

# **LOW INTENSITY COGNITIVE BEHAVIOURAL COMPETENCY SCALE MANUAL**

## **Assessment Sessions**

## **INTRODUCTION**

Low intensity cognitive behavioural interventions are often delivered by Psychological Wellbeing Practitioners (PWP) who provide guided self-help (GSH) in a 'coaching' style to patients with mild-moderate common mental health problems. A crucial aspect of the PWP role is the assessment of patients, aiming to identify the patient's main presenting problem and evaluate the suitability of the specific style of the low intensity clinical method and model of intervention for the patient, their problems and their goals. Assessment competencies are also essential in ensuring the safety of the patient and in the right choice of treatment.

## **ASSESSING FOR BEHAVIOUR CHANGE**

Consideration of behavior change theory is fundamental to the low intensity cognitive behavioral approach. It is essential the practitioners are able to consider the way in which behavior change underpins the low intensity method and apply this knowledge within the assessment. The integrative model of behavior and behavior change that informs PWP work is the COM-B model (Michie et al., 2014). The model conceptualizes behavior change as resulting from the interaction of three factors (a) capability to perform behavior change (b) the opportunity to carry out necessary behavior change and (c) the motivation for behavior change. During assessment, practitioners should utilize the COM-B model to inform and influence the gathering and synthesis of information to aid clinical decision-making and treatment planning. There are no scales measuring the use of COM-B, but the model should be used to inform the assessment process.

The three areas are outlined:

### ***CAPABILITY***

Does the patient have sufficient knowledge or skills to change their behavior/reasoning/executive functioning through understanding of their common mental health problems?

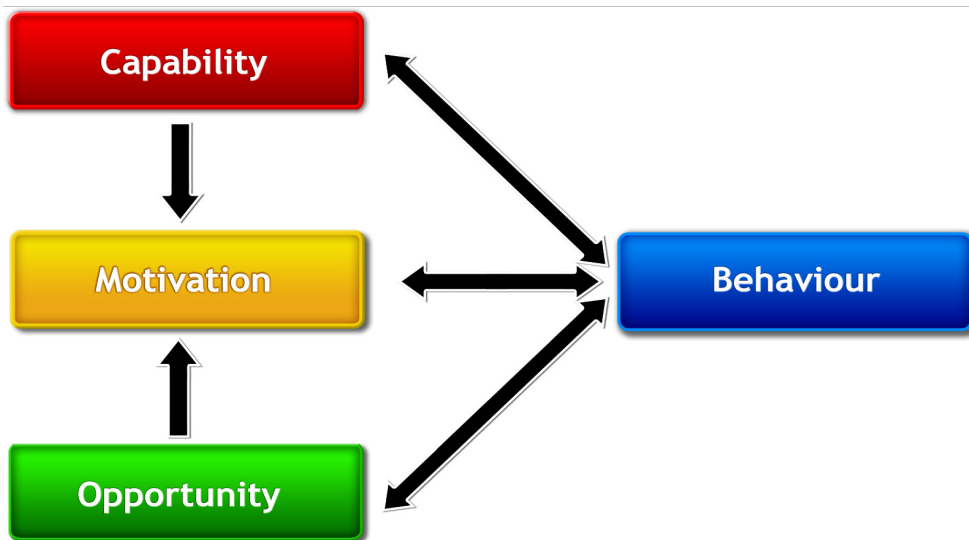
### ***OPPORTUNITY***

What factors in the patient's environment maintain the problem behavior and make behavior change difficult? Does the patient have sufficient access to resources? What barriers to change need to be considered?

### ***MOTIVATION***

What is the patient's current readiness for change? What factors are currently impacting the patient's motivation? Is avoidance currently making change difficult or maintaining the problem? What other factors may play a role in decreasing motivation e.g. drugs/alcohol?

The COM-B model has been mapped to the PWP assessment tool to highlight areas where it will facilitate the PWP with their assessment of the patient and their presenting problem. The model should be applied such that the 3 factors are considered in relation to their impact on the patient's ability to engage in behavior change, and ultimately to engage in the PWP approach. The model is applied such that it informs PWP treatment planning, informs treatment goals and enables the PWP to anticipate challenges in behavior change.



