAPT-trained service managers will operate in their own service, considering how they will facilitate service change, along with trainee therapists and service managers.

### ***Principles of supervision***

The aim of this session is to ensure that supervisor graduates will understand the CYP IAPT process of supervision.

Supervisors will develop knowledge of:

- The core purpose of supervision, exploring the differences between clinical supervision, case management and clinical governance.
- The Core Competency framework for supervision (Roth & Pilling, 2007), and understanding of the importance of the four levels.
- The focus on clinical supervision of trainee therapists within the first year of implementation of CYP IAPT.
- The use of self-reflection in exploring the advantages and disadvantages of different styles of supervision.
- The importance of supervision as a space for support, teaching, clinical discussion, problem solving and reflection with trainees, in addition to considering how to give constructive advice, direction and critical analysis to aid trainee therapists.
- How to problem-solve dilemmas, including:
  - Challenges presented by clinical casework
  - Concerns regarding the competency of trainees
  - Issues in the supervisor/supervisee relationship
  - How supervision is important in preventing staff burnout
  - The importance of treatment fidelity in relation to CYP IAPT.
- Following clear guidance set out in previous documentation, as referenced, the module will then develop trainee understanding of the following:
  - The importance of how to set up supervision to maximise the learning of trainee therapists, attending to the setting, regularity and timing of supervision sessions
  - The importance of contracting with trainee therapists to allow for clarity, both between supervisor/supervisee and also in order to comply with course requirements
  - The importance of the course requirements around client contact, recording, and other formal requirements of the course

- The mechanisms for providing feedback to the trainee and course, including placement visits.

### ***Promoting psychological knowledge in supervision***

The aim of this session is to develop supervisor skills in broadening trainee therapists' understanding of psychological theory directly relevant to CYP IAPT, psychological knowledge in the context of working with children, young people, parents and families, and service-related issues in CAMHS.

Supervisor trainees will develop strategies for helping supervisees to develop and apply knowledge in the following areas:

- How to guide supervisees on appropriate literature/reading/evidence-based thinking relevant to CYP IAPT modalities.
- The core principles of the main theoretical approaches adopted in CYP IAPT, in particular the following:
  - Social Learning Theory
  - Cognitive science/social development
  - Behavioural models
  - Cognitive behavioural interventions.
- The importance of integrating psychological theory in the process of formulation and ongoing understanding of children, young people and families.
- The importance of holding multiple conceptualisations of presenting issues, as well as the necessity to employ pragmatic, evidence-based interventions, as matched to collaboratively agreed goals.
- The additional models/interventions appropriate to the CYP IAPT context, but not necessarily delivered as part of the curriculum.
- The importance of family systems for all children and young people, and how supervision can enhance trainee therapists' understanding of systemic factors influencing treatment approaches.
- How to enhance trainee therapists' understanding of the broader CAMHS context, and how IAPT-specific interventions may complement other approaches, such as:
  - Psychiatric approaches to treatment and the use of medication/diagnosis
  - Family/systemic approaches to treatment
  - Psychodynamic approaches to treatment, with particular reference to Attachment Theory.
- How supervision can enhance trainee therapists' knowledge of the broader CAMHS context, its range and scope, local organisational structures and the multiagency context.

### ***The use of outcomes data in supervision***

The aim of this session is to introduce supervisors in the use of outcomes data as part of routine supervision with an emphasis of using routine outcomes monitoring to enhance the use of outcomes information for clinical decision making shared between clinician and the child, young person and or family.

Supervisors will develop the ability to:

- Supervise therapists on how to determine collaboratively with service users the main areas to work on, and how to record and monitor this each session.
- Guide therapists in:
  - Introducing outcomes evaluation to children and families
  - Making use of information from measures to identify the degree and nature of improvement
  - Discussing this with children and families.
- Incorporate regular and consistent discussion of outcomes data into supervision.
- Help therapists to develop an awareness of the strengths and limitations of different forms of outcomes data, and to use this to interpret measures.
- Help therapists to use outcomes data and other sources of information to decide whether a change of therapy (or a change of techniques within that therapy) is needed.
- Use outcomes data along with other information to evaluate the therapeutic effectiveness of therapists and services, so that appropriate action can be taken, such as specific training.
- Have clear protocols on how to access outcomes data in a timely way to make use of in supervision.

