iapt

Improving Access to Psychological Therapies

NHS

Reach Out

National Programme Supervisor Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions

David Richards, Marie Chellingsworth, Roslyn Hope, Graham Turpin and Mark Whyte

National Mental Health Development Unit

rethink

This publication was commissioned by the National IAPT Programme to support training courses for practitioners delivering LI interventions. It is therefore recommended for use by those courses to facilitate consistent and high quality standards across England.

Further copies of this publication can be downloaded from http://www.iapt.nhs.uk/publications/

First published in the UK by Rethink 2010

www.rethink.org
Rethink Welcome Team 0845 456 0455
Email info@rethink.org
Registered Charity Number 271028

For more information about Rethink publications and other products on mental health, please visit www.mentalhealthshop.org or call 0845 456 0455.

Some of the content in this guide is reproduced with permission from Richards, D. and Whyte, M. (2008). *Reach Out: National Programme Educator Materials to Support the Delivery of Training for Practitioners Delivering Low Intensity Interventions*. London: Rethink

Contents

Acknowledgements 4

Introduction 6

The role of the Psychological Wellbeing Practitioner 5

Supervision 7

C8 Supervision Checklist 14

A7 Supervision Simulation Assessment 17

I1 – I2 24

Low-intensity treatment interventions 28

Record keeping 51

Practise outcomes 54

Reference 57

Acknowledgements

The IAPT programme has been a huge collaborative effort with important contributions from very many people too numerous to mention. However, we cannot let the occasion pass without acknowledging Professor Lord Richard Layard and Professor David Clark for their joint vision and tenacity in ensuring IAPT has come to fruition and James Seward in directing the programme.

The original *Reach Out* materials were the culmination of more than 20 years work developing education programmes for people from non mental health backgrounds including practice nurses, employees of banks, NHS Direct nurse advisors and most recently, graduate primary care mental health workers. Sharing the journey, there have been far too many people to list individually, save a few: Karina Lovell and Bob McDonald who have both been vital spirits and John Rose who has been a firm fellow traveller. These supplementary materials on supervision for PWPs were developed from early work by Wayne Katon and Greg Simon at the University of Washington in the US and our experience of the specific clinical case management supervision methods pioneered at the IAPT Doncaster Demonstration Site. We thank all those who participated in this early work and those who also worked in the parallel IAPT demonstration site in Newham.

We must also place on the public record the contribution of Isaac Marks. More than 30 years ago, against vociferous professional objection, Isaac originally implemented the notion of training people from diverse professional and non-professional backgrounds in the application of evidenced based psychological therapies. The last 20 years would not have been possible without his courageous leadership and we would like to thank him for his inspiring vision.

We would also like to thank the team at Rethink for their help in producing these materials, not least Hilary Caprani and Natasha Coleman.

Thanks are also due to Della Bailey, Abi Coe, Clare Walker, Sarah Khalid, Gemma Cheney, Paul Farrand and Jo Woodford for allowing us to film their work and to Dominic Ennis and Paul Scott for their skilled camera work. We would also like to thank all those who assisted as actors.

David Richards, Marie Chellingsworth, Roslyn Hope, Graham Turpin and Mark Whyte, January 2010.

Introduction

Improving Access to Psychological Therapies (IAPT)

The Improving Access to Psychological Therapies (IAPT) programme has one principal aim, to support Primary Care Trusts in implementing National Institute for Health and Clinical Excellence (NICE) guidelines for people suffering from depression and anxiety disorders. At present, only a fraction of the 6 million people in the UK with these conditions are in treatment, with debilitating effects on society.

The programme began in 2006 with demonstration sites in Doncaster and Newham focusing on improving access to psychological therapies services for adults of working age. In 2007, 11 IAPT Pathfinders began to explore the specific benefits of services to vulnerable groups.

These pilot services, through routine collection of outcome measures, showed the following benefits for people receiving services:

- Better health and wellbeing
- High levels of satisfaction with the service received
- More choice and better access to clinically effective evidence-based services
- Helping people stay employed and able to participate in the activities of daily living

On World Mental Health Day 2007, Health Secretary Alan Johnson announced substantial new funding to increase services over the following three years. This allows:

- The commissioning of IAPT services by Primary Care Trusts
- Regional training programmes to deliver 3,600 newly trained therapists with an appropriate skill mix and supervision arrangements by 2010/11
- 900,000 more people to access treatment, with half of them moving to recovery and 25,000 fewer on sick pay and benefits, by 2010/11

Stepped Care

The delivery of intervention in IAPT services is based on a 'stepped care' delivery model. Stepped care is an attempt to modify traditional referral systems to improve access and efficiency without sacrificing effectiveness. It has two main principles:

1. The principle of '*Least Burden*': treatments received by patients should be the least restrictive possible whilst achieving the required outcomes. This means that the treatment should burden the patient and the health care system as little as possible on the way towards a positive clinical outcome.

2. The principle of '*Self-Correction*': stepped care should have a feedback system whereby the intensity of treatments can be adjusted. In many cases clinical decision-making is conducted in an ad hoc, unsystematic and subjective manner. Stepped care systems put a systematic mechanism in place to feed into clinical decision-making, informed by objective measures of patient outcome.

Self-correction can be applied at two stages in stepped care. 1) Patients may be assessed and *allocated* to different treatments; 2) Subsequent reviews of patient progress may *step* patients up to another more intensive treatment. In reality, stepped care systems balance these two decision-making points, although individual systems occupy different places on the allocation-stepping continuum.

Low intensity interventions at step 2 are delivered by Psychological Wellbeing Practitioners (PWPs) and *high intensity* interventions being delivered at step 3 by High Intensity Therapists.

The role of the Psychological Wellbeing Practitioner

The primary purpose of the Psychological Wellbeing Practitioner (PWP) is to increase access to evidence-based psychological therapies for people with depression and anxiety. They also support patients with managing common medications, particularly antidepressants, and case-manage referrals or signposting to other agencies such as social care organisations.

PWPs are trained to identify common mental health disorders and come to a shared treatment plan with a patient that is both personalised and evidence-based. They are explicitly educated and skilled in 'common' as well as 'specific' therapeutic factors, so they know how to establish, develop and maintain therapeutic alliances with patients, and are able to be responsive and deal with real or potential ruptures in the alliance. They are purposely educated and skilled in delivering psychological interventions that are less intense than high intensity treatments such as Cognitive Behavioural Therapy (CBT) or Inter Personal Therapy (IPT). Nonetheless, CBT remains the theoretical underpinning of the low-intensity psychological therapies used by PWPs. The evidence for specific factors in psychological therapy points to the greater effectiveness of CBT when delivered in a low-intensity format (Gellatly et al, 2007; Hirai and Clum, 2006) compared to other types of treatment.

The term 'low-intensity' is a catch-all phrase which describes several dimensions of treatment. Low intensity treatment is less burdensome to patients, can be seen as a 'lower dose' of specific treatment techniques, often represents less support from a mental health worker in terms of duration or frequency of contact, and is often delivered in non-traditional ways such as by telephone or using the internet. Much behaviour exhibited by psychological wellbeing practitioners and by patients in treatment is similar to those utilised in high-intensity therapy. However, low-intensity work is qualitatively different to high-intensity therapy, requiring different competences (Holford, 2008; Roth and Pilling, 2007).

The behaviour of PWPs in contacts with patients can be likened to a 'coach' role, such as an athletics coach, or a personal fitness trainer. If people go to the gym or play sports, fitness trainers don't do the actual physical work of getting them fit;hat is up to the individual. However, the trainer will help devise a fitness plan, monitor a person's progress and keep encouraging them when the going gets tough. A low-intensity worker will act in the same way.

As a coach, a PWP has a role as educator and supporter, helping motivate the patient but always acknowledging that the real work is being undertaken by the patient. Coaches often devise treatment according to a coaching manual, and this idea can help differentiate between traditional therapy and low-intensity treatment. In low-intensity treatment, the main focus is often on a manual or other material (sometimes computerised); whereas in high-intensity work the materials are usually adjuncts to the work of therapist, not the main focus.

Although PWPs are skilled in face-to-face work with patients, they often deliver their care through a range of alternative delivery systems such as the telephone or web based support. Theirs is a high volume, low intensity role, so they will generally have larger numbers of contacts with patients and spend less time in sessions than their high-intensity colleagues. PWPs delivering low intensity interventions are expected to operate in a stepped-care, high volume environment, with workers completing treatment for around 250 patients per year. However, the number of low-intensity therapy sessions per patient is not limited and some PWPs may have ongoing contact with patients to assist in chronic disease management and relapse-prevention.

In the IAPT system, PWPs use the IAPT minimum dataset (MDS). They collect measures at every session and use them for individual patient management, feedback on progress to patients and in supervision discussions.

The PWP role is a new one, deliberately seeking to expand access to the large graduate supply nationally and to local people. People are recruited to a post within services as a PWP trainee at band 4 (agenda for change) or assistant practitioner level (career framework). Trainees undertake a 45 day training programme underpinned by a national curriculum (http://www.iapt.nhs.uk/2008/02/10/curricula-for-high-intensity-therapist-and-low-intensity-therapy-workers/) which focuses on the knowledge, skills and attitudes required to function in the PWP role. Qualification is either at post-graduate certificate level or through alternative routes for non-graduates. PWPs move to a band 5 (agenda for change) at qualification and hence to a practitioner level (career framework). Career progression options are currently being developed to include senior roles to provide supervision, training, management and specialist clinical expertise with underpinning CPD support.

Accreditation

All of the PWP training programmes will undergo an IAPT-led course accreditation process which will need to be approved to continue to deliver the training programme. As part of the IAPT-led PWP course accreditation process, three professional organisations are providing PWP Quality Assurance support: British Association of Behavioural and Cognitive Psychotherapies (BABCP); British Association for Counselling and Psychotherapy (BACP) and the British Psychological Society (BPS).

In addition, individual PWP accreditation is being offered by the BABCP through one of three routes. All routes require applicants to demonstrate they are competent in the PWP clinical method, receiving PWP supervision (clinical case management and clinical skills) from a supervisor who has completed PWP supervisor training and are working with patients using PWP clinical methods. Within two routes to accreditation, competence will be evidenced by PWPs having successfully completed either an IAPT accredited PWP full or top-up training programme. The third (grand-parenting) route will require trainees to have undergone PWP related training (e.g. graduate mental health worker) and demonstrate competence in the PWP clinical method via assessment of a taped assessment and support session, consistent with the PWP assessment schedules. Full details of the BABCP's PWP accreditation process are available from the BABCP website (www.babcp.org). It is anticipated that other organisations will also offer individual accreditation in the near future.

IAPT is also recommending specific criteria for supervisor training to Strategic Health Authorities (SHAs). This will outline the number of days, type of content and specific methods by which PWP supervisors can establish themselves as qualified to supervise PWPs and therefore assist them in meeting their personal accreditation criteria.

Supervision

Both the IAPT National Implementation Plan and the Commissioning Toolkit have stressed the importance of providing high quality supervision to therapists delivering both low and high intensity interventions and the IAPT Workforce Team has issued guidance on supervision (**http://www.iapt.nhs.uk/wp-content/uploads/2008/12/supervision-2008.pdf**). Supervision is essential to the clinical methods employed by PWPs. There is evidence that incorporating structured and scheduled supervision into routine clinical services predicts better patient outcomes in the care of people with depression (Bower et al, 2006).