## LOW INTENSITY COGNITIVE BEHAVIOURAL COMPETENCY SCALE MANUAL

This scale is used to measure the level of competency in practitioners delivering low intensity cognitive behavioural *assessment sessions*. The scale does not measure adherence to the PWP assessment approach (i.e. whether something was done), but rather the competency with which the PWP completed the assessment (e.g. the skillfulness of the assessment and the methods used). The scale contains 6 items to enable raters to examine a range of key competencies:

- Introduction to the assessment session
- Engagement competencies
- Interpersonal competencies
- Information gathering competencies: problem focused
- Information giving competencies: suitable to the problem
- Shared planning and decision making competencies

The low intensity cognitive behavioral competency measure is a rating scale to be used by supervisors, trainers and managers to assess practitioner's performance in *assessment sessions*. The examples included within the manual are considered as guidelines. The examples provide both descriptive and explanatory examples for reference. As practice is complex, then raters need to be able to use the manual as guidance to ratings, as exhaustive descriptors cannot be provided.

The scale and manual is suitable for use in benchmarking the competencies of both trainee and qualified PWPs.

## SCORING

The low intensity cognitive behavioral assessment competency scale scoring system uses the Dreyfus system (1990), whereby competencies are rated on a Likert scale (0-6). Each level has been defined in detail to conform to the levels of competence. This has been set out in the table below.

PWP Competence Level	Score	Descriptor
	0	Absence of feature, or highly inappropriate performance
<i>Incompetent</i>	1	Inappropriate performance, with major problems evident
<i>Novice</i>	2	Evidence of competence, but numerous problems and lack of consistency
<i>Advanced beginner</i>	3	Competent, but some problems and/or inconsistencies
<i>Competent</i>	4	Good features, but minor problems and/or inconsistencies
<i>Proficient</i>	5	Very good features, minimal problems and/or inconsistencies
<i>Expert</i>	6	Excellent performance, or very good even in the face of patient difficulties

For a low intensity practitioner to be graded as competent in an assessment session, the session has to score  $\geq 18$  overall (range 0-36). The PWP must score 3 or more on the summary rating in each of the six sections - **half-point scoring is accepted**.

The summary rating of each section is NOT the average of the ratings given on specific aspects and is not cumulative.

The competency-rating tool is designed to be appropriate for assessment sessions lasting 30-45 minutes.

Raters are encouraged to use the whole scale during competency assessment. A 6 is often characterized by the application of competencies “in the face of patient difficulties.” It is possible to score a 6 in the absence of patient difficulties should the rater feel this provides the most accurate rating of the practitioners competence.

## Competency Rating Criteria

### Introduction to Assessment Session

The low intensity cognitive behavioral practitioner or PWP should demonstrate competence in introducing themselves and clarifying their role, as well as providing information on the process and features of the assessment – this should be fluently and confidently presented. The practitioner should ensure that the patient understands what to expect will occur in the initial assessment appointment. The key features of the ‘introduction to assessment’ item as outlined in the low intensity cognitive behavioral competency scale are as follows:

#### Key features:

- PWP’s introduce themselves and gain the patient’s full name and preferred name
- Role clarification
- Outline confidentiality and its boundaries
- Describing the purpose of the assessment session and what methods will be used
- Defining a time scale for the assessment session

At the start of the assessment session the practitioner should **introduce their name and their role**. This should be welcoming and clear.

**Confidentiality** should be described fully. The patient should be informed that information discussed in session will not be shared with anyone beyond the Primary Care team, in terms of record keeping and supervision. In terms of risk concerns then the practitioner should inform the patient about who they would share information with in such circumstances that there is concern about the level of risk posed to the patient or others. Confidentiality should be agreed with the patient.

The practitioner should explain the **purpose** of the assessment is to develop a *shared understanding of the problems to inform appropriate treatment or signposting*. The assessment methods should be explained to the patient for example; defining exactly what the problem is, completing outcome measures and discussing appropriate treatment options.

A **time scale** should be defined and then the session adhere to this time scale.

#### Checklist-

- Has the practitioner stated their name and asked for the client’s full name?
- Have they clarified their job title and given a description of their role?
- Did the practitioner appear confident in their introductions, so putting the patient at ease?
- Has the practitioner outlined how the sessions will be set out (i.e. the methods used)?
- Did the practitioner explain and agree confidentiality and boundaries (e.g. information discussed with supervisor, GP, risk assessment)?
- Was there a time scale for the assessment session clarified?
- Did the practitioner check understanding of all the above when and if necessary?

