A competence framework for psychological interventions with people with personality disorder

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The competences described in this report are designed to be accessed online and can be downloaded from www.ucl.ac.uk/CORE/

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Executive summary
The report describes a method for identifying competences for staff working with people with personality disorder. It organises the competences into six domains, with an overarching domain that identifies the 'therapeutic stance, values and assumptions' for work in this area. The domains are:

Core underpinning competences for work with people with personality disorder

Generic therapeutic competences required for managing clinical sessions and any form of psychological intervention

Assessment and Formulation competences

Structured Clinical Interventions

Specific interventions

Meta-competences – overarching, higher-order competences which practitioners need to use to guide the implementation of any assessment or intervention.

The report then describes and comments on the type of competences found in each domain, and organises these into a 'map' which shows how all the competences fit together and inter-relate. Finally it addresses issues that are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

A competence framework for working with people with personality disorder

How to use this document

This report describes the model underpinning the competence framework, and indicates the various areas of activity that, taken together, represent good clinical practice. It describes how the framework was developed and how it may be used.

The report does not include the detailed descriptions of the competences associated with each of these activities. These are available to download as pdf files from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE/)

A note on implementation

This framework was developed as part of the Severe Mental Illness initiative of the Improving Access to Psychological Therapies programme (along with a separate, but linked, competence framework for working with individuals with psychosis and bipolar disorder).

Effective care for most people with personality disorder usually requires sustained multi-disciplinary input provided in the context of specialist mental health services. Both of these emphases are reflected in this competence framework.

Although the current framework has some overlap with those developed for the IAPT programme for the management of depression and anxiety disorders (Department of Health, 2007; Roth and Pilling, 2008), work with these client groups is essentially primary care focused, and is based on a stepped-care model.

This means that the competences required to deliver psychological interventions in each context are different, and this framework should not be seen as endorsing the provision of psychological care for severe mental illness within those IAPT services whose primary purpose is to provide psychological interventions for depression and anxiety disorders.

Scope of the competence framework

Clients to whom the framework applies
It is widely acknowledged that "personality disorder" is a very broad term covering a wide range of presentations, and that diagnostic systems are an imperfect representation of the difficulties with which individuals present. A high percentage of individuals diagnosed with one personality disorder meet criteria for another, along with coexisting (or comorbid) diagnosable mental health conditions and presentations. The Expert Reference Group debated whether diagnostic systems were a helpful way of shaping the architecture of the framework. There was agreement that in practice interventions often need to be tailored less to a diagnosis (or diagnoses) but more to the range of difficulties with which individuals present. As such much of this framework is relevant across the range of personality disorders. Nonetheless it is worth noting that the clinical trials that constitute the evidence-base for the specific psychological therapies contained in the framework are largely focused on work with people with Borderline or Antisocial Personality Disorders.

Staff to whom the framework applies
The framework is designed to be relevant to staff in a range of clinical settings – it defines clinical knowledge and skills relevant to a range of professions, including clinical psychologists, psychiatrists[1], psychotherapists, family therapists, nurses, occupational therapists and social workers).

Areas of clinical work covered by the framework
The competence framework is focused primarily on clinical work, and excludes service management and development skills. Audit and research skills are not specified in depth, though the ability to make use of measures (and to monitor outcomes) is identified as a core clinical skill, as is the ability to make informed use of the evidence base relating to therapeutic models.

Role of supervision in supporting the implementation of the framework
Supervision plays a critical role in supporting competence practice, and the ability to make use of supervision is included in the framework. Competences associated with the delivery of supervision are detailed in a separate framework, available on the CORE website (www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm).

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[1] Specialist skills relating to prescribing medication are not detailed in the framework; these have been specified by the Royal College of Psychiatrists as part of the training curriculum for psychiatrists (Royal College of Psychiatrists (2010) A Competency Based Curriculum for Specialist Training in Psychiatry: www.rcpsych.ac.uk/training/curriculum2010.aspx)

The development of the competence framework

1. Oversight and peer-review: The work described in this project was overseen by an Expert Reference Group (ERG) comprising experts in work with people with personality disorder from the UK, selected for their expertise in research, training and service delivery (the ERG membership is detailed in Appendix A). The ERG met regularly throughout the project to ensure that key texts, policy documents, service user documentation, and trial manuals were identified, advise on process, and to debate and review materials as they emerged.

In addition to review by the ERG, competence lists for specific areas of clinical activity and for specific interventions were reviewed by individuals identified as having particular expertise (on the basis of having published widely in an area of clinical activity, or as the originator or developer of the approach being described in the competence list). This process of open and iterative peer-review ensured that the competence lists were subject to a high level of scrutiny (peer reviewers are listed in the acknowledgments section).

2. Incorporating service user perspectives: Incorporation of the service user perspective was ensured by including service users as members of the ERG and by drawing on relevant literature which describes service users' experiences of being in receipt of the interventions on which the framework was based.

3. Adopting an evidence-based approach to framework development[2]: A guiding principle for the development of previous frameworks (Roth and Pilling 2008) has been a commitment to staying close to the evidence-base for the efficacy of therapies, focussing on those competences for which there is either good research evidence or where this is limited, strong expert professional consensus about their probable efficacy.

While we have applied this principle to this framework, it is important to note several important issues in relation to the evidence-base for work with people with personality disorder (all of which needed to be taken into account):

> a) <u>Number of published research trials:</u> Although an area of active research, there are relatively few randomised controlled trials examining the efficacy of

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[2] An alternative strategy for identifying competences could be to examine what workers in routine practice actually do when they carry out a psychological intervention, complementing observation with some form of commentary from the workers in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological interventions are rooted in a theoretical framework which attempts to explain human distress, and this framework usually links to a specific set of actions aimed at alleviating the client's problems. It is these more 'rigorous' versions of an intervention that are examined in a research context, forming the basis of any observations about the efficacy of an approach or intervention. In routine practice these 'pure' forms of an intervention are often modified as workers exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which does not reflect the model they claim to be practising. This is not to prejudge or devalue the potential benefits of eclectic practice, but it does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice

psychological interventions in people with personality disorder. Consonant with guideline methodology the ERG examined the evidence and debated how best to manage where the absence of high quality evidence had implications for inclusion of an approach in the framework. Clearly an over-reliance to the current limited evidence base could narrow inclusion to a point where the range of interventions being described did not reflect those in common use; equally, adopting a low threshold could invalidate any claim to an evidence-based approach. As a consequence of the approach taken there is some restriction in the range of specific interventions included in the present framework, but it is important to acknowledge that this is a rapidly developing field with a number of trials in progress, and as the nature of the evidence changes over time this will need to be reflected in revisions of the framework.

