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# IAPT – is it like Frankenstein's monster?

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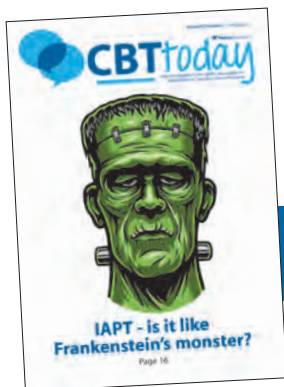
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Official magazine of the British Association for Behavioural & Cognitive Psychotherapies



## IAPT - is it like Frankenstein's monster?



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**Volume 47 Number 1**

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Welcome to the first issue of the year. Our Spring conference is almost upon us, and the Annual conference is shaping up nicely, with a visit to Bath coming in September. Details of these are here, while our contributors continue to give readers fascinating perspectives on CBT and mental health issues.

Our main feature is a thought-provoking look at how IAPT has developed in the decade since its introduction in England, with David Clark responding to Jason Roscoe's thoughts.

You can also discover the current workshops that our branches and Special Interest Groups have organised, with a look at the impact they made in 2018.

Peter

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Managing Editor

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# BABCP Conference and Workshops 2019



www.babcp.com

University of Bath, 3 – 5 September

Confirmed Keynote and Workshop speakers so far include:

**David A Clark**, Beck Institute of Cognitive Behavioural Therapy

**Georgina Charlesworth**, University College London

**Kate Davidson**, University of Glasgow

**Jaime Delgado**, University of Sheffield

**Thomas Ehring**, Ludwig Maximilian University of Munich, Germany

**Jonathan Green**, University of Manchester

**Gillian Haddock**, University of Manchester

**Peter Langdon**, University of Kent

**Stephen Kellett**, University of Sheffield

**Richard McNally**, Harvard University, USA

**Ailsa Russell**, University of Bath

**Paul Salkovskis**, University of Oxford

**Chris Williams**, University of Glasgow

**ALSO:**  
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Plus more to be announced soon!



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# Offer digital CBT to young people with mild depression, says NICE

Children and young people can be offered digital CBT (also known as computer CBT) as a first-line treatment for mild depression.

Digital CBT is delivered on mobile phones, tablets or computers, meaning users can access help quickly, avoiding waiting lists.

Group CBT, group interpersonal psychotherapy and group mindfulness are also recommended as first-line treatments.

NICE says that the choice of treatment should be based on clinical need and patient and carer preferences. The child or young person's history, circumstances and maturity should also be considered.

Paul Chrisp, director of the Centre for Guidelines at NICE, said: "In this update to our depression in children guideline, we reviewed evidence for the most effective psychological interventions for children and young people with depression. The guideline update emphasises the importance of a child or young person's personal choice when receiving treatment for depression.

"We want to ensure children are offered a range of therapies to suit their needs and individual preferences are placed at the heart of their care. The evidence showed digital CBT and group therapy were most effective at reducing depressive

symptoms and we have recommend these as first-line options for children and young people with mild depression."

Claire Murdoch, NHS England's national mental health director said: "Given how quickly technology is constantly evolving and the fact that young people are usually at the forefront of this change, updating this draft guidance is another step forward. Digital and online interventions can play an effective and important role in treatment, particularly when backed up by face to face support, and the NHS Long Term Plan makes clear that the health service will continue to look to harness the benefits these advancements can bring."

This draft recommendation is made in a fast-tracked update to NICE's existing guideline on depression in children and young people aged 5 to 18. It follows a trial published in *The Lancet Psychiatry* which showed the benefits young people can gain from psychological therapies.

Digital CBT is already recommended for adults with mild to moderate depression.



## Online journal Special Issue – Call for papers

Past, present and future: Ten Years of the Improving Access to Psychological Therapies (IAPT) programme - *the Cognitive Behaviour Therapist* is pleased to mark the tenth anniversary of the IAPT Programme with a call for papers to be included in a Special Issue of the journal to be published in 2020 and introduced by National IAPT Clinical and Informatics Advisor, Professor David Clark.

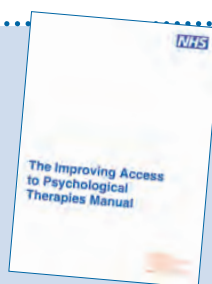
We want to publish papers that will make a difference to the future quality of IAPT service delivery, that will help clinicians and service leads reflect on their own practice or their service and give them ideas of the changes they can make now and start to think about potential future developments.

We want to see papers that will help this ground-breaking psychological therapy programme to continue to improve in its delivery of evidence-based CBT to all adults regardless of faith, social deprivation, culture, ethnicity or sexuality. We welcome Practice Articles, Literature Reviews, Case Studies and original research on clinical interventions, training and supervision or service delivery.

We encourage submissions from both experienced authors as well as first-time authors who work in IAPT services who want to share their research findings. To help first-time authors we are looking at how we can link them with a mentor or buddy who can provide supportive yet challenging comments and guidance in order to get papers into a publishable format. Closing date for submissions is 31 July 2019.

**Follow @theCBTjournal on Twitter for further updates**

# BABCP Response to the NHS 10 Year Plan



in brief...



## Group CBT Special Interest Group launch

Our latest Special Interest Group has been formed, with its inaugural event taking place in Liverpool recently. Their interactive workshop – Running a group for depression, was fully booked, and the SIG are looking at future events to arrange. Any BABCP member interested in the development practice of group CBT can join – simply email us at [group-cbt@babcp.com](mailto:group-cbt@babcp.com).

## No Manx is an island

Thanks to the efforts of a dedicated group of members, we now have an Isle of Man Branch. Interim Chair Tara O'Donoghue has worked with others to arrange the delivery of CPD events on the island, with full details to follow once these are confirmed.



*The government released its 10-year plan for the NHS on 7 January 2019, setting out strategic priorities for the next decade.*

BABCP welcomes several of the ambitions and priorities laid out, whilst cautioning about the impact of setting unachievable targets for an already stretched workforce without a clearer explanation of how recruitment and retention will be better encouraged. We also note how far we are from parity of funding for mental and physical healthcare.

We particularly welcome the focus on both adult and child and adolescent mental health, provision of psychological therapies and better crisis care, focus on prevention and intervention and the emphasis on improving workforce wellbeing and equality and diversity in patient and staff populations.

We note that concrete plans for funding and provision of social care have been delayed. We recognise that adequate funding for social care is vital to enable health, social care and education to work together effectively to improve mental health and await the green paper on social care with interest.

One of the challenges to the aims of the 10-year plan is the ongoing tension between the goal of better national integration and the local commissioning of services. This leads to local decision-making on how limited budgets are spent and variations in service nationwide.

We note the specific priorities within the plan and makes the following comments;

### Mental health

BABCP is clear that parity of esteem between mental and physical health requires parity of funding. We welcome the pledge to spend at least £2.3bn more a year on mental health care and also to grow the mental health budget faster than the overall NHS budget for each of the next 5 years. However, we note that the overall increase over the next five years is said to be £20.5 billion "in real terms", suggesting that there is still a long way to go in terms of parity of funding. We also consider that this may be insufficient because of the cumulative effects of chronic spending cuts to mental health and social care.

**The IAPT manual can be found online at <https://www.england.nhs.uk/wp-content/uploads/2018/06/the-iapt-manual.pdf>**

### Psychological therapies

BABCP welcomes the celebration of IAPT services in England as 'world leading' and the pledge to expand provision to help 380,000 more people receive therapy for depression and anxiety by 2023/24. We support continued funding of IAPT training places to meet the increased demand for psychological therapists. We hope that financial support for psychological therapies will also be forthcoming across the UK. We assert that this must be done in the context of keeping to the standards set in the IAPT manual in England and with corresponding quality assurance measures in the devolved nations.

### Children and young people's mental health

BABCP agrees that child and adolescent mental health is crucial and welcomes the emphasis on prevention and early intervention, and the pledge that ring-fenced CYP MH funding will grow faster than both overall NHS spending and total mental health spending. We also welcome the extension of services for young people up to 25. Whilst early intervention in education settings is welcome, we call for this to be evidence-based and carefully evaluated.

### NHS Staff Wellbeing

Whilst BABCP welcomes a focus on staff wellbeing, it calls for further access to confidential support for wider groups of healthcare professionals and for more compassionate leadership of the NHS. Workforce shortages may be related to previous unachievable targets, salary freezes and cuts to training budgets. There is a lack of clear or detailed planning for how short-staffing in the NHS will be overcome, particularly in the current climate of uncertainty.

### Equality and diversity

BABCP welcomes the emphasis on equality and diversity in both patient and staff populations and recognition of specific needs of certain populations including looked after children, LGBTQ+ and BAME populations. We will watch with interest to see how these aims translate into practice.

A photograph of several bright yellow daffodils with green stems and leaves, positioned on the left side of the page. The flowers are in various stages of bloom, with some fully open and others as buds. The background is a plain, light color.

# Making CBT work in Challenging Times

This year's Spring Workshops and Conference looks at the important factors that can impact on the effectiveness of CBT and the therapeutic innovations that can help to address these. Increasingly therapists are beginning to include factors outside of the individual in their formulations and this programme brings together some of the leading researchers and therapists in mental health to look at the degree to which we can still provide high quality and effective treatments.

The first day of workshops include leading therapists looking at how people who have experienced trauma can recover even when justice has not been achieved, how innovative treatments can help refugees even in short term therapy, how therapists can work with people struggle with mental health problems and long term health conditions and how behavioural activation can be an effective treatment even when young people are struggling with a range of challenges.

The day of keynotes covers a wide range of social and circumstantial factors that will impact directly on service users and how they make use of therapy. Topics include the impact of loneliness, injustice and trauma, mental health and parenthood, long term health problems and the impact of debt. The implications about how these contextual factors impact on mental health and the need for therapists and researchers to shape the way that public health initiatives respond to these will also be considered.

