

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

## **Treatment Sessions**

## **INTRODUCTION**

Practitioners delivering low intensity cognitive behavioral interventions offer treatment for patients with mild-moderate depression and anxiety disorders. Using a guided self-help approach, practitioners employ a 'coaching' style. Self-help materials based on cognitive behavioral theory and principles provide the focus for treatment. The guided self-help clinical method emphasizes the skill of practitioners in utilizing psychoeducational materials and helping patients use them effectively to self-manage their symptoms. The competency of the practitioner in delivering low intensity treatment is crucial to ensure the progress/safety of the patient. Practitioners need to display fidelity to the low intensity treatment model and evidence base.

## **TREATMENT USING THE COM-B AS A THEORETICAL GUIDE**

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 treatment. The integrative model of behaviour and behaviour change for low intensity cognitive behavioural practitioners is the COM-B model (Michie et al, 2014). This conceptualises the patient's problem behaviour as resulting from the interaction of three factors (a) capability to perform behaviour change (b) the opportunity to carry out necessary behaviour change and (c) the motivation for behaviour change. Therefore when treating patients using low intensity treatment methods, the COM-B model can be used to particularly inform, guide and influence PWP treatment delivery. 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.

The manner in which this can be achieved is set out below:

### **CAPABILITY**

Considerations about the patient's capability to engage in behavior change should be built into the treatment plan. The practitioner should show evidence of providing low intensity materials, exercises, interventions and techniques that enable the patient to change their behavior/reasoning/executive functioning. The practitioner should aim to facilitate the patient in developing a good understanding of their common mental health problems and also of the mechanisms that must be targeted to create change to promote recovery.

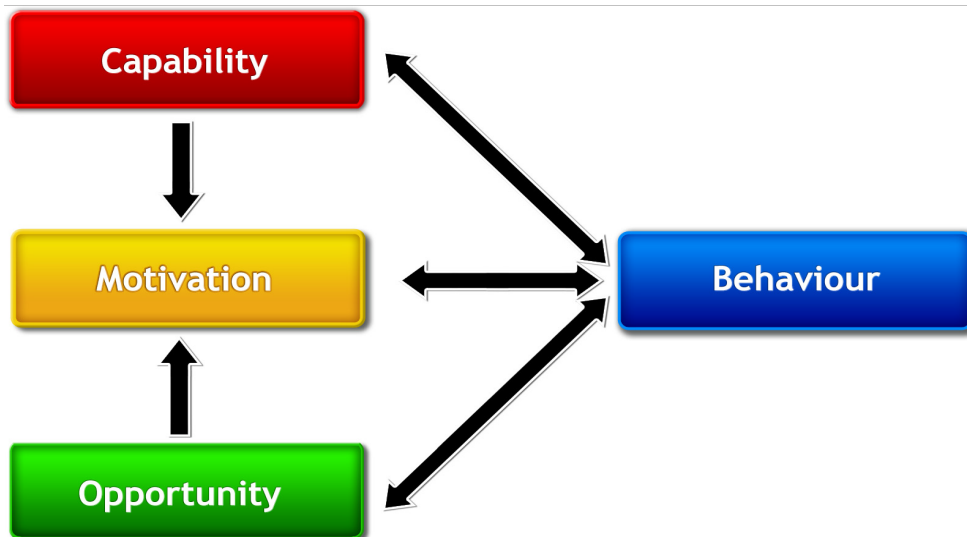
### **OPPORTUNITY**

Consideration of the patient's opportunity to engage in behavior change should be integrated into the treatment plan. Practitioners should focus on supporting the patient to change factors in their environment (or their response to their environment) that would facilitate symptom change or lead to a reduction of the impact of their anxiety or depression.

### **MOTIVATION**

Practitioner should focus on addressing any issues with patterns of avoidance with a view to enable effective engagement with self-management strategies for example in behavioral activation the focus would be on enhancing access to positive reinforcers. Alternatively practitioners should aid patients in reduced cognitive/behavioral/emotional avoidance strategies that maintain their problem.

The COM-B model has been mapped to the low intensity cognitive behavioral treatment competency scale to show key areas for consideration. The model enables treatment to take place with a consideration of the interaction between the three factors (Capability, Opportunity and Motivation) and how these underpin the behaviors which maintain the patients presenting problem (depression and/or anxiety). The emphasis being that the practitioner applies the model to capitalize on opportunities to facilitate change. Applying the framework in this way aims to assist practitioners to deliver in session interventions or between session work, sensitively to patients.



