Volume 47 Number 3 • October 2019

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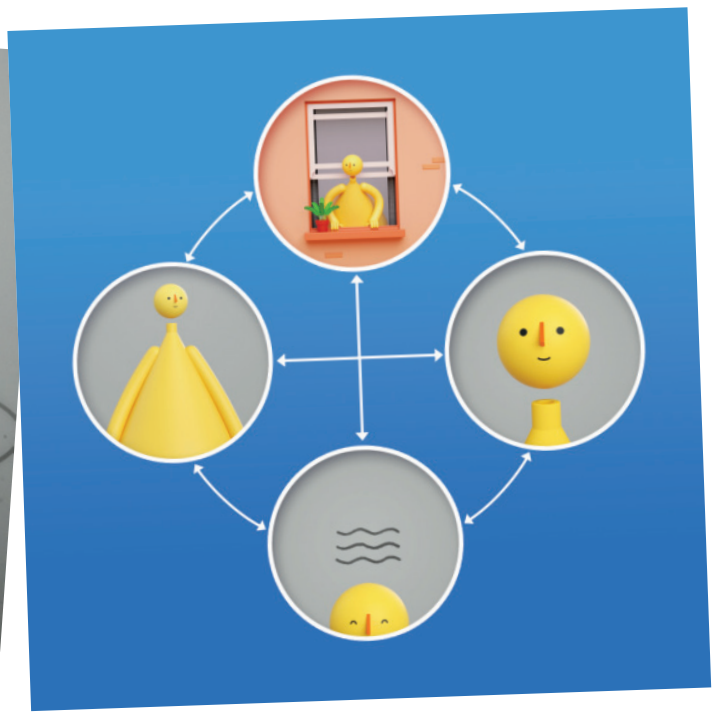
CBT today

Official magazine of the British Association for Behavioural & Cognitive Psychotherapies

What is CBT?

Our animation featuring Jo Brand was launched at our Annual Conference

Read more conference news inside



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Volume 47 Number 3
October 2019

Welcome to the latest (slightly delayed) issue of CBT Today. We have a packed issue this time around, with some great pieces on collaborative working.

It's great to know that so many members are interested in writing for the magazine on a range of topics. I'll be at the Equality & Culture SIG workshop in Manchester on 6 December along with tCBT Editor Richard Thwaites talking about how you can harness your thoughts for publication in the magazine or journal.

Thanks as always to all our contributors, both old and new.

Peter

Peter Elliott
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Contributors

Maria Bromage, Hannah Carroll, Laura Cocks, Jaime Delgadillo, Natalie Hanley, Zoë Hepburn, Rod Holland, Heather Howard-Thompson, Houda Jaouhar, Katherine Jonas, Allán Laville, Michelle Livesey, Patricia Murphy, Saiqa Naz, Sarah Rees, Andy Robbins, Jessica Rutter, Nick Stevenson, Mark Stubbings

CBT Today is the official magazine of the British Association for Behavioural & Cognitive Psychotherapies, the lead organisation for CBT in the UK and Ireland. The magazine is published four times a year and posted free to all members.

Back issues can be downloaded from **www.babcp.com/cbttoday**

Next deadline
9.00am on 11 November 2019 (for distribution week commencing 6 December 2019)

Advertising
For enquiries about advertising in *CBT Today*, please email advertising@babcp.com.

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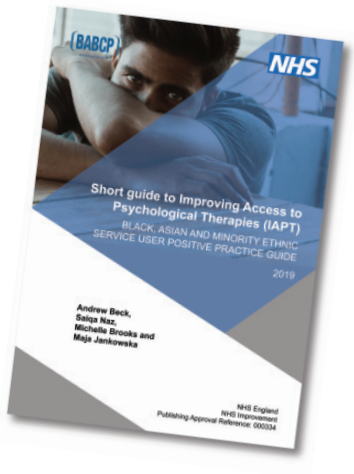
Also in this issue

IAPT BAME Service User Positive Practice Guide



We recently launched the long-awaited updated IAPT Black, Asian and Minority Ethnic (BAME) Service User Positive Practice Guide. Thanks to the efforts of Andrew Beck, Saiqa Naz, Michelle Brooks and Maja Jankowska, this updated version of the guide has been compiled by both IAPT clinicians and service users.

BABCP President Paul Salkovskis said: "I welcome this guide as pointing to the way forward in terms of how to shape IAPT services, the therapy they deliver, the workforce it recruits and nurtures and the communities which it seeks to involve and serve.

"The BABCP is proud to endorse this fantastic piece of work, and will actively seek to promote its objectives."

The guide can be downloaded at www.babcp.com

Membership Fees 2019/20

At the Annual General Meeting on Wednesday 4 September 2019, it was agreed unanimously to amend the BABCP membership rates for 2019/20.

The rates for 2019/20 took effect from 1 October 2019 and will remain in place until 30 September 2020. The rates are as follows -

	UK & Ireland	Overseas
Membership	£82.00	£91.00
Reduced Rate Membership*	£48.00	£57.50
Associate Membership**	£22.50	£31.00
Student Membership**	£28.00	£37.00

* The reduced rate is available to Members who can demonstrate that they have a gross annual income of less than £24,214

** Associate Membership is aimed at retired CBT practitioners and applicants from developing countries

*** Student Membership is aimed at those in full-time Higher Education and IAPT trainees

Members will receive individual notification of these rates one month prior to renewal.

Accreditation Fees

The fees for BABCP Accreditation also increased from 1 October 2019 as detailed below -

	Fee amount
Provisional Accreditation	£169
Provisional Accreditation - Level 2	£169
Provisional Accreditation with KSA	£219
Full Accreditation	£65
Provisional Reinstatement	£120
Full Reinstatement	£65
Extended Practitioner Accreditation	£25
Supervisor Accreditation	£105
Trainer Accreditation	£105
Annual Fees	
Accreditation Maintenance Fee	£52
CBT Register - Full Listing	£125.50

Blended CBT treatment

Talking Helps Newcastle (THN) is the adult Primary Care IAPT Service provider for Newcastle upon Tyne. Along with many services we face the longstanding challenge of being able to offer timely CBT treatment in the face of increased demand and limited resources, says **Maria Bromage.**

Early intervention is crucial. The longer clients who are vulnerable and distressed have to wait to start treatment, the more susceptible they are to an increase in symptoms and a further deterioration in their mental health. Within THN waiting times to begin treatment are lengthy and national targets are missed. As a clinician, alongside the management team and CBT colleague Andrew Rogers, I have been part of how to address this challenge. The aim has been to identify how we can reduce waiting times whilst keeping patient need, quality and an evidence-based approach at the heart of what we do. Without additional resources our focus has been on adapting and developing our existing CBT resources. Could we find a way to increase existing clinician capacity to allow resources to be directed towards the waiting list?

NEWCASTLE TALKING HELPS
THE PSYCHOLOGICAL WELLBEING SERVICE

Historically, THN offered all clients waiting for CBT individual therapist-led treatment in community clinical settings. Whilst this approach is appropriate for some clients this singular approach is also time intensive and restrictive. In addition it can be disruptive and less appropriate for some clients. Over the last 18 months we have been exploring whether we could expand our individual treatment option.

Digital treatment options are increasingly being used within health services. We questioned whether we could adapt and expand our treatment with computerised resources whilst still meeting clients' needs. Would this also provide an opportunity to redirect some staffing resources and reduce treatment waiting times? After a lot of discussion, debate and exploration of the use of available computerised treatments we felt that there was potential to increase provision and provide clients with CBT in a format which had not previously been available.

Computerised CBT (CCBT) is a well-established NICE recommended treatment option. Within IAPT services it is routinely offered as a standalone intervention at a Step 2 level for those with mild presentations. There is however limited use of it for those with moderate to severe presentations.

As a service we considered various ways computerised programmes could be used to benefit clients within the Step 3 treatment tier. CCBT is often used as a pre therapy treatment and this option was considered. However, we consider that clients in Step 3 have more complex needs and require more support, not less. We then considered a blend of individual sessions and computerised sessions. By integrating CCBT with individual sessions we believed we could more effectively meet the needs of patients and offer appropriate support.

An integrative approach combines the valuable and irreplaceable human connection with flexible, effective technological advances in psychological therapy. We felt an integrative approach could empower clients whilst reducing social isolation and stigma often experienced by people with mental health issues. Although waiting time reduction was a catalyst for change we also wanted to increase patient choice around their treatment. The blend of individual and computerised sessions allows clients increased choice around how their treatment is delivered. Clients also have flexibility around when they engage in the computer-based element of their treatment.

It has been 12 months since we introduced the changes to CBT treatment delivery. The option of integrative blended Step 3 CBT treatment for clients is routinely considered. Clients have assessment sessions with a CBT therapist and based on their formulation, learning style and choice, can be offered a course of individual sessions or integrative blended treatment sessions. In practice, integrated blended treatment is individual therapist-delivered CBT, delivered alongside sessions accessed via a computerised CBT therapy programme.

As clinicians this new way of working presents challenges and opportunities. Computerised treatment is a contentious issue. As therapists working in the NHS, targets, financial investment, morale and staff retention are never far from our minds. The balance between delivering what patients need and what resources dictate they are offered constantly seeps into the consciousness.

From a personal perspective of delivering blended care, I have found there to be a number of opportunities. Clients have been empowered and there is a greater continuity and momentum built by the accessibility of CCBT programmes. Sessions can be more efficient with clients more prepared as a result of the work done by computer. I am also able to be more creative, marrying together the elements that a computer programme can successfully offer with the unique elements a therapist brings. Clients have fed back that using relevant computer modules has helped them to engage, and the tools and content help develop understanding and reflection. This enhances the therapist led sessions as clients are more focused due to a deeper recognition and understanding of their problem. Colleagues with clients using a blended approach have also fed back that clients are attending sessions with more curiosity, questions and insight into their problems.

There have also been challenges. Self-directed learning and a collaborative approach is often met with confusion or fear. I am often viewed as the expert who will 'fix' the problem. This is often identified when clients do not engage with the computerised elements of treatment. These problems are not unique to integrated care. Learning from this has been that clients need to see the value and personal relevance of the computer modules in order to engage with them. Crafting the sessions so they blend and link together is essential and requires a shared understanding of the problem and ways to address it. Integrated Blended care highlights issues in these areas quickly.

Computer treatment can be viewed as impersonal, diminishing the value of human contact. This is perhaps the most difficult challenge and highlights the importance of the face-to-face sessions. These

Continued overleaf

"We felt an integrative approach could empower clients whilst reducing social isolation and stigma often experienced by people with mental health issues."

