

# Reach Out

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

David Richards and Mark Whyte

2nd edition



**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.**

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First published in the UK by Rethink 2008  
Reprinted by Rethink July 2008  
Reprinted by Rethink August 2009, 2nd edition

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Research Council and the National Institute for Health Research which is examining new models of delivering treatment including stepped care, guided self-help and collaborative care. The results of this research programme have been fundamental to the clinical and educational methods pioneered by the IAPT demonstration site in Doncaster and now implemented nationally.



**Mark Whyte** was a Lecturer in Mental Health at the University of York until his retirement in 2009. He has extensive experience of the design, development and delivery of mental health education programmes. He is committed to expanding access to psychological therapies for people experiencing common mental health problems and equipping practitioners with the knowledge and skills to deliver patient-centred evidence-based treatments. He taught on the Graduate Primary Care Mental Health Worker programme and the Short-term CBT course at York and, with David, played a key role in the development of the clinical model, and associated training, at the IAPT National Demonstration site in Doncaster and several IAPT wave one sites nationally.

## 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.

We would also like to thank Roslyn Hope and Graham Turpin for commissioning these materials. The materials themselves are the culmination of more than 20 years of effort in 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.

Most importantly of all, however, we must place in the public record the contribution of Isaac Marks. More than 30 years ago, and 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. None of the last 20 years would 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 Chloe Kyle and Lauren Bourque.

Thanks are also due to Della Bailey, Abi Coe, Clare Walker, Sarah Khalid and Gemma Cheney 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, Exeter and Mark Whyte, York, August 2009**

## Reach Out: Preface to the second edition

During 2008 and 2009, the first IAPT low-intensity training courses were commissioned and began to train their first workers. The first edition of these Reach Out materials was quickly snapped up. During 2008-2009 the IAPT national team, clinical services and education providers all learnt a lot through the roll out of IAPT to 35 new sites. In 2009-2010 over 100 mental health provider organisations will come on stream and a number of new courses will begin. The opportunity arose to revise and reprint these materials in time for the next cohort of trainees.

Feedback from educators and students was extremely positive about the quality and content of the materials. Many people also made very helpful suggestions as to ways in which they could be amended. As a consequence we have edited the materials to take account of these suggestions.

The main difference is in the name. Few people were happy with the term, 'Low-intensity Worker' and the IAPT Board agreed the new name of 'Psychological Wellbeing Practitioner'. We have incorporated this change throughout the materials. We also found that students were downloading the educators' manual to access the module details and competency assessment guidelines and rating sheets. Educators were also using competency assessment rating sheets in their feedback on student clinical simulation role plays. Therefore, the student manual now contains an appendix with module details and all the assessment materials. Each module description is also accompanied by a list of the suggested reading and resources specifically related to the learning needs of the module, as some students found it difficult to distinguish which references they should use from the amalgamated list at the back of the student guide.

The reference section of the teachers' guide has been replaced by more recent work, specifically the job descriptions for both trainee and qualified Psychological Wellbeing Practitioners. Following feedback from the first round of courses, the competency assessment for module 4 (A7) has been rewritten to give a better balance of percentage marks across the various competency domains. Reference to the elusive publication, 'Richards and Whyte, 2008' has been withdrawn and in its place we have inserted its replacement, due to be published by Oxford University Press in May 2010: 'The Oxford Guide to Low Intensity CBT Interventions', edited by James Bennett-Levy, David Richards, Paul Farrand and colleagues; a multi-author, international textbook for practitioners delivering low-intensity interventions.

We would also like to draw readers' attention to the work on the 'Ten Essential Shared Capabilities: A framework for the whole of the mental health workforce'. This was developed and published in 2004, with people who use mental health services and their carers, to identify what would make a real difference to them in their experience of care. This was in response to their enduring call to be listened to, empowered and valued for their experience of dealing with their own distress. Respecting Diversity, Challenging Inequality, Promoting Recovery, Promoting Safety and Positive Risk Taking are some of the Shared Capabilities, as is Making a Difference, which highlights the importance of evidence and values based practice. All professional bodies, employers and training courses were asked to implement the 10ESC, which has happened to a variable degree. Learning materials were developed and evaluated and these are now available on a DVD, together with other relevant values based materials. This is an important source of learning to support module 3. These can be obtained from [imcgonagle@lincoln.ac.uk](mailto:imcgonagle@lincoln.ac.uk) or on the website of the Centre for Clinical & Academic Workforce Innovation (CCAWI) <http://www.lincoln.ac.uk/ccawi/publications/Ten%20Essential%20Shared%20Capabilities.pdf>. For further reading consult: Stickley & Bassett, (2008). Learning about Mental Health Practice, Wiley.

In the course of the twelve months from the publication of the first edition of these materials IAPT has published a considerable amount of guidance on its website. Foremost among these are *The National Plan, Curricula for High and Low intensity Therapy Training, Commissioning for the Whole Community, The IAPT Equality Impact Assessment, Special Interest Group Good Practice Guides, The Supervision Good Practice Guide* and materials from a conference on self-help in February 2009. These important documents can all be accessed on <http://www.iapt.nhs.uk/publications/>.



Finally, we would like to thank Roslyn Hope and Graham Turpin for their continued support and our appreciation goes to all the people who made suggestions for improvement. We hope we have addressed people's ideas and that this edition of the materials represents an enhancement to the first edition.

**David Richards, Exeter and Mark Whyte, York**  
August 2009

# Foreword

by Ann Bowling, Patient Advisor to the IAPT programme

As one of the Patient Advisors to Improving Access to Psychological Therapies (IAPT), I have been continuously involved with its planning, implementation and growth. My initial input was with the pilot project in Doncaster and then subsequently expanded to include the national picture.

The appointment and training of the Case Managers, now known as Psychological Wellbeing Practitioners, is obviously of paramount importance. They require a broad base of low-intensity clinical knowledge to add to their existing life skills and previous experience to enhance their professionalism and confidence. They will be faced with an extremely wide variety of challenges as they offer relevant advice and interventions to their patients, and it is imperative that the training they receive fully reflects this need. The evidence of this that I have so far witnessed has been both impressive and inspiring. The material being made available here bears full testament to all that has been available to them along the steep learning curve.

I am particularly happy that this is a collaboration between Rethink and a number of universities. I firmly believe that academia, advocacy organisations and the patients themselves should always have an equal voice when deciding the way current and future needs are met.

I write this as someone who has personal experience of the dark world of depression and whose own care and interventions, although superb, were plagued by interminable waiting lists – so difficult to cope with when you already feel that your life has been placed on hold. So much to lose and such an awful waste of precious time. Imagine then how delighted and impressed I am by the wonderful service that is now available to more and more of those who are unfortunate to find themselves in similar circumstances.

With the quality of training described and illustrated here, there is every reason to believe that the achievement and success of a far brighter mental health future will very soon be evident nationwide.

## A note on terminology

Choosing the correct term to describe people receiving mental health care is a contested area. The term 'patient' has been criticised by some as a label, and one which implies a passive relationship with health care providers. As a consequence, psychological therapists often use the term 'client', whereas specialist mental health services and advocacy groups prefer the term 'service user'.

However, when interviewed, most people experiencing depression and anxiety do in fact prefer the term 'patient'. This term is consistent with people's experiences of seeking help for

physical health complaints from primary care. The use of the term 'patient' helps to normalise the experience of mental distress and de-stigmatise mental health problems. Further, many people with these conditions may consult health services infrequently and do not regard themselves as regular 'service users'. We have therefore chosen to use the term 'patient' in these materials. However, educators and workers alike should always remember that those suffering from mental health difficulties are firstly always people, and only very secondly are they patients.

reshape

Introduction

# Reshape

## Introduction

Psychological wellbeing practitioners delivering low intensity interventions assess and support patients with common mental health problems (principally anxiety and depression) in the self-management of their recovery. Treatment programmes are designed to aid clinical improvement and social inclusion – including return to work or other meaningful activity. Psychological wellbeing practitioners do this through the provision of information and support for evidence-based low-intensity psychological treatments, mainly involving cognitive behavioural therapy (CBT).

Low-intensity psychological treatments place a greater emphasis on patient self-management and are less burdensome than traditional psychological treatments. Examples include guided self-help and computerised CBT. Support is specifically designed to enable patients to optimise their use of self-management recovery information and may be delivered through face-to-face, telephone, email or other contact methods. Psychological wellbeing practitioners delivering low intensity interventions are expected to operate in a stepped-care, high-volume environment carrying as many as 45 active cases at any one time, with workers completing treatment of between 175 and 250 patients per year. Psychological wellbeing practitioners also provide information on common pharmacological treatments and support patients in decisions which optimise their use of such treatments.

Psychological wellbeing practitioners will operate within the Improving Access to Psychological Therapies (IAPT) service delivery model defined in the IAPT business plan agreed by the UK Treasury Comprehensive Spending Review settlement in 2007. This delivery model requires workers to collect, as a matter of routine, clinical, social and employment outcomes at each treatment session, as part of a national outcome system. The performance of workers will, therefore, be measured through their clinical, social and employment outcomes. Likewise, the performance of courses implementing this curriculum will be judged on the ability of their graduates to achieve these outcomes in practice.

The curriculum is based on four modules delivered over 45 days in total. Although each module has a specific set of foci and learning outcomes, the clinical competences build module upon module and courses will be expected to focus the majority of their classroom activity on clinical competency development through clinical simulation / role play. All modules will be assessed on participants' practical demonstration of competences, according to pass / fail criteria. Participants will not necessarily possess previous clinical or professional expertise in mental health, and will be able to undertake academic assessments at either undergraduate or postgraduate level, depending on their prior academic attainment. Skills based competency assessments will be independent of academic level and must be achieved according to a pass / fail criterion.

### **Recognition: Module 1**

**Engagement and assessment of patients with common mental health problems**

### **Recovery: Module 2**

**Evidence-based low-intensity treatment for common mental health disorders**

### **Respect: Module 3**

**Values, policy, culture and diversity**

### **Reflection: Module 4**

**Working within an employment, social and healthcare context**

## The low-intensity clinical method

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 modules.

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). Low-intensity treatment is part of the stepped care system recommended for depression and most anxiety disorders (NICE, 2007a; 2007b).

Cognitive behavioural therapy is the theoretical underpinning of the low-intensity psychological therapies used in this curriculum. The evidence for specific factors in psychological therapy points to the greater effectiveness of cognitive behaviour therapy when delivered in a low-intensity format (Gellatly et al, 2007; Hirai and Clum, 2006) compared to other types of treatment.

## How to use these materials

The curriculum and these accompanying materials will enable teachers to develop courses for psychological wellbeing practitioners delivering low intensity interventions, with a particular emphasis on clinical skills. The course has been developed as a postgraduate certificate. However, in order to promote access to students with different academic starting points, particularly people who are non-graduates, courses should be designed so as to allow for a range of entrance requirements for accrediting the training of suitably experienced candidates. Such arrangements will be decided on a local institutional basis and can use a) advanced standing procedures to allow applicants to provide the evidence that they can work at a graduate level and could successfully complete the post graduate programme and / or b) the possibility for course delivery at final year undergraduate as well as post-graduate certificate level. Where more than one level of course delivery is to be implemented, education providers may need to rewrite some learning outcomes together with assessment procedures using suitable language to provide the course at undergraduate level. Please see the IAPT Workforce Team briefing, May 2008 for further clarification.

Each learning outcome in the curriculum is presented separately. Each learning outcome is also described in more detail and suggested teaching methods are identified. Each student should be given a copy of '**Reach Out: Student Support Materials for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions**'.

Some learning outcomes also include additional materials. This is particularly true for module 2, where brief descriptions of low-intensity clinical procedures are provided. These materials do not replace more detailed study sources. However, they represent a distillation of much of what psychological wellbeing practitioners delivering low intensity interventions will find themselves undertaking clinically. Many workers adapt such materials as patient handouts. Each learning outcome also includes a description of how it should be assessed. Suggested assessments include a combination of written and practical

# Reshape

assessments. Finally, each learning outcome is accompanied by a list of further sources of information.

Teachers should use the curriculum and the curriculum materials to plan courses and individual learning sessions. We have not presented detailed learning session plans, nor replicated information widely available in the source materials listed. Rather, we have provided materials which will allow teachers to construct courses tailored to individual organisational situations.

Much of the material is practical and skills based. The film clips in particular allow teachers and students to observe the required competences in detail. We have provided materials to assist teachers and students when undertaking practical skills competences exercises in clinical simulations: interview schedules, planning guides and supervision guides. We have also provided skills based competences assessment sheets for all four module assessments and a model practice-based skills assessment portfolio.

## Suggested teaching methods

Teachers will need to use a variety of teaching and learning methods to enable students to achieve the learning outcomes within the curriculum. In order to achieve competence, students will need to understand the nature of the skills employed and the rationale and theoretical basis for them. This cognitive component can be achieved by lectures, guided reading and student presentations, and by observing the skills being modelled.

The key components of low-intensity interventions are the 'common' and 'specific' factor skills which underpin them. These need to be broken down into the associated micro-skills so that students understand what they are, can identify when they are being demonstrated, and can engage in repeated practising of the skill in order to develop their own competence. For example, when using questioning skills to gather information, students would need to be able to distinguish between general open questions (e.g. "What would you say

is your main problem?"), specific open questions (e.g. "What do you do when you can't get to sleep?") and closed questions to clinch detail (e.g. "Do you drink caffeine before going to bed?").

## Teaching skills are undertaken in the following ways:

**Modelling:** observing the key skills is a crucial part of developing students' competence. We hope that the film clips will provide useful examples of these skills but they are usefully supplemented by teachers modelling particular skills in the classroom.

**Simulated practice:** having learnt what a skill comprises, students need lots of opportunity to practise before using it in real life encounters with patients. Teachers should create scenarios and vignettes to support role play and skills practice and provide clear instruction on what it is that the students are expected to demonstrate.

**Feedback:** when students are engaged in small group role play and skills practice it is crucial that they are able to develop the skill of giving each other detailed, specific and constructive feedback. It is likely that teachers will need to model feedback skills to students which are safe, constructively critical and non-confrontational. We have provided an example of a feedback sheet on page 10 which students and teachers can use to give specific feedback.

**Reflection:** all teaching and learning activities should promote students' ability to reflect on their own performance and personal development. Learning activities and assessments should incorporate reflection by students on what they have done well and how they could improve their performance, linked to an understanding of the rationales for particular skills and an ability to accurately identify their use.

Written into the Department of Health Curriculum Document is the expectation that students will spend one week at the beginning of the course in intensive, classroom based skills practice. In our experience, this is critical to make the best of the skills based competency teaching which underpins this course. Five consecutive days of intensive clinical skills simulation practice, with modelling and accurate feedback, is a highly effective way of ensuring both novice and qualified mental health workers acquire the critical patient-centred clinical competences required for low-intensity working. This week should be immediately followed up by weekly skills practice days, observation in clinical environments and, as students develop the required competences, supervised practice with patients. In our experience, students can begin to see patients under supervision within six to ten weeks of starting a course.

## Assessment methods

Each module is assessed by means of an exam, a skills based exercise and a practice based assessment portfolio. Exams can be a range of formats, for example, multiple choice, short answers or essays. The requirements for examinations differ in different institutions and, therefore, we have not included an exam in these materials.

We have, however, included skills based exercise assessment sheets. These delineate the core competences included in the curriculum. Students should be able to demonstrate these competences to the satisfaction of examiners. The most effective way of examining the attainment of the patient-centred competences in modules 1, 2 and 4 is through filming and recording students' performance in clinical simulation sessions with actors. Module 3 is best assessed through a case presentation. Although it is possible to give students a percentage mark for these assessments, they are marked as pass / fail since these types of competences are essentially attained or not. Students should pass all the required sections of the assessment indicated in each module's assessment sheet.

## Suggested reading

Gellatly, J. et al., 2007. What makes self-help interventions effective in the management of depressive symptoms? Meta-analysis and meta-regression. *Psychological Medicine*, 37, p.1217-1228.

Hirai, M. & Clum, G., 2006. A meta-analytic study of self-help interventions for anxiety problems. *Behavior Therapy*, 37 (2), p.99-111.

Holford, E., 2008. Improving access to psychological therapy: the Doncaster demonstration site organisational model – commentary. *Clinical Psychology Forum*, 181, p.22-24.

National Institute for Clinical Excellence, 2007a. Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2009. Depression in Adults (update), Depression: the treatment and management of depression in adults. London: National Institute for Clinical Excellence.

Richards, D. & Suckling, R. 2008. Improving access to psychological therapy: The Doncaster demonstration site organisational model. *Clinical Psychology Forum*, 181, p.9-16.

Roth, A. & Pilling, S., 2007. The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders. London: Department of Health.

## Clinical simulation feedback sheet

	Identify the specific skills demonstrated in the interaction in each of the areas	Indicate things that you would like to have seen being done differently
<b>Introduction</b>		
<b>'Common Factors' Skills</b>		
<b>Information Gathering</b>		
<b>Problem Statement, Information Giving and Shared Decision Making</b>		
<b>Ending</b>		



# recognition

## Module 1

engagement and assessment of patients  
with common mental health problems

# Recognition

## Aims of module

Psychological wellbeing practitioners delivering low intensity interventions assess and support people with common mental health problems in the self-management of their recovery. To do so, they must be able to undertake a patient-centred interview which identifies both the person's main difficulties and areas where the person wishes to see change and / or recovery, and which makes an accurate assessment of the risk the person poses to self or others. Psychological wellbeing practitioners need to be able to engage patients and establish a therapeutic alliance while gathering information to begin assisting the patient to choose and plan a collaborative treatment programme. They must have knowledge of mental health disorders and the evidence-based therapeutic options available, and be able to communicate this knowledge in a clear and unambiguous way so that people can make informed treatment choices. This module will, therefore, equip workers with a good understanding of the incidence, prevalence and presentation of common mental health problems, and of evidence-based treatment choices.

