Low Intensity CBT Coach Training Curriculum and Course Outline

Background

The CBT Institute training for LiCBT coaches is based on the UK Improving Access to Psychological Therapies (IAPT) programme established nationally in 2008. The aim was to establish responsive psychological therapy services enabling service users to receive evidence based, NICE approved psychological therapies and interventions for common mental health problems. A key part of the programme has been to develop a competent workforce to deliver the stepped care model in IAPT services.
https://www.ucl.ac.uk/pwp-review/the-pwp-review

In Australia the IAPT Model for Low Intensity CBT has been modelled successfully by *beyondblue's* NewAccess Program.
https://www.beyondblue.org.au/get-support/newaccess

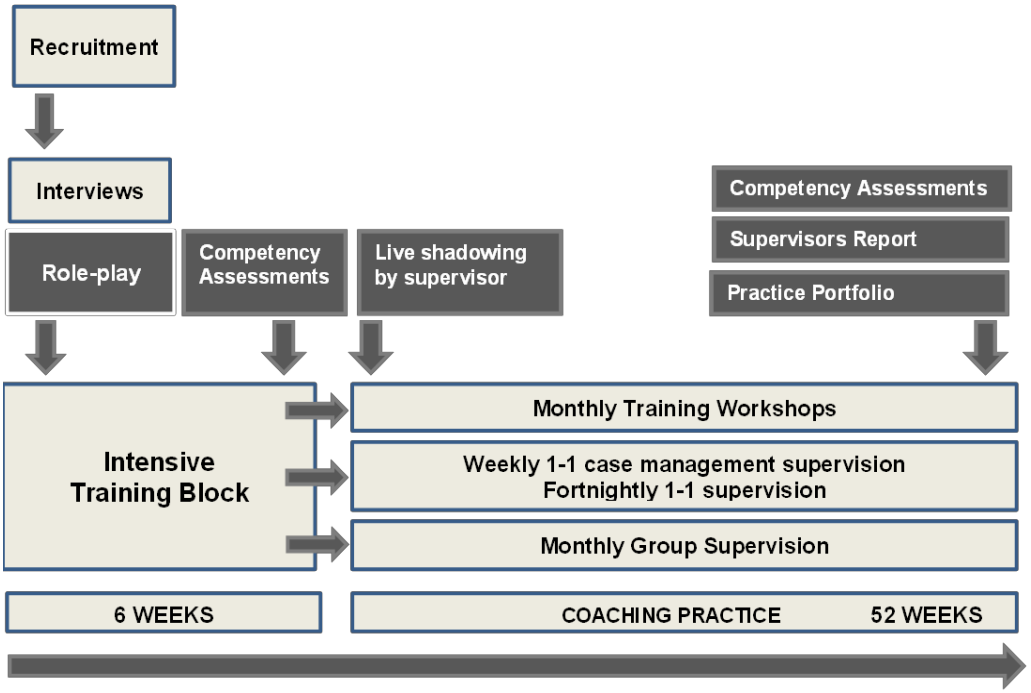
The CBT Institute Expertise

The CBT Institute Coach curriculum, training and supervision is based on the UK IAPT Curriculum and on *beyondblue's* NewAccess Program. Adhering to these programs to deliver training appears straightforward given national guidelines and evidence base. However, CBT training worldwide is almost exclusively high intensity-based, for therapists rather than coaches; and few are experience in delivering and developing low intensity training and services. What makes the CBT Institute team unique is their extensive track record of skills and experience in the UK and Australia of delivering low intensity IAPT services. The multidisciplinary team at the CBT Institute and associated consultants have combined expertise from working in both UK and Australian Mental Health Services and Higher Education. We have extensive expertise in IAPT and CBT training. This includes curriculum development, course accreditation and service development. We have expertise in scaffolding clinical systems with training and supervision to develop empirically grounded services. All CBT Institute team members and consultants are trained least to masters level in Cognitive-Behaviour Therapy. The goal of the CBT Institute training and supervision is to pursue 'innovation and best practice in CBT skills'. As such our training is competency based, emphasising fitness to practice over academic achievement.

