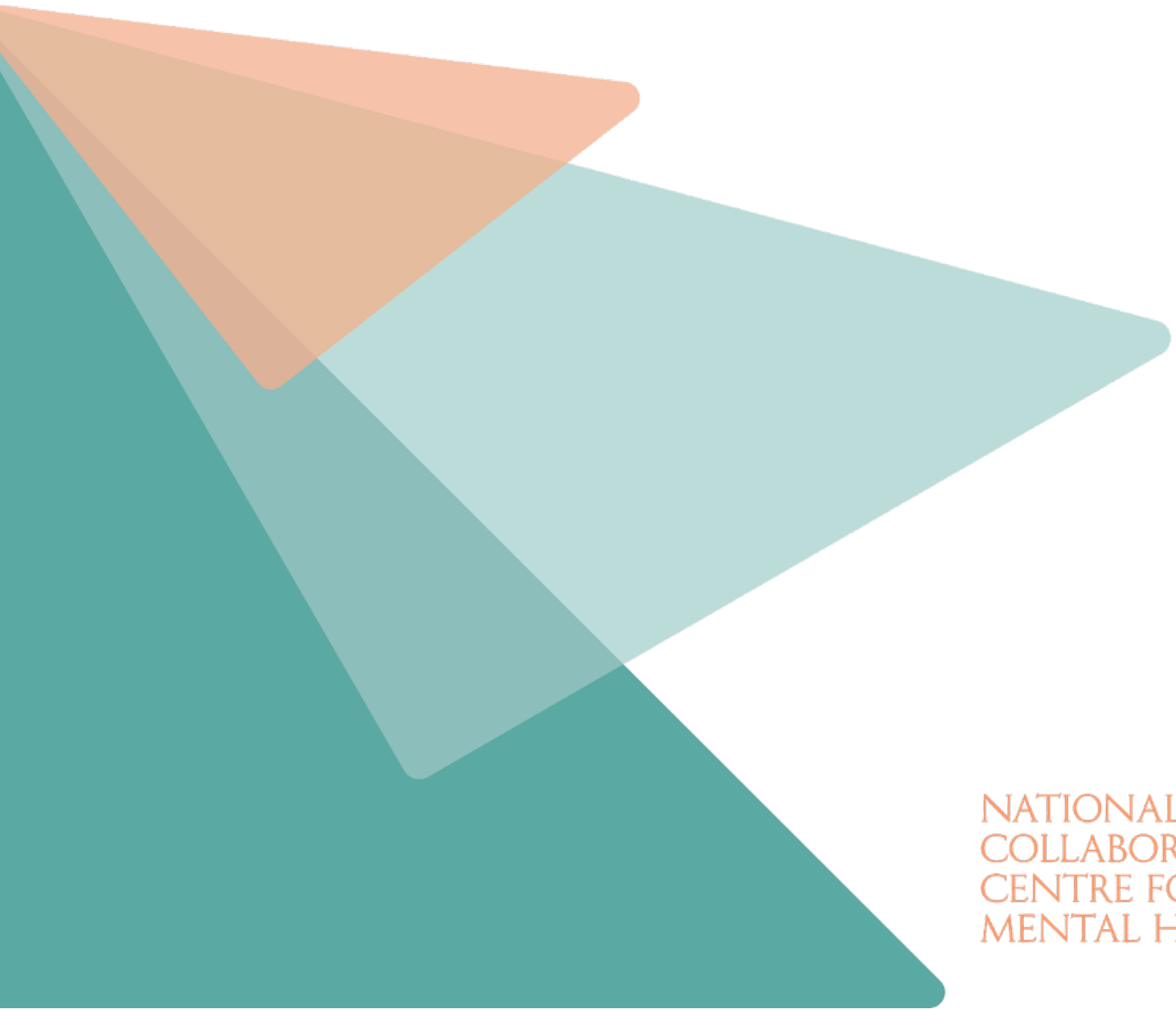
The Competence Framework for Physician Associates in Mental Health

Full listings of the competences



NATIONAL COLLABORATING CENTRE FOR MENTAL HEALTH

Authorship statement

Prof. Tony Roth is the main author of the competence framework and curriculum. Prof. Roth and Dr Pranav Mahajan authored the supporting document. The Expert Reference Group (ERG) and NCCMH Project Team contributed to the development of the framework and supporting document, with notable contributions from ERG members Ellie Wildbore, Frances Leach, Dr Phil Crockett, Sarah Markham and Dr Helen Crimlisk.

National Collaborating Centre for Mental Health, 2022.

Contents

1. Knowledge

Knowledge and understanding of mental health presentations across the lifespan

An ability to draw on knowledge of the range of mental health and neurodevelopmental conditions usually seen in clinical services, and:
the ways these emerge and present in children/young people, adults and older adults
the potential impact of these difficulties on the patient
the ways in which developmental issues persist and present across the lifespan (e.g. attention deficit hyperactivity disorder [ADHD])
An ability to draw on knowledge of the range neurodegenerative conditions often but not exclusively seen in older adults in clinical services, and:
the ways in which these emerge and present
the potential impact of these difficulties on the patient

An ability to draw on knowledge of the diagnostic criteria for mental health conditions specified in the main classification systems (i.e. the Diagnostic and Statistical Manual or the International Classification of Diseases)
An ability to draw on knowledge of the incidence and prevalence of mental health presentations, and their incidence and prevalence across the lifespan, genders, cultures, ethnicities and social classes

An ability to draw on knowledge that the experience of trauma is part of the life story of many people, and of the role trauma plays in the development and maintenance of mental health problems

An ability to draw on knowledge of the influence of normal lifespan development and developmental psychopathology on the ways in which mental health difficulties present
An ability to draw on knowledge of the social, psychological, family and biological factors associated with an increased risk of developing and maintaining mental health problems
An ability to draw on knowledge of factors that promote wellbeing and emotional resilience (e.g. good physical health, high self-esteem, secure attachment to caregiver, higher levels

of social support)
An ability to draw on knowledge of problems that commonly co-occur with mental health presentations

An ability to draw on knowledge of the ways in which mental health problems can impact on functioning and individual development (e.g. maintaining intimate, family and social relationships, or the capacity to maintain employment and study)	
	an ability to draw on knowledge of the ways in which mental health problems can impact on family functioning
An ability to draw on knowledge of the ways in which mental health problems can manifest interpersonally, so as to avoid escalating or compounding difficult or problematic behaviour that is directly attributable to the mental health condition	

Knowledge of biopsychosocial models of mental health

An ability to draw on knowledge that the biopsychosocial model aims to understand mental health difficulties in a holistic way by recognising the biological, psychological and social factors that influence a presentation
An ability to draw on knowledge that the biopsychosocial model is key in the presentation of mental health difficulties, and that:
biological factors that contribute to mental health difficulties (e.g. physical health, genetic vulnerabilities, impact of illicit drugs and medication)
psychological factors that contribute to mental health difficulties (e.g. low self-esteem, trauma, poor family relationships, poor coping skills)
social factors that contribute to mental health difficulties (e.g. addiction, significant financial difficulties, poor interpersonal functioning, unstable or absent occupational history, stressful occupations)
An ability to draw on knowledge that the biopsychosocial model is key in the assessment of mental health difficulties, and that:
biological factors that require assessment (e.g. blood tests, neuro-imaging, and developmental milestones, and history of physical health, family, medication and substance misuse)
psychological factors that require assessment (e.g. psychological development, relationship history, trauma history, education history, cultural history)
social factors that require assessment include (e.g. substance misuse history, social and financial history, relationship history, occupational history, personal and developmental history)
An ability to draw on knowledge that the biopsychosocial model is key in the management of mental health difficulties, and that:
management that addresses biological factors includes pharmacological management, treatment of comorbid physical health conditions, management of substance misuse
management that addresses psychological factors includes psychoeducation, individual psychological therapies, family intervention, group psychological therapies
management that addresses social factors includes occupational support (e.g. advice on job hunting), financial advice and support, family interventions, social skills training, transcultural interventions that address cultural beliefs about mental health

Knowledge of mental health interventions

An ability to draw on knowledge of the range of pharmacological, psychological and psychosocial interventions available to people experiencing mental health difficulties
An ability to draw on knowledge of national guidance that include recommendations regarding the role of different interventions (e.g. National Institute for Health and Care Excellence [NICE] or Scottish Intercollegiate Guidelines Network [SIGN] guidelines), and:
an ability to recognise that interventions can be recommended in the absence of specific NICE/SIGN guidance
an ability to draw on relevant evidence that indicates the basis for the use of particular interventions, and that there are different levels of evidence
An ability to draw on knowledge that interventions are recommended to people with mental health problems based on a comprehensive assessment and formulation that draws on the biopsychosocial model
An ability to draw on knowledge of basic non-pharmacological interventions, e.g. online and written self-help programmes or psychoeducation
An ability to draw on knowledge of specialist interventions and the specific circumstances for which these are indicated (e.g. ECT)

An ability to draw on knowledge of the interventions commonly offered by members of the multidisciplinary mental health team (e.g. doctors, psychologists, pharmacists, nurses, occupational therapists)

Knowledge of pharmacology in mental and physical health

An ability to draw on knowledge of mental and physical health disorders in which medication potentially forms part of the intervention, and that commonly present in the service
An ability to draw on knowledge of national guidance that include recommendations regarding the role of medication (e.g. NICE or SIGN guidelines), and:
an ability to recognise that medication can be prescribed in the absence of specific NICE/SIGN guidance
an ability to draw on relevant evidence that indicates the basis for safe and effective prescribing, and that there are different levels of evidence

An ability to draw on knowledge that prescribing and monitoring medication may have varying intensity and time-course, depending on the complexity, co-morbidity and chronicity of the condition treated
An ability to draw on knowledge of medications for which specific investigations need to be carried out (e.g. blood tests, electrocardiogram [ECG], blood pressure, pulse)

An ability to draw on knowledge of the role of medication in the treatment of people with mental health problems, and:
an ability to draw on knowledge of evidence for the benefits both of medication-alone and medication offered in combination with psychological interventions
An ability to draw on knowledge of the ways in which medication can be combined with psychological or other interventions to maximise its likely effectiveness
An ability to draw on knowledge of those disorders presenting in the service context where there is no evidence base for using medication as a primary treatment, e.g.:
autism spectrum disorder (ASD)
intellectual disability
An ability to draw on knowledge of common concerns/controversies regarding the prescription of medication, while retaining a balanced view of the utility of psychopharmacology, e.g.:
the need to weigh up benefits versus risks for the patient, both short- and long-term
An ability to draw on knowledge of the relative risks of psychiatric medication in patients with modifiable and non-modifiable risk factors and co-morbidities (e.g. age, gender,

ethnicity, type 2 diabetes mellitus, cardiac history)

Implementing knowledge

An ability to carry out an assessment (or to elicit the appropriate help to do so) to identify people with a condition where medication may be indicated	
An ability to discuss in general and specific terms with clients and their significant others/carers/ families:	
	the potential role and benefits of medication in their treatment regimen
	the potential side effects of medications
An ability to recognise significant side effects and to take appropriate action (e.g. to liaise with or refer to a psychiatrist or medical practitioner)	

Supervision and support for pharmacology

An ability to identify individuals within the service with sufficient knowledge of pharmacology from whom to seek advice and support, or to be able to refer on appropriately when necessary (e.g. a pharmacist, psychiatrist or other medical practitioner)
An ability for physician associates (PAs) involved in supporting pharmacological treatments to seek ongoing training, professional development and supervision

Supporting colleagues

An ability for appropriately experienced PAs to act as a resource to their colleagues (e.g. acting as sources of advice or consultation regarding pharmacology)

2. Professional and legal issues

2.1. Knowledge of legal frameworks relating to working with children/young people and adults

An ability to draw on knowledge that clinical work with children/young people and adults is underpinned by legal frameworks
An ability to draw on knowledge that the sources and details of law may vary across the four home nations of the UK
an ability to draw on knowledge of the relevant legislation and policies that apply to the settings in which interventions take place

Mental health

An ability to draw on knowledge of mental health legislation

Capacity and informed consent

An ability to draw on knowledge of the legal framework that determines the criteria for capacity and informed consent

Data protection

An ability to draw on knowledge of legislation that addresses issues of data protection and the disclosure of information

Equality

An ability to draw on knowledge of equality legislation designed to protect people from discrimination when accessing services (including the statutory requirement for service providers to make reasonable adjustments for disabled patients)

Resources

All relevant legal acts can be accessed in full at: www.legislation.gov.uk

Mental health legislation

Mind (2018) Mental Health Act 1983: An Outline Guide

Available at: www.mind.org.uk/media-a/2909/mha-1983-2018.pdf

Scottish Government, Mental Health and Social Care Directorate (2007) The New Mental Health Act: Easy Read Guide

Available at: www.gov.scot/publications/new-mental-health-act-easy-read-guide-2/

Capacity and consent

Mind (2017) Mental Capacity Act 2005: A general guide on how the Mental Capacity Act affects you and how you can plan ahead for when you no longer have the mental capacity to make decisions for yourself. [Applies to England and Wales]

Available at: www.mind.org.uk/information-support/legal-rights/mental-capacity-act-2005/overview/

McDougall S, Scottish Association for Mental Health (2005) The New Mental Health Act: What's it all about – A Short Introduction (2005)

Available at: https://www.webarchive.org.uk/wayback/archive/20150219150627/http://www.gov.scot/Publications/2005/07/22145851/58527

Mental Welfare Commission for Scotland. Law and Rights [Web page]

Available at: www.mwcscot.org.uk/law-and-rights

Age of Legal Capacity (Scotland) Act 1991

Available at: www.legislation.gov.uk/ukpga/1991/50/contents

National Society for the Prevention of Cruelty to Children (2020) Gillick competency and Fraser guidelines

Available at: https://learning.nspcc.org.uk/child-protection-system/gillick-competence-fraser-guidelines

Confidentiality

Department of Health (2003) Confidentiality: NHS Code of Practice

Available at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4069253

Data protection

Data Protection Act 1998

Available at: www.legislation.gov.uk/ukpga/1998/29/contents

Equality

Equality Act 2010

Available at: www.legislation.gov.uk/ukpga/2010/15/contents

Human rights

Human Rights Act 1998

Available at: www.legislation.gov.uk/ukpga/1998/42/contents

2.2. Knowledge of, and ability to operate within, professional and ethical guidelines

An ability to draw on knowledge that ethical and professional guidance represents a set of principles that need to be interpreted and applied to unique situations
An ability to draw on knowledge of legislation relevant to professional practice
An ability to draw on knowledge of the relevant codes of ethics and conduct that apply to the PA role (including the Code of Conduct for Physician Associates and, when regulated, the General Medical Council Interim Standards for Physician Associates)
An ability to draw on knowledge of local and national policies in relation to:
capacity and consent
confidentiality
data protection

Autonomy

An ability for PAs to recognise the boundaries of their own competence and not attempt to practise an intervention for which they do not have appropriate training, supervision or (where applicable) specialist qualification
An ability to recognise the limits of their competence, and at such points:
an ability to refer to colleagues or services with the appropriate level of training and/or skill
an ability to inform users of services when the task moves beyond their competence, in a manner that maintains their confidence and engagement with services

Ability to identify and minimise the potential for harm

An ability to respond promptly when there is evidence that the actions of a colleague put a patient or another colleague, at risk of harm by:
acting immediately to address the situation (unless there are clear reasons why this is not possible)
reporting the incident to the relevant authorities
cooperating with internal and external investigators

When supervising colleagues, an ability to take reasonable steps to ensure that they recognise the limits of their competence and do not attempt to practise beyond them
An ability to consult or collaborate with other professionals when additional information or expertise is required

Ability to gain consent from patients

An ability to help patients make an informed choice about a proposed intervention by setting out its benefits and its risks, along with providing this information in relation to any alternative interventions
An ability to ensure that the patient grants explicit consent to proceeding with an intervention
If consent is declined or withdrawn, and the patient's presentation means intervention in the absence of consent is not warranted, an ability to respect the individual's right to make this decision
If a patient withholds consent but the nature of their presentation warrants an immediate intervention, an ability to:
evaluate the risk of the intervention and, where appropriate, proceed as required
attempt to obtain consent, although this may not be possible
ensure the patient is fully safeguarded

Ability to manage confidentiality

An ability to ensure that information about service users is treated as confidential and used only for the purposes for which it was provided
When communicating with other parties, an ability:
to identify the parties with whom it is appropriate to communicate
to restrict information to that needed in order to act appropriately
An ability to ensure that users of services are informed when and with whom their information may be shared
An ability to restrict the use of personal data:
for the purpose of caring for the users of services
to those tasks for which permission has been given

An ability to ensure that data is stored and managed in line with the provisions of Data Protection legislation

Sharing information to maintain safety

An ability to draw on knowledge that it is appropriate to breach confidentiality when withholding information could:
place an individual or others (e.g. family members, significant others, professionals or a third party) at risk of significant harm
prejudice the prevention, detection or prosecution of a serious crime
lead to an unjustified delay in making enquiries about allegations of significant harm to others

An ability to judge when it is in the best interest of the patient to disclose information, taking into account their wishes and views about sharing information, holding in mind:
that disclosure is appropriate if it prevents serious harm to a patient who lacks capacity
the immediacy of any suicide risk (e.g. the degree of planning, the type of suicide method planned or already attempted, circumstances e.g. being alone, refusing treatment, drinking heavily or being under the influence of drugs)

An ability to draw on knowledge that the duty of confidentiality does not preclude listening to the views of family members/significant others, or providing them with non-person specific information about managing a crisis or seeking support
An ability to judge when sharing information within and between agencies can help to manage risk
An ability to discuss concerns about disclosure with colleagues (e.g. by discussing the case without revealing the patient's identity or raising the issue in supervision)

An ability to report critical incidents/near misses using locally agreed systems and procedures

Ability to maintain appropriate standards of conduct

An ability to ensure that service users are treated with dignity, respect, kindness and

consideration
An ability to maintain professional boundaries, e.g. by:
ensuring that they do not use their position and/or role in relation to the service user to further their own ends
not accepting gifts, hospitality or loans that may be interpreted as attempting to gain preferential treatment
maintaining clear and appropriate personal and sexual boundaries with users of services, their families and significant others
An ability to recognise the need to maintain standards of behaviour that conform with professional codes both in and outside the work context
An ability to represent accurately their qualifications knowledge, skills and experience

Ability to maintain standards of competence

An ability to have regard to best available evidence of effectiveness when employing therapeutic approaches
An ability to maintain and update skills and knowledge through participation in continuing professional development
An ability to recognise when fitness to practice has been called into question and report this to the relevant parties (including both local management and the relevant registration body)

Documentation

An ability to maintain a record for each patient that:
is written promptly
is concise, legible and written in a style that is accessible to its intended readership
identifies the patient who has entered the record (i.e. is signed and dated)
An ability to ensure that records are maintained after each contact with users of services or with professionals connected with them
An ability, where necessary, to update existing records in a clear manner that does not overwrite existing elements (e.g. to correct a factual error)
An ability to ensure records are stored securely, in line with local and national policy and guidance

Ability to communicate

An ability to communicate clearly and effectively with users of services and other practitioners and services
An ability to share knowledge and expertise with professional colleagues for the benefit of the patient

Ability appropriately to delegate tasks

When delegating tasks, an ability to ensure that these are:	
	delegated to individuals with the necessary level of competence and experience to complete the task safely, effectively and to a satisfactory level
	completed to the necessary standard by monitoring progress and outcome
An ability to provide appropriate supervision to the individual to whom the task has been delegated	
An ability to respect the decision of any individual who feels they are unable to fulfil the delegated task through lack of skill or competence	

Ability to advocate for users of services

An ability to work with others to promote the health and wellbeing of users of services, their families and significant others in the wider community by e.g.:	
	listening to their concerns
	involving them in plans for any interventions
	maintaining communication with colleagues involved in their care
An ability to draw on knowledge of local services to advocate for users of services in relation to access to health and social care, information and services	

An ability to respond to complaints about care or treatment in a prompt, open and constructive fashion (including an ability to offer an explanation and, if appropriate, an apology, and/or to follow local complaints procedures)	
	an ability to ensure that any subsequent care is not delayed or adversely affected by the complaint or complaint procedure

2.3. Knowledge of, and ability to work with, issues of confidentiality and consent

Note about the competences in this sub-domain

All professional codes relating to confidentiality make it clear that where there is evidence of imminent risk of serious harm to self or others, confidentiality can be breached and relevant professionals and family members/significant others informed.