Skills teaching will develop workers' core 'common factors' competences of active listening, engagement, alliance building, patient-centred information gathering, information giving and shared decision making.

## Learning outcomes

1. Demonstrate knowledge, understanding and critical awareness of concepts of mental health and mental illness, diagnostic category systems in mental health and a range of social, medical and psychological explanatory models.
2. Demonstrate knowledge of and competence in using 'common factors' to engage patients, gather information, build therapeutic alliances, manage the emotional content of sessions and grasp the patient's perspective or world view.
3. Demonstrate knowledge of and competence in patient-centred information gathering to arrive at a succinct and collaborative definition of the patient's main mental health difficulties and the impact these have on their daily living.
4. Demonstrate knowledge of and competence in recognising patterns of symptoms consistent with diagnostic categories of mental disorder from a patient-centred interview.
5. Demonstrate knowledge of and competence in recognition and accurate assessment of the risk posed by patients to themselves or others.
6. Demonstrate knowledge of and competence in the use of standardised symptom assessment tools and other psychometric instruments to aid problem recognition and definition and subsequent decision making.
7. Demonstrate knowledge of and competence in giving evidence-based information about treatment choices and in making shared decisions with patients.
8. Demonstrate understanding of the patient's attitude to a range of mental health treatments, including prescribed medication and evidence-based psychological treatments.
9. Demonstrate competence in accurate recording of interviews and questionnaire assessments using paper and electronic record-keeping systems.

## Learning and teaching strategies

### Knowledge

Lectures  
Seminars  
Discussion groups  
Guided reading  
Independent study

### Skills

Clinical simulation in small supervised groups  
Supervised practice through direct patient contact

## Assessment strategies

A standardised role-play scenario where workers are required to demonstrate skills in engagement, information gathering, information giving and shared decision making. This will be filmed and assessed by teaching staff using a standardised assessment measure.

Workers must also provide a 1,000-word reflective commentary on their performance.

Both parts must be passed.

An exam to assess module knowledge against the learning outcomes.

Successful completion of the following practice outcomes:

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

Knowledge assessments are at undergraduate and / or postgraduate level and assessed using percentage criteria. Skills based competency assessments are independent of academic level and must be achieved according to a pass / fail criterion.

## Duration

**11 weeks, 15 days in total, running parallel with module 2:**

- Five days intensive skills practice undertaken in a one-week intensive workshop.
- One day per week for 10 weeks, half the time to be spent in class in theoretical teaching and clinical simulation, the other half in the workplace undertaking supervised practice.

## Learning outcome

Demonstrate knowledge, understanding and critical awareness of concepts of mental health and mental illness, diagnostic category systems in mental health and a range of social, medical and psychological explanatory models.

## Knowledge and skills

### The student should be able to:

- articulate knowledge of DSM and ICD categorisation systems in mental health.
- understand the similarities and differences between a diagnostic model and a patient centred model of health care and other models such as social, psychological and contextual.
- understand prevalence and phenomenological information for both common and low-prevalence mental health problems.
- understand the impact of culture, class, ethnicity and gender on prevalence and help seeking.
- understand the policy context within which health care is delivered and how it relates to psychological therapies, including the concept of evidence-based treatments, guidelines and policy directives.

## Assessment

This outcome is tested in the exam by assessing students' knowledge of diagnostic systems, models of mental health, prevalence, phenomenology, aetiology and policy, as well as the completion of the relevant practice outcome.

## Suggested reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV. 4th ed. Washington DC.: American Psychiatric Association.

Appleby, L., 2004. The national service framework for mental health – five years on. London: Department of Health Publications.

Department of Health, 1999. National service framework for mental health: modern standards and service models. London: Department of Health.

Department of Health, 2000. The NHS Plan: A plan for investment, a plan for reform. London: Department of Health.

## Teaching aids

There are no specific teaching aids provided for this learning outcome. Teachers should consult the range of policy, clinical and epidemiological literature and classification systems to assist students to attain this objective. Aside from introductions in class, this objective is best achieved by students through directed reading.

Layard, R., 2006. The depression report. London: London School of Economics.

Mead, N. & Bower, P., 2002. Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient Education and Counseling*, 48, p.51-61.

National Institute for Clinical Excellence, 2007a. Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2009. Depression in Adults (update), Depression: the treatment and management of depression in adults. London: National Institute for Clinical Excellence.

Pilgrim, D. & Rogers, A., 2005. Sociology of mental health. 3rd ed. Maidenhead: The Open University Press.

Raistrick, H. & Richards, D., 2006. Designing primary care mental health services. Hyde: Care Services Improvement Partnership.

World Health Organization, 1992. ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- demonstrate verbal empathy, summarising, reflection, clarification, non-verbal and verbal prompts and non-verbal skills such as posture.
- demonstrate warmth and maintain appropriate eye contact while taking notes.
- demonstrate the ability to introduce themselves to patients in a calm, efficient and reassuring manner, ensuring they provide the patient with a clear set of expectations regarding session content and duration.
- manage endings to sessions effectively and efficiently whilst engendering hope in the patient.

## Assessment

This outcome is tested in the exam by assessing knowledge of the theory of alliance building with patients; in the simulation assessment and reflective commentary, where the student should demonstrate, describe and reflect on their common factors skills; and in the practice outcome, where students should demonstrate the common factors competences necessary to develop individualised therapeutic alliances that enable patients (and, where appropriate, their carers) to be purposefully involved in a partnership of care.

## Teaching aids

**I** **Interview** I1

**F** **Film clips** Gathering information 1, Gathering information 2, and Gathering information 4, which demonstrate common factors such as introductions, empathy, reflection, summarising and endings.

**A** **Assessment** A1, A2

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Egan, G., 2001. *The skilled helper: a systematic approach to effective helping*. 7th ed. California: Brooks / Cole.

Heron, J., 2000. *Helping the client: a creative practical guide*. 5th ed. London: Sage.

Mead, N. & Bower, P., 2000. Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science and Medicine*, 51, p.1087-1110.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

Pilgrim, D. & Rogers, A., 2005. *Sociology of mental health*. 3rd ed. Maidenhead: The Open University Press.

Silverman, J., Kurtz, S. & Draper, J., 2005. *Skills for communicating with patients*. 2nd ed. Oxford: Radcliffe Publishing.

## Learning outcome

Demonstrate knowledge of and competence in 'patient-centred' information gathering to arrive at a succinct and collaborative definition of the person's main mental health difficulties and the impact this has on their daily living.

## Knowledge and skills

### The student should be able to:

- demonstrate the use of effective information gathering through non-leading, general open, to specific open and finally specific questions in a patient-centred funnelling approach to gather problem specific detail for all aspects of a patient's problem(s).
- gather information on the physical, behavioural and cognitive aspects of a patient's problem, triggers of the patient's current difficulties and the impact of these difficulties.
- ascertain where patients' problem(s) occur, with whom they are better or worse and when they occur.
- gather information on onset, duration, previous episodes, attitudes to and receipt of past and current treatments, alcohol and drug use, expectations of patients, goals for treatment and other information which patients feel is important to divulge.
- gather information on risk.
- collaboratively agree a problem statement with the patient using triggers, physical, behavioural and cognitive aspects and impact to describe the problem(s) accurately and succinctly.

## Assessment

This outcome is tested in the exam by assessing knowledge of the theory of patient centred interviewing, in particular the nature of information gathering in interviews; in the simulation assessment and reflective commentary, where the student should demonstrate, describe and reflect on their information gathering skills; and in the practice outcome, where students should formulate and record mental health care assessments appropriate to the identified needs of patients.

## Teaching aids

**I** **Interview** I1

**F** **Film clips** Gathering information 1, Gathering information 2 and Problem Statement, which demonstrate how to gather information from patients in a patient-centred and funnelling manner and how to agree a collaborative problem statement.

**A** **Assessment** A1, A2

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Goldberg, D. & Huxley, P., 1992. *Common mental disorders: a biosocial model*. London: Routledge.

Mead, N. & Bower, P., 2002. Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient Education and Counseling*, 48, p.51-61.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

Newell, R. & Gournay, K., 2000. *Mental health nursing: an evidence-based approach*. Oxford: Elsevier Health Services.

## Learning outcome

Demonstrate knowledge of and competence in recognising patterns of symptoms consistent with diagnostic categories of mental disorder from a patient-centred interview.

## Knowledge and skills

### The student should be able to:

- demonstrate how to use information gathered in a patient-centred interview to understand patterns in the patient's symptom presentation. These patterns can be understood in terms of diagnostic systems for common mental health problems.
- differentiate between different anxiety disorders and between anxiety and mood disorders when patients present their difficulties.
- use the specific constellation of autonomic, behavioural and cognitive symptoms to help distinguish between mild, moderate and severe depression and between obsessive, phobic, traumatic or general anxiety disorders.

## Assessment

This outcome is tested in the exam by presenting symptom cluster patterns for recognition; in the simulation assessment and reflective commentary, where the student should describe the patient's presentation in terms of one or more diagnostic systems; and in the practice outcome, where students should formulate and record mental health care assessments appropriate to the identified needs of patients.

## Teaching aids

- I** **Interview I1**
- F** **Film clips** Supervision 1, Supervision 2 and Supervision 3, where psychological wellbeing practitioners discuss their initial assessment of patients with their supervisor.
- A** **Assessment A1, A2**

## Suggested reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV. 4th ed. Washington DC.: American Psychiatric Association.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

World Health Organization, 1992. ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

## Learning outcome

Demonstrate knowledge of and competence in accurate risk assessment and is able to assess and recognise any risks to self and others posed by patients.

## Knowledge and skills

### The student should be able to:

- gather information on risk of suicide, self-harm or neglect to self from the patient.
- determine any risks to other people including family or dependents.
- differentiate between thoughts, plans, actions and preventative factors associated with suicide.
- agree a collaborative summary with the patient on their risk status.
- recognise where additional support is needed for the patient and at what level according to the risk assessment.

## Assessment

This outcome is tested in the exam by seeking answers to questions on risk, in the simulation assessment and reflective commentary where the student should demonstrate, describe and reflect on a risk assessment and in the practice outcome where students should formulate and record mental health care assessments appropriate to the identified needs of patients.

## Teaching aids

### I Interview I1

**F Film clips** Gathering information 1, Gathering information 2, Supervision 1, Supervision 2 and Supervision 3, where psychological wellbeing practitioners gather information on risk during a patient centred interview and discuss their risk assessment with their supervisor.

### A Assessment A1, A2

## Suggested reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV. 4th ed. Washington DC.: American Psychiatric Association.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

Care Services Improvement Partnership, 2006. Primary care services for depression – a guide to best practice, appendix 4: asking about risk. Hyde: Care Services Improvement Partnership.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

National Institute for Clinical Excellence, 2009. Depression in Adults (update), Depression: the treatment and management of depression in adults. London: National Institute for Clinical Excellence.

World Health Organization, 1992. ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- demonstrate knowledge of and the use of a range of standard 'off the shelf' and patient-centred problem scales.
- demonstrate how these measures are sensitively applied, scored, interpreted and fed back to the patient.
- demonstrate the ability to give a sound rationale for the measures used and a full understanding of their implications together with skill in using measures in clinical and supervision situations.

## Assessment

This outcome is tested in the exam by seeking answers to questions on measures, their use and structure; in the simulation assessment and reflective commentary, where the student should demonstrate, describe and reflect on their application of measures in a clinical simulation; and in the practice outcome, where students should formulate and record mental health care assessments appropriate to the identified needs of patients.

## Teaching aids

**I** Interview I1

**F** **Film clips** Gathering information 3 and Supervision 1, where psychological wellbeing practitioners use measures to assess symptoms against patient-centred information and discuss the measures with their supervisor.

**A** **Assessment** A1, A2

## Suggested reading

American Psychiatric Association, 1994. The diagnostic and statistical manual of mental disorders (DSM) IV, 4th edition. Washington DC.: American Psychiatric Association.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

IAPT minimum data set. [www.iapt.nhs.uk/2009/03/improving-access-to-psychological-therapies-key-performance-indicators-and-technical-guidance-2009/](http://www.iapt.nhs.uk/2009/03/improving-access-to-psychological-therapies-key-performance-indicators-and-technical-guidance-2009/)

Gray, P. & Mellor-Clark, J. (eds.), 2007, CORE: A Decade of Development. CORE IMS: Rugby.

Kroenke, K., Spitzer, R. & Williams, J., 2001. The PHQ-9: validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16, p.606-613.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

Spitzer, R. et al., 2006. A brief measure for assessing generalized anxiety disorder: the GAD-7. *Archives of Internal Medicine*, 166, p.1092-1097.

World Health Organization, 1992. ICD-10 Classification of mental and behavioural disorders: clinical descriptions and diagnostic guidelines. Geneva: World Health Organization.

## Learning outcome

Demonstrate knowledge of and competence in giving evidence-based information about treatment choices and in making shared decisions with patients.

## Knowledge and skills

### The student should be able to:

- demonstrate competent and accurate information giving about problems identified in the patient-centred interview and about evidence-based treatment choices for these problems.
- articulate the rationale for a range of CBT based low-intensity treatments, including behavioural activation, self-help recovery programmes and computerised CBT.
- discuss common medicines used to treat anxiety and depression and impart knowledge on effects and side effects.
- give information about interventions offered by both the psychological wellbeing practitioner and other members of health, social care and third sector organisations including employment agencies.
- involve patients in informed collaborative decisions as to choosing treatment.
- demonstrate the competent use of information products such as books, leaflets and CD-ROMS to assist them in their communication of treatment choices and the patient's decision making.

## Assessment

This objective is tested in the exam by seeking answers to questions on evidence based treatment options; in the simulation assessment and reflective commentary, where the student should demonstrate, describe and reflect on information giving and shared decision making at the end of an initial information gathering session; and in the practice outcome, where students should formulate and record mental health care assessments appropriate to the identified needs of patients.

## Teaching aids

**I** Interview I1

**F** **Film clips** Gathering information 1, Gathering information 2 and Medication, where psychological wellbeing practitioners demonstrate information giving and shared decision making with patients.

**A** **Assessment** A1, A2

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Kennerley, H., 1997. *Overcoming anxiety*. London: Constable Robinson.

Lovell, K. & Richards, D., 2008. *A recovery programme for depression*. London: Rethink.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

National Institute for Clinical Excellence, 2007a. *Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2009. *Depression in Adults (update), Depression: the treatment and management of depression in adults*. London: National Institute for Clinical Excellence.

Newell, R. & Gournay, K., 2000. *Mental health nursing: an evidence-based approach*. Oxford: Elsevier Health Services.

Westbrook, D., Kennerley, H. & Kirk, J., 2007. *An introduction to cognitive behaviour therapy: skills and applications*. Michigan: Sage.

Williams, C., 2003. *Overcoming anxiety: a five areas approach*. London: Arnold.

Williams, C.J., 2006. *Overcoming Depression and low mood: A Five Areas Approach Second Edition*. London: Hodder Arnold

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- demonstrate the ability to determine the views of patients on the choices of treatment and intervention offered as part of their low-intensity role.
- demonstrate competence in eliciting patient's knowledge, attitudes and opinions about medication and about evidence-based psychological treatment choices.
- show how they use this information to inform their own information giving about therapeutic options to enable patients to come to a collaborative shared decision.

## Assessment

This outcome is tested in the simulation assessment and reflective commentary, where the student should demonstrate, describe and reflect on information gathering and giving about patient's knowledge, attitudes and opinions towards pharmacological and psychological interventions; and in the practice outcome, where students should formulate and record mental health care assessments appropriate to the identified needs of patients.

## Teaching aids

**I** Interview I1

**F** **Film clips** Gathering information 1, Gathering information 2 and Medication, where psychological wellbeing practitioners demonstrate information gathering about patient's knowledge, attitudes and opinions on pharmacological and psychological treatments to inform their own information giving.

**A** **Assessment** A1, A2

## Suggested reading

Bazire, S., 2003. Psychotropic drug directory 2003/2004: the professionals' pocket handbook and aide memoire. Salisbury: Fivepin Publishing.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

BMA & RPS. 2008. British National Formulary. London: British Medical Association and Royal Pharmaceutical Society of Great Britain.

Mead, N. & Bower, P., 2002. Patient-centred consultations and outcomes in primary care: a review of the literature. Patient Education and Counseling, 48, p.51-61.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

Norfolk and Waveney Mental Health NHS Foundation Trust. NWMHP Pharmacy Medicine Information. <http://www.nmhct.nhs.uk/Pharmacy/>.

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- demonstrate accurate record keeping in the form of clinical notes and other records such as clinical outcome measures. These should be in the format used in the service within which the student is working but include a record of the patient-centred assessment, problem statements, goals, risk, treatment plan and continuation notes.
- demonstrate competence in the electronic entry of the minimum data set required by the Improving Access to Psychological Therapies programme.
- demonstrate competence in the operation of one of the approved or recommended data management systems (such as PC-MIS).

## Assessment

This outcome is tested in the practice-based evidence approved by clinical supervisors, where students should formulate and record mental health care assessments appropriate to the identified needs of patients.

## Teaching aids

**I** Interview I1

**F** **Film clips** Supervision 1, Supervision 2 and Supervision 3, where psychological wellbeing practitioners demonstrate the discussion of notes and clinical measures with a supervisor.

**A** **Practice-based evidence**

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

IAPT minimum data set. [www.iapt.nhs.uk/2009/03/improving-access-to-psychological-therapies-key-performance-indicators-and-technical-guidance-2009/](http://www.iapt.nhs.uk/2009/03/improving-access-to-psychological-therapies-key-performance-indicators-and-technical-guidance-2009/)

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

Pullen, I. & Loudon, J., 2006. Improving standards in clinical record-keeping. *Advances in Psychiatric Treatment*, 12, p.280–286.

