NORTH AMERICA CBT FOR PSYCHOSIS NETWORK

CBTp Competence Standards

NACBTPN Position on Training and Competence:

The position of the NACBTPN is that competence in provision of CBTp is attained through rigorous training, consultation and/or supervision, inclusive of the following elements:

1. Training consistent with needs of learners, as assessed by an initial formal assessment of these needs (although this may not be possible in some settings where training is offered to diverse groups of learners from multiple settings)
2. Recognition that awareness of learning needs is crucial in order to determine the level of training in CBTp that would be required to reach either
   i. competence in CBTp, or
   ii. competence in CBTp-informed care

   and recognition that each of these levels of competence require significantly different levels of training and skill development
3. Inclusion of longitudinal, formal, consultation and/or supervision of CBTp clients
4. Recognition that in order to achieve a level of competence, all learners ought to be evaluated and assessed for adherence to CBTp. Evaluation ought to include consideration of CBTp intervention skills as well abilities in case formulation and treatment planning

Criteria for Competence in CBTp[1]:

Competence in General CBT (see list of general CBT competencies in Table 1):

1. Individuals who are competent in CBTp must also be able to demonstrate competence in generic psychotherapy skills (e.g., establishing a therapeutic alliance, identifying appropriate goals and pacing, managing ruptures) as well as competence in general CBT theory and skills (e.g., conceptualizing cases from a cognitive framework, setting agendas, assigning homework, ability to select and implement appropriate cognitive restructuring and behavioral skills) related to common disorders of mood and anxiety.
   Some individuals may come to CBTp training with this competence in general CBT already established. This would include both those individuals who have been certified by the Academy of Cognitive Therapy (ACT) or the Canadian Association of Cognitive and Behavioural Therapies (CACBT), or an equivalent accrediting body, or those who have completed a similar level of training and supervision or consultation on cases (i.e., a minimum of 40 hours of didactic training and/or graduate coursework, 10 supervised cases, evaluation of adherence, and presentation of case conceptualizations and treatment summaries). For many other individuals, this training will need to be incorporated into training efforts for CBTp.

Note: [1] These criteria for didactic training, consultation and supervision are based on a review of the literature, consideration of the depth and breadth of CBTp components/criteria defined in Roth & Pilling (2013) & Morrison & Barratt (2010), consultation with international CBTp experts, as well as cross referencing of certification criteria for other therapeutic approaches (e.g., Emotion Focused Therapy, Motivational Interviewing, Mindfulness Based Stress Reduction etc,..). Consistent with Brabban et al. (2016), these criteria were developed due to the complexity of psychosis and CBTp and the professional imperative of minimizing harm by ensuring adequate training, consultation and supervision in the provision of competent CBTp.

CBTp specific training requirements, in addition to competence in general CBT as described above (see list of CBTp competencies in Table 2)

2. Must have received didactic training in CBTp, by a CBTp competent trainer
    * Training must be consistent with criteria and competencies outlined in both Roth & Pilling (2013) and Morrison & Barratt (2010)
    * Didactic training must include information and reference materials for common comorbidities that may not be addressed in general CBT training (e.g., trauma, substance use, OCD) as well as working with cognitive deficits and addressing stigma and cultural competence as related to working with psychosis
    * This would involve a minimum of 40 hours of didactic training over the course of the initial didactic training period with additional follow-up consultation and/or supervision by a competent CBTp trainer/supervisor. Typically, CBTp competent trainers will suggest an initial didactic training of 3-5 days in order to assure coverage of the bulk of the required competencies, with additional didactic training during the follow-up consultation as well as assigned reading of a minimum of 5 recommended CBTp books.
3. Must have received consultation and/or supervision in provision of CBTp to 8 individual clients for a duration of a minimum of 16 sessions (up to 2 groups can also be counted towards this total if they are cofacilitated by a CBTp competent practitioner)
4. Adherence to model must be evaluated through submission of session recordings, taken from various points in treatment (i.e., from initial, middle and final stages of treatment) and representing a variety of clinical presentations (i.e., individuals presenting with different distressing positive and/or negative symptoms) and a minimum of 3 of these must reach an acceptable level of adherence (with ongoing submission of sessions until an acceptable level of adherence is achieved) using a validated competency measure (e.g., CTSR or CTRS) with established cutoff scores for competency.
5. Ability to formulate cases and plan treatment must be formally evaluated through submission of case formulations and treatment plans

Typically, the above would be completed over a minimum of a 6-month to 1-year period for those individuals who are coming to CBTp training with established competence in general CBT[2]

Proposed criteria for certification in CBTp[3] that ought to be considered by accrediting bodies would include the competence criteria outlined in 1-5 above, along with the following:

6. Must be licensed for autonomous practice and eligible to provide psychotherapy in their State/Province
7. Must carry liability insurance
8. Evidence of 1-5 above, including submission of recorded sessions, case formulations and treatment plans
9. Two letters of reference from supervisors or from other practitioners who are familiar with the clinician's work and who meet criteria for CBTp competence themselves

Note: [2] The CBTp specific training requirements (points 2 – 5 above) must be provided by and/or evaluated by a CBTp competent trainer/supervisor or CBTp credentialing body

