5.1. Management of Mental Health Problems

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 MDT)

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, for example:
the benefit of developing a positive and explicitly collaborative relationship which 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
contra-indications 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, mental state examination, 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 MDT (e.g. to further develop the management plan)

Managing psychiatric emergencies

An ability to recognise and assess for psychiatric emergencies, for example:	
	Neuroleptic Malignant Syndrome (NMS)
	Serotonin Syndrome (SS)
	Delirium

An ability to communicate and deliver initial management plans for psychiatric emergencies
An ability to escalate concerns to senior members of the MDT
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[1]

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 for example:
liaison and discussion with other mental health teams such as Crisis Resolution and Home Treatment Teams, Mental Health Liaison Teams
liaison and discussion with Approved Mental Health Professionals (AMHPs)
liaison and discussion with emergency services including police and ambulance
liaison and discussion with social services and local safeguarding teams

[1] A more detailed account of the management of risk can be found in the relevant section of this framework

5.2. Management of Physical Health Problems

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 other specialities)

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
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, for example:
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, for example:
the benefit of developing a positive and explicitly collaborative relationship which 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. National Early Warning Score (NEWS))

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, for example:

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, for example:

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, for example:

chronic physical conditions and their diagnosis and treatment (e.g. Type I or Type 2 Diabetes, Asthma, COPD)
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

This document is divided into two sections. The first covers competences that relate to the daily practice of Physician Associates, the second 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 service users

Knowledge

An ability to draw on knowledge that:
health is more than the absence of disease, and is characterised by a state of complete well-being
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 which 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 well-being 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 well-being
an ability to draw on knowledge that mental health interventions can positively benefit physical health problems and well-being
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, for example by using participatory and empowering approaches to support the capacity of service users to make healthy decisions

Health promotion competences relevant to public health initiatives

An ability to draw on knowledge of the principles which 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 (e.g. 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 such as community members, parents 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
focussing 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, such as a reduction in weight among obese individuals)
    - outcome (long-term effects after the programme has ended, such as sustained weight loss)

identify appropriate methods for evaluating the programme (including both qualitative and quantitative methodologies)
identify and select appropriate evaluation tools (such as 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 which 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 contra-indications)
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 contra-indications
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, for example:

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 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 use/abuse 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
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, for example 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-steps 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 A&E 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
  - 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)

<u>Management of overdose and withdrawal</u>

- An ability to draw on knowledge of the acute physical effects of substance abuse, 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 abuse (e.g. using the Clinical Institute Withdrawal Assessment for Alcohol (CIWA) scale and responding to adverse signs/symptoms)
  - an ability to recognize when adverse signs/symptoms indicate the need for medical intervention, and to refer the patient to a relevant practitioner with appropriate urgency

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 FPA matrix)
An ability to draw on knowledge of core clinical conditions (as set out by the FPA 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, for example:
assessing patients by taking a thorough history and performing relevant physical examinations
identifying and diagnosing acute and chronic illness (such as 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[2] (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 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 such as 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 such as 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

[2] The content of this section draws on Deary, V., Chalder, T., & Sharpe, M. (2007) The cognitive behavioural model of medically unexplained symptoms: A theoretical and empirical review. Clinical Psychology Review, 27, 781-797

current trauma, or reminders of earlier traumas (retraumatisation)

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, for example:
changes in the functioning of the HPA axis* (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 well-being 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)

* HPA – 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 - for example:
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 which 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 a generic model of adjustment to physical health conditions

- An ability to draw on knowledge that adjustment is not an end-point but a process of assimilation that takes place over time, and which can be expected to vary in response to changes in the person'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 people are contending
  - optimal adjustment will not always be signalled by preserved functional status or low negative affect, but is determined by the individual'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 person'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 well-being (such as decreased mood or increased anxiety)
indicators that the person is finding it difficult manage their condition (such as 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 person's health difficulties
An ability to draw on knowledge that intervention strategies should focus on the factors that are most likely to help the person manage their health conditions more effectively:
a focus on mental health issues may not always be relevant, and hence may not be acceptable to service users
helping people 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 person's response to illness, rather than the illness *per se*)
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 (for example) 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 such as 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)
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 which impact adversely on their capacity to manage their physical health*
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)

* detailed in the ‘competences to promote adjustment’ section of this competence framework

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 (for example, 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 (for example by pairing new behaviours (such as 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 A&E attendance), adjusting

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

* described fully in the ‘Knowledge of models of behavioural change and strategies to achieve it’ section of this framework