This applies both to individuals who are at risk of suicide or self-harm.

Decisions about issues of confidentiality and consent may be influenced by judgements regarding the individual's capacity. Capacity is referred to in this section, but is considered in more detail in the relevant section of this framework.

Knowledge of policies and legislation

An ability to draw on knowledge of local and national policies on confidentiality, information-sharing and duty of candour, both within and between teams or agencies
An ability to draw on knowledge of the application of relevant legislation relating to legal capacity

Knowledge of legal definitions of consent to an intervention

An ability to draw on knowledge that valid legal consent to an intervention is composed of three elements:	
	the person being invited to give consent must be capable of consenting (legally competent)
	the consent must be freely given
	the person consenting must be suitably informed
An ability to draw on knowledge that individuals have a right to withdraw or limit consent at any time	

Knowledge of capacity[1]

An ability to draw on knowledge relevant to the capacity of individuals to give consent to

[1] See also '4.5. Knowledge of and ability to assess capacity'.

- an intervention:
  - that a person aged 16 or over is presumed to have capacity to give or withhold consent, unless there is evidence to the contrary
  - that a child under 16, who is able to understand and make their own decisions, is able to give or refuse consent
  - that the capacity to give consent is a 'functional test' and is not dependent on age or factors e.g. mental disorder or intellectual disability:
    - that a person with sufficient capacity and intelligence to understand the nature and consequences of what is proposed is deemed competent to give consent
- An ability to draw on knowledge that capacity is specific to the decision and context it relates to

Knowledge of parental rights and responsibilities

- An ability to draw on knowledge of the principles of legislation relating to:
  - parental/carer rights and responsibilities
  - working with children and young people who are subject to care orders ('looked after' children)
- An ability to draw on knowledge that if a child is judged to be unable to consent to an intervention, consent should be sought from a carer with parental responsibilities, and:
  - an ability to seek legal advice about specific circumstances when consent can be accepted from a person who has care or control of the child, but who does not have parental rights or responsibilities
  - an understanding of the role and rights of others (including carers) for a person who lacks the ability to consent
  - an understanding of relevant incapacity legislation that appoints others to help take decisions on behalf of a person

Ability to gain informed consent to an intervention

- An ability to give individuals the information they need to decide whether to proceed with an intervention e.g.:
  - what the intervention involves and who is offering it
  - the potential benefits and risks of the proposed intervention

what alternatives are available to them
An ability to use an interpreter where the first language of the service users is not that used by the practitioner and their language skills indicate that this is necessary
Where service users have a disability, an ability to ensure that information is provided in an accessible form (e.g. using an interpreter for people with hearing-impairments)
An ability to invite and to actively respond to questions regarding the proposed intervention
An ability to address any concerns or fears regarding the proposed intervention

An ability to draw on knowledge that even where consent has been granted, it is usual to revisit this issue when introducing specific aspects of an assessment or intervention

Ability to draw on knowledge of confidentiality

An ability to draw on knowledge that a duty of confidentiality is owed to:
the individual to whom the information relates
any individuals who have provided relevant information on the understanding it is to be kept confidential
An ability to draw on knowledge that confidence is breached where the sharing of confidential information is not authorised by those individuals who provided it or to whom it relates
An ability to draw on knowledge that there is no breach of confidence if:
information was provided on the understanding that it would be shared with a limited range of people or for limited purposes, and information has been shared in accordance with that understanding
there is explicit consent to the sharing

Sharing information to maintain safety

An ability to draw on knowledge that it is appropriate to breach confidentiality when withholding information could:
place an individual or others (e.g. family members, significant others, professionals or a third party) at risk of significant harm
prejudice the prevention, detection or prosecution of a serious crime

lead to an unjustified delay in making enquiries about allegations of significant harm to others

An ability to judge when it is in the best interest of the patient to disclose information, taking into account their wishes and views about sharing information, holding in mind:
that disclosure is appropriate if it prevents serious harm to a patient who lacks capacity
the immediacy of any risk of suicide or self-harm (e.g. the degree of planning, the type of suicide method planned or already attempted, circumstances e.g. being alone, refusing treatment, drinking heavily or being under the influence of drugs)

An ability to draw on knowledge that the duty of confidentiality does not preclude listening to the views of family members/significant others, or providing them with non-person specific information about managing a crisis or seeking support
An ability to judge when sharing information within and between agencies can help to manage suicide risk
An ability to discuss concerns about disclosure with colleagues (e.g. by discussing the case without revealing the patient's identity or by raising the issues in supervision)

An ability to share the decision to disclose information with the person it concerns, at the first opportunity, when safe to do so

Ability to inform all relevant parties about issues of confidentiality and information-sharing

An ability to explain to all relevant parties (e.g. users of services, significant others and other professionals) the limits of confidentiality and circumstances in which it may be breached (e.g. when an individual is considered to be at risk)
An ability to inform all relevant parties about local service policy on how information will be shared, and to seek their consent to these procedures (e.g. the ways information about the assessment and intervention will be shared with referrers)
An ability to revisit consent to share information if:
there is significant change in the way the information is to be used
there is a change in the relationship between the agency and the individual

there is a need for a referral to another agency who may provide further assessment or intervention
An ability to draw on knowledge that safeguarding needs usually take precedence over issues of consent and confidentiality

Ability to assess the capacity to consent to information-sharing[2]

An ability to gauge the individual's capacity to give consent by assessing whether they:
have a reasonable understanding of what information might be shared, the main reason(s) for sharing it and the implications of sharing or not sharing the information
appreciate and can consider the alternative courses of action open to them
express a clear personal view on the matter (as distinct from repeating what someone else thinks they should do)
are reasonably consistent in their view on the matter (i.e. are not changing their mind frequently)

Ability to share information appropriately and securely

An ability to ensure that when decisions are made to share information, the practitioner draws on knowledge of information-sharing and guidance at national and local level, and:
shares it only with the person or people who need to know
ensures that it is necessary for the purposes for which it is being shared
check that it is accurate and up to date
distinguishes fact from opinion
understand the limits of any consent given (especially if the information has been provided by a third party)
establishes whether the recipient intends to pass it on to other people, and ensure the recipient understands the limits of any consent that has been given;
ensures that the person to whom the information relates (or the person who provided the information) is informed that information is being shared, where it is safe to do so

[2] See also the competences in sub-domain 4.5 on assessment of capacity.

An ability to ensure that information is shared in a secure way and in line with relevant local and national policies

2.4. Ability to work with difference (maintaining equalities)

Note about the competences in this sub-domain

There are many factors that need to be considered in the development of culturally competent practice and finding a language that encompasses all of them is a challenge. For example, issues around gender, disability or sexual orientation may vary between cultural groups. Nonetheless, the competences required to work in a culturally competent manner are likely to be similar. They relate to the capacity to value diversity and maintain an active interest in understanding how people may experience specific beliefs, practices and lifestyles, and to consider any implications for how an intervention is carried out.

There are, of course, many ways in which practitioners and the people they work with may vary in beliefs, practices and lifestyles. Some may not be immediately apparent, leading to an erroneous assumption that they do not exist. It is a person's sense of the impact of specific beliefs, practices and lifestyles that is important (the meaning these have for them) rather than the factors themselves. Almost any encounter requires the practitioner to carefully consider any potential issues relating to specific beliefs, practices and lifestyles, and relevance to the intervention being offered.

Because issues of specific beliefs, practices and lifestyles often relate to differences in power and to inequalities, practitioners need to be able to reflect on the ways in which power dynamics play out, in the context of the service in which they work and when working with people.

Stance

An ability to draw on knowledge that in working with specific beliefs, practices and lifestyles, it is stigmatising and discriminatory attitudes and behaviours that are problematic, rather than any specific beliefs, practices and lifestyles, and therefore:
an ability to value equally all people for their particular and unique constellation of characteristics and an awareness of stigmatising and discriminatory attitudes and behaviours in themselves and others (and the ability to challenge these)
an awareness that there is no 'normative' state from which people may deviate, and therefore no implication that a 'normative' state is preferred and other states are problematic

Knowledge of the significance for practice of specific beliefs, practices and lifestyles

An ability to draw on knowledge that it is the individualised impact of background, lifestyle,

beliefs or religious practices that is critical
An ability to draw on knowledge that the demographic groups included in discussion of 'different' beliefs, practices or lifestyles are usually those that are potentially subject to disadvantage and/or discrimination
An ability to draw on knowledge that a person will often be a member of more than one 'group' (e.g. a gay person from a minority ethnic background); as such, the implications of combinations of lifestyle factors need to be held in mind
An ability to maintain an awareness of the potential significance for practice of social and cultural variation across a range of domains, including:
ethnicity
culture
gender, gender identity and gender diversity
sexual orientation
religion and belief
socioeconomic deprivation
class
age
disability
An ability to draw on knowledge of the relevance and potential impact of social and cultural factors on the effectiveness and acceptability of an assessment or intervention

Knowledge of social and cultural factors that may impact on access to the service

An ability to draw on knowledge of cultural issues that commonly restrict or reduce access to interventions, e.g.:
language
marginalisation
mistrust of statutory services
lack of knowledge about how to access services
the range of cultural concepts, understanding and attitudes about mental health that

affect views about help-seeking, treatment and care
stigma, shame and/or fear associated with mental health problems (which makes it likely that help-seeking is delayed until or unless problems become more severe)
stigma or shame and/or fear associated with being diagnosed with a mental health problem
preferences for gaining support in the community rather than through 'conventional' referral routes (e.g. their GP)
cultural beliefs that influence the acceptability of some physical interventions

An ability to draw on knowledge of the potential impact of socioeconomic status on access to resources and opportunities
An ability to draw on knowledge of the ways in which social inequalities affect development and mental health
An ability to draw on knowledge of the impact of factors such as socioeconomic disadvantage or disability on practical arrangements that influence attendance and engagement (e.g. transport difficulties, poor health)

Ability to communicate respect and valuing of people

Where patients from a specific sociodemographic group are regularly seen within a service, an ability to draw on knowledge of relevant beliefs, practices and lifestyles
An ability to identify protective factors that may be conferred by membership of a specific sociodemographic group (e.g. the additional support offered by an extended family)
An ability to take an active interest in the patient's social and cultural background and hence to demonstrate a willingness to learn about their sociocultural perspectives and world view

Ability to gain an understanding of the experience of specific beliefs, practices and lifestyles

An ability to work collaboratively with patients to develop an understanding of their culture and world view, and the implications of any culturally specific customs or expectations for a therapeutic relationship and the ways in which problems are described and presented, and:
an ability to apply this knowledge in order to identify and formulate problems, and intervene in a manner that is culturally sensitive, culturally consistent and relevant
an ability to apply this knowledge in a manner that is sensitive to the ways in which patients interpret their own culture (and therefore recognises the risk of culture-related

stereotyping)
An ability to take an active and explicit interest in the patient's experience of the beliefs, practices and lifestyles pertinent to their community, to:
help them discuss and reflect on their experience
identify whether and how this experience has shaped the development and maintenance of their presenting problems
identify how they locate themselves if they 'straddle' cultures
An ability to discuss the ways in which individual and family relationships are represented in a person's culture (e.g. notions of the self, models of individuality and personal or collective responsibility), and to consider the implications for organisation and delivery of any interventions

Ability to adapt communication

Where the practitioner does not share a patient's language, an ability to identify appropriate strategies to ensure and enable their full participation in the assessment or intervention, and:
where an interpreter/advocate is employed, an ability to draw on knowledge of the strategies that need to be in place for them to work effectively and in the patient's interests
An ability to adapt communication with patients who have a disability (e.g. using communication aids or by altering the language, pace, and content of sessions)

Ability to use and interpret standardised assessments/measures

Where standardised assessments/measures are used in a service, an ability to ensure that they are interpreted in a manner that takes into account any individual or familial demographic factors, e.g.:
if the measure is not available in the patient's first language, an ability to take into account the implications of this when interpreting results
if a bespoke translation is attempted, an ability to cross-check the translation to ensure that the meaning has not been changed
if standardised data (norms) are not available for the patient's demographic group, an ability to explicitly consider this issue when interpreting the results

Ability to adapt psychological interventions

An ability to draw on knowledge of the conceptual and empirical research base that informs thinking about the impact of social and cultural factors on the effectiveness of psychological interventions
Where there is evidence that specific beliefs, practices and lifestyles are likely to impact on the accessibility of an intervention, an ability to make appropriate adjustments to it and/or the manner in which it is delivered, with the aim of maximising its potential benefit
An ability to draw on knowledge that culturally adapted treatments should be judiciously applied, and are warranted if there is evidence that:
a patient's particular clinical problem is influenced by their membership of a given community
people from a given community respond poorly to certain evidence-based approaches

Ability to demonstrate awareness of the influence of a practitioner's own background

An ability for practitioners of all backgrounds to draw on an awareness of their own group membership, values and biases, how these may influence their perceptions of a person, their problem and the therapeutic relationship
An ability for practitioners to reflect on power differences between themselves and their patients

Ability to identify and to challenge inequality

An ability to identify inequalities in access to services and take steps to overcome these:
considering ways in which access to and use of services may need to be facilitated for some patients (e.g. home visiting, flexible working, linking families and carers with community resources)
where it is within the practitioner's role, identifying groups whose needs are not being met by current service design/procedures and potential reasons for this, and identifying and implementing potential solutions

2.5. Ability to recognise and respond to concerns about child protection

Note about the competences in this sub-domain

Effective delivery of child protection competences depends critically on their integration with knowledge of:

- child/young person and family development and transitions
- consent and confidentiality
- legal issues relevant to child and family work
- interagency working
- engaging families and children/young people.

Knowledge of policies and legislation

An ability to draw on knowledge of national and local child protection standards, legal frameworks and guidance that relate to the protection of children
An ability to draw on knowledge of local policies and protocols regarding:
confidentiality and information-sharing
recording of information about young people and their families
An ability to draw on knowledge of the statutory responsibilities of all adults (e.g. parents, carers, school staff) to keep young people safe from harm
An ability to draw on knowledge that practitioners are responsible for acting on concerns about a young person even if he/she is not their client

Knowledge of child protection principles

An ability to draw on knowledge of child protection principles underlying multiagency child protection work
An ability to draw on knowledge of the benefits of early identification of at-risk young people and families who can then receive appropriate and timely preventative and therapeutic interventions
An ability to draw on knowledge of the importance of maintaining a child-centred approach that ensures a consistent focus on the welfare of the young person and on their feelings and viewpoints
An ability to draw on knowledge that assessment and intervention processes should be

continually reviewed, and that they should be timed, and tailored to the individual needs of the young person and family

Ability to draw on knowledge of the ways in which abuse and neglect present

An ability to draw on knowledge of the concept of significant harm, including:		
	a threshold that justifies intervention in family life in the best interests of children	
An ability to draw on knowledge that there are no absolute criteria for significant harm, but that this is based on consideration of:		
	the degree and the extent of physical harm	
	the duration and frequency of abuse and/or neglect	
	the extent of premeditation	
	the presence or degree of threat	
	the actual or potential impact on the child's health, development and/or welfare	
An ability to draw on knowledge that significant harm can be indicated both by a 'one-off' incident, a series of 'minor' incidents, or as a result of an accumulation of concerns over a period of time		
An ability to draw on knowledge of areas in which abuse and neglect are manifested:		
	physical abuse (e.g. causing deliberate harm, female genital mutilation)	
	emotional abuse:	
		persistent emotional maltreatment that is likely to impact on the child's emotional development
	sexual abuse (the abuse of children through sexual exploitation), which includes:	
		penetrative and non-penetrative sexual contact
		non-contact activities (e.g. watching sexual activities or encouraging young people to behave in sexually inappropriate ways)
	neglect – usually defined as an omission of care by the young person's parent/carer (often due to unmet needs of their own), including:	
		persistent failure to meet a child's basic physical and/or psychological needs
An ability to draw on knowledge of the short- and long-term effects of abuse and neglect		

including their cumulative effects
An ability to draw on knowledge that (while offering support and services to parents of abused children) the needs of the young person are primary
An ability to draw on knowledge that young people may experience multiple forms of abuse from different individuals or groups during their development from young person to adult

Ability to recognise possible signs of abuse and neglect

An ability to recognise behaviours shown by young people that may be indicators of abuse or neglect, and which may require further investigation, e.g.:
young people who appear to be frightened or intimidated by an adult or peer
young people who act in a way that is inappropriate to their age and development

An ability to recognise possible signs of physical abuse, e.g.:
explanations that are inconsistent with an injury or an unexplained delay in seeking treatment
parent/s who seem uninterested or undisturbed by an accident or injury
repeated or multiple bruising or other injury on sites unlikely to be injured as a consequence of everyday activity/ accidents