### Introduction to Assessment Session

Competency ratings:

0	No introduction provided.
1	Inappropriate introduction provided, key information omitted e.g. fails to explain role, does not outline confidentiality or the purpose the of session.
2	Introduction provided but numerous problems evident and important information missing e.g. states name and role but does not elaborate on what the role is, description of confidentiality is vague and unclear, does not describe the purpose or process of the session. Fails to elicit patient preferred name.
3	Introduction present, key information provided with basic detail on confidentiality provided, aims of session outlined briefly. Lacks fluency. Preferred name elicited, role explained briefly.
4	Clear and informative introduction to self, role and session provided. Name and preferred name elicited. Confidentiality explained, purpose and process of session outlined, time for session agreed. Reasonably fluent.
5	As above with explicit consideration of methods used in assessment, clear and concise description of confidentiality with clear feedback elicited from patient to check understanding. Good fluency.
6	As above, even in the face of patient difficulties.

## Establishing and Maintaining Engagement

The low intensity cognitive behavioral practitioner or PWP should demonstrate their ability to engage the patient throughout the assessment session. The aim is that the patient feels heard and that their problems are appropriately acknowledged and validated – this is done by a combination and blend of a collaborative stance/approach, reflections, summaries and the key absence of any ‘interrogatory’ style. The key features of the ‘establishing and maintaining engagement’ item as outlined in the low intensity cognitive behavioral competency scale are as follows:

### Key features:

- Ensuring a collaborative approach
- Acknowledge the problem by reflection
- Using capsule summaries
- Using major summaries
- Appropriate ratio of questions to feedback

The practitioner should ensure a **collaborative stance and approach** is taken during the session to develop a shared understanding of the patient’s problems and difficulties. Language should be collaborative in nature (e.g. shall we have a look at how your low mood is impacting on your home life at the moment?). The practitioner should not *falsely collaborate* (e.g. let’s look at how we are coping with that’ or ‘shall we move on?’). When conceptualizing, the PWP should ensure that the patient can see and contribute to the conceptualization.

The practitioner should ensure that problems are **acknowledged by simple and complex reflections** so that the patient feels listened to and that they feel that their problems are validated. The simple reflections should provide a narrative of the current difficulties and enable the practitioner and patient to work towards developing a problem statement (e.g. “so you felt like you were having a heart attack” or “so you’ve been feeling really low and crying often.”). Complex reflections should be used as appropriate.

The practitioner should ensure that the patient feels listened to be providing appropriate, accurate and regular **capsule summaries and also section summaries**. The capsule summaries are used to show the patient that the practitioner recognizes certain themes or collections of statements about, for example, how the patient has been feeling, acting or thinking. Section summaries are used to create transfer from one section of the assessment process to another. The practitioner should not over chunk or over summarize. The assessment section should end with a brief summary from the practitioner of the process, content and outcomes from the assessment.

There should be an **appropriate ratio of questions to feedback**. This is to ensure that there is not an interrogatory approach to the assessment, and is feedback *to* the patient. Feedback should be elicited *from* the patient to clarify information and ensure an accurate description of the problem is being gained.

### Checklist-

- Was there a collaborative approach to discussing the patient’s difficulties?

- Was collaborative language used?
- Was there any false collaboration?
- Was the effort to engage the patient evident across the session?
- Did the practitioner offer a variety of simple and complex reflections?
- Did the practitioner provide capsule and major summaries of the patient's difficulties, without over summarizing?
- Were the reflections and summaries appropriate and accurate to the patient's descriptions?
- Was there an appropriate ratio of questions to feedback?
- Was feedback elicited from the patient?
- Did the PWP work with the patient when conceptualizing the problem?