b) Importance of, and evidence for, core, generic therapeutic and assessment and formulation skills: There is a clear professional consensus that interventions in this area rest on a set of 'underpinning' skills (core and generic therapeutic competencies), as well as a set of assessment and formulation skills. Denoting the former as 'underpinning' skills should not be taken to indicate that they are simple or easy to deploy. For example, knowing how to adapt collaboratively engage with someone who may be highly sensitive to rejection or at risk of serious self harm is far from straightforward. Providing psychological interventions in the context of a complex care package in multi-disciplinary team requires considerable skill and knowledge. However, there is often little *direct* evidence of the benefit of these skills from randomised control trials or from other types of study, possibly reflecting researchers' understandable reluctance systematically to manipulate clinician behaviour in this area, and also because researchers may assume that the inclusion of these elements in an intervention does not need to be explored further. However, although evidence on the causal contribution of underpinning and assessment skills is lacking, correlational studies have established the importance of several of the areas included in the framework (notably the importance of the therapeutic relationship to outcome (e.g. Horvath, Del Re, Flückiger & Symonds,2011; Shirk, Carver & Brown, 2011). Within the assessment field, evidence of the accuracy of the diagnostic process has been gathered through measuring the reliability and validity of standardised tests, scales and interview schedules (all of which are usually accompanied by detailed guidance for their delivery, equivalent to a therapy manual). Nonetheless, in the main the inclusion of specific "underpinning" skills usually rests on expert professional opinion and consensus rather than evidence.

c) Lack of formal evidence in basic areas of practice: Reinforcing the sense that many 'underpinning' and assessment skills are assumed to be critical to effective clinical practice and treatment delivery, most treatment manuals make general reference to their application; however they rarely detail the specific skills involved. As a consequence the competency team needed to draw on a range of resources to generate lists of relevant skills, including diagnostic manuals and textbooks, training materials and (where gaps in the lists remained) their own

clinical experience. As such this becomes a process led by professional judgement and experience rather than experimental studies, making peer review (described above) especially critical.

These issues all have bearing on the capacity of the framework to stay as close to the evidence base as possible, and in practice research has had to be is supplemented by expert professional consensus, congruent with models of evidence-based practice (e.g. Roth, Parry and Fonagy, 2005), and with the methodology adopted by NICE for clinical guideline development (NICE (2012).

4. Inclusion and exclusion of specific interventions

An initial task for the ERG was to identify those interventions with evidence of efficacy, based on outcomes obtained in clinical controlled trials. This scoping exercise was based on extant clinical guidelines and reviews of the available evidence, in particular relevant NICE and SIGN clinical guidelines.

This exercise identified those interventions for which there was good evidence of efficacy, and which therefore needed to be included. However, the ERG also identified a number of interventions which warranted inclusion because:

a) Evidence for an intervention had not been published prior to the publication of the relevant NICE or SIGN guideline and this precluded its inclusion in the relevant guidance (e.g. psychoeducational interventions such as the STEPPS programme) and therefore precluded their inclusion in the relevant guidance.

b) The intervention is a development of an existing intervention already included in an existing NICE/SIGN guideline (e.g. structured clinical management)

c) The intervention is established in routine NHS practice, has a sound theoretical base and there was emerging evidence for its efficacy (e.g. recently completed trials and/or trial(s) in progress which would warrant its inclusion (e.g. Cognitive Analytic Therapy[3];)

The ERG noted that decisions about inclusion or exclusion of particular approaches will change over time, as new evidence becomes available and our knowledge of the efficacy of specific interventions improves. This flags an important point - that the exclusion of an intervention should not be taken to indicate that it is ineffective, but only that at present lack of evidence for its efficacy does not support its inclusion at this time.

It should also be noted that in contrast to modality specific competence frameworks (which focus on the uni-professional delivery of an intervention) the model recognises the central importance of providing interventions in a multi-professional context, and this is reflected in the content of both the core and generic competences.

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[3] For example Clarke, Thomas & James (2013)

5. Extracting competence descriptions

"Underpinning" competences (Core Competences, Generic Therapeutic Competences, Assessment and Formulation Competences) As noted above, professional consensus indicates that effective practice requires clinicians to deploy "underpinning" competences and assessment and formulation skills. However, because these are not well-specified in manuals The process of competency extraction involved the following steps:

i. The core team generated an initial set of high-level descriptors that characterise areas of clinical and professional activity within each domain, drawing on:

- literature which contains behavioural descriptions of the relevant skills, such as textbooks, professional guidance materials, manuals and teaching materials
- other related competence frameworks developed by the UCL team which include broad descriptions of 'underpinning' and assessment skills,(in particular the frameworks for child and adolescent mental health services and for the delivery of CBT for depression and anxiety disorders).

Examples of these high-level descriptors within the domain of core competences include 'the Ability to Work Within and Across Agencies', or '"Knowledge of Common Physical Health Problems in People with Psychosis and Bipolar disorder"

The scope and implied content of these descriptors were debated by the ERG; through iterative review the areas of competence considered to constitute underpinning competences and assessment and formulation skills were agreed.

ii. An initial set of competence statements for these areas was generated by the core team, and subjected to internal review to check for accuracy, completeness and clarity.

iii. Each competence list was discussed and peer-reviewed by members of the ERG and by external experts, identifying omissions and any points of contention.

b) Specific interventions
The basis for inclusion of specific interventions is evidence of efficacy in a research trial, and most such trials will have developed or adopted a manual that describes the treatment model and associated treatment techniques. The manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Many research trials monitor therapist adherence (by assessing audio or video recordings), making it possible to be reasonably confident that if the procedures set out on the manual are followed there should be better outcomes for clients.

The procedure for extracting competences starts by identifying representative trials of an effective technique (bearing in mind that in some areas more than one research group may be publishing data on the same or a closely related intervention package). The manuals associated with these successful approaches are identified; where there is more than one manual describing the same 'package' a decision made as to whether there is overlap between the approaches (in other words, whether they are variants of the same approach) or whether there are distinctive differences (justifying a separate competence list for each). Finally, the manuals are examined in order to extract and to collate therapist competences – a process detailed in Roth and Pilling (2008). As described above, draft competence lists were discussed by members of the ERG and subject to peer-review by members of the ERG and by external experts.

The competence model for personality disorder

Organising the competence lists

Competence lists need to be of practical use. To achieve this they need to be structured in a way that reflects the practice they describe, be set out in a structure that is both understandable (in other words, is easily grasped) and be valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into seven domains.

