Ensuring Quality in IAPT Services: Supervision, Training and Therapists’ ‘Flexibility within Fidelity’

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Centre for Anxiety Disorders and Trauma
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Thanks

• Adrian Whittington
• David Clark
• Anke Ehlers, Paul Salkovskis, Simon Darnley, Sheena Liness, Suzanne Byrne, Alicia Deale, Colette Hirsch
• CADAT
• IOPPN
Learning Objectives

• To know some of the factors that affect quality in psychological services
• To understand the importance of therapists understanding treatment conceptually as well as technically
• To know how to make the most of training and supervision
• To understand how the way services are organised affects quality
Get the most effective treatments to as many people as need them at a high quality.
Improving Access to Psychological Therapy

*Nature*

“The IAPT “programme represents a world beating standard, thanks to the scale of its implementation and the validation of its treatments”

*Sir Simon Wessely (Royal College Psychiatrists)*

“The greatest revolution in British mental health in 50 years”
IAPT So Far

- Revolutionized treatment of anxiety & depression
- Implementation of NICE guidelines
- Stepped care psychological therapy services established in every area of England (211 CCGs).
- 15.6% of local prevalence seen in services***
- Around 60% have course of treatment (504,000 per year)
- Outcomes recorded in 97% of cases (pre-IAPT 38%)
- Very strict (depression & anxiety) recovery criteria
- Nationally 45.5% recover and further 16% improve.
Clinical example: working with images associated with shame

- Hannah
- Drug induced paranoid episode
- Attempted suicide 10 years previously
- Detachment and numbing very strong
<table>
<thead>
<tr>
<th>image</th>
<th>meaning</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standing at top of bridge</td>
<td>I must be bad if they want me dead</td>
</tr>
<tr>
<td>Lying on road and being put on stretcher</td>
<td>It’s my fault, I’m a bad person</td>
</tr>
<tr>
<td>Sexual abuse at hospital</td>
<td>My body responded which is disgusting and makes me a bad person</td>
</tr>
<tr>
<td>Blood coming out of mouth at hospital</td>
<td>I’m going to die</td>
</tr>
</tbody>
</table>
• Reliving
  – Devoid of emotion
• Didn’t allow emotions generally as triggered the trauma and reinforced belief as being bad person
• Shame - 90%
Done shortly after trauma

- None of sexual abuse as was too disgusting and shameful
Asked to draw images of how feeling now

- Done early in therapy
- Overall representation of being bad
- Draw hotspots too
Drawings of hotspots

• Matched the images re-experienced
Sexual abuse not my fault

• Shame 70%
Contextualising the drug use

• Earlier experience
  – School
  – Father
  – First love
  – Physical ‘benefits’
  – RTA bereavement

• Trauma not an isolated event
  – Shame 50%
  – “I’m not so bad”

• Drawing to update the images emotionally
  – Hotspots (“no longer bad”) and more generally too (“no longer alone”)
NOT ALONE
Outcome

• At end of treatment shame 10%
• Images no longer re-experienced
• At 3 month and 1 year follow up, shame 0%

• Shows how images used and manipulated to enhance change in meanings through use of drawings rather than imaginal reliving
The individual therapist
The training and supervision
The treatment provided
The service and organisation

Quality
The Therapist

• Basic clinical skills
  – Warmth
  – Empathy

• Build a therapeutic relationship

• Selecting therapists for training
NICE mental health guidelines – *positive recommendations*

- **Psychological Therapies**
  - **Cognitive Behaviour Therapy** (Depression, OCD, APMH, PTSD, PD, SAD, GAD, Child Depression, Eating Disorders, Antisocial Personality Disorder)
  - **Guided Self Help** (Depression, GAD, PD, SAD, OCD)
  - **Interpersonal Therapy** (Depression, Eating Disorders)
  - **Parent training** (ADHD, Antisocial Personality Disorder)
  - **Behavioural Couples Therapy** (Depression; Substance Misuse)
  - **Analytic Therapy** (Depression, SAD, Childhood Depression)
  - **Family Interventions** (Eating Disorders)
  - **Eye Movement Desensitisation and Reprocessing** (PTSD)
  - **Counselling** (Depression)
  - **Motivational Interviewing** (Substance Misuse)
  - **Contingency Management** (Substance Misuse)
NICE mental health guidelines – *negative /no recommendations*