An ability to recognise possible signs of emotional abuse, e.g.:
developmental delay and/or non-organic failure to thrive
indicators of serious attachment problems between parent and child
markedly aggressive or appeasing behaviour towards others
indicators of serious scapegoating within the family
indicators of low self-esteem and lack of confidence
marked difficulties in relating to others

An ability to recognise possible behavioural signs of sexual abuse, e.g.:
inappropriate sexualised conduct (e.g. sexually explicit behaviour, play or

conversation, inappropriate to the child's age)
self-harm and suicide attempts
involvement in sexual exploitation or indiscriminate choice of sexual partners
anxious unwillingness to remove clothes for e.g. sports events (when it is not related to cultural norms or physical difficulties)

An ability to recognise possible physical signs of sexual abuse, e.g.:
genital discomfort
blood on underclothes
pregnancy
An ability to recognise that allegations from young people of sexual abuse by young people may initially be indirect (to test the professional's response)

An ability to recognise that, in most cases, evidence of neglect accumulates over time and across agencies, and:
an ability to compile a chronology and discuss concerns with other agencies to determine whether minor incidents are indicative of a broader pattern of parental neglect
An ability to recognise possible signs of neglect, e.g.:
failure by parents or carers to meet essential physical needs (e.g. adequate or appropriate food, clothes, hygiene and medical care)
failure by parents or carers to meet essential emotional needs (e.g. to feel loved and valued, to live in a safe, predictable home environment)
the young person thrives away from home environment
the young person is frequently absent from school
An ability to recognise the potential for professionals to be desensitised to indicators of neglect when working in areas with a high prevalence of poverty and deprivation

Ability to draw on knowledge of bullying

An ability to draw on knowledge that bullying can become a formal child protection issue when carers, school and other involved agencies fail to address the bullying in an adequate

manner
An ability to draw on knowledge that bullying is defined as deliberately hurtful behaviour, usually repeated over a period of time, where it is difficult for those bullied to defend themselves
An ability to draw on knowledge that while bullying can take many forms the four main types are:
(1) physical (e.g. hitting, kicking, theft)
(2) verbal (e.g. racist or homophobic remarks, threats, name-calling)
(3) emotional (e.g. isolating someone from the activities and social acceptance of their peer group)
(4) cyberbullying (the use of technology by children and young people to intimidate peers, and sometimes those working with them (e.g. teachers)
An ability to draw on knowledge that bullying can affect the health and development of children, and at the extreme, causes them significant harm (including self-harm)

An ability to recognise parental behaviours associated with abuse or neglect

An ability to recognise parental behaviours that are associated with abuse or neglect, and which may require further investigation, e.g.:
parents who persistently avoid routine child health services and/or treatment when the child is ill
parents who persistently avoid contact with services or delay the start or continuation of treatment
parents who persistently complain about /to the child and may fail to provide attention or praise (high criticism /low warmth environment)
parents who display a rejecting or punitive parenting style or are not appropriately responsive to their child's signals of need
parents who are regularly absent or leave the child with inappropriate carers
parents who fail to ensure the child receives an appropriate education

Ability to recognise risk factors for, and protective factors against, abuse or neglect

An ability to draw on knowledge that abuse and neglect are more likely to occur when the accumulation of risk factors outweighs the beneficial effects of protective factors
An ability to recognise child, parental and family/social protective factors
An ability to recognise parental risk factors for abuse or neglect, e.g.:
parents who have significant problems that impact on their ability to parent (e.g. significant mental health difficulties or substance misuse)
parents who are involved in domestic abuse or involvement in other criminal activity
An ability to recognise family/social risk factors for abuse or neglect, e.g.:
social isolation
socioeconomic problems
history of abuse or neglect in the family
An ability to recognise child risk factors for abuse or neglect, e.g.:
recurring illness or hospital admissions or disability
difficult or aggressive temperament

Ability to respond where a need for child protection has been identified

An ability to work with the multidisciplinary team to ensure that actions taken in relation to child protection are consistent with relevant legislation and local policy and procedure

Ability to report concerns about child protection

An ability to work collaboratively with young people and their families to promote their participation in gathering information and making decisions
An ability to report suspicions of risk to appropriate agencies, and:
to share information with relevant parties, with the aim of drawing attention to emerging concerns
to gather information from other relevant agencies (e.g. school, GPs)
An ability to follow local referral procedures to social work and other relevant agencies, for investigation of concerns or signs of abuse or neglect
An ability to record information, setting out the reasons for concern and the evidence for it

An ability to contact and communicate with all those who are at risk, ensuring that they understand the purpose for the contact with, and referral to, other agencies
An ability to follow local and national procedures where there is difficulty contacting young people and families and there is a concern that they are missing from the known address
An ability to follow guidelines on how confidentiality and disclosure will be managed

Ability to contribute to the development of a child protection plan

An ability to contribute information to multi-agency child protection meetings including child protection case discussions, child protection case conferences, and core group meetings	
	where necessary, an ability to express a concern or position that is different from the views of others, and to do so during (rather than subsequent to) the meeting
An ability to participate in the development of a multi-agency protection plan, as per local and national guidance	

Ability to implement protective interventions

An ability to work with the multidisciplinary team to implement protective interventions within the remit of the service and which are outlined in the child protection plan, aiming to:	
	reduce or eliminate risk factors for abuse or neglect
	build on the strengths and resilience factors of parent/carer, family and young person
An ability to maintain support for young people and families when compulsory measures are necessary	
Where relevant, an ability to maintain therapeutic support for the young person and family during an ongoing child protection investigation, and/or when the young person is called to be a witness in court	
An ability to respond appropriately to contingencies that indicate a need for immediate action, and:	
	to provide a single agency response without delay
	where additional help is required, an ability to work with others to ensure that this is timely, appropriate and proportionate

Ability to record and report on interventions that the practitioner is responsible for

An ability to document decisions and actions taken, and the evidence for taking these decisions, what further help is required and how this will be actioned

Interagency working

An ability to draw on knowledge of the roles and responsibilities of other services available to the young person and family	
	an ability to draw on knowledge of the ways in which other services should respond to child protection concerns
An ability to collaborate with all potentially relevant agencies when undertaking assessment, planning, intervention, and review	
An ability to ensure that there is timely communication with all agencies involved in the case, both verbally and in writing	
An ability to escalate concerns within one's own or between other agencies (e.g. when the implementation of the child protection plan is problematic or to ensure sufficient recognition of risk factors and/or signs of abuse)	

Ability to seek advice and supervision

An ability for the practitioner to make use of supervision and support from other members of staff, in order to manage their own emotional responses to providing care and protection for children
An ability to recognise the limits of one's own expertise and to seek advice from appropriately trained and experienced individuals

2.6. Ability to recognise and respond to concerns about safeguarding

An ability to draw on knowledge that safeguarding concerns can arise across the lifespan, from infancy through to old age
An ability to draw on knowledge of factors that make adults vulnerable (e.g. mental health or physical health problems, communication difficulties or dependence on others)
An ability to draw on knowledge of type of abuse and neglect that could trigger a safeguarding concern, e.g.:
physical abuse
domestic violence
psychological abuse
financial or material abuse or exploitation
sexual abuse or exploitation
neglect
abuse in an organisational context
An ability to identify signs or indicators that could flag the need to institute safeguarding procedures
An ability to share concerns with relevant members of a multidisciplinary team and participate in generating an action plan to address these

An ability to draw on knowledge of national guidance and legal frameworks regarding responsibility for acting on safeguarding concerns
An ability to act on knowledge of local agencies and local procedures for invoking, investigating and acting on safeguarding concerns

An ability to approach the management of safeguarding procedures in a way that protects the safety of the individual but does so in a manner that is compassionate, empathic and supportive

2.7. Knowledge of human rights law and principles

Note about the competences in this sub-domain

PAs need to understand the legal powers that allow for restriction of non-absolute rights and the principles that guide the use of restrictive practices under human rights law. Because any restrictions will take place in a multidisciplinary context, PA's will need to consult with the team before contributing to or acting on such decisions.

An ability to draw on knowledge that the Human Rights Act 1998 places a legal duty on people working in a public authority to act in compatibility with human rights and (as far as possible) apply all laws, policy and guidance in a way that respects these rights

An ability to draw on knowledge that key human rights principles (e.g. fairness, respect, equality, dignity and autonomy) apply to everyone, regardless of their background or circumstances
An ability to draw on knowledge that human rights principles should always inform decision-making
An ability to draw on knowledge that human rights legislation and principles should inform the procedures associated with any episode of care (e.g. admission, inpatient stay and discharge)

An ability to draw on knowledge that absolute human rights can never lawfully be restricted (e.g. the right to life or the right not to be subjected to degrading treatment)

An ability to draw on knowledge of the proportionate restriction of non-absolute rights, usually to protect someone with mental health issues or protect others who may be affected by that person's actions or behaviour	
An ability to draw on knowledge that any restrictions on non-absolute human rights need to be:	
	(a) lawful (based on a law that sanctions that action, e.g. the Mental Health Act or Mental Capacity Act)
	(b) legitimate (based on a decision that can be justified, e.g. to protect a person or others from harm)
	(c) proportionate (that is, after due consideration there is no alternative action that

can be taken)
An ability to draw on knowledge that the legal basis for any decision must be given (in an accessible form) to the patient (or their family, carer or advocate, if capacity is an issue)

An ability to draw on knowledge that where non-absolute rights are restricted, practitioners should be able to show that they have met the three-stage test (above), taken the patient's other rights into account, and that any restriction is:
kept to the minimum possible
in proportion to the circumstances
assessed and applied on an individual basis
An ability to draw on knowledge that restrictive practices should not be adopted as a blanket approach that affects all patients

An ability to draw on knowledge that decisions related to the Mental Health Act should be compatible with human rights
An ability to draw on knowledge that because there are particular risks to fairness when people are compulsorily detained under the Mental Health Act, patients should:
understand their rights and how to claim them
have an opportunity to challenge reports and other evidence that led to their detention
have the opportunity to be represented at a tribunal hearing
have the right to legal representation

An ability to draw on knowledge that, based on human rights principles, all patients should:
receive care that respects their personal and cultural needs
be treated equally, without discrimination and with respect

2.8. Ability to make use of supervision

Note about the competences in this sub-domain

Supervision is understood differently in different settings.
Here, supervision is defined as an activity that gives practitioners the opportunity to review and reflect on their clinical work. This includes talking about areas that are experienced as difficult or distressing for the practitioner. Usually supervisors of PAs will be a consultant psychiatrist or specialist psychiatrist.

This definition distinguishes supervision from line management or case management.

An ability to hold in mind that a primary purpose of supervision and learning is to enhance the quality of the treatment received by users of services

Ability to work collaboratively with the supervisor

An ability to work with the supervisor to generate an explicit agreement about the parameters of supervision (e.g. setting an agenda, being clear about the respective roles of supervisor and supervisee, the goals of supervision and any contracts that specify these factors)
An ability for the supervisee to help the supervisor be aware of their current state of competence and your training needs
An ability to present an honest and open account of the work being undertaken (including areas that have not gone well or that the supervisee fears might reflect badly on them)
An ability to discuss work with the supervisor as an active and engaged participant, without becoming passive or avoidant, or defensive or aggressive
An ability to present material to the supervisor in a focused manner, selecting (and so concentrating on) the most important and relevant issues

Capacity for self-appraisal and reflection

An ability to reflect on the supervisor's feedback and to apply these reflections in future work
An ability to be open and realistic about your capabilities and to share this self-appraisal with the supervisor
An ability to use feedback from the supervisor in order further to develop the capacity for

accurate self-appraisal

Capacity for active learning

An ability to act on suggestions regarding relevant reading made by the supervisor, and to incorporate this material into practice
An ability to take the initiative in relation to learning, by identifying relevant reading based on (but independent of) supervisor suggestions, and to incorporate the material into practice
An ability to maintain and update knowledge and skills in line with changes in practice, through supervision, appraisal and reflective practice
An ability to proactively seek opportunities for personal supervision, personal development and learning

Ability to use supervision to reflect on developing personal and professional roles

An ability to use supervision:	
	to discuss the personal impact of the work, especially where this reflection is relevant to maintaining the likely effectiveness of the work
	to reflect on the impact of the work in relation to professional development
	to understand issues arising from team dynamics

Ability to reflect on supervision quality

An ability to reflect on the quality of supervision as a whole, and (in accordance with national and professional guidelines) to seek advice from others where:	
	there is concern that supervision is below an acceptable standard
	where the supervisor's recommendations deviate from acceptable practice
	where the supervisor's actions breach national and professional guidance (e.g. abuses of power and/or attempts to create dual [sexual] relationships)

3. Engagement and communication

3.1. Communication skills

Knowledge

- An ability to draw on knowledge of the value of basic communication skills:
  - as a way of helping patients feel supported by a practitioner who is focused on their concerns and needs, and that helps them:
    - feel respected, heard and understood
    - feel connected to others (and so experience themselves as less isolated and alone)
    - express themselves and makes sense of their experience
    - reflect on and request the support that they feel is appropriate to their immediate needs
  - as a way for the practitioner to gain an accurate sense of the concerns and needs of the patient

- An ability to draw on knowledge that where verbal communication is challenging for the person, other forms of communication (e.g. drawing or writing) are appropriate and may be the main way in which the person communicates
  - an ability to make use of a range of communication strategies where this is indicated

- An ability to draw on knowledge that asking about and talking about difficult issues does not necessarily increase the likelihood of behaviours that put the person at risk (e.g. self-harm), and that it is helpful to communicate openly and with frankness

Application

- An ability to deploy communication skills that help to engage patients in a collaborative discussion of their circumstances and immediate needs, and:
  - an ability to make adjustments for patients who may have difficulty expressing themselves (for whatever reason)

To gain an accurate sense of the patient's account, an ability for the practitioner to be aware of (and avoid) any 'filters' they may find themselves imposing, e.g.:
listening in a judgemental way
making assumptions (in advance of, or instead of, listening fully)
using diagnostic labels as explanations

An ability to convey an attentive stance through body language, e.g.:
sitting close (but not too close) to the patient
sitting next to or at an angle to the patient (rather than across a desk)
adopting an open posture
maintaining an appropriate level of eye contact (i.e. a level with which the patient is comfortable)

An ability to listen attentively to the individual by:
actively listening to the individual's account and trying to make sense of their experiences, behaviours and feelings, and the social context in which these arise
listening to the tone and pace of what is said, as well as its content
allowing silences if this appears to help the patient express themselves at their own pace
attending to the individual's non-verbal behaviour e.g. agitation (as a guide to the areas that are more intensely distressing or as an indicator of 'unspoken' feelings that might be difficult to express verbally)
adopting a pace that 'matches' (but does not mimic) that of the patient

An ability to help the patient expand on or explore relevant issues by using:
statements (e.g. brief summaries of what has already been said)
questions
non-verbal prompts

An ability to ask both:
‘closed’ questions (that usually have a specific or binary answer and that are best used to establish factual information)
‘open’ questions (that require more than a yes/no answer and encourage discussion)

An ability to judge when questioning is being experienced as helpful and when less so (e.g. where the individual is feeling ‘grilled’)
An ability to judge when to move away from areas that the patient is finding too difficult or distressing (and to judge when and whether to return to them at a later point)

An ability to listen ‘empathically’ to the individual:
actively trying to understand their perspective and the way they understand their situation
‘stepping into their shoes’ in order to understand their world
taking on board and recognising their feelings (but taking care not to mirror these feelings in oneself)
An ability to maintain an awareness of one’s own perspective or frame of reference in order not to inadvertently impose it

An ability to convey a basic and empathic understanding of what has been said or conveyed, e.g. by:
paraphrasing what has been said (but not ‘parroting’, i.e. simply repeating verbatim)
making short summaries that try to connect various aspects of what has been conveyed
using appropriate non-verbal behaviour that ‘chimes’ with what has been said (e.g. through appropriate facial expression)

An ability to check the patient’s understanding by asking them to summarise the discussion and/or any decisions that have been agreed

An ability to ask the patient whether all the issues that they wished to raise have been discussed

3.2. Ability to understand and respond appropriately to people in distress

Note on the terminology in this sub-domain

Throughout this sub-domain, 'service users/s' refers to children and young people as well as their family/carers and significant others.

- An ability to draw on knowledge that service users will often experience high levels of emotional arousal and distress, and that acknowledging and addressing this should be a primary goal, and:
  - an ability to listen to, maintain contact with and respond to service users who are expressing strong emotions

- An ability to help service users access, differentiate and experience their emotions in a manner that best facilitates adaptive change
- An ability to help service users express their emotions while also monitoring their capacity to tolerate this and to deploy strategies that help to manage any difficulties that emerge, e.g. by:
  - ensuring that discussion moves at the service user's pace (i.e. their readiness and capacity to discuss an issue)
  - 'pulling back' if areas appear to be too difficult and returning to them at a later stage
  - helping the service user to stay with the emotion without escalating it
  - helping the service user recognise and accurately put a name to emotions
- An ability to introduce techniques designed to manage unhelpfully strong emotions (e.g. aggression or extreme fear and withdrawal), e.g.:
  - helping the service user link emotions to the 'messages' that they convey
  - indicating what behaviour is appropriate (setting limits)

- When sessions include both the patient and family/carers, an ability to help carers:
  - support the patient's capacity to express emotion in an appropriate manner
  - express their emotions in an appropriate manner

Ability to reflect on the expression of behaviours and strong emotions

An ability to understand that the patient's emotional expression (including behaviour that challenges) is a form of communication
An ability to reflect on the meaning of the behaviour/emotional expression and its relation to the current and past context
An ability to describe the emotion/behaviour and elicit the patient's interpretation of its meaning, and:
an ability to discuss any such interpretations with the patient

An ability for the practitioner to reflect on their own reaction to the emotional/behavioural expression and their influence on the patient's behaviour
an ability for the practitioner to make use of supervision to reflect (and, if need be, to act) on these issues

3.3. Ability to foster and maintain a good therapeutic relationship, and to grasp the service user's perspective and 'world view'

Note on the terminology in this sub-domain

Work in services often incudes work with family/carers, as part of an integrated intervention or in the form of a parallel treatment. As such, each party is potentially the 'service user' referred to in this section.

