A competence framework for psychological interventions with people with persistent physical health conditions

Anthony D. Roth and Stephen Pilling

Research Department of Clinical, Educational and Health Psychology, UCL

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

Author affiliations

Professor Anthony Roth, Joint Course Director, Doctorate in Clinical Psychology, Research Department of Clinical, Educational and Health Psychology, UCL

Professor Stephen Pilling, Director of CORE, Director of the National Collaborating Centre for Mental Health, Research Department of Clinical, Educational and Health Psychology, UCL

Acknowledgements

Contents

A competence framework for working with people with persistent physical health conditions

Executive summary

The report describes a method for identifying competences for staff working with people with persistent physical health conditions. It organises the competences into seven domains, with an overarching domain that identifies the 'therapeutic stance, values and assumptions' for work in this area. The domains are:

- o Core professional competences for work with people with persistent physical health conditions

- o Core knowledge and clinical competences for people with persistent physical health conditions

- o Competences relevant to psychologically-informed cross-condition interventions

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

- o Assessment, Formulation, Engagement and Planning competences

- o Condition-specific interventions

- o 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 persistent physical health conditions

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):

<p style="text-align:center;font-size:larger;">www.ucl.ac.uk/CORE/</p>

Scope of the competence framework

Clients to whom the framework applies

The framework applies to clients who present to healthcare systems with persistent physical health conditions, and where there are indications that a psychological intervention may help them to manage their condition more effectively.

Conventionally clinicians have placed these patients into one of two groups:

> a) those with 'Long Term Conditions' (LTC), where there is a known physical problem with which patients are contending (for example, cardiac disease or diabetes)
>
> b) those with 'Medically Unexplained Symptoms (MUS) where currently there is no known physical cause for the symptoms they are experiencing (for example, chronic fatigue syndrome or fibromyalgia)

This distinction is unsatisfactory for several (well-rehearsed) reasons. 'MUS', is a portmanteau term that encompasses a very diverse set of presentations linked only by the absence of a known pathological cause for the patient's symptoms. More critically, the term 'unexplained' can be misinterpreted as indicating that patients with MUS do not have 'real' physical symptoms, and that their condition is 'all in the mind'.

This sort of thinking reflects the assumption that it is possible to make a clear distinction between mind and body, so that patients either present with a 'real' physical problem, or are somehow misrepresenting psychological problems as physical. This is both unhelpful and – more to the point – inaccurate, because there is increasing evidence of the autopoietic[1] inter-relationship between physical and psychological states, and indeed, between physical states and the social environment (Deary, Chalder and Sharpe, 2007).

Unfortunately it is all too easy for healthcare workers and patients to fall into the trap of 'either-or' thinking, and this can result in professionals relating differently to patients from each group - more positively to those with an LTC, but less sympathetically to those with MUS. It is probably no accident that many patients whose condition is labelled as MUS report feeling devalued and discounted by their encounters with the healthcare system, despite the fact that their symptoms can lead to considerable distress and disability.

In response to these concerns there have been several attempts to revise nomenclature in this area (e.g. Picariello, Ali, Moss-Morris & Chalder (in press)), not only on conceptual grounds but also because the issues that confront and challenge people with 'LTC' or 'MUS' are often very similar. Unfortunately these efforts have not resulted in terminology that has been widely accepted. Since most policy documents continue to use these terms, they are – reluctantly – retained in this competence framework, so as to ensure that there is no confusion about the people to whom this work might apply.

---

[1] 'autopoietic' refers to a system capable of reproducing and maintaining itself.

However, it is worth observing that a number of conditions labelled as MUS have received their own diagnostic labels, and where this is the case this document refers to these directly (for example, Fibromyalgia, Chronic Fatigue Syndrome, or Irritable Bowel Syndrome).

Staff and service contexts to whom and to which the framework applies: The framework is designed to be relevant to staff in a range of clinical settings – it defines clinical knowledge and skills relevant to the wide range of professionals who work with people with persistent physical health conditions.