These workshops and presentations will look at challenges faced across the lifespan and provide therapists with practical tools and up to date knowledge about how to understand the impact of these factors on service users and how to work towards meaningful change.

Presentations cover a wide range of social and circumstantial factors that will impact directly on service users and how they make use of therapy. Topics include the impact of loneliness, injustice and trauma, mental health and parenthood, long term



health problems and the impact of debt. The implications about how these contextual factors impact on mental health and the need for therapists and researchers to shape the way that public health initiatives respond to these will also be considered.



**Workshops 11 April**

- Workshop 1: Real World Trauma Therapy in a Changing Environment**  
*Alastair Bailey and Sarah Heke, CNWL NHS Trust*
- Workshop 2: Brief Behavioural Activation for Adolescent Depression**  
*Shirley Reynolds Charlie Waller Institute, University of Reading*
- Workshop 3: The Role of Language and Culture in Treating Distress in People with Long Term Conditions**  
*Trudie Chalder, King's College London, SLAM NHS Trust*
- Workshop 4: Treating Multiply Traumatized Populations. An Introduction to Narrative Exposure Therapy**  
*Katy Robjant, University of Konstanz, Germany*

**Conference 12 April**

- After Grenfell: Working with trauma when justice has yet to be done  
**Sarah Heke, Central and North West London Foundation Trust**
- Mental health, discrimination and marginalisation  
**Richard Bentall, University of Sheffield**
- Loneliness and mental health - is there a missed opportunity to intervene?  
**Sonia Johnson, University College London**
- Does CBT work for expectant and new parents? An overview of perinatal mental health policy, research and practice.  
**Camilla Rosan, National Programme Lead for Perinatal Mental Health, NHS England**
- The Silent Killer: Debt, suicidality and mental health  
**Brian Semple and Helen Undy, The Money and Mental Health Policy Institute, London**
- Treating symptoms and distress in people with long term conditions  
**Trudie Chalder, King's College London, South London and Maudsley NHS Trust**

**Registration fees**

	<b>BABCP Members</b>	<b>Non-Members</b>	<b>Student Members</b>
<b>Workshop</b>	£125	£160	£80
<b>Conference</b>	£90	£120	£70

Registration and full abstracts can be found at: <https://www.babcp.com/Conferences/Spring/Spring.aspx>





# Leadership and CBT

All of us can be a leader even if we have not been given the designated title. In current mental health services there is never a better time to think about how we lead. 'Are we a good enough leader? Can we lead by example?' asks **Elaine Davies**.

I have been very fortunate in my career to have had the designated title and I hope those I served will be able to say that I walked the talk. My brain works to convince me that I am better than I really am! When we are given the leader title, role or position, sometimes, this in itself, can be problematic because doesn't that mean the leader is better than everyone else? We all have to be careful of this unconscious power. Leaders are distributed along a bell curve - a few of us are not good at leading, a few are exceptional and most are average. Think of our current and past leaders not just in the day job but outside of work in our hobbies, interests and friendships. Then of course look at the wider world. I'm sure as you read, you are able to draw on the idea of a leader who has good and bad character traits.

I have long since appreciated Robert K Greenleaf's Servant Leadership theory. This way of relating to others fits my own values whilst spending my working life as a public servant. In Servant Leadership the intrinsic value and potential of the individual or the follower of the leader is at the uppermost of the leader's mind. The leader and follower are intertwined and both growing emotionally, relationally, ethically and spiritually. Servant leaders see themselves as the steward of the organisation but does not bypass the performance obligations entrusted to them. The servant leader will think about the sustainability in the follower's psychological need and not sacrifice

people for figures and targets. This point is important to digest when those of us serving mental health patients are showing signs of poor mental health ourselves.

I believe that CBT can sit alongside servant leadership. Using theory, skills and knowledge combined from both gives us all the essential resources to lead well and survive in current NHS target driven services or other areas of our working lives.

Leaders have problems every day but discuss them less than they ought to. Many leaders - particularly new leaders believe that they have the answers to all the problems. They do not and should not. Some fail to discuss their mistakes for fear of a sign of weakness. Some leaders know the very solution to the problem but may not have the confidence, knowledge or know how to implement. None of us want to do what make us feel uncomfortable. Asking for help through supervision and talking to other detached colleagues can be the important link to develop the growth of the leader.

Like our client work, define the problem succinctly, question the feelings. Unpleasant feelings tell us so much about our unconscious belief systems. Take your feelings seriously without judgement whilst remembering that our brain can lead us to believe our feelings. Try and capture your feelings immediately, then your thoughts and behaviour. We can revisit what to do differently another time. Reflection and humility will be important to understanding ourselves as a leader.



Leadership looks easy until you try it. Use supervision and colleagues who can help and support your growth as a leader. Keep a journal. Own your mistakes and never bully or blame others. I'm writing and still reflecting on my own leadership. I have a long way to go myself, I am human and continue to grow each and every day. Those I have led will know of my success and my mistakes. My childhood beliefs still get activated which in turn leads me to feel and behave in ways I would rather not. Good trusting supervision helps me to identify thoughts, feelings and behaviours. On my own and in supervision I can find ways to construct new thoughts, behaviours and beliefs to program my brain into other ways of being. Always working towards being a better person and leader.

If we lead in any capacity we need to be excellent. We owe it to ourselves and others to continue to strive for change.

**Elaine Davies is BABCP-Accredited and Senior Lecturer at Coventry University**



*Leaders have problems every day but discuss them less than they ought to. Many leaders - particularly new leaders believe that they have the answers to all the problems. They do not and should not.*



news extra

# Member feedback

You should have received emails from us recently asking for feedback on two initiatives - our new Draft Strategy and Membership Consultation Policy.

If you haven't managed to get in touch yet, there is still time to do so. To give us your feedback on the Draft Strategy, you can email us at [strategy@babcp.com](mailto:strategy@babcp.com) by Monday 4 March.

The Membership Consultation Policy is due to be launched later in March, and feedback on this can be sent to [consultation@babcp.com](mailto:consultation@babcp.com) no later than Friday 8 March.



If you want something to listen to or to recommend to patients, don't forget we have a whole series of BABCP podcasts available on the different types of CBT. More is coming soon on the range of difficulties that CBT can help with. You can download the full set so far at <http://letstalkaboutcbt.libsyn.com>

# Training delivery at Gulu.



In the September 2018 issue of CBT Today, we introduced readers to the Gulu-Sheffield Mental Health Partnership. Here, **Catherine Kemp**, who delivered training at the project in November 2018, reflects on her time in Uganda.



Many cultural beliefs impact on suicide prevention, such as bad spirits, a cursed clan/family line. There are practices to cleanse the area after suicide, such as sprinkling goat faeces in a home or the blood of a sheep, uprooting a tree and burning it, or burning a temporary structure if a suicide is enacted there. The body will not receive a proper burial ceremony and in some cases the body may be abused by local police. Families may turn to local witch doctors or raise money in the clan to try to end the lineage of suicide within a clan. There are legal issues around Suicide, which Christian religion interacts with. So those who attempt suicide are liable to imprisonment and court judgement. This is due to one of the 10 commandments being 'Thou Shalt Not Kill'.

In the post war era in Northern Uganda suicide is high. There is a high prevalence of mental illness; especially in Abwoch and other nearby villages which were a regular route used by the Lord's Resistance Army; an insurgency group which terrorised local populations from the mid 1980s until recently. Some men (and some women) became addicted to alcohol through loss of role, stress and boredom in the government displacement camps. This for some led to financial, social issues and suicidality. It also led to regular domestic violence against some women, due to increased aggression by their male family member, which led some women to contemplate or enact suicide.

The pilot Suicide awareness training which was based on the WHO community engagement toolkit for Suicide Prevention and the Zero Suicide Alliance's recommendations in the UK was well received. Over forty community members attended of all ages and both genders in roughly equal numbers. It focussed on advice giving about strategies for working with suicidality. The advice was around asking if a person is feeling suicidal and coming up with an action plan. Key points in the action plan



were removing access to means and identifying who in the community can help. Also following up with the person after the immediate crisis to check they are continuing to improve in their mental health and take steps towards addressing any stressors which may have led to their suicidality.

It largely used discussion in large and smaller groups to generate ideas from the community themselves about suicide prevention. Some barriers were mentioned by the attendees such as aggression and refusal to accept help. However a number of solutions were generated such as peer support groups and a peer visiting service should a vulnerable individual be identified. Informal occupational therapy was also highlighted as key to community cohesion and social support, and possible income generation, such as beadmaking and tailoring, drama, dance and song, and sports such as football and basketball. Other small business initiatives were also discussed such as tree planting and a piggery.

Local stakeholders were identified which included local leaders (LCs), teachers, health care workers and informal local counsellors, police, religious leaders amongst others. A macro challenge that was identified was that these organisations themselves may not be trained in suicide awareness and prevention. With one participant voicing that it is not until Health Care Centre 4 (of stepped care model) are psychologist/psychiatrists present; with the villages only being able to easily access Health Care Centre 1&2. Likewise, having spoken to a psychiatrist and university lecturer at

Gulu Regional Referral Hospital Mental Health Unit, not all staff at a regional level are sufficiently trained in suicide awareness and prevention. Therefore, there are clear gaps in provision even if an individual with suicidality tendencies were to access local or regional care.

Positive feedback was given about it being a comfort to feel supported with this prevalent local issue and people said they felt more confident in knowing what steps to take to address suicidality within the local community. People were open about their experiences on mental health and suicide personally and as carers. I believe that the role of Mental Health Uganda (Uganda's service user organisation) as facilitators was key with this. They likewise were candid in their experiences of suicide as carers and service users, modelling open discussion and hope for recovery. It was exactly the key message of the training, that communication is essential for recovery, alongside accessing much needed social support from the community and local stakeholders.