Low Intensity Coach Training Outline

The CBT Institute trains new LiCBT coaches over a 12-month period. This involves an initial intensive 6-week block. The intensive is followed up by a series of monthly training workshops and ongoing clinical supervision. Supervision is integral to embedding skills from training into services. Coaches receive weekly 1-1 case management supervision and monthly group supervision during their 12 months training. Supervision is of further importance given the relative inexperience of LiCBT coaches who are recruited from non-health professionals and non-graduates to reflect the wider community they serve. Due to the flexible delivery of LiCBT, geography and configuration of Australian health services, full use of technology is made to deliver coaching, training and supervision remotely. Coaches are trained to work in a stepped care framework and only treat mild to moderate presentations. This emphasises development of focussed expertise rather than breadth of experience. Coach training is scaffolded by a framework of supervision, including risk management support, clinical procedures and protocols applied throughout repeated clinical contact. CBT Institute can train health professionals to supervise coaches but in time, with some additional training, experienced coaches make ideal LiCBT supervisors.

Training Outline



CBT Institute Coach Training Curriculum

The curriculum is based on the national IAPT NHS England/Department of Health PWP Curriculum 3rd edition, adapted to the Australian context due to differences in the healthcare system.

Modules: The curriculum had 4 modules

1. Assessment & Engagement in Low Intensity CBT
2. Evidence-based Low-Intensity Interventions & Protocols
3. Values and Attitudes in Ethical & Professional Practice
4. Coaching Practice: Development & Reflection

Course Aims

The overarching aim is to produce work-ready coaches that can competently assess and treat common mental health problems (under supervision) using evidence based low intensity interventions. This is delivered adhering to the CBT Institute mission, to pursue 'innovation and best practice through skills-training'.

Teaching and Learning Methods

The curriculum includes

1. Theoretical learning
2. Skills practice
3. Practice-based learning

Minimum Requirements

Training: Over the 4 modules of 52 weeks, a minimum of 20 days are delivered as learning and skills practice and an additional 15-20 days as practice-based learning, including shadowing/observation, role play/practice with peers/colleagues, directed problem-based learning. This includes reflecting on practice and self-practice of interventions with reflection (i.e. applying techniques to issues from one's own life). Only the first week of the 6 weeks' intensive is delivered face to face in class. The remainder of the training is delivered online or involves practice-based learning.

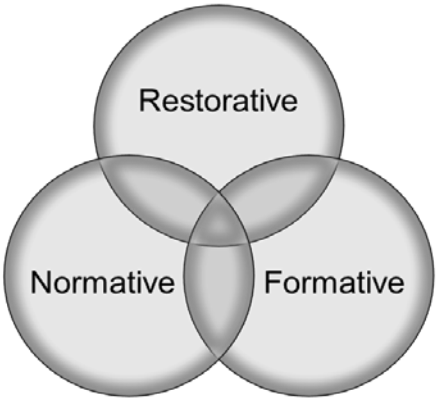
Supervision: Coaches must complete a minimum of 100 clinical contact hours with clients (face-to-face or on the telephone) in the 52 weeks. Coaches should undertake a minimum of 50 hours of supervision of which at least 30 hours should be case management and at least 20 hours should be clinical skills supervision. Supervision hours are in addition to the 15-20 practice-based learning days directed by the training provider. A supervision learning contract will be developed and reviewed to assist the supervision process. Supervision will be used to embed skills into practice. This emphasises a conceptual thread underpinning LiCBT coaching practice, integrating LiCBT formulation and change methods. Supervision involves reviewing regular samples of recordings (audio or visual) of coaching sessions to benchmark competencies and accelerate development. Supervision will also be used to enhance self-practice/self-reflection (SP/SR). Training and ongoing supervision will promote and enhance reflection, resilience and tolerance of uncertainty in coaching practice. An 'end of course' portfolio and supervisors report will be submitted prior to passing final clinical competencies required for qualification.

Principles, Models and Learning Frameworks

Proctors Framework for Clinical Supervision

The CBT Institute uses an established theoretical model as a framework for clinical supervision. The purpose of a model of supervision is to provide a framework for practice which clarifies the purpose and characteristics of supervision for both parties. This includes an educational emphasis and developmental perspective (i.e. that supervisees will change as they gain experience, proceeding through different stages towards competence/expertise. Proctor's (1986) Model of supervision is a theoretical framework that describes the process within supervision and throughout a series of regular sessions. The model categorises clinical supervision into three distinct areas, Normative, Formative and Restorative. It allows the balancing of content in supervision to be observed in session and over time. The model has been widely researched and adopted mental health settings, particularly in Australia. It may be appropriately salient in one particular area within certain sessions.