Blended CBT treatment

Continued

provide the opportunity for stories to be told and pain to be expressed, listened to and acknowledged. As a service additional group clinical supervision supports the use of the integrated blended care model. It allows space to share experiences and explore how best to achieve a successful blend of the two delivery methods. It also provides an opportunity to voice the experience of a different way of working and supports us to be mindful of personal bias influencing clinical judgement.

THN's blended CBT treatment is in an early stage. Outcomes are monitored using data gathered in treatment sessions. This is currently in the form of patient reported questionnaires on the nature, frequency and severity of symptoms. We are enhancing the quantitative data by gathering qualitative feedback on patients' treatment experiences. To date, treatment outcome recovery rate data has found blended care is comparable to individual treatment. Recovery rates from April to September 2019 are 53% (n=72). Waiting times have not significantly reduced due to increased demand for CBT and reduced staffing. This new way of working is taking time to bed in with the number of clients being offered integrative blended care being relatively small.

Patient feedback for those who have completed a successful blend of the two treatments has been positive. The evaluation is ongoing but the opportunities and potential afforded by adapting what has always been done is encouraging.

"THN's blended CBT treatment is in an early stage. Outcomes are monitored using data gathered in treatment sessions. This is currently in the form of patient reported questionnaires on the nature, frequency and severity of symptoms."

Open call for a special issue of tCBT

TRIP: Transforming Research In Practice, edited by Gary Brown and Jaime Delgadillo

This special issue is primarily aimed at CBT therapists without a research background. The goal is to motivate CBT therapists to integrate research findings and methods into their practice, and to generate new practice-based research, consistent with the scientist-practitioner model. To achieve this, this series of articles will focus on methods; including updates on research design, psychometrics, single case research and routine outcome monitoring using relevant CBT examples from a range of patient groups.

Submissions should be made online at https://mc.manuscriptcentral.com.cbt

Deadline for submissions is 1 May 2020

Don't need your printed journal copy?

Both BABCP journals are fully available online to BABCP members as part of your membership.
If you would like to opt out of receiving the printed version of *Behavioural and Cognitive Psychotherapy* and decrease the environmental impact of printing and distribution of the six annual issues please email babcp@babcp.com with your membership details and request to opt out.

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Let's talk about **CBT**

We released the latest podcast episode *CBT for Post Traumatic Stress Disorder*. Dr Lucy Maddox speaks with Nick Gilbert about how he sought help for PTSD, as well as his therapist Dr Jen Wild, who explains the theory behind the treatment.

All the episodes are available at **letstalkaboutcbt.libsyn.com**

BABCP

Caerdydd/ Cardiff 2020

48ain Cynhadledd Blynyddol a Gweithdai /
48th Annual Conference and Workshops

14-16 Gorffennaf | 14-16 July

Submissions are now open

The closing date for Symposium outlines, Symposium abstracts, Workshops, Skills Classes, Panel Debates and Roundtables is midnight on 12 January, while Open Papers and Posters can be submitted by midnight on 20 March.

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The integration of physical and mental health care

Winter pressures innovation in North East Essex

Hannah Carroll and Jessica Rutter are Assistant Psychologists working for Health in Mind, the North East Essex IAPT Service. They are part of an innovative project in which they are based at the local general hospital, initially as part of a winter pressures project, acting as mental health care navigators.

Physical and mental health are closely interconnected and affect each other through a number of pathways (Prince et al, 2007), in a biopsychosocial framework with strong links between physical health, mental health and social determinants. Health can be understood as a product of these three separate processes; biological, psychological and social.

Although as health professionals we are trained to respond to any of these elements in a holistic and integrated way, a number of factors make it difficult to do so. As a result, patients are receiving care in a way in which their physical and mental health needs are disconnected. It is difficult to ignore the wealth of evidence supporting the link between the physical and the psychological and the strains on both medical and mental health services is increasingly calling to light the need for integrated approaches.

There is a need for healthcare professionals to consider psychological wellbeing when treating the physical symptoms of a condition and vice versa.

Mental illnesses, most specifically, depressive disorders, are associated with increased prevalence of chronic diseases (Chapman et al, 2004). This association between depression and chronic disease appears attributable to depressive disorders precipitating chronic disease and to chronic disease exacerbating symptoms of depression.

The complex interrelationship between depressive disorders and chronic disease has important implications for both chronic disease management and the treatment of depression. Depression has also been found to be associated with an increased risk of coronary heart disease (MHF, 2018). Anxiety and depression are common in people with diabetes; people with diabetes are twice as likely to suffer with depression as those how do not have diabetes (Anderson et al, 2001), and a third of people with Type 2 Diabetes have mild to severe anxiety (Collins, Corcoran and Perry, 2009).

Abnormal anxiety levels are found in up to 40% of patients with Inflammatory Bowel Disease (IBD) (Bannaga et al, 2015). The reported prevalence of depression in renal dialysis populations can be up to 39.3% (Ma et al, 2015). A staggering 60.8% of chronic pain patients meet the threshold for depression (33.8% meet the threshold for severe depression) and it is estimated that in a three-month period health care costs are £731 for patients with depression, compared with £448 for patients without depression (Rayner, 2016). These findings across various physical health areas reveal the extent, severity, and impact of mental health in patients with physical health conditions and make evident a need for action.

The NHS Five Year Forward View makes the case for the development of integrated care, spanning people's physical, mental and social needs (Mental Health Taskforce, 2016). People with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent. The significant increase in access to psychological therapies, following the introduction of the national IAPT programme in 2008 is still meeting only 15 per cent of the need in adults.

The recommendations for transformation given in The Five Year Forward View suggest that dedicated mental health provision as part of an integrated service can substantially improve outcomes and IAPT has an integral part to play in this; nine out of ten adults with mental health problems are supported in primary care (The Kings Fund, 2016). The report also calls for a focus on treating people who are living with long-term physical health conditions.

It was into this climate that the current 'A&E Project' was born; initially in response to the winter pressures across A&E departments nationwide. IAPT representatives in the form of Assistant Psychologists would have a presence in the A&E department at Colchester General Hospital to

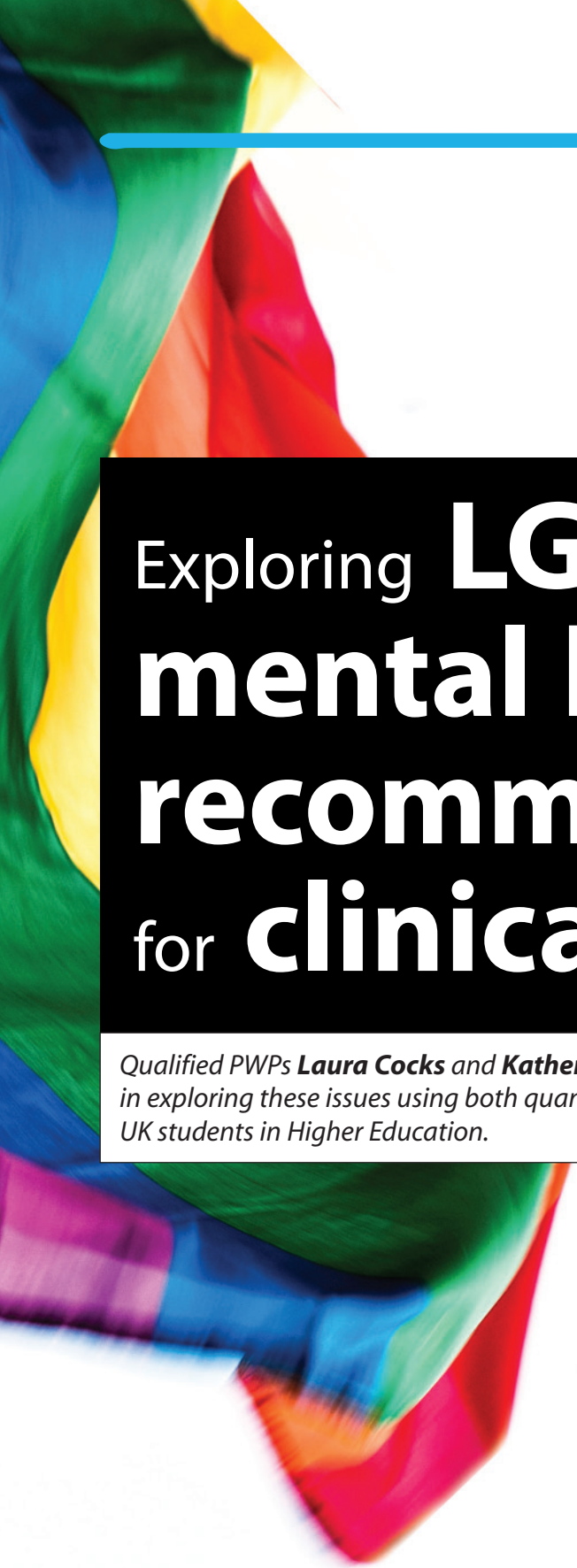
support hospital staff identify, signpost and facilitate access to the North East Essex IAPT Service. This project began with a view to ease winter pressures within the hospital by identifying individuals with common mental health problems potentially frequenting the hospital who would benefit from brief psychological intervention. For A&E attenders there are patients whose mental health difficulties can manifest in physical symptoms which may result in a hospital admission, for example: panic presenting as coronary events, anxiety presenting as COPD symptoms or stress presenting as gastrointestinal difficulties. Other needs identified are carers attending with patients who themselves have anxiety or depression and individuals who present at hospital with a physical health problem, but express concern around anxiety, low mood, stress, or ability to cope. Providing access to primary care mental health services in an acute medical setting hopes to address the need to improve access to psychological therapies for individuals who present with mental and physical health difficulties as well as social/practical issues, supporting them to access the most suitable treatment required, to enable recovery. In doing so, this may reduce future demand and frequency of attendance at the local hospital.

The work of the Assistant Psychologists quickly developed to cover medical wards and outpatient clinics. Following basic psycho-education to the medical staff on how to identify mild to moderate mental health difficulties in their patients, pathways were set up to facilitate referrals to the APs who would refer the patient into the service if appropriate or signpost elsewhere if not. The APs available on site, would meet with the patients on the wards or in the clinics to briefly assess their suitability for IAPT and follow with a referral into a suitable service. Other services that are frequently referred into other than IAPT are; secondary care mental health services, the specialist perinatal mental health team, bereavement counselling services, befriending services for older adults, Emotional Wellbeing Mental Health Service (EWMHS), Macmillan, the Pain Management Service and local exercise groups.

