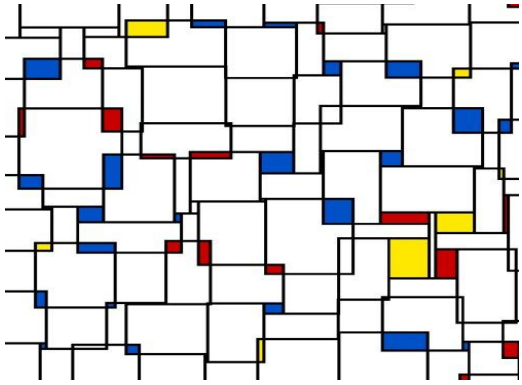

A competence framework for psychological interventions with people with psychosis and bipolar disorder

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The competences described in this report are designed to be accessed online and can be downloaded from:
www.ucl.ac.uk/CORE/

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The project team was headed by Anthony Roth and Stephen Pilling.

Expert Reference Group (ERG)
The work was overseen by an Expert Reference Group whose invaluable advice, editorial comments and collegial approach contributed enormously to the development of the work.

The ERG comprised:

Dr Katie Ashcroft, Dr Alison Brabban, Dr Frank Burbach, Professor Tom Craig, Dr Grainne Faden, Professor Philippa Garety, Professor Andrew Gumley, Andrew Harrison[1], Elizabeth Holford, Ian Hulatt, Dr Suzanne Jolley, Dr Steve Jones, Dr David Kingdon, Professor Elizabeth Kuipers, Dr Thomas Meyer, Professor Anthony Morrison, Dr Emmanuelle Peters, Professor Stephen Pilling, Professor Tony Roth, Professor Jan Dr Scott, Craig Steele, Professor Graham Turpin

Peer Reviewers
We are very grateful both to the members of the ERG, as well as to the following external reviewers: Dr Francesc Colom, Professor Ellen Frank, Dr Fiona Lobban, Dr Oliver Mason, Dr Anna Ruddle, Jo Smith, Dr Holly Swartz, Peter Woodhams, Dr Eduard Vieta

[1] Andrew Harrison was a very active contributor to the ERG, and his untimely death in 2012 was a major loss to the project

Contents

Executive summary

The report describes a method for identifying competences for staff working with people with psychosis and Bipolar Disorder. It organises the competences into five domains, with an overarching domain which identifies the 'therapeutic stance, values and assumptions' for work in this area. The domains are:

Core underpinning competences for work with people with psychosis and Bipolar disorder

Generic therapeutic competences required for managing clinical sessions and any form of psychological intervention

Assessment and Formulation competences

Specific interventions

Meta-competences – overarching, higher-order competences which practitioners need to use to guide the implementation of any assessment or intervention.

The report then describes and comments on the type of competences found in each domain, and organises these into a 'map' which shows how all the competences fit together and inter-relate. Finally it addresses issues that are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

A competence framework for working with people with psychosis and bipolar disorder

How to use this document

This report describes the model underpinning the competence framework, and indicates the various areas of activity that, taken together, represent good clinical practice. It describes how the framework was developed and how it may be used.

The report does not include the detailed descriptions of the competences associated with each of these activities. These are available to download as pdf files from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

A note on implementation

This framework was developed as part of the Severe Mental Illness initiative of the Improving Access to Psychological Therapies programme (along with a separate, but linked, competence framework for working with individuals with personality disorder).

Effective care for most people with bipolar disorder and psychosis usually requires sustained multi-disciplinary input provided in the context of specialist mental health services. Both of these emphases are reflected in this competence framework.

Although the current framework has some overlap with those developed for the IAPT programme for the management of depression and anxiety disorders (Department of Health, 2007; Roth and Pilling, 2008), work with these client groups is essentially primary care focused, and is based on a stepped-care model.

This means that the competences required to deliver psychological interventions in each context are different, and this framework should not be seen as endorsing the provision of psychological care for severe mental illness within those IAPT services whose primary purpose is to provide psychological interventions for depression and anxiety disorders.

Scope of the competence framework

Staff to whom the framework applies
The competence framework is designed to be relevant to staff in a range of clinical settings – it defines clinical knowledge and skills relevant to a range of professions (including clinical psychologists, psychiatrists[2], psychotherapists, family therapists, nurses, occupational therapists and social workers).

Areas of clinical work covered by the framework
The competence framework is focused primarily on clinical work, and excludes service management and development skills. Audit and research skills are not specified in depth, though the ability to make use of measures (and to monitor outcomes) is identified as a core clinical skill, as is the ability to make informed use of the evidence base relating to therapeutic models.

Role of supervision in supporting the implementation of the framework
Supervision plays a critical role in supporting competence practice, and the ability to make use of supervision is included in the framework. Competences associated with the delivery of supervision are detailed in a separate framework, available on the CORE website (www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm).

[2] Specialist skills relating to prescribing medication are not detailed in the framework; these have been specified by the Royal College of Psychiatrists as part of the training curriculum for psychiatrists (Royal College of Psychiatrists (2010) A Competency Based Curriculum for Specialist Training in Psychiatry: www.rcpsych.ac.uk/training/curriculum2010.aspx)

The development of the competence framework

1. Oversight and peer-review: The work described in this project was overseen by an Expert Reference Group (ERG) comprising leaders in the field of work with people with psychosis and Bipolar disorder from the UK, selected for their expertise in research, training and service delivery (the ERG membership is detailed in Appendix A). The ERG met regularly throughout the project to ensure that key texts, policy documents, service user documentation, and trial manuals were identified, advise on process, and to debate and review materials as they emerged.

In addition to review by the ERG, competence lists for specific areas of clinical activity and for specific interventions were reviewed by individuals identified as having particular expertise (on the basis of having published widely in an area of clinical activity, or as the originator or developer of the approach being described in the competence list). This process of open and iterative peer-review ensured that the competence lists were subject to a high level of scrutiny (peer reviewers are listed in the acknowledgments section).

2. Incorporating service user perspectives: Incorporation of the service user perspective was ensured by including service users as members of the ERG and by drawing on relevant literature which described service users' experience of being in receipt of interventions included in the framework.

3. Adopting an evidence-based approach to framework development[3]: A guiding principle for the development of previous frameworks (Roth and Pilling 2008) has been a commitment to staying close to the evidence-base for the efficacy of therapies, focussing on those competences for which there is either good research evidence or (where this is limited) strong expert professional consensus about their probable efficacy.