"Underpinning" skills

Core competences for work with people with personality disorder

Generic Therapeutic Competences

Assessment and formulation skills

Assessment

Formulation and planning

Interventions

General Clinical care

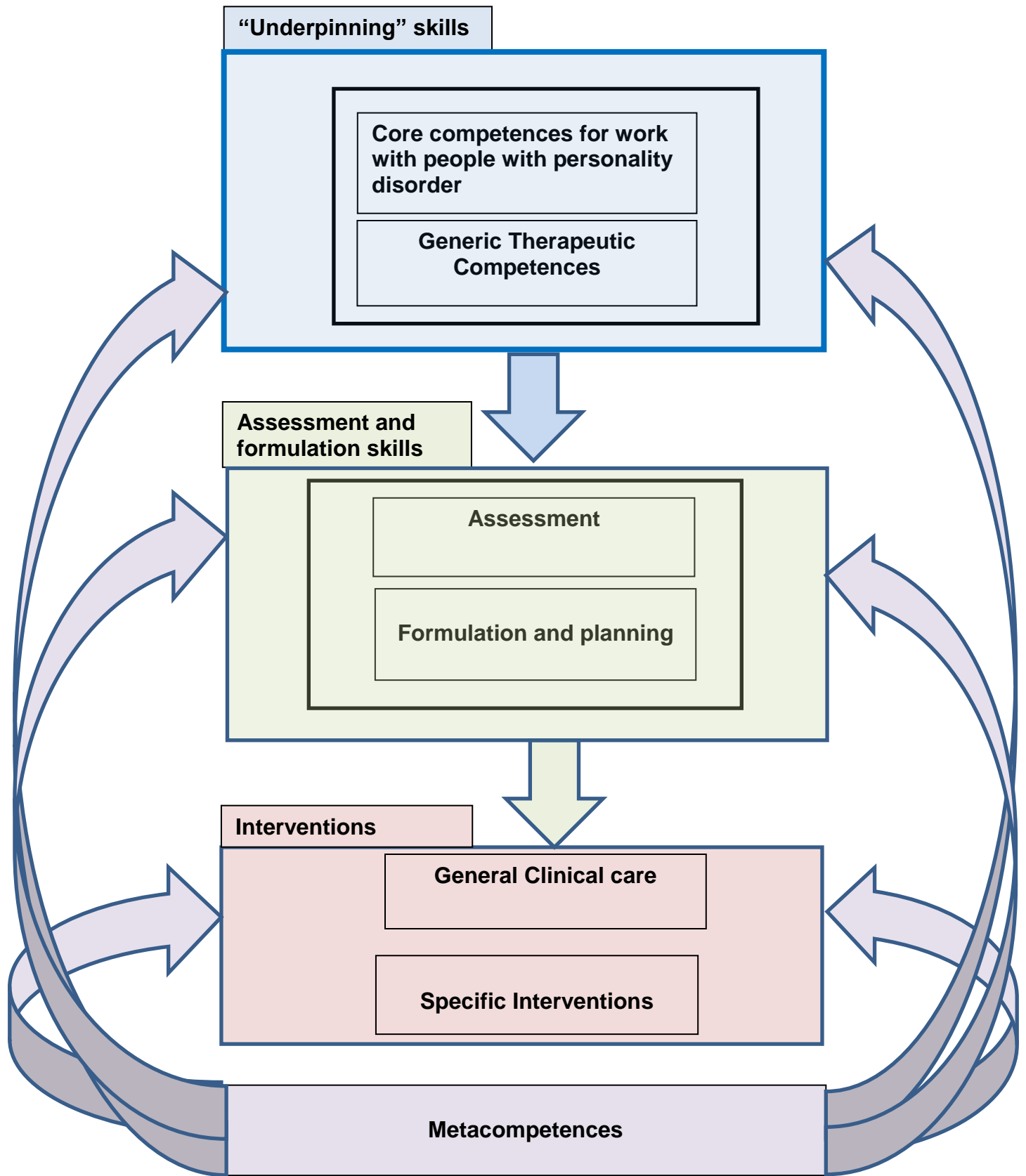Specific Interventions

Metacompetences

Figure 1 – Outline model for the Personality Disorder Framework

The whole framework rests on two domains of 'underpinning' competences. The first is '**Core Competences For Work With People with Personality Disorder**' which identifies the knowledge needed by staff a) to understand the nature of presenting problems in this area of work b) to apply the professional and legal frameworks which exercise governance over service procedures c) to work within an agreed framework for confidentiality and consent d) to understand and be able to assess capacity e) to work with difference f) to liaise with colleagues and other agencies, g) to work with families and significant others h) to apply knowledge of common physical health problems in people with personality disorder and g) the pharmacological treatment of these presentations. The second domain ('**Generic Therapeutic Competences**') identifies the competences required to manage clinical sessions and any form of psychological intervention including collaborative engagement and fostering a therapeutic alliance. Taken together, the skills in these two domains should be demonstrated by all staff working psychologically with people with personality disorder; their description as "underpinning" skills draws attention to the fact that they secure the integrity of all subsequent assessments and interventional procedures.

The next domain relates to **assessment, and formulation and planning**. Assessment competences focus both on the ability to undertake a comprehensive assessment and on risk assessment, as well as the ability to undertake an assessment in the context of the multiple systems to which clients are exposed. The section on formulation and planning recognises the importance not only of developing a formulation, but also the capacity to communicate this to all relevant parties and to coordinate work with the various agencies involved in an individual's care, thereby ensuring the effective delivery of any intervention.

Psychological interventions are divided into two main domains, both of which share a common therapeutic stance or approach to the provision of psychological interventions. The first focuses on **Generic Structured Clinical Interventions,** including structured clinical care, programmes for psycho-education and problem solving, and consulting to teams and individuals working with personality disorder. The second domain describes **psychological therapies** specifically developed to help people with personality disorder,
.
The final domain in the model focuses on 'Meta-competences', so-called because they permeate all areas of practice, from "underpinning" skills through to specific interventions. Meta-competences are characterised by the fact that they involve making procedural judgments – for example, judging when and whether something needs to be done, or judging the ways in which an action needs to be taken or to be modified. They are important because these sorts of judgments are seen by most clinicians as critical to the fluent delivery of an intervention; effective implementation requires more than the rote application of a simple set of "rules": meta-competences attempt to spell out some of the more important areas of judgment being made.

