

Covid Addendum 1 Guidelines – for the period 11th Mar 2020 to 4th Oct 2020 only for Students/Pre-Accredited Applicants regarding video/phone (where appropriate) for Clinical Practice, Supervision, Personal Therapy, Didactic Supervision, & Group Therapy hours which took place during this time. Please note: The Governing Body of IAHIP reserve the right to adjust the guidelines at any time.

This form must be completed in full and submitted in the spiral bound pack with your Accreditation Application.

Working remotely is defined as 1:1 video or phone clinical practice, personal therapy and supervision and must have a duration of a minimum of 50 - 60 minutes per psychotherapy session (more frequent shorter sessions that accumulate to 50 – 60 minutes do not constitute a psychotherapy session).

A clear distinction needs to be made between psychological/parent/family support etc. and psychotherapy. Psychological support for the parents and/or family members of the main client are an example of this. Psychological support sessions do not qualify for the purposes of accreditation.

Complete the Original Application Form in full with only all face to face work. Only Covid 19 Non-Face-to-Face hours must be on the Addendum 1 and/or 2 Application Forms.

Please note that supervision of clinical practice whether Phase 1 or Phase 2 where possible should be face-to-face with the exception of Covid 19 restrictions.

Video/Phone Clinical Practice, 1:1 & Group Supervision, Personal Therapy and Didactic Supervision before Covid 19 Restrictions on the 11th March 2020 are not permissible by IAHIP for Accreditation purposes.

Records/logs are to be attached to identify video & phone clinical practice/supervision sessions separately.

Reasons outside of Covid 19 restrictions for video/phone sessions must be given throughout this document.

Regarding Under 18 Clients - Guardians are contracted to provide a space that is confidential to the under 18 client & therapist only. Guardians are also contracted that sessions are not recorded in whole or part recorded. The ongoing cooperation of guardians in these issues are a minimum requirement for therapy to proceed. The guardian is mandated that, in partnership with therapist, they keep the therapist informed on these matters. Supervisors need to be vigilant in their Supervision of client hours for under 18 clients.

End-to-End Encryption Platforms must be used to ensure the confidentiality of clinical practice. Therapists need to be vigilant with regard to the platforms they use for clinical work.

Therapists working remotely need to contract with their clients that sessions in whole or part are not recorded i.e. Siri & Alexa etc.

Group Supervision, Group Therapy & Didactic Supervision hours by phone are not permissible for Accreditation purposes.

Therapists need to discuss with their supervisors their own fitness to practice should they test positive for Covid 19 or if they are isolating due to being a close contact with a positive case of Covid 19.

Insurance: Legally and ethically all IAHIP psychotherapists are mandated to have Professional Indemnity insurance in place for the chosen modes of practice used. All Insurance Certs must list both Video & Phone if those modes of practice are used for the relevant periods of remote practice forwarded for application. For those working in agencies, evidence of the agency's Professional Indemnity Insurance governing the modes of practice used in the agency is required. If working with clients in other legal jurisdictions the insurance cert must specify the legal jurisdiction that the policy covers.

Video/Phone Clinical Practice hours for 4th years, between 11th Mar 2020 and 20th April 2020 were not permitted. After 20th April 4th year students could see clients remotely provided they had a long-standing established relationship (face to face) prior to Covid 19. If you were 3rd year between 11th Mar 2020 and 8th June 2020(End of first lockdown), you were not permitted to see clients throughout the whole of this period because of Covid19 restrictions by phone/video.

Clinical Practice hours carried over from Phase 1 to Phase 2 from 11th Mar 2020 to 4th Oct 2020.

If you were a student on 11th Mar 2020, when Covid 19 guidelines were implemented by GB for students, you were allowed to carry over Phase 1 Clinical Practice hrs (from the minimum requirement of 200 hrs) to complete them in Phase 2. If this is the case, please see specific section for recording these hours.

All changes in supervisor/s during this period, must be completed on the original Accreditation Application form.

Details of remote Clinical Practice (whether carried over from Phase 1 or all from Phase 2), Supervision (Individual/Group) Hours, Personal Therapy Hours, Didactic Supervision Hours and Group Therapy Hours between 11th Mar 2020 to 4th Oct 2020.

Name of Applicant: _____

On 11th Mar 2020 - what Year of your Training were you in _____

1.0 Are any of the hours being submitted psychological, family or parent support hours _____
Yes or No

1.1 When did you start/end video/phone work during this period? _____
Start Date _____ **End Date** _____

1.2 Does your insurance during this time cover you for video/phone psychotherapy? Yes or No
If yes – please include a copy of the insurance certificate/s for the relevant periods

1.2a Are any of your clients residing outside the jurisdiction? Yes or No
If yes, where did these clients reside? _____

1.2b Did you have appropriate insurance to cover these jurisdictions? Yes or No
Please include a copy of the insurance certificate/s for the relevant jurisdictions

1.3 Did you take part in specific training for video/phone psychotherapy _____
Yes or No

If Yes - Dates of this training _____
Please provide certificate of completion in the overall Application Pack **Start Date** _____ **End Date** _____

1.4 Duration of the Training (Hours): _____

1.5 Training Title : _____

1.6 Training/Certification Body (provide copy of Cert) _____

1.7 Were you assessed for competency for video/phone psychotherapy? _____
Yes or No

1.8 Were your clients assessed for suitability to these modes of practice? _____
Yes or No

1.9 Does the platform you use have End-to-End encryption? Yes or No
If No give reasons: _____

Section 2.0 - If you carried over Phase 1 hours to Phase 2 - Record them here, otherwise skip to Section 3 of this document