The APs also have a very active role in the rehabilitation groups run at the hospital, providing out-patient care to those who received acute medical care as an inpatient. These groups include; the Cardiac Rehabilitation programme, Vascular Rehabilitation programme, Cancer Fatigue programme and the Critical Care group. Tailored stress management and sleep hygiene workshops were run as part of these rehab programmes, giving the patients taster sessions as well as an opportunity to learn about IAPT and the treatments they can provide for people living with LTC's. Referrals into the service were frequently made from these rehab cohorts.

The breadth of services and wards that have benefitted since the beginning of this project highlight the need for continued integration of mental and physical health services. The Assistant Psychologists hope to extend their work to further areas of the hospital as well as to more community-based services to improve accessibility to IAPT across all demographics. There are innumerable advantages for patients as a result of co-location and joint working between mental health teams and other health professionals that we hope to grasp not only within this winter pressures project but also continue to extend within the IAPT service as a whole.

> People with long term physical illnesses suffer more complications if they also develop mental health problems, increasing the cost of care by an average of 45 per cent.



Previous research has indicated that lesbian, gay, bisexual and transgender (LGBT) individuals experience higher levels of mental health problems including anxiety, depression, self-harm and suicide. However, there is relatively little research with young adults specifically, and although many studies recognise the existence of barriers to help-seeking, few link their findings directly to clinical practice and what services can do to help.

Exploring LGBT mental health and recommendations for clinical practice

*Qualified PWPs **Laura Cocks** and **Katherine Jonas** joined Clinical Psychology lecturer **Dr Allán Laville** in exploring these issues using both quantitative and qualitative research methods with a sample of 201 UK students in Higher Education.*

The study

To understand differences between LGBT and non-LGBT mental health, as well as within-group differences, we used the Patient Health Questionnaire-9, Generalised Anxiety Disorder-7 and Work and Social Adjustment Scale to measure depression, anxiety and functioning, providing insight into how LGBT young adults might present to IAPT services. Happiness was also measured using the Oxford Happiness Questionnaire, and demographic information was collected using open-ended questions.

We also completed structured interviews with seven LGB and seven transgender or gender non-conforming (TGNC) individuals, gathering deeper information on general difficulties, mental health, perception of the future, views on education, politics and media, and how they feel about accessing mental health services.

Questionnaire findings

The questionnaire results supported existing research, indicating that both LGB and TGNC individuals experience significantly more difficulty with anxiety, depression, daily functioning and happiness than non-LGBT individuals. Our findings also suggest that having an LGBT minority identity correlates with higher anxiety and depression than no LGBT minority identity. However, there were no significant differences between LGB and TGNC individuals. These results contribute to current understanding by indicating that having a diverse sexual or gender identity of any kind could correlate with greater distress.

Sexuality

Hope, Representation, and *Coming Out* were identified as three core themes from the LGB interviews. Participants commented on elements of social progress, such as the increase of LGB representation in the media, with providers such as Netflix producing more diverse content. They also had optimism for their future and the way their sexuality would be regarded by others.

Participants recognised progress in general representation while commenting on areas that are still neglected, for example sex education. The importance of seeing oneself represented was highlighted, with participants commenting on how this affects others' understanding and behaviour as well as personally feeling more comfortable and able to be themselves.

'Coming out' by openly telling others about one's sexuality is a common difficulty for LGB individuals and participants reinforced how this is a continual process rather than a single event. The negative impact of others disregarding their sexuality, not accepting them and the stress of hiding their sexuality due to fear of negative reactions and bullying were also highlighted as key concerns.

Gender

Autonomy, Social Understanding, and Lack of Clarity were the three core themes from the interviews with transgender and gender non-conforming individuals. Participants commented on a variety of situations that compromise their sense of personal control, for example not being able to express their gender identity due to family expectations, social difficulties from being misgendered and feeling like they needed to prove their identity in order to receive medical help. These themes also manifested positively for almost all participants, with many commenting on the hope they had for their own future and looking forward to a time when they could determine their own circumstances.

Similar to the LGB findings, others' understanding was crucial in helping TGNC individuals feel comfortable in their surroundings and confident in accessing mental health services. Of particular relevance to healthcare, participants highlighted barriers of not knowing where to go for help, not knowing if their practitioner would have sufficient understanding of gender and not being certain that they would receive gender-affirming care. However, some participants commented on improved knowledge and sensitive practice, suggesting that training and guidance could have a highly meaningful impact.

Recommendations

On an individual level, practitioners can demonstrate supportive LGBT care by being mindful of any expectations they might have about sexuality or gender, for example any assumptions that a patient is heterosexual or that they identify fully with the gender assigned to them at birth.

Additionally, understanding specific difficulties and the impact that support can have for a patient is crucial, and knowing signposting options and when to use them is important, as explored in Laville (2013; 2017). On a wider level, services can increase accessibility by actively showing support for LGBT individuals, for example through signs on websites, in waiting rooms and use of LGBT lanyards. Self-referral forms can show understanding by simply providing a space for the patient to self-identify, or by providing more options for gender and sexuality.

Clinical skills supervision could also be used as an opportunity to share experiences of working with sexual and gender diversity and broaden clinicians' knowledge of current LGBT topics. The combination of understanding specific problems, demonstrating 'appropriate' awareness and flexibility, and showing generalised support can give LGBT patients more confidence that accessing mental health services will be a positive, affirming process.

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"The combination of understanding specific problems, demonstrating 'appropriate' awareness and flexibility, and showing generalised support can give LGBT patients more confidence that accessing mental health services..."

Social inequalities in wealth and health

Depression and anxiety problems impose an enormous burden on individuals' health, with huge costs to society and healthcare systems, writes ***Dr Jaime Delgadillo.***

In England, around 1.4 million people experiencing depression or anxiety are referred for psychological interventions each year to IAPT services [1], in one of the world's largest and most impressive efforts to implement evidence-based treatments.

Formal evaluations and national statistics indicate that interventions offered in IAPT are broadly effective [1], although it is also clear that not all patients respond equally well to standardised treatments. In a series of studies examining data from multiple cities, multiple services and thousands of patients, our research group has found evidence that:

- Prevalence rates of common mental disorders are higher in socioeconomically deprived neighbourhoods, and lower in affluent neighbourhoods [2].

> "People living in deprived neighbourhoods are less likely to recover from depression and anxiety symptoms after therapy"

- People with mental health problems who are living in deprived neighbourhoods are less likely to access therapy even if it is available in their local area [2,3].
- People living in deprived neighbourhoods are less likely to recover from depression and anxiety symptoms after therapy [3], even after controlling for patient-level symptom severity and employment status [4].
- People who are unemployed, and those living in low-income and high crime-rate neighbourhoods, tend to require lengthier and more intensive interventions to attain symptomatic improvements [4,5].
- These findings converge with international studies, as evidenced in a systematic review of the association between socioeconomic deprivation and psychological treatment outcomes [6].

Other UK research groups [7] and national statistical reports [8] have also found associations between psychological treatment outcomes and socioeconomic deprivation, which indicates that this is a robust and replicated finding, regardless of who is analysing the data. There is little question that wealth and health are interrelated, in such a way that poverty undermines wellbeing and stifles the effectiveness of standardised psychological treatments.

None of this is surprising to those of us who deliver therapy in deprived neighbourhoods. We understand how difficult it would be to improve anxiety symptoms if you or your children are threatened by antisocial behaviour and crime outside of your doorstep. We can see how debt and joblessness can erode people's sense of optimism and hope. We feel as bewildered and frustrated as our chronically ill patients who are denied disability allowance, or evicted from their homes because they can't afford the rent.

What is surprising to us is the lack of recognition of socioeconomic inequalities in mental healthcare policy, in service planning, in psychological theory and in clinical training. Laudable efforts have been made by UK policymakers, commissioners, educators, therapists and campaigners to recognise and to address mental healthcare inequalities in relation to ethnicity, religion, age, sexual orientation, and comorbid long-term conditions. It is now widely recognised that therapy can work better if it is adapted to meet the specific needs of individuals from ethnic minorities, or people with chronic illnesses.

There is now plenty of evidence that similar efforts are necessary to ensure that psychological services are responsive to the needs of people living in deprived circumstances. The wealth and health association is a major source of inequality, undermining the NHS's mandate to offer free and effective care to all, irrespective of their income. The literature in this field has highlighted several directions for improvement.

Flexibility around the duration of therapy is important, since patients living in poverty require lengthier interventions. Empathy and understanding are necessary, but not sufficient when patients are experiencing hunger, harassment, debt and need urgent practical support.

Continued overleaf

> Historically, psychotherapy has been mostly available for privileged, educated and fee-paying clients. Textbooks and case studies based on these clients are hardly instructive for therapists working in poor neighbourhoods.

Social inequalities in health and wealth *continued*

Sometimes it is appropriate and necessary for the therapy session agenda to be focused on crisis management, problem solving, or practical support and signposting. Some may view this as drifting away from evidence-based treatment, but it is also legitimate to view this as responsive and compassionate care.

Co-ordinated care between psychological therapists, welfare/employment advisors and other allied health professionals can better meet multiple social and health needs. Gaining and/or maintaining employment is important for patients to sustain their improvements and well-being after therapy.

All of this requires awareness of socioeconomic circumstances, time, flexibility and multi-disciplinary care. Currently, IAPT and other mental health services are pressured to offer unsuitably brief interventions, disjointed from other professionals' input, which are inadequate to support some of the poorest, marginalised, discriminated and most vulnerable members of society.

Policy changes are necessary to remedy this injustice, but the onus is also on psychological therapists to advance psychological theory and to adapt practice. Historically, psychotherapy has been mostly available for privileged, educated and fee-paying clients. Textbooks and case studies based on these clients are hardly instructive for therapists working in poor neighbourhoods.

The IAPT programme in England has made a positive difference to challenge this stereotype and to make therapy more accessible for people from all walks of life. As a community of CBT and psychological therapists, we are now at the tipping point of recognition and remediation of the wealth and health conundrum.

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BABCP
BATH2019
47th Annual Conference & Workshops

It took 30 years to return to Bath for our Annual Conference but it was worth the wait! Our last visit was in 1989 when we were still BABP and the size of our membership was just 1,750. Back then our 250 delegates were able to fit into the Guildhall in the middle of Bath and we able to run the AGM in the magnificent Pump Room.