Understanding the concept of the therapeutic relationship

An ability to draw on knowledge that a therapeutic relationship is usually seen as having three components:
the relationship or bond between practitioner and service user
an evolving consensus between practitioner and service user regarding the techniques/methods employed in an intervention
an evolving consensus between practitioner and service user regarding the goals of an intervention
An ability to draw on knowledge that all three components contribute to the maintenance of the therapeutic relationship

Knowledge of practitioner factors associated with building a positive therapeutic relationship

An ability to draw on knowledge of practitioner factors that increase the probability of developing a positive therapeutic relationship:
being flexible so as to ensure that the service user has the opportunity to discuss issues that are important to them
being respectful
being warm, friendly and affirming
being open
being alert and responding actively
being able to show honesty through self-reflection (e.g. recognising and 'owning' any missteps or errors)

being trustworthy
being consistent
being able to be oneself

Knowledge of practitioner factors that reduce the probability of developing a positive therapeutic relationship:

being rigid
being critical
being distant or aloof
being distracted
making inappropriate use of silence
being inconsistent and/or unreliable
being disrespectful

Knowledge of service user factors associated with building the relationship

An ability to draw on knowledge of service user factors that affect the probability of forming a positive relationship, e.g. service users feeling:

validated (that their ‘story’ is being heard and respected)
enabled to communicate their story
able to be themselves without fear of judgement

An ability to draw on knowledge of service user factors that may reduce the probability of forming a positive relationship e.g.:

interpersonal issues (e.g. assuming that the practitioner will not believe their perspective on events)
involuntary presentation (e.g. detained under the Mental Health Act or attending a session only because of external pressures)
issues related to complex needs (e.g. substance misuse or self-harm)
service-related issues (e.g. previous negative experiences of services)

cultural factors (e.g. cultural needs not being recognised or met by services)
influence of family and peers (e.g. families who encourage or discourage a patient from maintaining contact with services, or peers who stigmatise them for being in receipt of an intervention)

Capacity to develop the therapeutic relationship to support an intervention

An ability to listen to the service user's concerns in a manner that is non-judgemental, supportive and sensitive, and that conveys an accepting attitude when the service user describes their experiences and beliefs
An ability to validate the service user's concerns and experiences
An ability to ensure that the service user is clear about the rationale for the intervention being offered
An ability to gauge whether the service user understands the rationale for the intervention, has questions about it, or is sceptical about the rationale, and to respond to these concerns openly and non-defensively to resolve any ambiguities
An ability to help the service user express any concerns or doubts they have about the planned intervention and/or the practitioner, especially where this relates to mistrust or scepticism
An ability to help the service user form and articulate their goals for the intervention, and to gauge the degree of congruence in the aims of the service user and practitioner

Capacity to grasp the service user's perspective and 'world view'

An ability to grasp the ways in which the service user characteristically understands themselves and the world around them
An ability to hold the service user's world view in mind throughout the course of an intervention and to convey this understanding through interactions with the service user, in a manner that allows the service user to correct any misapprehensions
An ability to establish the service user's point of view by exploring their position in an open and accepting manner, taking their concerns at face value and suspending any tendency to disbelief
An ability to hold the service user's perspective in mind
while gathering all relevant information in a sensitive manner
while retaining an independent perspective and guarding against collusion with the

service user

Capacity to maintain the therapeutic relationship

Capacity to recognise and to address threats to the relationship

An ability to recognise when strains in the relationship threaten the progress of an intervention
an ability for the practitioner to recognise and explicitly take responsibility for actions that they themselves have taken and that appear to be responsible for disrupting the relationship

An ability to deploy appropriate interventions in response to disagreements about tasks and goals, and:
to check that the service user is clear about (and agrees with) the rationale for the intervention and to review this with them and/or clarify any misunderstandings
to judge when it is best to refocus on tasks and goals that are seen as relevant or manageable by the service user (rather than keep exploring issues that are giving rise to disagreement)
An ability to deploy appropriate interventions in response to strains in the bond between practitioner and service user, e.g.:
for the practitioner to give and ask for feedback about what is happening in the here-and-now interaction, in a manner that invites exploration with the service user
for the practitioner to acknowledge and accept responsibility for their contribution to any strains in the therapeutic relationship
where the service user recognises and acknowledges that the therapeutic relationship is under strain, an ability (when appropriate) to help them make links between the rupture and their usual style of relating to others
to allow the service user to assert any negative feelings about the relationship between the practitioner and themselves
to help the service user explore any fears they have about expressing negative feelings about the relationship between the practitioner and themselves (e.g. by indicating a willingness to talk about this or drawing attention to ways in which this is already being expressed implicitly)

3.4. Communicating with people with cognitive and neurodevelopmental challenges

Note about the competences in this sub-domain

This section identifies communication issues that may arise when working with people with neurodevelopmental presentations or conditions. Three exemplar conditions are included, but it is important to hold in mind that:

- there are a range of conditions
- some people will have more than one neurodevelopmental disorder
- challenges to communication may be present with people who do not meet formal diagnostic criteria, but who are subthreshold.

An ability to draw on knowledge that where verbal communication is challenging for the patient, other forms of communication (e.g. drawing, writing or play) are appropriate and may be the main way in which the person communicates, and:

- an ability to make use of a range of communication strategies where this is indicated

Intellectual disabilities

Communicating with patients with intellectual disabilities

An ability to draw on knowledge that the linguistic and cognitive abilities of patients with intellectual disabilities will vary considerably from person to person, but that they may have specific communication difficulties, e.g.:

- difficulty understanding abstract concepts
- their speech may be unclear
- they may need more time to process and retrieve information
- they may have a limited vocabulary
- they may be prone to suggestibility (they may change their answers in response to the feedback they get)
- they may be prone to acquiescence (they may tend to answer ‘yes’ to questions)
- they may struggle to express themselves and become frustrated by this

An ability to draw on knowledge that people with intellectual disabilities may have acquired social strategies to help them 'mask' their difficulties understanding and following verbal communication

An ability to address any difficulties the patient has communicating by making appropriate adjustments, e.g.:

listening carefully and asking them to clarify or repeat information if it has been hard to understand what has been said
allowing time for them to respond
using simple, straightforward, everyday language
limiting the number of key concepts or ideas that are communicated in a sentence
using concrete examples (rather than abstract ideas)
asking short, simple either/or questions (but taking care to avoid leading questions)
creating a context for comments (i.e. to orient the patient to the reasons for comments or questions)
regularly asking them to summarise or repeat what has been discussed (to check that it has been accurately understood)

Autism spectrum disorder (ASD)

Communicating with patients with ASD

An ability to draw on knowledge that people with ASD vary considerably in their capacity to communicate, but that they may:

have difficulty articulating and communicating how they are feeling, both via speech and non-verbal communication (e.g. facial expression, body language)
have a very literal interpretation of language and so find figurative language (metaphors, idioms, similes) challenging to understand
have a higher level of expressive language (their ability to use language to communicate with others) than receptive language (how much they understand when people are talking to them)
find lengthy and complex communications difficult to follow
find it difficult to modulate the pitch, tone or speed of their voice (e.g. talking in a

monotone or more loudly than is socially appropriate)
find it uncomfortable to maintain continuous eye contact
have difficulty interpreting facial expression
have difficulty interpreting body language

An ability to adjust communication with people with ASD to accommodate their communication difficulties, e.g. by:
keeping communications short and straightforward
taking care not to use metaphors, idioms, similes or analogies
using concrete examples/facts to explain things
asking specific questions
taking care not to overload the patient with verbal information
allowing time for the patient to respond (allowing for 'thinking time')
regularly asking the patient to summarise or repeat what has been discussed (to check that it has been accurately understood)
being aware of difficulties and differences in non-verbal communication (e.g. facial expression, eye contact, and personal distance)
making use of alternative modes of communicating that may be easier for the individual (e.g. writing [including text and email] rather than speaking)
allowing them to use techniques they find soothing (e.g. fidget toys)

Attention deficit hyperactivity disorder (ADHD)

Communicating with people with ADHD

An ability to draw on knowledge that people with ADHD:
have difficulty directing and sustaining attention
can appear to be inattentive and forgetful
often have difficulty with impulse control
can experience social difficulties arising from the combination of inattention, impulsivity and hyperactivity

An ability to draw on knowledge that people with ADHD can find it difficult:
to attend to the thread of a conversation
to concentrate on long conversations
to attend to conversations in a noisy environment

An ability to draw on knowledge that people with ADHD may:
‘blurt out’ answers
interrupt
talk excessively
struggle to organise their thoughts
be easily distracted
feel overwhelmed

An ability to adjust communication to take account of the difficulties experienced by people with ADHD, e.g.:
minimising potential distractions (e.g. noisy or busy environments, or distractions such as mobile phones)
keeping communications short and focused
giving a ‘big picture’ summary before moving to a succinct account of details (and so accommodate to difficulties holding attention)
avoiding long conversations

3.5. Ability to work using telemedicine

Knowledge

An ability to draw on knowledge that telemedicine involves consultations made using telephone calls or audio/video digital platforms
An ability to draw on knowledge that because initial consultations (where the patient and PA are unknown to each other), may be more challenging than when working face-to-face, PA's need to:
be sensitive to the patient's comfort level with technology and identify early in the consultation what objectives can be reliably achieved using this
ensure that patients who are unfamiliar with (or lack confidence in) digital literacy or do not have access to digital platforms are not disadvantaged

An ability to draw on knowledge of situations where face-to-face treatment may be preferable to telemedicine, e.g. when:
the patient has complex needs
the patient is known to be at high risk
the PA does not have access to the patient's medical records
a physical examination is required
it is unclear whether the patient has capacity to decide on the form of treatment

Setting up the meeting

An ability to use:
secure encrypted platforms
an institutional account (i.e. not a personal one)
An ability to check the security of the system used by both the PA and the patient
An ability to gain explicit consent to the use of telemedicine, including the patient's right to withdraw from the process at any time (especially if the consultation is recorded by the PA or the patient)
An ability for the PA to ensure:

that they are familiar with the IT platforms being used
that there is good and consistent audio and video quality
if working with video, that the set-up of the room is appropriate to a professional conversation or that background filters are used

An ability to start meetings by establishing the context, e.g.:
introducing oneself and checking the identity of the patient
checking where the patient is, and whether there are others in the room with them (and if so, identifying who they are and whether they will be involved in the call)
ensuring that both the PA and patient have contact information in case the call is interrupted, and identifying who will contact who if this happens

Where contact will be ongoing, an ability to discuss frequency of meetings, expectations of contact between meetings, and (if required) emergency management plans between sessions

3.6. Co-production

Note about the competences in this and the next sub-domain

These competences on co-production and those in the following section of competences, on shared decision-making, share the same principles. However, but the former usually refers to planning service development, and the latter to planning the care of an individual. In practice, these two areas can overlap, but for clarity they are separated in this framework.

- An ability to draw on knowledge that co-production:
  - aims to develop more equal partnerships between service users, professionals and other staff
  - focuses on enhancing the quality of service delivery by involving experts by experience in the design and delivery of services that meet their needs
  - brings together service users with managers and clinicians
  - is where professionals and experts by experience share power to plan and deliver services together, recognising the contribution of all parties and aided by:
    - professionals being open to constructive challenge and power sharing
    - recognising that past experience of disempowerment might lead some service users to be reticent about expressing themselves

- An ability to draw on knowledge that co-production recognises people and their experiences as ‘assets’, and so:
  - builds on the capabilities of experts by experience
  - develops two-way, reciprocal relationships
  - encourages peer support
  - blurs the boundaries between delivering and being a recipient of services (by involving experts by experience in service delivery)

- An ability to draw on knowledge of principles of co-production:
  - equality – that no one group or person is more important than anyone else and

everyone has skills and abilities to contribute
diversity – making co-production as inclusive and diverse as possible, and trying to ensure that seldom heard and other marginalised groups are included
accessibility – trying to ensure that everyone has an equal opportunity to participate fully in the way that suits them best
reciprocity – ensuring that participants get something back for putting something in (e.g. seeing results)

3.7. Shared decision-making

Note about the competences in this and the previous sub-domain

These competences on shared decision-making and those in the previous section of competences, on co-production, share the same principles, but the former usually refers to planning a person's care, and the latter to planning service development. In practice, these two areas can overlap, but for clarity they are separated in this framework.

An ability to draw on knowledge that shared decision-making involves a collaboration between practitioners and service users to make decisions about the goals they are working towards, and the treatments that will be used, and that:
recognises the expertise and experience of service users as well as that of practitioners and draws on this when making decisions about treatment
involves genuine collaboration between service users and practitioners
is based on a relationship of equal partnership between service users and practitioners
explicitly recognises that there is an inevitable power imbalance that should not be ignored

An ability to ask service users:
how they would like to be involved in shared decision-making
what information and support they need in order to participate effectively
An ability to recognise that because service users' preferred balance of responsibility for decision-making may shift over the course of an intervention, and in relation to the issues being considered, shared decision-making needs to implemented flexibly

An ability to draw on knowledge that shared decision-making has the potential to:
encourage service users to feel more involved, engaged and empowered
encourage practitioners to be more open and transparent about their sense of what might help
promote open, honest conversations, even in stressful contexts

An ability to draw on knowledge that common challenges to shared decision-making include:

practitioners who pitch conversations at a level of complexity that service users might struggle with (and so failing to make appropriate adjustments to content)
the need to make (and possibly revise) multiple decisions through the course of treatment (and so recognising that shared decision-making is not a one-off event)
restrictions on shared decision-making that arise from concerns about safety or capacity

An ability to take risk management into account, and consider responsibilities around safeguarding and duty of care (which may limit a practitioner's ability to be open to shared decision-making, and to the expressed wishes of those receiving care)

4. Diagnostic assessment and treatment planning

4.1. Ability to undertake a comprehensive (biopsychosocial) assessment

Note about the competences in this sub-domain

Effective delivery of assessment skills depends on their integration with background knowledge of relevant presentations and of appropriate ways of addressing these, along with engagement and communication skills.

Assessments need to be comprehensive, identifying biological, psychological and social/societal factors that may be contributing to a patient's strengths and difficulties – usually referred to as a biopsychosocial assessment. The aim is to develop an understanding of the whole person, placing them in the context of their community.

Knowledge of the assessment process

An ability to draw on knowledge that the focus of the assessment process is to create a formulation (including a possible diagnosis) that guides the choice of intervention and aims to improve the quality of life of the patient and relevant significant others
An ability to draw on knowledge that assessments generate working hypotheses that need to be updated or corrected in response to further information that emerges during the course of contact
An ability to draw on knowledge that different parties may have multiple perspectives, and that their aims for intervention can be significantly different
An ability to draw on knowledge that the assessment process can in itself alter views towards the matter at hand

Knowledge of standardised assessment frameworks

An ability to draw on knowledge of local and national assessment forms, including those that can be completed by several different agencies working together

Ability to coordinate a multidimensional assessment

An ability to coordinate the assessment process across the team in a way that ensures that different facets and sources of experience are sufficiently explored while not creating

- repetition, overlap or increased burden for patients

- An ability to undertake a multidimensional assessment of the patient, which is:
  - multimethod: including information from interviews, observations, and measures as well as any other methods that seem appropriate
  - multisource: including information from the family/carers, as well as any other sources of particular relevance to the patient
  - multilevel: including information about the patient's physical (including sexual), emotional, cognitive, social development, along with cultural and spiritual influences

Ability to identify people and agencies who need to be included in the assessment

- An ability to identify and involve the individuals and agencies who constitute the patient's network of carers, including:
  - identifying the primary carers (e.g. partners, parents, foster parents, residential staff)
  - in young people, identifying who has parental rights and responsibilities (e.g. parent, family member, social work department)
  - identifying the professionals and agencies already involved with the patient

Ability to focus assessment

- An ability to develop initial hypotheses on the basis of information gleaned from the referral, and an ability to use these to plan the assessment
  - where appropriate and possible, an ability to liaise with professionals from agencies involved with the patient prior to the assessment in order to determine their roles

- An ability to adapt assessments in response to information that emerges that appears to be of particular significance, and:
  - an ability to draw on knowledge of theory and research around development, mental health and safeguarding/child protection, to:
    - focus on topics that appear to be problematic or of particular significance for the patient and (where relevant) their family

move away from areas that do not appear problematic for or salient to service users

Ability to engage the patient and (where relevant) their carer/family/ in the assessment process

An ability to identify who should attend assessment sessions
An ability to discuss confidentiality and its limits (e.g. the potential for information that emerges to be shared with other agencies)
An ability to explain the structure of the assessment and the areas that it will cover
An ability to explain the relevance of particular areas of the assessment
An ability to respond non-judgmentally to information that emerges during the assessment
An ability to balance problem-focused questioning with questions that elicit areas of strength and resilience, e.g.:
attending to the potential for the language used in assessment to convey a negative connotation, and making appropriate adjustments to counter this (e.g. describing a task as a challenge rather than difficult)
helping the patient to portray a balanced view of themselves rather than feeling defined by their problems
recognising the potential impact on engagement of ‘relentless’ questioning of problems and difficulties

Ability to adapt the assessment to match the abilities and capacities of the service user

An ability to tailor the language used to match the abilities and capacities of the service user
An ability to engage service users with physical and sensory impairment (e.g. by altering the pace and content and modes of discussion)
An ability to make effective use of interpreters when working with patients who do not speak the same language as the interviewer

Ability to assess risk of harm[3]

Ability to assess risk of harm to self and others
Ability to identify child protection concerns

Ability to take a history

An ability to make appropriate use of basic interview techniques (e.g. appropriate range of questioning formats, facilitation, empathy, clarification, and summary statements)
An ability to elicit specific detailed and concrete examples of behaviour when assessing and exploring areas of concern

Problem history

An ability to identify and explore the behaviours/symptoms/risks that are causing concern to the service user, including:	
	emotional symptoms (including their somatic expressions and any self-harming behaviours)
	relationship difficulties
An ability to help the service user elaborate the details of problems that concern them, including the frequency, duration and intensity of problems	
An ability to analyse the function of specific problematic behaviours by identifying:	
	the settings in which the problematic behaviours or symptoms manifest (including the people who are present, and specific details of places and times)
	the situations or events that occur immediately before the behaviour, and that appear to trigger it
	the consequences that immediately follow the behaviour (e.g. the reactions of others)
An ability to assess the broader impact of symptoms or problems, including:	
	the degree of social impairment

[3] Described in detail under '2.5. Ability to recognise and respond to concerns about child protection', '2.6. Ability to recognise and respond to concerns about safeguarding', '4.3. Assessment of risk and need in relation to suicide and self-harm' and '4.4. Assessment of risk and needs in relation to violent ideation and risk of harm to others'.

the degree of distress for the patient
the degree of disruption to others

An ability to assess the patient's current functioning
An ability to assess the patient's use of drugs and alcohol
An ability to identify the patient's current and past contact with legal services
An ability to identify previous attempts to solve the problems or manage symptoms (including any previous contacts with services)
An ability to identify the service user's explanations of how behaviours/symptoms have developed