The training looked at the detrimental impact of high suicide rates on the community as a whole. It encouraged a need to adapt some ideas about suicide to reduce stigmatisation and encouraged community responsibility and ability to change current levels of suicide in Abwoch.

More information on the Gulu Sheffield Mental Health Partnership can be obtained by contacting Partnership Clinical Lead, [kim.parker@shsc.nhs.uk](mailto:kim.parker@shsc.nhs.uk)

“

The pilot suicide awareness training which was based on the WHO community engagement toolkit for suicide prevention and the Zero Suicide Alliance's recommendations in the UK was well received.

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# There's something wrong with our pipeline

*There has been a lot of discussion recently, not least at the 2018 BABCP conference, regarding the transfer of knowledge between clinical research and clinical practice, writes **John Barber**.*

Whilst this problem is far from new, there seems to be a consensus that difficulties have escalated over the last decade or so.

Reports of the crisis highlight two aspects. The first is about time-to-market: Even in the USA it is estimated that new psychotherapeutic interventions “languish for 15-20 years before they are incorporated into usual care”. If you think this is a shocking statistic, you might like to consider that even such a key invention such as the Clark model of panic has taken this sort of time to filter into the treatment plans of the average UK mental health practitioner.

The implication is that clients with significant mental health needs may spend a significant part of their lives without ever accessing state-of-the-art therapeutic techniques. The second aspect is perhaps more insidious and concerns a growing cultural divide between researchers and practitioners. Whilst the former are usually trained in scientific method the latter are often not even deterministically minded, and this represents a chasm between the culture of practice and the culture of research.

It is said to be growing. In 2006 Ann Garland and colleagues noted that “the extent of polarization and the explicit rancour is being portrayed as greater than ever....the issue driving the wedge of the conflict is the implementation of evidence-based treatments in practice.” To use a simple metaphor: the knowledge is being broadcasted, but the receiving sets are tuned to a different channel.

I need to confess an interest. Rather unusually I parachuted into CBT after a main career as a research scientist in a multinational fmcg (fast-moving consumer goods) company. In industrial research, transfer of benefit to the consumer is an obsession, and it is probably the area where this sort of expertise is most highly developed. So I

want to share some insights from that perspective, but also from the position of someone who is no longer working in research, but on the other side of the hill as a practising CAMHS CBT therapist.

## Making the analogy

It is tempting to think that the twin menaces of slow speed of delivery and cultural divide are related, the former being caused by the latter - I don't think so. There has always been a divide between thinkers and doers, and also some degree of mutual contempt. Even in fmcg this is apparent, the thinkers regarding the doers as cloddish delivery vehicles, and the doers regarding the thinkers as out-of-touch with practicalities. Yet this does not stop complex innovations travelling from laboratory bench to millions of homes via regulators sometimes within months. No, the culture divide is a common tension in all sorts of enterprises (shades of CP Snow) and will therefore not do as an explanation for our current problem. It is to organisational and systemic issues that we must look.

In fmcg there are specialised units whose job is to manage technology transfer. Researchers may still publish their papers in academic journals, but nobody would dream that this was an end to their responsibilities; that is just proof of concept. They must liaise with transfer specialists to scale, package, and market what has by then become a product.

Where are the analogous processes in clinical psychology research? Who for instance are the overarching transfer bodies? Certainly not NICE. NICE is what would be called a transfer gateway: it certainly does not have governance over the transfer process. What about university external liaison bodies and spin-off companies? We certainly have good examples of psychology research being ‘packaged’ for web delivery and very effectively marketed, but the aim here is

financial return not dissemination for the public good.

What we need is a continuous pipeline of best practice right through the system which does not rely solely on traditional publication as the sole means of dissemination. At the moment we have no such pipeline but the occasional bucket of water lands on your doorstep if you are a lucky therapist who knows how to recognise it.

The key to systemic change lies in identifying where responsibility for change lies. Undoubtedly, we have a responsibility vacuum here. However, every vacuum is also an opportunity to occupy free space, and you only need to advance a step at a time to get going. What about, for instance, a research digest which packages research into language that therapists can understand? What about an accompanying forum whereby practice experience can be returned to researchers in order to breed collaboration? Where are the communities of practice, those vital organs of knowledge management that are known to short-circuit blocked pipelines? All these things can be organised or sponsored at the supply end of the pipeline, much to the benefit of research departments.

I mentioned earlier that psychotherapists – even some CBT practitioners are not fully attuned to the output of scientific research. If researchers have a responsibility to package, we practitioners have a similar responsibility to unwrap what is offered us. Of course, not all of us have an understanding of F-ratios, confidence intervals, effect sizes etc. necessary to do a lot of this. Nevertheless we have a role, and to explain it I need to expand a little on the sub-processes within transfer.

## Gates

Every transfer process consists of gates specifically designed to weed-out weak and risky proposals. They are all slightly different, but they can be condensed into the following questions that can be applied to any innovation:

1. Is the science true?
2. If it's true, will anyone notice the benefit?
3. If it's true and delivers noticeable benefit, will the delivery scale?
4. And if it can do all these, will the cost/benefit make it all worthwhile?

The question then devolves to whether these gates are working properly for us. Let's dispose of the early ones, because they are met by invoking relatively standard existing practice. Number 1 is obviously a matter of validity and reliability and we note here that there are increasing concerns that publication of results is not necessarily a reliable indicator of quality.

Number 2 is equally well-catered for by standard practices eg the assessment of statistical effect sizes. I do not wish to dwell on these, for it is not here that I feel we need to look for blockage in the innovation pipeline. Moreover, NICE has a handle on 1,2 and 4, for its demands for multiple well-designed randomised control trials and credible scientific

foundations are designed to form very strict gateways to technology transfer for the protection of society.

One might grizzle about the strictness of the NICE guideline process, but ultimately those processes are there for very good reasons. Loosening their criteria will not solve our problems of getting research to market.

It is Number 3, scaling, I wish to draw attention to. In fmcg scaling is a matter of bulk production, packaging, advertising, and confirming in the real world that what is seen in the lab. Now our analogies get interesting because I wish to assert that the scaling-up of research in psychotherapy is done via psychotherapists.

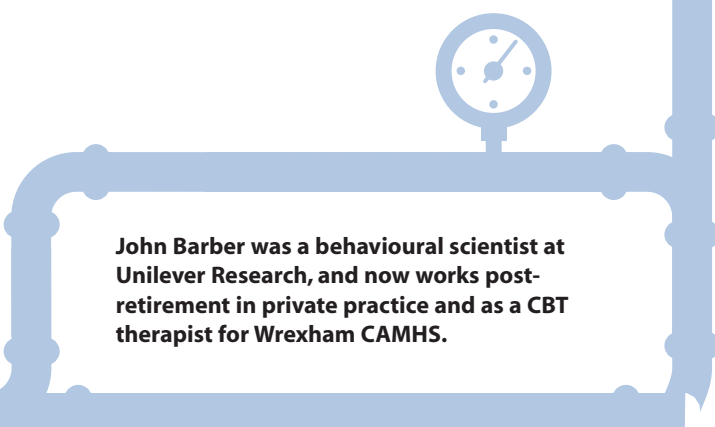
It is the Band 5,6 and 7 working therapists, both low and high-intensity workers, who are the real packaging and delivery agents of the transfer process. The ideas developed in university departments see light of day through the words and actions of professional psychotherapists behind the closed doors of therapy rooms up and down the country. The agents of rollout are ourselves.

We are therefore part of the dissemination process and have a responsibility to listen to research. However if we try to scale-up what is not in the pipeline we will get in a mess. There has recently been a case made for exactly this circumstance in relation to the rollout of mindfulness.

## Conclusion

So my propositions are firstly, that although clinical psychology is (especially in this country) a fabulously effective academic blue-sky research operation, as an applied research subject, it is alarmingly immature. Frustratingly it seems to me perfectly obvious that this subject should have a vibrant technology-transfer limb to function effectively for its major customer, the NHS. Yet this need is not reflected organisationally.

If you want to be a researcher you join an academic department and advance our understanding of mental illnesses and disorders. You can also suggest treatment protocols that arise from your research, but beware! The next part of the innovation pipeline is largely missing, and complaining that nobody is listening to you will not fill that gap. Secondly, a plea to my fellow practitioners: Don't run ahead of the game! Evidence is everything – especially in CBT.



**John Barber was a behavioural scientist at Unilever Research, and now works post-retirement in private practice and as a CBT therapist for Wrexham CAMHS.**

Cygnets Healthcare Beckton has a long-established and successful Adherent DBT programme, writes **Dawn Miller**, with clinical outcomes being commended at the 2017 Society for DBT Annual Conference, and their DBT Team awarded the APT Award for Excellence in Dialectical Behaviour Therapy Award in 2018.



## Adapting DBT to Increase Access for a Learning Disability Population

The Psychology service at Cygnets Healthcare Beckton noted an increase in the number of individuals diagnosed with Emotionally Unstable Personality Disorder (EUPD) being admitted to our Learning Disability service. While DBT is a NICE recommended treatment for those with EUPD there is a requirement for a certain level of intellectual and cognitive ability (IQ>70) in order for the material to be accessible and beneficial. As such the standard DBT program was not suitable for this growing population within our Learning Disability service.

In order to enable this client group to access the benefits of DBT we set out to develop an Adapted DBT programme, and we faced challenges along the way.

### **Balancing the dialectic of Adherence and Adaptation**

When setting out on this journey we were mindful that we had to ensure a balance between adaptation and adherence; adapting the material to enable access to this new population while also maintaining enough adherence to ensure the programme remained true to DBT and the underlying principles.