As detailed below, not all sections of the framework apply to all staff, but it does encompass the skills of individuals with a primary training in psychological interventions (such as clinical and applied psychologists, psychiatrists or psychotherapists) as well as staff (at all levels of the healthcare system) whose training included only limited exposure to psychological models and interventions (such as general practitioners, specialist medical staff or nurses).

Age range: The framework applies to individuals from late adolescence through to old age. A pragmatic decision was made to exclude presentations or interventions associated with early or middle childhood, largely because work with this population has to be adapted to their developmental stage, and this involves the application of a specific set of competences. Although many of the principles embodied in the framework will be relevant to this work, the ERG considered that it would be over-ambitious to attempt to encompass all age-groups in a single structure.

Range of conditions identified in the framework: A very large number of conditions come under the ambit of LTC and MUS, making it impractical to include specific reference to each of them in the framework. Choices have to be made, and the intent is that the conditions that are specified can be seen as exemplars, and can be used to identify intervention principles that generalise to other presentations.

The ERG was concerned that not including reference to a condition might be misunderstood as indicating that no effective interventions have been developed for it, with implications for commissioning and service provision. This would be inappropriate, particularly because there are several areas of the framework where the competences being described are intended to apply to many conditions. For example, the description of competences for developing and implementing self-management draws on the principles used in well-researched programmes for conditions such as Chronic Obstructive Pulmonary Disease (e.g. Howard &DuPont, 2104), Coronary Heart Disease (e.g. NHS Lothian, 2011), Arthritis (e.g. Lorig and Fries, 2006), Diabetes (e.g. NHS Lothian 2011) and Stroke (e.g. NHS Lothian, 2011). Naturally, delivery of each programme includes content relating to the condition they are addressing, but this content is not referred to in the competences themselves, and nor are these specific conditions identified in the text.

Clients with "multiple morbidity"
Many clients present with co-existing conditions, and although this is well-recognised in clinical practice, there is little research examining the most effective packages of treatment for this group. As such determining the treatment pathways most likely to address their needs will rely on clinical judgment (based on careful engagement, assessment and formulation). Although this means that the framework cannot directly point to a specific intervention package for these individuals, there may be aspects of their presentation for which there are well-developed intervention strategies – as might be the case, for example, where an individual is struggling with fatigue, or exhibits behavioural avoidance as a way of coping. As such it should be possible to draw on areas of knowledge and skills that are applicable to specific conditions in order to produce an individualised care plan for patients with complex needs.

Areas of work not covered by the framework
The competence framework is focused primarily on clinical work, and excludes service management and service development skills. Audit and research skills are not specified in depth, though the ability to choose and make use of appropriate 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.

Issues related to the application of the framework

Formulating the relationship between adjustment and mental health: While many of the clients to whom this framework is addressed present with psychological issues, the ERG noted that a traditional mental health perspective may not be the most useful way of formulating their difficulties. Often it can be more productive to consider adjustment to a health condition as a primary focus, and to locate cognitive, behavioural, affective and social responses to the condition into this context. This perspective makes it easier to hold in mind the inter-connectedness of physical, psychological and social issues, and where mental health presentations (such as depression or anxiety) are evident, to conceptualise their relationship to (and their impact on) the physical presentation with which the client is contending.

Goals of interventions: Many research trials in this field report changes in psychological symptoms as their primary index of outcome, but this can make it hard to determine the impact of the intervention on the physical health condition. The ERG noted that an excessive orientation towards symptom-change can overlook the importance of functional change to clients, especially when this is objectively limited but subjectively significant. It makes sense that many clients may be less concerned to reduce symptoms than to improve functioning, and so making meaningful changes in what they can do and achieve in their daily lives.

In clinical practice, foregrounding functioning over symptom change may make sense; nonetheless the aims of an intervention should be determined by an explicit discussion of

the client's goals and values, so that the expected outcomes are congruent with what each client is seeking to achieve – no matter whether this maps directly to the professional's conceptualisation - and where multi-disciplinary teams have an agreed and consistent approach to working with the patient's goals and values.

Role of supervision in supporting the implementation of the framework
Supervision plays a critical role in supporting competent 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).