[3] The NACBTPN is not a credentialing body, but is working to recommend certification processes and grandparenting procedures

Table 1: General CBT Competencies	
Engagement	* Demonstration of warmth and caring * Ability to listen to, and accurately reflect, client experience * Recognition and communication of client strengths * Ability to recognize and repair ruptures in alliance
Collaboration	* Working collaboratively with clients to set agenda, to explore experience in session, and to select appropriate homework * Soliciting of feedback from clients
Exploration	* Exploration of client experience in nonjudgmental manner * Emphasis on collaborative empiricism * Use of Socratic questioning
Agenda and Pacing	* Identification of appropriate targets for intervention * Ability to prioritize items on agenda * Use of appropriate pacing for different agenda items and interventions * Ability to summarize key points, summarize sessions, and bridge from one session to the next
Homework	* Working collaboratively to set appropriate homework * Checking in on homework completed in between sessions * Addressing and trouble shooting barriers to homework completion
Assessment and Formulation	* Understanding of cognitive formulation of client difficulties * Awareness of predisposing, precipitating, perpetuating and protective factors * Awareness of different levels of cognitions (e.g., core beliefs vs. automatic thoughts) * Awareness of maintaining factors (e.g., the role of behavioral avoidance or safety behaviors) * Consideration of cultural factors that influence one's world views * Ability to conduct a comprehensive assessment in order to gather information about all of the above * Ability to conduct a thorough risk assessment as necessary * Ability to communicate formulations to clients in a clear and understandable manner
Treatment Planning	* Awareness of formulation and treatment planning guidelines for a variety of common mood and anxiety disorders (e.g., depression, social phobia, panic disorder, generalized anxiety disorder) * Ability to develop an individualized treatment plan based on consideration of client goals and comorbidities
Selection and Application of CBT Skills	* Competence in a variety of CBT skills and strategies, including: Provision of psychoeducation Activity Scheduling Self-monitoring (e.g., moods, thoughts, behaviors) Goal setting Problem Solving Relaxation Skills (e.g., breathing, progressive muscle relaxation, guided imagery) Cognitive Restructuring Techniques Thought Records/Examining the Evidence Generating Alternative Explanations Discussion of Cognitive Errors Behavioral Experiments Exposure/Reducing Avoidance Role Play/Skills Practice Assertive Communication Skills Training Modifying Core Beliefs Relapse Prevention

Table 2: CBTp Competencies	
Additional Engagement Factors and Required Knowledge	* Communication of hope about recovery * Recognition of the importance of client choice * Awareness of the impact of stigma and of the impact of prior experiences of mental health services * Sensitivity to the manner in which clients make sense of their illness and difficulties and the language that they use, as well as sensitivity to cultural considerations * Ability to respond appropriately to situations in which symptoms of psychosis (e.g., paranoia or voice content) may involve, or be activated by, the clinician or within sessions * Knowledge of psychosis, including understanding of the heterogeneity in presentation of psychotic symptoms and comorbidities, knowledge of the role of trauma, basic knowledge of pharmacotherapy, and knowledge of mental health legislation
Normalization	* Use of normalization strategies (e.g., appropriate self-disclosure, discussion of the experience of others) to reduce stigma and increase engagement * Awareness of prevalence of psychotic experiences in general population * Recognition of psychotic experiences as existing on a continuum
Additional Considerations with Formulation	* Understanding of cognitive formulation of each of the following: Voices and other hallucinations Paranoia Delusions Negative symptoms Thought Disorder
	* Recognition of the manner in which core beliefs typically effect experience of psychotic symptoms, and that these symptoms can often "make sense" in the context of an individual's learning history * Ability to identify factors that serve to drive and maintain the distress associated with symptoms of psychosis * Ability to differentiate coping behaviors (those with sustained positive benefits) from safety behaviors (those with long term negative effects) * Understanding of the role of trauma in psychosis * Understanding of cognitive formulation of common comorbidities (e.g., depression, social phobia, obsessive-compulsive disorder, sleep disturbance, substance use, low self-esteem) * Ability to develop an individualized formulation of each client based on consideration of their history, symptoms, comorbidities, goals, values and level of insight and cognitive function * Ability to communicate these formulations to clients in a clear and understandable manner
Treatment Planning	* Awareness of formulation and treatment plans for positive and negative symptoms of psychosis (e.g., voices and other hallucinations, paranoia, delusions, negative symptoms and thought disorder) * Awareness of adaptations to treatment planning that may be necessitated due to cognitive deficits and/or thought disorder * Ability to develop a culturally competent and individualized treatment plan based on consideration of client symptoms, goals and comorbidities
Selection and Application of CBT Skills	* Competence in a provision of all of the general CBT skills listed in Table 1, as well as a variety of CBTp-specific skills and strategies, including: Provision of specific psychoeducation (e.g., regarding psychotic symptoms, recovery ,stress vulnerability) Self-monitoring tools (e.g., voices, paranoid thoughts) Building Coping Skills (e.g., switching attention, increasing activity, positive self talk, etc.) Addressing Avoidance Behaviors and Social Withdrawal Examining Pros and Cons of experience of, and beliefs about, voices and paranoid or unusual thoughts Cognitive Restructuring Techniques (specifically applied to psychotic experiences and paranoid or unusual thoughts), for example: Exploring and Shifting Beliefs About Voices Exploring and Shifting Voice Content Exploring alternative explanations for paranoid or delusional thinking Reality checks
Metacompetencies	* Clinical judgment and flexibility to adjust treatment and session planning based on response to client needs * Ability to determine appropriate application and pacing of CBTp skills (for example, awareness of implication of challenging delusional beliefs directly vs. challenging more peripheral evidence that supports delusional beliefs at various points in treatment)

