|  |
| --- |
|  |
| Children and Young People’s Psychological Trainings (CYP PT)Core Curriculum  |
|  |
| Version 1.4, 26 March 2024 |

Contents

[Part A: The key features of CYP Mental Health (MH) practice 3](#_Toc169878338)

[A1 Introduction: Expectations for trainees 3](#_Toc169878339)

[A2 What are the core values of CYP PT? 3](#_Toc169878340)

[A3 CYP PT collaborative care model (see also goals-based practice) 5](#_Toc169878341)

[A4 Young people’s and parents’/carers’ participation 6](#_Toc169878342)

[A5 The CYP PT active outcomes framework 9](#_Toc169878343)

[A6 Evidence-based practice/practice-based evidence 11](#_Toc169878344)

[A7 Children and young people with learning disabilities and/or autism 12](#_Toc169878345)

[Part B: The core knowledge base for delivery of CYP MH care 13](#_Toc169878346)

[B1 Ensuring the delivery of inclusive and anti-discriminatory services that reduce mental health inequities 13](#_Toc169878347)

[B2 Fundamentals of therapy adapted to CYP MH principles 17](#_Toc169878348)

[B3 Shared aspects of evidence-based practice with children, young people and families 18](#_Toc169878349)

[Part C: Introduction to CYP PT modalities of therapy 21](#_Toc169878350)

[C1 Fundamentals of high-intensity Cognitive Behavioural Therapy for children and young people (CBT CYP) 21](#_Toc169878351)

[C2 Parenting programmes 23](#_Toc169878352)

[C3 Interpersonal psychotherapy for adolescents (IPT-A) 25](#_Toc169878353)

[C4 Systemic family practice 26](#_Toc169878354)

[Appendix 28](#_Toc169878355)

#### Core competencies for working with children and young people

This version of the core elements of the Children and Young People’s Psychological Trainings (CYP PT) curriculum is intended for staff working in services participating in the CYP PT programme, including potential trainees, supervisors and managers. Its purpose is to outline the core components of the module. The learning objectives of this module are common to all trainees completing courses developed within the CYP PT programme. Higher education institutions (HEIs) will deliver this module both by interweaving aspects into modality-specific training and by running separate sessions. For example, collaborative practice is essential throughout CYP PT, so our expectation is that all therapeutic training will be seen through the prism of how a trainee in a particular modality uses the therapy in collaboration with the child or young person and, where appropriate, their family.

# Part A: The key features of CYP Mental Health (MH) practice

## A1 Introduction: Expectations for trainees

#### Key learning outcomes

* Understanding the nature of the course and its requirements.
* Knowledge of the close interplay between services and HEIs, and the need to follow their employing organisation’s processes as well as those of the HEI.
* Ability to use the HEI’s e-learning system and other resources.

#### Knowledge

Knowledge for the course will be provided in the course handbook.

#### Skills

* To negotiate clear arrangements with their personal tutor at the HEI, along with arrangements with the supervisor in their employing organisation participating in CYP PT.

## A2 What are the core values of CYP PT?

#### Key learning outcomes

* The rationale for evidence-based approaches to treatment and implementation.
* Understanding of approaches to improving value in healthcare systems.
* Knowledge of methods of quality improvement that increase productivity and ensure rapid interventions (‘prevention’ or ‘pre-emptive treatment’).
* Acquisition of an intellectual framework for measuring outcomes.
* Understanding and appreciation of how to work in partnership with the child and family[[1]](#endnote-2) contextually, considering such factors as culture, personal identities, family dynamics and interfaces with different systems of social life, the presence of difficulties that may create inequality for the child or family’s developmental stage/level, and communication.

#### Knowledge

(It is assumed that trainees have knowledge of child development and developmental life stages as this is a core competency for working with children and young people.)

* Knowledge of the nature of evidence in healthcare for clinical interventions.
* Understanding the framework of risks of disorders, including social and contextual factors and strategies for early intervention.
* Understanding of outcomes that matter to children, young people and families, including the costs of achieving these.
* The collaboratively designed model of service organisation and delivery.
* Placing service users in charge of their own care, including in relation to intersectionality, physical health and treatment of their long-term health conditions.
* Understanding and appreciation of the role of professionals involved in multi-agency, multidisciplinary meetings.
* Supporting shared decision-making with the child or young person that involves their parent/carer/guardian around the type of treatment received by the child or young person.
* Working in partnership with children, young people and, where appropriate, their parents/carers/guardians to define goals and outcomes that matter to them all.
* Working in partnership with other organisations and agencies involved with children, young people and families, such as schools, children’s social care, and voluntary and community services.
* Understanding the implications of transitions between services, including transitioning out of children’s to adult services.
* Understanding of the process of transformation in delivery of children and young people’s mental health care.
* Basic ideas from implementation science.
* Working to ensure that clinicians meet the standards set by both regulatory and professional bodies.
* Demonstrating knowledge of relevant pharmacological interventions and competence in informing and supporting clients on combined treatment approaches.

#### Skills

* Communication skills with children, young people, families and colleagues, and management in relation to the above.
* Understanding of the legal frameworks around consent, confidentiality and the recording and sharing of information, and the skills and confidence in applying and communicating this to parents and carers.
* Listening to, appreciating and understanding the parent/carer/guardian perspective.
* Integrating CYP PT models into existing professional expertise.
* Contributing to the development of host bodies as learning organisations.
* Skills to engage children and families in decision-making and contributing to service transformation.

## A3 CYP PT collaborative care model (see also goals-based practice)

#### Key learning outcomes

* Knowledge and understanding of the collaborative stance in all aspects of the child or young person’s experience, including assessment, formulation and treatment.
* Ability to implement a shared decision-making approach.
* Understanding of the child or young person, their family, their thoughts, feelings and motivation, and the full context of their identity, considering individuals’/families’ intersectional identities (including protected characteristics and aspects of social location such as class).

#### Knowledge

* Awareness of the power imbalance and difference within professional–client relationships.
* Awareness of individuals’/families’ intersectional identities and how to explore and keep these in mind in formulation and therapy with children, young people and families.
* Integration of the clinician’s expertise with service user expertise.
* Understanding of the evidence base for collaborative practice.
* Understanding of the importance of accurately determining the state of mind of the child, young person or, where appropriate, parent/carer/guardian, including cognitive/communication skills, styles and needs.