Supervision is a term commonly used across health and social services and may describe quite *different* activities ranging from personal development through to management, case and clinical supervision. It can be performed individually or in groups, it can be formal or informal, it can focus on processes or outcomes, and involve peers, trainees or senior line-management staff. It is essential that services understand the different functions and types of supervision available:

Fidelity to the evidence base

- Ensuring workers choose treatments and use them in a way which is as close as possible to the protocols tested in clinical trials which have led to these treatments being recommended in clinical guidelines

Case management

- Ensuring all patients are reviewed according to specific clinical and organisational criteria in order to make effective and efficient clinical decisions, often relating to the stepping-up of treatment intensity or offering alternative low-intensity treatments.

Clinical governance

- Ensuring safety for patients and workers, by routinely reviewing patient risk and workers' clinical practice for ALL patients, not just those that a therapist or supervisor selects for discussion.

Skills development

- Assisting workers to improve their own clinical and therapeutic skills by supervisor feedback on workers' sessions, for example, through direct observation, review of notes or taped records.

Worker support

- Ensuring that workers' own mental health is addressed where they are working with emotionally difficult material, high clinical volumes or are themselves in distress unrelated to their work.

Box 1: five purposes of supervision drawn from the large literature on supervision: (for example, Ladany, 2004; Lambert and Hawkins, 2001; Milne, 2009).

Becoming a Supervisor of Psychological Wellbeing Practitioners

Supervision of PWPs takes two main forms: *Clinical Case Management Supervision* and *Clinical Supervision*. Clinical Case Management Supervision (CCMS) is a significant departure from traditional supervision models and is the principal means of ensuring treatment fidelity, good case management and clinical governance. Clinical Supervision (CS) will be more familiar to supervisors and is the method by which PWP skills development and support is ensured. During PWP training supervisors also have an additional role to support trainee PWPs, who are required to demonstrate that they have achieved eleven *Practice Outcomes* in order to graduate from their course. It is the supervisors' responsibility to assess trainees' achievement of these practice outcomes.

Potential supervisors of PWPs must ensure that they are familiar with both the low-intensity interventions undertaken by PWPs and the two contrasting CCMS and CS supervision methods. The national IAPT workforce team have recommended that PWPs receive a minimum of one hour per week of individual CCMS and one hour per fortnight of CS, which can be undertaken in groups. Supervisors should ensure that they have sufficient time to devote to these activities as well as the knowledge of low intensity interventions and the PWP delivery methods.

If PWPs are using self-help materials, supervisors should be fully familiar with the content of these materials. They should also be conversant and comfortable with any computerised treatment programmes in use. It is also essential that PWP supervisors familiarise themselves with local stepped care protocols operating in clinical services and the wider provision of health and social care services available locally, so that they can assist PWPs with their clinical decision-making around stepped care, case management and signposting. In order to familiarise themselves with the PWP methods, it is highly desirable – if not essential – that supervisors will have delivered treatment to patients themselves using PWP protocols. This is by far the best method by which supervisors can understand the issues faced by PWPs in their clinical practice.

Training for Supervision

The IAPT workforce group has recommended that all IAPT supervisors should attend a specific supervision course from an education provider with an established track record of IAPT supervisor training. They should also have relevant and specific knowledge of and familiarity with IAPT services, supervising CBT therapists and high volume case management supervision.

The recommendation is that courses should be of five or seven days in duration, depending upon whether both low and high intensity IAPT supervision is to be covered. Courses may have a basic format of an introductory two day workshop which focuses on generic supervision competences followed by a further two days which focus individually on either clinical supervision for high intensity CBT therapists or CCMS and CS supervision for supervisors of PWPs. A final day workshop should integrate the previous days and deal with issues such as evaluation of clinical and supervisory skills.

It is also desirable that the competences of supervisors attending these courses are assessed and evaluated. This may be via a course training staff or through peer or self-assessment. This may be achieved through supervisors bringing in examples (e.g. audio tapes or DVDs) of their work with supervisees during the previous weeks clinical work within services. Ratings and feedback on supervision provided by supervisees might also be included, subject to the usual consent and confidentiality procedures being applied.

Although there is as yet no specific IAPT curriculum for supervisor training, the contents of courses should be based around the Roth and Pilling supervision competences (**http://www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm**). The critical component of supervision training for supervisors of PWPs will be the CCMS module and familiarisation with the low intensity clinical method. Although supervision training is currently accessible from a variety of providers, the CCMS aspect of training is not widely available. As a consequence, we have produced this guide and accompanying DVDs to assist PWP supervisors undertaking both CCMS and CS for PWPs.

However, the guide does not replace training. As specific IAPT training courses become more widely available, supervisors should ensure that they attend such a course and in particular the days dedicated to PWP supervision methods. The guide and DVDs should be used in conjunction with training, not as a replacement.

Supervising Psychological Wellbeing Practitioners

1. Clinical Case Management Supervision

There is evidence that workers delivering low-intensity interventions achieve better patient outcomes through regular and structured supervision (Bower et al, 2006). This has led to the development and testing of a supervision protocol for 'clinical case management supervision' for a clinical trial of low-intensity working (Richards et al 2008). This protocol was then implemented in the IAPT demonstration site in Doncaster (Richards and Suckling 2008). The clinical outcomes from this site (Clark et al, 2009; Richards and Suckling 2009) provide further evidence of the effectiveness of this type of supervision as part of an overall low-intensity clinical protocol.

Clinical case management supervision in low-intensity working is directed towards high-volume case management and clinical governance. Low-intensity supervision is highly structured with cases identified according to clear pre-determined protocols where the responsibility for raising particular patients in supervision is not dependent on the wishes of the worker or their supervisor. Low-intensity supervision is as high-volume as the clinical work itself.

Clinical case management supervision for low-intensity working is, therefore, part of the 'IAPT method' tested in both clinical trials and the demonstration sites. In order to replicate the positive results of these sites, IAPT services should provide Psychological Wellbeing Practitioners with clinical case management supervision.
We recommend that Psychological Wellbeing Practitioners (PWPs) working in IAPT services should receive **a minimum of one hour per week** of clinical case management supervision.

2. Clinical Supervision for low-intensity skills development

A focus of clinical case management supervision by no means implies a neglect of skills development or worker support. Clinical supervision of a more traditional nature is still required, in addition to clinical case management supervision and particularly during training, to focus on the specific skills required for effective low-intensity working.

Supervisors should schedule **additional** supervision time to discuss some cases in more depth to assist PWPs hone their specific low-intensity clinical skills. Much material for discussion will flow from issues raised in clinical case management supervision sessions. We recommend that Psychological Wellbeing Practitioners (PWPs) working in IAPT services should receive **a minimum of one hour per fortnight** of individual or group clinical supervision.

Of critical importance in this type of clinical supervision is keeping PWPs 'boundaried' within the low-intensity method and avoiding '*medium-intensity creep*'. To do so, supervisors must be fully aware of, and preferably experienced in, the clinical content and focus of low-intensity interventions.

3. Practice Outcomes for Trainee PWPs

The low-intensity curriculum consists of 45 days of training split between the University or other training providers and the clinical service. In order to pass the course, students must demonstrate that they have achieved eleven 'clinical practice outcomes'. It is the role of the practice-based supervisor to support the student in achieving these practice outcomes. The supervisor must then sign a document indicating to the course leader(s) that these outcomes have been achieved.
In order to do so, supervisors must monitor and assess the developing clinical skills of the student through a variety of methods.

It makes sense for supervisors to use information presented to them during clinical case management and clinical supervision sessions to appraise student's competence.

However, we recommend that supervisors do not restrict themselves to this information. Other sources of information could include direct observation, the use of audio tapes of clinical interviews undertaken by the student, and reflections by the student on their developing practice. It is the student's responsibility to provide evidence of achievement to the supervisor so that the supervisor is satisfied that the student has met their outcomes.

Summary

Supervision for Psychological Wellbeing Practitioners working with low-intensity interventions consists of:

1. Clinical case management supervision for a minimum of one hour per week.

2. Clinical supervision for a minimum of one hour per fortnight.

Additionally, trainee PWPs require supervisors to:

3. Monitor and support their attainment of 11 clinical practice outcomes.

The following pages describe how clinical supervisors can implement clinical case management supervision, understand the boundaries of the low-intensity clinical method and detail the clinical practice outcomes which students are required to achieve in order to qualify as Psychological Wellbeing Practitioners.

References

Bower, P, Gilbody, S, Richards, DA, Fletcher, J, Sutton, A. (2006). Collaborative care for depression in primary care. Making sense of a complex intervention: systematic review and meta regression. *British Journal of Psychiatry*, **189**, 484-493.

Clark, D.M., Layard, R., Smithies, R., Richards, D.A., Suckling, R., and Wright, B. (2009). Improving access to psychological therapy: initial evaluation of two UK demonstration sites. *Behaviour Research and Therapy* **47**, 910-920

Department of Health (2008). *Improving Access to Psychological Therapies. Implementation Plan: Curriculum for Low Intensity Therapies Workers*. London: Department of Health/Mental Health Programme/Improving Access to Psychological Therapies. (http://www.iapt.nhs.uk/2008/02/10/curricula-for-high-intensity-therapist-and-low-intensity-therapy-workers/)

Ladany, N. (2004). Psychotherapy supervision: what lies beneath? *Psychotherapy Research*, **14**(1): 1-19.

Lambert, M.J. and Hawkins, E.J. (2001). Using information about patient progress in supervision: are outcomes enhanced? *Australian Psychologist*, **36**(2): 131-138.

Milne, D.L. (2009). *Evidence-Based Clinical Supervision: Principles & Practice*. Leicester: BPS/Blackwell.

Richards, DA, Lovell K, Gilbody S, Gask L, Torgerson D, Barkham M, Bower P, Bland JM, Lankshear A, Simpson A, Fletcher J, Escott D, Hennessy S, Richardson R. (2008). Collaborative Care for Depression in UK Primary Care: A Randomised Controlled Trial. *Psychological Medicine*, **38**: 279-288.

Richards, D.A. and Suckling, R (2008). Improving access to psychological therapy: the Doncaster demonstration site organisational model. *Clinical Psychology Forum*, **181**: 9-16.

Richards, D.A. and Suckling, R (2009) Improving Access to Psychological Therapies (IAPT): Phase IV Prospective Cohort Study. *British Journal of Clinical Psychology* (in press) doi: 10.1348/014466509X405178

Turpin, G. and Wheeler, S. (2008). Improving Access to Psychological Therapies (IAPT): Supervision Guidance. http://www.iapt.nhs.uk/wp-content/uploads/2008/12/supervision-2008.pdf

Implementing Clinical Case Management Supervision

Clinical case management supervision (CCMS) is organised differently from most other models of supervision to account for the high case loads carried by psychological wellbeing practitioners (PWPs). Nonetheless, all supervision requires discussion between a worker and the supervisor about patients' clinical presentations, safety and progress, and about the process and techniques being used by the worker. This type of supervision is essential since in high volume working environments it is easy for cases to slip through the net and never be discussed. It is best facilitated by automated IT-based case management systems.