### ***Facilitating therapeutic processes in supervision***

This session aims to equip supervisor trainees with the knowledge of how to guide trainee therapists in the core processes of the CYP IAPT programme. In line with both the CBT and social learning component of the programme, this session will emphasise a number of key characteristics central to delivering effective therapeutic interventions

Supervisor trainees will develop strategies for helping supervisees to develop their skills in the following areas:

- Importance of treatment fidelity and how to guide trainee therapists in the following:
  - Agenda setting in both individual and group therapeutic sessions, and how to guide trainee therapists to appropriately provide structure and direct each session
  - Therapeutic structure across a given intervention, in order to guide trainee therapists in planning the number and content of sessions appropriately
  - Treatment protocols and their importance in providing coherence and direction to treatment.

- The importance of consent and confidentiality, and how to guide trainee therapists in ensuring these are appropriately considered and sought where applicable, e.g. permission for videotaping.
- The importance of non-specific therapeutic factors, and how to guide trainee therapists in developing appropriate skills in listening, warmth and genuineness.
- The importance of group processes as they relate to Parenting Training, and how to guide trainees in attending to, managing and utilising group dynamics in the development of behaviour change.
- The importance of engagement, assessment, and collaboration and how to guide trainee therapists in maximising treatment outcomes via careful attention to building a therapeutic alliance both individually and in groups.
- The importance of safeguarding, risk assessment and risk management, and how to guide trainee therapists in making appropriate, timely decisions about risk and safeguarding, including providing information regarding local and national protocols.
- How to guide trainee therapists in working with resistance, passivity and poor attendance in young people and parents.
- How to guide trainee therapists in decision making around therapeutic interventions, in particular when and how to consider alternative approaches to treatment outside of the CYP IAPT models.

### ***Delivering modality-specific supervision***

This session focuses on enabling supervisor trainees to understand and develop skills in providing direct modality-specific supervision to trainee therapists.

Supervisor trainees will develop knowledge of:

- The importance of theory–practice links in the delivery of CBT and parenting interventions with young people and parents, and how to guide trainee therapists to articulate and explain these links throughout their work.
- The importance of assessment as a key skill for trainee therapists in gathering salient information to guide future interventions.
- The importance of formulation as a key skill for trainee therapists in understanding and communicating psychological ideas to young people and parents.
- The importance of both condition-specific and general methods of formulation, in order to develop trainee therapists' confidence in representing psychological difficulties in pictorial form, and translating ideas about predisposing, precipitating and maintaining variables in an age-appropriate, user-friendly format.
- The importance of being creative and confident in developing teaching methods to enable trainee therapists to understand the links between theory and practice, and in turn promote creativity in the work of trainee therapists.

- Teaching trainee therapists in a range of therapeutic change methods in CBT for children and adolescents with anxiety and depression, and cognitive and behavioural change methods in individual and group parenting training.
- How to use Socratic dialogues to guide trainee therapists in developing solutions to clinical casework.
- How to use their own clinical experience to illustrate and develop themes in the work of trainee therapists.
- How to rehearse, model and role play condition-specific scenarios, enabling trainee therapists to practise techniques in supervision prior to clinical sessions.
- How to effectively use video-feedback methods to enable trainees to critically evaluate their own work, understand and identify dynamics in individual and group sessions, and identify areas for modification in ongoing therapeutic work.
- How to assist trainee therapists in designing and implementing relapse prevention protocols, including therapeutic blueprints.

IPT supervisor trainees will:

- Demonstrate advanced knowledge, understanding and critical awareness of the principles and strategies of IPT practice and their application across the range of interpersonal difficulties addressed in IPT-A.
- Demonstrate a critical understanding of the evidence base for IPT-A as a treatment of depression and advanced knowledge of the clinical application of the evidence base with identified sub-groups in depressed children and adolescents.
- Demonstrate a critical understanding of the theoretical and clinical literature related to IPT clinical supervision.
- Demonstrate advanced knowledge, understanding and critical awareness of the principles and protocols of IPT supervision.
- Demonstrate knowledge and understanding of the importance of developing and maintaining a working partnership in supervision and competence in applying this knowledge in practice.
- Demonstrate knowledge and skill in establishing and modelling a professional framework for supervision and in contracting and negotiating boundaries.
- Demonstrate understanding and skill in using recorded material in a structured manner (between and within supervision sessions) to identify learning needs and plan specific training tasks.
- Demonstrate competence in providing supervision in a variety of settings, e.g. individual, group, face-to-face, remotely via telephone or video conferencing.
- Demonstrate knowledge and skill in identifying trainees' learning style and adapting supervision practice to optimise learning.