In order to do this we consulted with a wide range of individuals, bringing together specific DBT knowledge from our DBT Clinical Specialist and DBT therapists and specific Learning Disability knowledge from our Registered Learning Disability Nurses and our Speech and Language Therapist. This ensured we were able to draw together all the skills and knowledge to develop a synthesis of the two dialectics.

### **Adaptation of Group material**

The biologically predisposed limitations in cognitive functioning associated with learning disability impacts on the ability to acquire and execute new skills, so we had to think carefully about how to present new skills in the group and the most effective format of it.

Structural changes were made, such as shorter sessions in greater frequency over the week, focus on one element of a skill per session so as not to overwhelm individuals, and a focus on behavioural skills rather than those that are cognitively.

Existing DBT skills were adapted to reflect the essence of the original skill, using non-complex language and concrete examples. This was



reflected in the acronyms used to support the retention of new information. Practical exercises were utilised in session to increase engagement and experiential learning.

**Generalisation and Initiation of Skills**

As mentioned, those with a learning disability are likely to have difficulties, not only acquiring new skills but also initiating and executing new skills. There is therefore an increased reliance by the individual on the environment and external cues to aid initiation.

In order to support this within the ward environment a dedicated Adapted DBT team was set up, ensuring that individuals had an in-depth working knowledge of the skills and the ability to coach service users in their implementation.

In order to maintain the programme we have invested highly in developing the workforce and all staff on the ward have engaged in some form of DBT training. Staff say that training has not only developed their knowledge but has given them a new found sense of confidence when working with this client group, reducing restrictive practices.

To aid service user initiation each skill taught in the group was supported by a visual cue card that service users had with them day to day on the ward. This supported recall of the skill and prompted them with how the skill could be implemented. Examples are shown here:

Service users are also supported to build their own Crisis Calm Down box, or have access to the ward box, which contains a range of aids to assist implementation of Distress Tolerance skills.

Service users also had access to a weekly Peer Assisted Learning Session (PALS), a concept integrated from the R&R programme, which aimed to support them to recap the information taught in



the group session, aid them to complete their homework and coach them in behavioural practice of newly acquired skills.

**Individual session and Behavioural Chain Analysis**

Recognising the challenges faced by individuals from a learning disability population, in conjunction with our Speech and Language Therapist, we adapted our DBT Contracts, Diary cards, and developed visual aids to assist Behavioural Chain Analysis and Solution Analysis.

Diary cards were adapted with pictorial aids to encourage an understanding and recognition of the problem behaviour(s), the emotions and skills they used. Behavioural chain analyses were made interactive with each link of the chain being cut out so that individual could move the pieces around to complete a chain of events.

**Outcome**

The programme has shown positive results in relation to observable changes in service users behaviours and their ability to implement more effective ways in which to manage their emotional experiences.

**The Next Big Challenge - Outcome measures**

Now we have developed the programme to increase accessibility for a growing client population we want to find out if it actually works over and above the observations we have made.

Feedback has been positive and our current service specific outcome measures, for the LD population, demonstrate positive change, but we want to want develop a robust battery of psychometric assessments to specifically explore the areas targeted by the Adapted DBT programme in order to measure its efficacy.

We have successfully achieved this with our Adherent programme and our goal is to be able to report on the Adapted programme in the same manner with LD specific measures.

**Dawn Miller is a DBT Clinical Specialist/  
CBT Therapist in the DBT Team at  
Cygnet Healthcare Beckton**

“ Staff say that training has not only developed their knowledge but has given them a new found sense of confidence when working with this client group, reducing restrictive practices. ”



# “Has **IAPT** become a bit like Frankenstein’s **monster?**”

asks Jason Roscoe

*In Mary Shelley’s novel Frankenstein, the main character Victor (Frankenstein) sets out with good intentions - that is to regenerate dead tissue perhaps with the aim of improving the world rather than adding to its problems. Little did he realise at the time what he was creating. The monster took on a very different purpose to that which its creator intended.*

This may not be far off the current image of the IAPT project, an initiative developed by David Clark and Lord Layard with the economic argument of getting more people back to work and reducing the health burden of anxiety disorders and depression.

IAPT has without doubt changed the landscape of mental health care in England. It has led to increased awareness of talking therapies such as CBT and has provided evidence-based treatment to thousands of people who suffer from common mental health problems. Personally, I owe a great deal to IAPT as it allowed me to train as a Cognitive Behavioural Therapist and I am now involved in training high intensity therapists as part of the continuing IAPT curriculum.

The creation of Clark and Layard has unfortunately been transformed into something that does not always resemble what it should. The way that NHS Trusts and Clinical Commissioning Groups impose session limits that do not adhere to NICE guidelines makes one suspect

that Aaron Beck might cringe if he heard about how rigid CBT has become in England. Rather than being responsive and formulation driven, many CBT trainees describe a need to rigidly apply disorder specific protocols even when they do not fit the patient’s presenting problems.

I regularly hear from trainees that I teach and supervise about the restrictions placed upon them in clinical practice. Some are not allowed out of the clinic room to do in vivo exposure because a prolonged session affects targets for number of patients seen in a day. Some are not allowed to even talk about core beliefs with the clients for fears that it will lead to patient suicides. The gap between what the literature advises and what management allow seems to be widening leaving the patients as the ones who are being given sub-therapeutic, watered-down CBT.

The result? A revolving door where patients return in quick succession for multiple episodes of treatment with a different therapist each time because dose related treatment or booster sessions were not offered in the first place. The misconception amongst some that CBT is superficial and only a sticking plaster rather than a long-term solution will surely be reinforced by these patient experiences. Not only this but IAPT also seems to be making its own workers ill with reports of compassion fatigue and burnout not uncommon.

The solution? Can the monster be captured and brought back under control? If so, what would this look like? I don’t pretend to have all the answers but I do think that IAPT has become what it set out to change. If they are not careful there will be an even greater economic burden from burnt out therapists going off on sick leave or leaving the profession altogether.

**Jason Roscoe**

**In response to Jason's points, we invited BABCP Honorary Fellow and Past President David Clark to reply.**

I am grateful to the editor of *CBT Today* for giving me the opportunity to respond to Jason Roscoe's thoughtful and concerning letter.

Before IAPT few people with depression or anxiety problems had an opportunity to have a course of CBT or other evidence-based therapy in the NHS. By training and employing over 10,500 new therapists IAPT has greatly increased public access to psychological therapy. It has also created unprecedented public transparency about mental health services.

Almost everyone (99%) who has even a minimal course of treatment (two or more sessions) has their anxiety and depression measured at the beginning and end of treatment. Service outcomes are available on public websites (see *NHS Digital's IAPT Annual Reports and Public Health England's Common Mental Health Disorders Profiles Tool*). Learning from this data has improved understanding of how to better deliver therapy and has enabled many services to progressively improve the help they provide to patients.

The latest data (see NHS Digital's Annual IAPT report for 2017/18) shows that around 550,000 people receive a course of treatment each year. Nationally, approximately seven of every 10 (67%) show reliable and substantial reductions in their anxiety/depression. Around five in every 10 (51%) improve so much they are classified as recovered. These are remarkable achievements that have improved many people's lives.

As CBT is by far the most common treatment in IAPT, the achievements are a stunning testament to the skill, hard work, openness to learning, and dedication of the thousands of BABCP members

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Before IAPT few people with depression or anxiety problems had an opportunity to have a course of CBT or other evidence-based therapy in the NHS.

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who work as PWPs or High Intensity therapists in IAPT services or who teach on IAPT training courses. Thank you. You are tremendous, and your work is widely admired, both nationally and internationally.

However, despite the successes, IAPT is far from perfect. It is clearly still a work in progress. To be fully effective, CBT needs to be delivered in an adequate dose and relapse prevention plans need to be developed with clients before they are discharged. Therapists have to be able to conduct out of office behavioural experiments and exposure sessions with their clients. Regular, good quality supervision and CPD opportunities should be available and services need to pay careful attention to the well-being of their staff, as well as that of their patients. Therapist workloads should not be excessive. Services should have written plans for supporting staff wellbeing which are discussed with the team and updated regularly. While these crucial features are in place in many IAPT services, Jason Roscoe's letter shows that they are not universal. This is a serious problem.

In order to help commissioners, service leads and staff further improve their services, NHS England has recently published a comprehensive and authoritative IAPT Manual which outlines the quality standards affirmed above and many more. I would encourage all BABCP members who work in IAPT to download a copy of the IAPT Manual and to use it as a basis for local, collaborative discussions that will help raise awareness, and implementation, of the quality standards that are so important for effective and sustainable psychological therapy services.

**David M Clark,**  
BABCP Honorary Fellow and Past President

**The IAPT Manual referred to here can be downloaded at [www.england.nhs.uk](http://www.england.nhs.uk)**

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The gap between what the literature advises and what management allow seems to be widening leaving the patients as the ones who are being given sub-therapeutic, watered-down CBT.

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Please note - no further correspondence on this will be entered into.



# Stalking and Mental Health

Stalking is as much a public health issue as a criminal justice problem and due to its ongoing and pervasive nature, stalking victims are amongst some of the most vulnerable and traumatised victims of crime, says **Ann Moulds**.

It is a crime that spans the gamut underpinning some of the worst forms of psychological abuse and if left unattended can escalate to others serious crimes such as; domestic abuse, child abuse, forced marriage, human trafficking and sexual exploitation, sexual assault, rape and murder.

Whilst there are certain visible, though not universal, trends in reported instances of stalking, research consistently concludes, the majority of stalkers are male, and the majority of victims are female.

Criminal Justice figures for England and Wales state that one in five women and one in 10 men will be stalked in their lifetime whereas in Scotland the 2016/17 Scottish Criminal Justice Survey figures show one in six men and women equally experienced stalking within a 12-month period. Sadly, only 20 per cent of victims choose to report to the police

Stalking is the repeated unwanted intrusion of one person into the life of another in a manner that causes untold disruption, damage, anxiety, fear and distress.