## LOW INTENSITY COGNITIVE BEHAVIOURAL COMPETENCY SCALE TREATMENT MANUAL

This a scale used to measure the level of competency of low intensity cognitive behavioral practitioners during *treatment sessions*. The scale contains 6 items which should enable raters to examine a range of competencies:

- Focusing the session
- Continued engagement competencies
- Interpersonal competencies
- Information gathering: specific to change
- Within session self-help change method
- Planning and shared 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 treatment sessions. Practitioners can make use of the self to self-rate sessions to enhance reflections and development.

### SCORING

The low intensity cognitive behavioral treatment 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 a treatment 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 treatment sessions lasting 30-35 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.

## Focusing the Session

The low intensity cognitive behavioral practitioner should demonstrate their competency in firstly fluently developing and the subsequently adhering to an agenda for the treatment session. This should be the 'containing frame' of the session.

The key features of the 'introduction to treatment session' item as outlined in the low intensity cognitive behavioral competency scale are as followed:

### Key features:

- Welcomes the patient back to their next session
- Agrees collaborative agenda with client
- Introduces standing items: reviews of progress, risk, measures and homework
- Subsequent adherence to agenda

The introduction of the treatment session should be an opportunity for the practitioner to reengage with the patient and to outline to the planned and agreed content of the treatment session. Time should be taken to **co-create an agenda** and to ensure that any concerns raised by the patient about the treatment process are attended to. It should be clear where the patient is in the treatment contract (e.g. at the fourth of the six sessions agreed).

The practitioner should **introduce standing items** to provide the opportunity for the patient to reflect on their treatment progress. Homework should be reviewed and evaluated. The practitioner should remain positive and flexible in their reviewing. It is crucial that any possible risk concerns presented in previous sessions or between sessions are reviewed and discussed, and appropriate action is taken.

The practitioner should subsequently ensure that the set **agenda is adhered to** within the session to ensure that there is a continuation of progress and there is an adherence to the treatment model.

### Checklist:

- Was the practitioner welcoming in the manner they re-introduced the patient into the session?
- Did the practitioner state the session number (e.g. 'its session 4 of the 6 we agreed today')?
- Did the patient and practitioner agree collaboratively on a clear, appropriate and achievable agenda?
- Were appropriate standing items included?
- Did the practitioner provide a brief summary of the previous sessions and recognize any previous progress made or problems with treatment experienced by the patient?
- Was the agenda subsequently adhered to?

### Focusing the session

Competency ratings:

0	No focus for the session agreed or provided.
1	Ineffective agenda setting as key information omitted (e.g. failure to plan to review progress or failure to plan to discuss between session work). Very vague agenda that is unilaterally set without input from patient. No fluency. Poor subsequent adherence.
2	Framing provided, but numerous problems evident and important information missing (e.g. failure to plan to review progress or failure to plan to discuss between session work). Somewhat vague agenda set with minimal patient input. Lacks fluency. Patchy and piecemeal subsequent adherence.
3	Competent start to the session with effective agenda, but somewhat lacking in fluency. Key standing items of low intensity treatment session planned and agreed. Could be more fluent. Adherence to agenda is a little inconsistent.
4	Clear and collaborative agenda agreed - fluent. Key standing items of low intensity treatment session planned and agreed. Responsive to any patient requests. Good subsequent adherence.
5	As above with excellent collaboration and fluency in agenda setting and consistent adherence throughout. Key standing items of low intensity treatment session planned and agreed.
6	As above, even in the face of patient difficulties.

## Establishing and Maintaining Engagement

The low intensity cognitive behavioral practitioner should demonstrate their competency in continuing to engage the patient in the process of change. The key features of the 'establishing and maintaining engagement' item as outlined in the low intensity cognitive behavioral competency scale are as followed:

### Key features:

- Collaborative approach to facilitating change
- Acknowledges progress (or difficulties) using simple reflections
- Acknowledges progress (or difficulties) using complex reflections
- Use of capsule summaries regarding progress (or difficulties)
- Use of major section summaries
- Ratio of questions to feedback to facilitate change

The practitioner should ensure a **collaborative approach** is taken during the session to facilitate change. The patient should feel positive and confident about the changes they have or are made/making or that their problems are being approached in a collaborative manner. Barriers to change or the pace of change should be discussed in a collaborative manner.

The practitioner should ensure that progress is **acknowledged by reflection and summaries**. Simple reflections should be used to acknowledge progress or difficulties (such as '*it sounds like it is has been difficult for you*') as well as complex reflections (such as '*you have been able to complete a diary this week and I am wondering if this has made you feel more in control*'). The use of major section summaries enable patients to have a clear narrative of their progress.