While we have applied this principle to this framework, it is important to note several important issues in relation to the evidence-base for work with people with psychosis and Bipolar Disorder (all of which needed to be taken into account):

a) Number of published research trials: Although an area of active research, there are relatively few randomised controlled trials examining the efficacy of

[3] An alternative strategy for identifying competences could be to examine what workers in routine practice actually do when they carry out a psychological intervention, complementing observation with some form of commentary from the workers in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological interventions are rooted in a theoretical framework which attempts to explain human distress, and this framework usually links to a specific set of actions aimed at alleviating the client's problems. It is these more 'rigorous' versions of an intervention that are examined in a research context, forming the basis of any observations about the efficacy of an approach or intervention. In routine practice these 'pure' forms of an intervention are often modified as workers exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which does not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice

psychological interventions in people with psychosis and still fewer for Bipolar Disorder. Consonant with guideline methodology the ERG examined the evidence and debated how best to manage where the absence of high quality evidence had implications for inclusion of an approach in the framework. Clearly an over-reliance to the current limited evidence base could narrow inclusion to a point where the range of interventions being described did not reflect those in common use; equally, adopting a low threshold could invalidate any claim to an evidence-based approach. As a consequence of the approach taken there is some restriction in the range of specific interventions included in the present framework, but it is important to acknowledge that this is a rapidly developing field with a number of trials in progress, and as the further evidence emerges this will need to be reflected in revisions of the framework.

b) Importance of, and evidence for, core, generic therapeutic and assessment and formulation skills: There is a clear professional consensus that interventions in this area rest on a set of 'underpinning' skills (core and generic therapeutic competencies), as well as a set of assessment and formulation skills. Denoting these as 'underpinning' skills should not be taken to indicate that they are simple or easy to deploy. For example, knowing how to collaboratively engage with someone experiencing psychotic symptoms is far from straightforward, as is the process of engaging the families of people suffering from psychosis. Providing psychological interventions in the context of a complex care package in multi-disciplinary team requires considerable skill and knowledge. However, there is often little *direct* evidence of the benefit of these skills from randomised control trials or from other types of study, possibly reflecting researchers' understandable reluctance systematically to manipulate clinician behaviour in this area, and also because researchers may assume that the inclusion of these elements in an intervention does not need to be explored further. However, although evidence on the causal contribution of underpinning and assessment skills is lacking, correlational studies have established the importance of several of the areas included in the framework (notably the importance of the therapeutic relationship to outcome (e.g. Horvath, Del Re, Flückiger & Symonds,2011; Shirk, Carver & Brown, 2011). Within the assessment field, evidence of the accuracy of the diagnostic process has been gathered through measuring the reliability and validity of standardised tests, scales and interview schedules (all of which are usually accompanied by detailed guidance for their delivery, equivalent to a therapy manual). Nonetheless, in the main the inclusion of specific "underpinning" skills usually rests on expert professional opinion and consensus rather than evidence.

c) Lack of formal evidence in basic areas of practice: Reinforcing the sense that many 'underpinning' and assessment skills are assumed to be critical to effective clinical practice and treatment delivery, most treatment manuals make general reference to their application; however they rarely detail the specific skills involved. As a consequence the competency team needed to draw on a range of resources to generate lists of relevant skills, including diagnostic manuals and

textbooks, training materials and (where gaps in the lists remained) their own clinical experience. As such this becomes a process led by professional judgement and experience rather than experimental studies, making peer review (described above) especially critical.

These issues all have bearing on the capacity of the framework to stay as close to the evidence base as possible, and in practice research has had to be is supplemented by expert professional consensus, congruent with models of evidence-based practice (e.g. Roth, Parry and Fonagy, 2005), and with the methodology adopted by NICE for clinical guideline development (NICE, 2012).

4. Inclusion and exclusion of specific interventions

An initial task for the ERG was to identify those interventions with evidence of efficacy, based on outcomes obtained in clinical controlled trials. This scoping exercise was based on extant clinical guidelines and reviews of the available evidence, in particular relevant NICE and SIGN clinical guidelines.

This exercise identified those interventions for which there was good evidence of efficacy, and which therefore needed to be included. However, the ERG also identified a number of further interventions which warranted inclusion because:

a) Evidence for an intervention had not been published prior to the publication of the relevant NICE or SIGN guideline and this precluded its inclusion in the relevant guidance (e.g. relapse prevention interventions in bipolar disorder).
b) The intervention is a development of an existing intervention already included in an existing NICE/SIGN guideline (e.g. work on command hallucinations in psychosis).

The ERG noted that decisions about inclusion or exclusion of particular approaches will change over time, as new evidence becomes available and our knowledge of the efficacy of specific interventions improves. This flags an important point - that the exclusion of an intervention should not be taken to indicate that it is ineffective, but only that the current lack of evidence for its efficacy does not support its inclusion at this time.

It should also be noted that in contrast to modality specific competence frameworks (which focus on the uni-professional delivery of an intervention) the model recognises the central importance of providing interventions in a multi-professional context, and this is reflected in the content of both the core and generic competences.

5. Extracting competence descriptions

a) "Underpinning" competences (Core Competences, Generic Therapeutic Competences, Assessment and Formulation Competences) As noted above, professional consensus indicates that effective practice requires clinicians to deploy "underpinning" competences and assessment and formulation skills. However, because these are not well-specified in manuals the process of competency extraction involved the following steps:

i). The core team generated an initial set of high-level descriptors that characterise areas of clinical and professional activity within each domain, drawing on:

- literature which contains behavioural descriptions of the relevant skills, such as textbooks, professional guidance materials, manuals and teaching materials
- other related competence frameworks developed by the UCL team which include broad descriptions of 'underpinning' and assessment skills,(in particular the frameworks for child and adolescent mental health services and for the delivery of CBT for depression and anxiety disorders).

Examples of these high-level descriptors within the domain of core competences include 'the Ability to Work Within and Across Agencies', or '"Knowledge of Common Physical Health Problems in People with Psychosis and Bipolar disorder"

The scope and implied content of these descriptors were debated by the ERG; through iterative review the areas of competence considered to constitute underpinning competences and assessment and formulation skills were agreed.

ii). An initial set of competence statements for these areas was generated by the core team, and subjected to internal review to check for accuracy, completeness and clarity.

iii). Each competence list was discussed and peer-reviewed by members of the ERG and by external experts, identifying omissions and any points of contention.

b) Specific interventions

The basis for inclusion of specific interventions is evidence of efficacy in a research trial, and most such trials will have developed or adopted a manual that describes the treatment model and associated treatment techniques. The manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Many research trials monitor therapist adherence (by assessing audio or video recordings), making it possible to be reasonably confident that if the procedures set out on the manual are followed there should be better outcomes for clients.