### Establishing and Maintaining Engagement

**Competency ratings:**

0	No evidence of attempts to engage patient.
1	Inappropriate or ineffective engagement of the patient, absence of collaboration, absence of summaries. Absence of feedback. An interrogatory style.
2	Attempts to engage patient somewhat patchy across the session. Limited use of summaries and reflections or alternatively over summarizing. Limited collaboration and opportunities to build engagement regularly missed. Written material not shared. Tending towards an interrogatory style.
3	Engagement evident but with some problems. Some capsule summaries and major summaries evident, but sporadic in frequency and accuracy. Reflections are utilized. Collaborative approach present, but problems evident. Some sharing of the written material.
4	Clear demonstration of engagement. Both capsule and major summaries are used well. Complex and simple reflections are also present. There is a good level of feedback. Patient involved in the written material. Occasional inconsistent collaboration.
5	As above with regular and very effective use of capsule summaries and major summaries. Correct amount of simple and complex reflections evident. Question:feedback ratio is very well balanced. Patient fully involved in the written material (e.g. adding own written material). Clear collaborative stance.
6	As above, even in the face of patient difficulties.



## Interpersonal skills

The low intensity cognitive behavioral practitioner should demonstrate their interpersonal skills in developing and maintaining an effective therapeutic relationship with the patient in the assessment session. The key features of the 'interpersonal skills' item as outlined in the low intensity cognitive behavioral competency scale are as follows:

### Key features:

- Empathises through verbal communication
- Non-verbal communication
- Normalizing and non-judgmental stance
- Warmth, compassion and rapport
- Pacing

The practitioner should be able to establish a trusting and containing therapeutic relationship with the patient. This should be emphasised through the practitioner's **use of verbal communication**, such as paraphrasing, empathy and clarification.

A competent practitioner should also demonstrate their interpersonal skills in **non-verbal communication skills**, such as maintaining eye contact, smiling when appropriate, using appropriate facial expressions, having an open posture, and considering the seating arrangements. The practitioner should not take notes in a manner that disrupts or inhibits their interpersonal effectiveness.

The practitioner should be able to convey **warmth and compassion** with the patient. This should enable the patient to feel contained and able discuss their problems within the session. The patient's concerns and difficulties should be appropriately **normalised** and not dismissed. The practitioner should be able to **establish rapport**, building a trusting and warm relationship with the patient to encourage the development of optimism about treatment, as well as motivate the client to want to continue with the treatment process (if indicated).

**Pacing** should be patient-centred to ensure that the patient feels listened to and that they feel their problems are validated. The practitioner should be able to follow the assessment process without the patient feeling unheard or rushed. The session should not be so slow, that the key aspects are not covered.

### Checklist-

- Did the practitioner make attempts to develop a therapeutic relationship with the patient?
- Did the practitioner use good body language?
- Did the practitioner demonstrate verbal empathy?
- Did the practitioner demonstrate non-verbal empathy?
- Did the practitioner have an empathetic and warm approach?
- Was there evidence to suggest that the client felt listened to and their problems validated?
- Did the practitioner engender hope via realistic and accurate assurances and explanations?
- Was the patient was given enough time to talk and think?
- Was the practitioner patient-centred and adapted the session to the patient's needs?
- Was the pacing appropriate and flexible?

### Interpersonal skills

Competency ratings:

0	No evidence of interpersonal skills demonstrated.
1	Inappropriate interpersonal skills, absence of verbal empathy, sporadic eye contact, inappropriate non-verbal empathy. Poorly controlled pace of session. Lack of warmth. An absence of normalizing. No rapport.
2	Some evidence of interpersonal skills such as eye contact and non-verbal empathy. Few verbal empathy statements present and multiple opportunities to demonstrate verbal empathy missed. Limited warmth. Pacing is highly inconsistent. Infrequent normalizing. Limited rapport.
3	Interpersonal skills evident. Warmth and compassion demonstrated. Regular verbal and non-verbal empathy demonstrated but some opportunities missed. Attempts to pace the session are evident, but this is inconsistent. Non-judgmental attitude evident. Some attempts to normalize patient distress. Sufficient rapport.
4	Clear and frequent demonstration of effective interpersonal skills, regular empathy in both verbal and non-verbal forms evident. The sessions is paced suitably and with reference to time. Regular and appropriate normalizing of patient distress. Useful clarifications. Rapport evident.
5	As above with regular very good pacing of session. Regular, appropriate and genuine empathy present both verbally and non-verbally. Clear evidence of warmth, compassion and non-judgmental approach to session. Regular useful clarification evident. Strong rapport.
6	As above, even in the face of patient difficulties.