- Psychological Therapies
  - Individual debriefing (PTSD)
  - Family Interventions (Substance Misuse)
  - Interpersonal Therapy (BD, DCHP)
  - Analytic Therapy (OCD, PTSD, BPD, ASPD, APMH)
  - Counselling (GAD, PD, OCD)
  - Cognitive Behavioural Therapy (Substance Misuse)
  - Cognitive Remediation Therapy (Schizophrenia)
  - Facilitated mourning (APMH)
CBT competencies

- Roth & Pilling (2007)
- Generic therapeutic competencies
- Basic CBT competencies
- Specific behavioural and cognitive therapy
- Problem specific competencies
- Metacompetencies
  - Generic
  - CBT specific
- [www.ucl.ac.uk/CORE/](http://www.ucl.ac.uk/CORE/)
  - Interactive map
  - Written materials
“In a professional kitchen, recipes are essential to creating consistent food, so that everyone takes the same path to the same place. But cooks who rely only on strictly codified formulas miss out on what is really important. Are the carrots more or less sweet, more or less tender? Is the ginger very strong, so that less should be used, or too weak for the amount specified? Or the thorniest problem: How long does it take something to cook, in a specific oven, on a specific day, with a certain set of ingredients?”

Daniel Patterson, Head Chef, Coi, San Francisco
The empirical status of cognitive-behavioral therapy: A review of meta-analyses

Andrew C. Butler a,*, Jason E. Chapman b, Evan M. Forman c, Aaron T. Beck a

a University of Pennsylvania and the Beck Institute for Cognitive Therapy and Research, United States
b Medical University of South Carolina, United States
c Drexel University, United States

Table 1

<table>
<thead>
<tr>
<th>Meta analysis</th>
<th>Comparisons</th>
<th>Outcome variable</th>
<th>Comparison group</th>
<th>ES</th>
<th>V (95%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult unipolar depression</td>
<td>20</td>
<td>Beck depression inventory</td>
<td>Wait list or placebo</td>
<td>0.82</td>
<td>79</td>
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<tr>
<td></td>
<td>17</td>
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<td>Antidepressants</td>
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<td>Behavior therapy</td>
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<tr>
<td></td>
<td>22</td>
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<td>Other miscellaneous psychotherapies</td>
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<td>59</td>
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<tr>
<td>Adolescent unipolar depression</td>
<td>5</td>
<td>Within-study average of various depression measures</td>
<td>Wait list</td>
<td>1.11</td>
<td>87</td>
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<tr>
<td></td>
<td>1</td>
<td>Mood and feelings questionnaire</td>
<td>Relaxation</td>
<td>0.75</td>
<td>77</td>
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<tr>
<td></td>
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<td>Beck depression inventory</td>
<td>Supportive therapy</td>
<td>0.55</td>
<td>71</td>
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<tr>
<td></td>
<td>4</td>
<td>Within-study average of various depression measures</td>
<td>Wait list at follow-up (mean follow-up interval—6.3 weeks)</td>
<td>0.55</td>
<td>71</td>
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<td>Mood and Feelings Questionnaire</td>
<td>Relaxation at follow-up (3 months)</td>
<td>0.45</td>
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<td>Supportive therapy at follow-up (3 months)</td>
<td>1.12</td>
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<tr>
<td>Generalized anxiety disorder</td>
<td>4</td>
<td>Various self-report measures of anxiety or worry</td>
<td>Wait list or no treatment</td>
<td>0.82</td>
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<tr>
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<td>Non Directive therapy</td>
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<td>CT + relaxation vs. nondirective + relaxation</td>
<td>0.72</td>
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<tr>
<td></td>
<td>2</td>
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<td>Pill placebo</td>
<td>1.26</td>
<td>90</td>
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<tr>
<td>Panic disorder with agoraphobia</td>
<td>7</td>
<td>Fear questionnaire total score</td>
<td>Community norms</td>
<td>0.48*</td>
<td>69</td>
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<tr>
<td></td>
<td>11</td>
<td>Fear questionnaire</td>
<td>Community norms</td>
<td>0.17*</td>
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<tr>
<td></td>
<td>7</td>
<td>Agoraphobia score</td>
<td>Community norms — Follow-up (interval unspecified)</td>
<td>0.47*</td>
<td>68</td>
</tr>
<tr>
<td></td>
<td>11</td>
<td>Fear questionnaire total score</td>
<td>Community norms — Follow-up (interval unspecified)</td>
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<td>59</td>
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<tr>
<td>Schizophrenia</td>
<td>4</td>
<td>Positive symptoms (Various clinician rating scales)</td>
<td>Reduction from pre-to post-treatment</td>
<td>1.28*</td>
<td>90</td>
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<tr>
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<td>Negative symptoms (Various clinician rating scales)</td>
<td>Reduction from pre-to post-treatment</td>
<td>0.91*</td>
<td>82</td>
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<tr>
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<td>Total symptoms (Various clinician rating scales)</td>
<td>Reduction from pre-to post-treatment</td>
<td>1.50*</td>
<td>93</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Various questionnaire measures of marital adjustment</td>
<td>Untreated control couples at end of treatment</td>
<td>0.71</td>
<td>76</td>
</tr>
</tbody>
</table>