# 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.

# I1 Example interview schedule

	Empathy dots
<p><b>4 'Ws'</b></p> <ul style="list-style-type: none"> <li>• What is the problem?</li> <li>• Where does the problem occur?</li> <li>• With whom is the problem better or worse?</li> <li>• When does the problem happen?</li> </ul>	<p>•</p>
<p><b>Triggers</b> (antecedents)</p> <ul style="list-style-type: none"> <li>• Specific examples of situations and other stimuli that trigger the problem in the here and now</li> <li>• Past examples of triggers</li> </ul>	<p>•</p>
<p><b>Autonomic</b> (physiological) aspects of the problem</p>	<p>•</p>
<p><b>Behavioural</b> aspects of the problem</p>	
<p><b>Cognitive</b> aspects of the problem</p>	
<p><b>Impact</b> (consequence) of the problem</p> <ul style="list-style-type: none"> <li>• Work, home management, social leisure, private leisure, family life and intimate relationships</li> </ul>	<p>•</p>
<p><b>Assessment of risk</b></p> <ul style="list-style-type: none"> <li>• Intent: suicidal thoughts</li> <li>• Plans: specific action plans</li> <li>• Actions: current / past; access to the means</li> <li>• Prevention: social network, services</li> <li>• Risk to others</li> <li>• Neglect of self or others</li> </ul>	<p>•</p>
<p><b>Routine outcome measures</b></p> <ul style="list-style-type: none"> <li>• IAPT minimum data set including at least PHQ9 and GAD7</li> </ul>	
<p><b>Other important issues</b></p> <ul style="list-style-type: none"> <li>• Onset and maintenance</li> <li>• Modifying factors</li> <li>• Why does the patient want help now</li> <li>• Patient expectations and goals</li> <li>• Past episodes and treatments</li> <li>• Drugs and alcohol</li> <li>• Current medication and attitude to this</li> <li>• Other treatment being provided</li> <li>• Anything else that has not been covered in the assessment that is relevant from both perspectives</li> </ul>	<p>•</p> <p>•</p>

# A1 Patient-centred assessment

## How to use this assessment sheet

**This assessment sheet is divided into four sections:**

1. Introduction
2. Interpersonal skills
3. Information gathering
4. Information giving and shared decision making

Each section includes a number of competences which are specific and central to these four aspects of an initial patient-centred interview.

Each component of the assessment sheet is divided into three columns. Assessors should rate each competence according to observations made of the student's interview.

The right-hand column represents an aspect of the interview 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 assessment sheet to assist assessors in making an objective judgement of competence.

The four sections are weighted: 10% for the introduction section, 30% for interpersonal skills, 40% for information gathering and 20% for information giving and shared decision making. 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 middle two sections **MUST** be passed independently – students cannot fail the interpersonal skills section and make up marks on the other three sections. The same applies to the information gathering section. A missing risk assessment leads to an automatic fail. 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. As 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 clinical simulation interviews using actors with clear instructions on how to role play patients. 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 interview 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.

# A1 Patient-centred assessment

Participant Number: \_\_\_\_\_ Date: \_\_\_\_\_

## Introduction to the Session – WEIGHTING 10%

	<b>Clear evidence demonstrated</b> (The worker fully demonstrated the criteria)	<b>Some evidence demonstrated</b> (The worker demonstrates part of the skill or limited skill)	<b>Not demonstrated</b> (Not demonstrated)
<b>Introduces self by name</b>	(Clearly states own full name)	(States first name only)	(Does not introduce or just uses role e.g. "I am a case manager")
<b>Elicits patient's full name</b>	(Finds out patient's full name / preferred name)	(Finds out part of name e.g. first name)	(Fails to discover name or ascertains later during interview)
<b>Role of the worker made clear</b>	("I am a mental health worker, my job is....")	(Vague, e.g. "I work here")	(Does not state role)
<b>Describes purpose / agenda of interview</b>	(Purpose stated e.g. "I will be asking you to tell me what your main difficulties are, then we will look at what we can do about this")	(Vague statements e.g. "I am going to interview you")	(No purpose stated)
<b>Defines time scale for the interview</b>	(Explicitly states time) e.g. "we have 25 minutes")	(Vague statement about time scale e.g. "we only have a short time")	(Time not mentioned)

0      1      2      3      4      5      6      7      8      9      10

\_\_\_\_\_

# A1 Patient-centred assessment

## Interpersonal skills – WEIGHTING 30%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Displays empathy by verbal communication skills e.g. “I realise that this is very distressing for you”	(More than one occasion)	(One occasion only)	(Not demonstrated)
Displays engagement by non verbal cues e.g. eye contact, posture, nods, facial expression	(Displays all / most of the time)	(Displays some / part of the time)	(Not demonstrated)
Acknowledges the problem by reflection e.g. “so you felt that you were having a heart attack” or “so you felt really anxious”	(More than one occasion)	(One occasion)	(Not demonstrated)
Acknowledges the problem by summarising e.g. “you have told me your difficulties are... is that correct?”	(Two or more occasions)	(One occasion only)	(Not at all)
Uses patient centred interviewing and clear information gathering  Uses a funnelling process to elicit patient centred problem identification by: <ul style="list-style-type: none"> <li>• General open questions</li> <li>• Specific open questions</li> <li>• Closed questions</li> <li>• Summarising and clarification</li> </ul>	(Full elements of process demonstrated appropriately)	(Some evidence / not all appropriate use, e.g. general open questions leading too quickly to closed questions without intervening stage)	(Not demonstrated, e.g. mainly closed questioning or interrogative style)



# A1 Patient-centred assessment

## Information gathering – WEIGHTING 40%

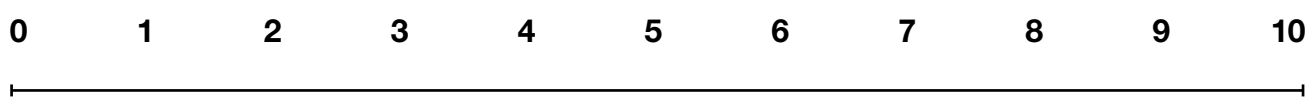
	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Uses four W's to structure questions: <b>What</b> is the problem <b>Where</b> does the problem occur <b>With</b> whom is the problem better or worse <b>When</b> does the problem happen	(At least first three evident)	(Two evident)	(Zero or one evident)
Elicits autonomic aspects of the problem e.g. physiological aspects of problem	(Asks specific questions and follows answers up to gain thorough understanding)	(Asks vaguely and fails to follow cues / or asks specifically but fails to obtain thorough info)	(Does not obtain information)
Elicits behavioural aspects of the problem e.g. what is the patient doing or not doing	(Asks specific questions and follows answers up to gain thorough understanding)	(Asks vaguely and fails to follow cues / or asks specifically but fails to obtain thorough info)	(Does not obtain information)
Elicits cognitive aspects of the problem e.g. what is the patient thinking – as internal mental scripts or images	(Asks specific questions and follows through answers to gain thorough understanding)	(Asks vaguely and fails to follow cues / or asks specifically but fails to obtain thorough info)	(Does not obtain information)
Enquires about 'triggers' e.g. current trigger specific examples of past trigger <b>NOT THE PRESUMED HISTORICAL CAUSE</b>	(Specifically asks about triggers)	(Vague in enquiry or does not follow up cues)	(No enquiry made)

Module 1

# A1 Patient-centred assessment

## Information gathering (continued) – WEIGHTING 40%

<p>Includes assessment of risk</p> <p><b>Intent:</b> suicidal thoughts</p> <p><b>Plans:</b> specific action plans</p> <p><b>Actions:</b> current / past; access to the means</p> <p><b>Prevention:</b> social network, services</p>	<p>(Comprehensive risk assessment appropriate to risk level articulated by patient)</p>	<p>(Risk investigated but limited in depth)</p>	<p>(No risk assessment undertaken)</p> <p style="text-align: center; background-color: #e91e63; color: white; padding: 5px;"><b>AUTOMATIC FAIL</b></p>
<p>Determines the impact of the problem on lifestyle</p>	<p>(Clearly enquires including domestic, work, social leisure, private leisure and family)</p>	<p>(Vaguely or incompletely enquires)</p>	<p>(No enquiry made)</p>
<p>Use of routine outcome measures</p>	<p>(Uses at least one clinical outcome measure from the minimum dataset and feeds back result)</p>	<p>(Uses a Likert scale or other means to assess problem severity or does not feed back result)</p>	<p>(Does not use any measures)</p>
<p>Asks about other important issues such as <b>modifying factors, onset and maintenance, why do they want help now, patient expectations and goals, past episodes and treatments, drugs and alcohol, current medication and attitude to this, other treatment, anything else</b> that has not been covered in the assessment that is relevant from both perspectives</p>	<p>(Clearly enquires including follow up of important leads from patient)</p>	<p>(Vaguely or incompletely enquires)</p>	<p>(No enquiry made)</p>



# A1 Patient-centred assessment

## Information giving and shared decision making – WEIGHTING 20%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Summarises and defines problem Using the framework: Four W's ABC Triggers Impact and in patient's own words	(All used with appropriate language in patient's words)	(Some demonstrated and / or in appropriate language)	(Vague / absent / poorly demonstrated)
Seeks patient's affirmation of problem statement	(Gives opportunity to revise statement)	(Presents statement but limited opportunity to revise)	(Does not seek patient's view)
Agreed ending, which should include the information giving and the presentation of options for the appropriate step. For example, the Recovery Programme for Depression and / or Anxiety; medication support, exercise, CBT, CCBT, support groups, signposting to other services.  At the very least, this should include an agreement on next steps in terms of next contact arrangements.	<ul style="list-style-type: none"> <li>- Session summarised</li> <li>- Next steps agreed collaboratively with patient</li> </ul>	(Brief ending with no collaborative action plan)	(None described)

0      1      2      3      4      5      6      7      8      9      10



# A2 Markers' guidelines for reflective commentary on patient-centred assessment

(% aspect weightings given in brackets)

Students should receive a copy of the film clip of their clinical simulation assessment in order to prepare a commentary on their performance. This commentary forms part of the academic assessment for the module. Suggested marking schedules are given below.

## **Knowledge and understanding (25%)**

Students should display knowledge and understanding of theories and concepts (relevant to the engagement and assessment of patients with common mental health problems), suitably integrated into their commentary.

## **Structure and organisation (10%)**

The commentary should be logically and systematically structured. It should be legible, error-free and presented in accordance with institution's guidelines.

## **Application of theory to practice (25%)**

Discussion of the student's practice performance should be substantiated with reference to particular skills and techniques, with a rationale for their use.

## **Critical reflection (30%)**

The commentary should be balanced, detailing what went well, what was learnt from the film clip, what would be done differently next time, and why. The critical reflection should be supported by reference to key concepts and theories.

## **Use of source material (10%)**

The commentary should be informed by reference to relevant source material, suitably acknowledged utilising the institution's accepted system of referencing.



A photograph showing a woman with long, wavy brown hair leaning over a person wearing a pink long-sleeved shirt and blue jeans. The woman is wearing a dark blue tank top and blue jeans. Her hands are resting on the person's back. In the background, a young boy in a red t-shirt is looking towards the camera. The scene is outdoors under a clear blue sky with some clouds. The word "recovery" is written vertically in white text on the left side of the image.

recovery

## Module 2

evidence-based low-intensity treatment  
for common mental health disorders

## Aims of module

Psychological wellbeing practitioners delivering low intensity interventions aid clinical improvement through the provision of information and support for evidence-based low-intensity psychological treatments and regularly used pharmacological treatments of common mental health problems. Low-intensity psychological treatments place a greater emphasis on patient self-management and are designed to be less burdensome to people undertaking them than traditional psychological treatments. Examples include guided self-help and computerised cognitive behavioural therapy (CCBT).

Support is specifically designed to enable patients to optimise their use of self-management recovery information and pharmacological treatments and may be delivered through face-to-face, telephone, email or other contact methods. Workers must also be able to manage any change in risk status. This module will, therefore, equip workers with a good understanding of the process of therapeutic support and the management of patients individually or in groups, and also support families, friends and carers. Skills teaching will develop workers' general and disorder-defined 'specific factors' competences in the delivery of CBT-based low-intensity treatment and in the support of medication concordance.

## Learning outcomes

1. Critically evaluate a range of evidence-based interventions and strategies to assist patients to manage their emotional distress and disturbance.
2. Demonstrate knowledge of and competence in developing and maintaining a therapeutic alliance with patients during their treatment programme, including dealing with issues and events that threaten the alliance.
3. Demonstrate competence in planning a collaborative low-intensity psychological and / or pharmacological treatment programme for common mental health problems, including managing the ending of contact.
4. Demonstrate in-depth understanding of, and competence in the use of, low-intensity, evidence-based psychological interventions for common mental health problems.
5. Demonstrate knowledge of and competence in low-intensity basic, intervention-specific, problem-specific and meta-CBT competences such as behavioural activation, exposure, CBT-based guided self-help, problem solving and the individualisation of CBT approaches.
6. Critically evaluate the role of case-management and stepped-care approaches to managing common mental health problems in primary care, including ongoing risk management appropriate to service protocols.
7. Demonstrate knowledge of and competence in supporting people with medication, in particular antidepressant medication, to help them optimise their use of pharmacological treatment and minimise any adverse effects.
8. Demonstrate competency in delivering low-intensity interventions using a range of methods including face-to-face, telephone and electronic communication.

## Learning and teaching strategies

### Knowledge

Lectures  
Seminars  
Discussion groups  
Guided reading  
Independent study

### Skills

Clinical simulation in small supervised groups  
Supervised practice through direct patient contact

## Assessment strategies

A standardised role-play scenario where workers are required to demonstrate skills in planning and implementing a low-intensity treatment programme. This will be videotaped and assessed by teaching staff using a standardised assessment measure.

Workers must also provide a 1,000-word reflective commentary on their performance.

Both parts must be passed.

An exam to assess module knowledge against the learning outcomes.

Successful completion of the following practice outcomes:

1. The identification and management of patients' emotional distress and disturbance through the use of interpersonal skills and evidence-based interventions.
2. 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.
3. High-quality case recording and systematic evaluation of the processes and outcomes of mental health interventions, adapting care on the basis of this evaluation.

Knowledge assessments are at undergraduate and / or postgraduate level and assessed using percentage criteria. Skills based competency assessments are independent of academic level and must be achieved according to a pass / fail criterion.

## Duration

**10 days in total over 10 weeks, running parallel with module 1:**

- One day per week for 10 weeks, half the time to be spent in class in theoretical teaching and clinical simulation, the other half in the workplace undertaking supervised practice.

## Learning outcome

Critically evaluate a range of evidence-based interventions and strategies to assist patients to manage their emotional distress and disturbance.

## Knowledge and skills

### The student should be able to:

- articulate knowledge of evidence-based interventions, supported in National Institute for Clinical Excellence (NICE) Guidelines, Cochrane and other reviews and in the primary empirical literature.
- use systematic review and primary study sources to critically evaluate the strength of the evidence underpinning low-intensity treatments.
- critically evaluate the evidence base for interventions other than those which the psychological wellbeing practitioners deliver.
- demonstrate knowledge of the range of empirically supported treatments outside their own competence.
- demonstrate knowledge of psychological and pharmacological interventions.

## Assessment

This outcome is tested in the exam by assessing students' knowledge of the evidence base for empirically supported treatments, as well as the completion of the relevant practice outcome.

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Centre for Reviews and Dissemination. Database of abstracts of reviews of effects (DARE). <http://www.york.ac.uk/inst/crd/crddatabases.htm#DARE>

Chambless, D. L. and Hollon, S. D. 1998. Defining Empirically Supported Therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.

Egger, M., Smith, G. & Altman, D., 2001. *Systematic reviews in health care: meta analysis in context*. London: BMJ Publications.

## Teaching aids

There are no film clips provided for this learning outcome. Teachers should consult the range of policy, clinical and research literature to assist students to attain this objective. Aside from introductions in class, this objective is best achieved by students through directed reading.

### Clinical procedures C1-C7

Hopko D., Lejuez C., Ruggiaro K. & Eifert G., 2003. Contemporary behavioural activation treatments for depression: procedures, principles and progress. *Clinical Psychology Review*, 23, p. 699-717.

Khan, K. et. al. eds., 2001. *Undertaking systematic reviews of research on effectiveness: CRD's guidance for those carrying out or commissioning reviews. Report 4 (2nd ed.)*, Centre for Reviews and Dissemination, University of York. Available from <http://www.york.ac.uk/inst/crd/report4.htm>

Martell C., Addis M. & Jacobson N., 2001. *Depression in Context. Strategies for Guided Action*. Norton: New York.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

National Institute for Clinical Excellence, 2007a. *Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2009. *Depression in Adults (update), Depression: the treatment and management of depression in adults*. London: National Institute for Clinical Excellence.

Salkovskis, P., 2002. Empirically grounded clinical interventions: cognitive behavioural therapy progresses through a multi-dimensional approach to clinical science. *Behavioural and Cognitive Psychotherapy*, 30, p.3-9.

The Cochrane Collaboration. <http://www.cochrane.org/>

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- demonstrate common factors skills (verbal empathy, summarising, reflection, clarification, non-verbal and verbal prompts, non-verbal skills such as posture, warmth, appropriate eye contact, unobtrusive note taking etc.).
- demonstrate the ability to develop and strengthen their alliance with patients, including where they need to recognise and manage ruptures in the alliance and be responsive to patients' changing agendas and expectations.
- be able to deal with patients' responses to setbacks in treatment which may also threaten the therapeutic alliance.

## Assessment

This outcome is tested in the exam by assessing students' knowledge of the theory of the therapeutic alliance; in the simulation assessment and reflective commentary, where the student should describe and reflect on their development and maintenance of the therapeutic alliance; and in the practice outcomes, where students should demonstrate the techniques necessary to develop and maintain individualised therapeutic alliances; as well as the completion of the relevant practice outcome.