#### Skills

* Understand the problem from the varying perspectives of the child and family.
* Develop an agreed shared understanding of the problem.
* Come up with an intervention plan, including explicit intervention goals, in partnership with the client and parent/carer/guardian that may need to be responsive to each of their specific needs.
* Ability to work towards creating a shared formulation between the clinician and the child or young person, and parents/carers/guardians where appropriate, taking account of biological, psychological and psychosocial issues and individuals’/families’ intersectional identities.
* Demonstrate an ability to integrate best clinical evidence with the unique context of the child or young person and their family/carers, including different aspects of their identity, culture and social context.
* Highlight the importance of defining the context of each child or young person from a multi-systems perspective, including:
	+ ensuring the influence of individuals’/families’ intersectional identities is considered at all points during the assessment and intervention
	+ ensuring all systems that the child/young person is engaged in are considered
	+ ensuring that other potential systems interfaces are also considered, for example, systems that might help or hinder
	+ ensuring the establishment of multi-dimensional case management and treatment approaches which take full account of all relevant systems
	+ ensuring a shared narrative and maximising coherence of care by interweaving this multi-systems and multidimensional approach with the formulation framework
	+ ensuring the consideration of all treatment approaches, and how such approaches can be integrated into care
	+ ensuring that the risks of ‘splitting’ are highlighted and stressing the importance of integration of care
* Demonstrate the ability to explain best evidence in a way that service users and parents/carers/guardians can understand.
* Produce written intervention plans with children, young people and families, where appropriate, co-produced and written in everyday, accessible language and other formats to aid communication; these should be regularly reviewed and updated to ensure that the aims remain relevant, understood and agreed with the young person.
* Develop responsibility for clinical decision-making across a range of complexity.

## A4 Young people’s and parents’/carers’ participation

(This section was co-produced with Jeanne Blair, Nikki Chapman, Aoife Healy, Usman Javaid, Andrew Macdonald and Alice Palmer – Charlie Waller Trust youth ambassadors, parent/carer lived experience partners, and lived experience team staff.)

Specific days of training should be dedicated to understanding meaningful participation and co-production: a day led by children and young people’s participation group members; and a day led by parents/carers/guardians with lived experience of supporting a young person experiencing mental health difficulties. This approach can be extended to further sessions.

#### Key learning outcomes

* Experience the value of co-produced materials within their clinical training, and evidence skills in meaningfully integrating co-production activities within their work.
* Demonstrate application of participation models with a range of children, young people and their parents/carers/guardians.
* Facilitate children and young people to be their authentic selves by incorporating their voice, and their intersecting identities and roles, into the shared understanding of the child/young person’s experience.
* Understand the societal/systemic misconceptions regarding children and young people as less mature, less competent or ‘little adults’, and how those misconceptions can undermine participation efforts through the exaggeration of the power dynamics inherent in healthcare and intergenerational relationships.
* Facilitate parents and carers to be their authentic selves by welcoming and hearing their voice, and their intersecting identities and roles, in the shared understanding of the family experience.
* Understand the societal/systemic misconceptions regarding parent/carer/guardian-blaming or viewing parents/carers/guardians as over-worriers and/or complainers, and how those can undermine participation efforts through the exaggeration of the power dynamics inherent in healthcare.
* Recognise that the degree of parent/carer/guardian involvement will be unique to each young person receiving care, and that where possible this should be guided by the young person’s wishes (recognising that on occasion aspects of capacity may need to be considered).
* Recognise the value and importance of parent/carer/guardian involvement in their child’s care. Encourage an open and honest flow of communication between all parties in which (with the young person’s consent) non-confidential information/exercises/goals are shared to facilitate parents’/carers’ support of their child. On the occasions where the young person has concerns around sharing information with parents/carers/guardians, it may be that parent/carer/guardian observations can still be sought and considered with the young person’s consent (for example, consideration of one-way information may still be possible). It should be noted that there are some rare but important instances where any information-sharing with parents/carers/guardians is not indicated (if there is unsafety in the home due to an aspect of the child or young person’s identity).
* Take a holistic view of a client with regard to participation, especially regarding intersectionality. Clinicians should be knowledgeable and educated on how different aspects of intersectionality can impact children, young people and parents/carers/guardians (see section B1 below), and this should inform their practice.

#### Knowledge

* Understanding that participation occurs at the level of individual clinical work (through listening to clients’ and parent/carer/guardian views, perspectives and preferences) as well as at the level of organisational change (participation groups which represent the communities that services serve should be a part of all discussions about service development and delivery, rather than being invited secondarily as a consulting body).
* Familiarity with rights and responsibilities frameworks, including:
	+ [Article 12 of the United Nations Convention on the Rights of the Child](https://undocs.org/Home/Mobile?FinalSymbol=A%2FRES%2F44%2F25&Language=E&DeviceType=Desktop&LangRequested=False), which states that every child has a right to give their opinion and have their views given due weight in all matters that affect them (with no lower age limit)
	+ international perspectives/comparisons
* Knowledge of the potential stigma of mental health provision (an anti-stigma stance):
	+ how children, young people and families experience exclusion and feel stigmatised by mental health problems (for example, school exclusion, social shame)
	+ societal and cultural attitudes, institutional practices that reinforce prejudice, and service configurations and individual practice that create stigma
	+ effective models to tackle stigma that are relevant to children and young people (for example, contact/peer models)
* Knowledge of the importance of multiple stories and perspectives within participation work and co-production. If participation efforts do not actively include all communities, they will be excluding communities.
* Knowledge of historical and current models and resources relevant to participation within child and adolescent mental health services:
	+ evidence from UK and international qualitative literature on the views of young people and parents/carers/guardians regarding mental health experiences and support
	+ the Sherry Arnstein and Roger Hart Ladder of Children’s Participation, Young Citizens initiative, Hear by Right participation standards, and shared decision-making principles
	+ the Lundy (2007) model and its use within CYP MH services; considering how it can apply to parent/carer/guardian participation as well as children and young people
	+ national resources and opportunities for participation support, including Young Minds, the PLACE Parent Support Network, Adoption UK, the Charlie Waller Trust, the Anna Freud Centre and the Carers Trust