## Information Gathering: Problem Focused

The low intensity cognitive behavioral practitioner should demonstrate their competency in gathering information from the patient regarding their problem(s), difficulties and impact of these problems and difficulties are having upon their life. The key features of the 'information gathering' item as outlined in the low intensity cognitive behavioral competency scale are as follows:

### Key features:

- Elicits a problem description
- Uses an appropriate questioning style
- Elicits cognitive/behavioral/emotional and physical symptoms of presenting problem
- Elicits onset, triggers for and moderators of the problem
- Determines the impact of the problem on valued activities
- Completes appropriate risk assessment
- Sensitively integrates outcome measures and provides feedback on result
- Recognizes of co-morbidity (both psychological and physical)
- Gather information about other relevant issues (e.g. why access help now, past treatments, current medication)

The practitioner should elicit **a problem description** from the patient. The 4 W's; What is the problem? Where does the problem occur? With whom is the problem better or worse? When does the problem happen? Has it happened before? When did it start? Triggers should be elicited to include examples of current situations or stimuli that trigger the problem in the here and now.

The practitioner uses an **appropriate questioning style** to elicit relevant information. A process of funneling is used to elicit patient centered problem identification by the appropriate use of open questions, specific open questions, closed questions, summarizing and clarification.

Following the low intensity model the practitioner should ensure that information is gained in regards to the **behavioral aspects** of the problem, any **physiological symptoms**, the **emotional response**, and **key cognitions**. This will aid in the conceptualization of the problem as well as enabling patients to recognise and reflect of the different aspects of their difficulties.

The practitioner should gather information about the **modifying factors** relating to the problem, which includes identifying the maintaining factors.

The practitioner should determine **the impact of problem** on the patient's life and their valued interests and activities.

A full **risk assessment** MUST be undertaken and responded to appropriately. Risk assessment should include identification of intent, presence and nature of suicidal thoughts, hopelessness, thoughts of self-harm, plans, actions past and present, access to means and protective factors. Other risk factors such as alcohol, substance misuse, and risk to/from others should also be gleaned. Self-neglect and neglect of others. Absence of risk assessment leads to an automatic 0 score on this item.

**Outcome measures** should be sensitively integrated into the assessment. The results should be feedback (use of measure cut-offs) and discussed in an appropriate and compassionate manner.

Practitioners should also address **any other issues** that may affect the patient's motivation to engage in guided self-help (e.g. such as past treatment, physical health problems and current medication). The practitioner therefore asks about previous treatments for previous episodes.

#### Checklist-

- Did the practitioner elicit a problem description from the patient
- Did the practitioner assess the 4 W's of the problem?
- Did the practitioner identify physical symptoms of the problem?
- Did the practitioner identify behavioral aspects of the problem?
- Did the practitioner identify the emotional impact of the problem?
- Did the practitioner identify key cognitions?
- Did the practitioner assess the impact on the patient's valued life activities?
- Did the practitioner elicit the triggers?
- Did the practitioner complete a full risk assessment? And was this dealt with appropriately?
- Was the onset and duration of the problem identified?
- Were modifying factors considered?
- Was information about alcohol and substance misuse elicited?
- Was information gained regarding possible co-morbidity?
- Were outcome measures completed by the patient? And the results discussed?
- Were other relevant issues discussed?

### Information Gathering: Problem Focused

Competency ratings:

0	No evidence of information gathering demonstrated and lack of risk assessment
1	Inappropriate information gathered, major omissions of information, questioning style inappropriate. Patient not allowed to share their information. No outcome measures completed. Piecemeal risk assessment.
2	Some evidence of information gathering evident. Problem description broadly elicited but major problems evident. Over reliance on use of closed questions. Fails to elicit cognitive, behavioral, physiological and emotional aspect of problem in sufficient depth. Key modifying information missed. Some use of the 4 W's. Risk assessment covered but lacking in depth and detail or lack of appropriate actions. No recognition of co-morbidity. Incomplete risk assessment.
3	Information gathering skills present. Some evidence of funneling with use of open and closed questions and summaries. 4W's. Problem description elicited and the relevant cognitive, behavioral, psychological and emotional features identified. The impact on functioning is considered. A risk assessment is completed and appropriate actions taken. Outcome measures are completed. Onset and duration identified. Risk assessed.
4	Good skills in information gathering present. Problem description elicited well and the appropriate cognitive, behavioral, physiological and emotional aspects are identified. Good funneling. 4 W's clearly present. Onset and duration identified. Impact considered and linked to patient's quality of life. Risk assessment evident. Outcome measures integrated into session well. Co-morbidity considered. Other important information also gathered e.g. past treatment. Full risk assessment,
5	As above with very regular use of funneling. Thorough and comprehensive risk assessment. Recognition of co-morbidity. Sensitive and meaningful integration of outcome measures into the sessions. Triggers and moderating features of the problem identified. Full risk assessment. Thorough and comprehensive assessment of cognitive, behavioural, emotional and physiological features of the problem.
6	As above, even in the face of patient difficulties.