BABCP **Annual Conference & Workshops** 2019

Leap forward 30 years, and BABCP's membership has increased by more than 600% and although conference attendance may not have kept pace we still managed to quadruple attendance with almost 1,000 delegates joining us for the pre-conference workshops, the Annual Conference and associated events.

The move to the University campus and Chancellors' Building provided us with a state-of-the-art conference venue under one roof and with most delegates, including the invited speakers, staying in University accommodation a few yards away it was just like old conference times when everyone stayed together.

Our 2019 conference programme included 12 Keynote speakers, 14 skills classes, 22 symposia, three panel/round tables and 45 posters as well as hosting meetings of some of our Special Interest Groups and Annual General Meeting. Members who missed the conference will soon be able to see footage of some of our keynote speakers on YouTube at BABCPtv - Rich McNally from the USA, David A Clark from Canada, Susan Bogels from the Netherlands and Tim Dalgleish from Cambridge.

Continued overleaf

BABCP **Annual Conference & Workshops** 2019 *Continued*

We also welcomed back Bedlam who entertained us after the opening reception and included our own David Veale, Helen McDonald and Trudie Chalder on saxophones. Thirty years ago Trudie was presenting her very first open paper on 'Cognitive Behavioural Management of Chronic Fatigue Syndrome' and this year she was back again convening, chairing and presenting a symposium on ACT for Long Term Conditions and playing in the band. What opportunities BABCP give to everyone for development in all directions!

David Clark and David A Clark

> "Our 2019 conference programme included 12 Keynote speakers, 14 skills classes, 22 symposia, three panel/round tables and 45 posters as well as hosting meetings of some of our special interest Groups and AGM."

Low Intensity workforce special event

We held our first Low Intensity day at our Annual Conference in Bath to celebrate the achievements and contributions of the Low Intensity CBT workforce to the mental health profession. The event was attended by almost 100 Low Intensity workers from across the country.

Speakers included David Clark, Paul Farrand, Paul Salkovskis, Lisa Atkinson and Liz Kell from the BABCP Low Intensity Special Interest Group, Lucy Maddox, Becky Gill, James Spiers and Adriana Natrinska, Fiona Dawson and Saiqa Naz.

The topics varied from understanding how IAPT started, diversity, therapists' wellbeing, using digital technology, child development, diverse careers, leadership and provision of low intensity services across the UK.

The day provided the LI CBT workforce and those presenting with an opportunity to network and to try and come to a shared understanding of how BABCP can support the LI workforce.

James Spiers, a PWP and presenter at the event, said: "Presenting at the LI CBT special event was an incredible experience. At the start of my career in IAPT I never envisaged that I would be talking to an audience as a Low Intensity Therapist alongside

What is CBT?

Stills from our new animated film featuring Jo Brand which had its premier at our Annual Conference in Bath. Thanks to animator Tim Ruffle for his work on this. See the film in its entirety at www.babcp.com

the people that wrote many of the models that we use. The feedback I've had since the event has been very encouraging."

Liz Ruth, a Senior PWP in the Sheffield Health and Wellbeing Service, said: "The day was refreshing, thought provoking and inspiring. It was helpful to hear from a range of people with an interest in LI CBT. I loved the emphasis on how we can develop as a profession, recognise our strengths as a workforce and respond to the challenges we work amongst."

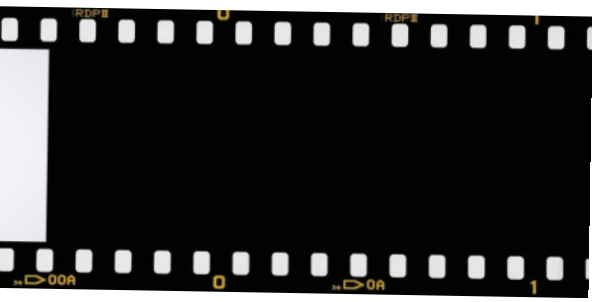
Paul Salkovskis said: "As President of the BABCP I am passionate about the Association including and representing those providing excellent CBT in the context of evidence-based 'Low Intensity' interventions. The BABCP also welcomes the considerable contribution they make to CBT in general and the Association in particular."

We hope this is the first of such events at our Annual Conference and look forward to continuing to build our relationship with the Low Intensity CBT workforce to enable the BABCP to support them.

Thank you to all the delegates for attending this event and enriching the day.

We would also like to thank Mayden for providing financial support towards supporting some LI workers to attend the conference.

BABCP BATH2019
47th Annual Conference & Workshops



Jolly good Fellows

At our Annual General Meeting in Bath, President Paul Salkovskis announced this year's recipient of the Honorary Fellowship in recognition of distinguished service to the Association and the CBT community as a whole.

Professor Roz Shafran has been committed to the science and practice of CBT since the start of her career working with Jack Rachman, a pioneer of behaviour therapy and then CBT, as a research assistant. She has excelled both in translating research into practice, evidenced by many awards, and practice into research, evidenced by a long list of publications. She has developed particular expertise in obsessive compulsive disorder, particularly mental contamination, eating disorders and anxiety disorders

Professor Shafran has been a BABCP member for over 25 years and contributed enormously to the scientific conferences on so many levels, from helping organise the event on the ground, and as a member and as Co-Chair of the Scientific Committee. She was pivotal in delivering CBT training directly through workshops at local, national and international conferences and has also served on the editorial board of the Cognitive Behaviour Therapist journal.

Among Professor Shafran's many achievements in furthering CBT she founded the Charlie Waller Institute of Evidence Based Psychological Treatment at the University of Reading, and has been responsible for introducing a range of highly effective services for clients, including a evidence-based, low intensity mental health 'drop? in' service in Great Ormond Street Hospital reception for all patients and family members, the 'The Lucy Booth'.

The far-reaching impact of her research work has resulted in the likes of the Marsh award for mental health in 2011. She has more than 200 peer-reviewed publications over a range of areas and has secured over £2.5m in research grant funding.

This year BABCP also bestowed Fellowships to the following recipients:

Dr David Johnson is a dedicated and knowledgeable psychiatrist, specialising in addiction, who covers a wide and diverse rural area, covering ten per cent of Scotland including 20 inhabited islands and a population exceeding 90,000. He took up the post of Consultant Psychiatrist in Addiction in 2007, following closure of the specialist inpatient addiction treatment unit.

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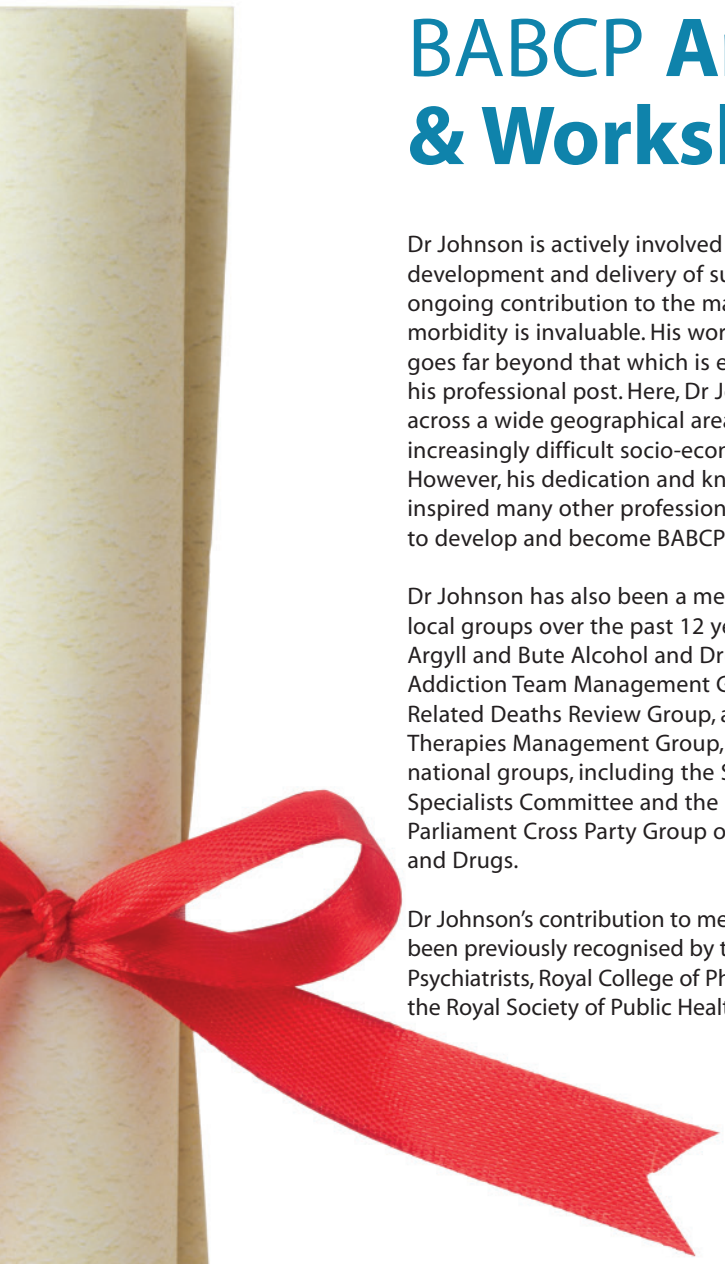
BABCP
Caerdydd/
Cardiff 2020

The 48th Annual Conference & Workshops will take place in Cardiff 14-16 July



BABCP **Annual Conference & Workshops** 2019 *Continued*

Dr Johnson is actively involved in the development and delivery of supervision, and his ongoing contribution to the management of co-morbidity is invaluable. His work in the CBT field goes far beyond that which is expected of him in his professional post. Here, Dr Johnson practices across a wide geographical area, experiencing increasingly difficult socio-economic issues. However, his dedication and knowledge has inspired many other professionals within his team to develop and become BABCP-accredited.

Dr Johnson has also been a member of various local groups over the past 12 years, including the Argyll and Bute Alcohol and Drug Partnership, Addiction Team Management Group, Drug Related Deaths Review Group, and Psychological Therapies Management Group, in addition to national groups, including the Scottish Addiction Specialists Committee and the Scottish Parliament Cross Party Group on Alcohol and Drugs.

Dr Johnson's contribution to mental health has been previously recognised by the Royal College of Psychiatrists, Royal College of Physicians and also the Royal Society of Public Health.

Krish Nath qualified as a Mental Health practitioner in 1980, before establishing services at both St Mary Abbots and The Gordon Hospital in London. Moving to Eastbourne in 1986, Krish established CBT clinics at GP practices across the area and created many opportunities for qualified mental health practitioners to gain first-hand experience in Behavioural Psychotherapy.