## Teaching aids

**I** Interviews I2, I3

**F** Film clip Behavioural activation 2, which demonstrates the management of setbacks through acknowledgement, empathy and problem solving.

**A** Assessment A3, A4

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

Cahill, J. et al., 2006. A review and critical analysis of studies assessing the nature and quality of therapist/patient interactions in treatment of patients with mental health problems. Final report to the National Co-ordinating Centre for Research Methodology. Available at: <http://www.ncchta.org/project/1556.asp>

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

Norcoss, J., 2002. Psychotherapy relationships that work: therapist contributions and responsiveness to patients. Oxford: Oxford University Press.

Norfolk, T., Birdi, K. & Walsh, D., 2007. The role of empathy in establishing rapport in the consultation: a new model. *Medical Education*, 41, p.690–697.

Pilgrim, D. & Rogers, A., 2005. *Sociology of mental health*. 3rd edition. Maidenhead: The Open University Press.

Silverman, J., Kurtz, S. & Draper, J., 2005. *Skills for communicating with patients*. 2nd ed. Oxford: Radcliffe Publishing.

## Learning outcome

Demonstrate competence in planning a collaborative low-intensity psychological treatment programme including medicines management issues for common mental health problems, and managing the ending of contact.

## Knowledge and skills

### The student should be able to:

- demonstrate competence in working with patients to plan treatment based on a patient-centred shared understanding of the patient's difficulties. Planning includes discussion of patient-identified goals, appropriate choices for intervention available, the 'pros and cons' of these choices and the effort required to undertake the range of interventions available.
- demonstrate the relevant stages of planning an intervention in terms of information giving and the collaborative use of information sources with a patient.
- discuss the use of medication and support with written information on best practice in medicines concordance.

## Assessment

This outcome is tested in the exam by testing students' knowledge of the stages of evidence-based low-intensity psychological treatments and medicines concordance; in the simulation assessment and reflective commentary, where the student should demonstrate ability to engage the patient in planning treatment; and in the practice outcomes on adapting care on the basis of systematic evaluations.

## Suggested reading

Bazire, S., 2003. Psychotropic drug directory 2003/2004: the professionals' pocket handbook and aide memoire. Salisbury: Fivepin Publishing.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

Gilbert, P., 2000. Overcoming depression. London: Constable Robinson.

Greenberger, D. & Padesky, C., 1995. Mind over mood: changing how you feel by changing the way you think. New York: The Guilford Press.

## Teaching aids

**C** Clinical procedures C1-C7

**I** Interviews I2, I3

**F** Film clip Exposure, which demonstrates how psychological wellbeing practitioners should plan treatment with patients based on the agreement of a collaborative problem statement, accurate information giving and shared decision making.

**A** Assessment A3, A4

Hopko D., Lejuez C., Ruggiaro K. & Eifert G., 2003. Contemporary behavioural activation treatments for depression: procedures, principles and progress. *Clinical Psychology Review*, 23, p. 699–717.

Lovell, K. & Richards, D., 2008. A recovery programme for depression. London: Rethink.

Martell C., Addis M. & Jacobson N., 2001. Depression in Context. Strategies for Guided Action. Norton: New York.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

NIMHE National Workforce Programme, 2008. Medicines management: everybody's business. a guide for service users, carers and health and social care practitioners. York: NIMHE.

Westbrook, D., Kennerley, H. & Kirk, J., 2007. An introduction to cognitive behaviour therapy: skills and applications. Michigan: Sage.

Williams, C., 2003. Overcoming anxiety: a five areas approach. London: Arnold.

Williams, C.J., 2006. Overcoming Depression and low mood: A Five Areas Approach Second Edition. London: Hodder Arnold

## Learning outcomes

Demonstrate in-depth understanding of, and competence in the use of, a range of low intensity, evidence-based psychological interventions for common mental health problems. Demonstrate knowledge of, and competence in low-intensity basic, intervention-specific, problem-specific and meta-CBT competences such as behavioural activation, exposure, CBT based guided self-help, problem solving and individualisation of CBT approaches.

## Knowledge and skills

Outcomes 4 and 5 refer specifically to the cognitive behavioural therapy (CBT) competences framework developed by Tony Roth and Steve Pilling at University College London (URL in sources below). This framework has areas related to basic CBT competences followed by intervention-specific, problem-specific and meta-CBT competences.

There are low-intensity versions of many CBT techniques, and students should be familiar with and skilled in implementing them. Most of these involve self-help or variants of CBT techniques. The most common ones are behavioural activation, exposure, CBT-based guided self-help (including simple cognitive restructuring) and problem solving. Students should implement these techniques within a basic CBT framework of collaborative guided empiricism.

## Assessment

These outcomes are tested in the exam by knowledge of cognitive behavioural therapy (CBT) techniques; in the simulation assessment and reflective commentary, where students should demonstrate at least one of these techniques and reflect on their performance; and in the practice outcomes through the use of evidence-based interventions.

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Ekers, D, Richards, D and Gilbody S. (2008). A Meta Analysis of Randomized Trials of Behavioural Treatment of Depression. */Psychological Medicine/, 38: 611-623.*

Gilbert, P., 2000. *Overcoming depression*. London: Constable Robinson.

Greenberger, D. & Padesky, C., 1995. *Mind over mood: changing how you feel by changing the way you think*. New York: The Guilford Press.

## Teaching aids

**C** **Clinical procedures** C1-C7

**I** **Interviews** I2, I3

**F** **Film clips** Behavioural activation 1, Behavioural activation 2, Cognitive restructuring and Exposure, where psychological wellbeing practitioners work with patients to implement examples of low-intensity CBT based techniques.

**A** **Assessment** A3, A4

Hopko D., Lejuez C., Ruggiario K.& Eifert G., 2003. Contemporary behavioural activation treatments for depression: procedures, principles and progress. *Clinical Psychology Review, 23*, p. 699–717.

Lovell, K. & Richards, D., 2008. *A recovery programme for depression*. London: Rethink.

Martell C., Addis M. & Jacobson N., 2001. *Depression in Context. Strategies for Guided Action*. Norton: New York.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

Richards, D., 2008. Behavioural activation. In Callaghan et. al. (eds.) *Mental health nursing skills in practice*. Oxford: Oxford University Press. Ch.12.

Roth, A. & Pilling, S., 2007. *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders*. London: Department of Health.

Westbrook, D., Kennerley, H. & Kirk, J., 2007. *An introduction to cognitive behaviour therapy: skills and applications*. Michigan: Sage.

Williams, C., 2003. *Overcoming anxiety: a five areas approach*. London: Arnold.

Williams, C.J., 2006. *Overcoming Depression and low mood: A Five Areas Approach Second Edition*. London: Hodder Arnold

## Learning outcome

Critically evaluate the role of case management and stepped care approaches to managing common mental health problems in primary care including ongoing risk management appropriate to service protocols.

## Knowledge and skills

### The student should be able to:

- articulate theoretical and empirical knowledge of modern methods of organising mental health care for high prevalence disorders, particularly the evidence base and operational characteristics of collaborative care and stepped care.
- understand and evaluate risk management strategies beyond initial risk assessment.
- critically appraise different models of stepped and collaborative care, including the different roles and relationships between primary care generalists, case managers and mental health specialists.

## Assessment

This outcome is tested in the exam by seeking answers to questions on organisational models of mental health care, specifically the implementation of collaborative care and stepped care; and in the simulation assessment and reflective commentary, where students show how they adhere to the principles of collaborative care follow-up of patients to ensure patients do not get 'lost' to the service.

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Bower, P. & Gilbody, S., 2005. Managing common mental health disorders in primary care: conceptual models and evidence base. *British Medical Journal*, 330, p.839-842.

Gask, L., Lester, H., Kendrick, A. & Peveler, R. eds., 2008. *Handbook of primary care mental health*. London: Gaskell Publishing (in press).

## Teaching aids

**I Interviews** I2, I3

**F Film clips** Telephone working, Supervision 1 and Supervision 2, where psychological wellbeing practitioners use and discuss assertive follow-up methods to ensure people with depression are not lost to the service.

**A Assessment** A3, A4

Gilbody, S. et al., 2006. Collaborative care for depression in primary care: making sense of a complex intervention: systematic review and meta-regression. *British Journal of Psychiatry*, 189, p.484-493.

Katon, W. et al., 1999. Stepped collaborative care for primary care patients with persistent symptoms of depression: a randomized trial. *Archives of General Psychiatry*, 56, p.1109-1115.

Richards, D. et al., 2008. Collaborative care for depression in UK primary care: a randomized controlled trial. *Psychological Medicine*, 38, p.279-287.

Richards, D. & Suckling, R., 2008. Improving access to psychological therapy: the Doncaster demonstration site organisational model. *Clinical Psychology Forum*, 181, p.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.

Simon, G., 2006. Collaborative care for depression. *BMJ*, 332, p.249-250.

Von Korff, M. & Goldberg, D., 2001. Improving outcomes in depression. *BMJ*, 323, p.948-949.

## Learning outcome

Demonstrate knowledge of and competence in supporting people with medication, in particular antidepressant medication, to help them optimise their use of pharmacological treatment and minimise any adverse effects.

## Knowledge and skills

### The student should be able to:

- demonstrate the ability to help patients optimise pharmacological treatments by giving competent and accurate information about medication.
- help patients address any concerns and questions about medication, based on information which is in the public domain.
- differentiate between accurate information giving and prescribing advice which is outside their competence and role.
- use accurate, published and bespoke information sources to assist patients in coming to informed and shared decisions about their medication.
- competently help patients address common concerns and misperceptions about medication, such as fears of addiction, taking medication in an ad hoc manner, expressed fears of inadequacy because of taking medication etc.
- demonstrate an ability to work with prescribers, including GPs and mental health experts, to assist patients to make the best of their pharmacological treatment.

## Assessment

This outcome is tested in the exam by seeking answers to questions on effective pharmacotherapy; in the simulation assessment and reflective commentary, where the student should describe and reflect on medication information giving and shared decision making; and in the practice outcomes through the use of evidence-based medication support.

## Teaching aids

- C** **Clinical procedure** C3
- I** **Interviews** I2, I3
- F** **Film clip** Medication, where psychological wellbeing practitioners use and demonstrate information giving and shared decision making with patients around the topic of medication use.
- A** **Assessment** A3, A4

## Suggested reading

Bazire, S., 2003. Psychotropic drug directory 2003/2004: the professionals' pocket handbook and aide memoire. Salisbury: Fivepin Publishing.

BMA and RPS. British National Formulary. 2008. London: British Medical Association and Royal Pharmaceutical Society of Great Britain.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

National Institute for Clinical Excellence, 2007a. Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in Adults in primary, secondary and community care. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2009. Depression in Adults (update), Depression: the treatment and management of depression in adults. London: National Institute for Clinical Excellence.

NIMHE National Workforce Programme, 2008. Medicines management: everybody's business. A guide for service users, carers and health and social care practitioners. York: NIMHE.

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- demonstrate knowledge of and competence in using telephones, face-to-face appointments and email or any other means of communication to deliver low-intensity interventions.
- demonstrate understanding of the adaptations required to session organisation, interpersonal style and therapeutic processes when conducting their work on the telephone compared with face-to-face.

## Assessment

This outcome is tested in the exam, simulation assessment and reflective commentary, where the student should demonstrate, describe and reflect on delivering treatment using a specific method of delivery; and in the practice outcomes, demonstrating the techniques necessary to develop and maintain individualised therapeutic alliances using the telephone.

## Teaching aids

**I** Interviews I2, I3

**F** Film clips Behavioural activation 2, Telephone working and Cognitive restructuring, where psychological wellbeing practitioners demonstrate supporting patients in treatment using the telephone

**A** Assessment A3, A4

## Suggested reading

Car, J. & Sheikh, A., 2003. Telephone consultations. *British Medical Journal*, 326, p.966-969.

Hunkeler, E. et al., 2000. Efficacy of nurse telehealth care and peer support in augmenting treatment of depression in primary care. *Archives of Family Medicine*, 9, p.700-708.

Hunkeler, E. et al., 2006. Long term outcomes from the IMPACT randomised trial for depressed elderly patients in primary care. *British Medical Journal*, 332, p.259-263.

Richards, D. et al., 2006. Developing a UK protocol for collaborative care: a qualitative study. *General Hospital Psychiatry*, 28, p.296-305.

Simon, G. et al., 2004. Telephone psychotherapy and telephone care management for primary care patients starting antidepressant treatment: a randomised controlled trial. *Journal of the American Medical Association*, 292, p.935-942.

# 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 et al (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

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

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

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# C1 Behavioural activation 2

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

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The most difficult

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Medium difficulty

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The easiest

# C1 Behavioural activation diary

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
<b>Morning</b>	What Where When Who						
	What Where When Who						
	What Where When Who						
<b>Afternoon</b>	What Where When Who						
	What Where When Who						
	What Where When Who						
<b>Evening</b>	What Where When Who						
	What Where When Who						
	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

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

# C2 Evidence recording sheet

My thought	My % belief
Evidence for	Evidence against

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 psychosocial 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](http://www.dtb.org.uk)) are helpful.

For detailed information, psychological wellbeing practitioners should consult the British National Formulary ([www.bnf.org](http://www.bnf.org)) and Steven Bazire's authoritative book (referenced in the suggested reading section of module 2, learning outcomes 3 and 7) and the associated web based materials at Norfolk and Waveney Mental Health NHS Foundation Trust ([www.nmhct.nhs.uk/Pharmacy](http://www.nmhct.nhs.uk/Pharmacy)).

# C4 Exposure therapy

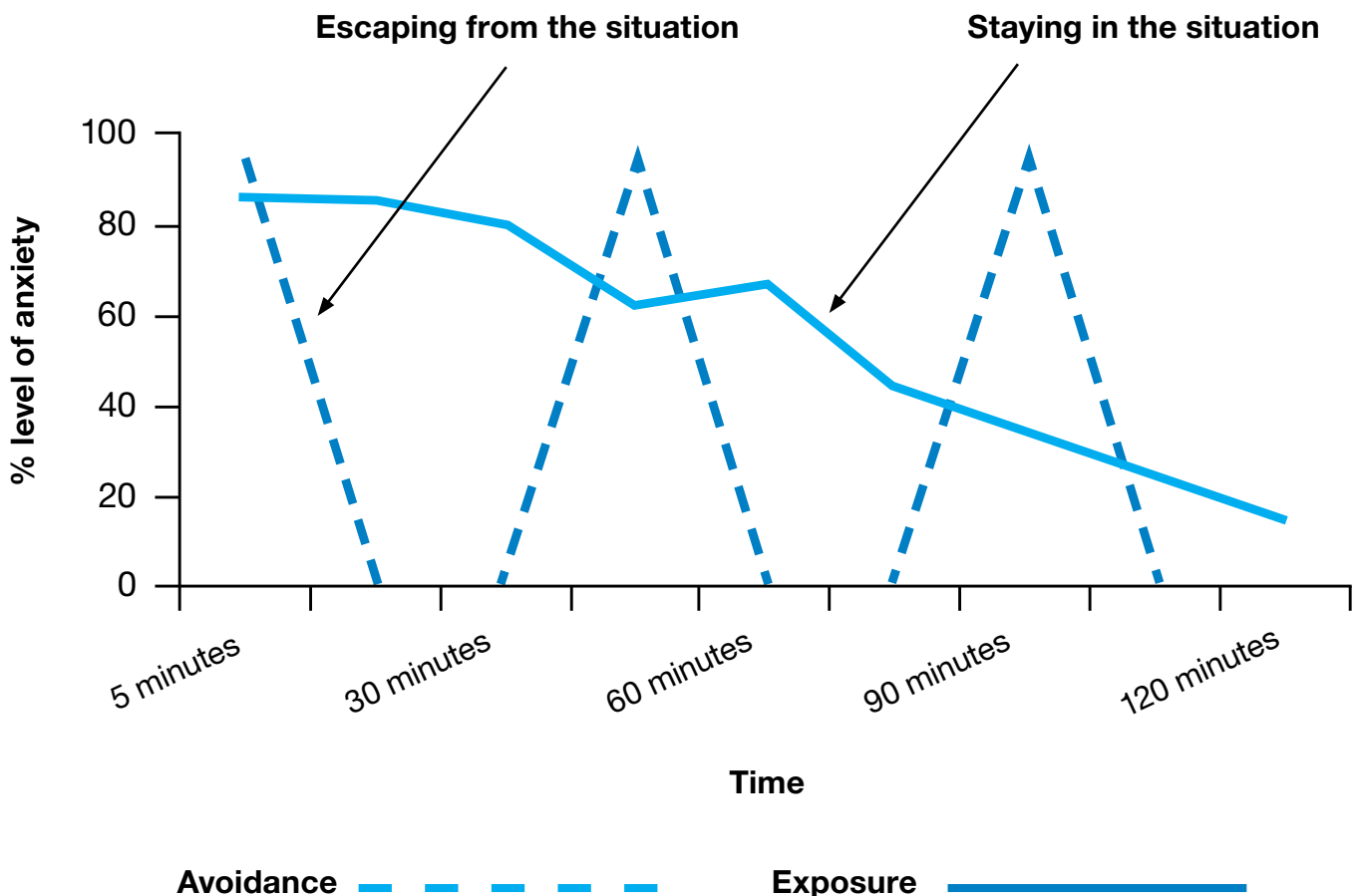
People will often try to avoid situations or objects they fear, and this avoidance does indeed successfully relieve anxiety. However, the more people avoid, the more they will continue to use it as a coping strategy. This leads to long-term difficulties as people find it more and more difficult to face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

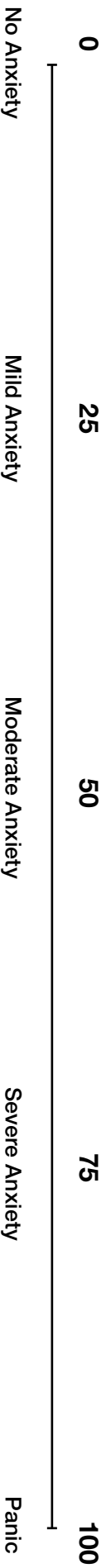
The first step is for psychological wellbeing practitioners to help patients compose a list of fearful objects or situations, ranking them in a hierarchy from the least anxiety provoking to the most feared one. Patients then start exposure with activities from the lower part of the list and practice 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)

## 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.

## 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 a clear rationale.

### 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.

## C6 Managing 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.

### Suggested reading

Myles, P. & Rushforth, D. (eds.), 2007. A complete guide to primary care mental health. London: Constable Robinson (see pages 148-152 and accompanying video clips from the CD-ROM set).