The procedure for extracting competences starts by identifying representative trials of an effective technique (bearing in mind that in some areas more than one research group

may be publishing data on the same or a closely related intervention package). The manuals associated with these successful approaches are identified; where there is more than one manual describing the same 'package' a decision made as to whether there is overlap between the approaches (in other words, whether they are variants of the same approach) or whether there are distinctive differences (justifying a separate competence list for each). Finally, the manuals are examined in order to extract and to collate therapist competences – a process detailed in Roth and Pilling (2008). As described above, draft competence lists were discussed by members of the ERG and subject to peer-review by members of the ERG and by external experts.

The competence model for psychosis and bipolar disorder

Organising the competence lists

Competence lists need to be of practical use. To achieve this they need to be structured in a way that reflects the practice they describe, be set out in a structure that is both understandable (in other words, is easily grasped) and be valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into seven domains.

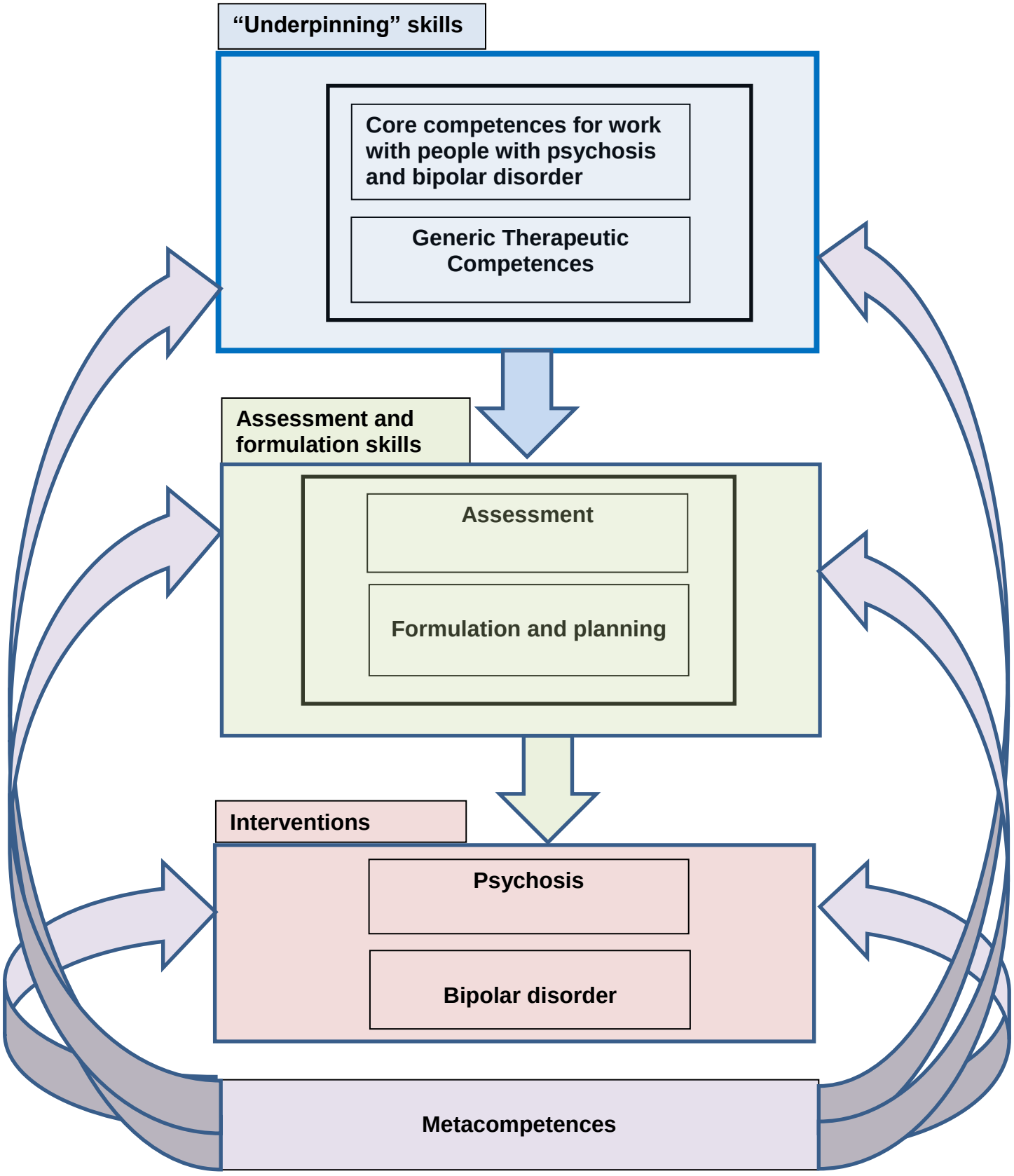


Figure 1 – Outline model for the psychosis and bipolar disorder Framework

The whole framework rests on two domains of 'underpinning' competences. The first is '**Core Competences For Work With People with Psychosis and Bipolar Disorder**' which identifies the knowledge needed by staff a) to understand the nature of presenting problems in this area of work b) to apply the professional and legal frameworks which exercise governance over service procedures c) to liaise with colleagues and other agencies, d) to work with difference d) to work with families and carers e) to apply knowledge of common physical health problems in people with psychosis and Bipolar Disorder and the pharmacological treatment of these presentations. The second domain ('**Generic Therapeutic Competences**') identifies the competences required to manage clinical sessions and any form of psychological intervention including collaborative engagement and fostering a therapeutic alliance. Taken together, the skills in these two domains should be demonstrated by all staff working psychologically with people with psychosis and Bipolar Disorder; their description as "underpinning" skills draws attention to the fact that they secure the integrity of all subsequent assessments and interventional procedures.

The next domain relates to **assessment, and formulation and planning**. Assessment competences focus both on the ability to undertake a comprehensive assessment and on risk assessment, as well as the ability to undertake an assessment in the context of the multiple systems to which clients are exposed. The section on formulation and planning recognises the importance not only of developing a formulation, but also the capacity to to communicate this to all relevant parties and to coordinate work with the various agencies involved in an individual's care, thereby ensuring the effective delivery of any intervention.

Specific psychological interventions are divided into two main areas, both of which share a common therapeutic stance or approach to the provision of psychological interventions. The first describes interventions for psychosis, the second interventions for bipolar disorder. A third area recognises the importance and relevance of common co-existing conditions such as depression and anxiety, and their impact on the effective delivery of the interventions in this domain.

