Health Education England

National Curriculum for Eye Movement Desensitisation and Reprocessing (EMDR) with Adults

Suitable for practitioners working in IAPT services, adult community mental health services and perinatal mental health services.

First Edition (September 2021)

1. Introduction

Eye Movement Desensitisation & Reprocessing (EMDR) Therapy NHS National Curriculum is designed to equip trainees within IAPT, adult community mental health and perinatal mental health services to become competent EMDR Therapists able to provide EMDR treatment for adults of all ages with PTSD (including Complex PTSD [cPTSD]) or clinically significant symptoms of PTSD consistent with NICE guidelines[1].

The 24-month training and supervision programme has been tailored to build upon trainees' core professional and generic therapeutic competences for the delivery of individual structured psychotherapy as well as a core understanding of trauma and PTSD (see the EMDR Competency Framework for more details[2]). The training will expand on this foundation knowledge and teach clinicians how to intervene effectively with PTSD or significant PTSD symptoms using EMDR Therapy. This prepares trainees to deliver EMDR within the scope of NICE guidance.

2. Entry Requirements

Core professional training in a psychological therapy and experience of delivering the therapy is a prerequisite for entry into EMDR training.

Candidate requirements:

- Recruited candidates must be one of the following:
  - HCPC registered Clinical, Counselling, Educational or Forensic Psychologist
  - BABCP Accredited CBT Therapist
  - GMC registered Medical psychotherapist having completed higher specialist training in psychotherapy
  - British Association for Counselling and Psychotherapy (BACP) Accredited
  - United Kingdom Council for Psychotherapy (UKCP) Registered as a Psychotherapist or Psychotherapeutic Counsellor
  - Association of Christian Counsellors Accreditation
  - National Counselling Society Accredited Professional registrant
  - British Psychoanalytic Council Registered

- Recruited candidates should be selected who are able to demonstrate:
  - Core professional competences and generic therapeutic competences highlighted in the EMDR Competence Framework[2]
  - A background working in mental health or wellbeing services
- A minimum of two years' experience of delivering one-to-one psychotherapy, after meeting one of the entry registration/accreditation requirements

[1] https://www.nice.org.uk/guidance/ng116/resources/posttraumatic-stress-disorder-pdf-66141601777861

[2] Roth, A.D., Pilling, S. & Dudley, O (2020). A competence framework for the supervision of psychological therapies. Available from: https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-18

- A good understanding of trauma
- The ability to be warm, empathic, show understanding and be able to support people in a state of significant distress
- Candidates should not be undertaking or plan to be undertaking any additional EMDR continuing professional development (CPD) training over the duration of the EMDR training programme they will be completing.

Service setting requirements:

- Candidates need to be based in a service where they will be able to deliver EMDR to adults (inclusive of all ages) with PTSD.
- Candidates need to be able deliver within a pathway that offers a range of NICE guided interventions for the sequelae of trauma
- Commitment from the service that the trainee will be able to undertake EMDR with a minimum of 6-8 clients per week
- Able to offer 90-minute sessions routinely

3. Learning and Teaching Strategy

The programme of learning and teaching should be aligned to the Roth and Pilling EMDR competency framework[3]. The syllabus should also be consistent with the latest EMDR Europe Criteria for the Certification of EMDR Standard Training Within Europe.

The taught components will take place over a minimum total of 8 days delivered across 4 parts.

The format of the instruction must include:

- Teaching for a minimum of 24 (60-minute) hours
- Supervised practice for a minimum of 18 hours.
- Clinical training supervision for a minimum 10 hours.

The training pathway begins with a 3-day workshop (Part 1). This is immediately followed by 24-month long fortnightly triad clinical supervision provided by a EMDR Europe Accredited Consultant (See Clinical Supervision section for further details). This fortnightly clinical supervision will be in addition to the supervision days arranged by the training provider in Part 2 and Part 4.

The first 6 months of the 24-month pathway is interspersed with Part 2, 3 and 4 of the teaching components. Around 6-8 weeks after Part 1 there will be a one-day Consolidation and Training Supervision Day (known as Part 2). At approximately the 3-4 month after Part 2, there will be another 3-day training concentrating on more advanced strategies and working with complexity (known as Part 3). After

[3] Roth, A.D., Pilling, S. & Dudley, O (2020). A competence framework for the supervision of psychological therapies. Available from: https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-18

approximately 6 months (from the start of the training) there will be the final element of the training component (Part 4) which will be another Consolidation and Training Supervision Day.