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<td>Obsessive-compulsive disorder</td>
<td>2</td>
<td>Obsessive-compulsive symptoms:</td>
<td>Reduction from pre-to post-treatment</td>
<td>1.86*</td>
<td>97</td>
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<tr>
<td></td>
<td>4</td>
<td>Behavioral measures and</td>
<td>Exposure with response prevention</td>
<td>0.19*</td>
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<tr>
<td>Posttraumatic stress disorder</td>
<td>National Collaborating Centre for Mental Health (2003)</td>
<td>Likelihood of having a PTSD diagnosis after treatment</td>
<td>Wait list</td>
<td>0.47*</td>
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<tr>
<td></td>
<td>8</td>
<td>Severity of PTSD symptoms (self-report measures)</td>
<td>Wait list</td>
<td>1.70</td>
<td>96</td>
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<tr>
<td></td>
<td>13</td>
<td>Severity of PTSD symptoms (clinician-rated measures)</td>
<td>Wait list</td>
<td>1.36</td>
<td>91</td>
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<tr>
<td></td>
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<td>Depression symptoms</td>
<td>Wait list</td>
<td>1.20</td>
<td>89</td>
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<tr>
<td></td>
<td>10</td>
<td>Anxiety symptoms (self-report measure)</td>
<td>Wait list</td>
<td>0.94</td>
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<tr>
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<td>6</td>
<td>Likelihood of having a PTSD diagnosis after treatment</td>
<td>Eye Movement Desensitization and Reprocessing (EMDR)</td>
<td>1.00*</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Severity of PTSD symptoms (self-report measures)</td>
<td>EMDR</td>
<td>0.31</td>
<td>62</td>
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<tr>
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<td>Likelihood of having a PTSD diagnosis after treatment</td>
<td>Stress management therapies (not trauma focused)</td>
<td>0.78*</td>
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<tr>
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<td>Severity of PTSD symptoms (self-report measures)</td>
<td>Stress management therapies (not trauma focused)</td>
<td>0.57</td>
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<tr>
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<td>5</td>
<td>Likelihood of having a PTSD diagnosis after treatment</td>
<td>Other therapies</td>
<td>0.71*</td>
<td></td>
</tr>
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<td>3</td>
<td>Severity of PTSD symptoms (self-report measures)</td>
<td>Other therapies</td>
<td>1.18</td>
<td>88</td>
</tr>
</tbody>
</table>

Gould, Otto et al. (1997)
Oei, Otto et al. (1999)
Rector and Beck (2001)

* Indicates a statistically significant effect.
Effectiveness in Routine Care

Dilution
Mild dilution of RCT effects (Westbrook and Kirk, 2005) and higher relapse (Gibbons et al., 2010)

Replication
Replication of RCT effects (Brewin et al., 2008; Foa et al., 2005) and almost equivalent relapse (DiMauro et al., 2013)

Enhancement
Improvement on RCTs (Ost, 2013)
Chuck away the research evidence
RCT Evidence – Myths

“RCTs not representative of clients seen in routine care”