#### Skills

* Put values and knowledge into practice:
	+ produce a diversity of case studies which include reflection upon participation (potentially co-produced by the young person or parent/carer/guardian as well as case studies written by professionals)
	+ demonstrate reflective practice around participation by children, young people and parents/carers/guardians
	+ ability to work with different age groups around participation
	+ ability to engage with the diversity of children and young people, recognising the various aspects of intersectionality
	+ ability to gather and organise a portfolio of participation skills, using an appropriate variety of participation methods
	+ ability to understand the best and most current approaches to engaging and working alongside young people and parents/carers/guardians, for example through digital, social media and creative approaches, as well as face-to-face work
	+ ability to recognise their challenges and limitations, reflecting on their own cultural values and attitudes
* Ability to develop participatory practice:
	+ seeking and acting upon children and young people’s feedback
	+ seeking and acting upon parents’/carers’/guardians’ feedback and creating feedback loops to share what has changed as a result
	+ having a dialogue with children, young people and/or their advocates and parents/carers/guardians (depending on the individual and their wishes) regarding parent/carer/guardian involvement
	+ enabling diverse groups of young people and parents/carers/guardians to participate in strategic decision-making that is reflective of the local population and minoritised/marginalised groups
	+ supporting children, young people and parents/carers/guardians with training and development and peer-to-peer mentoring

#### Assessment considerations

* Participative practice and expectations around co-production should be incorporated in all students’ assessments.
* Competency frameworks should have participation competencies threaded through them, and/or included as a separate competency heading/part of professional practice competency or core therapy skills. Achieving collaborative participation competencies should be evidenced on video submissions (for example, being able to ask about the views of the child/young person or parent/carer/guardian regarding a developed formulation or treatment plan) and/or reflected upon in an accompanying case report/reflection/oral presentation.
* Consideration should be given to the voices of children, young people and parents/carers/guardians in all assignments, and this should be explicitly named as an expectation in marking criteria (for example, inclusion of client feedback reports such as the CHI-ESQ for all training cases within the portfolio, with at least 2 of these including parent/carer/guardian-reported feedback).
* A note from the supervisor should be included on whether the student was able to develop in terms of working collaboratively and in a truly participation-led way; this should also be reflected in supervision reports as a course requirement.

## A5 The CYP PT active outcomes framework

#### Key learning outcomes

* Understand how to adopt a collaborative approach to evaluating outcomes.
* Ensure they can make decisions within the CYP PT framework about the best measures and tools to use for different children, young people, families and circumstances.
* Demonstrate that they understand the strengths and limitations of different measures and tools and how to use them clinically.
* Understand how to interpret data from outcome measures and service user feedback tools, and understand the limitations of the measures and the limits of any interpretation.
* Ensure they are trained to make use of information from patient-reported outcomes to support their work and their own development, not using this information purely as a performance management tool.
* Facilitate the use of information from outcome measures and service user feedback tools, including qualitative information obtained as well as the quantitative scores to inform and guide therapeutic interventions.
* Ensure they can engage children, young people and families, where appropriate, in the use of outcome measures so that the measures are meaningful and contribute to the overall outcome of the intervention.
* Understand the importance of personal identities that relate to race, ethnicity, gender, disability, age, sexual orientation, religion or belief that will have an impact on any intervention or outcome measure.

#### Knowledge

* Knowledge of outcome measures and service user feedback tools commonly used in the delivery of children and young people’s mental health care, and of their purpose, including:
	+ what each measure specifically aims to detect or to measure
	+ measurement development
	+ clinical usefulness of the tool
* Knowledge relevant to the application of measures, including:
	+ psychometric properties such as:
		- scoring and interpretation procedures
		- reliable change
		- clinically significant scores
	+ understanding that the measures may not be designed for specific equality groups (for example, minoritised ethnic groups, women, those identifying as LGBTQIA+, people with disabilities, people with a religion or other belief, or those whose first language is not English) and consideration of how to mitigate any adverse impact, and how to ensure the specific equality groups can still benefit from outcome monitoring
	+ understanding of the use of routine outcome and service user feedback information in active supervision

#### Skills

* Ability to introduce the ideas around service user feedback and outcomes to children, young people and carers in developmentally appropriate language (or using other communication techniques to address specific language needs).
* Ability to work collaboratively to choose appropriate feedback and outcome tools in keeping with the needs and wishes of the child, young person or carer.
* Ability to administer a full set of questionnaires at baseline and a smaller set of questionnaires at each session (appropriate for the person, for example, a person with learning disabilities).
* Ability to select and administer appropriate questionnaires based on problems identified in the initial session, addressing both symptoms and function, and (as required) completed by multiple informants.
* Ability to integrate the questionnaire results into sessions as part of the process of assessment and intervention, selecting which results should be fed back to clients and how to do this.
* Ability to use the results from questionnaires to help decide when a different approach in therapy, or a different therapist, is needed.
* Ability to present data from questionnaires in supervision and to consider its implications.
* Ability to know when and how to help clients complete outcome questionnaires when they have difficulty completing them on their own (for example, due to literacy problems, not speaking English as a first language, visual impairment or learning disabilities).
* Ability to judge when it is appropriate to desist from asking clients to complete a measure (for example, when the client is expressing reluctance to do so and the use of measures needs to be renegotiated with them).
* Ability to engage in active supervision using routine outcomes data and service user feedback, and to understand how supervisors can use this information to guide case supervision.

## A6 Evidence-based practice/practice-based evidence

#### Key learning outcomes

* Knowledge of the evidence for common mental health presentations for children, young people and their families.
* Knowledge of National Institute for Health and Care Excellence (NICE) guidance in relation to all children’s and young people’s disorders.
* Understanding of the main groups of drugs and their effects and side-effects. Method: key papers and lectures.

#### Knowledge

* General knowledge of the status of the evidence for:
	+ depression
	+ anxiety
	+ self-harm and suicidality
	+ maltreatment
	+ social intervention
	+ attachment disorders
	+ neurodevelopmental disorders
* Awareness of the use of psychoactive medication for children and young people with these disorders.
* Awareness of and familiarity with ‘[A competence framework for Child and Adolescent Mental Health Services](https://www.ucl.ac.uk/pals/sites/pals/files/camhs_competences_framework_v1_2.pdf)’ and other young people’s competency frameworks.
* Awareness of co-morbidities and the links between physical health and mental health conditions.
* Knowledge of relevant pharmacological interventions and competence in informing and supporting clients on combined treatment approaches.