- Demonstrate knowledge and understanding of the different stages of learning for therapists from a range of training backgrounds and levels of clinical experience, and competence in adapting supervision interventions accordingly.
- Demonstrate knowledge of the clinical and organisational context in which supervision is provided, and competence in adapting practice to this setting and in response to service user feedback and multiagency liaison.
- Demonstrate competence in formally and accurately assessing a trainee's IPT competence using standardised competency-based measures.
- Demonstrate competence in promoting and modelling the collaborative use of therapists' self-assessment and supervisors' evaluations to facilitate competent practice.
- Demonstrate knowledge of and competence in implementing procedures relevant to the assessment of poor performance and failure.
- Demonstrate critical understanding and competent ability to distinguish between the roles of therapist and supervisor in relation both to the patient and the IPT trainee.
- Demonstrate competence in accurately evaluating and effectively communicating about significant emotional and interpersonal processes in the therapy and supervision interactions.
- Demonstrate an ability to reflect and work within own training experience and competence.
- Demonstrate knowledge of and competence in clearly communicating the rationale for key IPT interventions to support learning.
- Demonstrate knowledge and skill to model and help supervisees to identify the relevance of difference (age, race, class, gender, ability, sexual orientation, religion) to their practice and to integrate awareness into clinical practice.
- Demonstrate knowledge and skill in helping trainees to balance attention to generic therapeutic skills and developing competent practice in IPT-specific interventions.
- Demonstrate knowledge and skill in helping supervisees through modelling to reflect on their work and identify relevant clinical information for review in supervision.
- Demonstrate knowledge and skill in providing supervision of supervision practice.

IPT supervisor trainees will complete two additional IPT cases, under supervised peer supervision, to meet the supervisor accreditation standard of six IPT cases, covering all four focal areas, completed under supervision. Casework completed during practitioner training will be credited toward this total. Supervisor trainees will use the paperwork and procedures set out in the IPT supervision protocol during peer supervision to gain practical experience of supervisory practice. Casework will be assessed following the assessment protocol for practitioner accreditation and feedback on supervisory practice and review of inter-rater reliability with a qualified supervisor will be discussed throughout the casework.

IPT supervisor training is conducted over five training days, split into three short teaching blocks. The first four teaching days run in parallel with the requirement for trainees to conduct additional IPT casework to complete the training portfolio. Days 1 and 2 are scheduled to coincide with trainees starting casework with cases 5 and 6 in their portfolio, and days 3 and 4 are conducted 2–3 months later, when trainees have experience of providing peer supervision on those cases. The final teaching day is conducted early in the cohort's first period of delivering supervision to new IPT trainees.

In this final stage of supervisor training the trainees will receive fortnightly supervision of their own supervision from a qualified IPT supervisor. IPT supervisor trainees record their first supervision case and submit three recordings, with self-assessments, for review against the IPT supervision competencies. A reflective case report is submitted at the end of the trainees' first supervision case.

Systemic practice supervisor trainees will develop knowledge of:

- How to use systemic ideas in relation to developing the supervisory contract, which includes the structure of supervision, forms of feedback, trainee level of experience, multiple relationships and individual practitioner learning needs.
- How to support and attend to the supervisory relationship, including alliance building, management of difference and constructive feedback.
- How to use various modes of supervision: live (in room or use of screen), retrospective using video, individual and group.
- How to support the development of personal and professional reflexivity by modelling and attending to relevant material in the practitioner's relationship to the case or supervisory relationship.
- Focus on the specific systemic use of theory–practice links.
- Means of facilitating development of specific systemic skills.
- Fostering competence and a self-reflexive stance in working with difference: class, race, culture, gender, ability, religion/belief.
- Different systemic theories of supervision and adult learning.
- Ethical principles, theory and promotion of anti-oppressive practices.
- How to support the development of a systemic framework which includes the young person, family context and connection to broader organisational systems, which develops over time and is responsive to new information.
- Show evidence of the ability to deliver the systemic supervision competencies ([http://www.ucl.ac.uk/clinical-psychology/CORE/Supervision\\_Competerences/ability\\_supervise\\_systemic.pdf](http://www.ucl.ac.uk/clinical-psychology/CORE/Supervision_Competerences/ability_supervise_systemic.pdf)).
- How to make use of supervision of supervision and 360-degree feedback.

### ***Assessment of trainees on the CYP IAPT supervisors' course***

Supervisor trainees will be assessed by a combination of:



- Video (e.g. of supervision sessions, peer support/mentor sessions)
- Supervision log
- 360-degree appraisals.

The supervision log refers to a document presented at the end of the course detailing ongoing supervision sessions with trainees, with reflections on the process of supervising CYP IAPT trainees and experience of service change.

The supervisor trainee reports will be evaluated by a panel of peers and experts in the field.