✧ Only 5% seen in routine care would be excluded from RCT, many because too ‘mild’ (Stirman et al., 2005)
✧ Trials with only minimal exclusions have achieved similar effects (DeRubeis et al., 2005)
✧ Those who would be excluded still achieved large effects (Ehlers et al., 2013)

“Interventions from RCT manuals are prescriptive and inflexible”

✧ Usually individualised formulation
✧ “Flexibility within fidelity” expected (Kendall and Beidas, 2007)
## RCT Evidence – Reality

### Likely true differences between RCTs and Routine Practice

<table>
<thead>
<tr>
<th></th>
<th>RCTs</th>
<th>Routine practice</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Resources</strong></td>
<td>Usually better resourced</td>
<td>Resources restricted</td>
</tr>
<tr>
<td><strong>Assessment</strong></td>
<td>More structured, detailed and regular</td>
<td>Procedures to identify focal problems and diagnoses less common</td>
</tr>
<tr>
<td><strong>Therapists</strong></td>
<td>More likely to be expert in administration of a particular treatment</td>
<td>Covering a wider range of main problems</td>
</tr>
<tr>
<td><strong>Caseloads</strong></td>
<td>Usually smaller</td>
<td>Usually larger</td>
</tr>
<tr>
<td><strong>Therapy</strong></td>
<td>Protocol controls duration and number of sessions</td>
<td>Often service demands control duration and number of sessions</td>
</tr>
<tr>
<td><strong>Engagement</strong></td>
<td>Sometimes greater efforts made to maintain engagement</td>
<td>Sometimes less emphasis on reducing attrition rates given the often large numbers waiting for treatments.</td>
</tr>
<tr>
<td><strong>Quality Control</strong></td>
<td>Adherence monitoring and high quality supervision</td>
<td>Adherence monitoring may be limited and supervision of less consistent quality</td>
</tr>
</tbody>
</table>
Drift away from CBT principles
The Dangers of Therapeutic Drift

- Drift away from pushing for behaviour change is common (Waller, 2009)

- Therapist switches away from core methods of CBT linked to poorer outcomes (Schulte and Eifert, 2002)
Apply techniques rigidly
The Dangers of Rigidity

- Pushing harder on rigid technique in the face of alliance problems is linked to poorer outcomes (Castonguay et al., 1996)

- Planned flex in structure e.g. providing more sessions or “stressor” sessions can maintain good outcomes (Galovski et al., 2012).
Metacompetences

Ability to implement CBT using a collaborative approach

Generic therapeutic competences
- knowledge and understanding of mental health problems
- ability to engage client
- ability to foster and maintain a good therapeutic alliance, and to grasp the client’s perspective and ‘worldview’
- ability to deal with emotional content of sessions
- ability to manage endings
- ability to undertake generic assessment (relevant history and identifying suitability for intervention)
- ability to make use of supervision

Basic CBT competences
- knowledge of basic principles of CBT and rationale for treatment
- knowledge of common cognitive biases relevant to CBT
- knowledge of the role of safety-seeking behaviours
- ability to explain and demonstrate rationale for CBT to client
- ability to agree goals for the intervention
- ability to structure sessions
  - sharing responsibility for session structure & content
  - ability to adhere to an agreed agenda
  - ability to plan and review practice assignments (‘homework’)
  - using summaries and feedback to structure the session
- ability to use measures and self-monitoring to guide therapy and to monitor outcome
- problem solving
- ability to enact therapy in a planned manner, and to plan for long term maintenance of gains after treatment

Specific behavioural and cognitive therapy
- exposure techniques
- applied relaxation & applied tension
- activity monitoring & scheduling
- guided discovery & Socratic questioning
- ability to use thought records
- ability to identify and work with safety behaviours
- ability to detect, examine, and help client reality test automatic thoughts/images
- ability to elicit key cognitive triggers
- ability to identify and help client modify core beliefs
- ability to employ imagery techniques
- ability to plan and conduct behavioral experiments
- ability to develop formulation and use this to develop treatment plan (case conceptualization)
- ability to understand client’s inner world and response to therapy