Newcastle, North Tyneside and Northumberland Mental Health NHS Trust, 2002. Panic: A self-help guide.

Rachman, S. & de Silva, P., 1996. Panic disorder: the facts. Oxford: Oxford University Press.

Silove, D. & Manicavasagar, V., 1997. Overcoming panic. London: Robinson.

Wells, A., 1997. Cognitive therapy of anxiety disorders: a practice manual and conceptual guide. Chichester: Wiley.

Westbrook, D. & Rouf, K., 1998. Understanding panic. Oxford: Oxford Cognitive Therapy Training Centre.

Williams, C., 2003. Overcoming anxiety: a five areas approach. London: Arnold.

Williams, C.J., 2006. Overcoming Depression and low mood: A Five Areas Approach Second Edition. London: Hodder Arnold



# Panic diary

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

# 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**).

## 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](http://www.umm.edu/sleep/sleep_hyg.html)

# 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
<p><b>Information gathering</b></p> <ul style="list-style-type: none"> <li>• Feedback of previous problem summary statement</li> <li>• Checking that problem statement is an accurate reflection of patient's difficulties</li> <li>• Further funneled information gathering if necessary</li> <li>• Clarification and adjustment of problem statement</li> </ul>	•
<p><b>Assessment of risk</b></p> <ul style="list-style-type: none"> <li>• Feedback of previous risk assessment</li> <li>• Checking that risk assessment is still accurate</li> <li>• If any change re-assess: <ul style="list-style-type: none"> <li>intent: suicidal thoughts</li> <li>plans: specific action plans</li> <li>actions: current / past; access to the means</li> <li>prevention: social network, services</li> <li>risk to others</li> <li>neglect of self or others</li> </ul> </li> </ul>	• •
<p><b>Routine outcome measures</b></p> <ul style="list-style-type: none"> <li>• IAPT sessional minimum data set including at least PHQ9 and GAD7</li> </ul>	
<p><b>Information review</b></p> <ul style="list-style-type: none"> <li>• Understanding of information given previously: <ul style="list-style-type: none"> <li>mental health condition information</li> <li>medication information</li> <li>low-intensity psychological therapies information</li> </ul> </li> </ul>	• •
<p><b>Medication review</b></p> <ul style="list-style-type: none"> <li>• Concordance behaviour</li> <li>• Benefit assessment</li> <li>• Unwanted effects assessment</li> <li>• Attitude to medication concordance</li> </ul>	•
<p><b>Low-intensity psychological therapy review</b></p> <ul style="list-style-type: none"> <li>• Understanding of options discussed</li> <li>• Review of treatment exercise implementation</li> <li>• Review of diaries and worksheets</li> </ul>	
<p><b>Shared decision-making</b></p> <ul style="list-style-type: none"> <li>• Choices discussed</li> <li>• Options selected</li> <li>• Treatment continued revised or initiated</li> <li>• Diaries and worksheets organised</li> </ul>	• •
<p><b>Ending</b></p> <ul style="list-style-type: none"> <li>• Session summarised</li> <li>• Next steps agreed and understood</li> </ul>	

# I3 Telephone interviews

An important feature of low-intensity working within a stepped care framework is the use of the telephone for the delivery of psychological and pharmacological interventions. The NICE Guideline on Depression states that “The provision of telephone support... informed by clear treatment protocols, should be considered for all patients, in particular for the monitoring of antidepressant medication regimes” (NICE 2007 p.32).

## Advantages of using the telephone to deliver low-intensity interventions

Using the telephone to deliver low-intensity interventions is flexible in that patients can be rung at times which suit them and not just between the hours of 9am-5pm. Telephone contacts can save patients time and money as they don't have to travel to appointments and can help alleviate other difficulties such as arranging child care during face-to-face appointments. Telephone working is not dependent on location and patients can be rung at home or elsewhere (at work for example in a lunch break) as most people now have mobile phones. For IAPT services it is also efficient in saving travelling time for staff. With the use of hands-free head sets, workers can also be entering data on to IT systems such as PC-MIS whilst talking to patients.

A further advantage of the telephone is that some patients, particularly those with depression, may not attend face-to-face appointments precisely because of their symptoms – low mood, lack of energy, etc. – which make it difficult for them to meet appointment deadlines. Maintaining contact with patients in an assertive manner does dramatically improve treatment concordance and adherence to therapeutic activities. This is far better than merely recording such people as ‘Did not attend’ or even discharging them.

Services need to develop their protocols for the use of telephone support, but it is generally recommended that the initial assessment interview is conducted face-to-face and is then followed up by telephone support. Clearly, for any patients who are uncomfortable with telephone working or where there may be good clinical reasons for seeing them in person, face-to-face interviews should be offered. The experience of the IAPT National Demonstration Site in Doncaster suggests that only a small minority of patients are unwilling to receive support via the telephone.

## The evidence for telephone working

Many mental health workers express initial reservations about using the phone for low-intensity psychological interventions (Richards et al, 2006). However, there is evidence that it is generally popular with patients (Car & Sheikh 2003) who have few such reservations (Richards et al, 2006). A recent report demonstrated high levels of satisfaction with a telephone helpline service for people with breast cancer (Dean & Scanlon 2007). Furthermore, there is strong evidence that telephone support and telehealth care improves outcomes and patient satisfaction in patients taking antidepressant medication (Hunkeler et al 2000 and Simon et al 2004) when care is organised through collaborative care (Gilbody et al, 2007).

# I3 Telephone interviews

## Preparing for telephone work

At the initial face-to-face interview workers can prepare patients for telephone working. Any self-help and information materials can be given to patients as can copies of measures such as the PHQ9 and GAD7 so that patients have these in front of them when subsequently talking to the worker on the phone. Workers should discuss issues around confidentiality with patients.

It's important to check who might answer the patient's phone at home, and whether any such persons are aware that the patient is receiving help; what the worker should say to avoid getting into difficult situations; and if it is acceptable for the worker to leave a message on an answering machine.

## How does telephone working differ from face-to-face contact?

The main and obvious difference is that neither party can see each other and therefore workers need to compensate for the lack of non-verbal communication. They need to pay particular attention to the patient's tone of voice and try to pick up on the emotions being experienced. Where workers would use nods and smiles in a face-to-face interview, they need to make sure they use verbal prompts. The verbal skills of paraphrasing, summarising, reflecting and clarifying, and of being empathic are important in all interviews. They become even more crucial in telephone working. Patients may need time to respond to questions and information so workers should be willing to tolerate short silences.

## The structure of telephone interviews

It is very important to stress that telephone interviews follow an identical structure to face-to-face interviews. At each contact the worker will be gathering information, giving information and coming to a shared decision with the patient regarding the next steps or action to be taken. Workers should begin the call exactly as they would a face-to-face appointment – by introducing themselves fully in terms of name and organisation. Given we do not have the advantage of facial recognition, it is vital that workers check that they are speaking to the right person. Although most telephone contacts will be scheduled much like face-to-face appointments, it is usually a good idea just to check to see if it is still convenient to speak, together with agreeing the duration and agenda for the interview.

At the beginning of the conversation, it is important to check that the patient has any materials required in front of them. The format for the call should be based around the protocols of the chosen clinical approaches used (e.g. medication support, behavioural activation, problem solving, etc.). Information giving should be done in 'bite size' chunks and it is useful to get the patient to summarise their understanding of any information given. The telephone interview should be ended by recapping on any agreed action and asking the patient to feedback their understanding and inviting them to ask any questions. It is usually a good idea to ask the patient to write down any agreed actions. Arrangements should then be agreed for the next telephone contact and any additional materials which are required posted out.

# I3 Telephone interviews

## How can workers develop their telephone skills?

Essentially, telephone skills can be practised and developed by workers undertaking role play scenarios whilst sitting back-to-back with other students so that they can learn how to compensate for the absence of visual cues. Educators will need to develop scenarios and briefs for both the worker and the person role-playing the patient so that both parties know what has happened in previous interviews.

## Suggested reading

Car, J. & Sheikh, A., 2003. Telephone consultations. *British Medical Journal*, 326, p.966-969.

Dean, A. & Scanlon, K., 2007. Telephone helpline to support people with breast cancer. *Nursing Times* 103:42, p.30-33.

Gilbody, S. et al., 2006. Collaborative care for depression: a systematic review and cumulative meta-analysis. *Archives of Internal Medicine*, 166, p.2314-2321.

Hunkeler, E. et al., 2000. Efficacy of nurse telehealth care and peer support in augmenting treatment of depression in primary care. *Archives of Family Medicine*, 9, p.700-708.

Myles, P. & Rushforth, D. (eds.), 2007. *A complete guide to primary care mental health*. London: Constable and Robinson Ltd. (p.190-192 and associated video clips in the accompanying CD-ROM 3).

NICE, 2004. *Depression: management of depression in primary and secondary care*, Clinical Guideline 23. London: NICE.

Richards, D. et al., 2006. Developing a UK protocol for collaborative care: a qualitative study. *General Hospital Psychiatry*, 28, p.296-305.

Simon, G. et al., 2004. Telephone psychotherapy and telephone care management for primary care patients starting antidepressant medication. *Journal of the American Medical Association*, 292, p.935-942.

# I3 How to conduct a telephone interview

## Before the phone call:

- Any self-help and information materials can be given to patients face-to-face so that patients have these in front of them when subsequently talking to the worker on the phone.
- Discuss issues around confidentiality with the patient. Checking who might answer the patient's phone at home is important; whether any such persons are aware that the patient is receiving help; and what the worker should say to avoid getting into difficult situations.
- Check whether it is acceptable to the patient to leave a message on an answering machine.

## General points while on the phone

- Workers need to compensate for the lack of non-verbal communication. They need to pay particular attention to the patient's tone of voice and try to pick up on the emotions being experienced.
- Make sure to use verbal prompts. The verbal skills of paraphrasing, summarising, reflecting and clarifying and of being empathic become even more crucial in telephone working.
- Patients may need time to respond to questions and information, so workers should be willing to tolerate short silences.

The structure of telephone interviews	Checklist
1. Workers <b>must</b> check that they are speaking to the right person.	
2. Workers should begin the call exactly like a face-to-face appointment: by introducing themselves fully in terms of name and organisation.	
3. Check to see if it is still convenient to speak.	
4. Agree the duration and agenda for the interview.	
5. Check that the patient has all of the materials required in front of them.	
6. Base the format of the call on the protocols of the chosen clinical approach (medication support, problem solving, etc.).	
7. Give information in 'bite-sized' chunks and ask the patient to summarise their understanding of any information given.	
8. End the interview by recapping on any agreed action, asking the patient to feed back their understanding and inviting them to ask any questions.	
9. It is usually a good idea to ask the patient to write down any agreed actions.	
10. Arrangements should then be agreed for the next telephone contact and any additional materials which are required posted out.	

# A3 Clinical simulation assessment

## How to use this assessment sheet

This assessment sheet is divided into six sections:

1. Introduction
2. Interpersonal skills
3. Information gathering
4. Information giving
5. Shared decision making
6. Ending

Each section includes a number of competences which are specific and central to these six aspects of a patient-centred interview, which is focussed on planning and implementing a low-intensity treatment programme.

Each component of the rating sheet is divided into three columns. Assessors should rate each competence according to observations made of the student's interview. The right-hand column represents an aspect of the interview which was not conducted sufficiently well to be regarded as competent. The middle column should be ticked when students display 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 to make an objective judgement of competence.

The six sections are weighted: 10% for the introduction section, 20% for interpersonal skills, 20% for information gathering, 20% for information giving, 20% for shared decision making and 10% for the ending. 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 middle four sections **MUST** be passed independently – students cannot fail **ANY** of the sections on interpersonal skills, information gathering, information giving or shared decision making. A missing risk assessment leads to an automatic fail. 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. As 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 clinical simulation interviews using actors with clear instructions on how to role play patients. 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 interview 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.

# A3 Clinical simulation assessment

Participant Number: \_\_\_\_\_ Date: \_\_\_\_\_

## Introduction to the Session – WEIGHTING 10%

	<b>Clear evidence demonstrated</b> (The worker fully demonstrated the criteria)	<b>Some evidence demonstrated</b> (The worker demonstrates part of the skill or limited skill)	<b>Not demonstrated</b> (Not demonstrated)
<b>Introduces self by name</b>	(Clearly states own full name)	(States first name only)	(Does not introduce self or just uses role e.g. "I am a mental health worker")
<b>Checks patient's full name</b>	(Ensures the worker is speaking to the right person by checking patient's full name)	(Uses patient's name without checking to whom they are speaking)	(Fails to use or check name or ascertains later during interview)
<b>Role of the worker reiterated</b>	("As we discussed last time, I am a mental health worker, my job is....")	(Vague, e.g. "as you know, I work here")	(Does not state role)
<b>Describes purpose / agenda of interview</b>	(Purpose stated e.g. "I will be reviewing what you told me the last time we met and then we will look in more detail at what you can do to help you overcome your difficulties")	(Vague statements e.g. "I am going to interview you again today")	(No purpose stated)
<b>Defines time scale for the interview</b>	(Explicitly states time e.g. "we have 25 minutes")	(Vague statement about time scale e.g. "we have some time today")	(Time not mentioned)

0      1      2      3      4      5      6      7      8      9      10

\_\_\_\_\_

# A3 Clinical simulation assessment

## Interpersonal skills – WEIGHTING 20%

	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Not demonstrated</b>
Displays empathy by verbal communication skills e.g. “I realise that this is very distressing for you”	(More than one occasion)	(One occasion only)	(Not demonstrated)
Displays engagement by non verbal cues e.g. eye contact, posture, nods, facial expression	(Displays all / most of the time)	Displays some / part of the time)	(Not demonstrated)
Acknowledges the problem by reflection, e.g. “So you felt you were having a heart attack” or “So you felt really anxious”	(More than one occasion)	(One occasion)	(Not demonstrated)
Acknowledges the information given by summarising, e.g. “You have told me your problem has remained constant with its main focus as... is that correct?”	(Two or more occasions)	(One occasion only)	(Not at all)
Uses patient centred interviewing and clear information gathering  Uses a funnelling process to elicit patient centred information by: <ul style="list-style-type: none"> <li>• General open questions</li> <li>• Specific open questions</li> <li>• Closed questions</li> <li>• Summarising and clarification</li> </ul>	(Full elements of process demonstrated appropriately)	(Some evidence / not all appropriate use, e.g. imposition of worker understanding without check-back with patient)	(Not demonstrated, e.g. dismissal of patient perspective)

0      1      2      3      4      5      6      7      8      9      10



# A3 Clinical simulation assessment

## Information gathering – WEIGHTING 20%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
a) Reminds patient about the main problem statement agreed at the last contact and  b) ascertains whether there has been any change since the last contact	(Both evident in depth)	(One evident or both superficially)	(None evident)
Includes assessment of risk, related to information gathered at the last contact and any new information  <b>Intent:</b> suicidal thoughts <b>Plans:</b> specific action plans <b>Actions:</b> current / past; access to the means <b>Prevention:</b> social network, services	(Comprehensive risk assessment appropriate to risk level articulated by patient)	(Risk investigated but limited in depth)	(No risk assessment undertaken)  <b>AUTOMATIC FAIL</b>
Use of routine outcome measures	(Uses at least one clinical outcome measure from the minimum dataset and feeds back result related to this and previous scores)	(Uses a Likert scale or other means to assess problem severity or does not feed back result)	(Does not use any measures)
Reviews patient's use of other treatments, including the effects and unwanted effects of medication	(Clearly enquires including follow up of important leads from patient)	(Vaguely or incompletely enquires)	(No enquiry made)
Reviews patient's use of psychological treatment agreed at previous contact	(Clearly enquires of use, including depth of understanding, attitudes to treatment, activities undertaken and diaries completed)	(Vaguely or incompletely enquires; does not use material completed by patient between contacts such as diaries)	(No enquiry made)

0      1      2      3      4      5      6      7      8      9      10

# A3 Clinical simulation assessment

## Information giving – WEIGHTING 20%

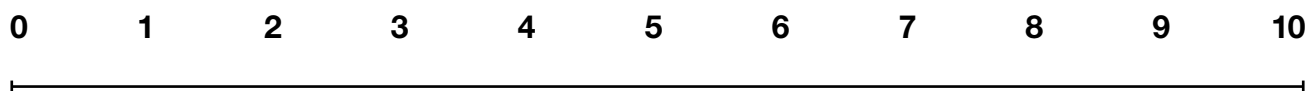
	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Not demonstrated</b>
Discussion of intervention options with methods of delivery where appropriate	(More than one option discussed or rationale for previous intervention reiterated and understanding checked with patient)	(Only one option discussed or previously selected intervention re-introduced without checking understanding)	(No discussion of options or previously selected intervention)
Use of educational material	<p>(Material provided in an accessible format appropriate to the patient's needs)</p> <p>Material used includes information on the patient's mental health problems and the choice of interventions available</p> <p>Material may include psychological information and / or information on medication</p> <p>All material is discussed interactively with the patient)</p>	(Little breadth or depth to material presented and small amount of interaction around the information)	(No material presented or material not discussed at all)

0      1      2      3      4      5      6      7      8      9      10

# A3 Clinical simulation assessment

## Shared decision making – WEIGHTING 20%

	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Not demonstrated</b>
Action plans	(Collaborative action plan arrived at. The patient's understanding and attitude towards the plan is checked)	(Action plan agreed but no understanding or attitude checked)	(Either no action plan or plan imposed by worker without collaboration)
Method of implementation and recording of action plan: e.g. diaries or record sheets	(Diaries or record sheets discussed interactively with patient. Plan includes a schedule of inter-session activity by patient and / or worker)	(Diaries or record sheets given to patient without planning any scheduled activity)	(No diaries or record sheets used)



## Ending – WEIGHTING 10%

	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Not demonstrated</b>
Summary of session	(Worker summarises the whole session and seeks agreement from patient)	(Brief summary and / or no agreement from patient sought)	(No summary)
Next steps agreed	(Collaborative agreement of next step with feedback from patient to check understanding)	(Next steps agreed with no check of understanding)	(No next steps or very vague decision for the future)



# A4 Markers' guidelines for reflective commentary on clinical simulation assessment

(% aspect weightings given in brackets)

Students should receive a copy of the film clip of their clinical simulation assessment in order to prepare a commentary on their performance. This commentary forms part of the academic assessment for the module. Suggested marking schedules are given below.

