Mental Health and Wellbeing Practitioner: A Guide to Practice

Section 1

Contents and Foreword

Contents

1. Foreword

2. Introduction: The Mental Health and Wellbeing Practitioner Role and Method

3. Engagement and Assessment with people with Severe Mental Health Problems

4. Care Planning in Partnership

Foreword

When people with severe mental health problems are asked what they want from services, several key themes emerge repeatedly: they want to be listened to, have their experiences and feelings validated, be seen as a whole person beyond their diagnosis, to be given hope, and to have choices, including access to a range of psychological interventions as part of their package of care.

The community mental health framework for adults and older adults offers a radical shift in how services for people with severe mental health problems will be delivered in England. The framework puts service users at the centre and aims to provide personalised, holistic care to meet their needs. The ambition is to create a more integrated and connected way of supporting people within their local communities, drawing on the strengths of all services and agencies.

As part of this, specialist mental health services are expected to focus more on the delivery of evidence-based interventions, including psychological interventions and therapies. A significant development programme is underway to increase access to psychological therapies for severe mental health problems.

Training is being delivered so that more members of multi-disciplinary teams can offer NICE-recommended psychological therapies for psychosis, bipolar disorder, a diagnosis of ‘personality disorder’, eating disorders or difficulties associated with these conditions.

Multi-disciplinary teams will be key to the success of community mental health transformation. Mental health nurses, psychiatrists, psychological professionals, allied health professionals, social workers and new roles such as peer workers and nursing associates will all play vital roles. We are excited to be welcoming you as a Mental Health and Wellbeing Practitioner to one of these teams.

You will make a significant difference to people by offering evidence-based psychological interventions, which service users may have found harder to access previously. You will also coordinate care, helping people access the best possible community and professional resources.

By doing so, you will help create much needed additional capacity in the team, including capacity for other team members to deliver more psychological therapies.

We hope you thrive in your new role, and that people with severe mental health problems benefit from your hope, enthusiasm and sensitivity to their needs. We also hope that this role will be part of a long and successful career for you in the NHS.

Professor Tim Kendall, National Clinical Director for Mental Health, NHS England (NHSE)

Laura Lea, National Lead for Expert by Experience Involvement: Psychological Professions, NHS England (NHSE)

Professor Mark Radford, National Director of Intensive Support & Deputy Chief Nursing Officer of England

Dr Alison Brabban, National Clinical Advisor for Adult Mental Health, NHS England (NHSE)

Rebecca Burgess-Dawson, National Clinical Lead, Mental Health Programme, Workforce, Training and Education (WT&E), NHS England (NHSE)

Dr Adrian Whittington, National Clinical Lead for Psychological Professions, NHS England (NHSE)

Section 2
Introduction

The Mental Health and Wellbeing Practitioner Role and Method

Section 2A: The Purpose and Stance of the Mental Health and Wellbeing Practitioner Role

The purpose and stance of the Mental Health and Wellbeing Practitioner role

Being a Mental Health and Wellbeing Practitioner (MWHP) involves providing compassionate, person-centred care for adults (including older people), hopeful and focused on the service user's goals.

It begins with skilled information gathering, information giving and shared decision-making to enable access to the best community and professional resources that can help. It also involves delivering specific psychological interventions under supervision from a suitably qualified psychological professional. The MHWP role is community-based but may, at times, involve supporting service users to make the transition from an inpatient stay back to the community.

The MHWP role has two main purposes:

- To support people with severe mental health problems, their families, and carers with collaborative care planning
- To provide people with severe mental health problems with wellbeing focused psychological interventions based on the best available evidence

Any clinical encounter between service users and practitioners requires:

- Gathering information in a user-centred manner – that is, in a way which fits with the beliefs and prior knowledge of service users and recognises specific needs, such as those of older people
- Providing information that may help, and
- Arriving at a shared decision between practitioner and service user (and family member / carer where appropriate) in as collaborative a manner as possible regarding next steps. This three-phase organisation of clinical encounters runs throughout the MHWP course

MHWPs work within a multi-disciplinary framework that recognises the place of diagnosis, but moves beyond this to understand, collaboratively, the service user's current main concerns, which may or may not be related to a specific diagnosis or 'symptoms' of mental health problems. Addressing the main concerns is likely to have a positive effect on wellbeing. These concerns may have behavioural, cognitive, emotional, or physiological elements, or may be more centred on relationships and life situations.