Problem specific competences
- Specific phobias
  - Social Phobia - Heinberg
  - Social Phobia - Clark
  - Panic Disorder (with or without agoraphobia) - Clark
  - Panic Disorder (with or without agoraphobia) - Barlow
- OCD - Steketee
- OCD - Keenan
- GAD - Beck
- GAD - Deegan
- GAD - Zinbarg/Clark/Barlow
- PTSD - Fox & Rothbaum
- PTSD - Rieger
- PTSD - Ehlers

Metacompetences
- capacity to use clinical judgment when implementing treatment models
- capacity to adapt interventions in response to client feedback
- capacity to use and respond to humour

CBT specific metacompetences
- Depression – High intensity interventions
  - Cognitive Therapy – Beck
  - Behavioural Activation – Jacobson
- Depression – Low intensity interventions
  - Behavioural Activation
  - Guided CBT self-help
Metacompetences
(Roth and Pilling, 2007)

• Higher order competences that “focus on the ability to implement models in a manner that is flexible and tailored to the needs of the individual client” (p.9)

• Procedural rules for applying therapy in a theoretically coherent but appropriately adapted way
Metacompetences

Examples of procedural rules:

– Don’t assume that complex or difficult problems necessarily mean you need to work with schemas or core beliefs

– Balance Socratic with direct enquiry, and balance Socratic and didactic teaching so that your patient feels enabled by your work together, never pressured or cornered into saying or doing something
Techniques, Tactics and Principles
In CBT...

**Techniques:** Thought records, activity scheduling, behavioural experiments, attention training

**Tactics:** Whether to introduce activity scheduling before cognitive work, whether to use a cognitive method such as Theory A/B to prepare for behavioural experiments

**Principles:** Formulation-driven, Socratic style, problems persist when cognition, behaviour and emotions are linked in vicious cycles
<table>
<thead>
<tr>
<th>Principles</th>
<th>Tight</th>
<th>Loose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tactics and</td>
<td>Competent</td>
<td>Metacompetent</td>
</tr>
<tr>
<td>Techniques</td>
<td>Adherence</td>
<td>Adherence</td>
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<tr>
<td>Tight</td>
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<tr>
<td>Loose</td>
<td>Rigid Practice</td>
<td>Unfocused</td>
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<tr>
<td>Principles</td>
<td></td>
<td>Practice</td>
</tr>
<tr>
<td>Tight</td>
<td></td>
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</tbody>
</table>
Implications for Mastering Metacompetence

• Make sure you have mastered competence!
• Beware drift or rigidity when uncertain
• Stick tightly to the principles of CBT
• Collect metacompetences (procedural rules) for flexing tactics and techniques
Case Formulation

Problem Formulation

Symptom Formulation
Disorder-specific vs. transdiagnostic

• Kuyken et al (2009); Dudley et al (2011)
• Different levels of empirical evidence for different disorders (strong for anxiety)
• Evidence for transdiagnostic processes not treatments (but McManus et al, 2014)
• Client strengths and resilience
• Disorder-specific where evidence exists and possible
Table 1
A guide to the selection of disorder specific or trans-diagnostic models.