Specifying the competences needed to deliver effective assessments and interventions

Commonalities across approaches

People with personality disorder frequently report that their experiences with clinical services have been difficult and sometimes unhelpful. Often they feel that their needs and difficulties have not been responded to, and that they have been rejected by services and clinicians. There may be many reasons for this, but such problems will be compounded where clinical staff do not have had the knowledge, skills and resources to respond appropriately, or where services do not have the appropriate level of structure and organization to identify and manage the needs of people with personality disorder.

In the development of this framework some important and common themes emerged as critical features of effective interventions, whether this comprises basic support or a specific psychological intervention. These can be summarized as follows:

- clinical work should take place in an organisational context where clients and clinicians can feel safe, usually because there is a clear service structure with agreed protocols and explicit therapeutic boundaries that are understood and agreed by both clinicians and clients
- where the service offers active supervision for the work that clinicians are undertaking.
- engaging clients in the intervention is a critical step, usually achieved by developing a collaborative therapeutic relationship that helps them feel understood and that allows them to experience themselves as an active participant in their treatment.
- acknowledging the client's often very troubling and difficult experiences and history is crucial, and clinicians need to become skilled in validating the client's experience and their ways of understanding these experiences, while also helping them to consider alternative (and more effective and adaptive) ways of approaching their difficulties.
- clients with personality disorder can be at risk of placing themselves and others at significant risk of harm, and clinicians and services need to be organised in a way that ensures that risk is both monitored and responded to, and that there are plans in place for managing and containing crises when these occur.

Integrating knowledge, skills and attitudes

A competent practitioner brings together knowledge, skills and attitudes. It is this combination which defines competence; without the ability to integrate these areas practice is likely to be poor.

Practitioners need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence.

Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about *how* to implement their skills, but also *why* they are implementing them. Beyond knowledge and skills, the practitioner's attitude and stance to an intervention is also critical – not just their attitude to the relationship with the client, but also to the organisation in which the intervention is offered, and the many cultural contexts within which the organisation is located (which includes a professional and ethical context, as well as a societal one). All of these need to be held in mind, since all have bearing on the capacity to deliver interventions that are ethical, conforms to professional standards, and which are appropriately adapted to the client's needs and cultural contexts.

The map of competences

Using the map
The competence map is shown in Figure 2. It organises the competences into the seven domains outlined above and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

The map shows the ways in which the activities fit together and need to be 'assembled' in order for practice to be proficient. A commentary on these competences follows.

Some sections of the map are shaded in order to show which sections apply to all staff providing psychological interventions, and which to staff with specific training, as follows:

Blue and orange shading:	Competences in these areas should be demonstrated by all staff providing psychological interventions for people with personality disorder
Green and no shading:	Competence in these areas should be demonstrated by those clinicians who have had the appropriate training and supervision to carry out the specific interventions that are listed in these sections.

Layout of the competence lists

Specific competences are set out in boxes.

Most competence statements start with the phrase "An ability to…", indicating that the focus is on the clinician being able to carry out an action.

Some competences are concerned with the knowledge that a practitioner needs to carry out an action. In these cases the wording is usually "An ability to draw on knowledge…". The sense is that practitioners should be able to *draw* on knowledge, rather than having knowledge for its own sake (hence the competence lies in the application and use of knowledge in the furtherance of an intervention).

As far as possible the competence descriptions are behaviourally specific – in other words, they try to identify what a clinician actually needs to do to execute the competence.

At a number of points the boxes are indented. This usually occurs when a fairly high-level skill is introduced, and needs to be 'unpacked'. In the example below, the high level skill is the notion of being "collaborative and empowering"; what follows are concrete examples of the sorts of things a clinician needs to do to achieve this.

An ability to work in a manner that is consistently collaborative and empowering, by:
translating technical concepts into "plain" language that the client can understand and follow
taking shared responsibility for developing agendas and session content

The competences in indented boxes usually make most sense if practitioners hold in mind the high-level skill that precedes them. So with the same example, although using the language of the client is always a sensible thing to do, there is a very good conceptual reason for doing this: it will impact on (and therefore contribute to) clients' sense of being understood, and thereby support their engagement in the therapy process. Bearing in mind the conceptual idea behind an action should give clinicians a 'road map', and reduce the likelihood that they apply techniques by rote.

Core competences for work with individuals with Personality Disorder (PD)

Knowledge of the range of presenting and diagnostic issues in individuals with PD

Ethical and legal issues

Knowledge of legal frameworks relating to working with individuals with PD

Knowledge of, and ability to operate within, professional and ethical guidelines

Knowledge of, and ability to work with, issues of confidentiality and consent

Knowledge of, and ability to assess, capacity

Professional skills and values

Ability to work with difference

Ability to operate within and across organisations

Ability to engage and work with families and significant others

Knowledge of psychopharmacology in individuals with Personality Disorder

Knowledge of common physical health problems in individuals with PD, and their management

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Therapeutic stance, values and assumptions

Generic Therapeutic Competences

Knowledge of models of intervention, and their employment in practice

Ability to collaboratively engage clients with the treatment model & options

Ability to foster and maintain a good therapeutic alliance and grasp the client's perspective and world view

Ability to understand and respond to emotional content of sessions

Ability to manage endings and service transitions

Ability to make use of measures (including monitoring of outcomes)

Ability to respond to and manage crises

Ability to deliver group-based interventions

Ability to make use of supervision and training

Assessment & formulation

Assessment

Ability to undertake a comprehensive assessment

Ability to assess the person's functioning within multiple systems

Ability to undertake risk assessment and management

Formulation and planning

Ability to develop a formulation

Ability to feedback the results of assessment and agree an intervention plan with all relevant parties

Ability to co-ordinate casework or intervention across different agencies and/or individuals

General clinical care

Generic structured clinical care

Psychoeducation and Problem Solving
———
STEPPS programme
PEPS programme

Consulting to individuals and teams regarding clients with personality disorder

Specific psychological therapies

CBT for Personality Disorder

Schema-focused CBT

Dialectical Behaviour Therapy

Mentalisation-Based Therapy

Transference Focused Psychotherapy

Interpersonal Group Psychotherapy

Cognitive Analytic Therapy

Management of co-existing issues (depression, anxiety, substance misuse, trauma, eating disorders, learning disabilities, psychosis, other personality disorders)

Meta competences

Meta-competences for work with people with PD

An outline of the framework

Core competences for work with people with personality disorder

Knowledge of the range of presenting issues & diagnostic criteria in people with personality disorder

Knowledge of mental health problems (including not only personality disorder but also co-existing conditions such as depression and anxiety) is fundamental to assessment and intervention: it guides the practitioner's understanding of the person's needs, and forms an important foundation for a treatment intervention. It also facilities an understanding of the likely impact the disorder on a person's functioning both interpersonally and occupationally, and helps to define and understand what an improved sense of self or well-being can mean to an individual.