My own experience of being the victim of a stalker highlighted the devastating impact this crime had on every aspect of my life. The year was 2004. At that time there was no such crime of stalking within Scottish law and the very few cases that

came before the courts were usually treated as a misdemeanour, overlooking the fact that stalking is a serious form of psychological abuse, with the propensity to escalate to physical violence. At that time fear, alarm, psychological impact and abuse were not recognised within criminal law.

My stalker - a man who I barely knew - chose to remain anonymous throughout his two-year campaign of terror. When I first reported to the police, I was met with dismissive, gender-based and derogatory attitudes. Because I was a single female, it was assumed my stalker was some ex-boyfriend, and I was made to feel I had been out there attracting the wrong type, bringing into disrepute my personal and social activities.

None of the officers I came into contact had any understanding of this type of crime, or the impact this was having on every aspect of my life and despite the escalating warning signs, I was constantly reminded he would have to attack me first before anything could be done. Stalking is not a physical crime, but a psychological crime where many of the behaviours that constitute the offence are not criminal acts within themselves. It is the chronic and compounding nature of the behaviours that plays a significant role in its contributions to its victims' psychological distress.

Cross jurisdictional research on victim impact coupled with anecdotal evidence all share in common that stalking is deleterious to a victims' mental and physical health and wellbeing. The 2017 Network for Surviving Stalking Victim's Voice Survey highlights the impact of stalking - long-term psychosocial damage to victims, with victims reporting anxiety, depression, panic attacks, and other mental health disorder including self-harm, suicide and attempted suicide, eating disorders and substance misuse. Engaging with the criminal justice system can often compound the trauma.

Living with constant fear and uncertainty soon took its toll. I suffered increasing anxiety, low mood, feelings of helplessness and despair. The longer the stalking continued the greater the impact this was having on my emotional, psychological, social and financial health and wellbeing. My work started to suffer. Being self-employed I couldn't afford to be off sick. I had responsibilities, bills to pay, a daughter at university. It took everything I could to keep going. Eventually too scared to leave the house, my health started to deteriorate.

Friends did try to support me, but it was obvious they had little or no understand the impact this was having on every aspect of my life or the fear I was living with otherwise, they wouldn't have continually told me to 'get a dog' or just move to a new house'. Fed up with their glib responses, I soon lost contact. It is understandable why victims of

stalking soon become lost and isolated in their own world of darkness, rendering them even more vulnerable to the stalker's intrusions.

I sought help from my GP who prescribed anti-anxiety medication. I sought support from victim support agencies and counselling through the NHS, but one seemed to have any understanding of this crime, the risks I was facing and how best to manage these risks.

Eventually my stalker was identified and charged, but he continued his behaviour.

It took over 15 months for my case to come to trial, time in which my stalker played the system to his advantage and at the last minute, he chose to enter into a plea bargain. I would have liked to attend a court trial where the full extent of his behaviours would be open to the judgement of the court, but I was denied that opportunity. During sentencing, I sat as a spectator listening as the defence put forward a strong plea for mercy; presenting my stalker as a good citizen and a hard worker, who had made nothing more than an honest mistake. To this day, the Sheriff has never heard my voice, or what it was like for me, or my role in society as a good mother and a decent and hardworking citizen.

In spite of a social work report stating a risk of reoffending, the sheriff decided my stalker was not a danger to the public, and with a lenient sentence he walked out of court.

I was determined that what happened to me must not be allowed to happen to another person. In March 2009, waved my right to anonymity and I launched my award winning national and international campaign 'Action Scotland Against Stalking'.

I was determined that stalking should be recognised as a distinct and serious crime within Scots law and to give victims an identity and a voice within the criminal justice process.

*Continued overleaf*

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*Living with constant fear and uncertainty soon took its toll. I suffered increasing anxiety, low mood, feelings of helplessness and despair.*

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# Stalking and Mental Health

Continued

In 2010, the 'Offence of Stalking' sec 39 Criminal Justice & Licensing (Scotland) Act (2010) ASAS soon became a national and international campaign driving forward major ground-breaking achievements. In 2012, England and Wales introduced two new offences of stalking into the Protection of Freedoms Act 2012, and the introduction of Stalking into the Council of Europe's European Convention to combat Violence Against Women and Children in March 2012 places a requirement of EU member states to codify stalking as a singular offence into criminal law.

The classification of stalking as a victim defined crime which recognises psychological abuse as a governing criterion of an offence and has been a major step forward in advancing the rights of victims. The work of ASAS triggered a new wave of legislative and criminal justice reforms across the UK. As a founder member of the Victim & Witnesses Collaboration forum, working with the Scottish Government to over view the drafting and implementation of the Scottish Governments Victim & Witnesses Act (2014), which recognises stalking victims as a specific category of vulnerable victims, with entitlement to Justice & Safety as outlined by the SCHR Scotland's National Action Plan for Human Rights.

Working with stalking victims requires specialised knowledge and currently there is little in the way of specialised support services for victims of stalking within the UK. Given the prevalence of this crime within our society, more and more victims will be seeking professional support. Unfortunately, counselling support for psychological abuse does not hold a specialised place within the prescribed protocols of NHS Psychological services forcing to engage with voluntary services and seek private counselling support.

Research shows CBT can be particularly effective in helping victims manage their anxiety, cope

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Working with stalking victims requires specialised knowledge and currently here is little in the way of specialised support services for victims of talking within the UK.

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with uncertainty, work with unhelpful avoidance behaviours and the disruption of schemas around trust, safety and relationships.

The development of specialised training for CBT therapists in supporting victims of stalking would be a major step forward in helping reduce the impact of this crime on its victims. As well as helping the victim manage the emotional and psychological effects, therapists should be trained in understanding what stalking is, what constitutes the offence, stalking typology and pathology, an understanding of the law, dynamic risk factors, victim safety planning and helping victims manage dealings with their stalker.

Stalking victims often present with feelings of despair, loss of control, a sense of blame and guilt, helplessness and vulnerability. Therapists must be careful about counter transference reactions when working with this particular cohort of victims that can possibly interfere with therapy.

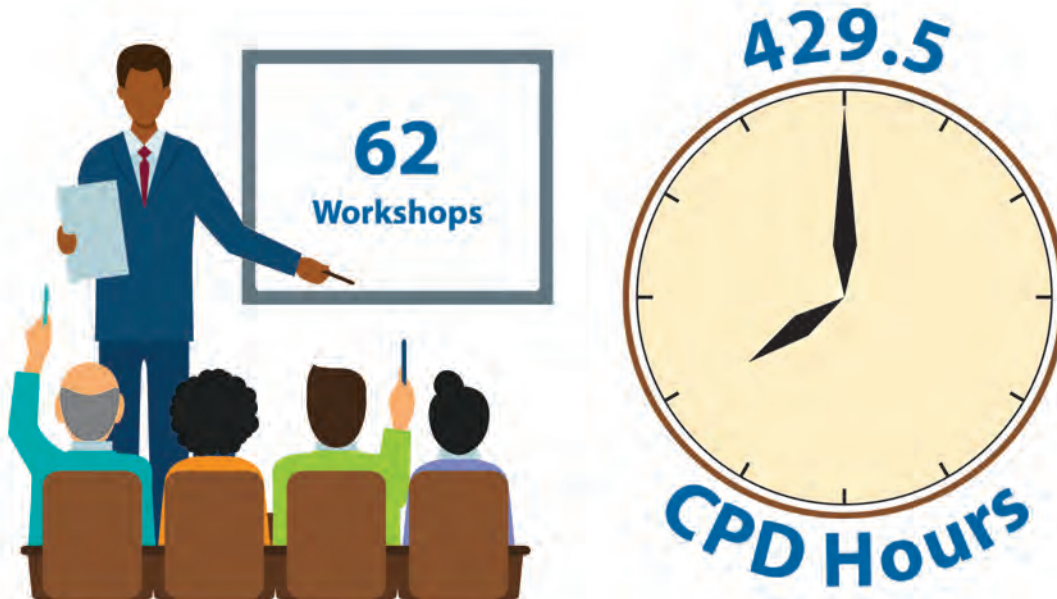
**Ann Moulds is a BABCP-Accredited CBT Psychotherapist, founder and CEO of Action Against Stalking, and has recently joined as a committee member of the BABCP Women and Gender Minorities Equality Special Interest Group.**

**Action Against Stalking (formerly Action Scotland Against Stalking ASAS) is a national and international charity which leads the way in advancing recognition of stalking, championing the rights of stalking victims globally and supporting those who are or have been victims of stalking and related predatory crimes. AAS is able to offer CPS certified training packages on all aspects of stalking. For further enquiries please contact [enquiries@actionagainststalking.com](mailto:enquiries@actionagainststalking.com)**



# Did you know...

That last year our fantastic network of branches and Special Interest Groups provided CPD opportunities across the UK and Ireland to more than 3000 CBT practitioners. Here are the standout figures from the workshops delivered in 2018. You can always see our latest workshops online at [www.babcp.com/events](http://www.babcp.com/events)





# Cultural Adaptions

*In January, BABCPs Equality and Culture Special Interest Group hosted the launch of the Cognitive Behaviour Therapist Journal Special Issue on Cultural Adaptations of CBT. Saiqa Naz wrote about the day.*



This event was exciting for the Equality and Culture SIG as we had fabulous speakers lined up, as well as launching the journal Special Issue, where some of our SIG members had their first articles published.

The theme of the day was 'Why behaviour change is required for inclusion and all of our wellbeing'.

Why did we choose this title? As a SIG we recognise that people often talk about the need to improve care for BAME communities in mental health services, but there does not seem to be enough commitment to drive the changes that are required to improve care for BAME communities and to demonstrate that people are sincere in their words. This is perpetuating the problem of BAME communities having poorer outcomes in primary mental health services and being overrepresented in secondary care.