The final domain in the model focuses on 'Meta-competences', so-called because they permeate all areas of practice, from "underpinning" skills through to specific interventions. Meta-competences are characterised by the fact that they involve making procedural judgments – for example, judging when and whether something needs to be done, or judging the ways in which an action needs to be taken or to be modified. They are important because these sorts of judgments are seen by most clinicians as critical to the fluent delivery of an intervention; effective implementation requires more than the rote application of a simple set of "rules": meta-competences attempt to spell out some of the more important areas of judgment being made.

Specifying the competences needed to deliver effective assessments and interventions

Commonalities across approaches

The framework describes a number of psychological interventions for people with psychosis and bipolar disorder. Although these vary in their content, all depend on a clinician's capacity to engage clients, their families and carers in a manner that is responsive to their needs and which engages with the client on their terms – by being sensitive to the ways in which they understand their illness and difficulties, and by being oriented to the fulfilment of aims and goals that are meaningful to them. This means that the focus of an intervention will vary from individual to individual and from family to family, depending on the factors that contribute to their problems, and the areas the client wishes to work on.

A second observation is that effective implementation of all the models described in this framework requires that they are implemented in a manner that is markedly more flexible and adaptive than is usual when working in other areas of mental health. This can be for a number of reasons – for example, clients may have a history of difficult relationships with mental health services that make them suspicious of help, they may have a limited understanding and experience of psychological approaches, or they may have cognitive difficulties that make it harder for them to concentrate and sustain prolonged periods of contact. This means that there should be no expectation of implementing a psychological model in a 'cookbook form; often a focus on engagement remains necessary throughout an intervention. Clinicians will need to be creative and adaptive in the ways that they implement treatments – for example, responding to the client's capacity and willingness to undertake therapeutic work, or being willing to engage in shared activities and informal conversations that serve to cement the therapeutic relationship and allow a 'breathing space' for the client. Maintaining this flexibility while staying 'on model' is challenging and demands a high level of skill, but is a necessary competence if clients are to achieve benefit.

Integrating knowledge, skills and attitudes

A competent practitioner brings together knowledge, skills and attitudes. It is this combination which defines competence; without the ability to integrate these areas practice is likely to be poor.

Practitioners need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence. Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about *how* to implement their skills, but also *why* they are implementing them. Beyond knowledge and skills, the practitioner's attitude and stance to an intervention is also critical – not just their attitude to the relationship with the client, but also to the organisation in which the intervention is offered, and the many cultural contexts within which the organisation is located (which includes a professional and

ethical context, as well as a societal one). All of these need to be held in mind, since all have bearing on the capacity to deliver interventions that are ethical, conforms to professional standards, and which are appropriately adapted to the client's needs and cultural contexts.

The map of competences

Using the map

The competence map is shown in Figure 2. It organises the competences into the seven domains outlined above and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

The map shows the ways in which the activities fit together and need to be 'assembled' in order for practice to be proficient. A commentary on these competences follows.

Some sections of the map are shaded in order to show which sections apply to all staff providing psychological interventions, and which to staff with specific training, as follows:

Blue and orange shading:	Competences in these areas should be demonstrated by all staff providing psychological interventions for psychosis or bipolar disorder
No shading:	Competence in these areas apply to those clinicians who have had the appropriate training and supervision to carry out the specific interventions listed in these sections.

Layout of the competence lists

Specific competences are set out in boxes.

Most competence statements start with the phrase "An ability to…", indicating that the focus is on the clinician being able to carry out an action.

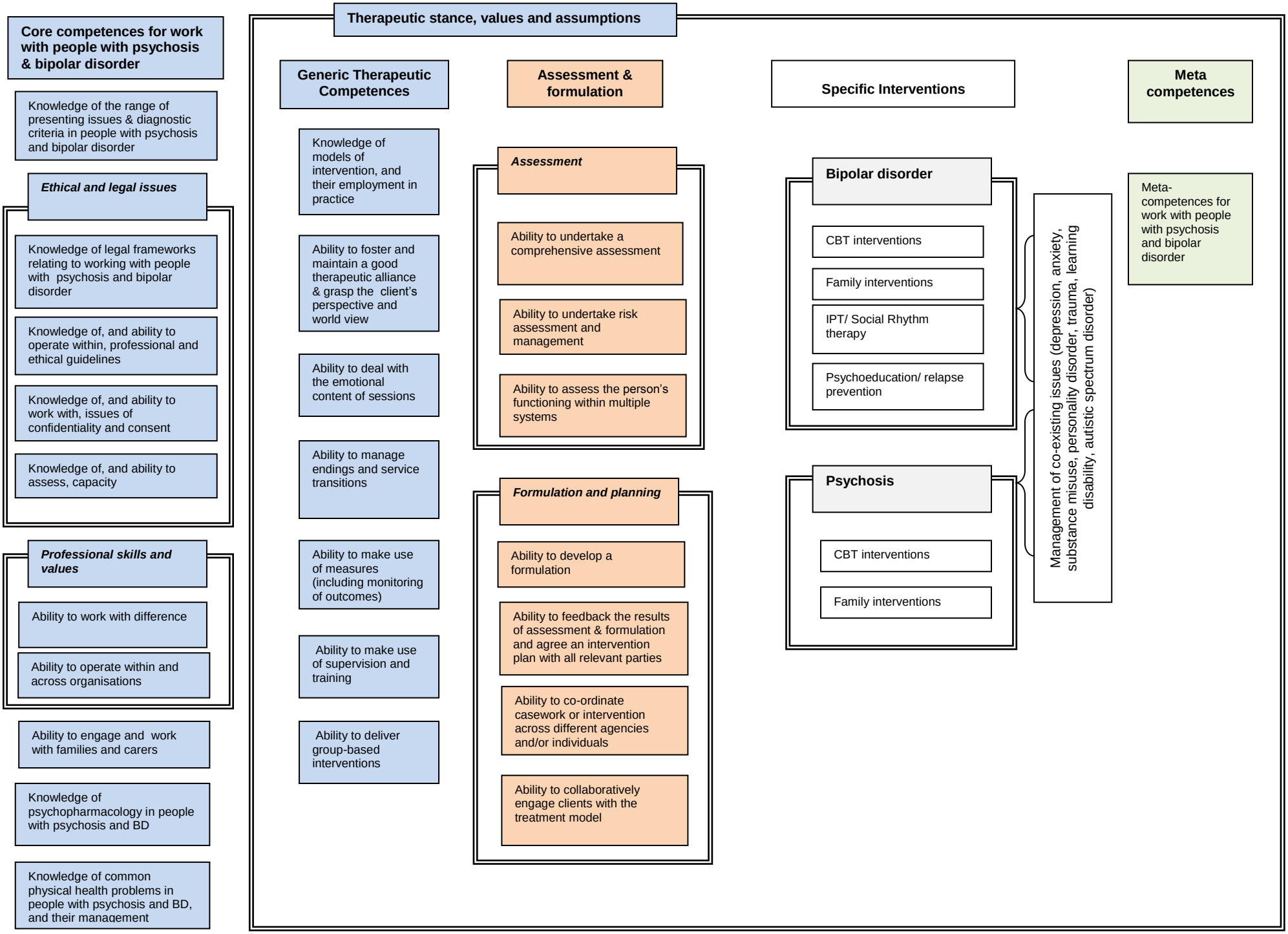
Some competences are concerned with the knowledge that a practitioner needs to carry out an action. In these cases the wording is usually "An ability to draw on knowledge…". The sense is that practitioners should be able to *draw* on knowledge, rather than having knowledge for its own sake (hence the competence lies in the application and use of knowledge in the furtherance of an intervention).