Each training day across all 4 parts will last at least 7 hours. Typically delivered 0900-1730 with 1.5 hours allocated for breaks. Part 1 must be delivered in-person, but the other Parts can be delivered either in-person or interactive virtual delivery depending on the needs of the commissioning body.

Outline of the EMDR Training Parts 1 to 4

Part 1 (3 days) - EMDR Therapy Core Skills and Knowledge

EMDR Research relating to PTSD
The EMDR adaptive information processing model (AIP)
The 8 Phase Standard Protocol
Treatment Planning
Working with Blocks
Client selection

Part 2 (1 day)

Training Supervision and Consolidation Day

Part 3 (3 days) – Revision and EMDR Therapy Advanced Strategies

Revision of the 8 Phases Standard Protocols
Revision of Treatment Planning
Revision of Unblocking Strategies
Working with complexity including strategies for managing dissociation, under accessing/ over accessing of distress, avoidance and other cPTSD strategies.

Part 4 (1 day)

Training Supervision and Consolidation Day

The training uses a blended approach to learning, with each training part employing a variety of strategies to optimize the clinicians' development. These include:

1. Didactic teaching by an EMDR Europe Accredited Trainer with PowerPoint or equivalent.

2. Videos and live demonstrations by the Training Team exemplifying a wide variety of therapeutic interventions focal to the 8 Phase protocol. The course content must also include relevant video examples of actual EMDR sessions with a psychotherapy client or live demonstrations. The purpose of video

examples or live demonstrations is to illustrate client symptomatology, clinical situations and how to manage these during an EMDR session. Video/live practice material should also demonstrate specific aspects of the EMDR methodology and patient responses during EMDR which otherwise are difficult to teach during a training course (e.g., cognitive interweave).

3. Extensive experiential practice by trainees employing these techniques with individual feedback from Training facilitators. The facilitator to participant ratio for any practical exercises cannot be more than 1 for every 12 participants.

4. The opportunity to reinforce learning with practical activities such as role-play. Role-play is essential in teaching the skills required to elicit Negative and Positive Cognitions during the Assessment Phase. It is also to help understand and use Cognitive Interweaves.

5. Extensive clinical handouts and materials for use by trainees in their own clinical work with clients with PTSD.

6. Experience of delivering EMDR in pairs or triads using a relatively contained personal events.

4. Trainer criteria

All presenters of EMDR training for this curriculum must be EMDR UK Association members and must also be current EMDR Europe Accredited Trainers. They must also have a good knowledge of the service settings and quality standards for practice where trainees are embedded (IAPT, adult community mental health and perinatal mental health services).

5. Course Content

5.1 Part 1 (3 days) - EMDR Therapy Core Skills and Knowledge

Aims:
To understand the foundation theory and become competent in the foundation practice skills of EMDR therapy so clinicians can safely and effectively implement EMDR for PTSD in their own NHS commissioned clinical practice following the 3-day training under fortnightly EMDR specific clinical training supervision.

Learning Outcomes:

- To understand the empirical support of EMDR therapy for PTSD, clinically significant symptoms of PTSD, and cPTSD
- To understand the EMDR adaptive information processing model (AIP) and how it relates to the understanding of PTSD, clinically significant symptoms of PTSD, and cPTSD.

