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)

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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

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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

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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

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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)

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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

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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

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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

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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

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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:

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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

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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

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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)