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 experts in work with people with physical health conditions 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: Although there were no service users on the ERG, the content of the framework draws on relevant literature which describes service users' experiences of being in receipt of the interventions on which the framework was based.

3. Adopting an evidence-based approach to framework development[2]: 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 physical health conditions (all of which needed to be taken into account):

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

---

[2] 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 ractice

psychological interventions in people with physical health conditions. Further, while some areas have been subject to multiple trials others are under-researched. 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 on the current relatively 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 nature of the evidence changes over time this will need to be reflected in revisions of the framework.

b) The importance of underpinning areas of core competence to the effectiveness of any intervention: Though research evidence is not strong, there is a clear professional consensus that all interventions in this area rest on a set of 'underpinning' skills, In the framework these are located in two domains of core skills - competences that relate to professional practice, and skills related to the application of knowledge about long-term persistent physical health difficulties. Because these areas of knowledge and skill underpin *any* intervention they need to be understood and deployed by any professional working in this area.

In addition to these core competences, there is a professional consensus that all psychotherapeutic interventions are underpinned by the generic therapeutic competences, as well as the generic assessment and formulation skills, identified in the framework. However, it has to be acknowledged that there is often little *direct* evidence of the benefit of these core and generic skills from randomised control trials or from other types of study, possibly reflecting researchers' understandable reluctance to systematically 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 condition-specific interventions
An important 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 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 a condition-specific intervention should not be taken to indicate that it is ineffective, but only that at present 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. Range of health conditions included in the framework: Psychological interventions have been developed and applied to a very broad range of health conditions. Not all of these are backed by a strong evidence base, though in many areas professional consensus supports their use.

Explicitly referencing all these conditions in the framework would not be practicable; those that are instanced are usually presentations for which there is a good evidence base. These are best seen as 'exemplars'- there is no implication that treatment should be restricted to people presenting with these conditions. It is important to hold in mind the fact that many treatment principles generalise from one condition to another – indeed there is increasing interest in developing 'trans-diagnostic' intervention packages

applicable to a range of conditions. As such the framework can be seen as setting out key principles that can be applied across a broad range of presenting problems.

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

Examples of these high-level descriptors within the domain of core competences include 'Promoting the client's capacity for adjustment' or 'Knowledge of models of behaviour change and strategies to achieve it'.

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) Condition-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 in 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 working with people with persistent physical health conditions

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).

The competences have been organised into seven domains; the relationship between these domains is illustrated in Figure 1 (the competence areas they cover are detailed below, in the section entitled "Outline of the framework").

Effective delivery of competences across the whole framework rests on two 'underpinning' domains. The first is a set of '**Core professional competences for work with people with persistent physical health problems'** which focuses on the knowledge and skills associated with basic professional practice. The second is concerned with **Core knowledge and clinical competences for work with people with persistent physical health conditions'**; the knowledge and skills needed to understand and begin working with people with physical health conditions.

As illustrated in Figure 1, the framework then describes two ways of delivering psychological interventions. The first is denoted as "psychologically-informed" (because the strategies being employed are based on psychological principles), and the second are formal psychological therapies. The distinction is important, in that to conduct a psychological therapy practitioners need to be able to employ the skills and knowledge contained in the domains of **Generic therapeutic competences** as well as **Assessment, formulation engagement and planning**; taken together these two domains set out competences common to all psychological therapies. However, not all of these competences are needed to carry out a psychologically-informed intervention, particularly because these interventions will usually be conducted by individuals without an in-depth training in psychological therapy.

The final domain in the model focuses on **'Meta-competences'.** These 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 how, when or whether something needs to be done, or judging the ways in which an action needs to be modified to take account of the client's particular needs or presentation. 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.