Ethical and legal issues

This includes four areas:

> **Knowledge of legal frameworks relating to working with people with personality disorder**
> Clinical work with people with serious and long-term mental health problems is underpinned by knowledge of the legal frameworks and policies that apply to the settings in which interventions take place. Practitioners also need to draw on knowledge of mental health legislation, the criteria for capacity and informed consent, data protection issues the conditions governing disclosure of information and equality legislation.

> **Knowledge of, and ability to operate within, professional and ethical guidelines**
> Practitioners need to draw on knowledge of ethical and professional guidance as a set of principles to be interpreted and applied to unique clinical situations. They also need to apply the codes of ethics and conduct that apply to all professional groups.

> **Knowledge of, and ability to work with, issues of confidentiality and consent**
> Managing confidentiality and consent requires practitioners to draw on knowledge of general ethical principles as well as their instantiation in local policies – for example, covering information sharing within and between teams or agencies.

Knowledge of, and ability to assess, capacity

Legislation on capacity applies to adults over the age of 16 and an ability to assess for and adjust interactions and interventions in relation to an individual's capacity is critical to good practice.

Working with difference (cultural competence)

Respecting diversity, promoting equality of opportunity for people with personality disorder and their families, and challenging inequalities and discrimination, is a significant aim in UK legislation and policy. The 'cultural competence' list teases apart and details the concrete values, knowledge and skills associated with this broad aim, and that should be demonstrated by all staff in routine clinical practice.

Ability to operate within and across organisations

Staff working with people with personality disorder routinely communicate with professionals from other agencies such as housing and social work, as well as drawing on the expertise of other disciplines within the team itself. Inter-agency and inter-disciplinary working requires a knowledge of the responsibilities of other agencies and disciplines, as well as knowledge of relevant policies, procedures and legislation. It also demands skills in information sharing and communication as well as the ability to contribute to the co-ordination of casework, and the ability to recognise and manage challenges to effective inter-agency working.

Ability to engage and work with families and significant others

Engaging families and carers requires a range of skills focused on building and maintaining contact, and responding to any challenges in this area. Working with families (as opposed to individuals) poses particular challenges, as it requires clinicians to maintain the active (and parallel) involvement of all family members, and to communicate with each of them in a way that is congruent with their different developmental stages and their roles within the family. Throughout contact, the clinician engages the family by demonstrating skills in communication and collaborative working, and by monitoring potential threats to engagement.

Knowledge of psychopharmacology in individuals with personality disorder

Prescribing clinicians will have extensive knowledge of psychopharmacology, but knowledge of the role and limitations of medication in the treatment of personality disorder is relevant for all clinicians. This includes knowledge of the recommendations of clinical guidelines and issues related to psychopharmacology in this area (such as the benefits and side-effects of medication).

Knowledge of common physical health problems in individuals with personality disorder and their management

People with personality disorder have an increased incidence of physical health problems. Knowledge of factors which contribute to this increased risk is important, as is a capacity to help individuals manage mitigate these (including those resulting from the side-effects of medication) by helping clients to access appropriate physical health interventions.

Therapeutic stance, values and assumptions

These competences shape the way that all interventions are understood and delivered; they set out the way in which clinicians position themselves in relation to clients and their families and carers, along with the values and assumptions that drive work in this area. So, for example, they assert the importance of working collaboratively, of validating the client's experience, of focusing on the whole person, their context, and their individual cultural and spiritual preferences, and of working in a spirit of hope and optimism and in a responsive and transparent manner. These are not abstract or aspirational competences; they are assumed to contribute to the effectiveness of clinical work.

Generic Therapeutic competences

Knowledge of models of intervention, and their employment in practice
All staff working psychologically with people with personality disorder need to know about the principles underlying the psychological interventions they or their colleagues are providing, as well as the evidence base for them, whether or not they actually practise the intervention themselves. Obviously the depth of their knowledge will vary in relation to the activity they are carrying out – for example, the knowledge required to discuss treatment options with an individual is different from that needed to deliver the intervention.

Ability to collaboratively engage clients with treatment models and options
Supporting clients in making informed choice involves careful and collaborative discussion of the treatment options open to them so they can develop a clear understanding of the models or approaches available to them.

Ability to foster and maintain a good therapeutic alliance and grasp the client's perspective and worldview
The "therapeutic alliance" is the capacity to build and to maintain a therapeutic relationship in which the practitioner develops a 'bond' with the individual and reaches agreement on the goals and tasks of the assessment and intervention. Successfully building a positive alliance is associated with better outcomes across all therapies, and developing the alliance depends on an ability to apprehend the ways in which an individual understand themselves and the world around them.

Ability to understand and respond to the emotional content of sessions
Managing the emotional content of sessions is central to all contacts with a person or family. The practitioner has to reflect on the meaning of the individual's emotional expression/behaviour, and during interventions elicits emotions that facilitate change. Throughout both assessment and intervention, the practitioner has to manage any strong

emotions such as excessive anger and related aggressive behaviour, and also avoidance of strong affect.

Ability to manage endings and service transitions
Endings and service transitions can be a difficult time for individuals and the practitioner. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the 'management' of the therapeutic relationship. The practitioner has to manage both planned endings and premature or unplanned endings where the client terminates contact with the service earlier than planned. An important consideration in all endings involves the assessment of any risk to the individual from terminating treatment or leaving the service.

Ability to make use of measures (including monitoring of outcomes)
There is considerable value in 'informal' self-reports regarding problems and any changes they have occurred. However, it is good practice for practitioners to record changes systematically, using measures, questionnaires, or diaries. These are somewhat distinct sources of information; measures usually capture phenomena that are common to individuals with a particular problem, whereas diary records are a way of helping to elaborate on their own idiosyncratic concerns. Both help to anchor assessment and therapy by making use of information that is current and (broadly speaking) objective.

Ability to make use of supervision and training
The ability to use supervision is a generic skill pertinent to all practitioners at all levels of seniority, reflecting the fact that clinical work is demanding and usually requires complex decision making. Supervision allows practitioners to keep their work on track and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

Ability to respond to and manage crises
Clinicians need to be able to work with the client (and their significant others) to develop a crisis plan. This identifies any patterns that characterise recent crises and identifies strategies which can be implemented to help deal with any emerging crises. It also specifies the role the client, family and friends and services will play in the plan. Reviewing these plans (and identifying any ways in which they need to be revised) is also central to effective crisis management.