## 13. CYP IAPT Outreach Enhanced Supervision Training

### *Aims*

The main aim of this brief curriculum is to support the delivery of outreach supervision training to clinical supervisors working in the CAMHS partnerships who have not completed or are due to undertake the CYP IAPT supervision training. The purpose is to enhance the competences of supervisors supporting staffs' clinical skills and to embed and sustain the CYP IAPT principles and values. The aim is to support reflective and collaborative practice and shared decision making between young people, children and families who use CAMHS with a particular focus on the routine use of feedback and outcomes

[www.corc.uk.net/resources/additional-information-about-the-measures/](http://www.corc.uk.net/resources/additional-information-about-the-measures/)

The training will focus on the development of generic knowledge and skills for the provision of effective supervision, which will be relevant to all clinical supervisors independent of the therapeutic modality being used in their clinical practice. The training will develop generic and specific supervision competences in line with the Roth and Pilling (2009) competency framework for supervision ([http://www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm)). During the training the supervision competences will be delivered in line with CYP IAPT core principles and aims. There will also be a focus on considering how to sustain rigorous supervision in local services (Turpin & Wheeler, 2011; <http://www.iapt.nhs.uk/silo/files/iapt-supervision-guidance-revised-march-2011.pdf>)

**Note** there is an expectation that trainees bring recordings of their supervision practice and attend all the training days. This is for the trainees' own learning and not for assessment.

***The outreach supervision training is suitable for:***

The training is suitable for practicing clinical supervisors. They will not be supervising trainee therapists attending the CYP IAPT courses, as these supervisors need to be enrolled on the CYP IAPT (PG Cert) supervisor training.

The training is for all clinicians who are engaged in and provide clinical case supervision to CAMHS staff or the wider services as part of the CYP IAPT service transformation programme (not for those solely providing line management supervision nor case management supervision).

**Scope**

The outreach enhanced supervision training sits within the overall programme of service transformation. The focus is on the sustainability of effective supervision in local services in line with the aims and principles of the CYP IAPT programme.

**Competences**

The Roth and Pilling core supervision competences ([http://www.ucl.ac.uk/clinical-psychology/CORE/competence\\_frameworks.htm](http://www.ucl.ac.uk/clinical-psychology/CORE/competence_frameworks.htm)), use of routine outcome measurement, and collaborative practice are the main competences taught and evaluated on the programme.

**Learning outcomes**

The aim of the training is to develop supervisory skills to broaden supervisees' understanding of psychological theory directly relevant to CYP IAPT and psychological knowledge in the context of working with children, young people, and families, and service-related issues in CAMHS.

At the end of the training learners will understand:

- The aims, objectives and principals of the CYP IAPT programme
- The specific role that supervision plays in CYP IAPT and how to embed CYP IAPT principles into supervisory practice
- The roles, principles and use of models of supervision in order to promote effective supervision
- How to appropriately use theory, research and evidenced-based practice within supervision to support supervisees' use of effective clinical interventions
- How to develop and assess own supervisory competences (e.g. Supervision Adherence Guidance Evaluation – SAGE; PM to send ref)

- How to use frameworks, and outcome and feedback tools to aid learning and reflection (e.g. Kolb, D.A. 1984 *Experiential learning experience as a source of learning and development*. New Jersey: Prentice Hall; PDSA cycles  
<http://www.ihl.org/resources/pages/tools/plandostudyactworksheet.aspx>)
- How to model good practice by routinely seeking and responding to feedback on supervision delivered (e.g. *Helpful Aspects of Supervision Questionnaire-HASQ*; PM to send ref).

### ***Training content***

#### ***Key learning outcomes:***

- I) Understand the nature of the course and its requirements.
- II) Knowledge of the close interplay between the CAMHS partnership and the learning collaborative
- III) Supervision within CYP IAPT:
  - Core principles of CYP IAPT
  - Context of CAMHS
  - CYP IAPT principles in supervision (including supervising collaborative practice)
  - Role of supervision in CYP IAPT
  - Definitions and experience of supervision
  - Distinguishing between clinical skills versus case management supervision
- IV) **Generic and specific supervision competences**  
([http://www.ucl.ac.uk/clinicalpsychology/CORE/Supervision\\_Competerences/competences\\_map.pdf](http://www.ucl.ac.uk/clinicalpsychology/CORE/Supervision_Competerences/competences_map.pdf))

#### **Generic Competencies:**

- Ability to employ educational principles which enhance learning (e.g. models of learning (e.g. *Experiential Learning*; Kolb, 1984) and supervision (e.g. *Declarative-Procedural-Reflective (DPR) Model of Supervision*, Bennett-Levy, 2006)
- Ability to enable ethical practice
- Ability to foster competence in working with difference
- Ability to take into account the organisational context for supervision
- Ability to form and maintain a supervisory alliance (e.g. managing dilemmas and ruptures)