## Information Giving: Focal to the Problem

The low intensity cognitive behavioral practitioner should demonstrate their competency in providing information that is appropriate, focal and suitable to the patient's problem.

The key features of the 'information giving: suitable to the problem' item as outlined in the low intensity cognitive behavioral competency scale are as follows:

### Key features:

- Co-creates an accurate ABC or 5-areas conceptualization
- Co-creates patient centered problem statement

The practitioner should work with the patient to provide a low intensity cognitive behavioral **conceptualization** of the patient's difficulties using either the ABC or 5-areas technique. The practitioner should attempt to ensure that the patient has a clearer understanding of their difficulties via the conceptualization.

The patient and practitioner should work together to **create a problem statement**. This will provide a summary of the main features of the problem and a rationale for the treatment method. Much of the problem statement is brought forward from the information gathering and repetition is to be avoided. The problem statement may also provide possible goals for treatment. The problem statement should summarize the triggers, behavioral/cognitive/physiological/emotional aspects of the problem, and should outline the impact of the problem on functioning. The problem statement should be written in the *first person*.

During the assessment session the practitioner should not drift into treatment and should be careful not to provide too much information too early. The practitioner can decide whether it is more useful to complete the problem statement or the conceptualization first. The practitioner may want to suggest areas that could be worked on within treatment, however the practitioner should focus primarily on giving information linked to the information gathered during assessment and its conceptualization.

### Checklist-

- Did the practitioner conceptualize the problem using an appropriate ABC or 5 areas approach?
- Did the practitioner elicit feedback as to the patient's understanding of the conceptualization?
- Was the practitioner able to explain the conceptualization in an accessible way?
- Did the problem statement include triggers, behavioral, cognitive, physiological, and emotional aspects of the problems, alongside the impact on functioning?
- Did the practitioner collaboratively generate a patient-centered problem statement that was succinct and also written in the first person?

### Information Giving: Focal to the Problem

Competency ratings:

0	No evidence of information giving
1	Inappropriate information given, absence of conceptualization of information using ABC or 5 areas. Problem summary presented didactically without any patient input/feedback and containing inaccurate or incomplete summary. Problem statement not in the first person.
2	Some evidence of information giving. Problem statement formed but incomplete e.g. does not contact all aspects of problem (cognitive, behavioral, physiological or emotional). Practitioner drifts into treatment. Problem statement not in the first person.
3	Information giving skills present with evidence of an ABC of 5 areas completed, but with some inconsistencies. Problems statement agreed and contains key components. Problem statement in the first person, but could be improved in terms of content.
4	Clear and coherent conceptualization of the case in 5 areas or ABC model. Completed collaboratively with patient. Comprehensive problem statement developed. Problem statement in the first person, which is mostly accurate.
5	As above with feedback elicited to check out patient understanding and excellent collaboration demonstrated. No drift into treatment. Comprehensive and sensitive problem statement written in the first person.
6	As above, even in the face of patient difficulties.

## Shared Planning and Decision Making

The low intensity cognitive behavioral practitioner should demonstrate their competency in identifying suitable treatment options (including signposting), as well as working with the patient to agree plans and actions subsequent to the session (e.g. provide appropriate psychoeducation) and also define the goals of the guided self-help.