Proctors Model



The Normative domain
Includes policy issues, organization, logistics, planning, setting ground rules, quality of care, supervisor role, evaluation/feedback, monitoring outcomes and negotiating and evaluating learning contracts.

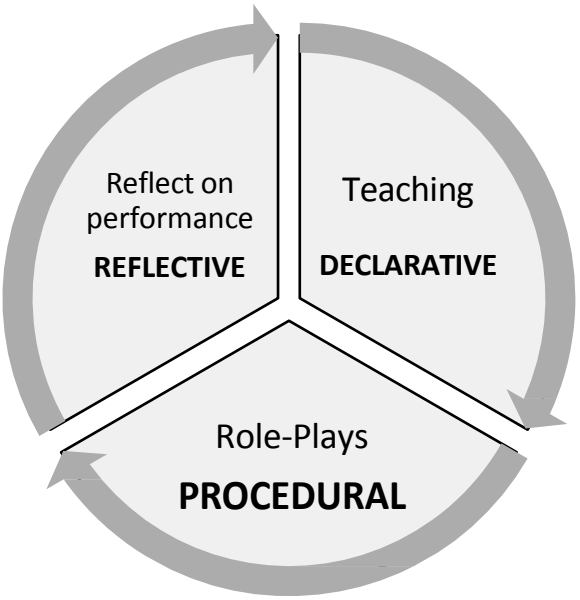
The Formative domain
Includes development of skills and competency, case formulation, problem-solving; sharing knowledge, education/training, reflection on treatment methods, identifying training needs, reviewing casework, understanding other perspectives.

The Restorative domain
Includes debriefing, emotional processing, understanding personalities, workplace support, validation, emotional support, impact of workplace issues on the individual, reflection on self, understanding any bias or ruptures in therapeutic relationships.

DPR Model (Bennett-Levy 2006) in LiCBT Intensive Training

A basis for Australian LiCBT training is a model of therapist skill development based on in information processing theory (Bennett-Levy 2006). This highlights three principal systems of skills and knowledge acquisition, categorised as *Declarative, Procedural and Reflective*. For example, the 6-weeks intensive heavily emphasises development of procedural skills via repeated role-plays, of structured assessments and treatment sessions. This is accompanied by declarative knowledge via teaching on depression and anxiety and treatment protocols such as Graded Exposure and Behavioural Activation. Declarative knowledge and reflective skills are developed by repeatedly practicing and honing procedural skills. This is implemented in training triads of coaches, each taking turns to play client, coach and observer. The client and observer feedback allows the reflective component of DPR. The trainers observe each group in rounds then elicit plenary feedback and overall reflections. The DPR model is also transferred into ongoing clinical supervision sessions as a basis for developing skills, knowledge and reflection on coaching practice.

DPR Model (Bennett-Levy 2006)



Module 1 Assessment & Engagement in Low Intensity CBT

Specific Module Aims

Coaches must be able to undertake a range of client assessments and identify the main areas of concern relevant to the assessment undertaken. They need to display knowledge and competence to apply these in a range of different assessment formats and settings. These different elements or types of assessment include screening/intake assessment within a low intensity service; risk assessment; provisional diagnostic assessment; mental health clustering assessment; psychometric assessment (using standardised symptoms measures); problem focused assessment; and intervention-planning assessment. In all these assessments they need to be able to engage clients and establish an appropriate relationship whilst gathering information in a collaborative manner. They must have knowledge of mental health disorders and the evidence-based therapeutic options available and be able to communicate this knowledge in a clear and unambiguous way so that people can make informed treatment choices. In addition, they must have knowledge of behaviour change models and how these can inform choice of goals and interventions. This module will, therefore, equip coaches with a good understanding of the incidence, prevalence and presentation of common mental health problems and evidenced-based treatment choices. Skills training will develop coaches core therapeutic competencies of active listening, engagement, alliance building, patient-centred information gathering, information giving and shared decision making. Coaches assess people with common mental health problems with a view to guiding self-management of their recovery. Assessment must therefore thread together functional analysis and engagement with interventions based on a CBT rationale of treatment, to guide clients to recovery. The CBT based principles must explicitly thread through and between sessions.