As far as possible the competence descriptions are behaviourally specific – in other words, they try to identify what a clinician actually needs to do to execute the competence.

At a number of points the boxes are indented. This usually occurs when a fairly high-level skill is introduced, and needs to be 'unpacked'. In the example below, the high level skill is the notion of being "to agree a shared language"; what follows are concrete examples of the sorts of things a clinician needs to do to achieve this.

An ability to draw on knowledge of the importance of working with each client to agree a shared language that embodies their model and understanding of their problems and concerns
an ability to hold in mind the fact that medical terms and diagnostic labels may be experienced as stigmatising, or as incongruent with the client's own model
an ability openly to discuss any differences in the language used by the client and by the therapist and other professionals involved in their care

The competences in indented boxes usually make most sense if practitioners hold in mind the high-level skill that precedes them. So with the same example, although using the language of the client is always a sensible thing to do, there is a very good conceptual reason for doing this: it will impact on (and therefore contribute to) clients' sense of being understood thereby support engagement in the therapy process. Bearing in mind the conceptual idea behind an action should give clinicians a 'road map', and reduce the likelihood that they apply techniques by rote.


Core competences for work with people with psychosis & bipolar disorder
Knowledge of the range of presenting issues & diagnostic criteria in people with psychosis and bipolar disorder
Ethical and legal issues
Knowledge of legal frameworks relating to working with people with psychosis and bipolar disorder
Knowledge of, and ability to operate within, professional and ethical guidelines
Knowledge of, and ability to work with, issues of confidentiality and consent
Knowledge of, and ability to assess, capacity
Professional skills and values
Ability to work with difference
Ability to operate within and across organisations
Ability to engage and work with families and carers
Knowledge of psychopharmacology in people with psychosis and BD
Knowledge of common physical health problems in people with psychosis and BD, and their management
Therapeutic stance, values and assumptions
Generic Therapeutic Competences
Knowledge of models of intervention, and their employment in practice
Ability to foster and maintain a good therapeutic alliance & grasp the client's perspective and world view
Ability to deal with the emotional content of sessions
Ability to manage endings and service transitions
Ability to make use of measures (including monitoring of outcomes)
Ability to make use of supervision and training
Ability to deliver group-based interventions
Assessment & formulation
Assessment
Ability to undertake a comprehensive assessment
Ability to undertake risk assessment and management
Ability to assess the person's functioning within multiple systems
Formulation and planning
Ability to develop a formulation
Ability to feedback the results of assessment & formulation and agree an intervention plan with all relevant parties
Ability to co-ordinate casework or intervention across different agencies and/or individuals
Ability to collaboratively engage clients with the treatment model
Specific Interventions
Bipolar disorder
CBT interventions
Family interventions
IPT/ Social Rhythm therapy
Psychoeducation/ relapse prevention
Psychosis
CBT interventions
Family interventions
Management of co-existing issues (depression, anxiety, substance misuse, personality disorder, trauma, learning disability, autistic spectrum disorder)
Meta competences
Meta-competences for work with people with psychosis and bipolar disorder

An outline of the framework

Core competences for work with people with psychosis or bipolar disorder

Knowledge of the range of presenting issues & diagnostic criteria in people with psychosis and bipolar disorder
Knowledge of mental health problems (including not only psychosis and bipolar disorder but also co-existing conditions such as depression and anxiety) is fundamental to assessment and intervention: it guides the practitioner's understanding of the person's needs, and forms an important foundation for a treatment intervention. It also facilities an understanding of the likely impact the disorder on a person's functioning both interpersonally and occupationally, and helps to define and understand what an improved sense of self or well-being can mean to an individual.

Ethical and legal issues

This includes competences in four areas:

Knowledge of legal frameworks relating to working with people with psychosis and bipolar disorder
Clinical work with people with serious and long-term mental health problems is underpinned by knowledge of the legal frameworks and policies that apply to the settings in which interventions take place. Practitioners also need to draw on knowledge of mental health legislation, the criteria for capacity and informed consent, data protection issues the conditions governing disclosure of information and equality legislation.

Knowledge of, and ability to operate within, professional and ethical guidelines
Practitioners need to draw on knowledge of ethical and professional guidance as a set of principles to be interpreted and applied to unique clinical situations. They also need to apply the codes of ethics and conduct that apply to all professional groups.

Knowledge of, and ability to work with, issues of confidentiality and consent
Managing confidentiality and consent requires practitioners to draw on knowledge of general ethical principles as well as their instantiation in local policies – for example, covering information sharing within and between teams or agencies.

Knowledge of, and ability to assess, capacity
Legislation on capacity applies to adults over the age of 16 and an ability to assess for and adjust interactions and interventions in relation to an individual's capacity is critical to good practice.

Ability to operate within and across organisations
Staff working with people with psychosis and bipolar disorder routinely communicate with professionals from other agencies such as housing and social work, as well as drawing on the expertise of other disciplines within the team itself. Inter-agency and inter-disciplinary working requires a knowledge of the responsibilities of other agencies and disciplines, as well as knowledge of relevant policies, procedures and legislation. It also demands skills in information sharing and communication as well as the ability to contribute to the co-ordination of casework, and the ability to recognise and manage challenges to effective inter-agency working.