Developmental history

An ability to obtain information on the patient's development, including strengths and interests as well as any delayed or unexpected developmental processes
An ability to undertake a detailed developmental assessment across biological, cognitive, communicative, emotional and social domains

Medical history

An ability to elicit details of the patient's physical health history, including:
immunisations, infections, allergies, illnesses, operations
prescribed and non-prescribed medication
fits/faints, loss of consciousness, head injury
hearing and vision problems
contact with hospitals and specialist health services

Relationship history

An ability to ask about the patient's friendships, e.g.:
first /early friendships (and how long these have lasted)

how many friends in primary school and beyond
what they did with their friends

An ability to assess the patient's interpersonal functioning (e.g. their relationship with partners, family, close friendships, friendship networks)

An ability to ask about the patient's intimate relationships, e.g.:
the history of any partnerships
the quality of their relationship with any current partners (and any other significant others with whom they are in regular contact)

An ability to ask about the influence of sexuality and gender diversity on the patient's identity and their experience of relationships
an ability to discuss any adverse experiences associated with the patient's sexuality or experience of gender diversity (e.g. difficulties accepting their sexuality, homophobic and/or transphobic bullying)

History of trauma, abuse and neglect

An ability to identify whether the patient has experienced trauma, abuse and/or neglect, e.g.:
physical abuse
exposure to domestic violence
psychological abuse
financial or material abuse or exploitation
sexual abuse or exploitation
neglect
abuse in an organisational context
mental health stigma

Educational history

An ability to obtain details of the strengths and interests and achievements shown by the patient within the education system as well as any difficulties
An ability to obtain a comprehensive educational history from the patient, including:
pattern of attendance including information on absences from school
pattern of contacts with school professionals e.g. teachers, educational psychologists, special educational needs assistants
academic ability and achievement
pattern of social relationships and play, and any experiences of bullying
emotional/behavioural, concentration or social difficulties

Routine screening for neurodevelopmental disorders (autism spectrum disorder [ASD] and intellectual disability)

An ability to draw on knowledge of diagnostic criteria for intellectual disabilities and for ASD, and use this to:
routinely screen for neurodevelopmental disorders
identify whether and how a neurodevelopmental disorder may contribute to the patient's presentation, resources and needs
identify the implications for the patient's care

Ability to assess the service users' cultural and social context

Social

An ability to draw on knowledge of the incidence and prevalence of mental health concerns across different cultures/ethnicities/social classes
An ability to ask about potential protective factors in the patient's social environment (e.g. social support, proximity to extended family or access to community resources)
An ability to ask about any potential stresses in the patient's physical or social environment (e.g. overcrowding, poor housing, neighbourhood harassment, problems with gangs)
An ability to ask about the patient's membership of peer groups (e.g. friendship groups, clubs)
An ability to ask about a patient's experience and membership of gangs

Cultural

An ability to draw on knowledge of the patient's cultural, racial and religious background when carrying out an assessment of their behaviours, beliefs, and the potential impact of this perspective on their views of problems
An ability to understand cultural influences on gender roles and gender identity, parenting practices and family values
An ability to identify the limits of one's own cultural understanding, and:
an ability to seek out further information about the patient's religious, racial and cultural background from them and other sources

Making use of observation of the patient and of interactions between them and their partners/carers/family during assessment

An ability to observe the interactions between the patient and significant others, e.g.:
the degree of sensitivity and warmth shown to each other
the degree of criticism
whether behaviours appear to be reinforced by other family members
the language people use to describe one another (i.e. as an indicator of their attitudes and feelings towards each other)

An ability to include knowledge of the patient's social and cultural background in any consideration of interaction patterns

Ability to draw on information obtained from other agencies

An ability to identify any agencies and/or key professionals currently or previously involved with the service users	
An ability to obtain consent prior to seeking information from an agency, and:	
	an ability to draw on knowledge of local policies on confidentiality and information-sharing when obtaining (and sharing) information about the service users
An ability to obtain relevant records from agencies and identify and draw on information likely to be relevant	

4.2. Ability to conduct a Mental State Examination

Knowledge of the aims of the Mental State Examination (MSE)

An ability to draw on knowledge that the MSE is an ordered summary of the clinician's observations of the patient's mental experiences and behaviour at the time of interview
An ability to draw on knowledge that the purpose of a MSE is to identify evidence for and against a diagnosis of mental illness, and (if present) to record the current type and severity of symptoms
An ability to draw on knowledge that the MSE should be recorded and presented in a standardised format

An ability to draw on detailed observations of the patient to inform judgements of their mental state, including observations of:
their appearance (e.g. standard and style of clothing, physical condition, etc.)
their behaviour (e.g. tearfulness, restlessness, distractible, social appropriateness, etc.)
their form of speech (e.g. quality, rate, volume, rhythm, and use of language, etc.)

An ability to draw on knowledge of the patient's developmental stage/cognitive capacity and hence to tailor questions to their likely level of understanding
An ability to draw on knowledge that people vary in their ability to introspect and assess their thoughts, perceptions and feelings
An ability to structure the interview by asking general questions about potential problem areas (e.g. depressed mood), before asking specific follow-up questions that enquire about potential symptoms
An ability to respond in an empathic manner when asking about the patient's internal experiences (i.e. their feelings, thoughts, and perceptions)
An ability to ask questions about symptoms that the patient may feel uncomfortable about in a frank, straightforward, non-judgemental and unembarrassed manner
An ability to record the patient's description of significant symptoms in their words
An ability to avoid colluding with any delusional beliefs by making it clear to the patient that the clinician regards the beliefs as a symptom of mental illness, and:
an ability to avoid being drawn into arguments about the truth of a delusion

Ability to enquire into specific symptom areas

An ability to ask about the symptoms that are characteristic of both uni-polar and bi-polar depression:
an ability to notice and enquire about any discrepancy between the patient's report of mood and objective signs of mood disturbance
An ability to ask about thoughts of self-harm:
an ability to assess suicidal ideation
an ability to assess suicidal intent
an ability to ask about self-injurious behaviour
An ability to ask about symptoms characteristic of the different anxiety disorders:
an ability to ask about the nature, severity and precipitants of any symptoms as well as their impact on the patient's functioning
An ability to ask about abnormal perceptions:
an ability to clarify whether any abnormal perceptions are altered perceptions or false perceptions
an ability to explore evidence for the different forms of hallucination
An ability to elicit abnormal beliefs
An ability to interpret the nature of abnormal beliefs in the context of the patient's developmental stage, family, social and cultural context:
an ability to distinguish between primary delusions, secondary delusions, over-valued ideas and culturally sanctioned beliefs
An ability to assess cognitive functioning:
an ability to assess level of consciousness
an ability to assess the patient's orientation to time, place and person
an ability to carry out basic memory tests
an ability to estimate the patient's intellectual level, based on their level of vocabulary and comprehension in the interview, and their educational achievements
an ability to conduct or refer for formal cognitive assessment if there are indications of an intellectual disability

An ability to assess the patient's insight into their difficulties, including:
an ability to assess their attitude towards any illness
an ability to assess their attitude towards treatment

4.3. Assessment of risk and need in relation to suicide and self-harm

Note about the competences in this sub-domain

The focus of this section is on working with patients who are presenting as suicidal or self-harming, or who use self-harm as a coping mechanism.

Judgement will be needed about the scope of a specific session of assessment. Where an individual is acutely distressed and/or judged to be at high risk of self-harm then this will need to be the focus, with a more detailed and/or broader assessment taking place once the individual's immediate needs are appropriately contained.

This section overlaps with '4.4 Assessment of risk and need in relation to violent ideation and risk of harm to others'.

Knowledge[4]

An ability to draw on knowledge that assessment of risk:
is more likely to be helpful (both to the patient and the assessor) if it focuses on engaging the individual in a personally meaningful dialogue
is less effective (and useful) if carried out as a 'checklist' that attempts to cover all bases, whether or not they are relevant to the patient

An ability to draw on knowledge that because it is difficult to predict future suicide attempts and acts of self-harm accurately, even comprehensive risk assessments may only yield a poor estimate of risk
An ability to draw on knowledge that although many factors have been identified as associated with risk:
they cannot be relied on to predict risk with any certainty
they are subject to change, meaning that assessments of risk can only relate to the short-term outlook

[4] A comprehensive account of issues relating to the management of suicide and self-harm can be found in the UCL Self-harm and Suicide Prevention Competence Framework (www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self). It includes a section on 'Understanding self-harm and suicidal ideation and behaviour', which represents a core area of knowledge.

An ability to draw on knowledge that talking about suicide does not necessarily increase the likelihood of suicide attempts, and that it is helpful to maintain an open and frank stance to discussion
An ability to draw on knowledge that self-harm and suicidal acts reflect high levels of psychological distress, and serve different functions for different individuals (and for the same individual, at different times)
an ability to draw no knowledge that self-harm can represent a coping mechanism to enable survival
An ability to draw on knowledge that (by building hope and identifying specific ways forward) a collaborative assessment can be a powerful intervention in its own right

An ability to draw on knowledge that the aims of a collaborative assessment are to:
help the patient understand the key factors leading them into crisis
assess the nature, frequency and severity of self-harm and (if this has changed) whether this indicates an imminent risk of suicide
assess the degree of intent, planning and preparation (as potential signs of imminent risk)
identify risk and protective factors (to help estimate the patient's risk of suicide and self-harm)
identify co-occurring psychiatric disorders that may contribute to self-harming and suicidal behaviour
determine the most appropriate level and type of intervention
identify which risk factors are likely to be modifiable through the intervention
develop a management plan

Engagement

An ability to conduct an assessment in a compassionate and collaborative manner that aims:
to actively engage the patient in the assessment process
to help the patient identify the factors generating and maintaining crisis
to identify interventions that will help to keep them safe

An ability to help the patient manage the potential distress associated with discussing difficult material by:
ensuring that they understand the rationale for the assessment questions
discussing how they might like to manage distress both during and after the interview (e.g. by taking a break)
helping them to manage distress if this becomes apparent and/or overwhelming

An ability to draw on knowledge that the process of assessment needs to be responsive to any interpersonal issues that threaten the integrity of the assessment, e.g. where there is evidence that the patient:
has negative expectations based on prior adverse and/or traumatising experiences with the health or social care system
perceives the assessor as an authority figure who is judging them
expects the assessor to fail them

Assessment

An ability to conduct a risk assessment that explores and understands the specific functions of self-harm for an individual and offers personalised risk management and intervention opportunities
An ability to identify and utilise historical information in a way that mitigates the impact of repeated assessments (e.g. by summarising what is already known), while recognising that information may change and require updating

An ability to assess potential key factors, including:
severity and method of self-harm and the motivations behind this behaviour
links between self-harm and suicidal ideation and behaviour
suicidal ideation and behaviours that are linked to suicidal intent
psychiatric conditions (including any psychiatric history and/or recent discharge from in-patient or crisis mental health services)
psychological vulnerabilities (e.g. hopelessness)
psychosocial vulnerabilities (e.g. recent loss, homelessness, experience of abuse)

An ability to work with the patient to identify behaviours (both currently and in the past) that relate to suicidal intent (e.g. preparing a will, writing a note, saying goodbye to significant others, acquiring the means to end life)

An ability to discuss with the patient the specific characteristics of suicide attempts (e.g. level of intent to die, level of regret about not dying, the function of the attempt, whether precautions against discovery were taken), and use this to estimate the likelihood of future acts
An ability to help the patient identify protective factors that are meaningful to them, and that may be associated with decreased thoughts of suicide or feelings that life was not worth living, e.g.:
attitudes or beliefs (e.g. hopefulness, reasons for living, a wish to live, a belief that suicide goes against their moral code)
a sense that it may be possible to manage the problem area associated with the suicidal crisis
a supportive social network
a fear of death, dying or suicide

Assessing cognitive factors associated with self-harm and/or suicide

An ability to work with the patient to identify cognitions that focus on suicide (including their content, duration, frequency and intensity of suicidal thinking, and the level of intent to die):
currently
at their most severe, in the immediate past and previously

Assessing interpersonal factors associated with self-harm and/or suicide

An ability to assess a sense of social isolation, e.g.:
the perceived absence of caring, meaningful connections to others
the absence of friends or relatives the patient can call when upset
recent losses through death or relationship breakdown
conflict with peers or bullying

- An ability to assess a sense of being a burden on significant others, e.g.:
  - expressing the view that others would be better off if they were gone
  - expressing the view that they are a burden on other people
  - recent stressors that undermine a sense of self-competence (e.g. job loss, exam failure)
- An ability to assess 'markers' that indicate the development of a capability to carry out suicide or self-harm (usually experiences that foster a diminished fear of pain and self-inflicted injury), e.g.:
  - current markers, e.g.:
    - fearlessness about injury or death
    - prolonged ideation and/or preoccupation about suicide
    - highly detailed and concrete plans for suicide
    - specified time and place for suicide
    - if self-harm has taken place, an intent to die at the time of injury
  - current and past experiences, e.g.:
    - previous suicide attempts (and especially multiple suicide attempts)
    - aborted suicide attempts
    - regret at surviving attempts
    - self-harming behaviours
    - exposure to childhood physical and/or sexual violence
    - participation in painful and provocative activities (e.g. jumping from high places, engaging in physical fights)
  - patterns of self-harm associated with substance use, e.g.:
    - previous self-harm attempts that have occurred when drinking
    - changes in thought patterns associated with drinking which are associated with self-harm
    - failure to control excess drinking which is associated with self-harming behaviour or suicide attempts

Assessing Internet use and online life

An ability to draw on knowledge of the potential risks as well as the potential benefits of Internet use in relation to suicidal behaviour and self-harm e.g.:
its potential to increase risk by 'normalising' self-harm, triggering and competition between users, or acting a source of contagion
its potential to decrease risk by creating a sense of community, offering crisis support and reducing social isolation
An ability to draw on knowledge that increased use of the Internet to view suicide-related material is a potential marker of suicide risk
An ability to ask directly about the patient's online life and Internet use, e.g.:
the sites or applications that they access regularly and the purpose or intention of use
the frequency with which they access sites or applications
the impact on their mood, suicidal ideation, daily life and functioning
An ability to respond to disclosure of potentially adverse experiences (e.g. exposure to cyberbullying or being encouraged to self-harm) by helping the patient identify ways in which the impact of these experiences can be mitigated

Developing a risk management plan

An ability to develop a risk management plan that balances the need for safety and the need for autonomy and agency in the patient's life
An ability to judge the appropriate level of intervention, guided by the presence and strength of risk and protective factors, and to evaluate the need for:
inpatient, outpatient or community-based crisis or intensive support
additional follow-up meetings to assess and manage ongoing risk
referral to other agencies
signposting to other organisations
obtaining more information from other sources
informing other clinicians or agencies of the level of risk
informing family members/significant others of the level of risk

4.4. Assessment of risk and need in relation to violent ideation and risk of harm to others

Note about the competences in this sub-domain

This section overlaps with the previous section, '4.3. Assessment of risk and need in relation to suicide and self-harm'. The principles set out in that section also apply here.

Engagement

An ability to conduct risk management collaboratively, based on a relationship with the individual and their carers that is:

- as trusting as possible
- within which relational boundaries are clearly defined and mutually understood (e.g. the duty of the PA to disclose to other members of the multidisciplinary team when a patient indicates an intention to harm others)

An ability to use risk assessment tools as a way of mediating conversations about risk, and to develop the relationship with the patient

An ability to allow the patient to express strong emotions in order to allow them to ventilate emotions, and:

- an ability to judge when threats of harm to others are part of emotional ventilation, and when they represent an actual (rather than perceived) threat

Assessment

An ability to draw on multiple sources of information to determine the patient's history of acts of harm to others, the specific circumstances that led up to these events and the consequences of such acts

An ability to identify any previous involvement with services, so as to access information about past history and behaviour (e.g. previous inpatient admissions, admissions to forensic units, involvement with the criminal justice system)

An ability to draw on multiple sources of information to assess and manage risk of harm to others in a proportionate, considered, non-reactive and evidence-based manner, e.g.:

conversations and interactions with the patient
available sources of information (e.g. care notes from previous admissions, or from other services or agencies)
informed perspectives (e.g. care team members, family and carers, external agency workers directly involved with the individual)

Where there are grounds for concern about informants being at active and direct risk from the patient, an ability to judge when it is appropriate to meet with them independently of the patient

An ability to seek specific information about factors that have direct bearing on appraising the level of risk, e.g.

the patient's explanation for threatened acts of harm to others
the motivation for such acts
the likely targets for such acts
factors that might mitigate or potentiate such acts (including the patient's current level of capacity)
the imminence of threat

Constructing a risk management plan

An ability to use clinical judgement to arrive at a risk management plan that:

represents a balanced appraisal of the likelihood and immediacy of harm to others
is closely based on available evidence (so as to reduce the likelihood of under- or over-estimating risk)
indicates the actions to be taken to mitigate risk
is clearly communicated verbally and in writing to all relevant parties and agencies

Where there are significant differences of opinion regarding the level of risk among informants or among members of the team, an ability to ensure that these are discussed openly, understood and resolved (e.g. by considering the evidence for these different points of view)

An ability to construct risk management plans in a way that maximises the involvement of the patient and carers, taking into account their age and mental capacity
An ability to implement positive risk management as part of the management plan (balancing necessary levels of protection while preserving reasonable levels of choice and control)

4.5. Knowledge of and ability to assess capacity

Knowledge of how capacity is defined

An ability to draw on knowledge that relevant legislation on capacity applies to adults over the age of 16 who (by reason of mental health problems or because of an inability to communicate because of physical disability) may be deemed to lack capacity if they meet one or more of the following criteria and are incapable of:
acting
making decisions
communicating decisions
understanding decisions, or
retaining the memory of decisions
An ability to draw on knowledge that where an individual is judged not to have capacity, any actions taken should:
be of benefit to them
be the least restrictive intervention
take account of their wishes, preferences and feelings
take account of the views of relevant others
encourage independence
An ability to draw on knowledge that capacity should be assessed in relation to major decisions that affect peoples' lives (e.g. managing day-to-day finances, safety/risk taking, appraisal of their health needs):
an ability to draw on knowledge that capacity is not 'all or nothing' and may vary across specific areas of functioning, (e.g. a person with dementia may be able to give informed consent about management of a health condition but be unable to manage their finances)
An ability to draw on knowledge that incapacity can be temporary, indefinite, permanent or fluctuating, and that it is important to consider the likely degree, duration and nature of the incapacity
An ability to draw on knowledge that diagnosis alone cannot be used to make assumptions about capacity

Assessment of capacity

An ability to ensure that judgements regarding capacity take into account any factors that make it hard for the client to understand or receive communication, or for them to make themselves understood
an ability (where possible) to identify ways to overcome barriers to communication
An ability to maximise the likelihood that the patient understands the nature and consequences of any decisions they are being asked to make, e.g. by:
speaking at the level and pace of the patient's understanding and 'processing' speed
avoiding jargon
repeating and clarifying information, and asking the patient to repeat information in their own words
using 'open' questions (rather than 'closed' questions to which the answer could be yes or no)
using visual aids

An ability to determine capacity where the patient has significant cognitive impairments and/or memory problems, e.g.:
where they are able to make a decision but is unable to recall it after an interval, asking for the decision to be made again, using the consistency of their response as a guide to capacity
deciding when further formal assessment is required to determine their capacity

4.6. Ability to formulate and identify and deliver a management plan

Note about the competences in this sub-domain

Formulation is a way of making sense of difficulties in order to develop solutions through a management plan.