#### Skills

* Read NICE guidance and draw conclusions about one’s own practice.
* Use appropriate websites for gaining up-to-date information on evidence.
* Communicate evidence to colleagues.
* Deliver tailored medication-related psychoeducation in relation to psychopharmacological interventions.

## A7 Children and young people with learning disabilities and/or autism

#### Key learning outcomes

* Core knowledge of the aetiology, presentation and course of children and young people with a learning disability and/or autism.
* Knowledge and awareness of conditions that commonly co-occur in children and young people with a learning disability and/or autism.
* Knowledge of the modifications to clinical practice that are required when assessing and treating children and young people with a learning disability and/or autism.
* Knowledge and awareness of the relevant legislation and the social model of learning disability.

#### Competencies

* Knowledge of learning disability and autism:
	+ knowledge of the diagnostic criteria for learning disability and autism (as set out in the ‘Diagnostic and Statistical Manual of Mental Disorders’ and the ‘International Classification of Diseases’)
	+ knowledge of ‘red flags’ for the identification of autism and where to seek help/advice
	+ knowledge of how the core features of learning disability present and why this occurs
	+ knowledge of how the core features of autism present and why this occurs
	+ knowledge of the risk factors for learning disability
	+ knowledge of the risk factors for autism
* Knowledge of common co-occurring conditions:
	+ knowledge of common co-morbidities in autism (mental health, physical health, neurodevelopmental and functional)
	+ knowledge of common co-morbidities in learning disability (mental health, physical health, neurodevelopmental and functional)
	+ awareness of the differences between presentations of mental and physical health issues in autism
	+ awareness of the differences between presentations of mental and physical health issues in learning disability
	+ knowledge of the impact of trauma/abuse/loss on an individual with autism and/or a learning disability
* Knowledge of social models of disability:
	+ understanding of the current models of disability and the historical context
	+ understanding of ‘lived experience of a disability’
	+ understanding of why it is essential to recognise strengths as well as difficulties in learning disabilities and/or autism, and why not to stereotype
* Understanding of relevant legislation such as the Mental Health Act and the Equality Act.
* Making reasonable adjustments in practice, assessment and therapy:
	+ understanding of the reasonable adjustments required to work with children and young people with a learning disability and/or autism, their families and other services
	+ knowledge of working with children and young people with multiple impairments, for example, sensory, physical, intellectual, speech, language and communication
	+ knowledge of the use of language and communication and how to adapt to meet the needs of children and young people with a learning disability and/or autism
	+ awareness of the impact of the environment (colours, lighting, stimulation, noise, distractions) on children and young people with a learning disability and/or autism)

# Part B: The core knowledge base for delivery of CYP MH care

## B1 Ensuring the delivery of inclusive and anti-discriminatory services that reduce mental health inequities

As well as being a ‘golden thread’ running through all teaching, a minimum of 4 days of training on anti-discriminatory practice is expected, with a flipped learning model encouraged. Example topics might be:

* identities, intersectionality and values
* understanding the gender spectrum
* considering race and racism within the therapy space
* demystifying disability
* working with neurodivergent clients
* cultural humility and culturally competent practice

HEIs might consider using an equity, diversity and inclusion (EDI) audit tool to reflect on their work in this area.

Experts by experience (children, young people and parents/carers/guardians rather than only adults with lived experience) should be incorporated into programme planning and delivery for these sessions in a meaningful way, emphasising co-production.

Programme assessment marking criteria should explicitly refer to EDI (see the section on assessment at the end of B1), and passing marks should be contingent on the demonstration of consideration and responsiveness to lived experiences, supporting students away from the inaccurate assumption that EDI is only a factor for racially minoritised clients.

Supervisors and leads should receive training to ensure that the guidance offered to students within their employing organisations and HEIs is culturally appropriate. The supervision should promote open discussions on EDI considerations, support student development, and encourage self-reflection on supervisors’ own assumptions.

HEIs should ensure that their materials are inclusive of accessible guidance (for example, pale background colours, use of [Blackboard Ally](https://ally.ac/) or an equivalent, co-producing learning materials with neurodivergent students), and staff should be prepared to demonstrate and model upstanding behaviour, allyship and anti-discriminatory practice within teaching and supervision. Staff continuing professional development needs around this work should be mandatory and regularly updated.

#### Key learning objectives

* Acquire abilities that promote inclusive and anti-discriminatory practice, and identify and minimise the adverse impact of inequalities in access to services delivering mental health care for children and young people for marginalised and minoritised groups and communities.
* Knowledge of how evidence-based assessment and interventions can best be delivered with marginalised and minoritised groups and communities, and culturally informed approaches to formulation.
* Knowledge of the impact of racism and other forms of discrimination on the mental health of children, young people and their families.
* Demonstrate self-reflective awareness and capacity regarding one’s own intersectional identities and the impact of these on all aspects of clinical work, including but not limited to therapeutic alliances, use of supervision, understanding of evidence bases, delivery of therapy, and use and limitations of routine outcome and feedback measures.
* Demonstrate critical thinking abilities, curiosity and cultural humility towards normative social constructs (for example, heteronormative and patriarchal assumptions, default white position, and dynamics of privilege and power).
* Critically appraise evidence-based literature with regard to applicability and limitations, and develop skills in how to use research literature in the absence of a clear evidence base.
* Understand the role of the individual in facilitating service change and in introducing, promoting, supporting and sharing an inclusive and anti-discriminatory philosophy across the service.
* Explore theories of change, critically appraise barriers to change, and explore ways in which service improvements can be facilitated and effectively implemented, including organisational barriers such as institutional discrimination.