Clinical case management supervision is undertaken at regular (usually weekly), timetabled intervals, rather than at the request of the supervisee. Discussions in clinical case management supervision always include supervisee presentations of patients at pre-determined stages in their care pathway and / or who have particular clinical characteristics. This type of supervision has been shown to be linked to better patient outcomes in a collaborative care system (Bower et al, 2006).

Supervisors of PWPs should be familiar with the nature of low-intensity work, ideally having themselves delivered low-intensity treatments. Currently, PWPs tend to be supervised by CBT therapists from high-intensity steps. However, more experienced PWPs with specific training in supervision should be able to take on a supervisor role. Clinical case management supervision is carefully structured to enable efficient support and shared decision-making by the PWP and their supervisors. A large number of cases will usually be discussed in any one supervision session.

In order to become proficient at clinical case management supervision, supervisors should watch the accompanying **Clinical case management DVD** and familiarise themselves with assessment sheet **A7**. This is the assessment schedule used to assess student PWP supervisee competences during training. The **Clinical case management DVD** shows a PWP presenting and discussing cases during a clinical case management supervision session.

The PWP has selected relevant cases from her caseload (in this case we have not included IT-mediated automatic selection, although we strongly suggest that automated selection is by far the most effective and safest way of selecting cases). She introduces the session, presents information, discusses cases with and receives feedback from her supervisor, and comes to a shared management decision which includes a clear plan of action with each patient. We recommend that supervisors watch the **Clinical case management DVD** whilst studying sheet **A7**.

We also recommend that supervisors practice clinical case management supervisor skills in simulated supervision sessions using the DVD as a guide. This should supplement formal training provided through IAPT/SHA commissioned supervision courses.

Learning aids

Supervision Checklist C8

Clinical Case Management DVD

Assessment Sheet A7

Overview of clinical case management supervision

Supervision should usually start with an overall discussion of a worker's full case load numbers, to enable the supervisor to assess the worker's ability to manage his or her case load. Following this first stage, the following principles should guide the selection of cases for discussion:

- Any new patients.
- All patients on the worker's case load should be discussed regularly, and certainly no less frequently than at four-weekly intervals.
- Any patients with risk levels above a predetermined threshold.
- All patients whose scores on clinical measures are above a predetermined threshold.
- All patients whose appointments are overdue or who have not been contacted recently by the psychological wellbeing practitioner
- Any patient for whom the worker requires further support

Presenting cases

PWPs should be able to present patients' demographic, clinical, process and outcome information succinctly and accurately. Preparation is key; as is good note keeping. As well as automatically detecting patients who require supervisory review, IT-mediated supervision systems make the rapid review of notes, outcome measures, risk and clinical activity far more efficient. Supervision ensures that the clinical protocols are being followed, including agreed strategies by which PWPs assess and manage any presenting risk.

In clinical case management supervision, psychological wellbeing practitioners normally present the following information for **all** new cases. This is information they will have gathered during their first contact appointment with patients:

- Gender, age, main problem statement, level of risk, onset and duration of current problem, previous episodes, past treatment, current scores on clinical measures, any co-morbidity issues, any cultural, language or disability considerations, employment status, current treatment from GP or other workers, low-intensity treatment plan, low-intensity action already initiated.

In addition, where supervision is concerned with patients being reviewed at pre-determined intervals (for example every four weeks), where risk level causes concern, where outcome measures remain high or where supervision is at the PWP's request, it is helpful if workers **also** present:

- An episode treatment summary which includes: intervention summary; number of contacts; duration of contacts; patient progress report including patients' engagement with and response to low-intensity treatment; risk management plan, scores on sessional clinical outcome measures; alternative low-intensity treatments available and suggestions for alternative treatments where necessary, for example stepping up to high-intensity treatment.

Where patients' appointments are overdue, if patients have not attended scheduled contacts (including telephone appointments) or have 'dropped out' of treatment, the following information is also useful:

- Number of attempts made to contact the patient including telephone calls, time of calls, letters and other contact attempts.

Following each discussion of an individual patient, supervisors need to record their agreed action. It is generally better from a clinical governance and audit perspective to have the supervisor enter the agreed plan, then sign and date the record. Certain IT-mediated supervision systems can automatically stamp the date and a supervisor's signature onto the record.

C8 Supervision checklist

Number of patients on case load	
Number of patients requiring supervision	

1. All Patients requiring supervision	
Gender, age	
Main problem statement	
Level of risk	
Onset and duration of current problem	
Previous episodes, past treatment	
Current scores on clinical measures (at least PHQ9, GAD7)	
Co-morbidity issues	
Cultural, language or disability considerations	
Employment status	
Treatment from GP or other workers	
Low-intensity treatment plan	
Low-intensity action already initiated	

2. Patients for scheduled review at risk, where measures remain high, or at student's request	
Summary of case as above in section 1	
Reason for supervision (scheduled review point, high scores, risk level)	
Intervention summary	
Number and duration of contacts	
Patient engagement with low-intensity treatment	
Patient response to low-intensity treatment	
Scores on sessional clinical outcome measures	
Low-intensity treatment plan	
Alternative treatment plan including stepping up to high-intensity treatment	

3. Patients overdue, not attended or 'dropped out'	
Summary of case as above in section 1	
Reason for supervision	
Summary of progress before non-contact	
Number of attempts made to contact the patient	
Number and methods of contact attempted	
Time of any telephone calls	

Pages 14-22 taken from *Reach Out National Programme Educator Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions*. 2nd edition David Richards and Mark Whyte.

A7 Supervision simulation assessment

How to plan the clinical case management supervision assessment

Students should be given a portfolio of at least 20 cases from which they will select 10-12 for supervision. These cases should meet the following criteria for supervision and should be pre-determined by educators and examiners, but not communicated to students. The remaining cases would be routine ones which do not require immediate supervision.

Cases should be a mix of patient scenarios which describe the following situations:

Some new patients: at least three scenarios
Each scenario should provide sufficient information so that students can extract a succinct problem summary statement from information in the scenario including: gender, age, main problem, triggers, autonomic, behavioural and cognitive symptoms, impact, level of risk, onset and duration of current problem, previous episodes, past treatment, current scores on clinical measures, any co-morbidity issues, any cultural, language or disability considerations, employment status, current treatment from GP or other workers, low-intensity treatment plan, low-intensity action already initiated. The information should be presented clearly but not necessarily in the 'right' order. At least one of these patients should be unsuitable for low-intensity treatment.

Some patients at certain predetermined intervals in treatment, no less than four-weekly: one to three scenarios
Information should be presented as above but with additional material on: intervention summary; number of contacts; duration of contacts; patient progress including patients' engagement with and response to low-intensity treatment; risk management plan, scores on sessional clinical outcome measures.

Some patients with risk levels above a predetermined threshold: one to three scenarios
A number of scenarios should be presented where patients are at higher risk: for example, someone with frequent thoughts of suicide but no plans; someone who is an active suicide risk; someone who may be at risk of neglecting their children. These scenarios should include all the information presented in first two scenario categories with the addition of information on what the psychological wellbeing practitioner did to manage the patient's risk during their last contact with this patient.

Some patients with high scores on clinical measures above a predetermined threshold – ordinarily a score of 15 or more on the PHQ9 or GAD7: one to three scenarios
Scenarios should include information covered in first two scenario categories where clinical outcome measures are above 15 on one or other of the PHQ9 and GAD7.

Some patients who are overdue for appointments: one to two scenarios
Scenarios should include all the information in first two scenario categories plus information on the number of attempts the psychological wellbeing practitioner has made to contact the patient including telephone calls, time of calls, letters and other contact attempts.

Some patients where it is clear the student / psychological wellbeing practitioner should be seeking self-determined advice: one to two scenarios
At least one scenario should be presented which is within the competency of the psychological wellbeing practitioner but where there is co-morbidity requiring advice from supervisors.

A7 Supervision simulation assessment

Clinical case management supervision assessment: How to use this rating sheet

This rating sheet is divided into five sections:

1. Selection of cases for supervision
2 Introduction to the supervision session
3. Information giving
4. Discussion of clinical options
5. Shared decision making

Each section includes a number of competences which are specific and central to these five aspects of clinical case management supervision.

Each component of the rating sheet is divided into three columns. Assessors should rate each competence according to observations made of the student's performance. The right-hand column represents an aspect of the performance which was not conducted sufficiently well to be regarded as competent. The middle column should be ticked when students displayed the behaviours necessary but could have done more. The left-hand column is reserved for students who are fully competent in the relevant skill. Guidelines are given in each cell of the rating sheet to assist assessors make an objective judgement of competence.

The four sections are weighted: 5% for the selection of cases for supervision section, 5% for the introduction to the supervision session section; 20% for the information giving section, 40% for the discussion of clinical options section, 30% for the shared decision making section.

Each section is rated from 0 – 10 and multiplied by the relevant weighting to give a final score. The assessment is marked as an overall pass / fail exercise.

The information giving section **MUST** be passed independently – students cannot fail the information giving section and make up marks on the other four sections. The section ratings given should reflect the amalgamated ticks given in each cell, the majority of which would need to be in the left-hand or middle columns to constitute a pass. Because competence ratings are dependent on multiple criteria, the overall percentage ratings are indicative only and used to give students feedback rather than indicate concrete competence performance differences between students.

It is best to use this assessment sheet on filmed supervision simulation interviews using actors, clinical or teaching staff with clear instructions on how to role play supervisors. This allows the scenarios being assessed to be consistent between students. Filming also allows double blind marking, external examiner scrutiny and an audit trail. Finally, filming allows students to observe their own supervision session in order to write a reflective commentary on their own performance. The reflective commentary is subject to the examination regulations of the awarding body and is assessed accordingly.