Working with difference (cultural competence)
Respecting diversity, promoting equality of opportunity for people with psychosis and bipolar disorder and their families, and challenging inequalities and discrimination, is a significant aim in UK legislation and policy. The 'cultural competence' list teases apart and details the concrete values, knowledge and skills associated with this broad aim, and that should be demonstrated by all staff in routine clinical practice.

Ability to engage and work with families and carers
Engaging families and carers requires a range of skills focused on building and maintaining contact, and responding to any challenges in this area. Working with families (as opposed to individuals) poses particular challenges, as it requires clinicians to maintain the active (and parallel) involvement of all family members, and to communicate with each of them in a way that is congruent with their different developmental stages and their roles within the family. Throughout contact, the clinician engages the family by demonstrating skills in communication and collaborative working, and by monitoring potential threats to engagement.

Knowledge of psychopharmacology
Prescribing clinicians will have extensive knowledge of psychopharmacology, but knowledge of the role of medication in the treatment of psychosis and bipolar disorder is relevant for all clinicians. This includes knowledge of the recommendations of clinical guidelines and understanding of the uses of medication in combination with psychological interventions), and issues related to psychopharmacology in this area (such as the benefits and side-effects of medication).

Knowledge of common physical health problems in people with psychosis and bipolar disorder and their management
People with psychosis and bipolar disorder have an increased incidence of physical health problems. Knowledge of factors which contribute to this increased risk is important, as is a capacity to help individuals manage mitigate these (including those resulting from the side-effects of medication) by helping clients to access appropriate physical health interventions.

Therapeutic stance, values and assumptions

These competences shape the way that all interventions are understood and delivered; they set out the way in which clinicians position themselves in relation to clients and their families and carers, along with the values and assumptions that drive work in this area,. So, for example, they assert the importance of working collaboratively, of agreeing a shared language with clients that embodies their understanding of their problems, of focusing on the whole person, their context, and their individual cultural and spiritual preferences, and of working in a spirit of hope and optimism and in a responsive and transparent manner. These are not abstract or aspirational competences; they are assumed to contribute to the effectiveness of clinical work.

Generic Therapeutic competences

Knowledge of models of intervention, and their employment in practice
All staff working psychologically with people with psychosis or bipolar disorder need to know about the principles underlying the psychological interventions they or their colleagues are providing, as well as the evidence base for them, whether or not they actually practise the intervention themselves. Obviously the depth of their knowledge will vary in relation to the activity they are carrying out – for example, the knowledge required to discuss treatment options with an individual is different from that needed to deliver the intervention.

Ability to foster and maintain a good therapeutic alliance and grasp the client's perspective and world view
The "therapeutic alliance" is the capacity to build and to maintain a therapeutic relationship in which the practitioner develops a 'bond' with the individual or family and reaches agreement on the goals and tasks of the assessment and intervention. Successfully building a positive alliance is associated with better outcomes across all therapies, and developing the alliance depends on an ability to apprehend the ways in which an individual understand themselves and the world around them.

Ability to deal with the emotional content of sessions
Managing the emotional content of sessions is central to all contacts with a person or family. The practitioner has to reflect on the meaning of the individual's emotional expression/behaviour, and during interventions elicits emotions that facilitate change. Throughout both assessment and intervention, the practitioner has to manage any strong emotions such as excessive anger and related aggressive behaviour, and also avoidance of strong affect.

Ability to manage endings and service transitions
Endings and service transitions can be a difficult time for individuals or families and the practitioner. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the 'management' of the therapeutic relationship. The

practitioner has to manage both planned endings and premature or unplanned endings where the individual or family terminates contact with the service earlier than planned. An important consideration in all endings involves the assessment of any risk to the individual from terminating treatment or leaving the service.

Ability to make use of measures (including monitoring of outcomes)
There is considerable value in 'informal' self-reports regarding problems and any changes they have occurred. However, it is good practice for practitioners to record changes systematically, using measures, questionnaires, or diaries. These are somewhat distinct sources of information; measures usually capture phenomena that are common to individuals with a particular problem, whereas diary records are a way of helping them to elaborate on their own idiosyncratic concerns. Both help to anchor assessment and therapy by making use of information that is current and (broadly speaking) objective.

Ability to make use of supervision and training
The ability to use supervision is a generic skill pertinent to all practitioners at all levels of seniority, reflecting the fact that clinical work is demanding and usually requires complex decision making. Supervision allows practitioners to keep their work on track and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

Ability to deliver group-based interventions
Groups both for individual and families are an evidence based method for the delivery of psychological interventions, The focus and purpose of the group interventions may vary but this section covers a set of generic group competences including an ability to plan the group structure and to recruit appropriate service users, as well as a capacity to engage group members and manage group process.

Assessment

Ability to undertake a comprehensive assessment
A comprehensive assessment should be based on an acknowledgement that there are no clear-cut distinctions between engagement, assessment, formulation and intervention, and that formulations and intervention plans will need to be revised as new assessment information emerges. That said, the ability to undertake a thorough assessment is crucial to the effective delivery of any psychological interventions in this area. A comprehensive assessment will need to take account of engagement, confidentiality and the recovery model to provide a framework in which to integrate information from the client, referrers and other sources of information,. It should also include a careful assessment of any psychotic phenomena, mood states and any co-existing mental disorders. Assessment (and awareness of) physical health, family support and functioning and a person's capacity are all important features of a comprehensive assessment.

Ability to undertake risk assessment and management
A core part of a comprehensive assessment includes an appraisal of any risk to the individual or to others. Risk assessment is a challenging task and can be carried out to varying levels of detail, following different types of risk assessment model. Bearing this in mind, the ability of workers to know the limits of their competence and when to make use of support and supervision will be essential.

Ability to assess the person's functioning within multiple systems
A further component of a comprehensive assessment is the ability to assess an individual's functioning within multiple systems. Knowledge of the different care and support systems that surround the individual and their family is crucial for reaching an understanding of their beliefs and behaviour.

Formulation and planning

Ability to develop a formulation
Interlinked with assessment skills is the ability to create a tailored formulation of the individual's difficulties and to feedback the results of a treatment plan. The aim of a formulation is to explain the development and maintenance of the client's difficulties, Formulations and treatment plans are constructed in collaboration with the individual or the family, and the expectation is that they are periodically reviewed in the light of new assessment or intervention information.

Ability to feedback the results of assessment and agree an intervention plan with all relevant parties
Feedback is a collaborative process and the client should be consulted on how the assessment and the formulation will be presented. Feedback should include an outline of the presenting problems and the formulation, presented in a manner (in terms of pace and complexity) that is appropriate to the individual's capacity to process and assimilate the relevant information. This should facilitate the development of an agreed formulation which identifies any planned interventions, how these will be delivered, what outcomes are desired, who else may be involved in the treatment programme and when the intervention may end.