Module Learning Outcomes

1) Demonstrate knowledge of, and competence in applying the principles, purposes and different types of assessment undertaken with people with common mental health disorders

2) Demonstrate knowledge of, and competence in using ‘common factors’ to engage clients, gather information, build a therapeutic alliance with people with common mental health problems, manage the emotional content of sessions and grasp the client’s perspective or “world view”.

3) Demonstrate knowledge of, and competence in ‘client-centred’ information gathering to arrive at a succinct and collaborative definition of the person’s main difficulties and the impact this has on their daily living.

4) Demonstrate knowledge of, and competence in recognising patterns of symptoms consistent with diagnostic categories of mental disorder and established CBT protocols from a client-centred interview.

5) Demonstrate knowledge of, and competence in accurate risk assessment to client or others.

6) Demonstrate knowledge of, and competence in the use of standardised assessment tools including symptom and other psychometric instruments to aid problem recognition and definition and subsequent decision making.

7) Demonstrate knowledge, understanding and competence in using behaviour change models in identifying intervention goals and choice of appropriate interventions.

8) Demonstrate knowledge of, and competence in giving evidence-based information and treatment rationale about intervention choices and in making shared decisions with clients.

9) Demonstrate competence in understanding the client's attitude to a range of mental health treatments including prescribed medication and evidence-based psychological treatments.

10) Demonstrate competence in accurate recording of interviews and questionnaire assessments using paper and electronic record keeping systems.

Module learning and teaching strategy
Procedural skills-based competencies will be learnt through a combination of clinical simulation in small groups working intensively under close supervision with Reflective peer and trainer feedback and supervised practice through supervised, direct contact with clients' in the workplace. Declarative knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Module assessment strategy
Specific learning outcomes are assessed by -

1) Standardised role-play scenario(s) where coaches are required to demonstrate skills in undertaking both intake within a low intensity service and problem focused assessments. Assessments will be video-recorded or observed 'live' and assessed by training staff using standardised assessment measures.

2) Academic assignment: Coaches complete a reflective commentary on the above or an alternative assignment such as case report, essay, quiz/mini exam.

Module Duration
The key elements of this module are structured within the first 6 weeks of the course. They are assessed before coaches see live clients. Other aspects of assessment and engagement following this module are included and assessed in later modules.

Module 2 Evidence-based Low-Intensity Interventions & Protocols

Specific Module Aims

Coaches assist clinical improvement through provision of information and support for evidence-based low-intensity interventions. LiCBT places a greater emphasis on client self-management than traditional psychological treatments. Overall delivery of interventions is informed by behaviour change models and strategies which are protocol based. Examples include support for a range of low-intensity self-help interventions (often with the use of written self-help materials) informed by cognitive-behavioural principles, such as behavioural activation, exposure, behavioural experimentation, panic management, problem solving, computerised CBT and supporting physical exercise and medication adherence.

LiCBT coaching is designed to enable people in optimising their self-management toward recovery. Guided self-help information may be delivered individually or in groups (psychoeducational groups) and through face-to-face, telephone, email or other contact methods. Coaches must also be able to manage and monitor any change in risk status while implementing LiCBT. This module will, therefore, equip coaches with a good understanding of the process of therapeutic support and management of individuals and groups of clients including families, friends and carers. Skills teaching will develop coaches to general and disorder-defined 'specific factor' competencies in the delivery of low intensity treatments informed by cognitive-behavioural principles.

Module Learning Outcomes

1) Critically evaluate a range of evidence-based interventions and strategies to demonstrate in-depth understanding of clients presenting problems.

2) Demonstrate knowledge of, and competence in developing and maintaining a therapeutic alliance with clients during their treatment, including dealing with issues and events that threaten the alliance.

3) Demonstrate competence in formulating and planning a collaborative low-intensity psychological treatment programme for common mental health problems, including managing end of coaching contact.

4) Demonstrate competence in the use of, a range of low-intensity, evidence-based psychological interventions for common mental health problems.

5) Demonstrate knowledge, understanding and competence in applying behaviour change models, based on a CBT rationale and principles.