## **Knowledge and understanding (25%)**

Students should display knowledge and understanding of theories and concepts (relevant to evidence-based low-intensity treatment for common mental health disorders), suitably integrated into their commentary.

## **Structure and organisation (10%)**

The commentary should be logically and systematically structured. It should be legible, error-free and presented in accordance with institution's guidelines.

## **Application of theory to practice (25%)**

Discussion of the student's practice performance should be substantiated with reference to particular skills and techniques, with a rationale for their use.

## **Critical reflection (30%)**

The commentary should be balanced, detailing what went well, what was learnt from the film clip, what would be done differently next time, and why. The critical reflection should be supported by reference to key concepts and theories.

## **Use of source material (10%)**

The commentary should be informed by reference to relevant source material, suitably acknowledged utilising the institution's accepted system of referencing.





respect

**Module 3**  
values, policy, culture and diversity

# Respect

## Aims of module

Psychological wellbeing practitioners delivering low intensity interventions must operate at all times from an inclusive values base which promotes recovery and recognises and respects diversity. Diversity encompasses the range of cultural norms, including personal, family, social and spiritual values, held by the diverse communities served by the service within which the worker is operating. Workers must respect and value individual differences in age, sexuality, disability, gender, spirituality, race and culture.

Workers must also take into account any physical and sensory difficulties people may experience in accessing services and make provision in their work to mitigate these. They must be able to respond to people's needs sensitively with regard to all aspects of diversity, and must demonstrate a commitment to equal opportunities for all and encourage people's active participation in every aspect of care and treatment. Workers must also demonstrate an understanding and awareness of the power issues in professional / patient relationships and take steps in their clinical practice to reduce any potential for negative impact these may have.

This module will, therefore, expose workers to the concepts of diversity, inclusion and multiculturalism and equip them with the necessary knowledge, attitudes and competences to operate in an inclusive values-driven service.

## Learning outcomes

1. Demonstrate knowledge of, commitment to and action based on a non-discriminatory, recovery-oriented values base to mental health care.
2. Demonstrate respect for individual differences in age, sexuality, disability, gender, spirituality, race and culture, and show that these differences are valued.
3. Demonstrate knowledge of and competence in responding to people's needs sensitively with regard to all aspects of diversity, including the use of translation services.
4. Take into account any physical and sensory difficulties patients may experience in accessing services and if required refer to appropriate services.
5. Demonstrate knowledge of and a commitment to equal opportunities for all and encourage people's active participation in every aspect of care and treatment.
6. Demonstrate awareness and understanding of the power issues in professional / patient relationships.

## Learning and teaching strategies

### Knowledge

Lectures  
Seminars  
Discussion groups  
Guided reading  
Independent study

### Skills

Clinical simulation in small supervised groups  
Supervised practice through direct patient contact

## Assessment strategies

A practical clinical planning scenario where workers are required to demonstrate skills in preparing for the care of people with a variety of needs from a variety of diverse groups, and produce a 1,000-word write-up of the plan.

An exam to assess module knowledge against the learning outcomes.

Successful completion of the following practice outcomes:

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

Knowledge assessments are at undergraduate and / or postgraduate level and assessed using percentage criteria. Skills based competency assessments are independent of academic level and must be achieved according to a pass / fail criterion.

## Duration

**10 days in total over 10 weeks, running parallel with module 4:**

- One day per week for 10 weeks, half the time to be spent in class in theoretical teaching and clinical simulation, the other half in the workplace undertaking supervised practice.

## Learning outcome

Demonstrate knowledge of, commitment to and performance based upon a non-discriminatory, recovery orientated values base to mental health care.

## Knowledge and skills

### The student should be able to:

- demonstrate comprehensive knowledge of the diversity and social inclusion agenda.
- show how their work reflects a commitment to an inclusive, recovery orientated set of values which respects diversity and multi-culturalism.
- show how they understand that diversity represents the range of cultural norms including personal, family, social and spiritual values held by the diverse communities served by the service within which the worker is operating.

## Assessment

This outcome is tested in the exam by assessing students' knowledge of the social inclusion, diversity and recovery literature, including policy literature; in the practical clinical planning scenario, where they will demonstrate the ability to prepare for the care of people with a variety of needs from a variety of diverse groups; and in the practice outcomes, where they will demonstrate the effective engagement of people from a range of social and cultural groups in low-intensity treatments.

## Teaching aids

Teachers should consult policy, sociological and advocacy literature to assist students to attain this objective. Aside from introductions in class, this objective is best achieved by students through directed reading.

 **Assessment A5, A6**

## Suggested reading

Bhugra, D. & Bahl, V., 1999. Ethnicity: an agenda for mental health. London: Royal College of Psychiatrists/Gaskell.

CCAWI website, [www.lincoln.ac.uk/ccawi/publications/Ten%20Essential%20Shared%20Capabilities.pdf](http://www.lincoln.ac.uk/ccawi/publications/Ten%20Essential%20Shared%20Capabilities.pdf)

Department of Health, 2005. Delivering race equality in mental health care: a summary. London: Department of Health.

Lester, H. & Glasby, J., 2006. Mental health policy and practice. Basingstoke: Palgrave Macmillan, Chapters 2, 3, 8 & 9.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson. Ch. 2.1.

Pilgrim, D. & Rogers, A., 1999. A sociology of mental health and illness. Buckingham: Open University Press.

Repper, J. & Perkins, R., 2003. Social inclusion and recovery. London: Bailliere Tindall.

Rethink webpage on recovery at [www.rethink.org/recovery](http://www.rethink.org/recovery)

Rogers, A. & Pilgrim, D., 2003. Mental health and inequality. Basingstoke: Palgrave Macmillan.

Ryan, T. & Pritchard, J. eds., 2004. Good practice in adult mental health. London: Jessica Kingsley.

Thornicroft, G., 2006. Shunned: discrimination against people with mental illness. Oxford: OUP.

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- show how they respect and value individual differences in age, sexuality, disability, gender, spirituality, race and culture.
- demonstrate understanding of how different groups in society construct and interpret their experiences of mental health.
- demonstrate how this understanding will impact on their information gathering, information giving and shared decision making when planning treatments for patients with different identities and characteristics.

## Assessment

This outcome is tested in the exam by assessing students' understanding of how different identities and characteristics will impact on their clinical practice; in the practical clinical planning scenario, where they will demonstrate the ability to prepare for the care of people with a variety of needs from a variety of diverse groups; and in the practice outcomes, where they will demonstrate the ability to engage with groups representing diverse cultural communities.

## Teaching aids

 **Assessment** A5, A6

## Suggested reading

Department of Health, 2002. A sign of the times: modernising mental health services for people who are deaf. London: HMSO.

Department of Health, 2005. Delivering race equality in mental health care: a summary. London: DH Publications.

Ethnicity Online. Useful web resources and good practice guidelines at [www.ethnicityonline.net/resources.htm](http://www.ethnicityonline.net/resources.htm)

HM Government Office for Disability Issues at [www.officefordisability.gov.uk/](http://www.officefordisability.gov.uk/)

MIND Factsheet on Lesbians, gay men, bisexuals and mental health at [http://www.mind.org.uk/help/people\\_groups\\_and\\_communities/lesbians\\_gay\\_men\\_and\\_bisexuals\\_and\\_mental\\_health](http://www.mind.org.uk/help/people_groups_and_communities/lesbians_gay_men_and_bisexuals_and_mental_health)

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson. Chapter 2.1.

National Center for Cultural Competence (US) at <http://www11.georgetown.edu/research/gucchd/nccc/index.html>

O'Hagan, K., 2001. Cultural competence in the caring professions. London: Jessica Kingsley.

Prior, P., 1999. Gender and mental health. Basingstoke: Macmillan.

Royal National Institute for the Blind at [www.rnib.org.uk](http://www.rnib.org.uk)

Stokes, G., 2000. Mental health problems in older people. In Bailey, D. (ed.) At the core of mental health: key issues for practitioners, managers and mental health trainers. Brighton: Pavilion Publishing Ltd, p.80-128.

## Learning outcome

Demonstrate knowledge of and competence in responding to people's needs sensitively with regard to all aspects of diversity, including the use of translation services.

## Knowledge and skills

This outcome builds on outcomes 1 and 2 and specifically addresses the use of translation services for people where required.

### Students must be able to:

- demonstrate how they will assess the need for, access to and use of translation services.

## Assessment

This outcome is tested in the exam by assessing students' understanding of how translation services are used; in the practical clinical planning scenario, where they will demonstrate the ability to consider and prepare for the potential need for translation services; and in the practice outcomes, where they will demonstrate, where appropriate, competence in the use of face-to-face and telephone translation services for people whose first language is not English.

## Teaching aids

 **Assessment A5, A6**

## Suggested reading

Bhugra, D. & Bahl, V., 1999. *Ethnicity: an agenda for mental health*. London: Royal College of Psychiatrists/Gaskell.

Department of Health, 2007. *Positive steps: supporting race equality in mental healthcare*. London: Department of Health.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

National Institute for Mental Health in England & Department of Health, 2003. *Inside/Outside-improving mental health services for black and minority ethnic communities in England*. London: HMSO.

## Learning outcome

Takes into account any physical and sensory difficulties patients may experience in accessing services and, if required, refer users to appropriate services.

## Knowledge and skills

### The student should be able to:

- demonstrate how to take into account any physical and sensory difficulties people may experience in accessing services, and how they make provision in their work to ameliorate these.
- show how they are aware of the difficulties people with different physical and sensory abilities may experience in daily life, how this may impact on their mental health and how it may form a barrier to accessing mental health care.

## Assessment

This outcome is tested in the exam by assessing students' understanding of how differences in physical and sensory abilities impact on mental health and access to mental health care; in the practical clinical planning scenario, where they will demonstrate the ability to consider and prepare for patients with different physical and sensory abilities; and in the practice outcomes, where they will demonstrate the effective engagement of people from a range of social and cultural groups in low-intensity treatments.

## Teaching aids

 **Assessment** A5, A6

## Suggested reading

Department of Health, 2002. A sign of the times: modernising mental health services for people who are deaf. London: HMSO.

HM Government Office for Disability Issues at [www.officefordisability.gov.uk/](http://www.officefordisability.gov.uk/)

Royal National Institute for the Blind at [www.rnib.org.uk](http://www.rnib.org.uk)

## Learning outcome

Demonstrate knowledge of and commitment to equal opportunities for all, and encourage patients' active participation in every aspect of care and treatment.

## Knowledge and skills


### The student should be able to:

- demonstrate how to act upon a commitment to equal opportunities for all, and how to work to encourage all people's active participation in care and treatment. Overall this should be demonstrated by students in the way in which they approach their work, their planning of treatment and their clinical practice.
- show the use of the principles of patient-centred practice to show how they promote people's active engagement when information gathering, information giving and especially shared decision making at all stages of their low-intensity clinical practice.
- demonstrate a focus on accurate information giving and choice.

## Assessment

This outcome is tested in the exam by knowledge of patient-centred practice, choice and equal opportunities; in the practical clinical planning scenario, where students will demonstrate the ability to consider a global approach to equal opportunities for patients; and in the practice outcomes, where they will demonstrate the effective engagement of people from a range of social and cultural groups in low-intensity treatments.

## Teaching aids

 **Film clips** Treatment Planning 1 and Treatment Planning 2, where psychological wellbeing practitioners describe choices available for patients and seek information about the patients' views on the cultural suitability of these choices for them

 **Assessment** A5, A6

## Suggested reading

Copeland, M., 2005. Wellness recovery action plan (WRAP). Liverpool: Sefton Recovery Group.

Department of Health, 2005. Delivering race equality in mental health care: a summary. London: DH Publications.

IAPT website, <http://www.iapt.nhs.uk>

Lester, H. & Glasby, J., 2006. Mental health policy and practice. Basingstoke: Palgrave Macmillan, Ch.9.

Mead, N. & Bower, P., 2002. Patient-centred consultations and outcomes in primary care: a review of the literature. *Patient Education and Counseling*, 48, p.51-61.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson. Ch. 2.1 and 2.2.

Repper, J. & Perkins, R., 2003. Social inclusion and recovery. London: Bailliere Tindall.

Rethink webpage on recovery at [www.rethink.org/recovery](http://www.rethink.org/recovery)

Rethink, 2005. A report on the work of the recovery learning sites and other recovery-orientated activities and its incorporation into The Rethink Plan 2004-08. London: Rethink.

Ryan, T. & Pritchard, J. eds., 2004. Good practice in adult mental health. London: Jessica Kingsley.

## Learning outcome

Demonstrate awareness and understanding of the power issues in relationships between professionals and patients.

## Knowledge and skills

### The student should be able to:

- demonstrate an understanding of the literature on power in professional / patient relationships and show how they take steps in their clinical practice to reduce any potential for negative impact this may have.
- critically analyse the nature of professional / patient relationships, taking into account how such concepts might facilitate or impede a patient's ability to engage with and implement a low-intensity treatment programme.

## Assessment

This outcome is tested in the exam by the student's demonstrating knowledge of the relevant literature and reflecting on how they will try to minimise the potential for harming the low-intensity clinical relationship in their practice, as well as the completion of the relevant practice outcome.

## Teaching aids

 **Assessment** A5, A6

## Suggested reading

Abbott, P. & Wallace, C. eds., 1990. The sociology of the caring professions. London: Falmer Press.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

Cahill, J. et al., 2006. A review and critical analysis of studies assessing the nature and quality of therapist/patient interactions in treatment of patients with mental health problems <http://www.nchta.org/project/1556.asp>

Mead, N. & Bower, P., 2000. Patient-centredness: a conceptual framework and review of the empirical literature. *Social Science and Medicine* 51(7), p.1087-1110.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

Norcoss, J., 2002. Psychotherapy relationships that work: therapist contributions and responsiveness to patients. Oxford: Oxford University Press.

Pilgrim, D. & Rogers, A., 1999. A sociology of mental health and illness. Buckingham: Open University Press.

Silverman, J., Kurtz, S. & Draper, J., 2005. Skills for communicating with patients. 2nd edition. Oxford: Radcliffe Publishing.

# A5 Clinical planning with a patient from a diverse social and cultural background

## Clinical component

The student is required to identify a patient on their case load who represents some form of diversity in terms of the range of cultural norms including personal, family, social and spiritual values held by the communities within which the student is operating. This could, for example, be a patient from a black or minority ethnic community, a patient with a disability, or an older person. The student is required to document how they ensured that the initial assessment was sensitive to the patient's needs. The student should demonstrate that they have negotiated a collaborative treatment plan with the patient (and, where appropriate, involved any carers or supporters of the patient) and identify how the treatment plan has been adapted to take account of the patient's background and needs.

This work should be presented to the student's teachers and peers in the form of a clinical case presentation.

	Comments	Marks Awarded
<b>Knowledge and understanding (55%)</b>	E.g. respect, competence and commitment to meeting people's needs sensitively with regard to all aspects of non-discriminatory, recovery orientated values and equal opportunities.	/55
<b>Structure, organisation and timing (10%)</b>	E.g. beginning, middle, end. Intro, objectives covered / not covered, timing.	/10
<b>Use of audio-visual aids (10%)</b>	E.g. use, clarity and number of slides, use and clarity of handouts.	/10
<b>Delivery (15%)</b>	E.g. balance of slide and audience facing behaviours, supplementation of slide information with verbal information, clarity and calmness of delivery with just occasional faltering, response to questions.	/15
<b>Use of source material (10%)</b>	E.g. breadth and depth of sources, inclusion of sources in the slides and handouts and as a bibliography.	/10
<b>TOTAL</b>		<b>/100</b>

# A6 Markers' guidelines for reflective commentary on the clinical planning exercise with a patient from a diverse social and cultural background

## Academic component

The worker is required to complete a 1000 word reflective commentary on their conduct of the initial assessment and subsequent treatment plan.

Institutions might wish to produce their own marking grid for this assignment utilising their own in-house criteria. The following provides a possible template for the assignment with indicative percentages of the marks in various categories.

### Knowledge and understanding (25%)

The student should demonstrate good understanding of the principles of patient-centred assessment and collaborative treatment planning. They should display knowledge of how to ensure that assessment and treatment planning are sensitive to a range of patient needs.

### Structure and organisation (10%)

The commentary should be logically and systematically structured. It should be well written and error-free and presented in accordance with the institution's guidelines.

### Application of theory to practice (25%)

Discussion of the student's practice performance should be supported by reference to the literature on the skills involved in patient-centred assessment and collaborative treatment planning and with rationales for how these might be adapted to meet a range of diverse patient needs.