- To understand the clinical implications of the AIP model and how it guides case conceptualisation, treatment planning, intervention, and predicts treatment outcome for PTSD, clinically significant symptoms of PTSD and cPTSD
- To understand the theory for which there is empirical support for the application of EMDR for PTSD, clinically significant PTSD symptoms and cPTSD.
- To understand the key empirically supported mechanism of action theories relating to Alternative Bilateral Stimulation (ABLS) and how they relate to the trauma confrontation components of EMDR therapy and the AIP model.
- To develop foundation competence in the specific assessment and treatment planning procedures needed to select, implement, and re-evaluate EMDR treatment for PTSD in either IAPT services or NHS secondary mental health care in the time-limited ways detailed in the NICE PTSD guidelines.
- To develop foundation competence in clear and appropriate treatment planning in EMDR therapy for NHS settings, supporting a national approach to EMDR formulation for PTSD. Treatment plans must include the 3-pronged formulation (Past, Present, Future) and trainees should become competent in collaboratively developing this with clients including demonstrating the links between Past, Present and Future. The 'Present prong' must include a clear outline of the current trauma related problems / triggers / symptoms that client wants relief from. The 'Future prong' must include a clear list of therapy goals that are measurable through a reduction in trauma symptoms and achievable in NHS time limited settings. The Past targets are a collaboratively developed list of **core** trauma memories most clearly linked to the PTSD symptoms most troubling to the client[4]. Targets should then be processed with the highest SUD memories first, due to the time limited working that occurs in NHS clinical settings. Only if a client cannot tolerate this order of processing should a chronological or graduated target selection approach be taken.
- To develop foundation competence in the standard empirically validated 8 phase protocol and procedural steps for EMDR therapy including:
    - History-taking phase including:
        - how to take a contained longitudinal and trauma history, which is relevant for NHS time limited working including variations for IAPT compared to secondary care settings
    - Preparation phase including:
        - the 'safe/special place exercise' and alternative stabilisation skills training
        - Alternating bilateral stimulation (ABLS) demonstration
        - Socialisation to the model
        - Addressing client fears
    - Assessment / Activation of the chosen Target from the Treatment Plan
    - Desensitisation
    - Installation of the Positive Cognition
    - Body scan

[4] Floatback / Affect Bridge / Bridge back should NOT be taught as a Target Planning strategy during the Part 1 or Part 3 training due to the numerous anecdotal reports of the potential confusion it can bring to conceptualisation when NHS clinicians are new to the model. It can be taught within Unblocking modules in Part 1 and 3 to assist with locate feeder memories that might be creating the block, however, only when other more straightforward unblocking techniques have not worked.

    - Closure (for complete and incomplete sessions)
    - Re-evaluation, including:
        - Restarting a previously incomplete session
        - Reviewing a previously completed target
        - Selecting additional targets (where necessary) as relevant to the treatment plan
        - Re-evaluating the treatment plan both formally and informally
        - Time limited working adaptations
- Procedures for dealing with blocked processing[5].
- Foundation principles and procedures for assessing and building affect tolerance skills and management, including traditional stabilisation skills, 'safe place or alternatives', and procedures for recognising when such methods are needed.
- Adjustments for delivering face to face and digital therapy
- Managing the treatment plan within a defined number of sessions as specified by NICE guidance.
- Necessary precautions in the use of EMDR.
- Practical exercises during Part 1 must include at least the following and be supervised up to maximum ratio 1 Consultant/Facilitator to 12 delegate ratios
    - ABLS demonstration using both in-person and online variations
    - Safe Place exercise
    - Role play of the Phase 3 Assessment phase including refining the skills required to elicit Positive and Negative Cognitions.
    - Trainees should practice the EMDR standard protocol in twos or threes, taking a turn to be the client, clinician and if required, the observer.
        - Each trainee must deliver and receive the protocol at least **TWICE** during this Part 1 training.
        - Trainees must use their own relatively contained real-life experiences while receiving direct feedback from a trainer/facilitator.

5.2 Part 2 (1 day) - Training Supervision and Consolidation Day

Aims:
To integrate the theoretical learning from Part 1's didactic teaching and practical exercises to real world clinical settings including (but not exclusive to) working with blocks, client selection issues and treatment planning questions. This day will supplement the small group fortnightly EMDR specialist supervision trainees will be attending between each training part.

Learning and Teaching Strategy:

- Minimum of 5 hours Group supervision
- Minimum of 2 hours Clinical Q&A
- Both components have a maximum ratio 1 Consultant/Facilitator to 12 delegate ratios
- Delegates must bring at least one clinical case they are currently working with to the training supervision.

[5] Cognitive Interweaves should NOT be taught until Part 3.

- Delegates are allocated a minimum of 20 minutes each to discuss their case/s.
- Delegates will have the opportunity to bring other EMDR clinical questions to the Q&A.
- Delegates will have the opportunity for vicarious learning through hearing other trainees' clinical questions and challenges.