Krish led the development of the ENB 650 course in Behavioural Psychotherapy prior to his appointment at Surrey University as a Senior Lecturer. Here, he developed the first modularised course in CBT to extended access to other healthcare professionals. Krish has also exported his CBT skills to less advantaged countries such as the former Czechoslovakia in 1991. Currently, Krish is organising CBT training in Guyana, the country with the highest suicide rate in the world, and also Sri Lanka.

Krish was Vice Chair of the West London/Surrey branch for many years and organised several workshops at the Priory Hospital. Krish joined the BABCP Board in 2013. In 2016, he was elected as Chair of the BABCP Standards Committee and has been successful in developing this service for the benefit of members and to assist in the protection of the public. Now Krish is helping to ensure BABCP can meet the criteria required for entry to the Professional Standards Authority Accredited Voluntary Register.

Krish has also ensured BABCP members can access affordable professional indemnity and liability insurance as he led the negotiation with Balens Insurance Company to make discounted cover exclusively available for all BABCP members. Krish also established BABCP Associate Membership for retirees and directed at new members from disadvantaged parts of the world.

Nicky Lidbetter has been at the forefront of service development and innovation in the field of primary care and psychological therapy service delivery for 25 years through her work in the charity sector.

As founder of the charity Self Help Services (which has grown to be a leading provider of NHS-commissioned IAPT services), Nicky has been instrumental in creating the first user-led primary care mental health, psychological therapy service. This has also included leading on projects established to widen access to CBT for inaccessible groups in the community including those at risk of gang involvement/affected by gang-related activity, as well as military veterans and women of south Asian descent experiencing domestic abuse. Nicky successfully championed computerised CBT at national level resulting in eTherapy co-ordinators being accepted by the national IAPT team as 'step 2 other' IAPT workers. This was a key milestone in the IAPT service evolvement and through her strategic role in service development, has worked with researchers to build the evidence base for the digitalisation of CBT.

As CEO of Anxiety UK, Nicky developed the charity's successful APPTS-endorsed national therapy scheme which sees over 300 therapists (many are CBT professionals) offering their services across the country at accessible rates for those living with anxiety, stress and anxiety-based depression. Nicky has worked alongside key academics and renowned CBT experts to keep the service at the forefront of innovation and is soon to

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launch a digital online instant access service. Her work with esteemed academics has showcased the efficacy of CBT when delivered by telephone and through supporting this approach, has enabled many thousands of individuals to gain support through such services.

Over the years Nicky has collaborated on numerous research projects focused on CBT; bridging the gap between those in the UK with lived experience of common mental health difficulties and the research community, so translating research into service development.

Dr Sean Harper has made a significant contribution to the application, research base and dissemination of CBT throughout his career of twenty years. Dr Harper has worked largely in psychosis and complex mental health and has been relentless in his drive to improve accessibility of CBT for service users.

Dr Harper has continually been involved in research throughout his career, from regularly supervising D.Clin.Psych and MSc trainee theses, to co-founding a research group, Edinburgh Research and Innovation Centre for Complex and Acute Mental Health problems (ERRICA) expanding research into the causation of disease and development of psychological therapies in psychosis. and complex mental health. His research interests cover the areas of supervision and training in CBT so driving forward quality improvements such as competency-based CBT supervision training and making training accessible for remote and rural trainees. Dr Harper has also helped write, develop, deliver and evaluate innovative training programmes in clinical supervision in Scotland (NES Generic Supervision Skills Training in Psychological Therapies and the Specialist Supervision Training Programme in CBT), now implemented nationally across Scotland and delivered to several hundred psychological therapists.

Dr Harper has been the Director of the South of Scotland MSc in CBT programme for 12 years overseeing the development of around 250 cognitive therapists. Over this time the programme has expanded, created flexible routes through training and consistently delivered high quality CBT therapists. A significant milestone was BABCP accreditation of the programme in 2017. However, he has also led on making training available remotely so enabling access to therapists in areas where this would not have been previously possible. Dr Harper has also delivered papers for BABCP at both local and national levels.

Dr Harper has delivered training to over 100 acute in-patient mental health staff in a CBT psychological model based on Comprehend, Cope and Connect (Clarke & Nicholls, 2018) which was also the basis of a clinically-based feasibility study and meta-analysis which proved instrumental in the development of the acute in-patient psychology service in Lothian.

Neil Harmer Award for Branch Excellence

Claire Hobbs and Clare Green were on hand to receive the 2019 Branch of the Year Award from Paul Salkovskis at the Conference welcome reception. The Devon and Cornwall Branch help to support members in private practice in their CPD for supervision, with a new Supervisors Forum planned for 2020. The branch also canvasses the local PWP workforce to see how they can be supported, and actively seek new opportunities to bring fresh ideas into the branch committee in order to energise their work.

Engagement and Involvement Award

The first recipient of the BABCP Engagement and Involvement Award is Saiqa Naz. This new award is presented each year to the BABCP member who has significantly contributed to public engagement and/or the involvement of people with lived experience in relation to CBT.

Promoting community cohesion in mental health services

By Saiqa Naz

Interfaith Week, which is held 10-17 November, is almost upon us. I have been involved in an interfaith network in my hometown of Rochdale for several years now promoting community cohesion. Being involved with the organisation has provided me with opportunities to engage with people from different faiths and cultures. Our annual Holocaust memorial service is always a poignant event. It is through my involvement in this community cohesion work that I learnt about Holodomor, a man-made famine that killed millions of Ukranians. I also learnt about the ethnic cleansing of Bosnians in Srebrenica. Given what is happening around the world at the moment, I would recommend you learn about the ten stages of genocide.

I have previously written about us as mental health professionals and services taking responsibility for reaching into BAME communities and other groups that are under-represented in our services. Working inclusively means better outcomes for all and also financial savings in the long-term. We can't have services that meet the needs of some communities and not others. This creates unnecessary divisions in mental health services and indeed wider society. The most important stakeholders in our services are the communities we work in.

We need to co-produce services – some information on this can be seen in BABCP's Public Engagement Review and Strategy. I would also encourage you to read BABCP's press release of 22 May 2018 in response to NICE quality standards on

the accessibility of health and wellbeing services for Black, Asian and Minority Ethnic (BAME) users.

As clinicians, we have to embody the values of our profession and be actively engaged with challenging the systemic problems we have in services, otherwise we may be inadvertently colluding with structural racism and other forms of discrimination. We must learn to recognise our individual privileges and biases. This does not imply that you have not experienced any hardships in life, but that unbeknown to you, your experiences, access to opportunities, the colour of your skin, your gender, your sexuality, your health and the way society is constructed may privilege you above others.

The best way to overcome our biases is to spend time with and work with those we may perceive to be 'different' to ourselves, think about how we may be privileged in comparison to them and not make assumptions about them. This will also protect us from the negative and inaccurate media and political portrayals of diverse communities. We will learn more by placing our power and privileges to one side, and opening our hearts and minds to embrace diversity. It will not only enrich our clinical work, but our lives in general. On a human level, we are equal, but there are nuances we need to take into consideration.

Equality, diversity, inclusion and respect should be central to our conversations at work in team meetings, supervision and individual reflections. We can't accuse groups of not integrating or being 'hard to reach' when we're not making room for them in our services. If anyone is hard to reach, it's our mental health services.

We need to identify communities that have poorer uptake of care and outcomes in our services, for example BAME communities and men, and protect resources to do ongoing targeted work. By improving care for them, it will improve care for other groups of people. The Roma community is an example of this. I have previously worked with the Roma-Slovak community. I initially found it challenging to work with them but with the help on an interpreter and some research, I learnt they have a history of being persecuted and are a particularly vulnerable community that requires additional support. I realised I only found them challenging because I didn't have time in work to reflect about them and therefore I did not understand their history or culture - the problem was in my lack of understanding about them. Once I owned this, it became easier for me to connect with them and think about their needs. I sincerely hope resources are made available to support the Roma community and mentor the younger generation to reach their full potential.

If you're working in IAPT services, please stick to implementing the IAPT model as described in the IAPT Manual. Any services restricting the number of sessions or not delivering the appropriate 'dosage' of therapy as referenced in the NICE guidelines, need to stop doing this. It is unethical and attracts unnecessary criticism of IAPT. If your services are doing this, please address this collectively in your team meetings and also contact Ursula James from IAPTs central office on ujames@nhs.net and speak to her confidentially. You have a duty of care to your local communities.

> "As clinicians, we have to embody the values of our profession and be actively engaged with challenging the systemic problems we have in services, otherwise we may be inadvertently colluding with structural racism and other forms of discrimination."

Wouldn't it be great if mental health services, especially IAPT services, opened their doors and took the lead in developing and maintaining relationships with local communities, including planning and participating in community events? Food and music bring people together. I personally recommend expanding the Low Intensity/Psychological Wellbeing Workers (PWP) workforce to allocate half to one day a week for outreach work. This is in addition to their one day for admin and should be incorporated into the service design. I believe this will also improve their experiences of working with diverse communities and also provide communities with the basic psychoeducation that is required to help them identify they are struggling with their mental health. It may also help retain the Low Intensity workforce (please encourage your Low Intensity/PWP colleagues to join the BABCP).

The updated IAPT BAME Positive Practice has been launched recently. This provides services with guidance on how to work with BAME communities. It can be downloaded from the BABCP website. Using stigma and saying 'We don't have enough resources' are no longer acceptable excuses for not meeting the needs of BAME communities.

Our next BABCP Equality and Culture Special Interest Group event will be held on 6 December in Manchester, 'Writing for Change'. So many of our members have a wealth of experience that can fill in gaps in literature, yet they lack confidence to write. The first time I wrote an article, I managed to convince myself I was dyslexic and delayed submitting the article, so I understand how anxiety provoking it can be! Richard Thwaites, Editor-in-Chief of the *Cognitive Behaviour Therapist* journal will be helping us to address this on the day. I look forward to meeting you then.

To find out more about interfaith week, please look at **https://www.interfaithweek.org/about**

I would also like to take this opportunity to thank Neville Southall for allowing me to takeover his Twitter account and talk about men's mental health with his followers. I believe by implementing the above, we can also improve care and outcomes for men.

You can follow Saiqa on Twitter @saiqa_naz

To join the Equality & Culture SIG, please email babcp@babcp.com

Hello and welcome to the first article in a series on delivering CBT in private practice, write **Sarah Rees** and **Heather Howard-Thompson.**

Together we run the Facebook group *'CBT in private practice'.*

CBT in Private Practice

> Having a business plan in place that is reviewed regularly will ensure that the running of your business does not consume your time or overwhelm you.