#### Knowledge

* Develop an understanding of the limitations of current theoretical frameworks, assessment tools and the evidence base in meeting the needs of diverse populations.
* Develop awareness of up-to-date literature on human rights and anti-discriminatory practice in health and social care, and an appreciation of where to find relevant literature and advice.
* Gain knowledge of the interaction between social disadvantage/exclusion and experiences of discrimination as it affects the delivery of CYP PT (for example, with regard to referrals for talking therapies, models of therapy, the evidence base, assessment, and intervention and outcome measures).
* Develop an understanding of the limitations of the evidence base for diverse communities and seek consultation or other relevant forms of evidence where necessary.
* Understand and reflect upon the historical harm that the psychology and psychiatry disciplines have inflicted upon marginalised and minoritised groups and LGBTQIA+ communities. Students should be encouraged to critically appraise how the legacies of these actions are still evidenced today (for example, through increased admissions and school/college exclusion rates, under-representation in mental health professional roles).
* Develop an awareness of how ingrained normative assumptions can be inadvertently maintained within interventions (for example, the focus on scales of ‘redness’ as a social anxiety measure within video feedback).
* Understand that children and young people’s perceptions of mental health and physical health may be different from practitioners’, and how this might impact on a collaborative understanding of factors for change within an evidence-based framework.
* Understand intersectionality and how this relates to the therapeutic relationship within mental health assessment, formulation, intervention and outcome measurement.
* Understand theories of change and consider the culture, power and politics of leadership, discrimination and organisational change related to the dissemination of evidence-based practice.
* Identify and understand barriers and levers for change at the individual, team and systems organisational levels.
* Understand the effects of team and service change on the wider health, social care and educational systems, and on the third sector.

#### Skills

* Assessment, formulation and treatment should involve consideration of the child in their social, cultural and familial context, including their personal intersectional identities, and a self-reflective awareness on behalf of the practitioner regarding their own social, cultural and familial context in relation to this.
* Ability to work with the young person’s/family’s contextual and cultural explanatory models – for example, the meanings given to symptoms (including traditional models of healing) – and to explore expectations of treatment.
* Ability to recognise, enquire about and address issues associated with racism and other forms of discrimination, including homophobia and sexism.
* Ability to address discrimination alongside other factors impacting on mental health, including as part of an intervention where relevant.
* Exploring effective ways to influence and support service transformation to achieve more inclusive services focused on children/young people and parents/carers/guardians.
* Critically examining the role of, and strategies for enhancing, professional influence on an evolving system to support anti-discriminatory services.
* Examining how to view oneself as a change agent who can influence and bring about effective service transformation with regard to inclusion.
* Supporting services to reflect continuously on how provision fits the characteristics of the population, embedding a culture of participation within the service which addresses any adverse impact for marginalised and minoritised groups and how services might need to adapt intervention strategies.
* Using a wider range of community locations such as schools, homes, GP surgeries, places of religious worship, and support and advocacy groups.
* Use of technology to provide creative ways of interacting and delivering interventions – for example, computerised Cognitive Behavioural Therapy (CBT), telephone engagement, text/email reminders, and video/FaceLink appointments. The technology needs to be flexible to address the needs of people with disabilities or language and/or other communication issues, for example deaf children, young people and/or parents/carers/guardians.

#### Assessment considerations

* Anti-discriminatory practice and expectations around EDI should be incorporated in all students’ assessments.
* Competency frameworks should have EDI competencies threaded through them, and/or included as a separate competency heading/part of professional practice competency or core therapy skills. Achieving EDI competencies should be evidenced on video submissions (for example, being able to ask about the impact of any difference/diversity on mental health) and/or reflected on in accompanying case reports/reflections/oral presentations.
* Consideration should be given to EDI in literature reviews/the introduction to all assignments (for example, the range of evidence available in diverse populations should be critiqued; the applicability of the literature to the client should be commented on and/or its limitations noted). This should be explicitly named as an expectation in marking criteria.
* Consideration should be given to EDI in demonstrated or written assessments/formulations and treatment (for example, intersecting identities should be considered for both client and therapist; explicit and open questions about the client’s experience of unfairness or discrimination during assessment/treatment should be evidenced or written about). Consideration of discrimination/minority stress on mental health should be included in formulations as relevant, and there should be consideration of how this is addressed, for example within the system or in treatment.
* Consideration should be given to EDI in outcome measurements (for example, literature on the applicability of standardised measures to diverse populations as relevant to the client; whether the impact of EDI is reflected in goals for treatment, including measures of experience of discrimination in assessment).
* Consideration should be given to EDI in reflections/reflective analysis (for example, consideration of how any power imbalance impacted on the therapeutic relationship and whether/how this was discussed; reflections on how any biases might have impacted on the therapeutic relationship; whether there were any missed opportunities for addressing EDI; what was successful or unsuccessful in relation to EDI during the case; and how would the therapist change their practice in future).
* Supervision reports should include, as a course requirement, a note from the supervisor on whether the student was able to develop in terms of working ethically and professionally with regard to EDI.

## B2 Fundamentals of therapy adapted to CYP MH principles

#### Key learning objectives

* To demonstrate the CYP MH principles (for example, accessibility, accountability, awareness, evidence-based practice and participation) within clinical practice.
* To integrate CYP MH principles and practice with existing knowledge and skills.

#### Knowledge

* Knowledge of the impact of CYP MH principles and practice on:
	+ professional and ethical guidelines
	+ issues of confidentiality, consent and capacity
	+ ability to work with and across agencies
	+ the strengths and weaknesses associated with using standardised measures
	+ knowledge of methods using goals in working with children and young people
	+ knowledge of the principles and practice of participation by children in helping systems and schools (for example, school councils), as outlined in section A4 above
	+ understanding that one’s own intersectional identity might impact on assessment, formulation and intervention according to CYP MH principles
	+ understanding of the influence of changes in therapeutic and task alliance on therapeutic outcomes (for example, rupture–repair, dropout)

#### Skills

* Incorporation of CYP PT practice to enhance existing skills in:
	+ ability to undertake a comprehensive assessment
	+ ability to engage and communicate with children, young people and their parents/carers in an appropriate and responsive manner
	+ ability to communicate with children and young people of differing ages, developmental levels and backgrounds, including those with disabilities and other communication needs
	+ ability to use formulation with standardised measures and other measures where these are not applicable
	+ ability to feed back the results of an assessment to children, young people and their family/carers, and to agree a treatment plan flexibly and responsively – for example, a collaborative approach to the assessment process that includes consideration of the evidence across all modalities of intervention, including physical, pharmacological, psychological and social
	+ ability to undertake a risk assessment and to formulate, communicate and manage risk appropriately in line with new government guidelines on not relying solely on tools such as simple scales or questionnaires.
	+ ability to assess the child/young person’s functioning across systems (for example, the central position of client choice for other statutory services such as education and social services)
	+ ability to formulate the child/young person’s problem using participatory techniques and standardised measures and outcomes, alongside awareness of the limitations of standardised measures and the ability to find alternative means of assessment and progress suitable for the individual and family
	+ ability to develop shared goals with children, young people and parents/carers/guardians
	+ ability to involve children, young people and parents/carers/guardians in a review of progress