- Ability to structure supervision sessions including practical/procedural elements of supervision and their importance
  - contracts/agreements
  - structure of session, use of agenda, paraphrasing etc
  - supervision records – issues of accountability, being contemporaneous
  - Roles and responsibilities for effective supervision
- Ability to help the supervisee present information about clinical work
- Ability to help supervisee’s ability to reflect on their work and on the usefulness of supervision
- Ability to use a range of methods to give accurate and constructive feedback
- Ability to gauge supervisee’s level of competence

**Specific Competencies:**

- Ability to help the supervisee practice specific clinical skills
- Ability to incorporate direct observation into supervision
- Ability to conduct supervision in group formats
- Ability to apply standards

**V) The outcome measures and feedback tools:**

**Supervisors need to support the clinically meaningful use of feedback and outcomes to enhance supervisees’ clinical practice and supervision.**

Supervisors should understand:

- The rationale and value for the use of outcomes and feedback tools in supporting collaborative practice
- How to support supervisees’ in the use of outcome and feedback tools to facilitate a shared understanding and guide interventions
- How to support supervisees’ to select appropriate outcome and feedback tools and use them to reflect on the effectiveness of the intervention in conjunction with other clinical information.

- How to use information from outcome and feedback tools in supervision, and to explore limitations and dilemmas in how they are used in clinical practice

**VI) Frameworks for self-evaluation and using feedback to evaluate supervisor competency**

- a. Supervision of supervision
- b. The use of video recording to enhance supervisory practice
- c. Evaluation/ self-reflection of supervision using measures (e.g. Supervision Adherence Guidance Evaluation SAGE; Milne & Reiser, 2008 and Helpful Aspects of Supervision Questionnaire)

**VI) Active methods of supervision (e.g. direct observation, giving feedback, assessing competences in supervisees)**

- Practical/procedural elements of supervision and their importance
  - Methods – case discussion, active methods (role play), recordings, didactic vs Socratic
  - Obstacles to using more active methods
  - Giving and receiving feedback

**VII) Spread and sustainability**

- To increase awareness of development needs and support structure necessary for good supervisory practice – e.g. formal supervision training for supervisors, peer support, supervision of supervision, self-supervision
- To embed support for supervisors into CYP IAPT supervisory practice and services
- To generate an action plan with a particular focus on embedding learning and supervision processes locally and support sustainable good supervisory practice in own services.

**VIII) Outreach Supervision of supervision**

- Develop skills in practical application of supervision of supervision – e.g. use of recordings /SAGE in supervision
- How to set up and structure supervision of supervision considerations
- Experience the process and structure of supervision of supervision

***Self-assessment of trainees***

To assess learning outcomes, the supervision competences self-assessment tool which is based on the supervision competences framework (Roth & Pilling, 2008) can be completed pre, mid and post the training.

## **14. Transformational Leadership Curriculum for Service Directors/Managers & Clinical Directors/Leads: Embedding Sustainable Cultural Change**

**60 credits**

**(8-10 days plus on site work)**

### ***Aims:***

- To develop competency in leading service change to deliver evidence based, quality driven, client and outcomes informed services
- To have critical knowledge of the theoretical, research and implementation literature that underpins such service change
- To enable service leaders to initiate the necessary changes in their services during the training course
- To enable a process for continued service improvement through experiential and reflective learning that is sustained within the practices of the workforce.

### ***Scope:***

The Children and Young People's IAPT Project sets out to achieve whole system change. Service leaders, directors, managers and leads will be key; they, together with the therapist and supervisor graduates and wider workforce, will bring about this change.

Children and Young People's IAPT differs from the current adult IAPT project and it is important for curriculum providers to take note of this significant variance. This project will work from within existing service arrangements, bringing about transformation to incorporate and embed the tenets of Children and Young People's IAPT into the whole service. It will not be providing new or standalone services.

The principals of Children and Young People's IAPT are detailed in the overarching core offer document see [www.iapt.nhs.uk/cypapply](http://www.iapt.nhs.uk/cypapply)

Our vision for creating 'evidence based, quality driven, client and outcomes informed' CAMHS includes:

- Evidence based
- Outcomes informed and focused
- Capable of evidencing what they do from every perspective: clinical quality, performance and safety
- Predicated on user, carer and key partner feedback and input



- Capable of responding to such data feedback and modifying service and clinical delivery accordingly
- Collaborative shared decision making

**Core Principles:**

Demonstrate service quality and standards of care by;

- Working in partnership with children and young people and parents and carers to deliver the best evidence based therapies with optimal efficacy
- Using routine outcomes and feedback monitoring to collaborate with children and young people and keep them informed of how they are progressing and to guide supervision and service delivery
- Collecting and analysing data to inform clinical interventions and submit data to inform service design and delivery a local, NHS Trust/organisation, and national level.
- Improving accessibility

**The involvement of Children and Young People and Parents and Carers**

CYP IAPT requires that children and young people and parents and carers must be involved at all stages and levels. This is summarised in the table at the end of this section, and has been developed by the Department of Health CYP IAPT project team and Young Minds (2011-12) and GIFT (2012-current).