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Rationale:

The North American Cognitive Behavioral Therapy for Psychosis Network is an organization of health care professionals, academics and researchers who came together in large part as a reaction to the absence of clear training standards for CBTp in North America, and in response to a recognition of the relative lack of adequate training, consultation and supervision opportunities for clinicians who are working with often complex and vulnerable clients.

The mission statement of the NACBTPN states its goals as follows:

a. To further the availability of quality, effective, evidence-based training in CBT for psychosis throughout North America, which in turn will increase access to CBTp for consumers
b. To consider issues of competency, how this is defined and measured in training, and how we can contribute to standards of competency in North American CBTp going forward
c. Toward these issues, to discuss training and implementation of CBTp skills or CBTp informed care along the lines of a 'tiered approach' to ensure that all practitioners, regardless of their level of training, receive recognition
d. To share training materials, relevant literature, and discuss challenging clinical cases and foster a community of CBTp practitioners
e. To create a clinician directory per state/province/region of people who are trained and capable of offering CBTp (individual or group)

In keeping with this mission statement, an additional formal goal of the NACBTPN has been to:
Develop and promote evidence-based standards (incl. definitions of terms) and certification criteria for

i. CBTp Competency
ii. CBTp Informed Care
iii. CBTp Competency in Training , Consultation & Supervision

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These proposed standards have been based, in large part, on existing standards of competence and accreditation coming out of the extensive work in the United Kingdom, with particular attention paid to the following references, which serve as the basis for all CBTp accredited training programs in the UK.

Roth, A.D. & Pilling, S. (2013). A competence framework for psychological interventions with people with psychosis and bipolar disorder.

Morrison, A.P., & Barratt, S. (2010). What are the components of CBT for Psychosis? A Delphi study. Schizophrenia Bulletin, 36 (1), 136-142

In addition, attention has paid to existing standards of accreditation for general CBT coming out of North American CBT bodies such as the Academy of Cognitive Therapy (ACT) and the Canadian Association of Cognitive and Behavioral Therapies (CACBT).

A sample course description of UK-based CBTp training programs

King's College London: https://www.kcl.ac.uk/study/assets/pdf/cma/postgraduate-taught/cognitive-behavioural-therapies-for-psychosis-pgdip-pgcert.pdf

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Criteria for Competence in CBTp-Informed Care:

The North America CBT for psychosis Network (NACBTpN) recognizes that there is substantial variability in definitions of CBTp-informed care. Accordingly, the criteria for competence are more difficult to define. There are a wide range of competencies that fall under this umbrella, as CBTp-informed care includes providers in diverse roles who may be providing CBTp-informed case management, co-facilitating manualized CBTp-skills based groups, fostering a skills milieu on an inpatient unit, supporting technology-enhanced CBTp, or utilizing select CBTp skills to target specific symptoms. Care providers delivering CBTp-informed care should have foundational psychotherapy/counseling knowledge, skills, and abilities. In addition, practitioners delivering CBTp-informed care should also have an empirically-informed knowledge base of psychotic symptoms and psychotic disorders; have functional competencies in therapeutic communication (e.g., an ability to foster the development of a therapeutic alliance and to communicate in an open, nonjudgmental way using normalizing language) trauma-informed and culturally-responsive care practices, and therapeutic engagement strategies; and adhere to ethical and professional guidelines within their discipline. Finally, it is expected that practitioners administering CBTp -informed care are-at a minimum-trained to deliver or support psychoeducation; value and goal identification; as well as motivational, behavioral, cognitive, and/or problem-solving techniques. Practitioners delivering CBTp-informed care are not expected to have acquired the knowledge and skills required to develop individualized case formulations or to develop independent and comprehensive treatment plans. Rather, CBTp-informed practitioners will use cognitive, behavioral, and motivational techniques to target specific symptoms or problems of daily living.

Training to 'competence' in CBTp-informed care requires more than brief didactic training. Providers offering CBTp-informed care engage in training, supervision, and/or consultation to acquire declarative knowledge of cognitive-behavioral techniques for psychosis, procedural knowledge of supporting individuals in CBTp-informed care, and ongoing reflective practices to ensure both ethical and effective care. That is, each of the elements of CBTp training must be present (e.g., assessment of learning needs, didactic training that is relevant to the services that are to be provided, ongoing supervision or consultation, and evaluation of clinician skill/practice/competence).

Examples of several models of CBTp-informed interventions can be found on the NACBTpN website: https://www.nacbtp.org