NATIONAL TRAINING CURRICULUM FOR IAPT SERVICES TO MEET THE NEEDS OF REFUGEES AND ASYLUM SEEKERS

Outline structure of the training

There are four sections to the training:

1. An online, directed self-study module in which the IAPT therapists will revise the theoretical and diagnostic aspects of Post-traumatic Stress Disorder (PTSD), using the Ehlers and Clark (2000) Cognitive Model of PTSD as a guiding framework. They will also study some background information about asylum seekers and refugees (RAS). They will be required to undertake this module *first.*
2. A one-day, face-to-face overview workshop which will have two aims: first, for the therapists to revise the practical aspects of Ehlers and Clark's treatment for PTSD (CT-PTSD); second, for the therapists to learn about the conceptual and the practical aspects of delivering CBT to refugees and asylum seekers with PTSD and Depression, as well as looking at the evidence-base for such interventions.
3. A three-day training in Narrative Exposure Therapy (NET) (Schauer, Neuner and Elbert, 2011). NET has the strongest evidence at present for treating PTSD in RAS. The training is very practical and consists mainly of coached, small group role plays interspersed with some brief lectures on the theory, evidence base and practicalities of NET.
4. Once the rest of the training has been completed, the therapists will be offered six, monthly telephone/video group supervision sessions with the trainers.

More detail about each component will follow.

Entry requirements

Therapists will be BABCP Accredited CBT therapists, preferably having completed IAPT High Intensity CBT Training. or. In addition, each therapist will need to have had experience of at least three supervised cases treating PTSD using the Ehlers and Clark model.

Both requirements will be addressed in an application form for the training which: confirms the therapist's BABCP accreditation status; shows that their Clinical Lead has approved release to attend the training plus time to attend supervision; and contains confirmation from their Clinical Lead that they have completed the three supervised PTSD cases. The Clinical Lead will also confirm that the applicant will be enabled to work with refugees and asylum seekers on completion of the training.

Trainer and supervisor competences

For the online, directed self-study module (Section 1), the one-day overview workshop (Section 2) and the supervision groups (Section 4) trainers/supervisors should be experienced CBT practitioners with specialist clinical expertise in delivering CT-PTSD and in working with RAS experiencing PTSD and Depression (including the routine use of NET). Additionally, for each three-day NET training (Section 3), the trainers will need at least one

accredited NET trainer, assisted by a number of experienced NET trainers/practitioners (exact numbers will be determined by the size of the group to be trained).

Accreditation

This training will be suitable CPD for ongoing BABCP accreditation.

1. **Online, directed self-study module**

PTSD is the most common diagnosis in treatment seeking RAS. Because RAS tend to have experienced multiple traumatic events in their country of origin and en route to the UK, they present to services with a complex PTSD presentation. This is characterised by high levels of dissociation, nightmares and flashbacks to many different events and by some 'psychotic-like' symptoms e.g., hearing the voice of a torturer commenting on events in the here and now. IAPT Therapists working with PTSD in RAS need be confident in assessing and treating 'simpler' PTSD presentations before they can adapt this knowledge for the more complex RAS client group.

How to treat 'simple' forms of PTSD is a core part of the IAPT HIT curriculum. Once qualified, it is often the case that a few interested/experienced clinicians in each service tend to undertake most of the PTSD treatments. Thus, to target this training most effectively, it is these therapists (with some existing experience of treating PTSD) who should attend this training on working with refugees and asylum seekers. Further, prior to the training on working with RAS (Sections 2-4), they should revise/update their knowledge of 'simple' PTSD generally – in particular, the Ehlers and Clark (2000) model and treatment.

To reduce training costs, some of this PTSD revision can be achieved by directed online training. Background, theoretical and diagnostic issues can easily be covered in this way Conversely, practical treatment techniques need to be taught in face-to-face sessions (see 'Breakdown of online versus face-to-face training' below.)

The same distinction also applies to the general training on RAS issues - background information about why people become refugees, rates of asylum seeking in the UK, the asylum process and the prevalence of common mental health problems in refugees can all be covered in an online training. Whereas RAS assessment and treatment techniques will need to be taught in a face-to-face workshop.