Also, by focussing on BAME communities who continue to have poorer outcomes in mental health services and are overrepresented in secondary care services, we can improve care for all diverse groups including the elderly, LGBTQ communities, men, working class communities and people with physical health problems as BAME communities within these diverse groups will also be the most disadvantaged.

The day started with an arrival mindfulness meditation delivered by Meera Bahu.

## **Using data to describe ethnic inequalities in IAPT**

Lynne Carter, an Equality and Diversity manager was our opening speaker, introducing us to her research and how both men and women from Black and Asian backgrounds were not accessing IAPT services in line with the needs of that community, and of those who did enter IAPT, their recovery rates were lower. We look forward to Lynne and her team publishing this research.

## **Recognising and Promoting Diversity in CBT Research, Practice and Training**

Editor-in-chief of the Cognitive Behaviour Therapist journal and co-author of Reflection in CBT, Richard Thwaites talked about the Special Issue and shared data about its reach, with people from countries as far as Saudi Arabia having accessed the articles. Richard also spoke to attendees about the support they require to encourage them to write articles.

We invited Richard to deliver this session due to the lack of literature on working with diverse communities, hence the Special Issue on cultural adaptations. This is important as literature is what informs our practice of working with diverse communities and can influence national policy as well decisions made locally by commissioners and service managers. We hope to do more on this in our next SIG event. We will share the details once we have planned this.



## Gender inclusive practice - Why is it important and how do we do it?

Rachel Phillips, co-chair of the Women and Gender Minorities Equality SIG talked about the importance of having gender-inclusive practices including how we capture data that is reflective of the LGBT community. It is important for therapists to explore the experiences of our LGBT communities just as we may ask BAME service users about their experiences of racism.

## If you wait for the perfect conditions, nothing will get done

Kat Alcock, Clinical Psychologist, Principal clinical tutor and founder of the Division for Clinical Psychology's BME mentoring scheme shared her research about the under-representation of the BAME community in clinical psychology training and her experiences of supporting them. This included using a blueprint to go into schools to talk about the clinical psychology profession. I think this is an idea that can be adopted by the CBT profession to support and develop the next generation of CBT therapists to enter the profession. This is especially pertinent for working class areas like my hometown of Rochdale where there are limited opportunities for young people to gain relevant experiences that will support them to enter the psychology profession.

## Cross-cultural validity of psychological interventions offered by IAPT services to people from BME groups

Afsana Fahim, a visiting lecturer at Birmingham City University is currently looking at IAPT data with regards to the BAME community introduced us to some of her findings, though this is yet to be published.

## Advancing equality and tackling health inequalities: the role for commissioners

Maqsood Ahmed who has worked as Head of Equalities for the Home Office and Director for Inclusion and Equalities for NHS Midlands and East, was invited to talk about the role of commissioners in helping to reduce inequalities in mental health services. He highlighted the lack of accountability of senior leaders in mental health services and commissioners for being in breach of the Equality Act.

## Why a diverse and inclusive workforce is good for patient care

We were delighted Roger Kline, author of the *Snowy White Peaks* and joint Director of the NHS Workforce Race Equality Standard (WRES) team from 2015-2017, was able to join us and talk about an inclusive NHS workplace culture and its benefits. For those not familiar with Roger's work, we would encourage you to read his work which is readily available online. He talked about BAME staff more likely to face disciplinary action and how managers'

behaviours of avoiding having difficult conversations with their BAME staff may be a factor influencing this.

With more inclusive leadership and a workforce that better represent the communities in which we live and work in, we invite an array of ideas to care for the needs of diverse communities which will improve the experiences of our service users and the workforce and inevitably be more cost efficient.

## Challenges and excuses in organisations

BABCP President Paul Salkovskis spoke about challenging excuses in organisations, explaining SEP - Somebody Else's Problem and the need for us all to take ownership. He also talked about tackling institutional, cultural and structural problems at the level of systems and individuals, and empowering organisations and systems.

As therapists we can work in oppressive structures and institutions. We have a choice to challenge those practices. By staying silent, we inadvertently become complicit in those oppressive practices which put at odds with the values of our profession. This includes services capping CBT sessions to 6-8 sessions in some IAPT services when the recommendations in the IAPT manual states "The number of sessions offered should never be restricted arbitrarily." Such actions are not only unethical but undermine the ethos of IAPT and NICE guidance.

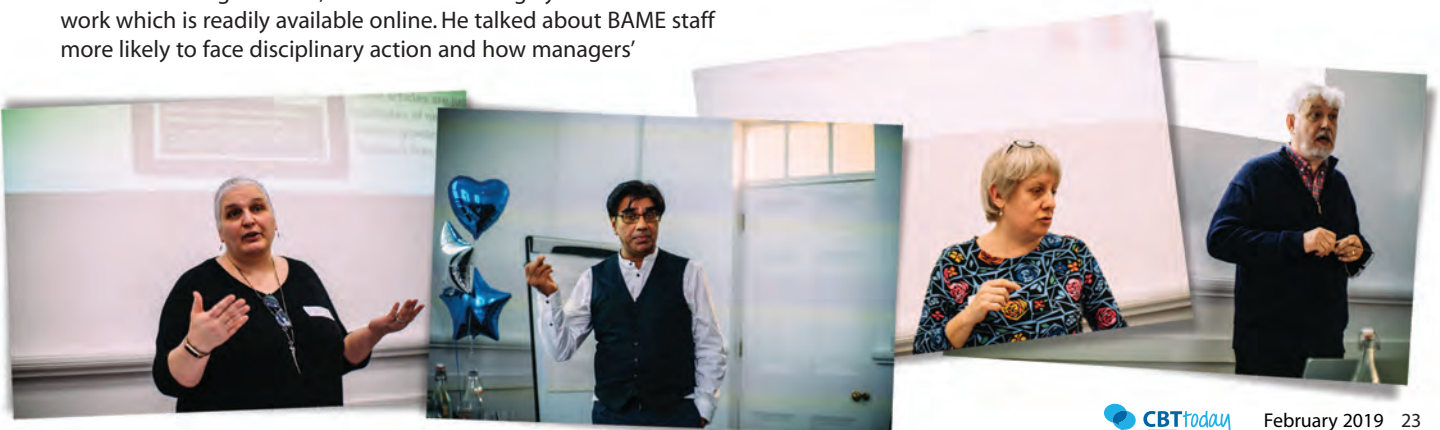
We were fortunate enough to have Javed Rehman, a Person with Personal Experience (PEP) join us on the question and answer panel. He talked about his experiences of mental health services and being referred to Prevent, although nothing came of this. Javed is now a service user representative advocating for improved care in mental health services for all communities.

Our future plans include launching the IAPT BAME Positive Practice guide in April 2019, helping therapists to use it and implement it in their services, as well as continuing discussions with others in BABCP about how to embed inclusion into the culture of the organisation.

Overall, a commitment is required by all of us to live by the values of our profession to enable us to do any of the above. I appreciate it is not always easy, but it is doable if we all work together and share the responsibility.

**To join the Equality and Culture SIG, please email [equality-sig@babcp.com](mailto:equality-sig@babcp.com)**

**For more information the tCBT Special Issue please see follow [@theCBTjournal](https://twitter.com/theCBTjournal) on twitter**



East Kent Coastal Branch  
presents

## Compassion Focused Therapy from the inside out

with Tobyn Bell



26 March  
Faversham

Eastern Counties Branch  
presents

## Treating Disgust across the Disorders

with Professor David Veale

21 March  
Ipswich



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Manchester Branch  
presents

## Cognitive Behavioural Analysis System of Psychotherapy – Innovative treatment for persistent depression

with Erin Graham and Jonathan Linstead

12 April  
Manchester

CBT Medics SIG  
presents



Prescription:

Medics in CBT  
Fourth Annual  
Conference

15 March, Leeds

**Couples SIG**  
presents

## Interventions for Anxiety

with Don Baucom

18 March  
London

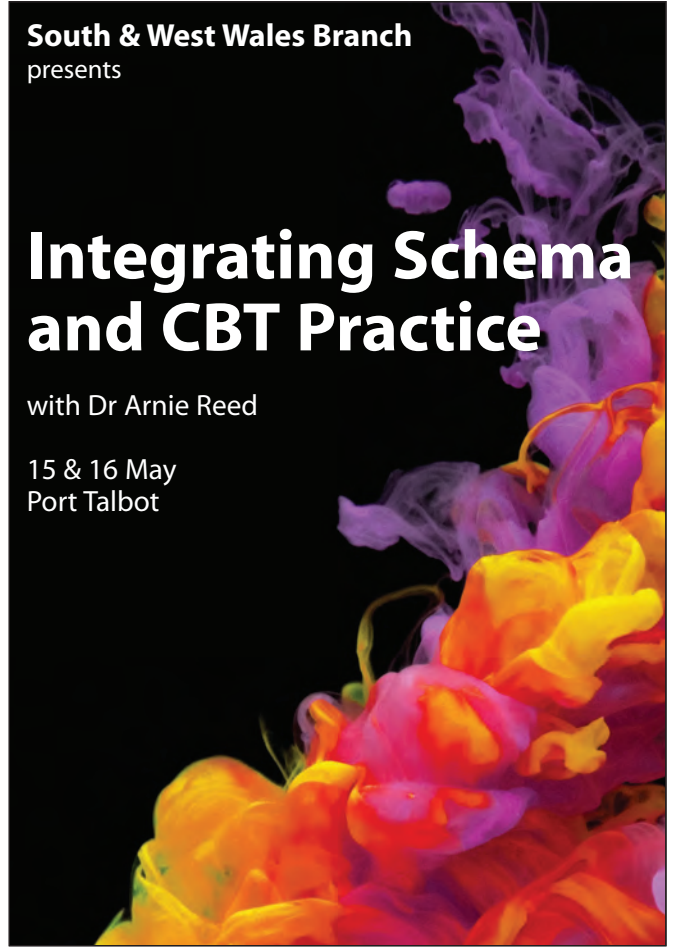


**South & West Wales Branch**  
presents

## Integrating Schema and CBT Practice

with Dr Arnie Reed

15 & 16 May  
Port Talbot



To find out more about these workshops, or to register, please visit [www.babcp.com/events](http://www.babcp.com/events) or email [workshops@babcp.com](mailto:workshops@babcp.com)