## B3 Shared aspects of evidence-based practice with children, young people and families

#### Key learning objectives

* Identify the key maintaining processes common to a range of presenting difficulties, and apply core intervention strategies from the evidence base and practice-based evidence to address these.
* Manage therapeutic alliances and appropriate boundaries, including confidentiality, with a range of children, young people and parents/carers/guardians, often with multiple parties present in the room at the same time.
* Gain skills in developing idiosyncratic formulations which meaningfully include individuals’/families’ intersectional identities (including protected characteristics and aspects of social location such as class). Formulations will include those that do not fit modal presentations and outcomes.
* Assess and formulate co-morbidity and/or multiple problems within the same family, and collaboratively determine treatment priorities.
* Develop skills in assessing and capturing complexity (for example, using the Current View tool), including aspects such as poverty, physical health difficulties, disabilities and parental mental health difficulties.
* Develop skills in appropriate adaptation of interventions for individuals’ intersectional identities and aspects of complexity (as above).
* Recognise and critically appraise the challenges of delivering evidence-based interventions within and across organisations and/or systems.

#### Knowledge

* Learn about core maintaining processes common across multiple mental health difficulties and the primary interventions used to address these.
* Learn to identify and appropriately apply distinct evidence-based components of treatment, and knowledge of where treatment components can be applied to problems.
* Learn about decision processes in choosing treatment components based on collaborative decision-making and routine outcomes monitoring.
* Learn about the hierarchy of problems identified in assessment, with due regard to barriers to treatment, including cultural and diversity issues.
* Knowledge of effective outreach programmes, and knowledge and skills in multi-agency working and issues that may affect this.

#### Skills

* Ability to share idiosyncratic formulations and treatment plans with children, young people and families, recognising and validating elements of co-morbidity and co-occurring systemic difficulties and complexities.
* Ability to respond to evolving treatment needs within episodes of care as discovered in frequent routine outcome monitoring.
* Ability to adjust treatment components to provide a developmentally and culturally sensitive intervention.
* Ability to develop systematic methods for addressing crises and externalising problems presenting during an evidence-based intervention for another primary difficulty.
* Developing skills in more effective joint agency interventions to supplement evidence-based practice (for example, harnessing education to support children’s needs) and supporting the integration of the work between school and home.
* Ability to consider and agree who is the best person to work with (for example, parent/carer/guardian, child/young person, both, school), the length of meetings and the approach (for example, verbal versus visual) in conjunction with the child/young person and parents/carers/guardians.
* Ability to explain the rationale for and process of the chosen therapy, including the ability to:
	+ explain the model to clients, provide a clear rationale for the treatment offered and describe the anticipated outcomes
	+ describe the child/young person’s specific problems using the general model
* Ability to create a shared formulation with the child and parents/carers/guardians.
* Ability to explain the likely course and process of treatment offered, including the ability to:
	+ explain the course of the intervention (for example, the anticipated number, frequency and duration of meetings)
	+ outline the collaborative nature of the treatment offered
	+ explain the active process of the treatment offered
	+ provide a rationale for the use of out-of-session tasks
* Ability to agree the possible role of the parent/carer/guardian in the intervention.
* Ability to define the boundaries of confidentiality and information-sharing.
* Ability to gain informed consent from children, young people and their parents/carers/guardians by:
	+ conveying information relevant to decision-making in a form which is age-appropriate and/or developmentally appropriate
	+ inviting, and responding to, questions regarding the proposed intervention
* Ability to apply developmental knowledge in the intervention.
* Ability to employ therapeutic skills, including the capacity to:
	+ develop and maintain the therapeutic alliance
	+ convey empathy
	+ employ active listening skills
	+ empathetically explore experiences of difference, discrimination and exclusion
	+ help the child/young person recognise and articulate different feeling states, moods and states of mind
	+ facilitate the development of new perspectives through questioning and reflection
* Ability to apply knowledge of systemic influences in the intervention, including ability to:
	+ involve relevant members of the child/young person’s system in the intervention
	+ identify the concerns and goals of different parties
* Ability to adapt the treatment offered to the individual needs and developmental level of the child/young person and/or parent/carer/guardian.
* Ability to make treatment engaging for children, young people, parents and/or carers.

# Part C: Introduction to CYP PT modalities of therapy

A key element of the CYP PT programme is to offer training in evidence-based therapies. The therapies selected are those based on best evidence and the level of prevalence of presentation. It is essential that CYP PT trainees have some basic understanding of other therapies within the programme. As the elements of the core module can be woven into the specific therapy trainings, the amount of time spent on this section will vary according to the therapy being taught. For example, CBT trainees will not require separate sessions on the CBT elements described here, as these should be covered in the modality-specific element of their course. Part C is intended to give space on the timetable for a basic introduction to the fundamentals of the specialty being taught and to give pointers to a brief overview of other areas. It is understood that the coverage of areas other than the one which is the focus of the course will be superficial and high level. It is not expected that the whole of Part C will be delivered, but the material is included in the core curriculum to support selection of specific topics.

## C1 Fundamentals of high-intensity Cognitive Behavioural Therapy for children and young people (CBT CYP)

CBT CYP trainees please note: these learning objectives form part of the ‘CBT fundamentals’ module and will be covered in more depth there.

#### Key learning objectives

This module aims to equip clinicians with a comprehensive understanding of the key concepts of CBT, tailored for children and young people. It further enables clinicians to explain these concepts when communicating with colleagues, children, young people and their families. It is anticipated to last for between 2 and 3 days.