There should be an **appropriate ratio of questions to feedback**. A range of open, specific open and closed questions should applied in a funneling technique to elicit specific information about change and how this is impacting on the patient life. Two-way feedback should be used to clarify and confirm information about progress and patient understanding. The practitioner should utilize praise and warmth in order to reinforce patient achievements so that patient should feel motivated and positive about treatment and changes made.

### Checklist-

- Was there a collaborative approach to discussing change?
- Was there a sense of teamwork evident?
- Did the practitioner provide the patient with simple and complex reflections regarding their progress (or problems with progress)?
- Did the practitioner use both capsule and major summaries of progress – or problems with progress?
- Were the reflections and summaries were helpful to the patient?
- Was there an appropriate ratio of questions:feedback to facilitate change?

## Establishing and Maintaining Engagement

**Competency ratings:**

0	No evidence of attempts to engage the patient with the low intensity treatment approach.
1	Inappropriate engagement of the patient, absence of collaboration, absence of summaries. Absence of feedback.
2	Attempts to engage patient in change somewhat evident. Limited use of summaries and reflections. Some collaboration evident. Opportunities to build and maintain engagement regularly missed.
3	Engagement in change evident, some use of summaries. Some capsule summaries and major summaries evident but sporadic in frequency. Feedback evident. Reflections utilized. Collaborative approach present, but problems evident.
4	Clear demonstration of engagement with supporting change. Both capsule and major summaries are used well to support change. Reflections on change present. There is a good level of feedback.
5	As above with regular and very effective use of capsule summaries and major summaries concerning change. Complex reflections concerning change evident. Feedback ratio is very well balanced.
6	As above, even in the face of patient difficulties.



## Interpersonal Skills

The low intensity cognitive behavioral practitioner should demonstrate their interpersonal skills in maintaining therapeutic relationships with patients and in providing an empathetic and containing space for patients to progress with their treatment. The key features of the 'interpersonal skills' item as outlined in the low intensity cognitive behavioral competency scale are as followed:

### Key features:

- Emphasizes through verbal communication
- Non-verbal communication
- Normalizing and non-judgmental stance
- Warmth and compassion
- Pacing

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

A competent practitioner should also demonstrate their interpersonal skills in **non-verbal communication skills**, such as maintaining eye contact, using appropriate facial expressions, having an open posture, and considering the seating arrangements. The practitioner should ensure that their note keeping does not get in the way of their therapeutic skills.

The practitioner should be able to convey **warmth and compassion** with the patient. This should enable the patient to feel contained and comfortable to discuss their problems and progress within the session. Problems with progress should be appropriately normalized and not dismissed and progress should be discussed in a positive and motivating manner.

**Pacing** should be patient-centered and flexible in treatment sessions. The practitioner should be able to follow the session agenda, as well as ensuring the patient has time to talk through any issues needed. The session needs to cover all the items agreed on the agenda without harriving the patient.

### Checklist-

- Did the practitioner create a positive and helpful relationship?
- Did the practitioner have an empathetic and warm approach?
- Was the practitioner's body language appropriate?
- Was normalization used appropriately?
- Did you feel that the practitioner gave the patient enough time to talk and think?
- Was the practitioner patient-centered and adapted the session to the patient's needs?
- Was the pacing appropriate to facilitate change?

### 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 or inappropriate pace. Lack of warmth. Absence of normalizing.
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.
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 but this is inconsistent. Non-judgmental attitude evident. Some attempts to normalize patient distress. Some clarification evident. Pacing a little inconsistent.
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.
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 clarification and feedback evident.
6	As above, even in the face of patient difficulties.

### Information Gathering: Specific to Change

The low intensity cognitive behavioral practitioner should demonstrate their competency in gathering information from the patient regarding the changes made and progress achieved over the course of treatment in a positive and considerate manner. This should be responsive to a joint awareness of where the patient is in the treatment contract. The key features of the 'information gathering: specific to change' item as outlined in the low intensity cognitive behavioral competency scale are as followed:

#### Key features:

- Problem statement review
- Review of goal progress
- Review of medication (if appropriate)
- Risk review
- Outcome monitoring
- Homework review

The practitioner should **review the problem statement** to determine how the patient is progressing with the treatment and to determine whether the statement still provides an accurate summary of the problem. The practitioner should help the patient identify any progress and changes here and compare this to the statement to facilitate the recognition of change and improvement. This is NOT a check of the accuracy of the original statement, but rather a yardstick of change. In the absence of change or improvement the practitioner should emphasize and acknowledge the challenges face and consider how the treatment may need to be adapted.

There should be a **review of the patient's goals**. The practitioner and patient should discuss how the treatment is progressing to meet these goals as well as ascertaining whether they are still appropriate to the patient. In the absence of change or improvement the practitioner should emphasize and acknowledge the challenges face and consider how the treatment may need to be adapted.