Ability to co-ordinate casework or intervention across different agencies and/or individuals
A focus on the welfare of the service user should be the overarching focus of all intra- and interagency work. Clinicians need be able to lead and co-ordinate casework both within ta team and across other agencies. This goes further than the knowledge and skills detailed in the competence of "interagency working" (which focuses on themes relevant to any interagency interaction) as the coordination of a specific case requires careful attention to the organisational and systemic processes known both to promote - and just as critically, to disrupt – effective working. As such, this section identifies the specific competencies required to co-ordinate a case at each stage from referral to discharge.

Specific interventions

The competences in this domain are set out under the two headings of bipolar disorder and psychosis, with a cross cutting domain addressing co-existing conditions. They are set out as a coherent description of the critical elements of (and pathways through) each intervention. For clarity each list is set out as a self-contained document, but all are prefaced by a reminder that their effective delivery will rest on employing relevant core, generic therapeutic, assessment and formulation competences (as well as metacompetences). The lists in this section are organised by broadly by diagnosis, though it is recognised that many people will present with co-existing conditions.

Wherever possible specific therapeutic approaches are represented by a single list, even where evidence for efficacy is derived from a number of different research groups, each with their own approach to the work. For example, although CBT for psychosis draws on a number of different manuals, each of these share a common root and a set of shared assumptions, and it would be misleading and unhelpful to present each as a distinct therapeutic approach. Similarly, family interventions for psychosis and for Bipolar disorder take essentially the same approach, and as such there is only one, integrated listing of competences.

Finally, it should be noted that effective delivery of CBT for psychosis and Bipolar disorder and of Interpersonal and Social Rhythm Therapy for Bipolar disorder are premised on clinicians being able to demonstrate the competences contained in the CBT and IPT competence frameworks accessed at: www.ucl.ac.uk/CORE/).

Cognitive Behavioural Therapy

CBT for bipolar disorder

This section sets out the knowledge required to structure a CBT intervention for bipolar disorder, including the processes of engagement, assessment, formulation and intervention. The emphasis throughout is on a collaborative and flexible approach to care, working with individual clients and where appropriate family members and professional carers. There is a specific focus on strategies to help clients manage fluctuations in mood state, including establishing routines to monitor and manage sleep and physical activity. There is also a focus on assessing and developing resilience, and on protective and risk factors relevant to therapy

CBT for psychosis

As with CBT for bipolar disorder the emphasis throughout this listing is on a collaborative and flexible approach to care. A central concern is a focus on identifying and working with the factors that drive and maintain distress. Along with psycho-education and ‘normalisation’, there is a specification of symptom-specific competences,

which focus on delusional beliefs, paranoid thinking and hallucinations, negative symptoms and trauma. .

Family interventions for bipolar disorder and psychosis
This section sets out the principles which underpin effective family interventions and the importance of understanding the impact that mental disorders can have on family life. It details the skills required to engage families and the core components of family interventions (including psychoeducation, problem solving, communication skills and crisis management). The competences to deliver Multi-Family Groups are also described.

Interpersonal Psychotherapy/ Social Rhythm therapy for bipolar disorder
IPT/SRT adopts many of the assumptions and techniques of IPT for depression. As a consequence it is based on a social role/interpersonal model, along with a focus on the impact of biological process (such as circadian rhythms) which can be disrupted in bipolar disorder, and the impact of the disorder on social role dysfunction and how these problems can be addressed.

Psycho-education/ relapse prevention for bipolar disorder
There is evidence of the benefits of psychoeducation as a stand-alone intervention, especially in when offered in a group context (rather than as a one-to-one intervention). Two programmes are included in this section, each following similar principles, but listed separately because they are delivered in somewhat different ways. Both focus on the skills needed to increase a client's understanding of the disorder, their adherence and involvement in treatment interventions (including medication) and reducing unhelpful strategies such as substance misuse. There is also a strong emphasis on detection of indicators of relapse, for hypomania, mania and depression. Enabling clients to develop structured routines and reduce psychosocial stressors is also an important element of these programmes.

Co-existing conditions
Most clients with psychosis or bipolar disorder present with co-existing conditions (such as depression or anxiety). Rather than describing these as 'co-morbid'(which implies that they are best seen as separate conditions) it may be more accurate to describe them as co-existing. Because they can directly contribute to the exacerbation of symptoms of psychosis and bipolar disorder, clinicians need to be able to consider their impact when assessing, formulating and intervening, and this listing sets out the competences relevant to this endeavour.

Metacompetences

The psychological treatment of psychosis and bipolar disorder cannot be delivered in a 'cook book' manner: by analogy, following a recipe is helpful, but it doesn't necessarily make for a good cook. Skilful implementation of most areas of clinical work rests on an ability to implement "procedural rules" – using clinical judgment to decide when, how and whether to carry out a particular action or set of actions in order to make an intervention or a procedure responsive to the needs of each individual child and their family.

On the whole metacompetences are more abstract than those described elsewhere and, as a result, there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Some of the list has been extracted from manuals; some are based on expert professional consensus and some on research-based evidence (for example, an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise).

Implementing the competence framework

A number of issues are relevant to the practical application of the competence framework.

Do all clinicians providing psychological interventions for bipolar disorder and psychosis need to be able to do everything specified in the competence list?
As described above, not all clinicians are expected to carry out all the competences in all the domains of the framework. However, any member of a team who is involved in the provision of a particular psychological intervention for psychosis or bipolar disorder *would* be expected to be able to demonstrate "underpinning" skills (core and generic therapeutic competences), and the relevant assessment, formulation and planning skills Whether or not an individual clinician will demonstrate competence across the range of specific interventions will depend on their having had the appropriate training and supervision to carry out the procedures and interventions that are listed in these sections.

How the metacompetences apply is more complex: some apply to all aspects of psychological work with psychosis or bipolar disorder, while others relate to the implementation of specific interventions or specific procedures, and so only apply when these are being carried out. For example, a metacompetence that applies to all workers is one that refers to information sharing and balancing confidentiality against the need to protect the client and the public. Others apply to the application of specific interventions (for example, "[adapting] treatment protocols so that they can be applied to the individual case"). As such, which metacompetences apply depends on the work a particular clinician is conducting.