In many settings, formulation is a process (rather than an endpoint) with different functions. These include exploring, understanding and improving responses to problems as well as collaboratively co-constructing shared meaning with service users.

Knowledge

An ability to draw on knowledge that the aim of a formulation is to understand the development and maintenance of the patient's difficulties, and that formulations:
are tailored to the services users (the individual patient and their partners/carers/family)
comprise a set of hypotheses or plausible explanations that draw on theory and research to understand the specific details of the patient's presentation (as identified through assessment)
An ability to draw on knowledge that models of formulation include:
'generic' formulations, which draw on biomedical, psychological and social theory and research
'model-specific' formulations, which conceptualise a presentation in relation to a specific therapeutic model and usually overlap with the generic formulation
An ability to draw on knowledge that the formulation should usually be explicitly shared and co-constructed with the service users
An ability to draw on knowledge that formulations are dynamic and should be reviewed and revised as further information emerges during ongoing contact with all parties

An ability to draw on knowledge that a formulation usually includes consideration and integration of:
the differential diagnosis
risk factors that might predispose to the development of psychological problems (e.g. trauma, neurodevelopmental difficulties, insecure attachment to caregiver, caregiver marital difficulties)

precipitating factors that might trigger the onset or exacerbation of difficulties (e.g. acute life stresses such as illnesses or bereavements, or developmental transitions such as leaving home or retirement)
maintaining factors that might perpetuate psychological problems once they have developed (e.g. unhelpful coping strategies, inadvertent reinforcement of behaviours that challenge)
protective factors that might prevent a problem from becoming worse or may be enlisted to ameliorate the presenting problems (e.g. a patient's capacity to reflect on their circumstances, good family communication and support)
An ability to draw on knowledge that one of the main functions of a formulation is to help guide the development of a management plan, and:
an ability to draw on knowledge that the management plan usually aims to reduce the effects of identified maintaining factors, and to promote protective factors

Ability to construct a formulation

An ability to generate a comprehensive list of all the presenting problems
An ability to appraise and resolve any apparently contradictory reports of a problem, e.g.:
when informants focus on different aspects of a problem or situation, or represent it differently
when a patient's behaviour differs depending on the context
An ability to understand the patient's inner world, affective and interpersonal experiences and frame them in a developmental and contextual perspective

An ability to evaluate and integrate assessment information obtained from multiple sources and methods, and to identify salient factors that significantly influence the development of the presenting problem(s), drawing on sources of information, e.g.:
the patient and their partner/family/carer's perception of significant factors and their explanation for the presenting problem(s)
theory and research that identifies biological, developmental, psychological and social factors associated with an increased risk of mental health difficulties
theory and research that identifies biological, psychological and social factors associated with mental wellbeing (e.g. good physical health, good social support network)
knowledge of normal child development and developmental processes (to identify

delays in the patient's development)
associations between the onset, intensity and frequency of presenting problem(s) and the presence of factors in the patient's psychosocial environment (e.g. traumatic life events)
the results of a functional analysis which records the antecedents and consequences of a particular behaviour

An ability to construct a comprehensive and integrated account that includes a differential diagnosis and demonstrates an understanding of the patient's inner world, affective and interpersonal experiences and frames them in a developmental and contextual perspective

Implementing the formulation

An ability to identify a management plan that accommodates and addresses the issues identified by the assessment and the formulation
An ability to revise the formulation in the light of feedback, new information or changing circumstance
An ability to use team reflections and responses, alongside evidence, to make sense of the maintenance of difficulties and identify team-level changes that might need to be made to address these

4.7. Communicating and recording the outcomes from an assessment and formulation

- An ability to adapt the pace, amount of information and level of complexity to the recipient(s) of information, to ensure that it is legible and relevant to them and conforms to general principles of confidentiality

- An ability to communicate the findings from an assessment:
  - verbally:
    - with the patient
    - with their relevant significant others (with the patient's consent, where required)
    - with other members of the team
    - with agencies/individuals who made the referral or who have a responsibility for the patient's care
  - in writing:
    - using clinical information systems in accordance with local procedures and policy
    - in reports to agencies/individuals who made the referral or who have a responsibility for the patient's care

- An ability to become familiar with procedures for entering and extracting information into and from local clinical information systems and to seek help or advice to overcome any obstacles to their use

4.8. Ability to collaboratively engage all relevant parties with a management plan

An ability to engage the patient and where relevant their significant others in a collaborative discussion of the treatment options open to them, informed by the information gleaned through assessment, the formulation emerging from the assessment, and the patient's aims, preferences and goals	
An ability to convey information about the management plan in a manner that is tailored to the patient's capacities, and that encourages them to raise and discuss queries and/or concerns	
An ability to provide the patient with sufficient information about the treatment and intervention options open to them so that they are:	
	aware of the range of options available to patients in the service
	in a position to make an informed choice from among the options available to them
An ability to ensure that patients have a clear understanding of the models or approaches being offered to them (e.g. the purpose and broad content of each intervention and the way it usually progresses)	
While maintaining a positive stance, an ability to convey a realistic sense of:	
	the effectiveness and scope of each intervention
	any challenges associated with each intervention
An ability to use clinical judgement to determine whether the patient's agreement to pursue an intervention is based on a collaborative choice (rather than being a passive agreement, or as an agreement that they experience as imposed on them)	

4.9. Ability to coordinate casework across different agencies and/or individuals

Note about the competences in this sub-domain

The principles set out in this document apply both to intra- and inter-agency working, and hence to work with both fellow-professionals and professionals from other agencies.

Effective delivery of these competences depends on their integration with many areas of the framework, but the section on confidentiality and consent will be especially pertinent.

General principles

An ability to draw on knowledge that an emphasis on the welfare of the patient should be the overarching focus of all intra- and interagency work
An ability to ensure that communication with professionals both within and across agencies is effective by ensuring:
that their perspectives and concerns are listened to
that there is explicit acknowledgement of any areas where perspectives and concerns are held in common, and where there are differences
where differences in perspective or concern are identified, an ability to identify and act on any implications for the delivery of an effective intervention

Case management

Receiving referrals from other professionals/agencies

An ability to recognise when the referral contains sufficient information to make an informed decision about how to proceed with the identified patient (including response to risk and identification of care pathways), and:
where there is insufficient information, an ability to identify the information required and to request this from the referrer and/or partner agencies
An ability to draw on knowledge of local policy and procedure to select the appropriate 'pathway' to ensure the case is allocated at an appropriate risk/response level
Where a decision is taken to place patients on a waiting list, an ability regularly to monitor risk levels of cases on the list

Initial contact phase (initiating cross-agency casework)

An ability to establish which partner agencies are also involved with the service users
An ability to establish/clarify the roles/responsibilities of other agencies in relation to the various domains of the patient's life
An ability to discuss issues of consent and confidentiality in relation to the sharing of information across agencies with the service users and to secure and record their consent to share information
An ability to identify and record which members of staff within a service will take a coordinating role for the overall plan
An ability to gather relevant information from involved agencies and to enter this into the patient's record
An ability to share relevant information with the appropriate agencies (based on the principle of a 'need to know'), and:
an ability to assess when sharing of information is not necessary and/or when requests for sharing information should be refused
An ability to share assessment information in a manner that supports partner agencies in:
understanding and recognising areas of risk
understanding any implications of this information for the work in which they are engaged
understanding the potential impact of interventions on the patient's functioning, and the ways in which this may manifest in other settings
understanding what it means for the patient to have an involvement with the multiple agencies
Where there are indications that agencies may employ different language and definitions, an ability to clarify this in order to identify:
the reasons for any concerns
the professionals and agencies who are best placed to respond to these concerns
the outcomes that are being sought from any planned response
An ability to draw on knowledge of custom and practise in each agency, to ensure that there is a clear understanding of the ways in which each agency will respond to events (e.g. their procedures for following-up concerns, or for escalating their response in response to evidence of risk)
An ability to co-ordinate with other agencies using both verbal and written communication,

and to agree with them on:
the tasks assigned to each agency
the specific areas of responsibility for care and support assumed by each agency, and by individuals within each agency
An ability for all individuals within a team to recognise when they are at risk of working beyond the boundaries of their clinical expertise and/or professional reach
Where a common assessment framework is used across agencies, an ability to:
record relevant information in the shared record
make active use of the shared record (to reduce redundancy in the assessment process)
maintain a shared record of current plans, goals and functioning

Involving the service users

An ability to ensure that service users are informed of any interagency discussions and the associated outcomes
When deemed appropriate, an ability to include the service users in any interagency meetings
An ability to support service users in making choices about how they use or engage with the partner agencies involved

Referring on for parallel work

An ability to draw on knowledge of local referral pathways (i.e. who to approach, and the protocols and procedures to be followed)
In relation to any agency to whom patients are referred, an ability to draw on knowledge:
of the agency's reach and responsibilities
of the agency's culture and practice
of the extent to which the agency shares a common language and definitions to those applied in those services making the referral
An ability to communicate the current intervention plan, and update other agencies with any changes as the intervention proceeds (including any implications of these changes for the work of other agencies)

An ability to communicate a current understanding of the patient's difficulties, and to ensure that this is updated when additional information emerges
An ability to maintain a proactive approach to monitoring the activity of other agencies and to challenge them if they do not meet agreed responsibilities
Where appropriate, an ability to act as a conduit for information exchange between agencies
An ability to recognise when effective inter-agency working is compromised and to identify the reasons for this, e.g.:
institutional/systemic factors (e.g. power differentials or struggles for dominance of one agency over another)
conflicts of interest
lack of trust between professionals (e.g. where this reflects the 'legacy' of previous contacts)
An ability to detect and to manage any problems that arise as a result of differing custom and practice across agencies, particularly where these differences have implications for the management of the case
an ability to identify potential barriers to effective communications, and where possible to develop strategies to overcome them
An ability to identify transitions that have implications for the range of agencies involved (e.g. moving out of area) and to plan how these can be managed, to ensure:
continuity of care
the identification of and management of any risks
the identification and engagement of relevant services
An ability to be aware when the patient's needs (in the domains of health, physical, emotional, social functioning) are not being met by the current intervention, and where the involvement of other agencies would be beneficial to the patient's welfare

Discharge and monitoring phase

An ability to inform all relevant agencies where there is an intention to discharge the patient
An ability to ensure all partner agencies are aware of current risk levels and have appropriate plans and monitoring in place
An ability to inform partner agencies of the circumstances under which links with current services should be reinstated

An ability to take a proactive stance in relation to monitoring the functioning of patients after discharge has taken place (and to reconnect with them if functioning deteriorates)
An ability to ensure those partner agencies involved have plans for monitoring the wellbeing of the patient

4.10. Ability to make use of relevant outcome measures

Knowledge of commonly used measures

An ability to draw on knowledge of validated measures commonly used as part of an assessment and when evaluating outcomes in domains e.g.:
measures that help to identify specific symptoms of a disorder
measures of risk (including self-harm and harm to others)
measures of functioning and adaptation (including interpersonal, work and social functioning)
measures that tap the patient's experience of services

Knowledge of the purpose and application of measures

An ability to draw on knowledge of the purpose of the measure (i.e. what it specifically aims to detect or to measure), e.g.:
measures used in a comprehensive assessment to assess particular clinical symptoms (e.g. symptoms of depression or psychosis)
measures used in outcome evaluation that are sensitive to change
An ability to draw on knowledge relevant to the application of a measure (e.g. its psychometric properties, including norms, validity, reliability), including:
the training required in order to administer the measure
scoring and interpretation procedures
guidance on the confidentiality of the measure and how results should be shared with the individual, other professionals and families
characteristics of the test that may influence its use (e.g. brevity, or 'user friendliness')
An ability to draw on knowledge of procedures for scoring and for interpretation of the measure

Ability to administer measures

An ability to judge when a patient may need assistance when completing a scale
An ability to take into account a patient's attitude to the scale, and their behaviours while

completing it, when interpreting the results
An ability to score and interpret the results of the scale using the scale manual guidelines
An ability to interpret information obtained from the scale in the context of assessment and evaluation information obtained by other means

Ability to select and make use of outcome measures

An ability to integrate outcome measurement into the intervention or management plan

An ability to draw on knowledge that a single measure of outcome will fail to capture the complexities of a patient's functioning, and that these complexities can be assessed by:
measures that focus on a patient's functioning, drawn from different perspectives (e.g. service users or professionals)
measures using different technologies (e.g. global ratings, specific symptom ratings and frequency of behaviour counts)
measures assessing different domains of functioning (e.g. home and work functioning)
measures that assess different symptom domains (e.g. affect, cognition and behaviour)

An ability to select measurement instruments that are designed to detect changes in the aspects of functioning that are the targets of the intervention
An ability to draw on knowledge that pre- and post-intervention measures are a more rigorous test of improvement than the use of retrospective ratings

5. Interventions

5.1. Management of mental health problems

Note about the competences in this sub-domain

PAs need to be able to acknowledge when the management of a mental health condition lies outside their competence, and seek advice and guidance (e.g. from supervision, from a more experienced practitioner or through liaison with the wider multidisciplinary team).

Knowledge of relational factors contributing to the management of mental health problems

An ability to draw on knowledge that the relationship between the PA and the patient can influence the management of mental health problems, e.g.:
the benefit of developing a positive and explicitly collaborative relationship that fosters shared decision-making
the importance of identifying the patient 's beliefs, concerns and expectations about their mental health and the ways these shape their understanding of (and willingness to comply with) treatments being offered

Reviewing and monitoring medication

An ability to perform basic medication reviews (as required and in line with local service arrangements), drawing on knowledge of:
the rationale for the patient's medication and dose
contraindications and side effects of medication
indications of interactions with other medication
common allergies and intolerances
An ability to monitor the impact of medication (both positive and negative) and carry out relevant investigations required for monitoring medication at the appropriate time intervals

Developing a management plan

An ability to communicate to the team (and medical supervisors) findings from a psychiatric assessment [including full psychiatric history, MSE, risk assessment and

collateral history where appropriate] and to discuss potential management plans, including onward referral

An ability to discuss with the patient:
their ideas, concerns and expectations with regards managing their mental health problem
the rationale for any potential interventions
the rationale for discussing the case with a supervisor or the multidisciplinary team (e.g. to further develop the management plan)

Managing psychiatric emergencies

An ability to recognise and assess for psychiatric emergencies, e.g.:
neuroleptic malignant syndrome
serotonin syndrome
delirium

An ability to communicate and deliver initial management plans for psychiatric emergencies
An ability to escalate concerns to senior members of the multidisciplinary team
An ability to help liaise with acute physical health organisations to arrange for transfer to the appropriate setting

Managing psychiatric conditions

An ability to draw on information gathered during an assessment to inform a management plan, using the biopsychosocial model
An ability to suggest a range of pharmacological, psychological and psychosocial interventions as part of a management plan

An ability to provide psychoeducation to people with mental health problems
An ability to discuss the risks and benefits of interventions with people with mental health

problems
An ability for the PA to recognise their limitations when developing a management plan and to seek support from others in a timely manner
An ability to discuss management plans with relevant members of the wider multidisciplinary mental health team (e.g. doctors, psychologists, pharmacists, nurses, occupational therapists)

Managing risk[5]

An ability to draw upon the information gathered during a comprehensive risk assessment to inform a management plan using the biopsychosocial model
An ability to appropriately document risk assessments
An ability to highlight risk management concerns to the wider multidisciplinary mental health team
An ability to recognise when to seek support from others, and to do so in a timely manner
An ability to liaise with other services when managing risk, e.g. liaison and discussion with:
other mental health teams (e.g. crisis resolution and home treatment teams, mental health liaison teams)
approved mental health professionals (AMHPs)
emergency services, including police and ambulance
social services and local safeguarding teams

[5] More competences on the assessment of risk to self and others can be found in sections '4.3. Assessment of risk and need in relation to suicide and self-harm' and '4.4. Assessment of risk and need in relation to violent ideation and risk of harm to others'. Other competences related to managing risk can be found in relevant sections of this Framework.

5.2. Management of physical health problems

Note about the competences in this sub-domain

PAs need to be able to acknowledge when the management of a physical condition lies outside their competence, and seek advice and guidance (e.g. from supervision, from a more experienced practitioner or through liaison with the wider multidisciplinary team).