A7 Supervision simulation assessment

Participant Number: _____ **Date:** _____

Selection of cases for supervision – WEIGHTING 5%

	Clear evidence demonstrated (The student fully demonstrated the criteria)	**Some evidence demonstrated** (The student demonstrates part of the skill or limited skill)	**Insufficient evidence demonstrated** (The student demonstrated insufficient skill)
Student has selected the correct cases identified for supervision from the case load in the simulation exercise	(All cases correctly identified)	(No more than 20% of cases missing from the student's selection)	(More than 20% of cases missing from the student's selection)

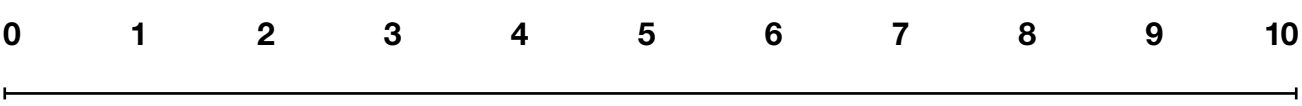
0 1 2 3 4 5 6 7 8 9 10

A7 Supervision simulation assessment

Participant Number: _____ **Date:** _____

Introduction to supervision session – WEIGHTING 5%

	Clear evidence demonstrated	Some evidence demonstrated	Insufficient evidence demonstrated
Student presents the total number of cases on his / her active case load to the supervisor	(Presents this information)		(Does not present this information)
Student presents the number of cases for supervision to the supervisor	(Presents this information)		(Does not present this information)
Student organises the cases for supervision using supervision case categories and states the numbers in each category	(Presents a category summary for all cases presented)	(Incompletely presents categories of cases)	(Does not present case categories)



A7 Supervision simulation assessment

Information giving skills – WEIGHTING 20%

	Clear evidence demonstrated	Some evidence demonstrated	Insufficient evidence demonstrated
Information presented for **ALL** cases	(Information presented for all cases)	(Information missing from no more than 20% of cases)	(Information missing from more than 20% of cases)
Gender			
Age			
Main problem statement			
Level of risk			
Onset and duration of current problem			
Previous episodes, past treatment			
Current scores on clinical measures			
Co-morbidity issues			
Cultural, language or disability considerations			
Employment status			
Treatment from GP or other workers			
Low-intensity treatment plan			
Low-intensity action already initiated			

A7 Supervision simulation assessment

Information giving skills (continued) – WEIGHTING 20%

Additional information presented in cases for:

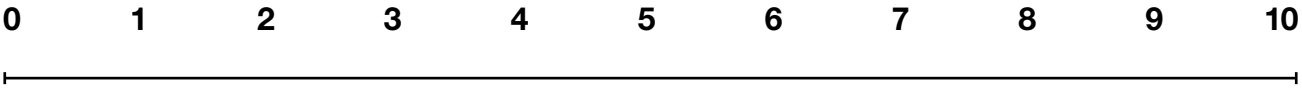
- scheduled review
- risk review
- where outcome measures remain high
- where student specifically requests supervision

	Clear evidence demonstrated	**Some evidence demonstrated**	**Insufficient evidence demonstrated**
	(Information presented for all cases)	(Information missing from no more than 20% of cases)	(Information missing from more than 20% of cases)
Reason for supervision			
Intervention summary			
Number and duration of contacts			
Patient engagement with low-intensity treatment			
Patient response to low-intensity treatment			
Continuation scores on sessional clinical outcome measures			
Low-intensity treatment plan			

Additional information presented in cases:

- overdue
- not attended
- 'dropped out'

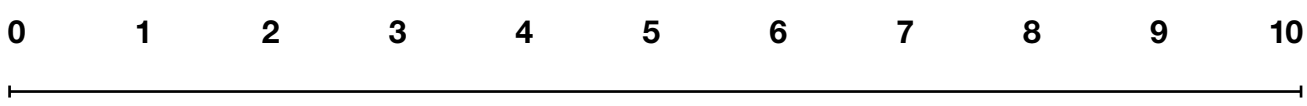
	Clear evidence demonstrated	**Some evidence demonstrated**	**Insufficient evidence demonstrated**
	(Information presented for all cases)	(Information missing from no more than 20% of cases)	(Information missing from more than 20% of cases)
Reason for supervision			
Summary of progress before non-contact			
Number of contact attempts made			
Number and methods of contact attempted			



A7 Supervision simulation assessment

Discussion of cases – WEIGHTING 40%

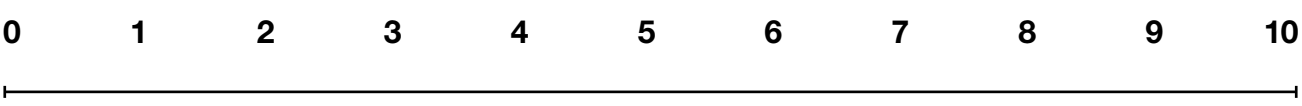
	Clear evidence demonstrated	**Some evidence demonstrated**	**Insufficient evidence demonstrated**
Student demonstrates ability to listen to supervisor	(Displays all / most of the time)	(Displays some / part of the time)	(Not demonstrated)
Student demonstrates ability to reflect upon and clarify supervisor's comments	(Displays all / most of the time)	(Displays some / part of the time)	(Not demonstrated)
Student demonstrates ability to make suggestions in supervision	(Displays all / most of the time)	(Displays some / part of the time)	(Not demonstrated)



A7 Supervision simulation assessment

Shared decision making – WEIGHTING 30%

	Clear evidence demonstrated	Some evidence demonstrated	Insufficient evidence demonstrated
Student demonstrates ability to accurately summarise supervision discussions for each patient	(Clear summary of discussions for all cases)	(Clear summary of discussions missing from no more than 20% of cases)	(Clear summary of discussions missing from more than 20% of cases)
Student demonstrates ability to formulate a clear action plan for each patient based on the supervision discussion and summary	(Clear action plan made for all cases)	(Clear action plan missing from no more than 20% of cases)	(Clear action plan missing from more than 20% of cases)
Student demonstrates an ability to move onto each subsequent case after previous action plan agreed	(Displays all / most of the time)	(Displays some / part of the time)	(Not demonstrated)



Clinical Supervision for low-intensity skills development

Low-intensity clinical work requires skilled information gathering, information giving and shared decision-making. A fourth critical activity is reporting and supervision. Information gathering, information giving and shared decision-making require a mix of 'common' and 'specific' factors skills. Any clinical encounter between patients and workers requires the gathering of information in a patient-centred manner, the giving of information in a way which is congruent with the beliefs and prior knowledge of patients, and the identification of a shared decision between patient and worker which is arrived at in as collaborative a manner as possible. This three-phase organisation of clinical encounters runs throughout all the PWP national curriculum modules.

This clinical method of low-intensity working runs throughout the whole PWP course which is structured as follows:

- Information gathering
- Information giving
- Shared decision making
- Low-intensity treatment interventions
- Values, policy, culture and diversity
- Supervision for low-intensity working

Psychological wellbeing practitioners use the materials in their own *Reach Out* student guide to develop **common** and **specific factors** skills. The materials are presented as written sheets and DVD film clips. Both of these are structured to enable PWPs to develop their skills in information gathering, information giving and shared decision-making. Much of the material is practical and skills-based rather than theoretical. The film clips in particular allow PWPs to observe the required competences in detail. The written materials are brief, and PWPs should supplement them by additional reading from the references section at the end of their *Reach Out* student guides.

What follows are copies of the assessment (I1) and subsequent contact (I2) interview schedules used by PWPs in their encounters with patients. Thereafter, we have included details of the specific clinical interventions PWPs are trained to deliver.

Supervisors should study these materials and the accompanying *Reach Out* DVDs to familiarise themselves with the **specific factor**s skills which represent the low-intensity method. Supervisors should be able to assist PWPs in their **specific low-intensity skills development**. Supervisors should watch for any evidence of '*medium intensity creep*' and focus PWPs on becoming expert at delivering collaborative, patient-centred interventions using the identified evidence-based techniques described in the following pages.

I1 Example interview schedule

Initial information gathering

Introduction

Each interview in a low-intensity programme takes the form of three sections: information gathering, information giving and shared decision making. The following interview schedule is used to gather information at the first contact between a psychological wellbeing practitioner and a patient.

Objectives of the interview

The objectives of the interview are to:

- elicit the main difficulties being experienced by a patient.
- assess the patient's level of risk.
- determine the patient's attitudes to his / her difficulties.
- come to a shared understanding of their problem.

The interview uses a well tried question schedule. It is important that this schedule is used in a non-dogmatic, patient-centred and flexible manner. The key skill is to ensure that information is gathered using a funnelling technique whereby general open questions are followed by specific open and then closed questions. This process of funnelling will be used many times in an information gathering interview as patients divulge information about their problems. In contrast, checklist-driven interviews are the antithesis of patient-centredness.

Empathy dots

Along the right hand border of the schedule are 'empathy dots'. Many therapists and workers use these as memory joggers to remind them to use verbal empathic statements at regular times in the interview.

Options for low-intensity treatment

Following successful information gathering, psychological wellbeing practitioners will generally complete the interview by agreeing a problem statement, identifying some patient-centred goals and giving information about treatment options. These options are dependent on the problem identified and on available resources locally. They may include:

- recovery programmes for depression and / or anxiety.
- medication support.
- exercise.
- step ups to cognitive behaviour therapy.
- computerised cognitive behaviour therapy.
- support groups.
- signposting to other services including employment programmes.

Although shared decisions can be made at the initial contact, many patients will prefer to read written information about these choices before making a decision.

The main focus of the next contact then becomes supporting patients to decide which approach suits them best in attempting to overcome their difficulties through a process of collaborative, informed, shared decision making.

Pages 24-27 taken from *Reach Out National Programme Educator Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions*. 2nd edition David Richards and Mark Whyte.

I1 Example interview schedule

	Empathy dots
4 'Ws' • What is the problem? • Where does the problem occur? • With whom is the problem better or worse? • When does the problem happen?	•
Triggers (antecedents) • Specific examples of situations and other stimuli that trigger the problem in the here and now • Past examples of triggers	•
Autonomic (physiological) aspects of the problem	•
Behavioural aspects of the problem	
Cognitive aspects of the problem	
Impact (consequence) of the problem • Work, home management, social leisure, private leisure, family life and intimate relationships	•
Assessment of risk • Intent: suicidal thoughts • Plans: specific action plans • Actions: current / past; access to the means • Prevention: social network, services • Risk to others • Neglect of self or others	•
Routine outcome measures • IAPT minimum data set including at least PHQ9 and GAD7	
Other important issues • Onset and maintenance • Modifying factors • Why does the patient want help now • Patient expectations and goals • Past episodes and treatments • Drugs and alcohol • Current medication and attitude to this • Other treatment being provided • Anything else that has not been covered in the assessment that is relevant from both perspectives	•

I2 Example interview schedule: subsequent contacts

Introduction

Each interview in a low-intensity programme takes the form of three sections: information gathering, information giving and shared decision making. Each low-intensity contact should build on the previous one, a continuation of a conversation between the mental health worker and the patient.

Objectives of the interview

The following interview schedule is a structure used to implement low-intensity treatment including medication support and low-intensity psychological therapy.

The objectives of the interview are to:

- ensure that the shared understanding between worker and patient is maintained.
- ensure the patient's level of risk is managed.
- provide information to the patient on their mental health problem and the treatment choices available to them.
- determine the patient's attitudes to the various treatment choices.
- come to a shared decision about how to progress with a therapeutic plan.

Empathy dots

Along the right hand border of the schedule are 'empathy dots'. Many therapists and workers use these as memory joggers to remind them to use verbal empathic statements at regular times in the interview.

Options for low-intensity treatment

Following successful information gathering, information giving and shared decision making, psychological wellbeing practitioners will generally spend the majority of the interview supporting patients to use an evidence-based low-intensity treatment.

Options vary locally and may include:

- recovery programmes for depression and / or anxiety.
- medication support.
- exercise.
- step ups to cognitive behaviour therapy.
- computerised cognitive behaviour therapy.
- support groups.
- signposting to other services including employment programmes.

Worksheets and diaries

Most options require patients to complete worksheets and diaries. These are completed towards the end of sessions and usually include actively scheduled activities. Alternatively, patients and workers may decide that signposting to other services is all that is required. The level of subsequent support from psychological wellbeing practitioners should be decided collaboratively with patients, whatever the option(s) chosen, and confirmed or changed via supervision.