**National Policy Perspective: central team to update**

A focus on both quality and outcomes has been and remains a key national policy driver, related documents include:

- The Department of Health Business Plan 2011-2015
- The Mental Health Strategy, *No health without mental health* NHS and Social Care Bill 2011
- Talking Therapies, a Four Year Action Plan
- The Mandates between the Department of Health and NHS England and Health Education England.
- Achieving Better Access to Mental Health Services by 2020

A core principle within this policy context is the commissioning of and delivery of ‘cost effectiveness’; that is the maximised combination of best clinical effect (defined from multiple perspectives including children, young people and carers’ feedback) with cost. In other words: achieving the greatest clinical gain, with appropriate regard to risk management-patient safety, for a given cost.

The core aim of Children and Young People's IAPT is to transform organisations into bodies capable of meeting these challenges and to strengthen delivery of mental health and wellbeing care for the children and young people sustainably into the future.

Given the highly interdependent and linked nature of CAMH services across multiagency boundaries and the linked agendas of 'evidence-based, quality driven, client and outcomes informed services' in, for example, schools, Children and Young People's IAPT aims to support the development of effective care pathways from universal to specialist services. This will assist and build integrated multiagency care pathways that start and end with the child or young person and their family or carers and where they are; from home to home not defined by service boundaries.

***Positioning of this course within the overall Children and Young People's IAPT Curriculum***

In some aspects of the curriculum, HEIs may wish to train service leads alongside supervisors and or therapists both because the training can be appropriately shared and to support the team of service lead, supervisor and therapists to work together as change agents. There will be parts of the course that are relevant to service leads alone.

***Experience/Competences: Service Directors/Managers, Clinical Directors/Leads***

Service Directors/managers and clinical directors/leads will be working in or with statutory or voluntary sector CAMHS, targeted and specialist services (generally known as tiers 2 and 3 CAMHS) language to be softened so it is less NHS focused

- They will have a key role in organisational development and in supporting change at a local level
- They will have been nominated by their organisation to undertake this training in support of the service's Children and Young People's IAPT bid

They will be responsible for:

- Service systems design and planning, outcomes and service KPIs and the commissioning/contracting of such services
- Job planning
- Continuing professional development
- Appraisal and performance

***General Learning Outcomes: reference to be made to the 2010 competency framework this inform these outcomes. Language to be reviewed, very NHS focused.***

At the end of the course Service Directors/Managers & Clinical Directors/Leads graduates will:

- Understand the service objectives in the Children and Young People's IAPT project
- Understand the competences in line with the Roth, Calder and Pilling competency framework for CAMHS ([http://www.ucl.ac.uk/clinical-psychology/CORE/child-adolescent-competences/CAMHS%20Competences%20Framework\\_V1%20%282%29.pdf](http://www.ucl.ac.uk/clinical-psychology/CORE/child-adolescent-competences/CAMHS%20Competences%20Framework_V1%20%282%29.pdf) )

- Understand and implement clinical and service Outcomes and Evaluation in Children and Young People's IAPT
- Understand and implement how outcomes and evaluation will be used in supervision and practice to guide delivery of care
- Understand and implement the establishment of young people's participation within their service.
- Understand the degree to which their existing service meets IAPT objectives
- Understand theories of complex organisations and processes of organisational change.
- Use theory and evidence from implementation science to achieve IAPT objectives
- Understand the new NHS commissioning system and how to engage with it
- Understand value for money, payment by results and other commissioning priorities
- Understanding of health economics and values based system change for Children and Young People's MH Services including the financial systems present within NHS, local authorities in so far as they relate to CAMHS
- Preparing for AQP, CAMHS payment system (formerly known as PbR) and an understanding of how to demonstrate value for money
- Understand Demand capacity theory and models and how they relate to CAMHS
- Be capable of workforce planning including job planning,
- Understand and implement performance management systems that link job planning, appraisal, CPD with needs assessments and workforce planning in order to improve service design in line with IAPT objectives
- Understand service design and implement changes relevant to IAPT objectives of increased access.
- Add link to CYP IAPT standards and values 'Delivering With, Delivering Well'.