Ability to deliver group-based interventions
The focus and purpose of the group interventions may vary but this section covers a set of generic group competences, including an ability to plan the group structure and to recruit appropriate service users, as well as a capacity to engage group members and manage group process.

Ability to make use of supervision and training
The ability to use supervision is a generic skill pertinent to all practitioners at all levels of seniority, reflecting the fact that clinical work is demanding and usually requires complex

decision making. Supervision allows practitioners to keep their work on track and to maintain good practice. Being an effective supervisee is an active process, requiring a capacity to be reflective and open to criticism, willing to learn and willing to consider (and remedy) any gaps in competence which supervision reveals.

Assessment

Ability to undertake a comprehensive assessment
A comprehensive assessment should be based on an acknowledgement   that there are no clear-cut distinctions between engagement, assessment, formulation and intervention, and that formulations and intervention plans will need to be revised as new assessment information emerges. That said, the ability to undertake a thorough assessment is crucial to the effective delivery of any psychological interventions in this area. A comprehensive assessment will need to take account of engagement, confidentiality and the recovery model to provide a framework in which to integrate information from the client, referrers and other sources of information. It should also include a careful assessment of the common features of personality disorder including the sense of self, impulse control, interpersonal difficulties and any co-existing mental disorders. Assessment (and awareness of) physical health, support from significant others, general functioning and a person's capacity are all important features of a comprehensive assessment.

Ability to assess the person's functioning within multiple systems
A further component of a comprehensive assessment is the ability to assess an individual's functioning within multiple systems. Knowledge of the different care and support systems that surround the individual, their significant others and their family is crucial for reaching an understanding of their beliefs and behaviour.

Ability to undertake risk assessment and management
A core part of a comprehensive assessment includes an appraisal of any risk to the individual or to others. Risk assessment is a challenging task and can be carried out to varying levels of detail, following different types of risk assessment model. Bearing this in mind, the ability of workers to know the limits of their competence and when to make use of support and supervision will be essential.

Formulation and planning

Ability to develop a formulation
Interlinked with assessment skills is the ability to create a tailored formulation of the individual's difficulties and to feedback the results of a treatment plan. The aim of a formulation is to explain the development and maintenance of the client's difficulties, Formulations and treatment plans are constructed in collaboration with the individual or

the family, and the expectation is that they are periodically reviewed in the light of new assessment or intervention information.

Ability to feedback the results of assessment and agree an intervention plan with all relevant parties
Feedback is a collaborative process and the client should be consulted on how the assessment and the formulation will be presented. Feedback should include an outline of the presenting problem along with the formulation, presented in a manner (in terms of pace and complexity) that is appropriate to the individual's capacity to process and assimilate the relevant information. This should facilitate the development of an agreed formulation which identifies any planned interventions, how these will be delivered, what outcomes are desired, who else may be involved in the treatment programme and when the intervention may end.

Ability to co-ordinate casework or intervention across different agencies and/or individuals
A focus on the welfare of the service user should be the overarching focus of all intra- and interagency work. Clinicians need be able to lead and co-ordinate casework both within ta team and across other agencies. This goes further than the knowledge and skills detailed in the competence of "interagency working" (which focuses on themes relevant to any interagency interaction) as the coordination of a specific case requires careful attention to the organisational and systemic processes known both to promote - and just as critically, to disrupt – effective working. As such, this section identifies the specific competencies required to co-ordinate a case at each stage from referral to discharge.

General Clinical Care

Specific Psychological Therapies

These two domains set out as coherent description of the critical elements of (and pathways through) interventions relevant to people with personality disorder. For clarity each list is set out as a self-contained document, but all are prefaced by a reminder that their effective delivery will rest on employing relevant core, generic therapeutic, assessment and formulation competences (as well as metacompetences).

Wherever possible specific therapeutic approaches are represented by a single list, even where evidence for efficacy is derived from a number of different research groups, each with their own approach to the work. For example, Generic Structured Clinical Care draws on two major sources and manuals, each sharing a common root and a set of shared assumptions, and it would be misleading and unhelpful to present each as a distinct therapeutic approach. Where approaches are distinctive (as is the case for between CBT for Personality Disorder and Schema-Focused CBT) these area described in separate lists .

In addition, it should be noted that the effective delivery of a number of the interventions below depends on the integration of the competence list with the knowledge and skills set out in other existing frameworks such as the CBT competence framework (accessed at: www.ucl.ac.uk/CORE/).

General Clinical Care

Generic Structured Clinical Care)
This intervention aims to help clients with borderline personality disorder by offering carefully structured and supportive care. It is a stand-alone intervention that may be particularly suitable for clients who are unable to tolerate or commit to the level of structure and intensity that characterises specific psychological interventions. There is a strong emphasis on multi-disciplinary working and on maintaining structure, for example by specifying clear roles and responsibilities for all staff, identifying clear boundaries and establishing a coherent, coordinated and consistent approach to all aspects of care. The intervention is built on a collaboratively agreed problem list structured around the four key problem areas associated with BDP (emotional dysregulation, an unstable sense of self, impulsivity and instability in personal relationships). It also aims to reduce self-harm and improve the ways in which crises are managed, as well as the ways in which clients regulate emotion and interpersonal relationships.,

Psychoeducation and problem solving
Two programs are included in this section (**Psycho-education combined with Problem Solving (PEPS)** and **Systems approach for Emotional Predictability and Problem Solving (STEPPS)**. Both adopt a psycho-educational model which aims to provide clients with a better understanding of personality disorder and to help them develop problem-solving skills in relation to the management of negative feelings, While PEPS can be offered as a stand-alone intervention offered in a mix of individual and group sessions, STEPPS is intended to augment other treatments provided by mental health services. and is provided in a group format.

Consulting to individuals and teams regarding clients with personality disorder
Consultation is an important role for specialist practitioners in personality disorder, and broadly aims to increase the effectiveness of clinicians' work. Practitioners need to be

able to identify the aims of a consultation (e.g. whether this is focused on a specific clinical problem (such as challenging behavior) or on patterns of communication and interaction within a team), and help individuals or teams discuss and identify relevant issues, develop a formulation of the problem, agree how best to proceed and identify how they will know whether the consultation has achieved its aims.

Specific interventions

Cognitive Behavioural Therapy (CBT) for Personality Disorder
This intervention is predicated on practitioners having a good level of competence in the theory and application of CBT, as well as specific knowledge and skills related to working with people with personality disorder. It involves a detailed assessment of both the problems arising from the personality disorder and from any co-existing conditions, working with the client towards a shared formulation of the problem(s). It stresses engagement of the client and where appropriate significant others, and has a primary focus on identifying and helping the client to modify core beliefs, emotions and behaviours.