If appropriate the practitioner should **review medication use** (i.e. if the patient is taking a medication).

Practitioners should determine the patient's **current level of risk** via a risk review and also respond appropriately to any change in risk status. Risk review should include clarification of intent, presence and nature of suicidal thoughts, thoughts of self-harm, plans, actions, access to means and summary of protective factors. Changes to other risk factors such as alcohol, substance misuse, and risk to/from others should also be reviewed. Absence of risk assessment leads to an automatic 0 score.

**Outcome measures** should be completed during the session and the results should be discussed to understand if any changes have been made or to highlight any further areas of concern. Scores need to be compared with base and subsequent sessions. In the absence of change and improvement, or deterioration, the practitioner should acknowledge and discuss the challenges and consider how the treatment may need to be adapted.

The practitioner should ensure that the patient's **homework is effectively reviewed** and discussed. The practitioner should encourage the patient to feel an active participant in the treatment process and to feel positive about the changes they have made at between the sessions. The practitioner should facilitate the patient in problems solving at barriers to engagement in between session work, where necessary utilizing the COM-B model.

Checklist-

- Did the practitioner identify and review the problem statement and progress made by the patient?
- Did the patient and practitioner come to a shared understanding of progress (or lack of progress) made?
- Was the patient was involved in reviewing their problems and progress?
- Was there a review of risk?
- Was there a review of the patient's medication use (if taking medication)?
- Was the homework effectively reviewed?
- Were outcome measures completed by the patient and results fed-back in a useful manner?

### Information Gathering: Specific to Change

Competency ratings:

0	No evidence of information gathering demonstrated. No risk review. No homework review.
1	Inappropriate information gathered, major omissions of information, questioning style inappropriate. Absence of review of problems statement. No review of goals. Limited homework review. No outcome measures completed. Risk not well reviewed.
2	Some evidence of information gathering evident. Problem statement reviewed, but major problems evident e.g. unilateral review with patient not encouraged to elaborate on progress. Goals unilaterally reviewed. Homework briefly reviewed, but patient unable to elaborate and opportunities to consider learning and change missed. Risk review covered, but lacking in appropriate or indicated depth and detail.
3	Problem statement reviewed and progress discussed. Goals are reviewed. The impact of progress on functioning is considered. A risk review is completed, but subsequent indicated actions a little neglected. Outcome measures are completed, but not well fed back. Medication reviewed, if appropriate. Some evidence of application of COM-B (e.g. consideration of 1 factor). Competent review of homework.
4	Problem statement, goals and homework reviewed collaboratively with evidence of facilitation of recognition of progress or challenges. Risk review evident and subsequent actions taken. Medication reviewed, if appropriate. Outcome measures integrated into session well. Good review of homework. Consideration of 2 factors of COM-B model.
5	Problem statement, goals and homework reviewed effectively and collaboratively with evidence of effective facilitation of recognition of progress or challenges. Risk review evident and subsequent actions taken. Medication reviewed, if appropriate. Detailed and clinically useful review of homework. Recognition and application of all 3 elements of COM-B appropriate to stage of treatment. Sensitive and meaningful integration of outcome measures into the sessions.
6	As above, even in the face of patient difficulties.

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### Within Session Self-Help Change Methods

The low intensity cognitive behavioral practitioner should demonstrate their competency in delivering low intensity cognitive behavioral treatment methods based on facilitating the self-management by the patient of the problem. There needs to be a clear low intensity change method apparent in the session that would help or does help the patient to self-manage their difficulties in a more effective manner. The session should not drift into a high intensity intervention. The key features of the 'within session self-help change' item as outlined in the low intensity cognitive behavioral competency scale are as followed:

#### Key features:

- Appropriateness of low intensity intervention
- Adherence to principles of low intensity treatment (e.g. providing educational materials for use in session)
- Lack of drift into a high intensity approach (e.g. counselling)
- Understanding and delivery of rationale for treatment intervention
- Evidence of a low intensity change method (e.g. thought diaries, BA planner sheets)

The practitioner should ensure that the treatment method is **appropriate** for the patient based on their problem, as well as other factors including the evidence base, stage of treatment, patient's preference, suitability to their life style and their motivation level. Practitioners should support patients in accessing a different self-help approach, when progress is evidently not being made.

The practitioner should be **adhering to the treatment principles** to ensure prevention of drift and so that the patient is not provided with an unsuitable or high intensity intervention. The practitioner should show a patient-centered, flexible approach in delivering the self-help as well as demonstrating a good understanding of the delivery of the treatment methods themselves.

The practitioner should revisit and reiterate (when appropriate) the **rationale** for treatment **using written methods** such as diaries, graphs, ABC and the 5- areas.