#### Content

* Suitability for CBT: In CBT, the first step is to evaluate whether the conditions are there to implement a CBT intervention with children and young people – and, if not, how to address any barriers. These may include social communication difficulties, learning disability and EDI considerations. If there is significant parental conflict and the family is in crisis, it may not be possible for the young person to attend sessions regularly or the trainee to conduct systematic exposure exercises.
* Evidence base: Knowledge of the evidence base for CBT, including efficacy and effectiveness. Trainees will be given an overview of the evidence for group-based interventions across conditions, with general principles of how evidence-based practice is used in high-intensity CBT. NICE guidance should be used as a basis for the provision of evidence, alongside updates from randomised controlled trials that have been conducted in the field since the production of the NICE guidelines.
* Style and structure: Knowledge of the style and structure of CBT, including the number, length and frequency of sessions; the extent of parental involvement; and the expectations of the young person. An overview of a typical CBT session structure should be provided (including questionnaires/patient-reported outcome measures and routine outcome measures, bridge discussion from previous session, setting the agenda, review of homework, discussion of issues on the agenda, setting new homework, summary), along with endings and relapse prevention and key stylistic features of CBT (summaries and feedback, collaboration, Socratic questioning, use of a shared formulation to guide treatment, a clear focus in each session on the presenting problems and agreed goals).
* Overview of key models of depression and anxiety:
	+ Knowledge of AT Beck’s longitudinal and maintenance model of emotional disorders should be demonstrated, with clarification of when a longitudinal formulation might be used. The difference between automatic thoughts, rules/assumptions and core beliefs in the treatment of depression should be clarified, with emphasis placed on automatic thoughts and maintaining factors as the principal focus of formulation/intervention. The relationship between AT Beck’s model and individual disorder-specific models of anxiety disorders should be clarified. Anxiety disorders, as well as individual-based interventions such as CBT for the specific anxiety disorders in young people, should be discussed.
* The premise on which CBT is based should be provided and its basic assumptions described, particularly:
1. that it is the interpretation of the event, not the event itself, that determines emotional response
2. the role of avoidance and other behaviour in maintaining anxiety, in accordance with behavioural theory and therapy
3. that symptom improvement results from the identification and reversal of maintaining mechanisms
* Formulation: Generic CBT formulation skills should be presented, including Padesky’s ‘hot cross bun’ model. The relationship between disorder-specific models and personalised formulations should be described. Trainees should be encouraged to see how such a framework can help them formulate their clients’ difficulties.
* Content of intervention: An overview of the generic content of CBT for depression and CBT for anxiety disorders should be provided. This could include:
	+ the importance of therapeutic alliance/therapeutic relationship
	+ psychoeducation, including fight/flight response and cognitive errors
	+ identification and challenge of maladaptive cognitions using thought records, positive self-talk and behavioural experiments
	+ identification and challenge of maladaptive behaviours using a fear thermometer and graded hierarchies for exposure exercises
	+ use of other strategies such as cognitive self-talk and relaxation
* It should be highlighted that key interventions for specific disorders differ according to the problem, for example, reliving for post-traumatic stress disorder or adaptations for neurodiversity.
* A brief overview of the differences in CBT therapy with children and young people:
	+ young people are brought for treatment
	+ engagement issues
	+ motivation issues
	+ cognitive developmental issues
	+ CBT and neurodivergence
	+ CBT and learning disability
	+ CBT and EDI considerations
	+ children are part of wider systems that may need therapist intervention (for example, carers, school)
	+ parental cognitions and behaviours and how these impact young people
* Useful information:
	+ useful information on the nature of CBT on the [NHS website](https://www.nhs.uk/mental-health/talking-therapies-medicine-treatments/talking-therapies-and-counselling/cognitive-behavioural-therapy-cbt/overview/)
	+ information on CBT for children and young people on the [Royal College of Psychiatrists website](https://www.rcpsych.ac.uk/mental-health/parents-and-young-people/cognitive-behavioural-therapy-%28cbt%29-for-young-people)

#### Suggestions for exercises

* Paired and group exercises can be used to encourage theory–practice links. A minimum of 2 exercises for a day’s teaching is recommended. Examples are given below:
	+ Trainees are invited to get into pairs (or groups of 3 if numbers are uneven) and reflect on a client with anxiety or depression with whom they have recently worked. They should reflect on:
		- the evidence base for the intervention they used
		- the style and structure of their intervention
		- the model on which their intervention was based
		- the formulation
		- the content of the intervention
		- differences between the intervention that they used and a cognitive behavioural intervention. After such reflection in pairs, the pairs should feedback on their reflection to the larger group
	+ Trainees are invited to get into pairs (or groups of 3 if numbers are uneven) and role-play communicating the basic principles of CBT, first to a child (aged 9) with separation anxiety, and second to an adolescent (aged 15) with depression. Each role-play should last approximately 20 minutes, with 1 trainee taking the role of the therapist and the other the role of the child/adolescent. Trainees should swap after 20 minutes so that each has a turn in playing the therapist and the young person. At the end of 40 minutes, the entire group should reflect on the role-play together as both the therapist and child/adolescent.

## C2 Parenting programmes

#### Key learning objectives

This module will enable clinicians to understand the key features of parenting training for conduct disorders and the central concepts of the Social Learning Theory (SLT) model. The course will explain how these key features manifest in both group and individual parenting interventions. On completion of the course, the trainees should be able to explain SLT approaches to colleagues and families, and should understand when group or individual-based parenting programmes are indicated. It is anticipated to last for between 1 and 1.5 days.

#### Skills

* Evidence base: Knowledge of the evidence base for SLT-based parenting interventions for parents of children aged 3 to 10 years with conduct problems.
* Trainees will receive an overview of the evidence base for both group and individual-based interventions (and an introduction to a decision-making process for whether a group-based or an individual format is adopted). The importance of early intervention will be included. NICE guidance should be used as a basis for the provision of evidence, alongside updates from randomised controlled trials that have been published since the production of the NICE guidelines. The literature for efficacy and effectiveness should be presented, as well as moderating factors such as the age of the young person, parental characteristics and co-morbidity.
* Style and structure: Knowledge of the style and structure of the parenting intervention, including the number, length and frequency of sessions and home visits and the expectations of the parent. An overview of a typical session structure should be provided, along with key stylistic features of the parenting programme and a clear focus in each session on the presenting problems and agreed goals. Examples of at least one group-based programme should be given and the role of group processes highlighted. An explanation of how individual programmes are structured should be provided, and the differences between consultation (carer only) and live (carer plus child) approaches discussed.
* Models: Knowledge of SLT (this will be addressed in full in later lectures for all trainees) and Patterson’s coercive cycle. Trainees will learn about the role of parental attention in the reinforcement of children’s behaviour. The unifying principles of SLT must be promoted throughout the sessions, not prioritising any brand of programme or group over individual approaches. Reference will be made to the basic cognitive behavioural maintenance cycle (the thoughts–feelings–behaviours cycle), ensuring trainees understand the role of parental cognition.
* Formulation: An idiosyncratic case example of Patterson’s coercive cycle should be described to illustrate the role of positive and negative reinforcement in children’s and caregivers’ behaviour.
* Content of intervention: An overview of the content of parenting work. The importance of role-play throughout the programme should be stressed. This includes (but is not limited to):
	+ assertive outreach work
	+ engagement issues and the importance of a non-blaming approach
	+ child-focused play
	+ specific labelled praise
	+ effective limit-setting
	+ ignoring
	+ time out