5.3 Part 3 (3 days) – Revision and EMDR Therapy Advanced Strategies

Aims:
To build further skills and confidence in the theory and practice of EMDR therapy so clinicians can safely and effectively implement EMDR for PTSD with clients from their own NHS commissioned clinical practice. This will include the ability to utilise EMDR therapy specific strategies with more complex presentations alongside case discussion in the fortnightly EMDR supervision.

Day 1 of Part 3 – Revision Day

Learning and Teaching Strategy:

- Revision of the whole 8 Phase standard protocol
- Revision of collaborative treatment planning (Past, Present, Future) principles
- Revision of Unblocking Strategies
- Trainees should practice the EMDR standard protocol again in twos or threes, taking a turn to be the client, clinician and if required, the observer.
    - Each trainee must deliver and receive the protocol at least once during this day.
    - Trainees must use their own relatively contained personal experiences while receiving direct feedback from a trainer/facilitator.
    - This exercise is to be supervised up to maximum ratio of 1 Consultant/Facilitator to 12 delegate ratios

Day 2 and 3 of Part 3 – Advanced EMDR Therapy Strategies

Learning Outcomes:

- To understand and become competent in applying protocol and procedural steps for possible adjustment to the standard EMDR protocol for cPTSD include additional considerations in history-taking and treatment-planning, preparation, 'safe/calm place', re-evaluation, assessment, desensitisation, installation, body scan and closure.
- To understand and become competent in applying principles and procedures for the assessment, recognition, and regulation of dissociation, together with methods for assessing and decreasing self-injurious and unhealthy tension-reduction behaviours.
- When working with complex cases and/or cPTSD to understand and become competent at the judicious use of the Wessex Dissociative Scale *(subject to confirmation of open access rights)* during EMDR Therapy. In addition, to have

awareness of the benefits and disadvantages of using Dissociative Specific Psychometric tools with complex cases.

- To understand and become competent in applying principles and procedures for dealing with more complex blocked responses to processing (including cognitive interweaves).
    - Trainees should practice Cognitive Interweaves methods through role play whilst being observed.
    - Each trainee must deliver Cognitive Interweaves through the role play.
    - This role play exercise can occur in groups up to a maximum ratio of 1 Consultant/Facilitator to 12 delegates.
- To understand and become competent in applying additional procedures for assessing and building affect tolerance skills and reducing dissociation, including more advanced stabilisation skills, and methods for recognising when such approaches are needed.
- To understand and become competent in applying advanced affect containment procedures, Resource Development and Installation (RDI).
    - Trainees should practice the EMDR RDI methods in twos or threes, taking a turn to be the client, clinician and if required, the observer.
    - Each trainee must deliver and receive RDI at least once during this section.
    - This role exercise is to be supervised up to maximum ratio of 1 Consultant/Facilitator to 12 delegates.
- To understand and become competent in applying the EMDR Flashforward (FF) Protocol[6], for when catastrophic predictions exist around the trauma confrontation phases that have not resolved through psychoeducation, normalising or graduated target selection. The FF protocol can also be utilised when irrational future fears continue after the main past core traumas have already been cleared with the EMDR standard protocol.
- To develop cultural competency when delivering EMDR therapy, how to adapt EMDR therapy when working with interpreters.
- To understand treatment planning, preparation factors and the use of the standard protocol with traumatic grief, which is leading to clinically significant symptoms of PTSD.
- To understand how to target and process somatic PTSD symptoms that have **not** resolved through first targeting of trauma memories with the Standard EMDR Protocol. This can include aspects of the EMDR Pain Protocol[7] that can sometimes be helpful in this situation.
- To understand treatment planning, preparation factors and the use of the standard protocol with PTSD or clinically significant symptoms of PTSD in clients with a co-morbid psychotic disorder (this is an optional subject if all trainees are working in IAPT).