6) Demonstrate case management and stepped care approaches to common mental health problems including ongoing risk management appropriate to service protocols.

7) Demonstrate competency in delivering low-intensity interventions using a range of methods including face-to-face, telephone and electronic communication.

Module learning and teaching strategy
Training in skills-based competencies will be delivered via combination of clinical simulation and role plays in small groups, under close supervision with peer and trainer feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Module assessment strategy
1) A video-recorded role-play scenario or live observation by trainer of a simulated low-intensity treatment session. This will be assessed by training staff using a standardised assessment measure.

2) Academic assignment: Coaches complete a reflective commentary on the above or an alternative assignment such as case report, essay, quiz/mini exam or high quality case documentation and systematic evaluation of the session.

Duration
The key elements of this module are structured within the first 6 weeks of the course. They are assessed before coaches see live clients. Other aspects of applying LiCBT interventions and protocols are included and assessed in later modules.

Module 3 Values and Attitudes in Ethical & Professional Practice

Specific Module Aims

The module broadly covers understanding, developing and maintaining - professional standards, ethical practice, professional boundaries. scope of practice, respect for diversity and social inclusion. Coaches operate at all times from an inclusive values base which

promotes recovery and recognises and respects diversity. Coaches are drawn together from members of the community without having to undergo core health professional training. The latter is often the basis for training in principles of values, equality and diversity. In addition, professional and ethical standards of practice are often related to specific professions. These are often developed in core professional training requiring breadth of experience in different health and social care settings. LiCBT coaching emphasises focussed expertise within in a specific step of the mental health system, over breadth of experience and doesn't require applicants to be health professionals. As such training in values, respect, professional and ethical practice are required during initial coach training. These are not taught as techniques like some aspect of LiCBT and are embedded as attitudes and standards underpinning and threaded throughout coaching practice. As such LiCBT coaches adopt their own standards of ethical and professional practice derived from the British Association for Behavioural & Cognitive Psychotherapies (BABCP) Standards of Conduct, Performance and Ethics.

http://www.babcp.com/files/About/BABCP-Standards-of-Conduct-Performance-andEthics.pdf

These have been adapted by the CBT Institute as a framework for coaching practice in Australia. The BABCP standards were chosen because a) they are multi-disciplinary rather than single-profession based, b) they apply to practitioners without a core health profession who are the UK equivalent of LiCBT coaches and c) the BABCP are the accrediting body for UK CBT practitioners and for IAPT.

Diversity represents the range of cultural norms including personal, family, social and spiritual values held by communities in which the worker is operating. LiCBT services in Australia following *beyondblue's* NewAccess model are 'community facing' services often viewed as part of the community which they serve rather than a branch of mental health services. Australia has some diverse cultural groups including indigenous Aboriginal and Torres Strait Island cultures, different waves of settlers and other distinct immigrant groups. Workers must respect and value individual differences in age, sexuality, disability, gender, spirituality, race and culture. This also takes into account sub-culture, for example young males of low socio-economic background in areas with low ethnic diversity. Other sub cultures may include rural and remote communities, older males and young mothers etc. This must take into account any group, culture or sub-culture where uptake of services is low or where there is an associated higher level of risk.

Coaches must also take into account any physical and sensory difficulties people may experience in accessing services and make provision in their work to ameliorate these. They must be able to respond to people's needs sensitively with regard to all aspects of diversity. They must demonstrate a commitment to equal opportunities for all and encourage people's active participation in every aspect of care and treatment. They must also demonstrate an understanding and awareness of the power issues in professional/client relationships and take steps in their practice to reduce any potential for negative impact this may have. This module will, therefore, expose coaches to the concept of diversity and inclusion to equip workers with the necessary knowledge, attitudes and competencies to operate in an inclusive values driven service. This is essential in 1) delivering LiCBT protocols and 2) in signposting clients to appropriate community resources and supports based on their idiographic and presentation and needs. The latter is an important aspect of LiCBT that differentiates coaching from HiCBT.

Module Learning Outcomes

1) Demonstrate knowledge of, and commitment to a non-discriminatory, recovery orientated values base to mental health care and to equal opportunities and encourage people's active participation in every aspect of care and treatment.

2) Demonstrate respect for and the value of individual differences in age, sexuality, disability, gender, spirituality, race and culture.