Schema-focused CBT (SF-CBT) for Personality Disorder
Again, this intervention is predicated on practitioners' prior competence in CBT. It differs from CBT for personality disorder in drawing on Gestalt Therapy and Emotion–Focused Therapy, and by focusing on "schemas". These are ways of organizing experience that develop early in life, and the focus is on maladaptive schemas such as sensitivity to rejection, or difficulties in setting limits for the self or respecting limits set by others. The intervention is phased, starting by arriving at a shared formulation and gaining a long-term commitment to treatment, followed by identifying and working with schema modes, using both CBT and a variety of experiential techniques (including role play and imagery re-scripting). The aim of treatment is to help the client modify schemas, core beliefs and associated problem behaviours.

Dialectical Behaviour Therapy (DBT)
DBT is a mindfulness-based cognitive behavioural therapy that balances change procedures derived from CBT with acceptance strategies derived from Zen philosophy. It is a highly structured treatment that sequentially focuses on decreasing behaviours that are life threatening, behaviours that will interfere with therapy, and behaviours that will impact negatively on the client's quality of life; after this there is a focus on increasing the client's skillful behaviour. It strongly emphasises the validation of client's experience alongside any attempt to help the client make changes.

Mentalisation-Based Therapy (MBT)
The mentalisation-based approach is grounded in attachment theory, and assumes that a primary problem for people with personality disorder is their difficulty in mentalising (accurately apprehending the metal states and intentions of others), a problem which is especially acute in interpersonal contexts. It is a structured therapy in which the therapist

uses a range of strategies to help the client adopt a more consistently mentalising stance. The focus is on the here-and-now of the session or recent past (rather than on unconscious or distal events), and also on exploring emotional experience in current relationships and (as this develops) the therapeutic relationship. MBT can be delivered both individually and in groups.

Transference Focused Psychotherapy TFP)

This form of psychoanalytic psychotherapy requires the practitioners to have a core competence in psychodynamic psychotherapy. It is rooted in object-relations theory and focuses on the client's sense of self and their capacity for reality testing. In contrast to some psychoanalytic approaches TFP is a structured treatment with clear phases that start with the development of a safe, containing therapeutic environment, followed by assessment and intervention. Work in the transference is focused on the client's self-other-relationships and their experience of reality.

Interpersonal Group Psychotherapy (IGP)

Again this group-based form of psychoanalytic psychotherapy requires a core competence in psychodynamic psychotherapy. A central focus of IGP is on identifying and understanding the client's problematic interpersonal patterns, as they emerge in the group. The emphasis is on creating a safe context within which clients can come to understand and change their expectations of themselves and others. IGP therapists aim to create and maintain a collaborative, consistent, caring, non-punitive and empathic relationship with the client in the "here-and-now", and to make use of group members' communications and interactions with each other. A key aim of the intervention is to promote and clients' capacity for emotional regulation

Cognitive Analytic Therapy (CAT)

CAT takes an integrative and collaborative approach to the treatment of personality disorder, drawing both on cognitive and analytic practice. It has a strong interpersonal focus which assumes that the development of a sense of self is constructed through interaction with others. It is a structured intervention begins with a clear phase of assessment in which the client and therapist formulate the problems experienced by the client and agree a shared formulation. A key aim is to identify procedural sequences: chains of events, thoughts, emotions and motivations that help the client understand the development and maintenance of their problems, and that also identify ways in which these could be managed differently.

Coexisting conditions

Most clients with personality disorder present with co-existing conditions (such as depression or anxiety). Rather than seeing these as 'co-morbid', which implies that they are best seen as separate conditions, it may be more accurate to describe them as co-existing. Because they can directly contribute to the exacerbation of symptoms of personality disorder, clinicians need to be able to consider their impact when assessing,

formulating and intervening, and this listing sets out the competences relevant to this endeavour.

Metacompetences

The psychological treatment of personality disorder cannot be delivered in a 'cook book' manner: by analogy, following a recipe is helpful, but it doesn't necessarily make for a good cook. Skilful implementation of most areas of clinical work rests on an ability to implement "procedural rules" – using clinical judgment to decide when, how and whether to carry out a particular action or set of actions in order to make an intervention or a procedure responsive to the needs of each individual child and their family.

On the whole metacompetences are more abstract than those described elsewhere and, as a result, there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Some of the list has been extracted from manuals; some are based on expert professional consensus7 and some on research-based evidence (for example, an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise).

Implementing the competence framework

A number of issues are relevant to the practical application of the competence framework.

Do all clinicians providing psychological interventions for personality disorder need to be able to do everything specified in the competence list?
As described above, not all clinicians are expected to carry out all the competences in all the domains of the framework. However, any member of a team who is involved in the provision of a particular psychological intervention for personality disorder *would* be expected to demonstrate "underpinning" skills (core and generic therapeutic competences (shaded blue on the map)), and the relevant assessment, formulation and planning skills Whether or not an individual clinician will demonstrate competence across the range of specific interventions will depend on their having had the appropriate training and supervision to carry out the procedures and interventions that are listed in these sections.

How the metacompetences apply is more complex: some apply to all aspects of psychological work with personality disorder, while others relate to the implementation of specific interventions or specific procedures, and so only apply when these are being carried out. For example, metacompetences that apply to all workers are "the ability to interpret legal and ethical frameworks in relation to the individual case", or to "apply only when more specific interventions are being carried out (for example, "[adapting]

treatment protocols so that they can be applied to the individual case"). As such, whether or not a metacompetence applies depends on the work a particular clinician is conducting.

Is every competence in a competence list of equal importance?
Many of the lists are quite detailed, and each of the competences are included either because they formed part of an intervention that shows evidence of efficacy, or because expert opinion indicates that these are important and relevant skills. Given that some of these lists are quite long, it is reasonable to ask whether al the skills are of equal value. This is a hard question to answer, because there is often little research evidence for the mutative value of *specific* skills – most evidence relates to *packages* of skills. This means that we cannot be sure which specific skills are likely to make a difference, and which are potentially neutral in their effect. Until we have more evidence it isn't possible to declare some skills more critical than others, but equally we cannot declare some skills or procedures optional. To that extent, all the competences are of equal value.