**South East Branch**  
presents

### CBT for OCD

with Jolyon Poole - 21 March

### CBT for Health Anxiety

with Triona McInerney - 23 May

### CBT for Body Dysmorphic Disorder

with Anna Smith  
19 September

### CBT for Social Anxiety

with Dr Robert Medcalf  
21 November

All events are in Sevenoaks

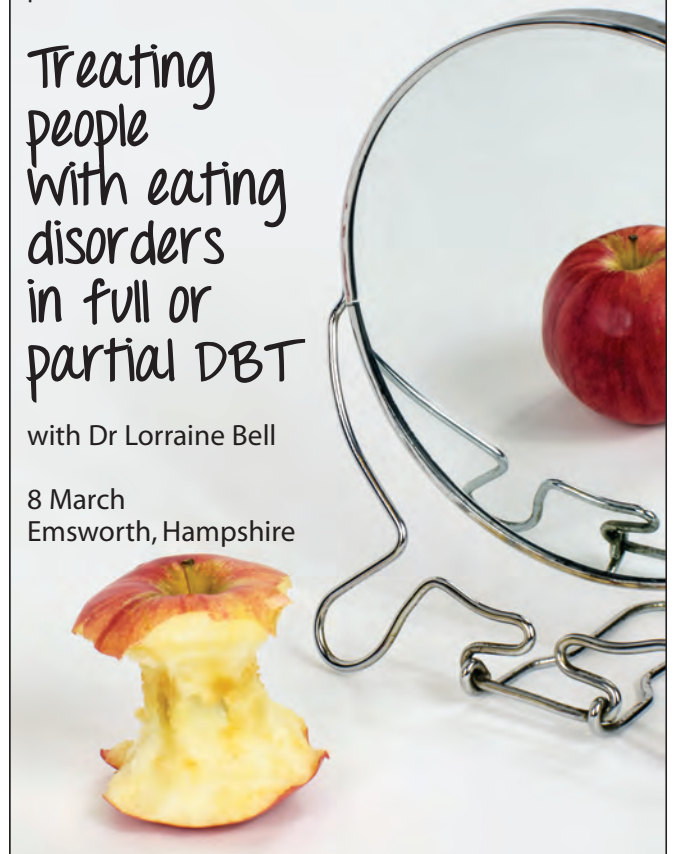


**Dialectical Behaviour Therapy SIG**  
presents

## Treating people with eating disorders in full or partial DBT

with Dr Lorraine Bell

8 March  
Emsworth, Hampshire



**North East & Cumbria Branch**

presents

## Trauma Focused Cognitive Therapy for PTSD

With Dr Nick Grey

10 & 11 April  
Grasmere



presents

## Working with suicidal thinking and self-harm behaviour

with Professor Kate Davidson

7 March  
Cardiff

To find out more about these workshops, or to register, please visit [www.babcp.com/events](http://www.babcp.com/events) or email [workshops@babcp.com](mailto:workshops@babcp.com)

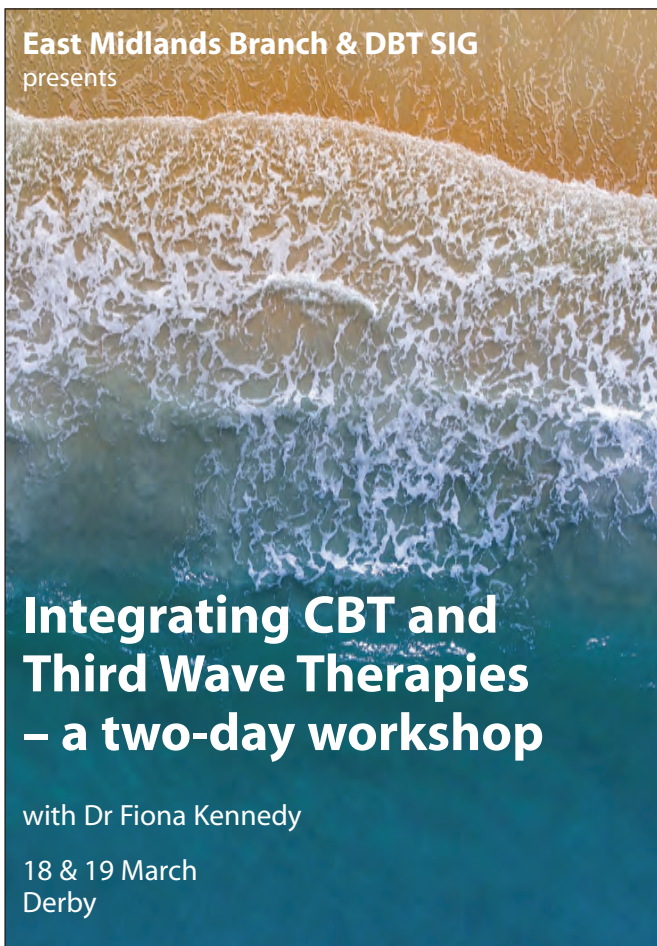
**East Midlands Branch & DBT SIG**

presents

## Integrating CBT and Third Wave Therapies – a two-day workshop

with Dr Fiona Kennedy

18 & 19 March  
Derby



**North West Wales Branch**

presents

## Turning a thought into a feeling – Using Compassion Focused Therapy to enhance CBT

with Dr Mary Welford

5 April  
Bangor

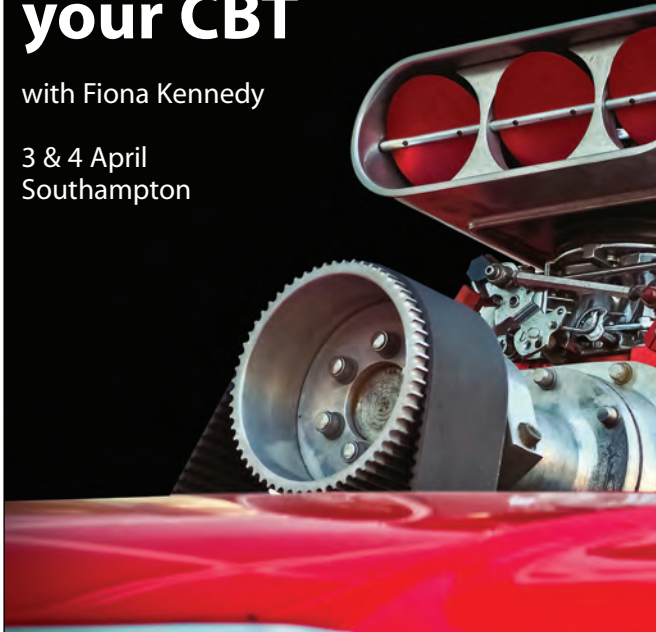


Southern Branch  
presents

# Supercharging your CBT

with Fiona Kennedy

3 & 4 April  
Southampton



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In our **FREE** online video training you'll learn:

- The perfect website template to generate a consistent stream of new client enquiries,
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# 9TH WORLD CONGRESS OF BEHAVIOURAL AND COGNITIVE THERAPIES

17th-20th July 2019 | Berlin

## Less than 6 months to go!

But it is less than 2 months before the Early Bird registration rate closes on 28th March so make sure that you don't delay your registration and save some money.

You can register on line by going to [www.wcbct2019.org](http://www.wcbct2019.org) where you can also download the Preliminary Programme.

**The World Congress (WCBCT2019) is returning to Europe for the first time in 12 years and will be organised by EABCT. The Congress will build on the success we achieved when the World Congress was run in Barcelona in 2007 and attracted over 3500 delegates. In 2019 you can expect to join a Congress of 5000 CBT practitioners from across the world.**



### **The Congress Programme**

The conference will run for three full days from Thursday 18th July-Saturday 20th July 2019 and there will be a programme of pre-congress workshops on offer on Wednesday 17th July. Details of the Invited Speakers and the Pre-Congress Workshops can be viewed on the website [www.wcbct2019.org](http://www.wcbct2019.org) and in the Preliminary Programme which you can download from the web. The Congress Theme "Cognitive and Behavioural Therapies at the Crossroads" addresses the reality that CBT is currently evolving at a rapid pace and in many directions, such that we may well be at the crossroads in terms of maintaining a unified field of theory and practice.

### **WCBCT19 e-news**

Keep Up To Date with news about the Congress by signing up for the WCBCT19 e-news by logging onto [www.wcbct2019.org](http://www.wcbct2019.org) and leaving your contact details.

**Andreas Veith and Rod Holland** | *Congress Organisers*

# Starts Spring 2019

## Certificate in CBT for Children and Adolescents

BPS Approved Certificate



Designed for SDS Seminars Ltd by Dr Andrew Beck, Consultant Clinical Psychologist, Honorary Senior Lecturer at the University of Manchester, Senior Lecturer on the Children and Young People's IAPT programme, a BABCP accredited CBT therapist and supervisor, a member of the BABCP Scientific Committee.