I2 Example interview schedule: subsequent contacts

	Empathy dots
Information gathering • Feedback of previous problem summary statement • Checking that problem statement is an accurate reflection of patient's difficulties • Further funneled information gathering if necessary • Clarification and adjustment of problem statement	•
Assessment of risk • Feedback of previous risk assessment • Checking that risk assessment is still accurate • If any change re-assess: intent: suicidal thoughts plans: specific action plans actions: current / past; access to the means prevention: social network, services risk to others neglect of self or others	• •
Routine outcome measures • IAPT sessional minimum data set including at least PHQ9 and GAD7	
Information review • Understanding of information given previously: mental health condition information medication information low-intensity psychological therapies information	• •
Medication review • Concordance behaviour • Benefit assessment • Unwanted effects assessment • Attitude to medication concordance	•
Low-intensity psychological therapy review • Understanding of options discussed • Review of treatment exercise implementation • Review of diaries and worksheets	
Shared decision-making • Choices discussed • Options selected • Treatment continued revised or initiated • Diaries and worksheets organised	• •
Ending • Session summarised • Next steps agreed and understood	

Low-intensity treatment interventions

Psychological wellbeing practitioners should support patients to implement a range of low-intensity treatments. These are the 'specific factors' of low-intensity working, as opposed to the 'common factors' of alliance building, interpersonal communication and patient-centred questioning.

In the next few pages you will find short explanatory notes on:

Clinical procedure	Page number
C1 Behavioural activation	27
C2 Cognitive restructuring	32
C3 Medication support	36
C4 Exposure therapy	38
C5 Problem solving	41
C6 Managing panic	43
C7 Sleep hygiene	47

This list is not exhaustive but represents the core clinical interventions you will use with patients. You should read from the Suggested reading to further your knowledge. You should also watch the DVD film clips of these interventions. There are also other film clips in the CD-ROMs attached to the Myles and Rushforth (2007) resource book.

Film Clips

The following film clips illustrate examples of psychological wellbeing practitioners using a range of low-intensity interventions in clinical sessions:

Gathering information 1

Behavioural activation 1

Behavioural activation 2

Cognitive restructuring

Exposure

Medication

Pages 28-50 taken from *Reach Out National Programme Student Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions*. 2nd edition David Richards and Mark Whyte.

C1 Behavioural activation

Behavioural activation is an effective treatment for depression, in either low or high-intensity formats. It is effective because it targets the role of avoidance in depression. It is focused on activities to help patients re-establish daily routines, increase pleasurable activities and address important necessary issues.

How does behavioural activation work?

When people are depressed they feel physically unwell, have negative thoughts and change the way they behave. People who are depressed reduce the frequency and type of their usual behaviours. They commonly stop going out with others, reduce interactions with friends, work colleagues and family, and make little effort to do things they may have previously enjoyed. By avoiding effort, people experience relief from burdensome activity, which leads to more avoiding of effort. Avoidance is, therefore, **negatively reinforced**, i.e. the frequency of avoidance increases.

As people avoid, they also reduce their opportunity for social and personal activities which bring them pleasure and achievement. They experience less **positive reinforcement** for these activities and thus these activities reduce further. Depression is, therefore, a vicious circle of negatively reinforced avoidance and reduced opportunity for positive reinforcement. Both these forces lead to reductions in usual activity for people who are depressed.

- Some of the things people avoid are just **routine** activities such as cleaning the house, doing the ironing, washing up. Other routines are disrupted such as the time they go to bed or get up, when they eat and how they cook for themselves. These are the important life routines that make people comfortable in their surroundings.
- Other activities that get disrupted are things people do for **pleasure** such as seeing friends, enjoying a day out with families or playing games with children. These are the things that often make people feel well.
- A third area where people avoid activities is in important **necessary** things such as paying bills or confronting difficult situations at work. These are activities which are important and if neglected may lead to an adverse consequence.

The stages of behavioural activation

The following protocol for BA is drawn from a clinical trial of depression management in the UK (Richards et al, 2008). It was developed from the clinical methods described by Martell et al (2001) and Hopko et al (2003). Further explanation is given in Chapter 12 of Callaghan et al (2008) and in Bennett-Levy (2010).

Step 1: Explaining behavioural activation

Psychological wellbeing practitioners should give patients a full and comprehensive rationale for behavioural activation, including reference to the interaction of physiological, behavioural and cognitive emotional symptoms, the role of avoidance in maintaining low mood and the idea of routine, pleasurable and necessary activities. Sometimes it is a good idea to supplement this explanation by filling in a **Behavioural activation diary** to provide an accurate baseline to evaluate change.

C1 Behavioural activation

Step 2: Identifying routine, pleasurable and necessary activities

Patients should identify routine, pleasurable and necessary activities – things that they would like to do but have usually stopped doing since they became depressed. The worksheet **Behavioural activation 1** is used to gather this information.

Step 3: Making a hierarchy of routine, pleasurable and necessary activities

Using the worksheet **Behavioural activation 2**, patients should organise the activities in **Behavioural activation 1** into a hierarchy of difficulty – most difficult, medium difficulty, easiest. Patients should include some of each type of routine, pleasurable and necessary activity in each section of **Behavioural activation 2**.

Step 4: Planning some routine, pleasurable and necessary activities

Psychological wellbeing practitioners should help patients to schedule some avoided activities into their week, using a blank diary **(Behavioural activation diary)** to specify a mixture of routine, pleasurable and necessary activities. These should be initially identified from near the bottom of their list in **Behavioural activation 2**. Activities should be detailed precisely: what, where, when, and who with. Small and regular activities are better in the early stages.

Step 5: Implementing behavioural activation exercises

Patients should undertake the planned activities written down in the diary. The principle of grading activities and using a mixture of routine, pleasurable and necessary actions should be followed. Patients should record in the same diary if they accomplished the planned activity.

Step 6: Reviewing progress

Psychological wellbeing practitioners should review **Behavioural activation diaries** during subsequent clinical contacts, so enabling patients to reflect on their programme, receive feedback on progress and problem-solve any difficulties experienced in implementation. Psychological wellbeing practitioners should be flexible as patients may make sporadic progress and activities may not go as planned. Shared decisions between psychological wellbeing practitioners and patients should be based on this review and further exercises planned.

C1 Behavioural activation 1

List some routine activities here: e.g. washing up, cleaning the house

List some pleasurable activities here: e.g. going out with friends or family

List some necessary activities here: e.g. paying bills, dealing with difficult situations

C1 Behavioural activation 2

Put your lists in order of difficulty, mixing up the different routine, pleasurable and necessary activities.

.....

.....

.....

.....

.....

.....

The most difficult

.....

.....

.....

.....

.....

.....

Medium difficulty

.....

.....

.....

.....

.....

.....

The easiest

C1 Behavioural activation diary

		Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning	What Where When Who							
	What Where When Who							
Afternoon	What Where When Who							
	What Where When Who							
Evening	What Where When Who							

C2 Cognitive restructuring

A major component of any emotional state is the thinking that accompanies the physical and behavioural symptoms. Most thoughts are automatic and many of these are 'unhelpful'. Key features are that these thoughts are automatic, seem believable and real at the time they appear, and are the kind of thoughts that would upset anybody. These thoughts act powerfully to maintain mood states. Cognitive restructuring is a way of changing unhelpful thoughts by identifying, examining and challenging them.

The stages of cognitive restructuring

Cognitive restructuring comes in three stages. Firstly, people need to identify their thoughts, particularly the exact content of their unhelpful thoughts. The key thoughts are those most congruent with someone's emotional state, so called 'hot thoughts'. Secondly, people examine their thoughts more objectively. This often requires people to collect 'evidence' as to how accurate their thoughts really are and come up with alternative evidence against their thoughts. The final stage is to reconsider thoughts in the light of the new evidence that has been collected – for and against. The thoughts are then reappraised, re-evaluated and alternative thoughts derived.

Implementing cognitive restructuring

Psychological wellbeing practitioners can use cognitive restructuring as a low-intensity intervention by supporting patients in the use of diaries and worksheets. Some examples are given in this section of materials. The main tool is the thought record.

Stage 1: Identification of thoughts

In order to identify their thoughts, patients should record a situation in which they felt in a certain emotional state and try to identify the emotion they felt at the time. They rate this emotion on a scale – usually from 0-100%. Patients then try and capture the exact thoughts that were in their mind when they felt this emotion and write these down in the thought record. In particular, the 'hot thought' is the one that needs to be worked on. Psychological wellbeing practitioners can help patients identify the 'hot thought' – i.e. the one which is most congruent with the emotion. The final aspect of stage 1 is for patients to rate their strength of belief in the thought, again from 0-100%.

C2 Cognitive restructuring

Stage 2: Looking for the evidence

Once the thoughts have been collected, patients should choose one to work on, ideally the hottest thought and one with a belief rating of at least 60%. The **Evidence recording sheet** is used to examine the evidence for and against the thought. Psychological wellbeing practitioners should help patients to write down the thought on top of the table, including the percentage belief rating.

In the **Evidence recording sheet**, one column is labelled 'evidence for' and one is labelled 'evidence against'. Next, almost like the prosecution and defence counsel in a court, evidence for and against the truth of the thought is written down. People often find this quite difficult, particularly coming up with evidence that the thought is not true. Here are some questions which can be used by patients to help:

- If I were speaking to a friend with this thought, what would I say for and against it?
- How would someone else think about this?
- If I rate the belief in my thought as 75%, then there is 25% of the thought I do not believe to be true. What makes up that 25%?
- If I was not depressed, would I believe this thought?
- Is there another way of looking at this situation?

Stage 3: Reconsidering thoughts

Once the **Evidence recording sheet** has been collected, patients need to reconsider their thoughts in light of the evidence. The idea is to come up with revised thoughts and consider if this changes their emotional feelings. In the fourth column of the **Thought diary** patients write down new thoughts and rate how much they believe them on a scale of 0-100%. In the final column they rate their feelings again using the same 0-100% scale. Psychological wellbeing practitioners should help patients to notice that by changing their thoughts, their mood also changes. This is the way cognitive restructuring works to change the way people feel.

Points to remember

- Unhelpful thinking takes time to change. Often people need to challenge their thoughts several times before change takes place.
- It can be useful for patients to ask a friend they trust to help them look for evidence for and against unhelpful thoughts.
- Cognitive restructuring should be practised with other thoughts using **Evidence recording sheets** to judge them.
- As people become more expert in this they can be advised to try and catch the thoughts and judge them as they actually occur.

C2 Thought diary

Situation	Feeling Rate how bad it was (0-100%)	Thought Rate how much you believe this thought (0 –100%)	Revised thought Rate how much you believe this thought (0 –100%)	Feeling How bad was it (0-100 %?)

C2 Evidence recording sheet

My thought	My % belief
Evidence for	Evidence against

C3 Medication support

The goal of medication support by psychological wellbeing practitioners is to assist patients in making the best decision on medication use (mainly antidepressants) by:

- **gathering information** on patients' attitudes to medication, medication use, clinical outcomes, medication effects and side effects.
- **giving information** regarding appropriate use of medication.
- negotiating **shared decisions** on patients' medication usage.