"Underpinning" core skills

Core professional competences for work with people with physical health conditions

Core knowledge and clinical competences for work with people with physical health conditions

Generic Therapeutic Competences

Assessment and formulation skills

Psychologically-informed, cross-condition interventions

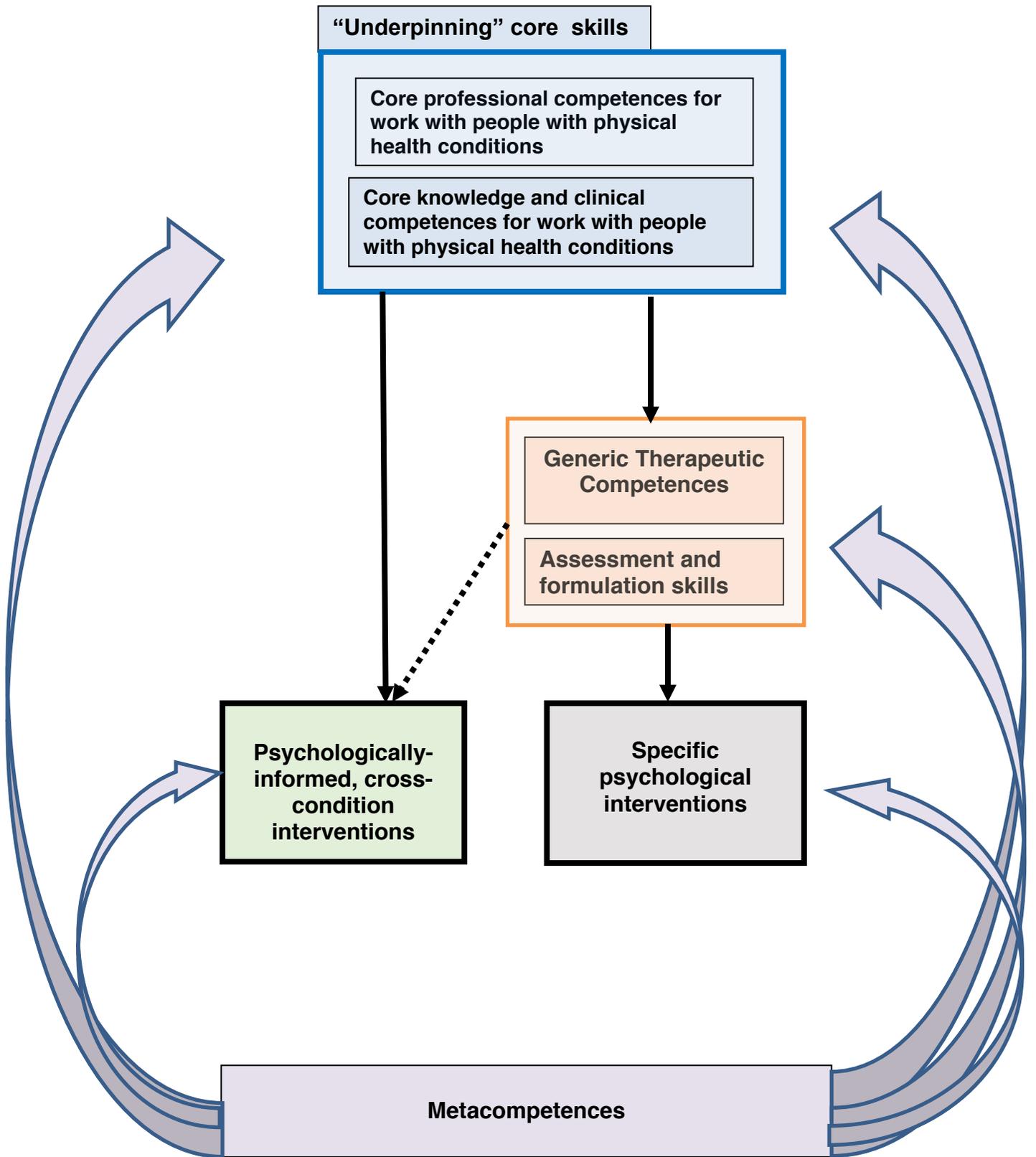**Specific psychological interventions**

Metacompetences

Figure 1 – Outline model for the framework

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 (along with an overarching set of competences concerned with 'professional stance, values and assumptions') and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences.

The competence lists are not included in this report; they are downloaded from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE/) – the menu bar contains the location of the competence framework.