The key features of the 'shared planning and decision making' item as outlined in the low intensity cognitive behavioral competency scale are as follows:

### Key features:

- Suitable treatment options offered
- A rationale for treatment provided
- Overall goals for treatment agreed
- Agreed plans and actions subsequent to the session (i.e. between session work)
- Effective ending to the session

The practitioner and the patient should work collaboratively to identify **suitable treatment options** based on the information gathered, the patient's goals and the relevant evidence base. Factors impacting behavior change as per the COM-B model should be considered. The practitioner should provide information about treatment options and discuss with the patient which would be appropriate and achievable. For example guided self-help interventions such as Behavioral Activation for Depression and medication support, alternative step 2 interventions such as C-CBT, group based interventions such as workshops, step 3 interventions or signposting to other services.

The practitioner should provide a **rationale for treatment** which should involve the consideration of the presenting problem, the patient's goals and the evidence base. The practitioner should not drift into treatment delivery at this point, but should provide an overview of what the patient could expect from their chosen treatment and how this links to information gathered at assessment.

The practitioner should work with the patient to create **overall goals** for the low intensity intervention. In the assessment session, efforts should be made to make these as SMART as possible. These are not the goals for the next session.

The practitioner should work with the patient to **agree appropriate plans and actions** subsequent to the assessment session. This is the work that is focal to the next session and might involve provision of psychoeducational material, starting to keep a thought diary, or doing some behavioural self-monitoring and so on. The practitioner should consider what adaptations the patient may require to access and engage in this work.

The practitioner should complete the assessment with an appropriate **ending to the session**. The practitioner should ensure the patient has a clear plan and information about appropriate treatment methods. Arrangements should be made regarding an agreement about next step in terms of contact arrangements, appointment etc. The patient should leave the assessment feeling



optimistic and confident about the process and confident in attending subsequent sessions. There should be a brief session summary that captures the key aspects of the assessment and outlines the information gathered and decisions made. The practitioner should elicit feedback from the patient about their experience of the session.

#### Checklist-

- Were treatment options discussed and decided or a plan for when this would take place decided (e.g. after the patient has read about the various treatment options)?
- Did the practitioner create SMART goals for treatment?
  - Was there evidence of shared decision making?
  - Did the practitioner identify suitable treatment options based on the information gathered during the assessment?
  - Was the agreed outcome and planned actions in line with the assessment, patient goals and the low intensity model?
  - Did the practitioner describe the next steps of treatment and outline what the patient should expect?
  - Did the practitioner provide a brief outline of the rationale for the agreed treatment?
- Did the practitioner and patient agree any the actions subsequent to the session (i.e. the between session work)?
- Did the practitioner consider the COM-B when making decisions with the patient?
- Did the practitioner review the session and the patient's experience?
- Did the practitioner appropriately end the session?
- Was there a useful session summary?
- Did the patient leave the session with a clear plan?

## Shared Planning and Decision Making

### Competency ratings:

0	No evidence of shared decision making or planning. Fails to achieve an agreed outcome to the session. No goals. No actions subsequent to the session. Inappropriate sign-posting.
1	Inappropriate decisions made about treatment. Decisions made unilaterally by the practitioner without any collaboration with patient. Rationale not discussed or outlined. Session ended abruptly. No goals. The actions subsequent to the session are unclear. No use of COM-B.
2	Appropriate outcome and treatment choice identified. Unilateral decision made. Brief and vague rationale for treatment choice provided. Vague plans and agreements for treatment established. Session ends without summary. Vague goals discussed. Little specificity to subsequent actions. Some sporadic use of COM-B.
3	Appropriate outcome and treatment chosen. Some evidence of inclusion of patient within decision making process. Rationale is either too brief with detail omitted or overly detailed or bordering on treatment. Ending of session evident with vague agreement for next steps. Sufficient evidence of COM-B features e.g. opportunity considered but does not consider motivation or capability. Specific goals agreed.
4	Treatment and outcome to session agreed collaboratively with patient. A concise rationale provided. Agreed actions and plans are clear and feedback elicited from patient to check understanding. Sessions ends well with summary and clear outcome. At least 2 elements of the COM-B model are considered. SMART goals.
5	As above with excellent end of session summary, concise and well informed rationale, collaboration and shared decision making evidence. 3 elements of COM-B are considered, (motivation, capability and opportunity) and this is discussed with regards to consideration of treatment and outcome of session. Actions subsequent to the session are appropriate and helpful. SMART goals.
6	As above, even in the face of patient difficulties.