Psychological wellbeing practitioners provide information and support patients' decision-making. They do not make independent decisions about prescribing (e.g. stopping medication, change in dosage). Mostly, psychological wellbeing practitioners support the patient in their decision to follow (or not) the medication recommendation made by the GP, providing information so that this decision is made in an informed manner. The only instance in which a psychological wellbeing practitioner should make a different direct recommendation to a patient on medication is if they identify possibly dangerous side effects. In these instances, workers must:

- advise the patient to temporarily discontinue medication.
- inform the GP of the possibility of dangerous side effects being present.
- strongly advise the patient to make an urgent appointment with their GP.
- discuss this with their supervisor as soon as possible.

Where a patient decides not to follow the prescription made by the GP, psychological wellbeing practitioners should ensure that the patient's decision is fully informed by information on the effects and side effects of medication. The pros and cons of their decision and alternative strategies should also be explored. Further discussions between the patient and the GP should be encouraged and non-pharmacological psycho-social support offered by the worker.

Where a psychological wellbeing practitioner is aware that a GP's prescription does not follow prescribing guidelines, this should be discussed with the worker's supervisor and a joint plan devised to assist the GP and the patient to make effective use of medication.

Antidepressant medication

Antidepressants are prescribed by GPs to many patients with depression. Modern antidepressants from the Selective Serotonin Reuptake Inhibitor (SSRI) and Selective Noradrenalin Reuptake Inhibitor (SNRI) classes are now more widely used than earlier antidepressants such as the tricyclics. However, older tricyclic antidepressants are still prescribed where clinically indicated.

Patients may stop taking antidepressants completely or take less than the prescribed dose for a range of stated reasons. Here are some possibilities:

- 'ineffective / not-helpful'.
- 'no longer necessary'.
- 'side effects'.
- 'concerned about safety'.
- 'concerned about addiction'.
- 'believes not appropriate – just a crutch'.
- 'family oppose it, others will find out'.
- 'forgot to renew prescription'.

C3 Medication support

Many patients take antidepressants in a less than optimum manner because they have beliefs about addiction or mode of action. For example, it is necessary to take antidepressants for a number of weeks at a therapeutic dose before beneficial effects are observed. Unfortunately, unwanted and unpleasant side effects often appear before these beneficial effects, causing many patients to reconsider or stop taking their antidepressants. Other patients may take antidepressants sporadically when they are feeling particularly low, in the belief that they have an immediate effect.

Finally, antidepressants should be taken for six months following remission of symptoms. Many patients stop taking their medication before this period has elapsed, increasing their chances of relapse.

Psychological wellbeing practitioners should, always, therefore:

- **Gather information** on the true reasons for medication non-concordance.
- **Give accurate information** about antidepressants.
- Assist patients to arrive at a **shared decision** about what to do next.

There are many examples of information materials for patients in general use. Most mental health patient and advocacy organisations such as Rethink, MIND and the Mental Health Foundation provide clear leaflets and booklets. 'Treatment Notes' produced by the Drugs and Therapeutic Bulletin (**www.dtb.org.uk**) are helpful.

For detailed information, psychological wellbeing practitioners should consult the British National Formulary (**www.bnf.org**) and Steven Bazire's authoritative book (referenced in Suggested reading) and the associated web based materials at Norfolk and Waveney Mental Health NHS Foundation Trust (**www.nmhct.nhs.uk/Pharmacy**).

C4 Exposure therapy

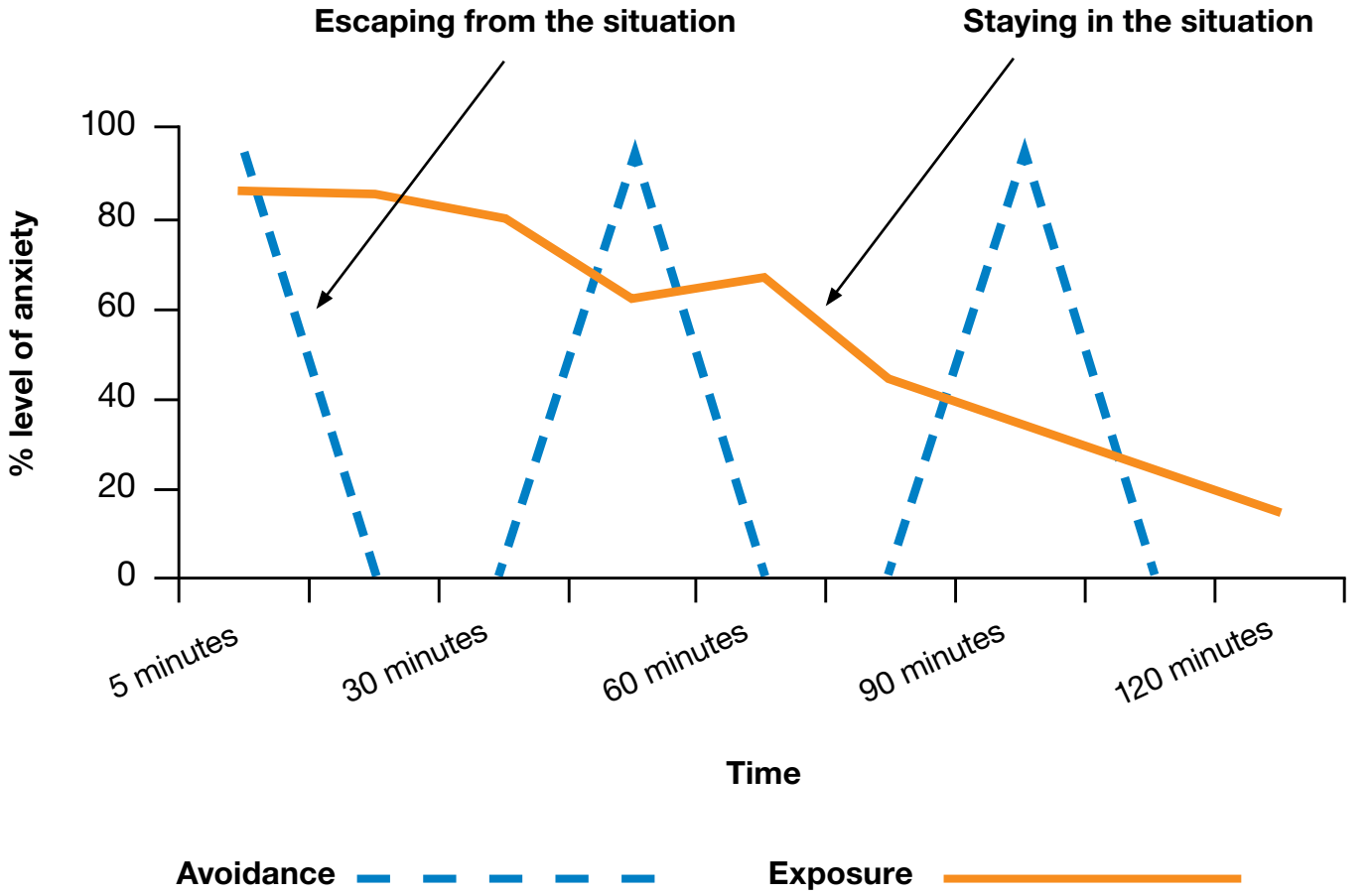
People will often try to avoid situations or objects they fear, and this avoidance does indeed successfully relieve anxiety. However, the more people avoid, the more they will continue to use it as a coping strategy. This leads to long-term difficulties as people find it more and more difficult to face their fears.

Exposure is the planned therapeutic confrontation to a feared situation, object or memory. It is a highly effective treatment for many anxiety disorders where behavioural avoidance is a key maintaining factor. Specific phobias, agoraphobia, social phobia, obsessive compulsive disorder and post-traumatic stress disorder all respond well to exposure treatment.

How does exposure therapy work?

Exposure therapy works through a process known as habituation. This is the natural reduction in arousal that occurs when people allow themselves to remain in the presence of a feared situation or object for a prolonged period of time. Over time, anxiety reduces gradually whilst the person remains in contact with the feared stimulus.

This is very different from avoidance. In avoidance, arousal reduces sharply but only when the person escapes from the feared situation or object. The problem with escape and avoidance is that the fear remains. The next time a person comes across their feared stimulus, their arousal levels will be the same as before. In exposure, habituation means that subsequent exposure sessions provoke less anxiety than previously. The graph below represents the difference.



C4 Exposure therapy

There are four conditions necessary for effective exposure treatment:

Grading
Overcoming fear is best achieved by a gradual confrontation with feared stimuli – the objects or situations which are avoided. This **does not** mean that exposure sessions should be shortened as a form of grading. The nature of the stimuli should be graded, for example by using photographs rather than real objects in the early stages of treatment.

Prolonged
Exposure **must** be prolonged if it is to be effective. There has to be sufficient time for arousal levels to reduce in **the presence of** the feared object or situation. Typically exposure sessions should last for between one to two hours or until anxiety has reduced by at least 50%.

Repeated
Additional exposure is necessary to cement improvement. The optimum number of repetitions should be balanced by the physical demands of feeling regularly fearful. Four or five prolonged repetitions weekly are usually manageable.

Without distraction
To experience a reduction in anxiety, people must feel some fear at first in order to experience and thus learn that fear reduces naturally in the presence of the feared object or situation.

Implementing exposure

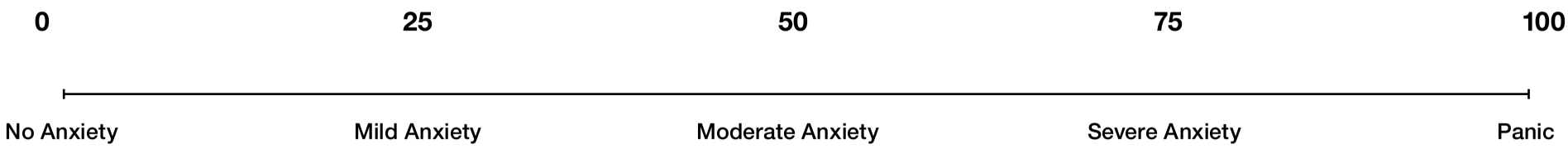
The first step is for psychological wellbeing practitioners to help patients compose a list of fearful objects or situations, ranking them in a hierarchy from the least anxiety provoking to the most feared one. Patients then start exposure with activities from the lower part of the list and practice these until they experience habituation. They then use the list to structure further exposure, picking objects or situations which are more fearful. Patients should always remember to remain in the presence of their feared situation or object until they experience a reduction in arousal.

Diary records are essential both to schedule activities and for psychological wellbeing practitioners to review progress. An example diary sheet is given next. The rating scales are helpful for patients and psychological wellbeing practitioners to monitor arousal levels and check for habituation. Psychological wellbeing practitioners should encourage and support patients during exposure and help them problem solve any difficulties experienced during their exposure exercises.

C4 Exposure exercise rating sheet

Fill in the details of the exercises you undertake, making sure you use the rating scale below before you start the exercise, at the beginning of the exercise and at the end of it. Please add any comments you want to discuss with your mental health worker or anyone who is supporting you.