The map shows the ways in which the activities fit together and need to be 'assembled' in order for practice to be proficient. The 'professional stance, values and assumptions' are an overarching set of competences, and for this reason the map show them encompassing nearly all the framework (as indicated by the black rectangle). The domains within the orange dotted rectangle show the competences related to a 'formal' psychotherapeutic intervention.

Layout of the competence lists

As above the lists of competences are accessed online. 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.

For clarity, each competence statement is set out in a 'box', At points these are indented, usually where 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 "collaborative and empowering"; what follows are concrete examples of the sorts of things a clinician needs to do to achieve this.

An ability to work in a manner that is consistently collaborative and empowering, by:
translating technical concepts into "plain" language that the client can understand and follow
taking shared responsibility for developing agendas and session content

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, and thereby support their 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.

Professional stance, values and assumptions

Core professional competences for work with people with physical health conditions

Ethical and legal issues

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

dashed line denotes competences for psychological therapies

Core knowledge and clinical competences for work with people with physical health conditions

Knowledge of a generic model of MUS

Knowledge of presenting conditions

Knowledge of the impact of physical health conditions in the context of life stage

Knowledge of generic models of adjustment to physical health conditions

Promoting the client's capacity for adjustment

Knowledge of models of behaviour change and strategies to achieve it

Supporting clients' capacity for self-management

Psychologically-informed cross-condition interventions

Applying psychological principles in different service contexts

Working with clinical services in medical settings

Shared care in primary care

Applying psychological principles to support self-help/ self-management

Developing self-management programmes

Implementing self-management programmes

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 understand and respond to emotional content of sessions

Ability to manage endings and service transitions

Ability to make use of measures (including monitoring of outcomes)

Ability to deliver group-based interventions

Ability to make use of supervision and training

Assessment, formulation, engagement and planning

Assessment

Ability to undertake a comprehensive biopsychosocial assessment

Ability to undertake risk assessment and management

Ability to assess the person's functioning within multiple systems

Formulation

Ability to develop a formulation

Engagement and planning

Ability to feedback the results of assessment & formulation and agree an intervention plan with all relevant parties

Ability to collaboratively engage clients with the treatment model

Ability to co-ordinate across different agencies and/or individuals

Specific interventions

Examples of CBT-based interventions

Diabetes

Chronic Fatigue

Chronic pain

Irritable Bowel Syndrome

Non-dissociative seizure

Neurological presentations

Psychodynamic Interpersonal Therapy for somatic presentations

Meta competences

Meta-competences for work with people with physical health conditions

An outline of the framework

Core professional competences for work with people with persistent physical health problems

Ethical and legal issues

This includes three areas:

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.

Professional skills and values

This includes two areas:

Working with difference (cultural competence)
Respecting diversity, promoting equality of opportunity for clients 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, which should be demonstrated by all staff in routine clinical practice.

Ability to communicate within and across organisations
Staff working with people with physical health problems routinely communicate with professionals both within and outside their own organisation, and often draw on the expertise of other disciplines. This sort of liaison requires a knowledge of the responsibilities and functioning of other agencies and disciplines, as well as knowledge of relevant policies, procedures and legislation. It also demands skills in information sharing and communication, maintaining (but also being aware of

limits to) confidentiality, as well as the ability to contribute to the co-ordination of casework, and the ability to recognise and manage challenges to effective cross-organisational working.

Core knowledge and clinical competences for work with people with physical health conditions

Knowledge of a generic model of Medically Unexplained Symptoms
The generic model of MUS set out here is based (as far as is possible) on empirical evidence, and describes the ways in which biological, psychological and social factors can interact in an iterative, reflexive and self-sustaining manner to produce the symptoms experienced by patients. As such the model makes it clear that MUS is not a product of any one of these domains, but arises in and through the interactions between them.

Knowledge of the range of presenting issues and diagnostic criteria in people with physical health problems
An in-depth knowledge of the physical health conditions with which the practitioner is working is fundamental: it guides the practitioner's understanding of the person's needs, and forms an important foundation for an 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 change can mean to an individual.

Knowledge of the impact of physical health conditions in the context of life stage
Contending with a significant physical health condition is always challenging, but the person's stage of life can be relevant to the ways in which they understand their illness and the ways in which they adjust to it.