The **change method** needs to be appropriate for the stage of treatment, the disorder and be in keeping with facilitating better self management by the patient.

#### Checklist-

- Did the practitioner provide an appropriate treatment intervention?
- Was the rationale clearly revisited or presented to the patient?
- Did the practitioner have good knowledge of the treatment used?
- Did the practitioner adhere to low intensity treatment principles?
- Did the practitioner demonstrate an appropriate and clear use of written materials?

**Please refer to the *treatment model competencies* section of this manual for treatment specific ratings.**

Note: Where more than 1 intervention is applied during a session, the main intervention should be graded using the competency rating tool. This should also be considered with the pacing of the session.

## Within Session Self-Help Change Methods

### Low Intensity Treatment Competencies

#### **Behavioral Activation**

Behavioral activation is an evidence-based intervention used at step 2 particularly in the treatment of depression. BA may be used at times effectively with other difficulties. The key features of BA are: targeting avoidance, re-establishing routine, increased pleasurable activity and re-engaging in necessary activity. There are 6 BA steps at step 2 (please note that the session rated may contain one or a number of steps and does not need to include all the steps):

Step 1 – Explaining behavioral activation

Step 2 – Identification of routine, necessary and pleasurable activities

Step 3 – Making a hierarchy of routine, necessary and pleasurable activity

Step 4 – Planning routine, necessary and pleasurable activity

Step 5 – Implementing behavioral activation exercises

Step 6 – Reviewing progress

#### Competency ratings:

<b>0</b>	<b>Incompetent BA</b>
<b>1</b>	BA techniques considered within in session but without rational, inappropriate behaviours focused on, absence of generation of new behavioral patterns. COM-B absent.
<b>2</b>	An attempt at BA is made but intervention is not in line with problem statement and/or patient goals. Absence of relevant steps of intervention e.g. absence of rational, planning or implementing behavioral changes. Very limited use of COM-B.
<b>3</b>	BA evident. Rationale given. Intervention is suitable for patient goals and problem statement. Links between feelings and behaviours elicited. Steps in intervention adhered to. Some problems are evident in the application. Some use of COM-B.
<b>4</b>	BA evident, rationale explained to patient, learning around links between feelings and behaviours are elicited and explored, leading to good patient understanding of their relationship to each other. Barriers to behavioral change explored. Good use of COM-B.
<b>5</b>	Very good application of BA technique, patient centred, key learning investigated with the patient. Good rationale given and feedback elicited from patient regarding their understanding. Collaborative planning and implementation of behavioral changes. Excellent use of COM-B.
<b>6</b>	Expert low intensity BA. Excellent eliciting of key learning regarding feelings and behaviours and their relationship to each other, appropriate and collaborative behavioral plans developed and implemented, even in the face of difficulties. Excellent use of COM-B.

**Cognitive restructuring**

It is acknowledged that thoughts are an important component of emotions, alongside the physical and behavioral symptoms. Cognitive restructuring is a way of influencing mood by targeting unhelpful thoughts via a process of identification and challenging.

There are three stages to step 2 cognitive restructuring (please note that the session rated may contain one or a number of steps and does not need to include all the steps):

Stage 1 – Identification of thoughts – use of recent incident analysis of emotional experience to identify thoughts and emotions. Identification and rating of ‘hot thought’

Stage 2 - Looking for evidence – in support and against the hot thought

Stage 3 – Reconsidering thoughts – in line with evidence collected, the patient generates alternative thoughts and rate belief in this thought.

**Competency ratings:**

<b>0</b>	<b>Incompetent cognitive restructuring</b>
<b>1</b>	Some discussion of thoughts but PWP fails to elicit appropriate thoughts, or key cognitions not explored, emotions not discussed. No use of COM-B.
<b>2</b>	Some cognitions highlighted and emotions identified but links not explored with patient and rational not clear. No ratings of thoughts or emotions present. Limited use of COM-B.
<b>3</b>	Cognitions identified, emotions identified, process of looking for evidence completed and generation of alternative thought achieved. Limited focus on emotions and some problems evident. Some use of COM-B.
<b>4</b>	Clear stage of cognitive restructuring evident, cognitions and emotions elicited and rated. Good explanation of rational. Some learning evident. Good use of COM-B.
<b>5</b>	Very good eliciting and selection of thoughts and feelings. Extensive exploration of emotions, cognitions, evidence and alternative thoughts with the patient through use of PWP intervention. Good rationale given and patient understanding checked. Collaborative and appropriate intervention. Good learning evident. Excellent use of COM-B.
<b>6</b>	Excellent eliciting of key thoughts and feelings and their relationship to each other, appropriate and collaborative intervention, even in the face of difficulties. Change evident in process and content of cognition. Excellent use of COM-B.