Date and Time	Duration	Exercise	Rating			Comments
			Before exercise	Start of exercise	End of exercise	



C5 Problem solving

Problem solving is an evidence-based low-intensity intervention which patients can use when their problems appear initially too big to solve. It is a practical approach which works by helping patients take a step back from their problems and consider what solutions might actually exist. It takes a systematic and step by step approach to what might seem overwhelming difficulties.

Implementing problem solving

Problem solving can be divided into seven steps. Use the following worksheet C5.

Stage 1: Identify the problem

Psychological wellbeing practitioners can help patients to identify the problem as clearly and precisely as possible. Each problem should be broken down into its constituent parts, for example, a financial problem can be broken down into the components of debt, income and expenditure.

Stage 2: Identify the solution

As many potential solutions as possible need to be identified. At this stage, nothing is rejected, no matter how apparently ridiculous solutions may seem. Staged solutions can be generated to different components of the problem identified in stage 1.

Stage 3: Analyse strengths and weaknesses

Each potential solution is subjected to an analysis of its strengths and weaknesses, to assess the main advantages and disadvantages of each solution. Advantages and disadvantages can refer to likelihood of success, possibility of implementation, resources needed, etc.

Stage 4: Select a solution

A solution is chosen based on the analysis in stage 3. Attention to resources available to implement the solution is important here since choosing a solution which has no chance of implementation will only lead to failure.

Stage 5: Plan implementation

Many solutions require careful planning. Steps should be outlined and resources listed. The steps should be specific, linked and realistic. Psychological wellbeing practitioners should use the 'Four Ws' – what, where, when, with whom – to help patients plan the implementation plan.

Stage 6: Implementation

Patients implement the plan identified in stage 5. Record of implementation should be recorded in a simple diary.

Stage 7: Review

The advantage of problem solving is that alternative options always exist. Psychological wellbeing practitioners should gather information on the progress of the plan, preferably by reviewing the diary. If the solution has worked, continued implementation or moving onto another problem is indicated. If not, another solution should be chosen.

C5 Problem solving

Problem identification (write your problem here)

Solution identification (write down as many different solutions as possible– use additional sheets if necessary)

Strengths and weaknesses analysis
(write down the advantages and disadvantages of each solution here – use additional sheets if necessary)

Solution selection (choose one solution)

Implementation plan
(write down the steps you will take to apply your chosen solution – use additional sheets if necessary)

Implementation (keep a separate diary of how you do)

Review (write down how the plan went)

C6 Managing panic

What is panic disorder?

Panic disorder is a common presenting problem in primary care with a prevalence rate of approximately 7 per 1000 population. It is important to distinguish between panic attacks and panic disorder. Panic attacks are very common and can be distressing. The DSM IV criteria (APA 1994) for a panic attack are:

A discrete period of intense fear or discomfort, in which four (or more) of the following symptoms developed abruptly and reached a peak within 10 minutes:

- Palpitations, pounding heart, or accelerated heart rate.
- Sweating.
- Trembling or shaking.
- Sensations of shortness of breath or smothering.
- Feeling of choking.
- Chest pain or discomfort.
- Nausea or abdominal distress.
- Feeling dizzy, unsteady, lightheaded or faint.
- Derealisation (feelings of unreality) or depersonalisation (being detached from oneself).
- Fear of losing control or going crazy.
- Fear of dying.
- Parathesias (numbness or tingling sensations).
- Chills or hot flushes.

Panic disorder occurs when people have recurrent or unexpected panic attacks and they become concerned about having further attacks, and the consequences of these and what the panic attacks mean. There is significant behaviour change – usually comprising avoidance or attempts to prevent attacks happening. Panic disorder is defined relative to the presence or absence of agoraphobia. Panic disorder with agoraphobia occurs when patients associate their panic attacks with particular situations or places.

These situations are avoided or endured with marked distress. Sometimes patients can enter these situations only in the presence of someone else supporting them. In other cases, patients do not associate their panic attacks with particular situations and say that their attacks 'come out of the blue'. This is panic disorder without agoraphobia.

What are the key features of panic disorder and what maintains the problem?

Essentially, patients with panic disorder view the normal symptoms of acute anxiety in a catastrophic manner. The distressing symptoms which occur in panic are misinterpreted as indications of an impending physical or mental disaster. Typical feared consequences might include "I'll collapse", "I'm going mad", "I'll have a heart attack". These frightening thoughts generate anxiety, of course, and tend to make the physical symptoms worse, thus fuelling the vicious cycle of panic.

A number of behaviours serve to maintain the problem once it is established. Patients often become hypervigilant for any bodily cues which might indicate to them an impending panic attack. Such hypervigilance often involves the misinterpretation of normal bodily symptoms and fuels the anxiety further. Patients often engage in a range of 'safety behaviours' designed to prevent their feared consequence. Avoidance of situations leads to short-term reductions in anxiety, making it more likely that patients will continue to avoid.

In the longer term this means that trigger situations become ever more frightening and patients never learn that their feared consequence doesn't occur. Other subtle forms of avoidance might involve carrying certain objects (e.g. water or medication) or having to be with certain people to enter particular situations. Again, these safety behaviours serve to maintain the problem.

C6 Managing panic

Steps in the low-intensity treatment of panic disorder

1. Assessment and information gathering

Psychological wellbeing practitioners need to gather detailed and individualised information about the symptoms of the patient's panic attacks and what they did. Clinically, a good technique is to ask the patient to recall a recent incident of panic as patients tend to have good recollection of what was a very frightening event. Questions should elicit:

- What physical and mental symptoms the patient experienced.
- What they thought was happening and their interpretation of the symptoms.
- How they felt.
- What they did – probe for safety behaviours.

The patient should be asked whether this incident was typical of what they experience during a panic attack. Further information and monitoring data can be gleaned through the use of a **Panic diary** (see sample at the end of this section). The first five columns can be used initially to ascertain the situation, the intensity of the panic, the physical symptoms they experienced, what they thought was happening and what they then did.

2. Information giving

Patients need to learn about the nature of anxiety symptoms and the 'fight-flight' response. This can be achieved by a variety of means- verbal explanation or by giving reading materials and self-help leaflets (see Suggested reading for details). Once they can begin to re-conceptualise the symptoms as those of anxiety rather than anything more sinister then their sense of panic should reduce. Often, psycho-education alone can have a major impact in panic patients.

There are also some very brief exercises which patients can be encouraged to undertake to illustrate that hypervigilance and focusing on their bodies can be unhelpful. For example, asking patients to focus on their breathing or their pulse for a few minutes can make them more anxious and illustrate the link between focusing on their bodily symptoms and anxiety.

Workers need to give patients information about the range of possible treatment interventions in order to promote choice and engagement in treatment. Each of the treatment options should be accompanied by clear rationales.

C6 Managing panic

3. Low-intensity treatment options

If patients are avoiding situations or are using safety behaviours in order to cope when entering particular situations they can be given a rationale for graded exposure to help them overcome their avoidance. (see **C4, Exposure**). Typically, exposure would work by facing the feared situations until habituation occurs and this can be graded by developing a hierarchy of feared situations and then gradually working up this hierarchy whilst eliminating safety behaviours.

Cognitive restructuring (see **C2**) can also be used to help patients respond to their catastrophic thoughts about what their symptoms mean. As they learn more about normal anxiety mechanisms it should be possible to help them reattribute different explanations to their symptoms. As they learn how to do this, the final column of the **Panic diary** can be used to identify alternative (non-catastrophic) explanations of what is happening that patients can use to challenge their frightening thoughts when experiencing panic.

Patients can also use behavioural experiments to test out their predictions of what might happen if they face the feared situation. This can be a powerful form of experiential learning. Sometimes, symptom induction experiments can be used to create the symptoms typically experienced in a panic attack and for patients to learn that their feared consequence doesn't occur (see Wells 1997 Chapter 5 for some tips on these).

Some self-help materials on the treatment of panic advocate teaching patients breathing control or relaxation techniques. Caution needs to be exercised here. Whilst it may be useful for a patient to understand that hyperventilation makes their symptoms worse and that healthy breathing might be helpful, it is important that workers do not reinforce the idea that the patient's anxiety symptoms are dangerous and that patients need to use relaxation techniques or breathing control in order to overcome their problem. To do so runs the risk of workers inadvertently encouraging patients to adopt more safety behaviours.

C6 Panic diary

Date and situation Where, when, with whom	**Intensity of panic** Rate from 0 - 100	**Physical symptoms** List	**Feared consequences** What did I think the symptoms meant? Rate your belief in these thoughts from 0 – 100%	**Behaviour** What did I do?	**Alternative explanation for symptoms**

C7 Sleep hygiene

Sleep hygiene involves the practice of following guidelines to promote more restful and effective sleep, to increase daytime alertness and to overcome problems with sleeping at night. Sleep problems are a common feature of anxiety and depression and providing patients with information about sleep hygiene is an important part of the role of psychological wellbeing practitioners.

Steps involved in promoting sleep hygiene

Step 1: Establish the nature of the patient's sleep difficulties

Gather information about the nature of the patient's concerns about sleep. These may include any of the following:

- Getting off to sleep.
- Staying asleep.
- Waking too early.
- Fitful sleep.
- Not feeling refreshed after sleep.
- Worrying about sleep

Elicit the detail of the patient's patterns of sleep. When do they go to bed? How long do they sleep for? What do they do prior to bed? What do they do if they wake up? Do they sleep or nap during the day? What is their level of daytime activity and exercise?

Asking patients to keep a sleep diary can provide useful baseline information and help establish patterns. People may be worrying about their sleep but actually getting enough.

Step 2: Provide information about normal sleep and the nature of sleep problems

There are no set rules about how much sleep people need – it varies from person to person. Whilst seven to eight hours sleep may be typical, some people need more and some less. Sleep patterns vary with age, with older people often needing less sleep than younger adults. Sleep is affected by the amount of physical activity people engage in.

Sleep problems may be caused by a number of factors:

- Medical problems such as pain or arthritis.
- Emotional problems such as stress, anxiety and depression.
- Certain medicines.
- Bladder problems, often affected by ageing
- Drug and alcohol use.
- Environmental factors such as a noisy, light or uncomfortable bedroom.

In anxiety and stress people often report difficulty in getting off to sleep. Sleep is often fitful and people wake feeling un-refreshed. In depression, early-morning waking is often a problem as well as difficulty getting off to sleep. People who are depressed are often less active during the day but, because they lack energy, they may be tempted to sleep during the day, which makes it difficult to sleep well at night (see section **C1 Behavioural activation**).