2. **One day overview workshop**

The workshop will aim to increase therapists' practical skills in undertaking CT-PTSD and to improve their theoretical and research knowledge about working with RAS. In addition, it will provide skills training in how to modify existing CBT treatments for working with this client group.

At the end of the workshop, therapists will:

i. Have knowledge of how to undertake the fundamental techniques involved in the application of CT-PTSD (reliving, hotspot identification and updating, stimulus discrimination and grounding)
ii. Have knowledge of how undertake CBT through interpreters and best practice guidance for doing CT-PTSD with an interpreter
iii. Have competence in how to approach making culturally sensitive modifications to CBT
iv. Have knowledge of what to consider when assessing RAS with reference to the most common diagnoses – PTSD, Complex PTSD and Depression
v. Have competence in how to 'flex' the Ehlers and Clark model to conceptualise PTSD in multiply traumatised people, including RAS
vi. Have competence in how to plan CBT for PTSD and Depression in RAS
vii. Have competence in how to maintain the focus in therapy on mental health difficulties and not on practical/medical/financial/social problems
viii. Have competence in how to understand and manage the common problem of dissociation in traumatised RAS
ix. Have knowledge of how to conceptualise and work with the 'psychotic-like' symptoms which are prevalent in RAS with PTSD
x. Have competence in how to do reliving with RAS who have experienced more than one traumatic event
xi. Have knowledge of the outcome research in this area and its limitations
xii. Have competence in how to address some of the cognitive themes common in this group e.g., mistrust, anger, shame, sadness, grief, loss and pain

The workshop can be taught face-to-face by one trainer over a day. It should involve: use of clinical vignettes and small group experiential work to practise the skills taught. Trainers should provide direction to further reading/online training films and handouts to summarize taught content. The workshop could be delivered to up to 100 therapists in one audience.

Further details of which topics will be taught in this workshop and which will be covered online are given below.

Breakdown of online versus face-to-face training

TOPIC	DELIVERY METHOD
Accurate identification of PTSD and knowledge of NICE guidance: 1. DSM-V and ICD-10/11 diagnostic criteria and why they are important 2. Understanding of concept, utility and limitations of the concept of "Complex PTSD" 3. NICE guidance including 2018 updates and	1-4 Narrated Powerpoint presentation film

recommendations regarding "Complex PTSD" 4. Differential diagnosis including: rumination, traumatic bereavement etc	
Use of measures in PTSD Treatment: 1. Use of IAPT measures (IES) 2. Use of other clinically useful measures e.g. PTCI, Dissociation Measures, Idiosyncratic measures e.g. frequency of main intrusions 3. Cautions of using standardised measures with this population	1-3 Narrated Powerpoint presentation film
Fundamental understanding of and skills in application of trauma-focused CBT: 1. Brief recap of Ehlers and Clark, 2000 PTSD model, theory and fundamental treatment elements: elaboration and processing of memory, cognitive and emotional processing and overcoming avoidance. 2. Key skills recap: reliving, hotspot updating, stimulus discrimination and grounding 3. Practical and service considerations: 90-minute sessions, working with interpreters etc	1. Narrated Powerpoint presentation film 2. Face-to-face teaching with direction to OxCADAT training films/resources 3. Face-to-face teaching
Working with emotions other than fear in PTSD/common emotional themes in RAS: 1. Shame & guilt 2. Anger 3. Sadness/grief/loss/pain (including from physical injuries) 4. Trust	1-4 Face-to-face teaching with direction to OxCADAT training films/resources where appropriate