Knowledge of generic models of adjustment to physical health conditions
Adjustment is not an end point but a process of assimilation that takes place over time, influenced by a large number of factors, some of which promote and some of which inhibit the achievement of an emotional equilibrium and quality of life.

Promoting the client's capacity for adjustment
Promoting adjustment usually starts by acknowledging the adverse impact of the illness, followed by helping the client to identify what 'adaptation' would mean to them, the resources they can draw on to promote this, and the strategies they can employ to achieve it.

Knowledge of behaviour change and strategies to achieve it: Behaviour change is the focus of many consultations, but it is a process that needs to be understood if it is to be achieved. It requires a detailed knowledge of the many factors that influence a person's

capacity for change, their motivation to do so, and the probability that they will achieve this. Strategies for promoting change start by engaging clients in a collaborative process so that they can identify the changes they wish to make (and have the potential to achieve), set goals and identify target behaviours, implement behavioural change strategies, focus on habit formation and monitor and review change over time.

Supporting the client's capacity for self-management: Developing skills in self-management requires a collaborative engagement which helps elaborate on the factors that will support or inhibit the client's capacity for self-management, and which supports them in identifying opportunities to practise self-management, applying self-management strategies and ensuring that they can maintain change.

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 validating the client's experience, 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.

Psychologically informed cross condition interventions

A) Applying psychological principles in different service contexts

There are two areas of competence described in this section:

Working with clinical services in secondary care:

Applying psychological principles to help people with physical health problems in the context of primary care: There is an increasing emphasis on shared care planning and decision-making[3] as a model for working in primary care. This involves taking a collaborative stance that emphasises the patient's engagement in decisions about their care, based on helping them to understand their condition and the options open to them with regard to its management. From

---

[3] Competences in this section are congruent with (and endorsed by) the Royal College of General Practitioner's curriculum for training in these skills

this standpoint patients are encouraged to identify their own aims for management of their health conditions.

B) Applying psychological principles to support self-management

Many conditions can be better managed if patients can become active participants in their own healthcare, drawing on an understanding of their condition and of the strategies they can use to maximise their functioning. There are a large number of well-evidenced self-management programmes for LTCs, covering a diverse set of health conditions (for example, Chronic Obstructive Pulmonary Disease (e.g. Howard & DuPont, 2014), Coronary Heart Disease (e.g. NHS Lothian, 2011), Arthritis (e.g. Lorig and Fries, 2006), Diabetes (e.g. NHS Lothian 2011) and Stroke (e.g. NHS Lothian, 2011). Most of these programmes are best described as *guided* self-management, with healthcare worker offering either individual or group-based support in order to engage clients in the process of self-management. Research usually indicates that this guidance is a critical component, resulting in significantly greater efficacy over 'pure' self-management (e.g. Loeb, Wilson, Gilbert & Labouvie (2000).

This section sets out two inter-related areas of competence:

> **Developing self-management programmes:** The effectiveness of guided self-management programmes depends on developing materials that are evidence-based, appropriately structured and engaging, and that are reviewed and updated in the light of feedback and experience.

> **Implementing self-management programmes:** Helping clients to engage in self-management requires professionals to take a very specific stance, offering support, but ensuring that this is oriented towards giving clients the skills they need to develop a capacity to help themselves.

Generic Therapeutic competences

Knowledge of models of intervention, and their employment in practice
All staff working psychologically with people with physical health conditions should 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 worldview

The "therapeutic alliance" is the capacity to build and to maintain a therapeutic relationship in which the practitioner develops a 'bond' with the individual 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 understand and respond to 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 and the practitioner. Because disengaging from an intervention 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 client 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 validated measures and questionnaires where possible, along with diaries and other systematic idiographic tools.   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 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 deliver group-based 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.

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.

Assessment

Ability to undertake a comprehensive biopsychosocial 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 psychological interventions in this area. This needs to capture the client's own understanding of their illness and their reactions to it, as well as its impact on their functioning.