<table>
<thead>
<tr>
<th>Presenting features</th>
<th>Levels of conceptualisation</th>
<th>Collaborative approach</th>
<th>Empirical approach</th>
<th>Strengths and resilience</th>
<th>Selection of disorder specific or trans-diagnostic approaches</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single disorder such as panic</td>
<td>Clear match between presenting issue and model</td>
<td>Client agrees that working on panic is important</td>
<td>Strong evidence base for effectiveness</td>
<td>Client demonstrates effective functioning in a wide range of domains</td>
<td>Disorder specific approach</td>
</tr>
<tr>
<td>Single disorder such as schizophrenia</td>
<td>Clear match between presenting issue and model</td>
<td>Client agrees that working on psychosis symptoms is important</td>
<td>Limited evidence base for effectiveness of CBT</td>
<td>Client demonstrates limited functioning in a wide range of domains</td>
<td>Disorder specific approach with emphasis on broadening and building domains</td>
</tr>
<tr>
<td>Single disorder but one that is NOS</td>
<td>Some match between presenting issue and model</td>
<td>Client agrees that working on presenting issue is important</td>
<td>Limited evidence base for effectiveness of CBT for that issue</td>
<td>Client demonstrates effective functioning in a wide range of domains</td>
<td>Disorder specific approach but with potential trans-diagnostic features incorporated</td>
</tr>
<tr>
<td>Two or more presenting disorders (i.e. OCD and Social Phobia)</td>
<td>Good match between presenting issues and models</td>
<td>Client identifies that working on one of the presenting issue is most important</td>
<td>Good evidence base for effectiveness of CBT for both issues</td>
<td>Client demonstrates effective functioning in a wide range of domains</td>
<td>Disorder specific approach but with potential trans-diagnostic features incorporated</td>
</tr>
<tr>
<td>Two or more presenting disorders (i.e. OCD and personality disorder)</td>
<td>Good match between presenting issues and models</td>
<td>Client identifies that working on one of the presenting issue is most important</td>
<td>Mixed evidence base for effectiveness of CBT for both issues</td>
<td>Client demonstrates limited functioning in a number range of domains</td>
<td>Disorder specific approach but with potential trans-diagnostic features incorporated</td>
</tr>
<tr>
<td>Two or more presenting disorders (i.e. psychosis and personality disorder)</td>
<td>Moderate match between presenting issues and models</td>
<td>Client identifies that working on one of the presenting issue is most important</td>
<td>Limited evidence base for effectiveness of CBT for both issues</td>
<td>Client demonstrates limited functioning in a number range of domains</td>
<td>Disorder specific approach but with potential trans-diagnostic features incorporated or a trans-diagnostic approach</td>
</tr>
</tbody>
</table>

planning (Dudley, Siitarinen, James, & Dodson, 2009; Eells, 2007). On balance, the research to date does not provide a strong rationale for principle based approach to case conceptualization that directly addresses some of the clinical and empirical challenges therapists
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<td>Limited evidence base for effectiveness of CBT</td>
<td>Client demonstrates effective functioning in a wide range of domains</td>
<td>Disorder specific approach but with potential trans-diagnostic features incorporated</td>
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<tr>
<td>Two or more presenting disorders (i.e. OCD and Social Phobia)</td>
<td>Good match between presenting issues and models</td>
<td>Client identifies that working on one of the presenting issue is most important</td>
<td>Good evidence base for effectiveness of CBT for both issues</td>
<td>Client demonstrates effective functioning in a wide range of domains</td>
<td>Disorder specific approach but with potential trans-diagnostic features incorporated</td>
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<td>Two or more presenting disorders (i.e. OCD and personality disorder)</td>
<td>Good match between presenting issues and models</td>
<td>Client identifies that working on one of the presenting issue is most important</td>
<td>Mixed evidence base for effectiveness of CBT for both issues</td>
<td>Client demonstrates limited functioning in a number range of domains</td>
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planning (Dudley, Siitarinen, James, & Dodgson, 2009; Eells, 2007). On balance, the research to date does not provide a strong rationale for a principle based approach to case conceptualization that directly addresses some of the clinical and empirical challenges therapists face.
Flexing

• Sessions
  – Number, length, frequency

• ‘Location’
  – Outside office, email, text

• Content
  – Therapeutic relationship (e.g. self disclosure)
  – ‘Protocol’
Reflection: Own Metacompetences

• Done something ‘outside the protocol’
• Why did it work?
• How did you decide what to do?
• Start collecting your ‘procedural rules’

• What can you do as an individual therapist to improve?
The individual therapist
The treatment provided
The training and supervision
The service and organisation

Quality
The training

• Generic
  – Professional
  – CBT
    • Intro
    • ‘Advanced’

• Specific
  – Particular CT treatments
    • Treatments are patient sessions PLUS supervision
Cognitive therapy supervision

- Process reflects the practice...
- Agenda
- Problem focused
- Balance of didactic information giving and socratic questioning
- Frequent summaries
- Feedback
- Homework
Making the most of supervision

• Supervision isn’t the time to start thinking about a case
• Do the thinking before supervision
• Supervision questions
• Tapes at right place
• Formulation / questionnaires available
• Supervision record / plan
How can we know?