**Course Structure:** While knowledge, facts, theories, approaches to problems and solutions will be taught, the course will give an equal weighting to learning through the implementation process itself, underpinned by a peer support and coaching/mentoring process. Particular weight should be given to the following key elements:

- A joint clinical and managerial approach to change management
- How to design a service
- Managing conflict
- Working with and managing commissioners
- The need to take a 'whole system' approach

This may be best achieved through **guided experiential action learning**. It will be important that it is guided by people who have experience and success of actually delivering such transformational change and who will be able to offer advice and support on the issues.

Graduates of the course will demonstrate practical understanding in the application of these Children and Young People's IAPT managerial and leadership competences, in their everyday service settings.

It is expected that this curriculum will be delivered in mixed format of formal learning and experiential 'guided action learning'. Trainees will be implementing change as they learn and learning from that experience with the support of the course leads, experts and their own peers.

It is expected that a 'Community of services and leaders' participating in the CYP IAPT programme will evolve which will in effect be a 'movement' for change in Children and Young People's MH care and this will provide further support into the future.

### ***The relationship of the manager's course to the other CYP IAPT courses***

The CYP IAPT service transformation programme will involve training in improving the quality of clinical services through multiple evidence-based methods, including the use of evidence-based therapies, clear and frequent supervision by fully-trained supervisors, and the use of session-by-session outcomes monitoring and feedback to inform therapy and supervision. While some CAMHS already use these methods, many do not. We intend that these methods will not be used solely by leaders and practitioners who have undergone courses delivered through the CYP IAPT programme.

Graduates (service leads, supervisors and therapists) will be asked, as part of being involved in Children and Young People's IAPT programme and training courses, to disseminate these practices throughout their local services whose management will have been asked to sign up for this change as a condition of acceptance. The training course will teach attendees how best to support local service change towards effective practice by all team members. It will therefore be appropriate for this aspect of the training for service managers, clinical leads, supervisors and therapists to be delivered as a coherent package to underpin and embed this partnership systems change in their local area.

A number of systems may need to be put in place in order to support effective coordination between courses, between participants on courses and between partnerships to assist with this transformation. This could include:

### ***Shared learning between courses***

#### ***Consultation/tutoring directly in the partnership***

Some of the management course tutoring could be delivered in the CAMHS partnership with tutors working alongside managers on particular aspects of service change/implementation. This input could be focussed on the manager but may involve other trained staff such as therapists or supervisors trained within the programme as appropriate.

### ***Creation of implementation teams within each partnership***

In addition to local Steering Groups, a further way to support organisational change would be the creation of local EBP Implementation Groups which include all the partnership staff on the respective CYP IAPT courses. Course teaching could be tailored to supporting the coordination and development of such groups.

### ***Teaching content***

The following will form the main teaching content for the course.

### ***Understanding the use of outcomes and feedback to inform clinical interventions and service evaluation and design***

Service leaders will develop the ability to:

- Ensure there are appropriate systems for collection of required data to support clinical practice in therapeutic sessions as well as for their services
- Ensure that consideration of outcome data is a core part of clinical practice, case management review and supervision
- Be cognisant of the strengths and limitations of different forms of outcome data and of how best to interpret information in the light of these
- Be able to liaise with IT providers and ensure that systems are fit for purpose and in particular are able to provide collated outputs in a timely way
- Use outcome and feedback data to support therapists who are having difficulty using outcome measurement in a clinically meaningful way.
- Transform services so as to embed a culture of useful measurement and ensure service capability to synthesise such data reports
- This will ensure data can usefully and safely inform children, young people and parents/carers care, service delivery and its development in iterative 'evidence based' cycles

### ***Understanding young people's participation in children and young people's mental health services***

Service leaders will develop the ability to:

- Understand models of user participation in mental health services.
- Learn examples of effective participation by children, young people and carers in organisations
- Ensure there are appropriate systems for children, young people and carer's participation in their own service
- Transform services so as to embed a culture of participation by children, young people and their carers within the service

***Applying organisational knowledge and theories of organisational change for children and young people's mental health services***

Service leaders will develop the ability to:

- Observe and describe their service from the perspective of complex systems
- Describe their service from an organisational perspective
- Understand the importance of organisational factors such as climate and culture on organisational processes
- Understand the factors that are likely to support change within an organisation.
- Gain knowledge of the evidence for effective management of CAMHS

***Applying knowledge from implementation science about dissemination of evidence based practice (EBP)***

Service leaders will develop the ability to:

- Understand the basis of evidence based interventions (EBIs)
- Obtain an overview of NICE guidance with respect to CAMHS
- Develop their knowledge base for dissemination of EBP in health and social care systems
- Apply this knowledge to understanding local barriers to implementation
- Develop an implementation approach based on EBP.