### Critical reflection (30%)

The commentary should be analytical in nature and should document what went well and why and identify any areas for improvement saying how and why these might be achieved. The analysis should make reference to key concepts and theories.

### Use of source material (10%)

The commentary should be supported by a good depth and breadth of source material, referenced in accordance with the institution's guidelines on referencing.



# reflection



## **Module 4**

working within an employment,  
social and healthcare context

# Reflection

## Aims of module

Psychological wellbeing practitioners delivering low intensity interventions are expected to operate in a stepped-care, high-volume environment carrying as many as 45 active cases at any one time, with workers completing treatment of between 175 and 250 patients per year. Workers must be able to manage case loads, operate safely and to high standards and use supervision to aid their clinical decision making. Psychological wellbeing practitioners need to recognise their own limitations and direct people to resources appropriate to their needs, including step-up therapy; and they must focus on social inclusion – including return to work or other meaningful activity – as well as clinical improvement. To do so they must have knowledge of a wide range of social and health resources available through statutory and community agencies.

They must have a clear understanding of what constitutes high-intensity psychological treatment and how this differs from low-intensity work. This module will, therefore, equip workers with an understanding of the complexity of people's health, social and occupational needs and the services which can support people to recovery. It will develop workers' decision-making abilities and enable them to use supervision and to recognise when and where it is appropriate to seek further advice or for the patient to access a signposted or step-up service. Skills teaching will develop workers' clinical management, liaison and decision-making competences in the delivery of support to patients, particularly where they require intervention or advice outside the core low-intensity evidence-based individual or group interventions taught in module 2.

## Learning outcomes

1. Demonstrate competence in managing a case load of people with common mental health problems efficiently and safely.
2. Demonstrate knowledge of and competence in using supervision to assist the worker's delivery of low-intensity psychological and / or pharmacological treatment programmes for common mental health problems.
3. Appreciate and critically evaluate a range of employment, occupational and well-being strategies to help patients manage their emotional distress and disturbance.
4. Demonstrate knowledge of and competence in gathering patient-centred information on employment needs, well-being and social inclusion.
5. Demonstrate an appreciation of the worker's own level of competence and an understanding of how to work within a team and with other agencies with additional specific roles which cannot be fulfilled by the worker alone.
6. Demonstrate a clear understanding of what constitutes high-intensity psychological treatment and how this differs from low-intensity work.
7. Demonstrate knowledge of and competence in liaison with and signposting to other agencies delivering employment, occupational and other advice and services.
8. Critically appraise how the complex systems of community, statutory and voluntary sector provision of services work together.

## Learning and teaching strategies

### Knowledge

Lectures  
Seminars  
Discussion groups  
Guided reading  
Independent study

### Skills

Clinical simulation in small supervised groups  
Supervised practice through direct patient contact

## Assessment strategies

A standardised role-play scenario where workers are required to demonstrate skills in preparing for and using supervision. This will be videotaped and assessed by teaching staff using a standardised assessment measure.

Workers must also provide a 1,500-word reflective commentary on their performance.

Both parts must be passed.

An exam to assess module knowledge against the learning outcomes.

Successful completion of the following practice outcomes:

1. 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.
2. Demonstrating the ability to use regular scheduled supervision to the benefit of effective case management and personal development.
3. Integration of worklessness and employment initiatives into daily clinical practice to the benefit of all patients.

Knowledge assessments are at undergraduate and / or postgraduate level and assessed using percentage criteria. Skills based competency assessments are independent of academic level and must be achieved according to a pass / fail criterion.

## Duration

**10 days in total over 10 weeks, running parallel with module 3:**

- One day per week for 10 weeks, half the time to be spent in class in theoretical teaching and clinical simulation, the other half in the workplace undertaking supervised practice.

## Learning outcome

Demonstrate competence in managing a case load of people with common mental health problems efficiently and safely.

## Knowledge and skills

### The student should be able to:

- demonstrate knowledge of patient pathways into and out of active treatment in a stepped care, high-volume environment.
- show competence in managing this process in terms of their own case load, with as many as 45 active cases at any one time.
- demonstrate competence in organising appointments or contacts for service-users at different stages in recovery.
- demonstrate competence in decision making and recognition of how to prioritise patients who would benefit from different frequencies of contact, dependent on diagnoses, problem identification, symptom severity, disability, distress and impact on daily living.

## Assessment

This outcome is tested in the exam by assessing students' knowledge of the critical issues surrounding case load management and clinical decision making; in the simulation assessment and reflective commentary, where the student should demonstrate case load planning in supervision; and in the practice outcomes, where students should demonstrate the effective management of a case load.

## Teaching aids

**F** **Film clips** Supervision 1, Supervision 2 and Supervision 3, where students demonstrate discussing the management of a case load.

**A** **Assessment** A7, A8

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

National Institute for Clinical Excellence, 2007a. *Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2009. *Depression in Adults (update), Depression: the treatment and management of depression in adults*. London: National Institute for Clinical Excellence.

Raistrick, H. & Richards, D., 2006. *Designing primary care mental health services*. Hyde: Care Services Improvement Partnership.

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

Sainsbury Centre for Mental Health, 2003. *On our own terms: users and survivors of mental health services working together for support and change*. London: SCMH.

## Learning outcome

Demonstrate knowledge of and competence in using supervision to assist the worker's delivery of low-intensity psychological and / or pharmacological treatment programmes for common mental health problems.

## Knowledge and skills

### The student should be able to:

- articulate and demonstrate the competences required for supervision.
- recognise where they should seek supervision based on an assessment of their own clinical competence, patient clinical presentation and patient response to low-intensity treatments.
- present cases accurately and succinctly in supervision.
- use electronic records systems, particularly those built to automatically trigger supervision, to the benefit of their clinical practice and personal development.
- use process and outcome data to aid their discussions with supervisors and assist their self-reflection on their clinical practice.

## Assessment

This outcome is tested in the exam by assessing students' knowledge of the supervision process; in the simulation assessment and reflective commentary, where the student should demonstrate skills in preparing for and using supervision; and in the practice outcomes, where students should demonstrate the ability to use regular scheduled supervision to the benefit of effective case management and personal development.

## Teaching aids

- C Clinical procedure C8**
- F Film clips** Supervision 1, Supervision 2 and Supervision 3, where students demonstrate clinical case management supervision with their supervisors, using process and outcome data to facilitate the discussions and decision making.
- A Assessment A7, A8**

## Suggested reading

- Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.
- Gilbody, S. et al., 2006. Collaborative care for depression in primary care: Making sense of a complex intervention: systematic review and meta-regression. *British Journal of Psychiatry*, 189, p.484-493.
- Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.
- Richards, D.A. & Suckling, R., 2008. Improving access to psychological therapy: the Doncaster demonstration site organisational model. *Clinical Psychology Forum*, 181, p.9-16.
- Roth, A. & Pilling, S., 2007. *The competences required to deliver effective cognitive and behavioural therapy for people with depression and with anxiety disorders*. London: Department of Health.

## Learning outcome

Appreciate and critically evaluate a range of employment, occupational and well-being strategies to assist patients to manage their emotional distress and disturbance.

## Knowledge and skills

### The student should be able to:

- demonstrate knowledge of the role of employment, occupational and well-being strategies in good mental health.
- show that they have knowledge of statutory and community agencies which assist patients in their return to work and / or meaningful activity.
- demonstrate how they will use this knowledge in their clinical activity with patients.

## Assessment

This outcome is tested in the exam by assessing students' knowledge of the importance of employment and occupation for mental health, as well as the completion of the relevant practice outcome.

## Teaching aids

There are no specific teaching aids provided for this learning outcome. Teachers should consult the range of policy and employment literature to assist students to attain this objective. Aside from introductions in class, this objective is best achieved by students through directed reading.

## Suggested reading

Adam, S., Emmerson, C., Frayne, C. & Goodman, A., 2006. Early quantitative evidence on the impact of the Pathways to Work pilots: A report of research carried out by the Institute of Fiscal Studies on behalf of the Department for Work and Pensions. Department of Work and Pensions Research Report No. 354.

Black, C., 2008. Working for a healthier tomorrow. London: TSO. Available at <http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf>

Cobb, A., 2006. Managing for mental health: the Mind employers resource pack. London: Mind.

Gray, P., 1999. Mental health in the workplace: tackling the effects of stress. London: The Mental Health Foundation.

Layard, R., 2006. The depression report. London: London School of Economics.

## Learning outcome

Demonstrate knowledge of and competence in gathering patient-centred information on employment needs, well-being and social inclusion.

## Knowledge and skills

### The student should be able to:

- demonstrate the use of effective patient-centred information gathering through general open, specific open and finally specific questions in a patient-centred funnelling approach to gather information on patients' employment needs, well-being and social inclusion.
- collaboratively agree a problem statement which includes a summary of these issues where information gathering has identified them as issues for intervention.

## Assessment

This outcome is tested in the exam by knowledge of patient centred interviewing techniques; in the simulation assessment and reflective commentary where the student should demonstrate that they can gather and summarise employment, well-being and social inclusion issues for the attention of their supervisor; and in the practice outcomes, where students should demonstrate the ability to integrate worklessness and employment initiatives into daily clinical practice to the benefit of all patients.

## Teaching aids

- C Clinical procedure C8**
- F Film clips** Employment, where a worker conducts a patient-centred interview including information gathering and information giving about employment and occupation.
- A Assessment A7, A8**

## Suggested reading

Adam, S., Emmerson, C., Frayne, C. & Goodman, A., 2006. Early quantitative evidence on the impact of the Pathways to Work pilots: A report of research carried out by the Institute of Fiscal Studies on behalf of the Department for Work and Pensions. Department of Work and Pensions Research Report No 354.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

Black, C., 2008. Working for a healthier tomorrow. London: TSO. Online at <http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf>

Cobb, A., 2006. Managing for mental health: the Mind employers resource pack. London: Mind

Gray, P., 1999. Mental health in the workplace: tackling the effects of stress. London: The Mental Health Foundation.

Layard, R., 2006. The depression report. London: London School of Economics.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

Repper, J. & Perkins, R., 2003. Social inclusion and recovery. London: Bailliere Tindall.

## Learning outcome

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

## Knowledge and skills

### The student should be able to:

- demonstrate the ability to recognise the limits of their own competence and when and where it is appropriate to seek further advice, a step up or a signposted service.
- appreciate how the delivery of support to patients often involves liaison work, particularly where people require intervention or advice outside the core low-intensity evidence-based interventions taught in module 2.
- show knowledge of how to communicate with other workers within and without their own clinical teams.

## Assessment

This outcome is tested in the exam by knowledge of the wider health and social care services environment; in the simulation assessment and reflective commentary, where the student should demonstrate that they bring such issues to the attention of their supervisor; and in the practice outcomes, where students should demonstrate the effective management of a case load including referral to step up and signposted services.

## Teaching aids

**C** Clinical procedure C8

**F** Film clips Supervision 2 and Supervision 3, where a psychological wellbeing practitioner discusses their case load in supervision, including a case where stepping up to high intensity CBT is required.

**A** Assessment A7, A8

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Lester, H. & Glasby, J., 2006. *Mental health policy and practice*. Basingstoke: Palgrave Macmillan. Ch. 2, 3, 8 & 9.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

Pilgrim, D. & Rogers, A., 2005. *Sociology of mental health*. 3rd edition. Maidenhead: The Open University Press.

Raistrick, H. & Richards, D., 2006. *Designing primary care mental health services*. Hyde: Care Services Improvement Partnership.

Repper, J. & Perkins, R., 2003. *Social inclusion and recovery*. London: Bailliere Tindall.

Westbrook, D., Kennerley, H. & Kirk, J., 2007. *An introduction to cognitive behaviour therapy: skills and applications*. Michigan: Sage.

## Learning outcome

Demonstrate a clear understanding of what constitutes high-intensity psychological treatment and how this differs from low-intensity work.

## Knowledge and skills

### The student should be able to:

- articulate the difference between high-intensity psychological treatment, specifically cognitive behavioural treatment, and their own work at low intensity.
- evaluate the criteria by which different intensities of treatment can be distinguished and by the types of mental health difficulties each type of treatment is designed to assist.
- demonstrate understanding of how these different intensities of treatment are organised and fit into the structure of a stepped care model.

## Assessment

This outcome is tested in the exam by seeking answers to questions on students' knowledge of cognitive behavioural treatment, in the simulation assessment and reflective commentary where the student should demonstrate awareness of high intensity treatment options and in the practice outcomes where students should demonstrate the effective management of a case load including referral to high intensity CBT.

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Bower, P. & Gilbody, S., 2005. Managing common mental health disorders in primary care: conceptual models and evidence base. *BMJ*, 330, p.839-842.

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* (in press) doi:10.1016/j.brat.2009.07.010 .

## Teaching aids

**C** **Clinical procedure C8**

**F** **Film clips** Supervision 2 and Supervision 3, where a psychological wellbeing practitioner discusses their case load in supervision, including a case where stepping up to high intensity CBT is required.

**A** **Assessment A7, A8**

Gask, L., Lester, H., Kendrick, A. & Peveler, R., eds., 2008. *Handbook of primary care mental health*. London: Gaskell Publishing.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

National Institute for Clinical Excellence, 2005. *Post-traumatic stress disorder (PTSD): the management of PTSD in adults and children in primary and secondary care*. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2006. *Obsessive-compulsive disorder: core interventions in the treatment of obsessive-compulsive disorder and body dysmorphic disorder*. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2007a. *Anxiety (amended): management of anxiety (panic disorder, with or without agoraphobia, and generalised anxiety disorder) in adults in primary, secondary and community care*. London: National Institute for Clinical Excellence.

National Institute for Clinical Excellence, 2009. *Depression in Adults (update), Depression: the treatment and management of depression in adults*. London: National Institute for Clinical Excellence.

Westbrook, D., Kennerley, H. & Kirk, J., 2007. *An introduction to cognitive behaviour therapy: skills and applications*. Michigan: Sage.

## Learning outcome

Demonstrate knowledge of, and competence in liaison and signposting to other agencies delivering employment, occupational and other advice and services.

## Knowledge and skills

### The student should be able to:

- demonstrate competence in their liaison role when signposting patients to other agencies, such as those involved in employment, occupational and other well-being initiatives.

## Assessment

This outcome is tested in the exam by seeking answers to questions on processes for helping patients access broader support services, in the simulation assessment and reflective commentary where the student should demonstrate the ability to articulate this process to a supervisor, and in the practice outcomes where students should demonstrate the ability to integrate worklessness and employment initiatives into daily clinical practice.

## Teaching aids

**C** **Clinical procedure C8**

**F** **Film clips** Employment, where a worker conducts a patient-centred interview including information gathering and information giving about support from other agencies.

**A** **Assessment A7, A8**

## Suggested reading

Adam, S., Emmerson, C., Frayne, C. & Goodman, A., 2006. Early quantitative evidence on the impact of the Pathways to Work pilots: A report of research carried out by the Institute of Fiscal Studies on behalf of the Department for Work and Pensions. Department of Work and Pensions Research Report No 354.

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. The Oxford Guide to Low Intensity CBT Interventions. Oxford: Oxford University Press. Publication forthcoming 2010.

Black, C., 2008. Working for a healthier tomorrow. London: TSO. Available at <http://www.workingforhealth.gov.uk/documents/working-for-a-healthier-tomorrow-tagged.pdf>

Cobb, A., 2006. Managing for mental health: the Mind employers resource pack. London: Mind.

Gray, P., 1999. Mental health in the workplace: tackling the effects of stress. London: The Mental Health Foundation.

Myles, P. & Rushforth, D., 2007. A complete guide to primary care mental health. London: Robinson.

Repper, J. & Perkins, R., 2003. Social inclusion and recovery. London: Bailliere Tindall.

## Learning outcome

Critically appraise how the complex systems of community, statutory and voluntary sector provision of services work together.

## Knowledge and skills

### The student should be able to:

- demonstrate critical awareness of systems of health and social care and the way these operate
- include an appreciation of the roles of various sectors in health and social care such as community, commercial, statutory and voluntary providers.

## Assessment

This outcome is tested in the exam by seeking the students' understanding of the complexity of health and social care systems, as well as the completion of the relevant practical outcomes.

## Teaching aids

There are no specific teaching aids provided for this learning outcome. Teachers should consult a range of literatures to assist students to attain this objective. Aside from introductions in class, this objective is best achieved by students through directed reading.

## Suggested reading

Bennett-Levy, J., Richards, D.A. & Farrand, P., et al., eds., 2010. *The Oxford Guide to Low Intensity CBT Interventions*. Oxford: Oxford University Press. Publication forthcoming 2010.

Myles, P. & Rushforth, D., 2007. *A complete guide to primary care mental health*. London: Robinson.

Pilgrim, D. & Rogers, A., 2005. *Sociology of mental health*. 3rd edition. Maidenhead: The Open University Press.

Raistrick, H. & Richards, D., 2006. *Designing primary care mental health services*. Hyde Care Services Improvement Partnership.

Repper, J. & Perkins, R., 2003. *Social inclusion and recovery*. London: Bailliere Tindall.

Sainsbury Centre for Mental Health, 2003. *On our own terms: users and survivors of mental health services working together for support and change*. London: SCM.

## C8 Supervision for low-intensity working

Supervision is a key activity which has a number of functions, not least to ensure that workers deliver treatments which replicate as much as possible the procedures developed in those trials that underpin the evidence base – **treatment fidelity**. Although some key principles are common to all supervision models, low-intensity supervision is organised differently from most other models of supervision to account for the high case loads carried by psychological wellbeing practitioners. 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. Supervision also assists the personal development of workers' skills by identifying learning needs.