Does this mean that clinicians can use their judgment to decide which elements of an intervention to include and which to ignore? This could be a risky strategy, especially if this meant that major elements or aspects of an intervention were not offered – in effect clinicians would be making a conscious decision to deviate from the evidence that the package works. Equally, manuals cannot be treated as a set of rigid prescriptions, all of which have to be treated as necessary and all of which must be applied. Indeed most of the competence lists for problem-specific interventions refer to an important metacompetence – the ability to introduce and implement the components of a programme in a manner which is flexible and which is responsive to the issues the client raises, but which also ensures that all relevant components are included. This involves using informed clinical judgment to derive an intervention mapped to the needs of an individual client while having due regard to what is known about 'best practice' (a process that parallels the judgment required to apply clinical guidelines to the individual case).

Another factor is that most interventions evolve over time, especially as research helps to identify the elements that make a difference and are associated with efficacy. However it can take some time before research validates the benefit of innovations, and as a consequence there is often a lag between the emergence of new ideas and their inclusion in clinical guidelines. This means that intervention packages should not be viewed as tablets of stone – though equally this is not a reason for clinicians to adopt "pick and mix" approach to the competences they incorporate into a 'standard' treatment.

The impact of treatment formats on clinical effectiveness: The competence lists in this report set out what a therapist should do, but most do not comment on the way in which an assessment or intervention is organised and delivered. For example, the duration of each session of a psychological treatment, how sessions are spaced (e.g. daily, weekly or fortnightly) or the usual number of sessions. However, these formats are often identified in clinical guidelines, and in manuals and research protocols, with the schedule constructed so as to match to clinical need and the rationale for the intervention.

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When implemented in routine services, treatment formats often deviate from the schedules used in research trials. This can be for a range of reasons, but it is reasonable to ask whether making significant changes to the format may impact on effectiveness. This is a difficult question to answer because on the whole there is rather little research evidence on which to draw. However, where research has been conducted – for example in the area of parenting programmes – it suggests that better outcomes are achieved when therapists show greater fidelity to the procedures set out in the manuals (e.g. Eames, Daley, Hutchings, Whitaker, Jones, Hughes, & Bywater, 2009). It is also the case that fidelity in parent programmes is best conceived as adherence to a number of overarching areas of activity (including an ability to apply social learning theory, a capacity to work with group process while also attending to each individual parent, and an ability to assure access and active support to maintain the engagement and involvement of parents). As such there is much that could be neglected if clinicians deliver bespoke programmes that include some, but not all, these areas. Generalising this observation across all interventions, it suggests that when clinicians vary a 'standard' treatment procedure they should have a clear rationale for so doing, and that where procedures are varied there should be careful monitoring and benchmarking of clinical outcomes in order to detect whether this has a neutral or an adverse impact.

The contribution of training and supervision to clinical outcomes: Elkin (1999) highlighted the fact that when evidence-based therapies are 'transported' into routine settings, there is often considerable variation in the extent to which training and supervision are recognised as important components of successful service delivery. Roth, Pilling and Turner (2010) examined 27 major research studies of CBT for depressed or anxious adults, identifying the training and ongoing supervision associated with each trial. They found that trialists devoted considerable time to training, monitoring and supervision, and that these elements were integral to treatment delivery in clinical research studies. It seems reasonable to suppose that these elements make their contribution to headline figures for efficacy - a supposition obviously shared by the researchers themselves, given the attention they pay to building these factors into trial design.

It may be unhelpful to see the treatment procedure alone as the evidence-based element, because this divorces technique from the support systems that help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the competence framework

This section sets out the various uses to which the competence framework can be put, and describes the methods by which these may be achieved. Where appropriate it makes suggestions for how relevant work in the area may be developed

Commissioning: The framework can contribute to the effective use of health care resources by enabling commissioners to specify both the appropriate levels and the range of competences that need to be demonstrated by staff providing psychological interventions for personality disorder to meet identified local needs. It could also contribute to the development of more evidence-based systems for the monitoring of commissioned services by setting out a framework for competences which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of services: The framework represents a set of competences that (wherever possible) are evidence -based, and aims to describe best practice - the activities that individuals and teams should follow to deliver interventions.

Although further work is required on their utility and on associated methods of measurement – they should enable:
- the identification of the key competences required by a practitioner to deliver psychological interventions for personality disorder
- the identification of the range of competences that a service or team would need to meet the needs of the populations with whom they work
- the likely training and supervision competences of those delivering psychological interventions for personality disorder

Because the framework converts general descriptions of clinical practice into a set of concrete specifications, it can link advice regarding the implementation of therapies (as set out in NICE guidance or National Quality Standards along with other national and local policy documents) with the interventions actually delivered. Further, this level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of research trials on which claims for the efficacy of specific interventions rest. In this way it could help to ensure that evidence-based interventions are likely to be provided in a competent and effective manner

Clinical governance: Effective monitoring of the quality of services provided is essential if service users are to be assured optimum benefit. The monitoring the quality and outcomes of psychological interventions for personality disorder is a key clinical governance activity; the framework will allow providers to ensure that interventions are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of clinician's performance

The introduction of the personality disorder competence framework into clinical governance can be achieved through local implementation plans for NICE/ SIGN guidance and their monitoring through the local audits procedures as well as by the monitoring systems of organisations such as the Care Quality Commission.

Supervision: Used in conjunction with the competence framework for supervision (www.ucl.ac.uk/clinical-psychology/CORE/supervision_framework.htm), this framework potentially provides a useful tool to improve the quality of supervision for psychological

interventions by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners; the framework will support both these through:

- providing a structure by which to identify the key components of effective practice for specified disorders
- allowing for the identification and remediation of sub-optimal performance

The framework can achieve this through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

Training: Effective training is vital to ensuring increased access to well-delivered psychological therapies. The framework can support this by:

- providing a clear set of competencies which can guide and refine the structure and curriculum of training programmes[4], including pre and post-qualification professional trainings as well as the training offered by independent organisations
- providing a system for the evaluation of the outcome of training programmes

Research: The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the relationship between therapy process and outcome and the evaluation of training programmes and supervision systems.

Concluding comments

This report describes a model which identifies the activities which characterise effective psychological interventions for personality disorder, and locates them in a "map" of competences.

The work has been guided by two overarching principles. Firstly it stays close to the evidence-base and to expert professional judgment, meaning that an intervention carried out in line with the competencies described in the model should be close to best practice, and therefore likely to result in better outcomes for service users. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way in which interventions are actually delivered and hence facilitates their use in routine practice.

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring, or commissioning – will test its worth, and indicate the

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[4] At the time of publication this application is in the process of being actioned

ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cook-book. Delivering effective interventions involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians need to operate using clinical judgment in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way which clarifies the activities associated with skilled and effective practice in the psychological treatment of psychosis or bipolar disorder should prove useful for staff in all parts of mental health services. The more stringent test is whether it results in more effective interventions and better outcomes for clients of these services.

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