Ability to undertake risk assessment and management
Comprehensive assessment should include 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, their significant others and their family is crucial for reaching an understanding of their beliefs and behaviour.

Formulation

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 client (and any 'significant others' who may be involved in an intervention), and the expectation is that they are periodically reviewed in the light of new assessment or intervention information.

Engagement and planning

Ability to feedback the results of assessment and agree an intervention plan with all relevant parties

Feedback is a collaborative process and should include an outline of the presenting problem along with 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 collaboratively engage clients with the treatment model

For many clients the proposed intervention may represent a significant change in the way they manage their condition. For this reason it is important to ensure that their engagement in treatment is truly collaborative, and is based on an informed appraisal of the options open to them.

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 a 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

This section sets out treatment 'packages', describing the complete set of strategies employed from the start to the end of an intervention. Effective delivery assumes mastery of the competences described in the initial domains of the framework, but for clarity these packages are set out as self-contained treatments in order to illustrate how the various components are assembled.

To be included in this domain treatment packages need to have good evidence for efficacy,[4] but it is critical that this list is not mistaken as delineating the conditions for which effective interventions exist. Two points need to be held in mind:

---

[4] Though it should be noted that the section on neurological presentations is a synthesis of best practice that has yet to be tested empirically

a) the evidence base for condition-specific interventions is growing rapidly, and it is certain that over time the number of evidence-based packages will grow

b) there is marked 'read-across' from one intervention to another, and although most of these packages focus on specific conditions, the principles involved will be generalizable to other conditions

The majority of conditions in this domain fall into the category of MUS, perhaps reflecting the fact that these are often more complex presentations, and that interventions for many LTCs are based on self-management – an approach described in the domain of 'psychologically informed cross-condition interventions'.

There are two sets of interventions

a) a number of approaches based on the application of Cognitive Behaviour Therapy (CBT) to specific disorders.

b) Psychodynamic–Interpersonal Therapy (PIT); an approach that is can be applied to a wide range of presentations – including those conventionally labelled as LTCs as well as those flagged as MUS. It encourages the client to address the meaning of the healthcare problem, and in so doing is directly concerned with the way this problem manifests, and the way in which it is managed.

Metacompetences

Psychological treatments 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).

I

mplementing the competence framework

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

Do all clinicians need to be able to do everything specified in the framework?
Although all clinicians would be expected to be familiar with the knowledge and core skills identified in its two core domains, and to work in a manner congruent with the 'professional values, stance and assumptions', the framework is intended to accommodate a range of clinicians – from non-specialist healthcare workers who will be implementing psychological interventions as part of their clinical practice to practitioners implementing psychological therapies. It would be unrealistic (and indeed unnecessary) for the former group to acquire competence across all domains of the framework.

How the metacompetences apply is more complex: some apply to all aspects of psychological work while others relate to the implementation of specific interventions or specific procedures, and so only apply when these are being carried out. For example, metacompetences that apply to all workers are "the ability to interpret legal and ethical frameworks in relation to the individual case", but some are relevant only when specific interventions are being carried out (for example, "an ability to judge when to maintain a specific treatment rationale and model, and when and whether adaptations and flexibility in delivery are appropriate"). As such, whether or not a metacompetence applies 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 approach 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 all 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 clinician 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 it suggests that better outcomes are achieved when therapists show greater fidelity to the procedures set out in the manuals. When clinicians vary a 'standard' treatment procedure they should have a clear rationale for so doing, and 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 people in the context of health conditions. 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 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

Because the framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice regarding the implementation of interventions and 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. Detecting the quality and outcomes of psychological interventions 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 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[5], 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.

---

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

Concluding comments

This report describes a model which identifies the activities which characterise effective psychological interventions for people with persistent physical health conditions, 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 framework 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 framework 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 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 should prove useful for staff in all areas of healthcare delivery. The more stringent test is whether it results in more effective interventions and better outcomes for clients.