### ***Linking job planning, appraisal, CPD with needs assessments and skills mixes in service design***

Service leaders will develop knowledge of, and ability to implement:

- Development of job planning as a whole service/network process, across all staff
- Linking job planning to service specification
- Matching needs, JSNA, service capacity and service specification
- Skills matching, linking with appraisal and continuing professional development
- The Choice and Partnership Approach (CAPA: York & Kingsbury, 2012; [www.capa.co.uk](http://www.capa.co.uk)) incorporates these elements in the model and can be delivered as a training package and service change support package in itself
  - Demand and capacity modelling is taught knowledge and skills on how to measure and monitor demand into a service, measure and balance the capacity needed for this demand. This includes skills to take a systems approach to demand and capacity management, skills to flex capacity and making best use of resources, including ability to identify and reduce waste in the system.

### ***Service design, user and family participation, equalities, capacity planning and performance management***

Service leaders will develop knowledge of, and ability to implement:

- Models of service improvement aimed at effective and efficient service delivery e.g. CAPA (Choice and Partnership Approach), or other models which incorporate 'Lean Thinking' as part of a service improvement approach
- Linking service design to function as determined by need, evidence for effectiveness, capacity and capability
- The importance of service user and family participation in service design and feedback - how to ensure service user participation at all levels of services
- An understanding of equalities and how to ensure children, young people and parents from all communities served can access evidence based interventions appropriate for their need
- Linking outcomes to service development, change, and outcomes based commissioning e.g. CQUIN payments etc.

### ***Understanding health economics and values based system change for CAMHS***

Service leaders will develop knowledge of, and ability to implement:

- 'Cost and clinical effectiveness': its meaning in practice
- 'Value for money' and 'values based' systems change
- Understand basic finance within CAMHS i.e. NHS and LA funding systems
- Prepare for new change levers e.g. PR, AQP – payments results
- Value-based systems of change see <http://www.jcpmh.info/good-services/values-based-commissioning/>

### **Assessment**

Service leads completing the training should be asked to prepare a 'case study' of their own service situations. This means that services and their managers will have to give thought to what it is they want to achieve and to then link their learning to those objectives.

The focus for such a case study might include

- The issues they want to address from a service leadership perspective
- Why they want to bring about this change
- The ideal – what will success look like
- The challenges - what are the difficulties that have to be overcome to achieve the ideal?

Success in the course will be assessed in part on the basis of their interim and final reports of their individual service implementation programme arising out of the 'case study'.

Assignments will need to follow the specific university requirements for post graduate certificate courses. Children and Young People's IAPT Managers course will be assessed by a combination of oral and written assignments. Consistent with the approach of guided experiential action learning, the assignments will aim to address skills central to implementing the CYP IAPT principles.

The oral assignment will comprise:

1. Video of a management situation and reflective logs on learning from it (e.g. team or management meetings of relevance to the tasks)
2. Guided role play of scenarios relevant to the course e.g. managing relationships with commissioners or conflict and challenges around change
3. 360 degree manager appraisal

The written assignment will comprise:

A case report specific to the implementation of Children and Young People's IAPT objectives. This report will be around 5000 words and should include a combination of the following.

- An analysis of the specific CAMHS context and examine the process by which specific CYP IAPT objectives are agreed and defined within the Trust.
- A reflection and analysis of key organisational and managerial issues
- Mapping out the stakeholders, the potential supports and barriers to implementing the principles of the CYP IAPT programme
- The change plan for your Trust and your role within this
- The engagement of wider systems
- A brief description of the implementation of the project



- The impact of feedback processes on the implementation process, your understanding of this and further action based on this analysis.
- The outcomes of the project.
- Plans for future sustainability of change.
- A critical review of the project
  - The impact of organisational systems on the process of change
  - The impact of parallel change processes on the process of change
- Reflections on one's own managerial practice
  - What aspects of the project were most challenging
  - What skills were helpful
  - What did you learn about yourself as a manager?

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<http://www.iapt.nhs.uk/workforce/high-intensity>

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<http://www.lean.org/WhatsLean/>

[www.iapt.nhs.uk/cypapply](http://www.iapt.nhs.uk/cypapply)

<http://www.ucl.ac.uk/CORE>

Health and Social Care Act 2012:

<http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted/data.htm>

No Health without Mental Health:

[http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH\\_123766](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_123766)

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