Knowledge of physical health problems

An ability to draw on knowledge of core clinical conditions (as set out by the Faculty of Physician Associates matrix)
An ability to draw on knowledge of physical health issues commonly seen in people with mental health difficulties, and:
an ability to draw on knowledge of organic causes of mental health presentations

An ability to draw on knowledge of guidance pertinent to the effective treatment of physical health problems, e.g.:
evidence-based guidance (e.g. NICE, SIGN)
local guidelines and treatment pathways
guidance from more experienced practitioners
liaison with other specialities

Knowledge of relational factors contributing to the management of physical health problems

An ability to draw on knowledge of ways that the relationship between the PA and patient can influence the management of physical health problems, e.g.:
the benefit of developing a positive and explicitly collaborative relationship that fosters shared decision-making
the importance of identifying the patient 's beliefs, concerns and expectations about their health problems and the ways these shape their understanding of (and willingness to comply with) treatments being offered

Assessment

An ability to take a history, conduct an examination and initiate appropriate investigations
An ability to interpret physical investigations (e.g. ECG, blood pressure monitoring)
An ability to examine different bodily systems competently (e.g. neurological examination, chest examination)
An ability to recognise different manifestations of physical disorders in different age groups
An ability to adapt history taking, examinations and investigations to different contexts and patient groups (e.g. older adults, children, different cultural groups)

An ability to recognise ways in which mental health issues and their treatments are impacting on physical health

An ability to use standardised monitoring measures to help track change (e.g. the National Early Warning Score)

Reviewing medication

An ability to perform basic medication reviews, drawing on knowledge of:
the rationale for the patient's medication and dose
contra-indications and side effects of medication
indications of interactions with other medication
common allergies and intolerances

Developing a management plan

An ability to communicate to the team (and medical supervisors) findings from physical examinations, medication reviews and tests, and to discuss potential management plans, including onward referral

An ability to discuss with the patient:
the outcome and implications of any assessments
the rationale for any potential interventions (including medication, physical or

psychological interventions)

An ability to ‘signpost’ patients to relevant services and interventions (e.g. by drawing on knowledge of the local services and arrangements for access)

Managing acute and urgent presentations

The ability to work confidently with acute and urgent presentations of physical disorders, e.g.:
recognising and communicating to the team the presence of acute physical illness or deterioration in a chronic physical condition
suggesting treatment options in discussion with medical team members (based on findings of the history, examination and investigations)
suggesting and arranging urgent referral to specialists when required
helping deliver urgent treatments, in discussion with medical colleagues
contributing to the management of patients who are at significant physical risk (e.g. developing abnormal cardiac rhythms, deteriorating level of consciousness, sepsis, showing signs of delirium, patients with anorexia nervosa in physical extremis)

An ability to perform relevant physical procedures appropriate to the condition and context (e.g. putting up an intravenous infusion for a dehydrated patient, taking blood, inserting a urinary catheter in retention)

Managing physical emergencies

An ability to contribute to the management of emergency presentations, e.g.:
maintaining first-aid skills and training for the management of physical emergencies
knowing about, and following local procedures in the event of a clinical emergency
communicating to other team members the steps to take to manage the physical emergency
contributing to a resuscitation team and the ability to perform effective CPR
being able to recognise and respond to ways in which emergency situations of

physical disorders manifest in different age groups

An ability to recognise emergencies due to physical complications of psychiatric treatment (e.g. neuroleptic malignant syndrome)

Managing chronic conditions

An ability to draw on knowledge of the treatment of chronic physical conditions and their interrelations with mental health, e.g.:

chronic physical conditions and their diagnosis and treatment (e.g. type 1 or type 2 diabetes, asthma, chronic obstructive pulmonary disease)
the impact of chronic conditions on patient's mental health
the potential impact of poor emotional adjustment/ mental health on the patient's capacity and motivation to manage such conditions
the links between some mental disorders and chronic physical conditions (e.g. the dementias, hypertension)

5.3. Health promotion

Note about the competences in this sub-domain

The competences on health promotion are divided into two sections. The first covers competences that relate to the daily practice of PAs; the second covers those that apply when PAs contribute to wider health promotion programmes/initiatives in collaboration with multidisciplinary colleagues across services and agencies, and/or with health promotion and public health specialists (where it is expected that PAs would usually be contributing to, rather than taking the lead on such initiatives).

Health promotion competences applicable to daily practice with patients

Knowledge

An ability to draw on knowledge that:	
	health is more than the absence of disease, and is characterised by a state of complete wellbeing
	health acts as a resource that can help people to get the best out of their lives
An ability to draw on knowledge that health promotion focuses on:	
	interventions that can strengthen the capacity of individuals to improve their own health
	interventions that impact on the systems within which individuals and populations live and that influence their choices, lifestyles and opportunities
An ability to draw on knowledge of the concepts of inequalities (e.g. differences in health between men and women) and inequities (e.g. poorer access to services for individuals living in remote and rural areas)	
An ability to draw on knowledge of the potential impact difference/diversity can have on the physical health and wellbeing of an individual (e.g. in areas such as disability, ethnicity, sexual orientation)	
An ability to draw on knowledge of the social determinants of health including, an understanding how these determinants influence the health of the population	
An ability to draw on knowledge that poor mental health can have a detrimental impact on physical health and wellbeing	
	an ability to draw on knowledge that mental health interventions can positively benefit physical health problems and wellbeing
An ability to draw on knowledge that the principle on which health promotion is based is a	

‘population health approach’, which aims to improve the health of the entire population and reduce health inequalities among population groups
An ability to incorporate health promotion principles into all clinical activities (e.g. by using participatory and empowering approaches to support the capacity of patients to make healthy decisions)

Health promotion competences relevant to public health initiatives

An ability to draw on knowledge of the principles that underpin practice in health promotion, including:	
	drawing on research evidence and appropriate guidance (e.g. NICE/SIGN) regarding the most effective ways of developing health promotion interventions
	drawing on multi-disciplinary knowledge
	following a principle of equity (prioritising those who are in greatest need)
	inter-sectoral collaboration (e.g. between health and other relevant sectors, such as education or town planning)
	taking a population health approach (i.e. targeting populations such as students within a school, or a target group such as teenage parents in a region)
	employing multi-strategic interventions (combining a range of complementary interventions targeted to the same outcome, such as a behaviour change group for obese individuals and implementing a change in the amount of weekly physical activity)
	working in partnership (involving other parties beyond health, including other relevant sectors e.g. community members, parent groups or local businesses)
	ensuring that any partners are empowered to participate fully in the process of planning and implementation (and hence that health is not seen as controlling the process with only minimal input from other partners)
An ability to draw on knowledge of the range of health promotion strategies that can be used to promote health, including health education, media campaigns, policy development, legislation and social marketing	
An ability to draw on knowledge of current local, national and international developments in health promotion strategies, including relevant policy developments	

Ability to contribute to the planning and implementation of health promotion programmes

An ability to draw on knowledge of research that identifies effective and ineffective ways of

implementing health promotion programmes, and to use this to guide planning and implementation, e.g.:
employing multiple intervention strategies rather than ‘single-stranded’ interventions
focusing on priorities identified by the community itself (rather than on a focus determined by external bodies)
holding in mind the challenge of successfully delivering health promotion initiatives to more vulnerable populations (including those who have low levels of literacy/education, low engagement with health services, and high levels of social and/or economic disadvantage)

An ability to draw on knowledge that preliminary plans for a health promotion programme need to include:
a needs assessment that identifies the priorities for health promotion
identification of realistic and measurable programme goals and objectives
identification of strategies that are matched to programme goals and objectives
identification of the resources needed to design, implement, monitor and evaluate a programme
An ability to identify strategies that are likely to increase the sustainability of the programme e.g.:
implementing an intervention that the community itself prioritises, and in which it is invested
consulting and collaborating with the community at all stages of the intervention (planning, implementation, evaluation and revision)
An ability to draw on knowledge of the requirement to ensure that programmes are culturally relevant and appropriate to their intended (target) recipients
An ability to draw on knowledge of the requirement to ensure that programmes are based on the principles of participation, partnership and empowerment

Ability to contribute to monitoring and evaluating health promotion programmes

An ability to draw on knowledge that plans for monitoring and evaluating a health promotion programme need to:
identify mechanisms to monitor how well the programme is implemented in relation to its goals and objectives

develop evaluation plans that include measures of:
process (e.g. whether the programme was implemented as intended)
impact (short-term effects apparent while the programme is running, e.g. a reduction in weight among obese individuals)
outcome (long-term effects after the programme has ended, e.g. sustained weight loss)
identify appropriate methods for evaluating the programme (including both qualitative and quantitative methodologies)
identify and select appropriate evaluation tools (e.g. questionnaires, focus groups, surveys, and including both quantitative and qualitative measures)
An ability to analyse outcome data by drawing on knowledge of data analytic procedures appropriate to the quantitative or qualitative methodology employed
An ability to communicate and disseminate findings from the evaluation to relevant participants and stakeholders

Ability to contribute to partnership working in health promotion

An ability to identify relevant partners/stakeholders within and outside the health sector
An ability to identify collaborative approaches to working with partners/stakeholders that support empowerment, participation, partnership and equity
An ability to identify consultation and collaboration strategies to promote stakeholder ownership of programmes

5.4. Monitoring and managing medication

An ability to draw on knowledge of medications commonly used to manage and treat mental and physical health conditions
An ability to draw on knowledge of local guidelines and policies, BNF and NICE guidelines to ensure that the appropriate treatment is being provided for patients
An ability to draw on knowledge of safe prescribing of psychotropic medications (e.g. allergies, common contraindications)
An ability for the PA to acknowledge limitations in their knowledge of pharmacology and to ask for support (e.g. from pharmacists, or members of the medical team)

An ability to draw on knowledge of pharmacology, including an understanding of:
the rationale for medications and their appropriate dosage
relevant contraindications
knowledge of different forms for administration and the most appropriate form of delivery (e.g. injection or tablets)
potential side effects
potential interactions
common allergies and intolerances

An ability to monitor medication by performing a basic medication review, e.g.:
monitoring for side effects and adjusting dose as required
identifying adjunctive medication to relieve side effects
requesting investigations to monitor physiological effects of medication
monitoring psychological effects of medication
interpreting results of laboratory/clinical investigations and acting on abnormal results
titrating medications appropriately

An ability to discuss the rationale of medication with patients and carers to create a patient centred care plan, including:
discussing benefits and disadvantages
dose and titration plans
potential side effects
alternative regimens or options
procedures for monitoring medication for both physical and psychological effect

5.5. Management of substance misuse and addictive behaviours

Knowledge

An ability to draw on knowledge of various types of addictions, including substance misuse and gambling
An ability to draw on knowledge that there are a number of models of addiction, but that integrative models take account of biological, psychological, societal and economic factors, and:
an ability to draw on knowledge that there will usually be multi-factorial reasons for the development and maintenance of a patient's addiction

An ability to draw on knowledge that because substance misuse and mental health presentations frequently coexist, treatment planning needs to attend to both areas of difficulty

An ability to draw on knowledge of potential harms resulting from addictions, e.g. the impact on:
physical and psychological health
social relationships
capacity to maintain work and maintain financial stability
disapproval and/or a lack of support from family/friends relating to cultural norms and assumptions regarding addictions
the potential for involvement in criminal activity

An ability to draw on knowledge of evidence demonstrating the benefit of peer support programmes in supporting recovery from addiction (e.g. 12-step programmes, Alcoholics Anonymous)
An ability to draw on knowledge of local agencies and services offering support for people with addictions

Interventions

An ability to maintain a non-judgemental stance when discussing addictive behaviours and their consequences for the patient
An ability to act on opportunities to raise the issue and/or impact of addiction (e.g. if addictive behaviours are identified in the course of an emergency department assessment)
An ability to make use of basic motivational interviewing strategies to help understand a patient's readiness and willingness to address their addiction
an ability to help the patient consider the risks of addiction (e.g. effects on physical, mental and social aspects of health)

An ability to facilitate access to peer support programmes by:
promoting the idea of peer support programmes
setting realistic goals regarding attendance
reviewing these to support engagement
an ability to encourage and answer queries about the programmes and address any negative perceptions
An ability to identify barriers to attendance and:
work with the patient to help them problem solve solutions
employ motivational interviewing strategies to explore ambivalence and strengthen motivation to attend

An ability to refer to appropriate statutory services for people with addictions, and:
an ability to engage the patient in a discussion of the referral (e.g. helping to identify their motivation and potential barriers to engaging with services)

Management of overdose and withdrawal

An ability to draw on knowledge of the acute physical effects of substance misuse, including indicators of overdose and relevant emergency treatment (e.g. naloxone in cases of opioid overdose)
An ability to assess the health of patients who are withdrawing from substance misuse (e.g. using the Clinical Institute Withdrawal Assessment for Alcohol scale and responding to adverse signs/symptoms), and:

an ability to recognise when adverse signs/symptoms indicate the need for medical intervention, and to refer the patient to a relevant practitioner with appropriate urgency

5a. Managing the interface of mental and physical health

5.6. Knowledge of common physical health problems in people with mental health problems and an ability to advise/intervene to manage these

An ability to draw on knowledge of mental health problems (as set out by the Faculty of Physician Associates matrix)
An ability to draw on knowledge of core clinical conditions (as set out by the Faculty of Physician Associates matrix)

An ability to draw on knowledge of adverse physiological effects related to or associated with:	
	psychotropic medication
	alcohol and recreational drugs
	mental health presentations (e.g. eating disorder, deliberate self-harm, self-neglect)
	unhelpful lifestyles (e.g. smoking, unhealthy diet, lack of exercise)

An ability to draw on knowledge of strategies to help manage acute and chronic physical illness commonly presenting in mental health patients, e.g.:	
	assessing patients by taking a thorough history and performing relevant physical examinations
	identifying and diagnosing acute and chronic illness (e.g. diabetes, or risk of heart disease)
	instituting appropriate investigations and interpreting results
	carrying out monitoring and health checks for potential conditions (e.g. blood tests, ECGs for cardiovascular screening) as per NICE guidelines
	drawing on knowledge of medication and treatment options
	titrating medication and monitoring for side effects

suggesting adjunctive medication and treatments for side effects
arranging for referral to appropriate services for acute (urgent) services and/or for specialised care

An ability to discuss with the patient:
the outcome and implications of any assessments
the rationale for any potential interventions (including medication, physical or psychological interventions):

An ability to help the patient:
consider the treatment choices open to them
identify and discuss any concerns about the proposed treatments
discuss any alternative options

An ability to discuss relevant lifestyle changes with patients and carers, and to:
help the patient identify potential changes, ensuring that these are ones they able and willing to make
implement appropriate strategies to help achieve these changes (e.g. problem solving, motivational interviewing)

5.7. Knowledge of a generic model of medically unexplained symptoms[6] (MUS; functional symptoms)

An ability to draw on knowledge that generic models of MUS assume that functional symptoms may be generated or maintained not by one specific disease process but by the self-sustaining interaction of physiological, behavioural and cognitive factors within an individual

Factors thought to predispose to MUS

An ability to draw on knowledge of factors hypothesised to predispose towards MUS, including:
early experience of childhood adversity and neglect/abuse
heightened reactivity to stressors
'emotional dysregulation' or a tendency to believe expressions of negative emotion are unacceptable
experience of serious illness in the family during childhood
personality traits, e.g. unhelpful levels of perfectionism, a tendency to respond to distress somatically, or not recognising physical symptoms as signs of stress
high levels of premorbid distress
a family environment characterised by somatic, rather than emotional, expression

Factors thought to precipitate MUS

An ability to draw on knowledge of factors thought to precipitate MUS, including:
an episode of physical illness e.g. an acute infection or injury
chronic stress (including high levels of daily stressors over a period of time) and/or major and adverse life events
current trauma, or reminders of earlier traumas (retraumatisation)

[6] The content of this section draws on: Deary V, Chalder T & Sharpe M. The cognitive behavioural model of medically unexplained symptoms: A theoretical and empirical review. Clinical Psychology Review. 2007;27:781–97.

Factors thought to perpetuate MUS

An ability to draw on knowledge of factors thought to perpetuate MUS, including:
physiological factors thought to be involved in the experience of persistent physical symptoms, e.g.:
changes in the functioning of the HPA axis[7] (i.e. low levels of cortisol associated with chronic stress)
central sensitisation (a heightened response to stimuli based on prior experience of them)
autonomic dysregulation (e.g. heightened stress or anxiety responses such as rapid heart rate, headache, fatigue)
disturbed circadian cycles (potentiating the experience of physical symptoms
absence of a consistent daily routine, including sleep/wake cycle, diet and exercise
coping by withdrawing and/or becoming less active, and/or by inconsistent (boom and bust) activity, and/or by overcompensating and taking on too much
unhelpful illness and symptom-related beliefs (e.g. that activity will be harmful, leading to behavioural restriction and exacerbation of symptoms)
focusing on symptoms (selective attention to symptoms and to the thoughts associated with them)
a cognitive bias to attend to symptoms, further amplifying them and leading to greater sensitisation
making unhelpful attributions, e.g.:
perceiving symptoms as a significant threat to wellbeing and/or safety
failing to make attributions that help to ‘normalise’ the experience of physical symptoms
finding it difficult to create a ‘narrative’ that can account for the symptoms (and so make them less threatening)
being exposed to high levels of medical uncertainty (i.e. a lack of explanation for symptoms or guidance regarding their management)

[7] The hypothalamic–pituitary–adrenal axis, which controls reactions to stress and regulates many body processes including digestion, the immune system, mood and emotions, and energy storage and expenditure.