[6] Logie & De Jongh (2014) '*The "Flashforward Procedure": Confronting the Catastrophe'. Journal of EMDR Practice and Research, 8(1).*

[7] De Roos, C et al (2010) 'Treatment of chronic phantom limb pain using a trauma-focused psychological approach'. *Pain Research Management, 15(2), 65-71.* doi:10.1155/2010/291634

- To understand and become competent in applying the EMDR Blind-to-Therapist (B2T) Protocol[8], to assist with processing trauma memories when the client does not wish to disclose any content around the traumatic events/s due to shame, guilt, embarrassment, cultural concerns, language problems, privacy concerns, etc.
    - Each trainee must deliver and receive the B2T protocol at least once during day 2 or 3.
    - Trainees must use their own relatively contained real-life experiences while receiving direct feedback from a trainer/facilitator.
    - This exercise is to be supervised up to maximum ratio of 1 Consultant/Facilitator to 12 delegates.
- To understand 'Expert by Experience' considerations including knowledge and awareness of how client's experiences of EMDR therapy need to be consistently considered by the therapist. Including the following:
    - Knowledge of the findings from qualitative studies into client's experiences of EMDR, e.g., Whitehouse [9] [10]
    - Inclusion of videos or live input, plus quotes from clients who have received EMDR Therapy in **both** IAPT and secondary care, that include their opinions of key factors that need to be considered by EMDR Therapists for its successful delivery as a client focussed approach.
- To understand legal, ethical and research issues regarding EMDR utilisation.

[8] Blore, D et al (2013) '*The Development and Uses of the "Blind to Therapist" EMDR Protocol'*. *Journal of EMDR Practice and Research, 7(2).*

[9] Whitehouse, J (2019) '*What do clients say about their experiences of EMDR in the research literature? A systematic review and thematic synthesis of qualitative research papers*.' European Journal of Trauma & Dissociation, 104. Available at: https:// doi.org/10.1016/j.ejtd.2019.03.002

[10] Marich, J (2012) *What Makes a Good EMDR Therapist? Exploratory Findings From Client-Centered Inquiry.* Journal of Humanistic Psychology *DOI: 10.1177/0022167811431960.* Available at: http://jhp.sagepub.com/content/early/2012/01/13/0022167811431960

5.4 Part 4 (1 day) - Training Supervision and Consolidation Day

Aims:
To integrate the theoretical learning from Part 3's didactic teaching and practical exercises to real world clinical settings including (but not exclusive to) working with complexity, unblocking strategies, client selection issues and treatment planning questions. This day will supplement the small group fortnightly EMDR specialist supervision trainees will be attending between each training part. During case discussions trainees are required to demonstrate a basic level of competence in safely and effectively integrating EMDR into their clinical practice.

Learning and Teaching Strategy:

- Minimum of 5 hours Group supervision
- Minimum of 2 hours Clinical Q&A
- Both components have a maximum ratio 1 Consultant/Facilitator to 12 delegate ratios
- Delegates must bring at least one clinical case they are currently working with to the training supervision.
- Delegates are allocated a minimum of 20 minutes each to discuss their case/s.
- Delegates will have the opportunity to bring other EMDR therapy clinical questions to the Q&A.
- Delegates will have the opportunity for vicarious learning through hearing other trainees' clinical questions and challenges.

Assessment Strategy

- 100% attendance in every component of the 4-part training.
- Full participation in all the practical exercises in Part 1 and 3.
- Discussing at least three active clients across the Part 2 and 4 clinical supervision sessions.
- Working with and discussing with their EMDR Europe Accredited Consultant at least 3 cases where EMDR Therapy was utilised within the external triads EMDR supervision between Part 1 and Part 4.
- Working with and discussing with their EMDR Europe Accredited Consultant at least 22 cases where EMDR Therapy was utilised within the external triads EMDR supervision in the 18 months following Part 4 training.
- Meeting the current criteria for EMDR Europe & UK Practitioner Accreditation by the end of the 24-month training period.
- One formative assessment by an EMDR Consultant of a video of a complete clinical session between 50-90 minutes involving Phase 3-7 of the standard protocol from the trainee's usual clinical work.
    - This needs to be submitted and feedback given before attendance on the Part 4 training.

  - This is a formative assessment using the EMDR fidelity rating scale (EFRS) Version 2 [11]. This must utilise at least section 3 (Adverse Life Experiences Processing subscale) and section 5 (Three-pronged Protocol Subscale).
  - The submission should include a Three-pronged conceptualisation/formulation relating to the case (to allow for section 5 rating).
  - This video should be student and consultant rated.
  - Additional sections of the EFRS can be used at the discretion of the student and supervisor but will remain formative.