2.1 Have you a shortfall due to Covid 19 in Phase 1 Clinical Practice Hours (6.1)? _____
If No skip to relevant section below, If Yes, you must fill in the following information **Yes or No**

2.2 If Yes - How Many Hours did you carry over? _____

2.3 From what training year are you carrying over these hours? _____

2.4 Did you have a long-standing face to face therapeutic relationship for all these clients? _____
If No, Give reasons: _____ Yes or No

2.5 Phase 1 Total Number of these carried over Clinical Practice hours by Video: _____

2.6 Phase 1 Total Number of these carried over Clinical Practice hours by Phone: _____

2.7 Please outline the specific circumstances that Clinical Practice Hours were carried over into Phase 2 and completed remotely: _____

Supervision of Phase 1 hours in Phase 2:

Supervisor Name/Supervision credentials: _____

2.8 Total number of these video/phone Clinical Supervision Hours: [7.2] _____

2.9 Dates of this Supervision:

_____ Start Date

_____ End of Phase 1 Date

Where min 200 hrs reached

2.10 Frequency of Supervision for these hours (Weekly/Monthly etc): _____

Please outline the specific circumstances that these Clinical Supervision Hours moved to Video/phone? _____

2.11 Breakdown of Phase 1 carried over Supervision Hours

Individual Video Supervision Hours: [6.1, 7.2 & subsections] _____

Duration of Sessions

_____ Shortest

_____ Longest

Individual Phone Supervision Hours: [6.1, 7.2 & subsections] _____

Duration of Sessions

_____ Shortest

_____ Longest

Group Video only Supervision Hours: [6.1, 7.2 & subsections] _____

Number of members in Video group [7.1.1] _____

Ratio of Phase 1 Supervision hours to these Clinical Practice hours [7.1] _____

Confirmation by Supervisor:

Please confirm that all these Phase 1 hours were carried out with clients in which the applicant had a long-standing face to face therapeutic relationship? _____ Yes or No

If No, please give details _____

Are any of the clients of this applicant residing outside the jurisdiction? _____ Yes or No

If yes, do they have insurance cover for the jurisdiction & modes of practice? _____ Yes or No

Supervisors Name: _____

Print Name

_____ Hand Signature

(Note: a Digital Signature is not acceptable.)

2.12 How many video Didactic Supervision hrs have you completed: [7.1.2] _____

2.13 Please outline the dates & specific reasons that Didactic Supervision Hours moved to Video?

3.0 Phase 2 – Supervised Clinical Practice Hours

Supervisor Name/Accreditation: _____

3.1 Phase 2 Total Number of Video/Phone Clinical Practice Hours : _____

3.2 Phase 2 Video/Phone Clinical Practice Dates: _____
Start Date End Date

3.3 Please outline the specific circumstances that Clinical Practice Hours in Phase 2 moved to video/phone?

3.4 Supervision of Clinical Practice hours:

Total video Clinical Practice Hours in Phase 2: [6.1] _____

Total phone Clinical Practice Hours in Phase 2: [6.1] _____

3.5 Please outline the specific circumstances that Supervision Practice Hours in Phase 2 moved to Video/Phone? _____

3.6 Breakdown of non face to face Supervision Hours

Individual Video Supervision Hours: [6.1, 7.2 & subsections] _____

Duration of Sessions _____
Shortest Longest

Individual Phone Supervision Hours: [6.1, 7.2 & subsections]- _____

Duration of Sessions _____
Shortest Longest

Frequency of Supervision: _____

Group only Video Supervision Hours: [6.1, 7.2 & subsections] _____

Number of members in Video group [7.2.2] _____

Phase 2 Ratio of Total Supervision hours to Total Clinical Practice Hours[7.2] _____

Confirmation by Supervisor:

Please confirm that all these hours were carried out with clients in which the applicant had a long-standing face to face therapeutic relationship? Yes or No

If No, please give details _____

Are any of the clients of this applicant residing outside the jurisdiction? Yes or No

If yes, do they have insurance cover for the jurisdiction & modes of practice? Yes or No

Supervisors Name: _____
Print Name

Hand Signature
(Note: a Digital Signature is not acceptable.)

4.0 Video/Phone Personal Therapy

Name/Accreditation details of Personal Therapist _____

4.1 Did you take part in video/phone Individual Personal Therapy hours [5.1]: _____

If Yes _____	_____	_____
Total Hrs Completed Remotely	Number of Phone Hours	Number of Video Hours

Yes or No

4.2 Dates of video/phone Personal Therapy _____

_____	_____
Start date	End date

What phase of your training/post training were you in when these were completed? _____

4.3 Reasons for video/phone Individual Personal Therapy: _____

4.4 Duration of video/phone Individual Therapy _____

	_____	_____
	Shortest	Longest

4.5 Frequency of video/phone Individual Personal Therapy _____

5.0 Video only Group Therapy

Name/Accreditation details of Group Therapist _____

5.1 Did you take part in Video Group Therapy hours (5.1): _____

If Yes How many hours were completed:	_____
Number in video Group Therapy:	_____

Yes or No

5.2 Dates of this video Group therapy _____

_____	_____
Start Date	End Date

What phase of your training/post training were you in when these were completed? _____

5.3 Reasons for video Group Therapy: _____

5.4 Duration of video Group Therapy: _____

5.5 Frequency of video Group Therapy: _____

5.6 What phase were you in for this Group Therapy: _____

Applicants Signature

I certify that the foregoing information is correct and I understand that any false or misleading statements made on this form or in any part of the Application process, or failure to disclose information relevant to this application may result in my affiliation with IAHIP being rejected and/or any Accreditation awarded rescinded.

Date _____ Print Name _____ Signature _____

Hand Signature