MHWPs are core members of the multi-disciplinary team in adult community mental health services, with specific competences for working collaboratively with people with severe mental health problems (the service user) and their families and carers.

These competences focus on being able to engage successfully, conduct a collaborative assessment to gather information, and collaboratively plan care with knowledge of the team and wider resources that may help. Access to community and professional help can sometimes be challenging. As an MHWP, you will be ideally placed to support service users, aiming to overcome these challenges and find the most appropriate sources of additional help.

As an MHWP, you will offer specific wellbeing-focused psychological interventions aligned to cognitive-behavioural principles. The interventions are designed to support wellbeing, but do not replace psychological therapies as recommended by NICE. They form part of a broader offer by the team.

Specific interventions

The specific interventions that every MHWP should develop competences to deliver and which will be covered in the training programme are:

a. Behavioural Activation

b. Graded Exposure

c. Teaching Problem-Solving Skills

d. Improving Sleep

e. Recognising and Managing Emotions

f. Guided Self-help for Bulimia and Binge-eating

g. Building Confidence

h. Medication Support – Based on Information-giving

What are Mental Health and Wellbeing Practitioners expected to do?

MHWPs coordinate care for a caseload of people with severe mental health problems. They also deliver some psychological interventions to people whose care they are coordinating, and other people being served by the community service.

MHWPs work under supervision, with their care coordination supervised by a suitably qualified team member. Because their interventions are based on cognitive-behavioural principles, their clinical skills supervision can be provided by a range of psychological professionals who can demonstrate specific competences in CBT-based interventions, supervisor competences, and who have attended the supervisor training.

Suggested reading:

- Mental health and wellbeing practitioner training curriculum
- Trainee mental health and wellbeing practitioner job description
- Qualified mental health and wellbeing practitioner job description
- NHS Careers

Section 2B: Professional and Ethical Practice

As a Mental Health and Wellbeing Practitioner, you are responsible for your own professional and ethical practice, although you will operate with supervision from other team members.

Ethical practice is a complex area, and whilst there are a number of ethical frameworks that provide principles, they will not offer solutions for every ethical dilemma you encounter as a practitioner. When facing a situation which presents ethical questions, you will need to keep in mind the principles, as well as the professional and service guidelines (local and national) under which you operate.

However, it is likely that resolving these dilemmas will involve taking them to supervision.

The four principles of biomedical ethics

One of the most widely used frameworks is Beauchamp and Childress' Four Principles of Biomedical Ethics. It offers a broad consideration of professional ethics issues generally, not just for use in a clinical setting.

The four principles are general guides that leave considerable room for your judgement in specific cases.

1. Respect for autonomy: respecting the service user's right to make their own choices.

This principle outlines the service user's right to self-determination, assuming their capacity to make reasoned, informed decisions based on informed consent. In some circumstances, such as when there is a risk of severe harm, respect for autonomy may be outweighed by the second principle, beneficence. However, this will be rare and only under specific legal safeguards such as the Mental Health Act.

2. Beneficence: acting with the best interests of the service user in mind.

As a practitioner, you should act only to benefit the service user and to do good. The intention is to balance any treatment's benefits with its risks and to ensure that, even in those rare instances where the service user's autonomy may be compromised, it is in their best interest.

3. Non maleficence: above all, do no harm.

You should not harm the service user, or act with the intention of causing them harm. Any treatment may potentially involve some harm (for example, the risk of side effects from medication), even if minimal, but the harm should not be disproportionate to the benefits of the treatment.

4. Justice: recognising the right of any individual to be created equally and fairly.

This principle considers the right to equity of treatment for all service users, recognising the differential impact of their circumstances or individual characteristics.

In your professional practice you should also follow more specific local and national guidance and frameworks:

- **The Law –** The need to uphold the law including in relation to the mental health act, mental capacity act, deprivation of liberty safeguards and other provisions that may be relevant
- **Rules of confidentiality and information sharing –** The need to safeguard private information in line with Caldicott Principles and information governance protocols
- **Evidence-based treatment guidance –** The need to ensure approaches are delivered in line with evidence of what is most likely to work

Suggested reading:

- Beauchamp and Childress; The Four Principles of Biomedical Ethics, OUP, 5th edition 2001
- Webster, A & Bond, TN 2002, ‘Structuring uncertainty’: Developing an ethical framework for professional practice in education ‘, Educational and Child Psychology, Vol. 19 (1), pp. 16 -29.