I met Heather in 2016 when I was volunteering for an Independent Practitioners Special Interest Group (IPSIG) event run for therapists in private practice. I had been in business on my own for a few years and had always wanted to find someone to collaborate within because it can feel isolating especially as most people like us have previously worked in the NHS in large teams.

I felt very aligned with Heather on meeting her and we shared common values and inspirations for our business and we were both finding our way in a business world that none of our training had prepared us for.

The IPSIG asked us to arrange a 'Getting started in private practice' training day, which was held in Manchester in 2017. One of the things that stood out for us at that event is that people really needed a place to talk and ask questions, lots of therapists felt isolated and out of their depth in the business world but also many people had lots of the answers too. A Facebook group seemed to be the perfect place for the conversation to continue and this is how it all started.

Over the last few years Heather and I have become more passionate about the world of business undertaking more training and coaching along with having the opportunity to learn from many mistakes. We are both a bit geeky about the world of business despite having slightly different business models that we work from. This has led us to take the Facebook group more seriously and begin to help other therapists develop successful, sustainable and profitable businesses that they love, getting the business of therapy right means that you can focus on what you are good at delivering high-quality CBT.

There are so many areas that we can talk about in the field of private practice but we thought that we would cover the first and most important area in this first article.

Step one on entering the world of private practice - complete a business plan.

Neither of us did a business plan until about a year ago when in one of our peer mentoring sessions we sat down together and worked through one. We should have done one at the very start, which would have saved us time, energy, and prevented some obvious mistakes we made. Most importantly it would have provided us with a clear direction of where we need to go, how we were going to advertise ourselves, set fees and acquire referrals. A good business plan allows you to see exactly what you need to do. It is a working living document, setting your objectives and the strategies you will put in place to meet them.

Having a business plan in place that is reviewed regularly will ensure that the running of your business does not consume your time or overwhelm you. When your business is running smoothly you can focus on the therapy you provide maintaining the delivery of high-quality CBT where people benefit from the results. Working in this way also maintains the reputation of CBT, securing your future and ensures that you are doing what you love and have trained hard to deliver.

Where to start with a business plan? We CBT therapists do like a process and a formula or model don't we! Well, you won't be disappointed with our idea of what a business plan should look like.

The first step is to do a problem list for your business. Spend about 30 minutes doing this, write down everything you can think of, then set your smart goals – Specific, Measurable, Achievable, Realistically and Timely

For example – I need a venue. What are the steps to achieving this? Where will I get referrals from? What are the steps that need to be in place? How much will I charge? What are the figures I need to calculate?

You may have many goals especially as you are starting out but breaking them down like this and prioritising them ensures that it feels achievable and manageable and prevents you from being overwhelmed. The more you can organise before you get started the better.

Also, it's exciting to start seeing your business come to life and you can reflect back on how far you have come over time.

Don't forget a good formulation – the key elements of what your business will look like in the short term, medium term and long term.

Get a mission statement in place, be clear about what your values are and what you will offer, when and how.

To have a business you love you need to know what it looks like. Having clear directions and objectives means that you can say no to the wrong things and yes to the important things.

Have a maintenance plan in place. What will you do if referrals dry up if you are ill or if you have to find new premises.

There's a lot of uncertainty and anxiety when starting your own business and we know that stress, anxiety and overwhelm narrows and alters our thinking style. A business plan is your wise mind, a support and mentor that can guide your business.

I hope we have helped you with thinking about putting together a business plan and you now feel motivated to get started. It's actually more aligned with good practice CBT than you think! I bet that surprised you.

Running your own business is one of the most rewarding things you can do.

You are your own boss, you set your own rules and you can be as creative as you like but you will likely work harder than ever before It doesn't come easy, to connect with people that have gone before you ask all the questions that you can and set yourself up with a solid foundation a business plan that will do the hard work for you and enjoy.

Sarah Rees is in full-time private practice in Wilmslow, Cheshire (sarahdrees.co.uk) seeing people throughout the age groups and also developed the online self-help tool 'The CBT Journal' as well as undertaking clinical supervision for other therapists in private practice.

Heather Howard-Thompson also delivers CBT in full-time private practice in Barnsley as director of Yorkshire Psychotherapy (yorkshirepsychotherapy.co.uk).

In Gloucestershire, IAPT Therapists sit side by side with Mental Health Nurses, working together within the same team. The 2gether NHS Foundation Trust Mental Health Intermediate Care Team (or MHICT) brings together primary care mental health nursing and IAPT (Let's Talk).

Collaborative working at its best?

By **Zoë Hepburn, Houda Jaouhar, Andy Robbins, Nick Stevenson** and **Mark Stubbings**

Working closely with General Practice and IAPT, MHICT nurses offer mental health triaging assessments targeted across clusters 1 to 4, 8 and 11. The nursing role includes prescribing antidepressant medication, signposting to other professionals (including IAPT, secondary care, substance misuse services and social prescribing) and offering brief nursing-led evidence-based interventions to help clients stabilise and, if appropriate, prepare to engage in psychological therapy with IAPT.

Benefits to staff

Both therapists and nurses describe benefitting from an awareness and appreciation of their different respective professional perspectives and cultures. For example, together they are able to bridge the gap between the psychological model and the medical model in order to build a more holistic perspective of the client's treatment needs. Since therapists and nurses are based within the same office, impromptu case consultations and referral discussions are possible (for example regarding risk management, possible symptoms of severe mental illness, or suitability for CBT), saving paperwork and time. Similarly, communication between therapists and nurses is aided through use of the same electronic system for patient notes. Regular joint team meetings (where all nursing and therapy staff attend together and host guest speakers) provide a forum for shared reflection on good practice and multi-disciplinary learning and an opportunity for continuing professional development.

Benefits to clients

The client's experience is improved due to easy communication between therapists and nurses and smooth referral and transition procedures between the professional groups. Clients receive a consistent message from both sets of professionals, and joint assessments and hand-over sessions can be arranged easily. Via the MHICT nursing team, specialist mental health medication advice and monitoring can be easily accessed, with nurse Non-Medical Prescribers (NMPs) having direct access to psychiatrists for advice, removing the need for a GP to seek advice separately. This also ensures that therapy with IAPT is not disrupted by medication problems.

Overcoming challenges

Despite overwhelmingly positive feedback from both therapists and nurses about working collaboratively, challenges do exist. Differences of opinion can arise, for example as a result of contrasting perspectives on risk and/or suitability for the CBT model. However these kinds of debate (which after all, are typical of many health service referral discussions) are resolved far more easily, and to the client's advantage, by MHICT colleagues being integrated than they would otherwise be if nurses and therapists were based in separate services. Therapists and nurses agree that the key to overcoming challenges lies in keeping open the channels of communication and being willing to listen to and learn from the different perspectives.

LET'S TALK
TALKING YOUR WAY TO BETTER MENTAL HEALTH

NHS
2gether
Making life better

How does it work in practice? A case study

Background:

Steve (a pseudonym used to protect confidentiality), aged 31, had a diagnosis of emotionally unstable personality disorder and described suffering from recurrent depression with debilitating levels of anxiety. He had received several unsuccessful episodes of treatment within secondary care and two psychiatric inpatient admissions, in relation to past suicide attempts. He was referred to MHICT by the Crisis Resolution and Home Treatment Team.

Nursing Team involvement:

During initial nursing triage assessment, Steve reported daily panic attacks and episodes where he would lock himself in a room and hide under a desk. He attended his first nursing appointment clutching a soft toy for comfort. Due to frequent suicidal ideation and expressed intent, Steve was not eligible for IAPT at the time of initial contact. Following nursing discussions with Steve, his previous Consultant Psychiatrist and with IAPT, he was referred to and accepted by IAPT, for treatment of his generalised anxiety disorder (GAD). While on the waiting list for CBT with IAPT (approximately 14 weeks) and during the first few weeks of his engagement with IAPT, he received a brief treatment intervention from a MHICT Mental Health Nurse.

The nursing intervention helped Steve to stabilise his mental health, reduce his risk of suicide and set some basic goals for structuring his time. Steve attended regular brief nursing appointments with his partner and both were socialised to MHICT ways of working. This provided a positive foundation for the CBT intervention for GAD, which followed a hand-over session involving Steve, his partner and the MHICT nurse and therapist.

Treatment outcomes:

On beginning CBT, Steve commented that he could not remember a time of his life when he had not felt depressed, and he could not imagine recovering from mental illness. He described feeling huge trepidation that, if he were to recover, he would lose a part of himself. Nevertheless, he showed great courage in engaging with the CBT model and experimenting with different ways of thinking, coping and communicating. Steve's self-esteem improved and his symptoms reduced steadily, such that he entered complete remission from both depression and GAD within 10 sessions of CBT. Steve became newly hopeful and optimistic about his future life prospects. Having been unable to work for several months prior to receiving CBT, during the last month of his CBT, he was in the early stages of setting up an online business in a field about which he felt passionate.

On discharge from MHICT, Steve commented that CBT had enabled him to become "more myself" instead of taking away part of him, as he had feared. He explained that the initial nursing intervention had prepared him well for therapy and he had felt secure and contained in the knowledge that his nurse and therapist were working collaboratively in his best interests.

> "Therapists and nurses agree that the key to overcoming challenges lies in keeping open the channels of communication and being willing to listen to and learn from the different perspectives."

Zoë Hepburn is a High Intensity Therapist, Houda Jaouhar and Andy Robbins are Personal Wellbeing Practitioners, Nick Stevenson is a Senior Triage Nurse and Mark Stubbings (RMN) is their Team Manager at the MHICT (North) in the 2gether NHS Foundation Trust.

Giving us all of the feels

The therapeutic benefits of poetry

Patricia Murphy

Poetry is the most ancient record of human literature and has a powerful effect on emotions and brain activity (Wassiliwizky et al, 2017).

It goes to the heart and soul of human experience charting life's central emotional themes of love and loss, twin refrains which have inspired poets through the ages. Who better than a poet to unite Manchester after the horrific terrorist attack in May 2017 when a suicide bomber chose a crowded concert to kill 22 people.

The attack left the city in total shock but when Mancunian poet Tony Walsh, AKA Longfella read aloud 'This is The Place' at a vigil held in Albert Square the following day, he gifted the people of Manchester a healing balm and an opportunity to come together around a heartfelt love song that totally eclipsed the usual banalities characterised by the 'thoughts and prayers' so often offered up by our leaders at times of national sorrow.