- Submission of two complete clinical sessions of between 50-90 minutes involving Phase 3-7 of the standard protocol from the trainee's usual clinical work.
  - These both need to be submitted and feedback given within 18 months of the Part 4 training day.
  - This is a summative assessment using the EMDR fidelity rating scale (EFRS) Version 2[12]. This must utilise at least section 3 (Adverse Life Experiences Processing subscale) and section 5 (Three-pronged Protocol Subscale). Each subscale must have a Fidelity Score that is equal to or greater than 2.0. However, low scores on critical elements should be seen as a signal that a clinician needs additional supervision support.
  - Each summative video tape will also be self-rated by students and will include a 500-word written case discussion and reflective analysis on therapy skills
  - The submission should include a Three-pronged conceptualisation/formulation relating to the case (to allow for section 5 rating).
  - Both assessed videos need to be passed to complete the training. On a failure of a summative video, then there will be an additional supervision meeting to discuss the session. Following this the trainee can resubmit one additional video tape for review.
  - 2 summative video failures will mean failure of the training programme.
  - After discussion and agreement of their line manager, trainees can submit an official appeal based on extenuating circumstances or appeal against application of correct process by the course. Appeals will not be heard based on disputes over the rating itself. If an appeal is upheld a third video recording review by a different EMDR Accredited Consultant may be offered.
  - Additional sections of the EFRS can be used at the discretion of the student and supervisor but will remain formative.

Programme Award

Upon successful completion the candidate should be provided with a certificate highlighting that they have successfully completed the full EMDR training programme

[11] Korn, D. L., et al. (2017). EMDR fidelity rating scale (EFRS). Retrieved from https://emdrresearchfoundation.org/emdr-fidelity-rating-scale
[12] Korn, D. L., et al. (2017). EMDR fidelity rating scale (EFRS). Retrieved from https://emdrresearchfoundation.org/emdr-fidelity-rating-scale

which will allow the candidate to obtain accreditation as an EMDR Europe Accredited Practitioner, once the appropriate paperwork has been submitted via the EMDR-UK accreditation process.

6. Outcome Measures

The outcome measure to be used is PCL-5 to measure PSTD symptoms during therapy to monitor progress.
The PTSD Symptom Checklist (PCL-5) is widely used to measure the PTSD symptoms as defined in DSM-5, it can be downloaded from https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp
The International Trauma Questionnaire (ITQ), a new measure that was developed to assess the new ICD-11 criteria for PTSD. ITQ should be used in secondary care services alongside PCL5 as a screening questionnaire and a way to identify PSTD and PSTD symptoms. ITQ can be downloaded from https://www.traumameasuresglobal.com/itq

7. Supervision Guidance

The EMDR training programme requires trainees to learn from observation and skills practice under supervision while working in NHS commissioned services, as well as through the theoretical teaching, skills practice and practice-based learning directed by the training provider.
The supervision provided should be aligned to the principles NHS IAPT Supervision Guidance in IAPT services[13] and the Supervision of Psychological Therapies Competence Framework[14]. A suggested EMDR Therapy Supervision preparation form is included as Appendix A.

The minimum requirements for Supervision are:

- Fortnightly supervision provided by EMDR Europe Accredited Consultants over the duration of the course for 90 minutes delivered in-person or via interactive virtual methods.
- Service should ensure that supervisor has up to date knowledge of delivery of EMDR in the NHS.
- EMDR clinical supervision should be provided in groups no larger than 3 trainees (except the training supervision and consolidation days provided during Parts 2 and 4, which can be groups up to 12 plus consultant/facilitator for 5 hours each).

[13] Turpin, L and Wheeler, S (2011). IAPT Supervision Guidance. Available from https://webarchive.nationalarchives.gov.uk/ukgwa/20160302160224mp_/http:/www.iapt.nhs.uk/silo/files/iapt-supervision-guidance-revised-march-2011.pdf
[14] Roth, A.D. & Pilling, S. (2015). A competence framework for the supervision of psychological therapies. Available from: https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks-8