The type of supervision required for psychological wellbeing practitioners is called **Clinical Case Management Supervision**, normally carried out weekly. 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 such as PC-MIS ([www.pc-mis.co.uk](http://www.pc-mis.co.uk)) or COREIMS ([www.coreims.co.uk](http://www.coreims.co.uk)). The characteristics of clinical case management supervision are that it is undertaken at regular (usually weekly), timetabled intervals, rather than at the behest 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 psychological wellbeing practitioners should be familiar with the nature of low-intensity work, ideally having themselves delivered low-intensity treatments. Currently, psychological wellbeing practitioners tend to be supervised by CBT therapists from high-intensity steps. However, more experienced psychological wellbeing practitioners 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 psychological wellbeing practitioner and their supervisors. A large number of cases will usually be discussed in any one supervision session.

### 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:

- any new patients.
- all patients on the worker's case load should be discussed regularly, and certainly no less 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 wishes further support.

# C8 Supervision for low-intensity working

## Presenting cases

Psychological wellbeing practitioners should be able to present patient 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 process of rapid review of notes, outcome measures, risk and clinical activity far more efficient.

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 student'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 such as PC-MIS 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	

# 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%

	<b>Clear evidence demonstrated</b> (The student fully demonstrated the criteria)	<b>Some evidence demonstrated</b> (The student demonstrates part of the skill or limited skill)	<b>Insufficient evidence demonstrated</b> (The student demonstrated insufficient skill)
<b>Student has selected the correct cases identified for supervision from the case load in the simulation exercise</b>	(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

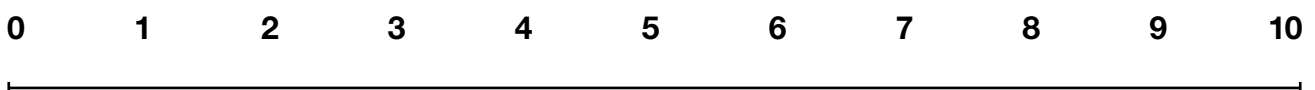
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# A7 Supervision simulation assessment

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%

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

# 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

	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Insufficient evidence demonstrated</b>
	(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'

	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Insufficient evidence demonstrated</b>
	(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			

0      1      2      3      4      5      6      7      8      9      10

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# A7 Supervision simulation assessment

## Discussion of cases – WEIGHTING 40%

	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Insufficient evidence demonstrated</b>
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)

0      1      2      3      4      5      6      7      8      9      10



# A7 Supervision simulation assessment

## Shared decision making – WEIGHTING 30%

	<b>Clear evidence demonstrated</b>	<b>Some evidence demonstrated</b>	<b>Insufficient evidence demonstrated</b>
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)



# A8 Markers' guidelines for reflective commentary on supervision simulation assessment

(% aspect weightings given in brackets)

Students should receive a copy of the film clip of their supervision simulation assessment in order to prepare a commentary on their performance. This commentary forms part of the academic assessment for the module. Suggested marking schedules are given below.

## **Knowledge and understanding (25%)**

Students should display knowledge and understanding of theories and concepts (relevant to giving information and shared decision making in supervision), suitably integrated into their commentary.

## **Structure and organisation (10%)**

The commentary should be logically and systematically structured. It should be legible, error-free and presented in accordance with institution's guidelines.

## **Application of theory to practice (25%)**

Discussion of the student's practice performance should be substantiated with reference to particular skills and techniques, with a rationale for their use.

## **Critical reflection (30%)**

The commentary should be balanced, detailing what went well, what was learnt from the video, what would be done differently next time, and why. The critical reflection should be supported by reference to key concepts and theories.

## **Use of source material (10%)**

The commentary should be informed by reference to relevant source material, suitably acknowledged utilising the institution's accepted system of referencing.



reinforce



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.

## 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.

## 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.

SAMPLE

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



# Reference

Taken from <http://www.iapt.nhs.uk/workforce/>

## JOB DESCRIPTION

**Post Title: IAPT Psychological Wellbeing Trainee**

**Band: 4**

**Responsible to:**

**Accountable to:**

**Key Relationships:**

### Job Purpose

This is a training role within the Improving Access To Psychological Therapies Programme (IAPT). The post-holder will work within the IAPT service providing high volume low intensity interventions whilst undertaking a programme of training for this role. The training post will equip the post-holder to provide a range of cognitive behavioural therapy (CBT) based self-management interventions to clients with mild to moderate anxiety and depression. The post-holder will attend all taught and self-study days required by the education provider, as specified within the National Low Intensity curriculum and work in the service for the remaining days of the week using their newly developed skills

The post holder will work with people with different cultural backgrounds and ages, using interpreters when necessary and should be committed to equal opportunities.

### Main Duties and Responsibilities

#### 1. CLINICAL

- 1.1 Accept referrals via agreed protocols within the service.
- 1.2 Assess and support people with a common mental health problem in the self-management of their recovery.
- 1.3 Undertake patient-centred interviews which identify areas where the person wishes to see change and / or recovery and make an accurate assessment of risk to patient and others.
- 1.4 Make decisions on suitability of new referrals, adhering to the department's referral protocols, refer unsuitable clients on to the relevant service or back to the referral agent as necessary or step-up the person's treatment to high intensity psychological therapy.
- 1.5 Provide a range of information and support for evidence based high-volume low-intensity psychological treatments. This may include guided self-help, computerised CBT, information about pharmacological treatments. This work may be face-to-face, by telephone or by other media.

- 1.6 Educate and involve family members and others in treatment as necessary.
- 1.7 Adhere to an agreed activity contract relating to the overall number of client contacts offered, and clinical sessions carried out per week in order to minimise waiting times and ensure treatment delivery remains accessible and convenient.
- 1.8 Attend multi-disciplinary meetings relating to referrals or clients in treatment, where appropriate.
- 1.9 Complete all requirements relating to data collection within the service.
- 1.10 Keep coherent records of all clinical activity in line with service protocols and use these records and clinical outcome data in clinical decision making.
- 1.11 Work closely with other members of the team ensuring appropriate step-up and step-down arrangements are in place to maintain a stepped care approach.
- 1.12 Assess and integrate issues surrounding work and employment into the overall therapy process.
- 1.13 Operate at all times from an inclusive values base which promotes recovery and recognises and respects diversity.

## **2. TRAINING AND SUPERVISION**

- 2.1 Attend and fulfil all the requirements of the training element of the post including practical, academic and practice based assessments.
- 2.2 Apply learning from the training programme in practice.
- 2.3 Receive supervision from educational providers in relation to course work to meet the required standards.
- 2.4 Prepare and present clinical information for all patients on their caseload to clinical case management supervisors within the service on an agreed and scheduled basis, in order to ensure safe practice and the clinical governance obligations of the worker, supervisor and service are delivered.
- 2.5 Respond to and implement supervision suggestions by supervisors in clinical practice.
- 2.6 Engage in and respond to personal development supervision to improve competences and clinical practice.

## **3. PROFESSIONAL**

- 3.1 Ensure the maintenance of standards of practice according to the employer and any regulating bodies, and keep up to date on new recommendations / guidelines set by the department of health (e.g. NHS plan, National Service Framework, National Institute for Clinical Excellence).
- 3.2 Ensure that client confidentiality is protected at all times.

# Reference

- 3.3 Be aware of, and keep up to date with advances in the spheres of treatment for common mental health problems.
- 3.4 Ensure clear objectives are identified, discussed and reviewed with senior therapists on a regular basis as part of continuing professional development.
- 3.5 Participate in individual performance review and respond to agreed objectives.
- 3.6 Keep up to date all records in relation to continuous professional development and ensure personal development plan maintains up to date specialist knowledge of latest theoretical and service delivery models / developments.
- 3.7 Attend relevant conferences / workshops in line with identified professional objectives.

## 4. GENERAL

- 4.1 To contribute to the development of best practice within the service.
- 4.2 To maintain up-to-date knowledge of legislation, national and local policies and procedures in relation to Mental Health and Primary Care Services.
- 4.3 All employees have a duty and responsibility for their own health and safety and the health of safety of colleagues, patients and the general public.
- 4.4 All employees have a responsibility and a legal obligation to ensure that information processed for both patients and staff is kept accurate, confidential, secure and in line with the Data Protection Act (1998) and security and confidentiality policies.
- 4.5 It is the responsibility of all staff that they do not abuse their official position for personal gain, to seek advantage of further private business or other interests in the course of their official duties.
- 4.6 This Job Description does not provide an exhaustive list of duties and may be reviewed in conjunction with the post holder in light of service development.

**Review date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

	Essential	Desirable	Assessment Method
<b>Qualification</b>	Evidence of working with people who have suffered with a mental health problem		Application Form
	Evidence of ability to study successfully at undergraduate year 1 level or the equivalent		Application Form
		Training in nursing, social work, occupational therapy, counselling or within a psychological therapy.	Application Form
		Psychology or other health related undergraduate degree.	Application Form
		Psychology or other health related postgraduate degree	Application Form
<b>Experience</b>	Evidence of working with people who have experienced a mental health problem		Application Form
		Experience of working in Primary Care Services	Interview Question
		Worked in a service where agreed targets in place demonstrating clinical outcomes	Interview Question
		Ability to manage own caseload and time	Interview
	Demonstrates high standards in written communication		Application Form / Test
Able to write clear reports and letters.		Portfolio / Test	

# Reference

	Essential	Desirable	Assessment Method
<b>Skills and Competencies</b>	<p>Ability to evaluate and put in place the effect of training</p> <p>Computer literate</p> <p>Excellent verbal and written communication skills, including telephone skills</p> <p>Able to develop good therapeutic relationships with clients</p>	<p>Received training (either formal of through experience) and carried out risk assessments within scope of practice</p>	<p>Interview Question</p> <p>Interview Question / Portfolio</p> <p>Interview / Application / Portfolio / Practical Test</p> <p>Practical Test</p> <p>Interview Question</p> <p>Reference</p>
<b>Knowledge</b>	<p>Demonstrates an understanding of anxiety and depression and how it may present in Primary Care</p>	<p>Demonstrates a knowledge of the issues surrounding work and the impact it can have on mental health</p> <p>Knowledge of medication used in anxiety and depression and other common mental health problems</p> <p>Demonstrates an understanding for the need to use evidence based psychological therapies and how it relates to this post</p>	<p>Interview Question / Practical Test</p> <p>Interview Question / Practical Test</p> <p>Interview Question</p> <p>Interview Question</p>
<b>Training</b>	<p>Able to attend a one day per week course</p> <p>Able to complete academic components of the course</p> <p>Able to integrate training into practice</p>		

	Essential	Desirable	Assessment Method
<b>Other Requirements</b>	High level of enthusiasm and motivation.		Interview
	Advanced communication skills		Interview
	Ability to work within a team and foster good working relationships		Reference
	Ability to use clinical supervision and personal development positively and effectively		Application Form / Interview
	Ability to work under pressure		Interview Test
	Regard for others and respect for individual rights of autonomy and confidentiality		Interview Question
	Ability to be self reflective, whilst working with service users, in own personal and professional development and in supervision		Interview Question
		Car driver and / or ability and willingness to travel to locations throughout the organisation	Interview Question
	Fluent in languages other than English	Application / Interview	

**Review date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

# Reference

Taken from <http://www.iapt.nhs.uk/workforce/>

## JOB DESCRIPTION

**Post Title: IAPT Psychological Well Being Practitioner**

**Band: 5**

**Responsible to:**

**Accountable to:**

**Key Relationships:**

### Job Purpose

The post-holder will work within the IAPT service providing high volume low intensity interventions which will be a range of cognitive behavioural therapy (CBT) based self management interventions to service to clients with mild to moderate anxiety and depression.

The post holder will work with people with different cultural backgrounds and ages, using interpreters when necessary and should be committed to equal opportunities.

### Main Duties and Responsibilities

#### 1 CLINICAL

- 1.1 Accept referrals via agreed protocols within the service.
- 1.2 Assess and support people with a common mental health problem in the self-management of their recovery.
- 1.3 Undertake patient-centred interviews which identify areas where the person wishes to see change and / or recovery and make an accurate assessment of risk to patient and others.
- 1.4 Make decisions on suitability of new referrals, adhering to the department's referral protocols, refer unsuitable clients on to the relevant service or back to the referral agent as necessary or step-up the person's treatment to high intensity psychological therapy.
- 1.5 Provide a range of information and support for evidence based high-volume low-intensity psychological treatments. This may include guided self-help, computerised CBT, information about pharmacological treatments. This work may be face-to-face, by telephone or by other media.
- 1.6 Educate and involve family members and others in treatment as necessary.

- 1.7 Adhere to an agreed activity contract relating to the overall number of client contacts offered, and clinical sessions carried out per week in order to minimise waiting times and ensure treatment delivery remains accessible and convenient.
- 1.8 Attend multi-disciplinary meetings relating to referrals or clients in treatment, where appropriate.
- 1.9 Complete all requirements relating to data collection within the service.
- 1.10 Keep coherent records of all clinical activity in line with service protocols and use these records and clinical outcome data in clinical decision making.
- 1.11 Work closely with other members of the team ensuring appropriate step-up and step-down arrangements are in place to maintain a stepped care approach.
- 1.12 Assess and integrate issues surrounding work and employment into the overall therapy process.
- 1.13 Operate at all times from an inclusive values base which promotes recovery and recognises and respects diversity.
- 1.14 Prepare and present clinical information for all patients on their caseload to clinical case management supervisors within the service on an agreed and scheduled basis, in order to ensure safe practice and the clinical governance obligations of the worker, supervisor and service are delivered.
- 1.15 Respond to and implement supervision suggestions by supervisors in clinical practice.
- 1.16 Engage in and respond to personal development supervision to improve competences and clinical practice.

## **2. PROFESSIONAL**

- 2.1 Ensure the maintenance of standards of practice according to the employer and any regulating body, and keep up to date on new recommendations / guidelines set by the Department of Health (e.g. NHS plan, National Service Framework, National Institute for Clinical Excellence).
- 2.2 Ensure that client confidentiality is protected at all times.
- 2.3 Be aware of, and keep up to date with advances in the spheres of treatment for common mental health problems.
- 2.4 Ensure clear objectives are identified, discussed and reviewed with senior therapists on a regular basis as part of continuing professional development.
- 2.5 Participate in individual performance review and respond to agreed objectives.
- 2.6 Keep up to date all records in relation to continuing professional development and ensure personal development plan maintains up to date specialist knowledge of latest theoretical and service delivery models / developments.
- 2.7 Attend relevant conferences / workshops in line with identified professional objectives.

# Reference

## 3. GENERAL

- 3.1 To contribute to the development of best practice within the service.
- 3.2 To maintain up-to-date knowledge of legislation, national and local policies and procedures in relation to Mental Health and Primary Care Services.
- 3.3 All employees have a duty and responsibility for their own health and safety and the health of safety of colleagues, patients and the general public.
- 3.4 All employees have a responsibility and a legal obligation to ensure that information processed for both patients and staff is kept accurate, confidential, secure and in line with the Data Protection Act (1998) and security and confidentiality policies.
- 3.5 It is the responsibility of all staff that they do not abuse their official position for personal gain, to seek advantage of further private business or other interests in the course of their official duties.
- 3.6 This Job Description does not provide an exhaustive list of duties and may be reviewed in conjunction with the post holder in light of service development.

**Review date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_

	Essential	Desirable	Assessment Method
<b>Qualification</b>	Qualification from PWP Training Course (Post Graduate Certificate or Level 3 undergraduate course) OR equivalent, e.g. Experience and Qualified Graduate Mental Health Worker with relevant Primary Care experiences and competences as required.		Application Form
		Training in nursing, social work, occupational therapy, counselling or within a psychological therapy.	Application Form
		Psychology or other health related undergraduate degree.	Application Form
		Psychology or other health related postgraduate degree	Application Form
<b>Experience</b>	Evidence of working with people who have experienced a mental health problem		Application Form
		Experience of working in Primary Care Services	Interview Question
		Worked in a service where agreed targets in place demonstrating clinical outcomes	Interview Question
	Demonstrates high standards in written communication	Ability to manage own caseload and time	Interview
			Application Form / Test
Able to write clear reports and letters.		Portfolio / Test	
	Evidence of working in the local community	Application Form / Interview	

# Reference

	Essential	Desirable	Assessment Method
<b>Skills and Competencies</b>	<p>Ability to evaluate and put in place the effect of training</p> <p>Computer literate</p> <p>Excellent verbal and written communication skills, including telephone skills</p> <p>Able to develop good therapeutic relationships with clients</p>	<p>Received training (either formal of through experience) and carried out risk assessments within scope of practice</p>	<p>Interview Question</p> <p>Interview Question / Portfolio</p> <p>Interview / Application / Portfolio / Practical Test</p> <p>Practical Test</p> <p>Interview Question</p> <p>Reference</p>
<b>Knowledge</b>	<p>Demonstrates an understanding of anxiety and depression and how it may present in Primary Care</p>	<p>Demonstrates a knowledge of the issues surrounding work and the impact it can have on mental health</p> <p>Knowledge of medication used in anxiety and depression and other common mental health problems</p> <p>Demonstrates an understanding for the need to use evidence based psychological therapies and how it relates to this post</p>	<p>Interview Question / Practical Test</p> <p>Interview Question / Practical Test</p> <p>Interview Question</p> <p>Interview Question</p>

	Essential	Desirable	Assessment Method
<b>Other Requirements</b>	High level of enthusiasm and motivation		Interview
	Advanced communication skills		Interview
	Ability to work within a team and foster good working relationships		Reference
	Ability to use clinical supervision and personal development positively and effectively		Application Form / Interview
	Ability to work under pressure		Interview Test
	Regard for others and respect for individual rights of autonomy and confidentiality		Interview Question
	Ability to be self reflective, whilst working with service users, in own personal and professional development and in supervision		Interview Question
		Car driver and / or ability and willingness to travel to locations throughout the organisation	Interview Question
	Fluent in languages other than English	Application / Interview	

**Review date:** \_\_\_\_\_

**Reviewed by:** \_\_\_\_\_





# iapt

Improving Access to Psychological Therapies



# rethink



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