Similarly, it was a poet who six years ago wowed a packed auditorium at the Royal College of Nursing's Annual Congress. Molly Case, a student nurse at the time, gave a passionate performance of her poem, 'Nursing the Nation' which had been written in response to the relentless media criticism of the NHS. It received a standing ovation and has been viewed half a million times on YouTube.

And it was poet Kate Tempest whose singular voice left a Glastonbury crowd emotionally undone but totally appreciated after closing her set with 'People's Faces', a protest poem against austerity and its divisive effects that mesmerised with its message of strength, compassion, hope and love.

These examples demonstrate what we now know, that poetry activates parts of the human brain distinct from those affected by other forms of literature. Researchers have recently used functional Magnetic Resonance Imaging (fMRI) to study just how the human brain reacts to poetry.

Reading or listening to poetry is useful for something besides just rousing our emotions and elevating our souls. The same mental skills that we exercise in struggling to understand TS Eliot's *The Love Song of J Alfred Prufrock* ie. flexible thinking and the ability to ponder multiple meanings also help us to navigate unpredictable events and make choices in our everyday lives.

Helping patients develop flexible thinking is at the heart of CBT but if only it were so simple. As useful as behavioural experiments, thought challenging, or drawing up a list of pros and cons can be they have their limitations. We already know that writing with deep feeling improves immune system function, decreases stress, lowers blood pressure and increases positive short and long term mood changes (Pennebaker, 2004).

Poetry has a distinctive, deeper, richer power which means "meticulous placing of a few simple words, can brush gently against deeply buried memories, emotions, joys and traumas and allow us to think metaphorically" (Storr, 2019). These associative processes increase awareness and enable us to find meaning in the complex. Poetry can elicit the therapeutic equivalent of the 'ah-ha' moment, akin

Poetry Therapy Study

As yet, there is little more than anecdotal evidence presented for the case of practising poetry as a mode of therapy within its own right. With a working title of Poetry therapy in practice: An exploration of theoretical mechanisms, their use, and implications for participants, the perceived impact of poetry therapy, research is being carried out at Canterbury Christ Church University.

A literature review will collate models of poetry therapy and art therapy, alongside those of methods described by traditional schools of therapy. These will be used to devise a framework against which poetry therapy in practice can be compared. Video recordings of poetry therapy sessions will be used to identify if and when these ideas are applied in practice, with interviews conducted with participants to explore their lived experience of attending poetry therapy.

It is thought by the research team conducting the research, that this process study is the first of its kind, making a unique contribution to the poetry therapy and wider arts in health literature.

to panning for gold and finding, well, gold.

It makes sense then that the profound psychological benefits people experience bonding over poetry should not be confined to times of national distress but encouraged as a means of promoting and maintaining psychological wellbeing. This is the mission of the "Wise Words For Well-Being" poetry group which has been running for some years now in the beautiful and historic city of Canterbury. It is led by trained Poetry Therapist and writer Victoria Field, who is a graduate member of the British Psychological Society and a visiting lecturer on the Metanoia Institute's MSc in Creative Writing for Therapeutic Purposes.

The group is held in a community room at the local library thus combining three of Vicky's passions, people, poetry and libraries. It has attracted the attention of clinical psychologist researchers at Canterbury Christ Church University who recently filmed the group in session as part of their exploration of poetry therapy in practice, studying the theoretical mechanisms, their use and implications for participants. The purpose of the research is to find out more about how poetry therapy works and what impact it has on people attending poetry groups.

It will be fascinating to see how the research will contribute to the knowledge base with regard to poetry therapy and whether this will have implications for future psychotherapeutic practice. In the next issue of *CBT Today* Vicky will share her thoughts about the project and her hopes for the future applications of Poetry Therapy.

References

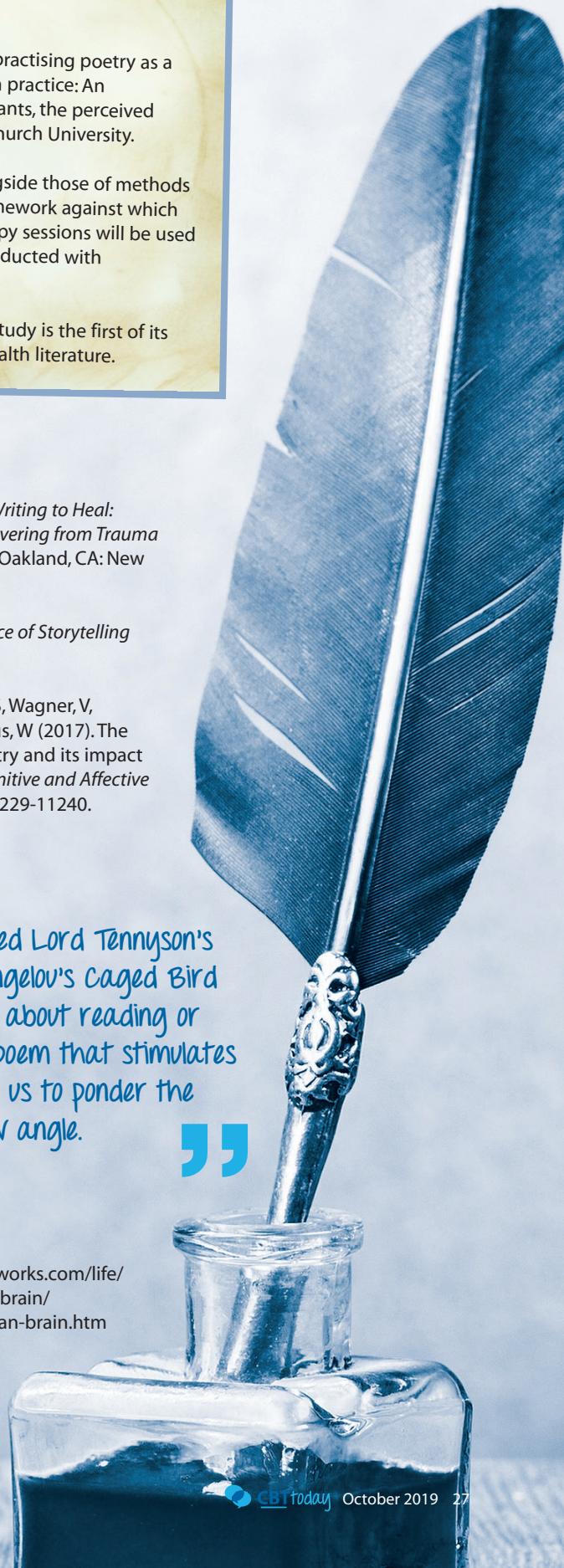
Pennebaker, JW (2004). *Writing to Heal: A Guided Journal for Recovering from Trauma and Emotional Upheaval* Oakland, CA: New Harbinger Publications.

Storr, W (2019). *The Science of Storytelling* London: Harper Collins.

Wassiliwizky, E, Koelsch, S, Wagner, V, Jacobson, T, Menninghaus, W (2017). The emotional power of poetry and its impact on our brains. *Social Cognitive and Affective Neuroscience* 12(8) , pp. 1229-11240.

> "Whether it's Alfred Lord Tennyson's Ulysses or May Angelou's Caged Bird there's something about reading or hearing a great poem that stimulates our minds, moving us to ponder the world from a new angle."

https://science.howstuffworks.com/life/inside-the-mind/human-brain/how-poetry-affects-human-brain.htm



Tidy Minds

*When **Natalie Hanley** started to communicate guided self-help CBT techniques in her role as a Psychological Wellbeing Practitioner she found that using doodles was helpful; especially for people with learning, memory and concentration difficulties or for more visual learners. Here, she tells* CBT Today *about her doodling.*

I love how one doodle can be interpreted in a very personal way – often depending on how that person is feeling and what they have going on in their lives.

I really wanted to promote the benefits of CBT and combine my limited doodling skills so I started a self-care wellbeing Instagram account, which presents CBT techniques, mindfulness and compassionate self-talk in an accessible, simple and uplifting way.

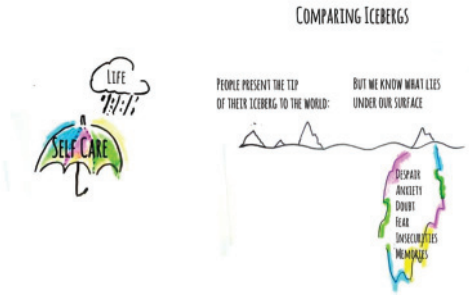
I also hoped it would encourage people to look after their own mental wellbeing by following simple tips in bitesize and colourful chunks – and possible share this information with people who might be struggling with this.

As a mental health professional, I know it can be easy to promote self-care but harder to follow. Creating these doodles helped me to follow my own advice and give me that gentle nudge I think many of us could benefit from.

The communications team at the 2gether Trust where I work are also including two of the illustrations on postcards for new starters and NHS staff – there will be around 5,500 staff members with these postcards as daily reminders to look after themselves in a light-hearted way due to the positive feedback from staff about how my doodles really resonate with them.

I am also in the process of offering an illustration to the Trust to be hung in the waiting room for patients to see whilst waiting for therapy and I am involved with the Social Inclusion team to promote access to CBT services in a friendly light-hearted way.

I hope you enjoy them and please share!



> “Creating these doodles helped me to follow my own advice and give me that gentle nudge I think many of us could benefit from.”

You can follow Natalie’s work on Instagram and Twitter at tidyminddoodles.
She can be contacted at nataie_hanley@yahoo.co.uk

What do you know about your BABCP membership?

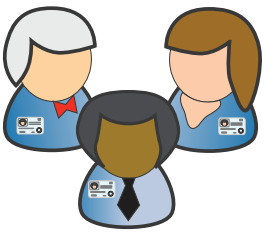
Did you know that you are one of almost 12,500 others who have an interest in CBT theory and practice? Of these, nearly 7,000 are BABCP accredited.

CPD Events

More than 70 events each year

3,000 individual bookings

Over 450 CPD hours



A team of dedicated staff

The Branches and SIGs are responsible for organising more than **70 events** each year and supported by the BABCP staff team account for more than **3,000 individual bookings** and the provision of over **450 CPD hours**. There is a team of **20-plus staff** who contribute to the work of BABCP and support the members and volunteers. We're happy to help where we can so please get in touch. Our contact details are on the website.

Follow us on twitter @BABCP

Branches and Special Interest Groups

All BABCP members are assigned a 'branch' dependent on their postcode. This is a network of members in your area, with 20 branches across the UK and Ireland.

