

**Covid 19 Addendum 2 Guidelines – for period of 5<sup>th</sup> Oct 2020 – 1<sup>st</sup> Sept 2021 only for 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 11<sup>th</sup> 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.

Up to a Maximum of 125 hrs Clinical Practice hours can be counted for consideration during this period.

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 the 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 between 11<sup>th</sup> Mar 2020 and 4<sup>th</sup> Oct 2020 must be added to Addendum 1 form only.

**Clinical Practice hours carried over from Phase 1 to Phase 2 from 5<sup>th</sup> Oct 2020 to 1<sup>st</sup> Sept 2021.**

If you were a student on 5<sup>th</sup> Oct 2020, you were allowed to carry over a maximum of 50hrs of the 200 minimum hrs in Phase 1 Clinical Practice to complete 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 the 5<sup>th</sup> Oct 2020 and 1<sup>st</sup> Sept 2021.

Name of Applicant: \_\_\_\_\_

On 5<sup>th</sup> Oct 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 Entire period of time related to in this document: \_\_\_\_\_  
(Note: dates pre 5<sup>th</sup> Oct 2020 cannot be considered on this form) 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 – Up to a Max of 50 hours only – 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  
(Note: These hours must be Supervised in line with (7.1) Maximum of 50 hrs can be considered here

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 Clinical Practice hours by Video: \_\_\_\_\_

2.6 Phase 1 Total Number of these 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] \_\_\_\_\_

**Phase 1 ratio of 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 specific reasons that Didactic Supervision Hours moved to Video?  
\_\_\_\_\_  
\_\_\_\_\_

### 3.0 Phase 2 – Supervised Clinical Practice Hours due to Covid 19 Restrictions

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 was moved to remote work?  
\_\_\_\_\_  
\_\_\_\_\_

### 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 Video only 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 these hours were carried out with the following conditions:

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.)