References

Deary, V., Chalder, T., & Sharpe, M. (2007) The cognitive behavioural model of medically unexplained symptoms: A theoretical and empirical review. *Clinical Psychology Review*, *27*, 781-797

Elkin, I. (1999) A major dilemma in psychotherapy outcome research: Disentangling therapists from therapies. *Clinical Psychology: Science and Practice*, *6*, 10-32

Horvath A. O., Del Re, A. C., Flückiger, C., & Symonds, D. (2011) Alliance in individual psychotherapy. *Psychotherapy*, *48*, 9-16

Howard, C. & DuPont, S. (2014) The COPD breathlessness manual': a randomised controlled trial to test a cognitive-behavioural manual versus information booklets on health service use, mood and health status, in patients with chronic obstructive pulmonary disease *Primary Care Respiratory Medicine*, *24*, 14076

Loeb, K.L., Wilson, G.T., Gilbert, J.S., & Labouvie, E. (2000) Guided and unguided self-help for binge eating. *Behaviour Research and Therapy*, *38*, 259-272

Lorig, K.L. & Fries, J.F. (2006) *The arthritis helpbook* (6th edition) Da Capo Press

NHS Education Scotland (2008) *The Matrix - A Guide to Delivering Evidence-Based Psychological Therapies in Scotland*. Available at: http://www.nes.scot.nhs.uk/media/606133/thematrix-final.pdf

National Institute for Health and Clinical Excellence (NICE). (2012) *The guidelines manual* (available at www.nice.org.uk/guidelinesmanual)

NHS Lothian (2011) *The Diabetes Manual*

NHS Lothian (2011) *Stroke Workbook*

NHS Lothian (2011) *The Heart Manual*

Picariello, F., Ali, S., Moss-Morris, R. and Chalder, T. (in press) The Most Popular Terms for Medically Unexplained Symptoms: The Views of CFS Patients. *Journal of Psychosomatic Research*

Roth A.D. and Pilling, S. (2008) Using an Evidence-Based Methodology to Identify the Competences Required to Deliver Effective Cognitive and Behavioural Therapy for Depression and Anxiety Disorders. *Behavioural and Cognitive Psychotherapy*, *36*, 129-147

Roth, A.D., Pilling S., & Turner, J. (2010) Therapist Training and Supervision in Clinical Trials: Implications for Clinical Practice. *Behavioural and Cognitive Psychotherapy, 38,* 291-302

Roth, A.D. and Fonagy, P. (2005) *What works for whom: A critical review of psychotherapy research.* New York: Guilford Press

Shirk S. R., Karver, M. S., & Brown, (2011) The alliance in child and adolescent psychotherapy. *Psychotherapy,* 48, 17-24

Appendix A: Members of the Expert Reference Group

Dr Pauline Adair	University of Strathclyde
Professor Paul Bennett	University of Swansea
Dr Chris Bundy	University of Manchester and Manchester Academic Health Sciences Centre
Dr Angela Busuttil	British Psychological Society, Division of Clinical Psychology (Physical Health Area Lead)
Professor Trudie Chalder	Institute of Psychiatry, Psychology and Neuroscience
Dr Alex Clarke	Clinical Health Psychologist
Dr David Craig	NHS Education for Scotland
Dr Vincent Deary	Northumbria University
Dr Diane Dixon	University of Strathclyde
Professor Christopher Dowrick	General Practitioner, University of Liverpool
Dr Arek Hassey	General Practitioner and IAPT lead (Long Term Conditions)
Professor Elspeth Guthrie	Manchester University and Manchester Academic Health Sciences Centre
Dr Jo Iddon	Clinical Neuropsychologist
Professor Lance McCraken	Institute of Psychiatry, Psychology and Neuroscience
Professor Rona Moss-Morris (IAPT)	Institute of Psychiatry, Psychology and Neuroscience and IAPT lead (Medically Unexplained Symptoms)
Dr Katherine Rimes	Institute of Psychiatry, Psychology and Neuroscience
Marie-Claire Shankland	NHS Education for Scotland
Dr Jon Stone	Western General Hospital
Dr Vivien Swanson	University of Stirling
Judy Thomson	NHS Education for Scotland
Professor Alison Wearden	University of Manchester and Manchester Academic Health Sciences Centre
Dr Abigail Wroe	Royal Holloway