### Exclusive for 2019 – BOOK NOW

#### This comprehensive course consists of:

- 19 training days spread over 12 months
- 15 training modules (1 – 3 days long)
- 133 training hours
- Final Online Exam

#### You can attend:

- At BPS, London
- Via Live Interactive Webcast
- One – off or spread payment options

#### Highly qualified tutors:

- Dr Andrew Beck, Consultant Clinical Psychologist
- Lisa Anderson, Accredited CBT Therapist
- Dr Rebecca Linnell, Principal Clinical Psychologist
- Dr Angela Latham, Consultant Clinical Psychologist
- Prof Paul Grantham, Consultant Clinical Psychologist

#### On completion you receive:

- BPS Approved Certificate in CBT for Children and Adolescents
- SDS Accreditation in CBT for Children and Adolescents
- Certificate of attendance after each module

#### Course Modules:

- CBT: Introductory Course
- Reintroduction to CBT and Applying These Models to Children and Adolescents
- Working with Parents and Teachers
- Behaviour Difficulties
- Panic Disorder
- Separation Anxiety
- Generalised Anxiety Disorder
- School Refusal
- Behavioural Activation for Depression
- Treatment of Phobias
- Impact of Trauma and Post Traumatic Stress Disorder
- Social Anxiety Disorder
- Working with Selective Mutism
- Treating Tics and Tourette's Syndrome
- Working Across Cultures

#### How to Book:

You can book the whole course and save up to £528.

You also can book the modules one by one, and enjoy spreading your payments over a year.

**Available via Live Interactive Webcast or at BPS, London**

Book at: [www.skillsdevelopment.co.uk/CBT-Child.shtml](http://www.skillsdevelopment.co.uk/CBT-Child.shtml)

Email us: [info@sds-seminars.com](mailto:info@sds-seminars.com) Call us: 01825 763710



# Inside This Moment: Using Focused Acceptance Commitment Therapy to Promote Radical Change

Thursday 12th and Friday 13th of September  
with *Kirk Strosahl Ph.D & Patricia Robinson, PhD*



**A defining feature of ACT is the use of present moment/mindfulness based interventions to counteract the corrosive effects of emotional avoidance and cognitive fusion.**

Based on their books, *Inside This Moment* and *Brief Interventions for Radical Change* the workshop will focus on working in the present moment to bring alive Focused Acceptance and Commitment Therapy (FACT).

Join Kirk Strosahl, one of the founders of ACT and Patricia Robinson as they take you through a practical masterclass on how to use present moment skills to build rapid and powerful interventions.

Don't miss out on this rare opportunity to see two world experts in ACT present their powerful and innovative model.

To register, go to:

[www.contextualconsulting.co.uk](http://www.contextualconsulting.co.uk)

**Check out our  
other 2019 workshops!**

Also available by Webcast 

**Flexible Exposure Webinar**  
with Eric Morris - 28 Feb

**ACT in the workplace: improving  
employees' psychological well-being**  
with Paul Flaxman and Ross McIntosh  
14 & 15 March

**Introduction to ACT**  
with Joe Oliver, 28 & 29 March

**ACT for Grief Webinar**  
with Ray Owen, 12 April

**Enhancing your ACT practice with  
Relational Frame Theory (RFT)  
- a Masterclass**  
with Yvonne Barnes-Holmes  
10 & 11 of October

**ACT for Young People**  
with Louise Hayes, 14 & 15 November





Collaborations between OCTC and the University of Oxford,

*Our new programme provides an accessible and flexible format of CBT training, well suited to the needs of contemporary mental health practitioners, whilst maintaining the 'gold-standard' delivered over the past two decades.*

### Postgraduate Certificate in Cognitive Behavioural Studies

*Course Lead: Dr Sarah Rakonsnik*

This course aims to equip researchers and practitioners with knowledge of the models and theories used in CBT treatment and supervision; it comprises 20 days of teaching over two years. The course does not aim to prepare students to practice, teach or supervise CBT. Instead, the emphasis is on acquiring and understanding of the theory and practice of CBT treatment and supervision, within an explicit theoretical framework in relation to associated empirical research.

### Postgraduate Certificate in Cognitive Behavioural Therapy

*Course Lead: Dr Sarah Rakonsnik*

The course aims to equip practitioners with the CBT skills necessary to implement evidence-based treatment for the most common psychological disorders. The course is open to all mental health professionals with at least one year's experience of supervised clinical practice. It comprises 20 days of teaching over two terms, including weekly supervision groups.

### Postgraduate Certificate in Enhanced Cognitive Behavioural Therapy

This course is open to mental health professionals with at least 2 years of supervised clinical practice and the equivalent of the University of Oxford Postgraduate Certificate in CBT.

Choose from one of the following four areas:

**Complex Presentations** — *Course Lead: Dr Sarah Rakonsnik*

**Psychological Trauma** — *Course Lead: Martina Mueller*

**Psychosis & Bipolar** — *Course Lead: Dr Louise Isbam*

**Supervision and Training** — *Course Lead: Dr Helen Kennerley*

### Postgraduate Diploma in Cognitive Behavioural Therapy

*Course Lead: Dr Sarah Rakonsnik*

Having successfully completed the Postgraduate Certificate in CBT or the Postgraduate Certificate in Enhanced CBT, you can apply to progress to the Postgraduate Diploma in CBT. To complete this, you will take one of the courses not taken as part of the Postgraduate Certificate: Complex Presentations; Psychological Trauma; Psychosis and Bipolar; Supervision and Training. For further information on BABCP accreditation of the Postgraduate Diploma CBT, please see:

<http://www.babcp.com/Training/BABCP-Level-1-Accredited-Courses.aspx>

### MSc in Cognitive Behavioural Therapy

*Course Lead: Dr Sarah Rakonsnik*

The course offers clinicians who have successfully completed the Postgraduate Diploma in CBT an opportunity to carry out high quality research and contribute to the evidence base for CBT. This two-year, research based award provides the foundation for carrying out research and publishing an academic paper. On successful completion the MSc will subsume the Postgraduate Diploma in CBT where already received.

### Short Courses in Advanced Skills:

#### Research Skills

*Course Lead: Dr Sarah Rakonsnik*

Clinicians wishing to acquire a foundation in research design and methodology may attend the preparatory module of the MSc. Teaching and discussion will prepare students to develop a comprehensive proposal for research that can be carried out in their clinical setting.

#### Advanced Clinical Practice

*Course Lead: Dr Kate Rosen*

The course offers clinicians the opportunity to refine advanced clinical skills and to be brought up to date with the latest advances in practice. Masterclasses include 'Anxiety', 'Depression' and 'Assessing and treating more challenging presentations'. It comprises seven workshop days over two terms.

Short courses can be taken for a University of Oxford "Attendance only" certificate, or as an assessed course for 15 CATS points.

OCTC  
Warneford Hospital  
Oxford OX3 7JX  
Tel: 01865 902801  
www.octc.co.uk

For more information or bookings, & the rest of our programme, see the OCTC website.

# APT-Accredited Open Courses 2019

The Association for Psychological Therapies (APT) is a leading provider of training in mental health and related areas. The majority of our training is provided onsite (we come to you) but for a few of our courses you can come to us in Leicester (about an hour by train from: London, Birmingham, and Sheffield).

Date	Course Title	Price*
Various dates	<b>Extended Training in DBT (10-days)</b>	£1,375
4-6 Feb 2019	<b>DBT Essentials</b>	£450
12-13 Feb 2019	<b>Providing Good Clinical Supervision</b>	£325
27-1 Mar 2019	<b>CBT Essentials</b>	£450
4-7 Mar 2019	<b>The DBT Masterclass</b>	£575
13-15 Mar 2019	<b>Motivational Interviewing and The Stages of Change</b>	£450
18-20 Mar 2019	<b>DBT Essentials</b>	£450
21-22 Mar 2019	<b>Mental Health Awareness for Teachers in Primary Schools</b>	£325
26-28 Mar 2019	<b>ACT Essentials (Acceptance and Commitment Therapy)</b>	£450
2-4 Apr 2019	<b>CFT Essentials (Compassion-Focused Therapy)</b>	£450
13-15 May 2019	<b>DBT Essentials</b>	£450
10-12 Jun 2019	<b>Running DBT Skills-Development Groups</b>	£450
18-20 Jun 2019	<b>SFT Essentials (Solution-Focused Therapy)</b>	£450
16-19 Sep 2019	<b>The DBT Masterclass</b>	£575
17-19 Sep 2019	<b>DBT Essentials</b>	£450
24-26 Sep 2019	<b>IPT Essentials (Interpersonal Psychotherapy)</b>	£450
1-3 Oct 2019	<b>CBT Essentials</b>	£450
8-10 Oct 2019	<b>Motivational Interviewing and The Stages of Change</b>	£450
4-6 Nov 2019	<b>DBT Essentials</b>	£450
12-13 Nov 2019	<b>Providing Good Clinical Supervision</b>	£325
12-14 Nov 2019	<b>MoodMaster</b>	£1,000**
19-21 Nov 2019	<b>The DICES® Risk Assessment and Management System</b>	£450
25-27 Nov 2019	<b>Running DBT Skills-Development Groups</b>	£450

\*All prices exclude VAT (\*\*apart for MoodMaster, where VAT is included).

## 1-day courses:

Modular format means you can attend individual days for the majority of our open courses. For more information see [www.appt.ac/open](http://www.appt.ac/open)

## What's included:

- Coffee on arrival.
- Lunch and refreshments.
- Course workbook.
- Tuition.
- Certification.
- APT-accreditation and access to post course resources.

## APT Tutors:

APT tutors are senior mental health professionals (experienced Clinical Psychologists or similar), with an excellent academic knowledge, and an aptitude for presenting information in a way that makes it interesting and relevant.

Find out more, or book, at:

[www.appt.ac/open](http://www.appt.ac/open)

To discuss or book, contact us:

[www.appt.ac](http://www.appt.ac) t: 0116 2418331 e: [office@appt.ac](mailto:office@appt.ac)

**APT: applying best psychology to the clinical setting.**

APT is the UK's world class provider of training for professionals in mental health and related areas. Over 100,000 professionals have attended APT courses.



The Association for Psychological Therapies