**Problem solving**

Problem solving is a systematic, step-by-step evidence-based low-intensity intervention. Patients learn a practical approach to stepping back from problems and consider what solutions might actually exist. Problem solving can be used across anxiety and depression presentations. Problem solving can be divided into seven steps. Please note that the session rated may contain one or a number of steps and does not need to include all the steps.

There are seven stages to step 2 problem solving:

Stage 1 – identify the problem

Stage 2 – identify the possible range of solutions

Stage 3 – analyze strengths and weaknesses of solutions

Stage 4 – select a solution

Stage 5 – plan implementation strategy

Stage 6 – implement the solution

Stage 7 – review the effectiveness of the solution in terms of choice, implementation and effect

**Competency ratings:**

<b>0</b>	<b>No effective structure to problem solving evident or missed opportunity to use problem solving.</b>
<b>1</b>	Identification of problem made, limited discussion of solution but absence of stages of problem solving, not collaborative- advice giving in nature. No evidence of application of COM-B.
<b>2</b>	Identification of problem and some attempts to implement problems solving approach but not including all 7 stages, absence of review and learning. Limited consideration of COM-B.
<b>3</b>	Problem identified and appropriate stage implementation but errors present e.g. problem too general, too PWP lead. Some consideration of COM-B.
<b>4</b>	Appropriate stage or stages of problem solving discussed collaborative on a well-defined problem. Homework to consolidate, minimal problems. Clear evidence of consideration of COM-B.
<b>5</b>	As above but excellent collaboration. Exploration of barriers to implementation of solutions. Skillful application of COM-B, integrated into delivery of intervention.
<b>6</b>	As above, in the face of patient difficulties.

**Exposure**

At step 2, exposure is the planned therapeutic confrontation of feared situation or object. It is a highly effective treatment for many anxiety disorders where behavioral avoidance is a key maintaining factor. Key skills in exposure therapy include explanation of rationale to include psycho education about processes of habituation, development of fear hierarchy, use of subjective units of distress, clear discussion about 4 key principles of exposure (graded, prolonged, without distraction and repeated). Diary records are an essential tool to both schedule and monitor tasks. Please note that the session rated may contain one or a number of exposure stages (e.g. reviewing a stage on the hierarchy and then moving up a stage) and does not need to include all the stages.

**Competency ratings:**

<b>0</b>	<b>Incompetent exposure therapy.</b>
<b>1</b>	Attempt to implement exposure without clear rationale, no discussion about habituation or key principles of exposure. No hierarchy planned and absence of goals. No use of COM-B.
<b>2</b>	Hierarchy developed but limited use of subjective units of distress (SUDS). Brief discussion about habituation, absence of discussion of key principles of exposure. Absence of shared decision making/ collaboration. Limited use of COM-B.
<b>3</b>	Hierarchy developed with adequate use of subjective units of distress (SUDS). Discussion of habituation and key principles present with links to goals and clear rationale evident. Some planning of exposure apparent and supported. Some evidence of application of COM-B
<b>4</b>	As above with excellent discussion of psycho education, key principles and subjective units of distress. Clear and effective planning of exposure apparent and supported. Clear evidence of consideration of COM-B.
<b>5</b>	As above with exploration or barriers to implementing changes. Use of in session subjective units of distress. Very effective planning of exposure apparent and supported. Skillful application and integration of COM-B concepts.
<b>6</b>	As above, in the face of patient difficulties.

**Sleep hygiene**

Sleep hygiene involved the key skills of information gathering and information giving with the aim of promoting the patient to engage in or cease to engage behavioral strategies to promote restful sleep.

There are four key stages to effective sleep hygiene (please note that the session rated may contain one or a number of stages and does not need to include all the stages):

- 1) identify nature of the patients sleep problems
- 2) Provide information about ‘normal’ sleep and the nature of sleep problems
- 3) Psycho education about sleep hygiene
- 4) Review and monitor effects of above.

**Competency ratings:**

<b>0</b>	<b>Incompetent sleep hygiene present in session.</b>
<b>1</b>	Sleep problems highlighted but PWP fails to elicit further detail, explore problems or discuss changes. No evidence of consideration or use of COM-B.
<b>2</b>	Sleep problems identified but with minimal exploration – PWP provides information but without discussion. Limited consideration of COM-B.
<b>3</b>	Sleep problems identified, nature of normal sleep patterns discussed. Barriers to good sleep discussed. Information on sleep provided. Planning of sleep hygiene changes. Some evidence of application of COM-B.
<b>4</b>	As above with clear and discussed discussion about changes patient can make to improve sleep. Effective planning of sleep hygiene changes. Psycho education provided about sleep inhibitors. Clear evidence of COM-B.
<b>5</b>	As above, barriers to making changes explored. Skillful application and integration of COM-B concepts.
<b>6</b>	As above but in face of patient difficulties.