#### Exercises

* Analysing the operant contingencies in case vignettes, to provide experience of delineating positive/negative and reinforcing/punishing dimensions in real-life situations. Discuss in small groups and then bring back to the bigger group.
* Case studies to help trainees formulate cases within an SLT framework, so that they can identify which presentations are most likely to be amenable to an evidence-based parenting programme, and the role of safeguarding issues, multi-agency working, co-morbidity, and the possible barriers/treatment moderators that the case study suggests. Trainees should experience reframing the generic descriptions of child and parent/carer/guardian behaviour and presentations used in children and young people’s mental health care into SLT-specific language (for example, specific observable behaviour in the here and now).
* Skills-based role-play exercises, for example from skills such as (but not restricted to) identifying and labelling child behaviour in commenting, labelled praise, ignoring specific behaviours, giving clear instructions, and examples of consequences.

## C3 Interpersonal psychotherapy for adolescents (IPT-A)

#### Key learning objectives

This half-day module will enable clinicians to understand the key features of interpersonal psychotherapy for adolescents (IPT-A), and explain IPT-A to colleagues, young people and families.

#### Content

* Evidence base: Knowledge of the evidence base for IPT-A, including efficacy, effectiveness and recent work on moderators of treatment effects, if not covered elsewhere in the core curriculum.
* Structure: Knowledge of the structure of IPT-A, including the number, length and frequency of sessions, extent of parental involvement, and expectations of the young person in IPT-A.
* Model: Knowledge of the basic model and assumptions of IPT-A, including evidence for the key role of interpersonal context in triggering and maintaining depression, and in recovery from depression.
* Content: Knowledge of the content of IPT-A sessions, including the 3 phases of therapy, use of the interpersonal inventory, the 4 possible foci, how to derive an interpersonal formulation, and introduction to goals and strategies for each focus area.
	+ Phases of IPT-A:
		- initial phase, including interpersonal interview and formulation
		- middle phase, including focus-specific strategies
		- termination phase
	+ Interpersonal inventory:
		- use of closeness circle and network grid
	+ Focus areas and treatment strategies:
		- role disputes
		- role transitions
		- grief
		- interpersonal sensitivities
	+ Presenting the formulation:
		- case examples to be given

#### Option for group exercises

* To encourage theory–practice links, a group exercise is suggested.
* Trainees in small groups are invited to recall an adolescent with depression with whom they have recently worked. They should consider: how depression was experienced by this young person; what were the main interpersonal issues in the onset and maintenance of depression; what were the vulnerability and protective factors; and what are the possible focus areas, for example, disputes, transitions, grief and sensitivities.
* Trainees should present a preliminary IPT-A formulation to the rest of the group, modelled on the formulations previously given by the trainer.

## C4 Systemic family practice

#### Key learning objectives

This module will provide clinicians with an introductory understanding of the systemic perspective on families and how family relationships are important for children and young people facing challenges. The focus will be on helping clinicians to improve their ability to work with multiple family members from diverse communities, both together and separately.

It is expected that this aspect of delivery of children and young people’s mental health care will cover 2 days.

#### Content

* Knowledge: Family patterns and beliefs, family life cycle, family structure, cohesion, intergenerational scripts, hierarchy, and the impact of wider systems on the family, including culture. A ‘family focus’ in which trainees will consider the impact of a problem on the family and the impact of the family on the problem. This will also involve brief references to the way family systems may be understood in different ways and problems may be understood from multiple perspectives. This section seeks to give clinicians a language to describe families and family interactions.
* Evidence base: Including an overview of the various evidence-based models such as Functional Family Therapy, Multisystemic Therapy and Multidimensional Family Therapy. The evidence base also includes process research which demonstrates that a split family alliance has an impact on the therapeutic outcome (see the [System for Observing Family Therapy Alliances (SOFTA)](https://softa-soatif.com/)). Ways of measuring family change (such as SCORE) also need to be described.
* Theoretical skills: How to construct several systemic hypotheses (formulations) and use them to orientate the clinician to the problem and the family.
* Clinical skills: How to engage multiple family members and communicate effectively with them. How to help all family members express their views without restraint and in the spirit of collaborative respect.
* Orientation of systemic family therapy: An overview of the general principles of systemic family therapy, the modules available, and the course and content of evidence-based family therapy.

#### Whole-group exercises

* The systemic aspects of human interactions can be demonstrated by creating a ‘chocolate factory’ with the participants: they each choose to take on a role in this factory, making the sounds that their ‘machine’ might make. The facilitator then removes a couple of ‘machines’ for ‘repair’ while telling the whole factory that they must still produce chocolate. This exercise shows how human systems are created, how they adjust to problems, and how hierarchy, communication, alliances and rivalries become central to the functioning of systems.
* Family processes can be demonstrated by taking the family tree of a real or fictional family. The family tree is drawn up by the facilitator and the group is asked to construct a systemic understanding of the ‘problems’ family members exhibit (for example, alcohol misuse, self-harm and suicide). See McGoldrick, M and Gerson, R (2008). ‘Genograms: Assessment and intervention’. New York: Norton.
* Building a family alliance can be explored using the SOFTA web-based resources, which help clinicians practise how to work with multiple family members and address issues such as ‘resistant’ family members, ‘blaming’ interactions and divided opinions in families.
* Exploring evidence-based interventions for the most common mental health problems affecting parents, and the relationship to cultural variations in the interpretation and understanding of such problems. Understanding whether a parent needs to be assessed under the Mental Health Act (1983) or the Mental Capacity Act (2005) or referred to specialist mental health services.
* Understanding the need for multidisciplinary and multi-agency working with families, and the importance of communication both with the parent/family and across the disciplines and agencies working with the parent/family.

# Appendix

1. In this document the terms ‘child’ and ‘young person’ are interchangeable, as are ‘family’, ‘parent’ and ‘carer’. [↑](#endnote-ref-2)