• We need to get evidence of what is actually happening.
• Is therapist report good enough evidence?
• Audio and/or video recordings
  – For patients
  – For supervision
  – For reliability checks and ensuring quality.
Competency model of supervision

Supervisee

CBT metacompetences (what to do when in therapy: ‘flexibility within fidelity’)

Guides use of competences

Supervisor

Supervision metacompetences (what to do when in supervision)

Guides use of competences

Supervision

Supervision will address supervisee competencies, meta-competencies and ability to make use of supervision

Ability to use supervision

Evidence of competence filtered through how use supervision

Supervision competences
Ability to use supervision

• Work collaboratively with supervisor
• Capacity for self-appraisal and reflection
• Capacity for active learning
• Capacity to use supervision to reflect on developing personal and professional role
• Capacity to reflect on supervision quality
### Supervision record

**Name:**

**My supervision goals:**
1. 
2. 
3. 

**Date:**

**Other items for agenda:**

| Client ID | Disorder / main problem | Sessions completed | Session 1 scores | Current scores | Action following last supervision | Supervision Question | What Learned? 
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<td>Brief update / plan for next session</td>
<td>Use role play / tape?</td>
<td>Which supervision / training goal addressed?</td>
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Lewin/Kolb learning cycle

Concrete Experience
Doing

Reflective Observation
What happened? Meaning?

Conceptualisation
Analysing, link with other experiences, generalising, theory building, abstracting principles

Active Experimentation
Planning, preparation
Supervision Learning Cycle

Concrete Experience
Roleplay in session. Try intervention with patient.

Active Experimentation
What next? Plan intervention.

Reflective Observation
What happened? Video / audio of therapy. Identify stuck point.

Conceptualisation
How can we understand this? Relate to theory and case formulation.
Doing

Planning

Reflection

How did what we discussed last time work out?
What happened? What did you learn?
What’s the supervision question?
How does this fit with your supervision goals?
What did you do? What did the client do?
How did you feel? What else have you done?
What change strategy did you try?
Was there enough emotion in the room?

PLAY TAPE
Doing

- How make sense of this?
- What’s the diagnosis?
- What’s the formulation?
- What are the key cognitions? And behaviours?
- What are the goals?
- Session number? Contract?
- What cognitive-behavioural model?
- What maintaining factors?

- What cases seen in past that are similar?
- What worked then?

Planning

Conceptualisation
How develop formulation more?
How address [key cognition] [maintaining factors]?
What strategies could you use?
What verbal change strategies (DTR, pie chart, etc)?
What behavioural experiments?
Does structure of treatment need addressing? E.g. agenda, out of office experiments?

What would you say to the client? How would you phrase that?
ROLEPLAY
“How would you say that in a session?”
What have you learned from this?
What will you take away from supervision?
What are you going to put in the action point column?
How has supervision been today?
Developing competence as a therapist and as a supervisor

- Reading
- Training workshops
- Model for therapy
- Practise
- Review/reflect
- View tapes
- Get supervision

- Reading
- Training workshops
- Model for supervision
- Supervise
- Review/reflect
- Own experience of supervision
- Supervision of supervision
Supervision of Supervision

• Acknowledge importance of developing supervision competence
• Be aware of own style as supervisor and need to adapt
• Identifying supervisor blindspots and own supervisor beliefs that affect process

• More routine in individual supervision
• Need to record supervision sessions
Evaluation

• Of therapy
  – Cognitive Therapy Rating Scale

• Of supervision
  – OCTC, Kennerley and Clohessy
  – STARS-CT, Newcastle group
  – SAGE, Milne
GIVING FEEDBACK IS A COMPLEX PROCESS
Making the most of supervision

• Make it about clinical skills not just caseload management

• Before supervision
  – Get supervisees to complete standard supervision plan
    • Questionnaires, questions, action points

• During supervision
  – Take supervisees round the learning cycle
    • Listen to tapes; do roleplays

• After supervision
  – Supervision of supervision
    • Record supervision sessions as routine
    • Listen to (parts of) recordings (and rate it?)
    • Play them to own supervisor / peer group
Reflection

- What can you and your service do to enhance supervision?
Service Organisation

• Stepped care
• Social care
• Service user involvement
• Families and carers
Lessons from analysis of national data

Services with higher recovery rates
- Higher average number of sessions
- Use stepped care appropriately
- Core of experienced staff
- NICE compliant treatment
- High problem descriptor (ICD-10 code) completeness
- High paired outcome completeness rates
- Low DNA rates
- Shorter wait times
Collaborative Networks

Focus on...