Application of CT-PTSD to "complex" presentations: 1 What is a "complex" trauma: early trauma, repeated or prolonged trauma, multiple traumas 2 What is "complex" PTSD: differentiating the type of trauma from the response (i.e. can have "complex" trauma experience resulting in presentation of "simple" PTSD, "complex" PTSD, another diagnosis or none) 3 How to 'flex' Ehlers and Clark (2000) for complex trauma/repeated trauma/refugees 4 Modifications of CT-PTSD for complex presentations/RAS: selecting memories to work on, paying attention to interpersonal aspects of therapy, risk, dissociation, when to use stabilisation, cultural adaptation of CBT 5 Treatment choice/phasing decision tree for complexity/comorbidity	1-5 Face-to-face teaching
Knowledge of background information about refugees: 1. Why people become refugees, rates of asylum seeking in the UK and the asylum process 2. The prevalence and predictors of common mental health problems in refugees	1-2 Narrated Powerpoint presentation film
Clinical considerations when working with RAS: 1. What to consider when assessing RAS with reference to the most common diagnoses – PTSD and Depression 2. How to maintain the focus in therapy on mental health difficulties and not on practical/social/medical/legal issues 3. How to conceptualise and work with the 'psychotic-like' symptoms which are prevalent in RAS with PTSD 4. How to understand and manage the common problem of dissociation in traumatised RAS 5. How to do reliving/updating hotspots with RAS who have experienced more than one traumatic event 6. The outcome research in this area and	1-6 face-to-face teaching

its limitations	

3. Three-day training in Narrative Exposure Therapy

NET was developed by the Schauer, Neuner and Elbert, members of NGO Vivo International, originally as a treatment to be used in refugee camps in low income countries (Robjant and Fazel, 2010; Schauer, Neuner and Elbert, 2011.) In recent years, it has been evaluated in randomized controlled trials in middle- and high-income countries. Currently, NET is accepted as the treatment with the most evidence for effectiveness in treating PTSD in RAS who have experienced multiple traumatic events (Crumlish and O'Rourke, 2010; Nickerson, Bryant, Silove and Steel, 2011; Nosè, Ballette, Bighelli, Turrini, Purgato, Tol et al., 2017; Turrini et al., 2017.)

NET is 10-session intervention which enables the client to talk through in detail all the pertinent traumatic events in his or her life. It starts with the construction of a 'lifeline', which gives the therapist and client an overview of the client's life, including traumatic and less traumatic events. Then, they agree on which traumatic events to focus in therapy and the rest of the treatment involves the detailed exposition of the traumatic events. The therapist transcribes this exposition in summary between sessions (this is known as 'the narrative'.)

NET has an experiential training model – there is little didactic teaching and most of the time is spent in small groups, role playing the techniques, with each small group being coached by an experienced NET trainer and practitioner. Each small group should have only 5 people in it - so to train a team of 20 IAPT HIT's, 4 trainers would be needed for 3 days. The entire NET training needs to be delivered face-to-face.

At the end of the workshop, therapists will:

i. Have knowledge of the theory behind and development of NET
ii. Know the outcome research in the area and its limitations
iii. Have knowledge of how to construct a lifeline with a client
iv. Have had small group, coached (by a NET trainer) experience of role-playing lifeline construction
v. Have knowledge of how to talk through traumatic events and less traumatic times in the client's life
vi. Have had small group, coached (by a NET trainer) experience of role playing talking through several traumatic events
vii. Have competence in understanding and managing dissociation during NET.

Assessment of competence in undertaking NET cannot be made at the end of the 3-day training. Therapists' competence in undertaking NET will be evaluated in the supervision phase (Section 4 below).

4. Six, monthly group supervision sessions

On completion of the training, the participants will be offered six, monthly group supervision sessions (lasting one hour) to help consolidate the learning. Ideally, the supervision sessions will be facilitated by the members of the original training team. Alternatively, the facilitators will need to be experienced CBT practitioners (with specialist clinical expertise in working with RAS who have PTSD) but who are also experienced NET trainers.

The supervision groups should contain no more than 5 therapists and be carried out over a group telephone or video conference call - whichever is most accessible to the therapists. The supervision sessions will involve detailed discussion of the therapists' RAS caseloads with clear, practical guidance from the supervisors on how to proceed with each case. This might also involve the supervisor recommending further reading/resources to enrich the learning from supervision.

The evaluation of the therapists' competence in using NET will be made during this phase of the training. Colleagues from Vivo International have suggested the following assessment of competence:

- each therapist must submit to their NET supervisor the entire written narrative for a completed episode of treatment with one patient
- in addition to this written narrative, the therapist must also submit a transcript of a section of a therapy session in which a traumatic event was discussed in detail. The transcript should contain details of what the therapist and client said, as well as any actions undertaken.
- if this narrative and transcription are not deemed adequate by their supervisor, the therapist must submit another.

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