Ability to draw on a coherent, multifactorial model of MUS

While being aware that the pathway for each client will differ, an ability to draw on knowledge of a coherent, multi-factorial empirically grounded model of MUS, e.g.:
a predisposition to somatopsychic distress and distress sensitisation, combined with childhood adversity, leads the individual to be more sensitive to symptoms by lowering the threshold for their detection
acute illnesses or injury trigger symptoms that are then perpetuated by a cycle of cognitive, behavioural, emotional and physiological interactions, which in turn influence the symptoms
life events and stress lead to physiological changes that produce more symptoms, which sets in train a process of sensitisation and selective attention, which in turn further reduces the threshold for symptom detection
a lack of explanation or advice increases anxiety, symptoms and a greater focus on symptoms
stress cues become associated with symptoms
avoidance of symptom provocation and symptom-led activity patterns leads to further sensitisation
the prolonged stress associated with the illness itself activates physiological mechanisms, producing more symptoms, sensitisation, selective attention and avoidance
the individual becomes locked into a vicious cycle of symptom maintenance

An ability to work collaboratively with clients to adapt general models of MUS into an individualised narrative that helps them make sense of their illness and their on-going symptoms

5.8. Knowledge of generic models of adjustment to physical health conditions

- An ability to draw on knowledge that adjustment is not an endpoint but a process of assimilation that takes place over time, and which can be expected to vary in response to changes in the patient's physical condition and any relevant life experiences
- An ability to draw on knowledge that optimal adjustment (and expectations about the adjustment that can realistically be expected) will be condition- and person-specific, and hence:
  - the tasks associated with adaptation will relate to the specific symptomatology and treatment with which patients are contending
  - optimal adjustment will not always be signalled by preserved functional status or low negative affect, but is determined by the patient's personal goals, wishes and preferences, e.g.:
    - in arthritis an adaptive outcome is one of maintaining quality of life in the face of pain and progressive disability
    - in advanced terminal illness the key task may be coping with (rather than being overwhelmed by, or not expressing) distressing feelings relating to imminent death

- An ability to draw on knowledge that adjustment to a health condition can be understood as the patient's capacity to maintain or restore their sense of emotional equilibrium, their identity and quality of life, and that this will be determined by:
  - predisposing factors:
    - personal background factors (e.g. early life experiences, personality [optimism, neuroticism], beliefs about themselves and the world, cultural and religious beliefs, values and life goals)
    - illness-specific factors (e.g. nature of symptoms, degree of uncertainty, prognosis, impact of treatment regimen)
    - background social and environmental factors (e.g. social support and relationships, availability of health and social care)
    - beliefs about the meaning of symptoms and their implications
    - beliefs about treatment
  - precipitating factors:
    - possible critical events (e.g. reactions to initial symptoms, or to the

diagnosis of a chronic condition; effects of, and response to, treatment; disease progression; threat to mortality; loss of sexual function and/or fertility, changes to identity or life roles)
possible ongoing stressors (e.g. threats to autonomy, management of stressful treatments, experience of relationships with healthcare professionals and systems, difficulties acknowledging their own limits)

Factors promoting emotional equilibrium and quality of life

An ability to draw on knowledge of factors thought to maintain or help people regain emotional equilibrium and quality of life, including:
biological factors, e.g.:
shorter duration and course of illness
circumscribed physical symptoms
good general health and physical fitness
cognitive factors, e.g.:
their sense of control regarding illness management
their sense of self-efficacy in relation to the illness itself as well as their general life situation
their tendency to positively connote their experiences
their acceptance of the illness
their perception that the social support they receive is appropriate
behavioural factors, e.g.:
setting and working towards goals
making use of social support
engaging in positive health behaviours (maintaining a healthy lifestyle)
adhering to medical and self-management regimes
maintaining activity levels in the face of illness
appropriate expression of emotion
social factors, e.g.:

receiving and accepting appropriate support from family and significant others

Factors inhibiting emotional equilibrium and quality of life

An ability to draw on knowledge of factors thought to maintain emotional disequilibrium and poor quality of life, including:
biological factors, e.g.:
chronic duration and course of illness
co-morbid physical symptoms whose interaction exacerbates difficulties (e.g. arthritis restricting options for exercise in individuals with diabetes)
cognitive factors, e.g.:
high perceived stress
consistently coping through 'wishful thinking'
negative and/or shameful beliefs about the illness/symptoms
unhelpful cognitions and cognitive biases (e.g. catastrophising)
rumination
helplessness and hopelessness
consistent suppression of negative affect
behavioural factors, e.g.:
consistent avoidance
excessive information seeking (e.g. via online media)
changing medical regimen inappropriately on the basis of incorrect information
maintaining unsustainably high levels of activity
unhelpful responses to symptoms (e.g. reducing activity in response to symptoms, stopping work inappropriately, attentional focus on symptoms)
excessive ventilation or denial of emotions
excessive reassurance-seeking

social factors, e.g.:
social disadvantage (e.g. financial difficulties, poor housing)
poor social support and social isolation
consistently rejecting support from others

An ability to draw on knowledge that poor adjustment to a long-term health condition could be signalled by:
changes in mental health or psychological wellbeing (e.g. decreased mood or increased anxiety)
indicators that the patient is finding it difficult manage their condition (e.g. unhelpful health behaviours or adverse impacts on life roles or close relationships)
An ability to draw on knowledge that formulating the relationship between psychological issues and physical health problems is critical when planning an intervention, given that:
mental health issues may be a precursor or a consequence of a physical disorder, or
may be independent of (and unrelated to) the patient's health difficulties
An ability to draw on knowledge that intervention strategies should focus on the factors that are most likely to help the patient manage their health conditions more effectively:
a focus on mental health issues may not always be relevant, and hence may not be acceptable to the patient
helping the patient to adopt more effective strategies for better condition management may be more relevant than a direct focus on mental health issues

5.9. Supporting the patients' capacity for self-management

Knowledge

An ability to draw on knowledge that because self-management is a process, the challenges presented to patients, and the techniques for overcoming these, may change at different points in an intervention

An ability to draw on knowledge of psychological theory in explaining how people respond to illness (e.g. cognitive processes (their knowledge of, and beliefs about, their illness), attitudes to risk, their perceptions of the illness)
An ability to draw on knowledge of the relationship between illness, psychological factors and individual differences in predicting disability and positive adjustment to illness (e.g. anxiety and depression, beliefs about control, dispositional optimism, coping style)
An ability to draw on knowledge of lifestyle factors that impact on disease outcomes (e.g. smoking, diet, weight management, exercise/activity, alcohol and substance misuse)
An ability to draw on knowledge of the concept of disability as a behaviour (i.e. that disability is a product of the patient's response to illness rather than the illness itself)
An ability to draw on knowledge of the evidence for the benefits of self-management

Engaging the patient in self-management

An ability to help the patient discuss their understanding of their condition:	
	an ability to relate the patient's understanding to the beliefs associated with their personal, social and cultural contexts
An ability to help the patient discuss how they manage their condition and the ways in which this is shaped by:	
	their values (e.g. ways in which their condition forces them to behave at variance with their sense of how they 'should' behave)
	the resources available to them
	their roles and identity
	their emotions (e.g. finding themselves frustrated or angry)
	their motivation to self-manage (based on their positive and negative beliefs about self-management)
	the 'systems' around them (e.g. on their family, or their work-colleagues

[e.g. engaging in unhelpful illness behaviours such as making illness the focus of conversations with others])

An ability to assess the patient's likely capacity to self-manage in terms of their:	
	capability (e.g. the necessary physical and psychological resources)
	opportunity (e.g. physical opportunities in terms of time, or social opportunities in terms of a socially supportive network)
	motivation
An ability to employ strategies, e.g. Motivational Interviewing, to help patients to identify both the costs and benefits of self-management	

An ability to ensure that self-management is a collaborative partnership between the patient and the health care provider, characterised by shared decision-making and responsibility, and a joint agreement with regard to treatment plans	
An ability to help the patient discuss any anxieties about tasks associated with self-management (e.g. worries about engaging in exercise), and:	
	an ability to ensure that self-management is a choice exercised by patients

Negotiating opportunities to engage in self-management

An ability to help the patient account for the emotional impact of the condition (e.g. loss and bereavement, anxiety about the future)
An ability to help the patient recognise and manage psychological issues that impact adversely on their capacity to manage their physical health[8]
An ability to help the patient identify factors that may help or hinder their capacity to achieve positive outcomes
An ability to help the patient identify and modify unhelpful or incorrect beliefs or expectations that directly impact on their capacity for, or willingness to undertake, self-management
An ability to help the patient identify and make use of appropriate resources for education, self-care and support (including family or relevant patient organisations)

[8] Detailed in '5.8. Knowledge of generic models of adjustment to physical health conditions'.

Applying self-management strategies

An ability to help the patient identify goals that they find meaningful and that relate to behaviours that they wish to change
An ability to help the patient institute the most appropriate change techniques, guided by principles of behavioural change and so following the sequence of:
identifying a 'starting line' and setting goals
instituting self-monitoring
'action planning'
problem solving any difficulties that emerge
planning appropriate levels of activity (e.g. matching activities to the patient's capacity)
embedding change through habit formation (e.g. identifying cues to action/memory prompts)
identifying and instituting incentives/self-reward
identifying ways to adapt their environment to support self-management goals
An ability to work with the patient to identify any challenges to effective self-management

Maintaining change

An ability to work with the patient to devise and implement strategies aimed at maintaining change (e.g. recruiting help from significant others, planning ahead, 'if-then' planning)
An ability to help patients understand the rationale for focusing on habit formation in sustaining behavioural change (using strategies to make new behaviours 'automatic' rather than being dependent on 'willed' action):
an ability to help patients identify opportunities to establish new habits (e.g. by pairing new behaviours, e.g. following healthcare regimens or taking exercise, with existing routines)
An ability to help patients reflect on the self-management techniques that they have found effective (so as to foster their sense of expertise and mastery)
An ability to help patients review and revise goals over time
An ability to work with the patient to design bespoke action plans (e.g. ensuring appropriate use of healthcare resources [including GP or emergency department

attendance], adjusting medication in response to symptom changes, managing condition-specific emergencies, recognising and responding to changes in the capacity to self-manage)

6. Team working

6.1. Ability to contribute to team working

Ability to draw on knowledge that a well-functioning team:
can maintain a capacity to be self-reflective in the face of the challenges of the work
can maintain a focus on the various tasks associated with the work
will not be drawn into unhelpful behaviours or attitudes that could adversely impact service users
can respond constructively to negative feedback from service users and other parts of the statutory system (e.g. other agencies, referrers or commissioners)
can raise concerns about poor or harmful practice clearly, confidently and responsively
works to mitigate the impact of discrimination and systemic inequalities
comprises team members who work to support their own and each other's wellbeing (and therefore capacity to help) by setting limits, holding boundaries and fostering compassion to self and others

An ability to sustain a therapeutic culture by ensuring that there is:
clarity over the team's organisational structure
clarity over (and agreement on) the leadership of the team
clarity over roles and role diversity
a capacity for mutual communication that is open, respectful and reflective
mutual valuing of team members

An ability to recognise signs that team working is becoming dysfunctional, e.g. teams that:
maintain consistency by applying the same inflexible procedures to all, and being unable to adapt them to individual need
have difficulty working together and arriving at a coherent formulation focused on the patient, rather than on what can be offered by each professional/viewpoint (and

so the professional organisation taking priority over the patient)
become preoccupied with internal team conflicts that they are unwilling to acknowledge and resolve
fail to implement a coherent team-based plan, with the result that individual members or subgroups of the team work independently of each other
avoid coming together to arrive at coherent plans because this reduces the likelihood of exposing team conflict
denigrate the input/efficacy of other agencies/systems and become an embattled and isolated unit (in tandem with an uncritical and idealised view of their own success)
become divided within themselves (e.g. different members of the team 'taking sides' with patients, or becoming preoccupied with advancing their own ideas)
become focused on professional hierarchies, with separate agendas and chains of management

An ability to reflect (individually and as part of a team) on the functioning of the team as a whole, and individual practice within it
An ability to reflect on challenges to team communication and functioning (usually through discussion with a supervisor or peer) to consider how these can be best managed, e.g. by:

identifying when (and when not) to challenge problematic team behaviours
presenting a case calmly and objectively
focusing on the challenges (rather than on personal issues)
focusing on the present and future rather than the past
listening to the point of view of other team members
contributing to problem solving (identifying potential strategies for resolving the issues)

An ability to actively contribute to meetings on planning, coordinating, maintaining and evaluating a patient's care or care plan
An ability to value the contribution of others but also to assert differences of view and to resolve issues or concerns through open dialogue

6.2. Leadership

Note about the competences in this sub-domain

Different types of problems require different types of leadership and no single leadership style is effective for all.

Nonetheless, this section identifies the competences associated with compassionate leadership, because these are likely to sustain stronger connections between people, improve collaboration, raise levels of trust and enhance loyalty.

Qualities associated with leadership can be displayed by all members of a team, not just those in formal management roles.

An ability to draw on knowledge that effective leaders articulate and represent the values and aims of a unit and the culture required to achieve these

An ability to draw on knowledge that effective leaders build trust with colleagues by:
demonstrating that they understand and value their motivations
encourage participation in decision-making
encouraging them to express their ideas and opinions, and showing respect for these
explicitly acknowledge and give credit to staff contributions
listen to their concerns and interests and responding by acting on them

An ability to draw on knowledge that effective leaders:
help colleagues to understand their roles and how they can contribute to the unit's overall success
instil colleagues with a sense of value and purpose and foster their engagement with the aims of the unit
develop a shared understanding with the team, embracing their ideas in the context of the needs of the population served by the service
encourage innovation (but can challenge ideas and behaviours respectfully if they are contrary to accepted professional practice/ the evidence base)
encourage an appropriately self-critical stance among colleagues (being open to

evaluating the efficacy and functioning of the unit and identifying ways in which it can be improved)
are committed to open communication and the identification and resolution of team conflicts where they arise

An ability to draw on knowledge that effective leaders contribute to an ethical and supportive environment that helps colleagues feel safe in their work (e.g. knowing that they will advocate for them and treat them fairly)

An ability to draw on knowledge that effective leaders:
are able to take and implement decisions (but also revise them if there are compelling reasons to do so)
take responsibility for their decisions, and identify and learn from their mistakes
demonstrate resilience when there are setbacks and maintaining the ability to show others the way forward
help colleagues cope with organisational change and address issues promptly, so that problems do not become entrenched or escalate

6.3. Audit and quality monitoring

- An ability to draw on knowledge that the aim of audit is to improve the quality of services
- An ability to draw on knowledge of the risk that audit and quality monitoring and improvement are seen by teams as a managerial activity (organised on a 'top-down' basis), reducing a sense of ownership (and potentially, participation), and:
  - an ability to increase the salience and relevance of audit for frontline staff and patients, e.g. by:
    - sharing decisions about which areas to audit (along with as those based on indicators of quality that are based on national and local standards)
      - inviting frontline staff and patients to indicate which aspects of services should be audited
      - encouraging audit of areas that are seen as priorities by teams and patients
      - encouraging service users and teams to lead on audits they see as a priority
    - sharing data and outcomes from audit in an accessible form
    - participating in developing and implementing quality improvement action plans based on data drawn from audit

6.4. Teaching and training others and enhancing skills in the team

- An ability for the PA to teach/train in areas:
  - for which they themselves have received appropriate training
  - in which they have the necessary knowledge, skills and experience

- An ability to identify areas where additional training would enhance the capacity of the team to work effectively with patients, and to specify the training that would achieve this, and:
  - an ability to make use of audit/quality improvement processes to help evaluate training needs in a service, and to evaluate the impact of training that has been delivered

- An ability to liaise with relevant team members to plan how training/teaching will be delivered, e.g.:
  - for which team members
  - whether it will be formal or informal teaching
  - whether it will be delivered to individuals or a group

- An ability to draw on basic knowledge of principles associated with effective learning, e.g.:
  - setting clear learning objectives
  - identifying the knowledge and skills trainees already possess
  - identifying what trainees needs to know and do in order to develop the new area of skill
  - identifying steps needed to bridge gaps between what trainees know before training, and what they should know and do afterwards e.g.
    - breaking down areas of knowledge and skills into manageable ‘chunks’
    - checking that trainees have understood what is being conveyed
    - modelling (i.e. demonstrating what needs to be done)

observing skills in action and offering constructive, structured feedback

An ability to break down complex or complicated concepts/skills into simpler units, and to link these into a coherent framework, with the aim of ensuring that teaching always stays within the trainee's zone of understanding/ability
An ability to help trainees make links between areas of knowledge and the ways these are linked to skills
An ability to check trainees' understanding at regular intervals and to adjust pace and content in response to feedback
An ability to give constructive and specific feedback when trainees practise skills

An ability to ensure that teaching/training is conducted in a collaborative and supportive manner that enables trainees to give feedback and so shape their learning (e.g. encouraging them to say what they do not understand, or areas that they need to focus more time on)
An ability for the PA to identify if issues arise that take them beyond their area of expertise, to be open with trainees if this is the case, and so to place limits on their teaching

An ability for the PA to evaluate the success of their teaching/training by asking for feedback, and to use this feedback to improve their teaching

7. Metacompetences for physician associates in mental health

7.1. Metacompetences relevant to the physician associate role

Style of interaction

An ability to balance being 'oneself' in interactions with offering clinical expertise and holding professional boundaries

Adapting practice to the needs of the individual patient

An ability to adapt practice to the needs and presentation of the individual patient so as to maximise their active involvement in the process of assessment, planning and intervention
An ability to creatively and flexibly adapt the assessment and intervention to the patient's needs, capacities and abilities
An ability to adapt communication and interventions (e.g. to any neurodevelopmental issues or sensory difficulties)

Equality and diversity

An ability to integrate equality and diversity issues into clinical practice, such that different perspectives, practices and lifestyles are addressed respectfully and non-judgementally
An ability for PAs to maintain an awareness of their own cultural values and assumptions, and to reflect on the ways that these impact (positively and negatively) on patients with whom they are working
Where patients discuss practices at variance with the norms and values of the practitioner, an ability to judge when this difference should be respected and when it represents a concern that should be responded to
Where there is evidence that social and cultural difference is likely to impact on the accessibility/acceptability of an intervention, an ability to make appropriate adjustments to the intervention and/or the manner in which it is delivered, with the aim of maximising its potential benefit

Capacity to implement interventions in a flexible but coherent manner

An ability to implement an intervention in a manner that is flexible and responsive to any

issues patients raise, but that also ensures that the pertinent components of an intervention are included
An ability to judge when and how to balance adherence to a 'protocol' against the need to attend to any issues that arise in the therapeutic relationship

Capacity to adapt interventions in response to feedback

An ability to accommodate issues that patients raise explicitly or implicitly, or that become apparent as part of the process of the intervention:

an ability to respond to **explicit** feedback that expresses concerns about important aspects of the intervention
an ability to detect and respond to **implicit** feedback that indicates concerns about important aspects of the intervention (e.g. as indicated by non-verbal behaviour, verbal comments or significant shifts in responsiveness/engagement)
an ability to identify when it seems difficult for patients to give feedback that is 'authentic' (i.e. responding in accordance with what they think the PA wishes to hear, rather than expressing their own view) and discussing this with them

Team working

An ability to recognise the value of the opinions and perspectives of colleagues and to integrate different perspectives into the overall approach
When sharing information with team members, an ability to judge what information needs to be shared and with whom, measuring and balancing the level of confidentiality against the need for colleagues to have sufficient information if they are to act in the interests of the patient
When undertaking work with other agencies, an ability to make a judgement about the potential impact of factors (e.g. differences in statutory responsibilities and the operation of service constraints) and to take these into account when planning a shared intervention

An ability to judge when there is evidence that the actions of a colleague (or colleagues) fall below appropriate professional standards or place users at risk of harm, and to draw on knowledge of relevant organisational procedures to identify the most appropriate way to alert others to these issues

Legal and ethical issues

An ability to interpret legal and ethical frameworks in relation to the individual case

Assessing risk

An ability to draw on knowledge of the difficulty of predicting risk in a patient and so be able to:
synthesise information from multiple sources of information about them
integrate information from questionnaire-based sources with information from discussion-based assessment

Working with the evidence base

An ability to make informed use of the current evidence base to guide decision-making about the interventions that are indicated
Where a patient presents with multiple problems and conditions, an ability to adapt treatment plans so that they can be applied to the individual case
An ability to plan interventions in a manner consistent with the available evidence-base, but to judge when and how to move beyond this where there are indications that this is indicated, e.g.:
where the patient is finding it difficult to engage with the evidence-based approach
where there is evidence of a lack of progress with a competently delivered evidence-based intervention

Safe practice, supervision and support

An ability for PAs to recognise the limits of their competence, and to judge when they should seek advice and/or supervision from more experienced colleagues

An ability to be aware of the inevitable personal feelings and responses elicited by challenging behaviours (e.g. hostility or aggression) and to judge when additional support or supervision is necessary in order:
to continue working effectively and compassionately
to ensure that decisions about the best way forward are taken on the basis of careful reflection (e.g. whether to persist with, adapt or stop an intervention)

An ability for the PA to judge when their work is placing unhelpful emotional demands on them, and to take steps to put in place appropriate levels of self-care