3) Demonstrate knowledge and competence in responding to peoples' needs sensitively with regard to all aspects of diversity, including working with older people, the use of interpretation services and taking into account any physical and sensory difficulties service users may experience in accessing services.

4) Demonstrate awareness and understanding of the power issues in professional / service user relationships.

5) Demonstrate competence in managing a caseload of people with common mental health problems efficiently and safely, showing awareness of issues such as confidentiality and maintaining professional boundaries.

6) Demonstrate knowledge and competence in using supervision to assist the worker's delivery of low-intensity treatment in keeping with its evolving evidence base, to maintain scope of practice and prevent therapeutic drift.

7) Demonstrate knowledge of, and competence in gathering client-centred information on employment needs, wellbeing and social inclusion and in liaison and signposting to other agencies delivering employment, occupational and other advice and services.

8) Demonstrate an appreciation of the worker's own level of competence and boundaries of competence and role, and an understanding of how to work within a team and with other agencies with additional roles which cannot be fulfilled by the worker alone.

9) In recognition of the universality of common mental health problems across all human cultures the coach must ensure the following. That any diverse, cultural or sub-cultural issues are factored in to delivery of evidence-based interventions, that these are delivered and adapted with sensitivity to diversity and cultural issues but without these dominating and replacing the evidence-based intervention itself.

10) Contribute toward an updated portfolio of community resources, services and networks available in your locality that clients can be signposted toward and supported to engage with as part of their self-management.

Learning and teaching strategy

knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study. Skills based competencies are learnt through a combination of clinical simulation in small groups, working intensively under close supervision with peer and trainer feedback; and supervised practice through direct contact with clients in the workplace. The overall aim being combination of skills and knowledge, in an attitude reflected by observation of ethical and professional practice throughout training.

Module assessment strategy

1) A clinical planning scenario, real assessment or treatment case, or other clinical task in which coaches are required to demonstrate knowledge and skills in working with a person or people with a variety of needs from one or more of a range of diverse groups. The assessment can be a case report, an oral presentation, a rated tape, or other method as appropriate. The module 1, 2 or 4 clinical assessments can be used as the basis of the assignment.

2) A clinical planning scenario, real assessment or treatment case, or other clinical task in which coaches are required to demonstrate knowledge and skills in aspects of ethical and

professional practice. The assessment can be a case report, an oral presentation, a rated tape, or other method as appropriate. The module 1, 2 or 4 clinical assessments can be used as the basis of the assignment, or a series of scenarios from different cases can be compiled to highlight areas such as confidentiality, professional boundaries, treatment fidelity and recognising limits in knowledge and skills.

3) A practice outcomes portfolio can be used to record aspects of the above, demonstrating-
• Ability to engage with people from diverse demographic, social and cultural backgrounds in assessment and low-intensity interventions. This could include adaptations to practice working with older adults, using interpretation services/self-help materials for people whose first language is not English, and/or adapting self-help materials for people with learning or literacy difficulties.
• Ability to effectively manage a caseload including examples of rationale behind referral to step up, employment and signposted services.

Duration
Training in values, attitudes, respect, professional standards and ethical practice are not purely taught as techniques like some aspect of LiCBT. They should be embedded as attitudes and standards underpinning and threaded throughout coaching practice. To reflect this, the module is more longitudinal than modules 1 and 2. Therefore exercises, reflections and assessments of values and attitudes in ethical & professional practice are completed throughout the 12 months training. Aspects of these are inexorably present in all other modules.

Module 4 Coaching Practice: Development & Reflection

Specific Module Aims

Treatment Fidelity
LiCBT Formulation-thread principles
Practice high dose narrow bandwidth
Awareness of step up
Caseload management
Risk management
Supervision goals and contract
Workready
SP/SR
Coaches are expected to operate in a stepped care, high-volume environment. During training, coaches should carry a reduced caseload, building up to a maximum of 60-80% of a qualified coach caseload toward the end of training. After 12 months' coaches are expected to be qualified and 'workready'. The rigorous CBT Institute training and supervision is geared toward this aim. As such an additional module covering aspects of practice development and coach competency is included. Coaches must be able to manage caseloads, operate safely and to high standards and use supervision to aid their clinical decision-making. Coaches need to recognise the limitations to their competence and role to direct people to resources appropriate to their needs, including step-up to high-intensity therapy, when beyond their competence and role. Their case management skills need to include increased competence in assessing and managing risk, including identifying protective factors (including engagement with coaching) and when clients can remain in LiCBT or require step-up in response to changing level of risk. Coaches must become increasing familiar and adept at delivering evidence-based LiCBT in rigorous but flexible ways. This must include use of low intensity case formulation to ensure guided self-help is conceptually driven and that the CBT rationale of treatment is explicitly shared with clients. LiCBT principles must be threaded throughout and between sessions to