- Arrangements will need to be in place arrangement in place (either telephone or digital) whereby the supervisor can be contacted between supervision sessions for a brief consultation, where required.
- Discussing at least three active clients during the Part 2 and 4 Training Supervision & Consolidation days with a Facilitator or Trainer from the training team.
- Working with and discussing (within triads supervision) at least 3 cases where EMDR Therapy was utilised within triads supervision with their EMDR Europe Accredited Consultant between Part 1 and Part 4.
- Working with and discussing (within triads supervision) at least 22 cases where EMDR Therapy was utilised with their EMDR Europe Accredited Consultant in the 18 months following Part 4 training.
- Ensuring through supervision that the trainee meets the current criteria for EMDR Europe & UK Practitioner Accreditation competency-based framework by the end of the 24-month training period.
- Ensuring 3 complete sessions are submitted together with their three-pronged formulations (1 formative and 2 summative) using the EFRS to rate these (see above Assessment Strategy for more details
- Supervisor/Consultant must have knowledge of the clinical setting and ways of working (e.g., time-limited therapy) of the services in which the students work (i.e., IAPT or secondary care).
- Supervisor/Consultants and Trainers must have undertaken specific supervision training to supervise the NHS EMDR programme. This should be 1 day of training to cover:
    - NHS models of practice in IAPT (as set out in the IAPT Manual[15]), Adult Community Mental Health Services (aligned to the implementation guidance for psychological therapies for severe mental health problems – PT-SMHP[16]) and Perinatal Mental Health Services
    - The role of EMDR alongside other therapies within the framework of NICE Guidance
    - Stepped care
    - Supervision requirements in service settings
    - Similarities/differences between the NHS EMDR training and independent EMDR trainings.

8. Equality, Diversity and Inclusion

Courses must align their programmes to statutory duties under the Equality Act 2010, requiring public authorities who exercise public functions, and organisations carrying out public functions on behalf of a public authority, to advance equality of

[15] https://www.england.nhs.uk/publication/the-improving-access-to-psychological-therapies-manual/

[16] https://ppn.nhs.uk/resources/approved-national-pt-smhp-resources/40-psychological-therapies-for-severe-mental-health-problems-implementation-guidance/file

opportunity, eliminate unlawful discrimination and foster good relations between people of all protected characteristics.
Courses should include equality, diversity and inclusion issues within all teaching, with a specific focus on:

1) Reducing inequity of access and outcome among those from minoritized groups accessing mental health services.
2) Seeking to eliminate all forms of discrimination from the experience of the mental health service users and staff.
3) Welcoming people from diverse backgrounds so ensuring reasonable adjustments are made where possible is key.

9. Expert by Experience Involvement in Training

People with lived experience make a positive contribution to the learning, practice and work of mental health professionals. The involvement of those with lived experience highlights to professionals the importance of placing the goals, needs and strengths of service users, families, carers and the wider community at the centre of all they do.

The inclusion of people with lived experience in training programmes improves trainees understanding of the way in which service users, families and carers experience and understand their situation. Trainees should be equipped to provide compassionate, empathetic and effective care and understand the networks and systems in which service users live. The service users included as part of the training should be appropriate to the population in training.

In addition to the lived experience of members of the public, it is also important that trainees have the opportunity to explore the relevance of their own lived experiences to their clinical practice.

Programmes should incorporate lived experience into the training. Informing, collaborating and co-production are all valuable contributions. Courses should attend to:

- How the involvement of those with lived experience is co-ordinated.
- How lived experience contributors are selected to be representative of all backgrounds, cultures and ethnicities.
- How people with lived experience are rewarded for their contribution.
- Involvement in:
    - Course development
    - Student selection and interview panels.
    - Teaching and learning.
    - Assessment
    - Student mentoring
    - Recruitment of staff
    - Planning of programmes and quality assurance

Appendix A

Suggested Preparation for EMDR Therapy Clinical Supervision Form

To be complete by the student prior to their supervision

Your background, clinical setting and session limits

……

……

The amount of EMDR you used since Part 1 (including numbers of EMDR clients, EMDR sessions, Safe Places, Phase 4s, completed memories to closure phase)

……

……

Supervision question?

……

……

BRIEF background to the difficulties that led to the Supervision Question

Please keep all background information to a **maximum of 20%** of your allotted time to allow enough time for problem solving - we can always ask for more information if needed. Below are considerations but usually 'less is more'.

Symptoms
……..……..

Duration……..……

Initial Cause……..…….

Additional past occurrences……..……..…

PROPOSED TREATMENT PLAN - **3-PRONGED APPROACH**

PAST TARGETS

……

PRESENT TRIGGERS / SYMPTOMS / PROBLEMS

……

FUTURE GOALS FROM EMDR THERAPY

……

Repeat Supervision Question

……