**Physical Activity and Exercise**

Physical activity and exercise (PAE) is an important treatment consideration in low intensity working, particularly in the treatment of depression and is generally a useful adjunct for all patients at step 2. A four-stage approach to using it as an intervention is described below. However, PWP’s may utilize other strategies to bring about change in PAE, which should be considered by the competency assessor. There are four stages in PAE (please note that the session rated may contain one or a number of stages and does not need to include all the stages):

1. Linking PAE and lack of PAE to presenting problem and subsequent psychoeducation about the benefits of PAE.
2. Agree usefulness of intervention for presenting problem utilizing COM-B.
3. Plan what an increase in PAE looks like for the patient (including 4 W’s and considering physical capabilities of patient) and consider potential barriers. Utilization of tools such as planning diaries or mood-PAE monitoring sheets.
4. Review – feedback around intervention, links to COM-B and achievement of goals. Consideration of impact of PAE on presenting problem.

Competency ratings:

<b>0</b>	<b>Incompetent PAE promotion present in session, or no PAE intervention despite request from patient.</b>
<b>1</b>	PAE problems identified, but PWP fails to elicit further detail, explore problems or link to presentation. No evidence of consideration of COM-B or psychoeducation provided.
<b>2</b>	PAE problems identified but with minimal exploration – PWP provides psychoeducation on PAE, but without discussion or link to presenting problem. Limited consideration or use of COM-B.
<b>3</b>	Lack of PAE identified, and role and function of exercise discussed in relation to presenting problem. Barriers to increased PAE discussed. Psychoeducation on PAE provided. Some evidence of application of COM-B in planning increase in PAE.
<b>4</b>	As above with clear and discussed discussion about changes patient can make to improve engagement in PAE. SMART between-session PAE goals are set and linked to presentation. Psychoeducation about exercise provided. Clear evidence of use of COM-B in planning exercise. Minor omissions in delivery of PAE intervention.
<b>5</b>	As above, barriers to making PAE changes explored. Skillful application and integration of COM-B concepts in planning exercise. PAE intervention delivered without omission and appropriate of stage of self-help.
<b>6</b>	As above but in face of patient difficulties.

**Medication support**

A medication support intervention involves the key skills of information gathering and information giving with the aim of promoting effective adherence to medications or collaborative decisions regarding reviewing of medication.

There are three key stages to effective medication management (please note that the session rated may contain one or a number of stages and does not need to include all the stages):

- 1) Gathering information on attitudes to medication, usage, positive outcomes and side effects.
- 2) Provide psychoeducation on appropriate usage and to dispel myths
- 3) Negotiating shared decisions on medication usage.

**Competency ratings:**

<b>0</b>	<b>Incompetent medication support present in session.</b>
<b>1</b>	Medication issues identified but PWP fails to elicit further detail, explore problems or discuss changes appropriately. No evidence of consideration of COM-B.
<b>2</b>	Medication issues identified but with minimal exploration – PWP provides psychoeducation on medication, but without discussion. Limited consideration of COM-B.
<b>3</b>	Medication issues identified, and role and function of medication discussed. Barriers to adherence and side effects discussed. Myths explored. Information provided on medication. Some evidence of application of COM-B in increasing adherence with medications.
<b>4</b>	As above with clear and discussed discussion about changes patient can make to improve adherence with medication. Psycho education about medication and myths discussed. Clear evidence of use of COM-B in increasing adherence to medication.
<b>5</b>	As above, barriers to making changes specifically explored. Skillful application and integration of COM-B concepts in planning increased adherence.
<b>6</b>	As above, but in face of patient difficulties.

**Managing panic**

Within managing panic at step 2 a choice of either exposure therapy or cognitive restructuring intervention are suitable. Where avoidance and safety behaviours are key features of the presenting problem PWP should implement exposure therapy and should be assessed using this item of the rating tool. Where catastrophic misinterpretations are impacting on a patient’s recovery, cognitive restructuring can be applied and this part of the rating tool used to score the session.

**Worry Management**

Use of a worry diary and worry time are a low intensity intervention suitable for patients with generalised anxiety disorder (GAD). Key features of the worry management are PWPs helping patients to notice worrying, categorising worries and then either letting go of hypothetical worries or dealing with the real problems identified by problem solving or engaging in worry time (where the patient worries for a specified period each day).

