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