Each branch has a committee of local volunteers who carry out a range of activities, including organising CPD events. We know there are some members who find that whilst their local branch may be close to where they live, they may be nearer to another branch at their place of work. In this case, we can link you up with a secondary branch. If you want us to do this please get in touch with the membership team at membership@babcp.com who will arrange this for you. You should note that you will only be able to attend and vote at the AGM for your local branch and not the secondary branch.

In addition to the regional branches we also have Special Interest Groups. Again, each of these also has a committee of volunteers working to promote a specific area of CBT. Take a look at the list below. You can visit our website for more information about them and if there is one that you would like to join please get in touch and we will add this to your membership record. This means next time there is information sent out linked to these groups you will be on the mailing list.

Special Interest Groups

- Acceptance and Commitment Therapy (ACT)
- CBT Medics
- Children, Adolescents & Families
- Cognitive-Behavioural Analysis System of Psychotherapy (CBASP)
- Compassion
- Control Theory
- Couples
- Dialectical Behaviour Therapy (DBT)
- Equality & Culture
- Group CBT
- Independent Practitioners
- IT
- Low Intensity Cognitive Behavioural Interventions
- Long Term Health Conditions and Medically Unexplained Symptoms
- Schema Therapy
- Supervision
- Women and Gender Minorities Equality

Devon & Cornwall Branch
presents

Chairwork in CBT

with Tobyn Bell & Matthew Pugh

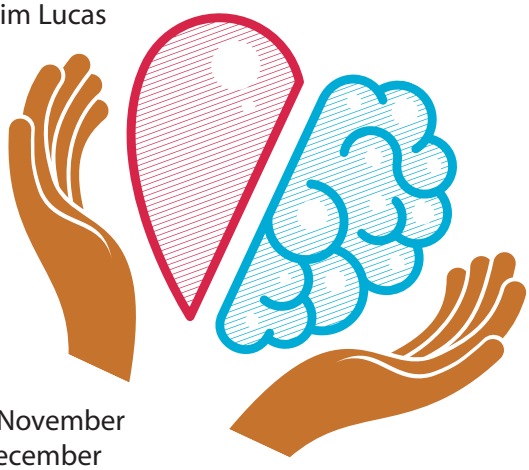
25 & 26 February 2020
Buckfastleigh

East Midlands Branch
presents

The Head, Heart and Hands of ACT:

A theoretical, experiential and practical introduction to the application of ACT for common mental health problems

with Jim Lucas



4 & 5 November
& 2 December
Nottingham

To find out more about these workshops, or to register, please visit www.babcp.com/events or email workshops@babcp.com

Isle of Man Branch
presents

An introduction to the underpinnings of CBT

with Helen Macdonald

21 November

Treating Long Term Conditions and Pain with CBT

with Helen Macdonald

22 November

Acceptance & Commitment Therapy: Two-day introductory workshop

With Dr Joe Oliver

9 & 10 December

All workshops are in Strang

North West Wales Branch
presents

What are emotions for?

An introduction to a DBT understanding of what emotions do for us, a model for emotional experiences, and how we can regulate emotional responses

with Stephanie Hastings

21 November
Bangor

Free to attend
No need to register

Scotland Branch
presents

Working effectively with Anxiety:

Flexibility with Fidelity

with Dr Nick Grey

8 November
Scone

South East Branch
presents

CBT for Social Anxiety

with Dr Robert Medcalf
21 November

Advanced Compassion Focused Therapy Three Day Workshop

with Dr Deborah Lee
27 - 29 November

Both workshops are in Sevenoaks

To find out more about these workshops, or to register, please visit www.babcp.com/events or email workshops@babcp.com

London Branch
presents

Cognitive Behavioural Chairwork: Advanced Skills and Applications

with Matthew Pugh & Tobyn Bell

4 & 5 December
London

IABCP
presents

CBT Supervision: Integrating practical skills with a conceptual framework

with Stephen Barton

22 November
Belfast

Couples Special Interest Group
presents

Group Supervision and Networking for Couples Therapists

with the Couples SIG committee

16 January 2020
London

Equality & Culture Special Interest Group
presents

Writing for Change

led by Richard Thwaites

6 December
Manchester

To find out more about these workshops, or to register, please visit www.babcp.com/events or email workshops@babcp.com

Independent Practitioners SIG
presents

Becoming a more effective Independent Practitioner

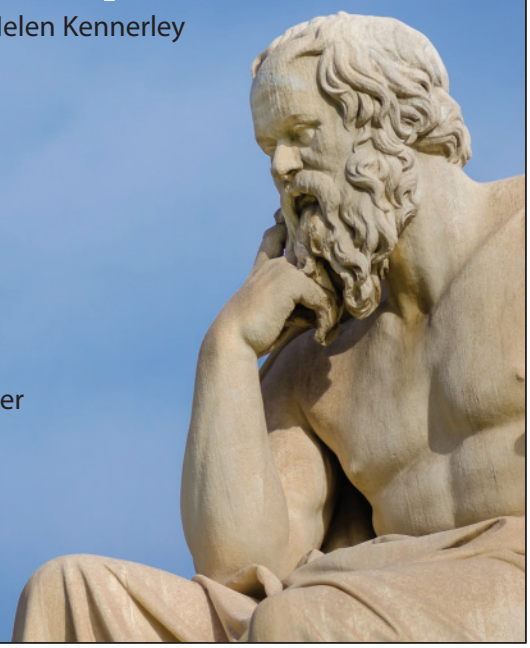
with Lee Grant & Stephen Wilson

26 October
London

Supervision SIG
presents

Ask Don't Tell: Socratic Methods in CBT Supervision

with Dr Helen Kennerley



29 October
Oxford

Russ Harris

2020 ACT Workshops

Dr Russ Harris returns to the UK in 2020 to deliver two highly acclaimed workshops

For the first time ever in the UK, an Introduction to ACT, and his very popular ACT for Depression and Anxiety.

Russ Harris presents ACT in a truly accessible style, seamlessly weaving together theoretical knowledge and practical application. His workshops are entertaining and inspiring, brimming with thoughtful experiential exercises presented with clarity and authenticity.

Contextual Consulting

Introduction to ACT workshop

Central London 23rd & 24th March

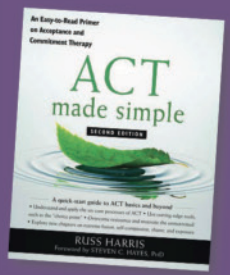
ACT for Beginners Workshop

A very practical, experiential workshop where you'll come out with a solid grounding in ACT. It will be useful for therapists, coaches and practitioners.

The workshop is a 'jargon-free zone' guided by three core values: simplicity, clarity, and accessibility and it covers so much material in such a short space of time. (There's also a big emphasis on having fun).

You will experience a wide variety of ACT exercises, and you will be encouraged to work with your own personal issues. You will be led through these exercises in the same way as you would instruct them to your clients.

You will also receive extensive support materials (more so than in any other ACT training around the world) including an album of professionally-recorded mp3s of key mindfulness skills, and a 3-months-long follow up e-course.



ACT for Depression and Anxiety

Central London 25th & 26th March

EVERY DAY, AROUND THE GLOBE, DEPRESSION AND ANXIETY SHATTER THE LIVES OF MILLIONS.

But you have the power to make a difference? ...

Do you want to help your clients find rapid relief from suffering? And go on to build richer, fuller lives? If so, this 2-day advanced level workshop on is for you. You'll go deeper into the ACT model, take your skills to the next level, and learn specific methods for depression and anxiety disorders. You'll learn about common stumbling blocks and sticking points, and how to quickly get around them.

And you'll discover a wealth of practical tools and strategies to effectively target depression (major depressive disorder and dysthymia) and the full range of anxiety disorders (from OCD & phobias to social anxiety & panic disorder). The workshop will include live demonstrations, videos of therapy sessions, and a wide range of experiential exercises.

Check out our other 2019 workshops!

Yvonne Barnes-Holmes – Enhancing ACT with RFT – October (available by webcast)

Louise Hayes – ACT for Young People – November

Joe Oliver – Intermediate Skills Workshop – November

Ray Owen – ACT for Physical Health – April

For more workshop information, rates and **special discounts for booking both workshops**, venue locations and how to register please see:

www.contextualconsulting.co.uk

Starts December 2019

BPS Approved Certificate in Dialectical Behaviour Therapy (DBT)

The Certificate in Dialectical Behaviour Therapy (DBT) is Approved by The British Psychological Society and is designed to provide a detailed training in the "taught elements" of DBT as well as guidance and support in its practical application and maintenance through the establishment of Consult Groups.

The course consists of 3 modules

Module 1 (Foundation)

Introduction to DBT

TWO DAYS (09.30-17.00)

A broad overview of DBT covering its basic background and key concepts and strategies contained within it. This two day course is an open access course designed for those who want a broad introduction to DBT.

Module 2 (Advanced Assessed Academic Competence)

DBT Skills Training Groups (STG):

FIVE DAYS – 4 courses (09.30-17.00)

- DBT STG on Emotional Regulation
- DBT STG on Distress Tolerance
- DBT STG on Interpersonal Effectiveness
- Mindfulness (2 days)

Modules 1 & 2 are followed by an online multiple choice exam. Pass mark – 80%.

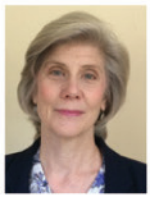
Module 3 (Clinical Proficiency)

Assessed casebook assignment, consult group attendance, reports and test

Course Dates

Introduction to DBT	05 – 06 December 2019
STG: Distress Tolerance	10 March 2020
STG: Emotional Regulation	11 March 2020
STG: Interpersonal Effectiveness	12 March 2020
Mindfulness	Full Course Recording

Course Tutors



Catherine Parker
Accredited CBT Therapist

Catherine completed her intensive **DBT training in 2001.** She was a founder member of the Derbyshire DBT Service, delivering **full programme DBT for over 15 years.** Throughout her career as a psychotherapist, she has delivered DBT workshops within her NHS Trust and at local universities. She has been the **Chair of the DBT Special Interest Group of the BABCP since 2013**.

Marie Wassberg
Accredited CBT Therapist

Marie has **Diploma in Dialectical Behaviour Therapy (DBT), gained in 2010.** She is also trained in Trauma Focused-CBT, including Supervisor training; Prolonged Exposure; and DBT for Schools (STEPS-A). Marie has been part of developing many DBT-informed programmes in different settings in Sweden, in England and in Mexico.

Available via Live Interactive Webcast or at BPS, London

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- Working with Extreme Behaviour
- Motivational Interviewing
- Solution-Focused Therapy
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