C7 Sleep hygiene

Step 3: Provide information on sleep hygiene and encouraging patients to establish regular sleep routines

Psychological wellbeing practitioners should try to problem solve sleep difficulties with patients, having ascertained the nature of their difficulties. The following tips are generally regarded as good advice on sleep hygiene:

- Try to establish a pattern of going to bed at the same time and arising at a set time each day.
- Avoid sleeping during the day but, if naps are taken, ensure that they are short.
- Exercise during the day, preferably outdoors, promotes sleep.
- If people have become inactive, gradually building up activity levels will help.
- Limit the use of stimulants such as nicotine and caffeine in the evening prior to bed.
- Avoid excessive alcohol as its soporific effects tend to be short lived.
- Try to ensure that the bedroom is quiet, cool and dark and that the mattress is comfy.
- Limit stimulating activities in the hour or so before bedtime.
- Avoid going to bed too hungry or too full.
- Try to do things which feel relaxing prior to bed, e.g. having a bath, taking a milky drink, listening to relaxing music.
- Try to avoid worrying about getting enough sleep – encourage patients to think of other things such as relaxing or pleasurable activities. Trying to command ourselves to go to sleep is counter-productive.
- If people haven't got off to sleep after half an hour or so, encourage them to get up, go to a different room and participate in a quiet activity until they feel sleepy and then return to bed.

Step 4: Monitor the effects of the above

Continuing to use sleep diaries can provide useful feedback on progress. Discuss any problems and try to establish any triggers for good or bad nights.

Sources of useful information

Newcastle, North Tyneside and Northumberland Mental Health NHS Trust. 2002. Sleep problems: a self-help guide. Newcastle: NTW NHS Trust.

University of Maryland Sleep Disorders Centre **http://www.umm.edu/sleep/sleep_hyg.html**

Record Keeping

The record sheets in the next few pages can be used to record supervision. It is important that you keep a copy for yourself as well as ensuring the PWP also retains a copy of all relevant forms. These will be required by PWPs for accreditation purposes. Please photocopy as required. Although other locally developed forms can be used, we recommend the following forms and that the supervision log in particular contains the following information.

Supervision Log

Date	**Nature of Supervision** Face-face (FF) Telephone (T) Email (E)	**Type of Supervision** Clinical Case Management (CCMS) or Clinical (CS)	**Length of Time** (mins)	**Student Signature**	**Clinical Supervisor Signature**

Record of Supervision

Student's Name		
Clinical Supervisor's Name		
Date		
Module		
Nature of Supervision (Please tick)	**Face-face (FF)**	
	Telephone (T)	
	Email (E)	
Type of Supervision (Please tick)	**Clinical Case Management (CCMS)**	
	Clinical (CS)	
Feedback on any actions from previous session		
Summary of key issues discussed		

Record of Supervision

Actions arising from this session	By whom

Date of next supervision session / contact	

Student's signature _____ Date _____

Clinical supervisor's signature _____ Date _____

One copy should be completed and given to the supervisor, original to be retained by the PWP.

Practice Outcomes

The curriculum includes a number of clinical practice outcomes which must be achieved by students in practice settings in order to successfully complete the programme. Students need to be allocated a suitably qualified clinical supervisor who can assess the student's competence in clinical practice. Institutions offering this curriculum will need to design a portfolio in which students provide evidence to demonstrate the achievement of these practice-based outcomes, signed off by their clinical supervisor. In this section we provide guidance on the role of the clinical supervisor, suggest sources of evidence that can be used by supervisors and provide a sample sheet for recording progress in the portfolio.

The practice-based outcomes for each of the four modules are:

Recognition: Module 1

- Formulating and recording mental health care assessments appropriate to the identified needs of patients.
- Demonstrating the common factor competences necessary to develop individualised therapeutic alliances that enable patients (and where appropriate their carers) to be purposefully involved in a partnership of care.

Recovery: Module 2

- The identification and management of patients' emotional distress and disturbance through the use of interpersonal skills and evidence-based interventions.
- Demonstrating the techniques necessary to develop and maintain individualised therapeutic alliances that enable patients (and where appropriate their carers) to be purposefully involved in a partnership of care.
- High quality case recording and systematic evaluation of the process and outcomes of mental health interventions, adapting care on the basis of these evaluations.

Respect: Module 3

- The effective engagement of people from a range of social and cultural groups in low-intensity treatments.
- Demonstrating the ability to engage with groups representing diverse cultural communities to improve the knowledge and understanding of different cultural values.
- Where appropriate, displays competence in the use of face-to-face and telephone translation services for people whose first language is not English.

Reflection: Module 4

- The effective management of a case load to ensure prompt and efficient access to care for patients on the worker's case load including referral to step up and signposted services.
- Demonstrating the ability to use regular scheduled supervision to the benefit of effective case management and personal development.
- Integration of worklessness and employment initiatives into daily clinical practice to the benefit of all patients.

The role of the clinical supervisor

Clinical supervisors need to be experienced practitioners who are familiar with the range of low-intensity interventions identified in this curriculum. As well as providing general support, the role of the clinical supervisor involves monitoring and assessing the competence of the student through a variety of methods. The clinical supervisor will therefore guide the student's development and formally assess the achievement of the clinical practice outcomes identified in the low-intensity curriculum.

Pages 54-56 taken from *Reach Out National Programme Educator Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions*. 2nd edition David Richards and Mark Whyte.

Practice Outcomes

Specific roles of the clinical supervisor

- Negotiate, sign and date a supervision contract clarifying boundaries and responsibilities of the supervisor and supervised student.
- Use a range of strategies to engage in the supervision process, including focused face-to-face contact, allocated telephone appointment time and e-mail contact.
- Facilitate ongoing practice teaching and experience for the student to ensure she or he has the opportunity to develop appropriate competence in clinical skills.
- Carry out observation of student's work, directly and indirectly, to develop and assess the level of competence.
- Identify the student's strengths and any shortfalls in development, identifying objectives with the student and how these may be achieved, and discussing with academic staff where difficulty is envisaged or encountered.
- Ensure that summative assessment of clinical skill competence is completed within the stated period of the practical skills assessment document, and that appropriate records are made.
- Where necessary, to raise issues regarding a student's progress with appropriate members of the staff of the institution delivering the low-intensity curriculum.
- Ensure with the student that supervision records are completed so that there is a record of supervisory contacts. Institutions will need to design a recording format.
- Complete an interim report on progress at the halfway point of the timescale for the achievement of the practice-based outcomes.
- Make a final decision on the progress of the student in achieving the practical skills outcomes for the module.

Possible sources of evidence for the demonstration of achievement of the practice-based outcomes

Clinical supervisors need to satisfy themselves that they have sufficient evidence of competence by the student in order to sign off the achievement of the practice-based outcomes. Sources of evidence could include:

- Direct observation of the student, either face-to-face or via audio / video recordings.
- Examination of students' clinical records and discussion of cases.
- Observation of students in simulated practice.
- Reflective commentaries by students on their clinical work.
- Testimony from other colleagues.
- Testimony volunteered by patients.

Preparation of clinical supervisors

Institutions providing the curriculum will need to ensure that clinical supervisors are briefed on the curriculum, course content and expectations surrounding their roles.

It will be for individual institutions to determine the particular processes and documentation for the assessment of the practice-based outcomes identified within the curriculum.

Practice Outcomes

Sample evidence sheet

Clinical Practice Outcome
Formulating and recording mental health care plans appropriate to the assessed needs of patients.

EVIDENCE (to be identified by student)

Using the space below, provide a reflective summary of how you have achieved the above outcome and document the nature of the evidence which you are presenting to your clinical supervisor.

Student's signature _____ Date _____

I confirm that the student has demonstrated satisfactory evidence of competence and has achieved the above practice learning outcome.

Clinical supervisor's name _____ (please print)

Clinical supervisor's signature _____ Date _____

reference

A full set of refernces are available on pages 54-56 of the Student Guide

What Supervisor Competences are required for Supervising PWPs?

Roth and Pilling (2008) have devised competences for Supervisors in Psychological Therapies. Specific competences have been devised for Low Intensity Supervision.

This work is available at: www.ucl.ac.uk/CORE/

Generic supervision competences	Specific supervision competences	Applications of supervision models/contexts	Meta-competences
Ability to employ educational principles enhancing learning	Ability to help the supervisee practice specific clinical skills	Supervision of clinical case management	Supervision metacompetences
Ability to enable ethical practice	Ability to incorporate direct observation into supervision	Supervision of Low Intensity interventions	
Ability to foster competence in working with difference	Ability to conduct supervision in group formats	Supervision of Cognitive and Behavioural Therapy	
Ability to adapt supervision to the organisational and governance context	Ability to apply standards	Supervision of psychoanalytic / psychoanalytic therapy	
Ability to form and maintain a supervisory alliance		Supervision of systemic therapy	
Ability to structure supervision sessions		Supervision of humanistic-person-centred/experiential therapy	
Ability to help the supervisee present information about linical work			
Ability to help supervisee's ability to reflect on their work and on the usefulness of supervision			
Ability to use a range of methods to give accurate and constructive feedback			
Ability to gauge supervisee's level of competence			
Ability for supervisor to reflect (and act on) on limitations in own knowledge and experience			

The Competences required by Low-intensity Supervisors

Supervisor's Expertise

An ability to draw on knowledge of the principles underpinning low intensity interventions.

An ability to draw on personal experience of the clinical applications of low intensity interventions.

An ability to recognise (and to remedy) any limitations in knowledge and/or experience which has implications for the supervisor's capacity to offer effective supervision.

An ability to ensure that supervision integrates attention to generic therapeutic skills (e.g. the ability to maintain a positive therapeutic alliance, an ability to respond appropriately to client's distress) while also focussing on the development and /or maintenance of skills specifically associated with low intensity interventions.

Adapting supervision to the supervisee's training needs

An ability to identify the supervisee's knowledge of, and experience with, low-intensity interventions.

An ability to identify and discuss any misconceptions that the supervisee may hold regarding the rationale for, and application of, low intensity interventions.

An ability to help the supervisee draw on knowledge of the rationale for low intensity interventions, and on the evidence base for their use.

Ability to support the supervisee in assessing suitability for low-intensity interventions

An ability to help the supervisee assess the appropriateness of a low intensity intervention for the client's identified problem.

An ability to help the supervisee develop their capacity to deliver evidence-based clinical and risk assessment tools (including routine outcome measures).

Ability to support the supervisee's delivery of low-intensity interventions

An ability to assess the supervisee's capacity to deliver and adhere to protocol-driven low intensity CBT interventions.

An ability to give advice and guidance on the conduct of specific low-intensity CBT techniques (e.g. guided self-help, CCBT, medication concordance, exposure and behavioural activation).

An ability to identify any difficulties the supervisee has working within a protocol-driven low intensity service and support them in overcoming these difficulties.

An ability to support and develop the supervisee's capacity to communicate effectively with other professionals about the outcome of the intervention.

An ability to support and develop the supervisee's capacity to alert relevant colleagues when there are any significant concerns about the client.

The Competences required by Low-intensity Supervisors (continued)

Ability to support routine outcome monitoring

An ability to monitor and support the supervisee's collection and clinical use of routine outcome measurement.

An ability to monitor and support the supervisee's use of routine outcome measures to evaluate the overall outcomes of the service provided.

Ability to support decisions about the appropriateness of interventions

An ability to help the supervisee decide when it is appropriate to maintain a client on a low-intensity intervention.

An ability to help the supervisee recognise when low-intensity interventions are unlikely to provide further benefit.

An ability in conjunction with the supervisee, to determine when it is appropriate to step a client up to more intensive therapy.

Notes

Notes

iapt

Improving Access to Psychological Therapies

NHS

National Mental Health Development Unit

rethink