Is every competence in a competence list of equal importance?
Many of the lists are quite detailed, and each of the competences are included either because they formed part of an intervention that shows evidence of efficacy, or because expert opinion indicates that these are important and relevant skills. Given that some of these lists are quite long, it is reasonable to ask whether al the skills are of equal value. This is a hard question to answer, because there is often little research evidence for the mutative value of *specific* skills – most evidence relates to *packages* of skills. This means that we cannot be sure which specific skills are likely to make a difference, and which are potentially neutral in their effect. Until we have more evidence it isn't possible to declare some skills more critical than others, but equally we cannot declare some skills or procedures optional. To that extent, all the competences are of equal value.

Does this mean that clinicians can use their judgment to decide which elements of an intervention to include and which to ignore? This could be a risky strategy, especially if this meant that major elements or aspects of an intervention were not offered – in effect clinicians would be making a conscious decision to deviate from the evidence that the package works. Equally, manuals cannot be treated as a set of rigid prescriptions, all of which have to be treated as necessary and all of which must be applied. Indeed most of the competence lists for problem-specific interventions refer to an important metacompetence – the ability to introduce and implement the components of a programme in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components are included. This involves using informed clinical judgment to derive an intervention mapped to the needs of an individual client while having due regard to what is known about 'best practice' (a process that parallels the judgment required to apply clinical guidelines to the individual case).

Another factor is that most interventions evolve over time, especially as research helps to identify the elements that make a difference and are associated with efficacy. However it can take some time before research validates the benefit of innovations, and as a consequence there is often a lag between the emergence of new ideas and their inclusion in clinical guidelines. This means that intervention packages should not be viewed as tablets of stone – though equally this is not a reason for clinicians to adopt "pick and mix" approach to the competences they incorporate into a 'standard' treatment.

The impact of treatment formats on clinical effectiveness: The competence lists in this report set out what a therapist should do, but most do not comment on the way in which an assessment or intervention is organised and delivered. For example, the duration of each session of a psychological treatment, how sessions are spaced (e.g. daily, weekly or fortnightly) or the usual number of sessions. However, these formats are often identified in clinical guidelines, and in manuals and research protocols, with the schedule constructed so as to match to clinical need and the rationale for the intervention.

When implemented in routine services, treatment formats often deviate from the schedules used in research trials. This can be for a range of reasons, but it is reasonable to ask whether making significant changes to the format may impact on effectiveness. This

is a difficult question to answer because on the whole there is rather little research evidence on which to draw. However, where research has been conducted – for example in the area of parenting programmes – it suggests that better outcomes are achieved when therapists show greater fidelity to the procedures set out in the manuals (e.g. Eames, Daley, Hutchings, Whitaker, Jones, Hughes, & Bywater, 2009). It is also the case that fidelity in parent programmes is best conceived as adherence to a number of overarching areas of activity (including an ability to apply social learning theory, a capacity to work with group process while also attending to each individual parent, and an ability to assure access and active support to maintain the engagement and involvement of parents). As such there is much that could be neglected if clinicians deliver bespoke programmes that include some, but not all, these areas. Generalising this observation across all interventions, it suggests that when clinicians vary a 'standard' treatment procedure they should have a clear rationale for so doing, and that where procedures are varied there should be careful monitoring and benchmarking of clinical outcomes in order to detect whether this has a neutral or an adverse impact.

The contribution of training and supervision to clinical outcomes: Elkin (1999) highlighted the fact that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (2010) examined 27 major research studies of CBT for depressed or anxious adults, identifying the training and ongoing supervision associated with each trial. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy - a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the competence framework

This section sets out the various uses to which the competence framework can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed

Commissioning: The framework can contribute to the effective use of health care resources by enabling commissioners to specify both the appropriate levels and the range of competences that need to be demonstrated by staff providing psychological

interventions for psychosis or bipolar disorder to meet identified local needs. It could also contribute to the development of more evidence-based systems for the monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of services: The framework represents a set of competences that (wherever possible) are evidence-based, and aims to describe best practice - the activities that individuals and teams should follow to deliver interventions.

Although further work is required on their utility and on associated methods of measurement – they should enable:

- the identification of the key competences required by a practitioner to deliver psychological interventions for psychosis or bipolar disorder
- the identification of the range of competences that a service or team would need to meet the needs of the populations with whom they work
- the likely training and supervision competences of those delivering psychological interventions for psychosis or bipolar disorder

Because the framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice regarding the implementation of therapies (as set out in NICE guidance or National Quality Standards along with other national and local policy documents) with the interventions actually delivered. Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of research trials on which claims for the efficacy of specific interventions rest. In this way it could help to ensure that evidence-based interventions are likely to be provided in a competent and effective manner

Clinical governance: Effective monitoring of the quality of services provided is essential if service users are to be assured optimum benefit. The monitoring the quality and outcomes of psychological interventions for psychosis or bipolar disorder is a key clinical governance activity; the framework will allow providers to ensure that interventions are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of clinician's performance

The introduction of the psychosis and bipolar competence framework into clinical governance can be achieved through local implementation plans for NICE/ SIGN guidance and their monitoring through the local audits procedures as well as by the monitoring systems of organisations such as the Care Quality Commission.

Supervision: Used in conjunction with the competence framework for supervision (www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm), this framework potentially provides a useful tool to improve the quality of supervision for psychological interventions by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two

aims – to improve outcomes for clients and to improve the performance of practitioners; the framework will support both these through:

- providing a structure by which to identify the key components of effective practice for specified disorders
- allowing for the identification and remediation of sub-optimal performance

The framework can achieve this through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Training: Effective training is vital to ensuring increased access to well-delivered psychological therapies. The framework can support this by:

- providing a clear set of competencies which can guide and refine the structure and curriculum of training programmes[4], including pre and post-qualification professional trainings as well as the training offered by independent organisations
- providing a system for the evaluation of the outcome of training programmes

Research: The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the relationship between therapy process and outcome and the evaluation of training programmes and supervision systems.

Concluding comments

This report describes a model which identifies the activities which characterise effective psychological interventions for psychosis or bipolar disorder, and locates them in a "map" of competences.

The work has been guided by two overarching principles. Firstly it stays close to the evidence-base and to expert professional judgment, meaning that an intervention carried out in line with the competencies described in the model should be close to best practice, and therefore likely to result in better outcomes for service users. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way in which interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen

[4] At the time of publication this application is in the process of being actioned

as a cook-book. Delivering effective interventions involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians need to operate using clinical judgment in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way which clarifies the activities associated with skilled and effective practice in the psychological treatment of psychosis or bipolar disorder should prove useful for staff in all parts of mental health services. The more stringent test is whether it results in more effective interventions and better outcomes for clients of these services.

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