The stages of the worry management are (please note that the session rated may contain one or a number of stages and does not need to include all the stages):

- Stage 1            Explaining the vicious cycle of worry via the initial 5 areas or producing a new worry vicious cycle
- Stage 2            Psycho-education about the difference between current and hypothetical worries
- Stage 3            Planning the recording of worries in a worry diary (between sessions)
- Stage 4            Classifying worries as current or hypothetical
- Stage 5 a          Letting go of hypothetical worries
- Stage 5 b          Problem solving for current practical worries or engaging in worry time.

**Competency ratings:**

<b>0</b>	<b>Incompetent worry management or absence of the approach when suitable.</b>
<b>1</b>	Worry management techniques considered in the session, but without effective rationale. Limited discussion. No use of 5 areas. COM-B absent.
<b>2</b>	An attempt at worry management, but with major problems evident. Limited evidence of COM-B. Intervention is not in line with the problem statement and/or patient goals. Limited use of 5 areas.
<b>3</b>	Vicious cycle explained (or reviewed); current and hypothetical worries explained; worry diary either explained or reviewed (depending on stage of treatment). Some reviewing of problem solving or worry time (depending on stage of treatment). Some evidence of use of COM-B. Limited focus and some problems evident with consistency.
<b>4</b>	Vicious cycle well explained (or reviewed); current and hypothetical worries well explained or reviewed; worry diary either well explained or reviewed (depending on stage of treatment). Satisfactory reviewing of problem solving or worry time (depending on stage of treatment). Clear discussion of letting go of hypothetical worries. Clear evidence of good use of COM-B.
<b>5</b>	Very good application of worry management, key learning investigated with the patient. Good rationale given and feedback elicited from patient regarding their understanding of current and hypothetical worries. Adaption evident to the stage in treatment. Good reviewing of problem solving or worry time (depending on stage of treatment). Clear helpful discussion of letting go of hypothetical worries. COM-B effectively considered and integrated.
<b>6</b>	Expert low intensity worry management, even in the face of patient difficulties

## Planning and Shared Decision Making

The low intensity cognitive behavioral practitioner should demonstrate their competency in planning actions subsequent to the patient needs, session content and stage of treatment, with consideration of the appropriate evidence base. In addition, practitioners should ensure planning and associated decisions are collaborative and patient-centred. The key features of the 'planning and shared decision making' item as outlined in the low intensity cognitive behavioral competency scale are as followed:

### Key features:

- Agrees next steps of treatment and the associated between session work
- Defines and agrees implementation plan for between session work
- Session review and ending

The practitioner should work with the patient to discuss and agree on appropriate **plans and actions**. These should be specific, realistic and achievable and the patient should understand the rationale of why it would be useful to follow the plan. The plans should sequence with the plans made from previous session (e.g. moving up to the next stage of the exposure hierarchy).

**Between session work** should be discussed, defined and agreed to ensure that the patient continues the process of treatment. There should be a useful degree of specificity to the actions agreed (e.g. defining the features of the actions planned). Barriers to completion should be considered and where appropriate the factors of the COM-B model integrated.

The practitioner should **end the session** leaving the patient with a clear plan around the next steps in their treatment. A brief session summary should be presented. The patient should leave the treatment session feeling optimistic and confident about their progress and willing to attend the subsequent sessions.

### Checklist-

- Did the practitioner collaborate on and then summarize the next steps of treatment?
- Was there a clear rationale for the next stage of treatment?
- Were barriers to completing the between session work completion considered?
- Did the practitioner appropriately end the session?
- Was there a session summary?

## Planning and Shared Decision Making

### Competency ratings:

0	No evidence of shared decision making or planning. Fails to achieve an agreed outcome to the session. No summary of session. No action plan.
1	Inappropriate decisions made about treatment. Decisions made unilaterally by the practitioner without collaboration with patient. Rationale not discussed or outlined. Ignorance of stage of treatment evident. Session ended abruptly. 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. Some awareness of stage of treatment during planning. Session ends without summary. Limited use of COM-B.
3	Appropriate outcome and treatment chosen. Some evidence of inclusion of patient within decision making process. Between session work agreed. Ending of session evident with vague agreement for next steps. Some evidence of use of COM-B features (e.g. opportunity considered but does not consider motivation or capability). Stage of treatment considered during planning.
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. Barriers to homework completion are considered. Planning is appropriate for stage of treatment.
5	As above with regular excellent end of session summary, concise and well informed rationale, collaboration and shared decision making evidenced. 3 elements of COM-B are considered and this is effectively discussed with regards to consideration of between session works. Plan integrated with stage of treatment and previous plans.
6	As above, even in the face of patient difficulties.