optimise client recovery, from problem identification, formulation of maintenance patterns, rationale of treatment, goal setting, homework, progress review, discharge planning and follow up. The initial emphasis of coach training is on declarative knowledge being embedded into practice vie procedural skills development. Once coaches develop procedural skills (competencies) them need to become increasingly reflective on their practice, supervision and themselves. Clinical supervision is the medium that develops this and increased reflective reflections, resilience and tolerance of uncertainty are associated with more effective practice. This increased coaching competence from novice to experienced coach shifts how they utilise and reflect during the supervision process. In this the development of coaching skill parallels development of clients learning during their recovery. A key factor in LiCBT competence is maintaining treatment fidelity to proven, evidence-based interventions and avoiding 'therapeutic drift'. This requires remaining within scope of LiCBT coaching rather than veering into high intensity psychotherapy. It also requires maintaining active interventions to produce change. For these reasons competency assessment for assessment and treatment sessions are repeated with actual clients at the end of training. This includes submitting of practice portfolio outlining case management experience, with a supervisors report and reflective log.

Module Learning Outcomes

Successful completion of the following practice outcomes, to be assessed by means of a practice outcomes portfolio, signed supervisors report and reflective journal.

1) Demonstrate a clear understanding of treatment fidelity in stepped care, what constitutes high-intensity treatment and how this differs from low-intensity work.

2) Demonstrate the ability to adhere to single strand interventions targeting the agreed primary problem practicing high dose '& narrow bandwidth' LiCBT.

3) Demonstrate the ability to thread together assessment, problem identification, goal setting and interventions with principle of CBT throughout; that are adhered to and shared explicitly with the client to optimise their understanding and recovery.

4) Demonstrate the ability to act on learning from supervision that is incorporated into subsequent client sessions.

5) Demonstrate the ability to conduct and end sessions efficiently and in a timely manner that retain the main ingredients of LiCBT.

6) Demonstrate the ability to use specific measures to inform interventions and monitor progress and weave these naturalistically into the session rather than as a separate didactic procedure.

7) Demonstrate clear and concise clinical documentation and formulation of case summary of each session and ensure notes are timely by being entered on the same day of contact.

8) Demonstrate the ability to document and flag risk in adherence to relevant clinical procedures to highlight safeguarding of clients and self.

9) Demonstrate knowledge, understanding and critical awareness of concepts of mental health and mental illness, diagnostic category systems in mental health and a range of social, medical and psychological models relating to LiCBT coaching.

10) Use portfolio and supervisors report to identify strengths and gaps in practice that need consolidation and development post-qualification, requiring inclusion in a revised supervision contract.

Learning and teaching strategy
Weekly 1-1 case management and clinical supervision plus monthly group supervision are the bases of learning strategy for this elongated module. This intensive experience is the means to develop and embed declarative, procedural and reflective skills into coaching practice.

Module assessment strategy

The two Competency Assessments from Module 1 and 2 are submitted using actual clients from coach caseload instead of role-plays. Portfolio including, case flow, practice outcomes, reflective learning log and signed supervisors report to demonstrate knowledge and competence in using case management and clinical skills supervision. The combined, competencies, portfolio and supervisors report are not graded and instead awarded an overall pass/fail.

Duration
This module is more longitudinal than modules 1 and 2, running in parallel with module 3 from the 6 weeks block to the end of the course. This is to allow a sufficient period of intensive thorough clinical supervision that is integral to developing competent and 'work ready' coaches. Therefore, case flow, exercises and reflections are recorded throughout training with 'end of course' competency assessments and portfolio completed at the end of the 12 months.

http://www.cbtinstitute.com.au/