• Paired outcome data completeness.
• Assessment procedures
  – screening instruments, getting right problem descriptor (diagnosis), mixed anxiety & depression problem
• In-depth look at recovery by clinical condition
• Local CPD workshops for clinicians
• Analyses of local data & profiles data
Improving Recovery rates: monitor your outcomes for individual conditions

Agoraphobia (37%) and Social Anxiety Disorder (44%).

• Also conditions for which RCT recovery rates are usually higher than for depression. Not true in IAPT data.

WHY?

• Both require longer sessions and therapist to do some work out of office. Happening in IAPT?
• Also video feedback?!
• In social anxiety disorder a third of treatment sessions are for interventions NOT recommended by NICE (low intensity therapy).
Public Transparency: A Revolution for Mental Health Services

Data processing

• IAPT services *required* submit to NHS Information Centre every month 50 data items *per patient* covering demographics, diagnosis, type of treatment and pre & post treatment scores.

Public Health England Website

• Displays numerous IAPT indices at CCG level. Makes it easy for services, commissioners and public to see how they are doing, and how they compare with neighbours.
• Intended to facilitate sharing of knowledge between service & help services judge the success of their innovation
• BUT will also make “gaming” visible to commissioners & public
Why getting complete data matters.

(Clark, Layard, Smithies, Richards, Suckling & Wright, 2009, Behav. Res. Ther)
Why specific measures matter
Agoraphobic avoidance (0-15)

- Treatment as usual
- Cognitive therapy
- CT Clark et al (1994)

pre-treatment  end weekly sessions
Outcomes

• Transparent (can be viewed on public websites)

• Before IAPT nationally only 38% patients had pre & post treatment scores recorded (Clark et al, 2007)

• NOW 97% of referrals that have finished a course of treatment have pre & post treatment depression & anxiety scores.

• IMMENSE achievement. World first.

• Recovery: strict *demonstrated & double* criterion (anxiety & dep)
  45 % Recovery (target min 50%)
  62 % Reliable improvement
Political and financial environment

- The individual therapist
- The treatment provided
- The training and supervision
- The service and organisation

Quality
Reflection

• What can you do to enhance the way your services work?
Ensuring quality

- Attaining, maintaining, ensuring *competence*
- Selection
- Training
- Supervision
- Service organisation
Ensuring quality

• Specialise?
  – Work on only a few disorders
  – Work on all disorders but have a ‘favourite’

• Balance
  – Work/life

• Responsibility
  – Not just the ‘boss’
  – All to take responsibility for quality

• Rewards
  – !!??

• Service culture
  – Good honest open communication
  – Formal appraisals
WELCOME TO
PARADISE
ENJOY THE JOURNEY
Learning Objectives

• To know some of the factors that affect quality in psychological services
• To understand the importance of therapists understanding treatment conceptually as well as technically
• To know how to make the most of training and supervision
• To understand how the way services are organised affects quality
The individual therapist

The training and supervision

The treatment provided

The service and organisation

Quality
Reflection

• What one thing will you do differently?
• Tell your partner
• Write it down
• Imagine doing it...
“Be yourself; everyone else is already taken”

Oscar Wilde
Style... as a therapist

• Be aware of your personal and therapeutic style
• Be aware of strengths and weaknesses of this style
• Be yourself and be easier on yourself
Style... as a supervisor

• Be clear re supervisees strengths and weaknesses
• Lets supervisees be themselves (at least a bit)
• Make adapting style a part of supervision
Style... as a trainer

• Be aware people will learn differently
• People will shape learning within their own style
• Help them find their own style rather than becoming you.
ALWAYS BE YOURSELF
unless you can be
BATMAN
then ALWAYS BE
BATMAN
“Batman”
Grey
Aged 4
Mood Anxiety and Personality
Clinical Academic Group (CAG)

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How to Become a More Effective CBT Therapist

Mastering Metacompetence in Clinical Practice

Edited by Adrian Whittington and Nick Grey

WILEY Blackwell