Section 2C: The Role of Supervision

Supervision is a collaborative process where a more senior practitioner has oversight of your work and where you can identify additional ways forward to coordinate care effectively and deliver effective psychological interventions.

Mental Health and Wellbeing Practitioner supervision is designed to ensure fidelity to the evidence base, to ensure timely review of all service users' care (not just the cases chosen by the supervisee), to support the safety of service users and others, to enable clinical skills development, and to support you. Supervision requires discussion between you and your supervisor about service users' progress and safety and the processes and competencies you use.

Trainees and qualified Mental Health and Wellbeing Practitioners receive two types of supervision in the service where they are based:

1. **Case management supervision** covers a review of your whole caseload, with specific cases flagged for more detailed discussion according to specific criteria. In this supervision, your care coordination work will be a particular focus. Case management supervision happens weekly (minimum 30 minutes, individual supervision). Your case management supervisor can be any suitably qualified multi-disciplinary team member.

2. **Psychological intervention supervision** covers the people you are working with using psychological interventions. Clinical intervention supervision happens weekly (minimum 30 minutes per supervisee, which can be delivered in a group). Because most of the interventions you will offer have a basis in cognitive-behavioural principles, your psychological intervention supervision must be provided by a psychological professional with significant training and experience in delivering CBT-based interventions for severe mental health problems, and who has attended specific supervision training linked to the training programme.

Your case management supervisor and your psychological intervention supervisor can be the same if they meet the criteria for both aspects. However, both types of supervision must be provided to ensure a comprehensive overview of the caseload and a chance for an in-depth review of intervention cases.

Presenting your work in Case Management Supervision

You will typically start case management supervision with a brief check-in on how you are finding your work and how you are managing your overall caseload. Following this, case management supervision follows a specific format for identifying cases for discussion and identifying new actions:

- Any new service users on your caseload
- All service users on your caseload regularly discussed at no less than four-weekly intervals
- Any service users who have identified thoughts of harming themselves or others
- All service users whose scores on clinical measures are above a predetermined threshold, are showing deterioration, or are not reducing
- All service users whose appointments are overdue or whom you have not contacted recently

- Specific cases identified by either the supervisee or the supervisor for further discussion and problem-solving of clinical questions or issues relating to assessment and engagement (including5ps formulation), or care coordination

Presenting your work in Psychological Intervention Supervision

After a brief check-in you will set an agenda with your supervisor for discussion of specific cases where you are conducting a psychological intervention, to allow problem-solving of clinical questions or issues relating to these interventions, you should arrive prepared, knowing which cases you want to discuss, and having identified a specific issue or question for each. The aim is not simply to present an overview of the case, but to solve specific problems to allow effective selection and delivery of interventions.

Presenting specific cases in Supervision

Preparation for supervision is key, as is good note-keeping. You will need to be able to present the information you have gathered about service users succinctly and accurately. The basic information you will need to present will normally cover:

- Gender
- Age
- Main problem statement
- Risk issues
- Onset and duration of the current problem
- Previous episodes
- Past treatment
- Current scores on clinical measures
- Any co-morbidity issues
- Any cultural, language or disability issues
- Employment status
- Current treatment from GP or other healthcare practitioners
- Care / intervention plan
- Action already initiated
- Specific questions for supervision about this case and next steps

Suggested reading:

- Supervision Competences Framework: Supervision of Psychological Therapies | UCL Psychology and Language Sciences - UCL – University College London

Section 2D: Personal Recovery and CHIME

In mental health, the meaning of the word ‘recovery’ has changed significantly over time. Whereas once it was associated with clinical recovery, it is now used as shorthand for personal recovery. The focus of clinical recovery and personal recovery are very different, with clinical recovery focused on treating illness and removing symptoms compared to personal recovery,which is concerned with meeting an individual’s personal needs and promoting wellbeing.

Clinical and Personal Recovery

Traditionally services for people with severe mental health problems focused on diagnosing ‘illnesses’ such as schizophrenia or bipolar disorder and then working to alleviate symptoms to get people back to how they were before they developed problems.

More recently, many people have questioned the concept of mental ‘illness’, which tends to suggest there is something wrong with the person or the way their brain is functioning. Instead, problems such as psychosis or problems associated with a diagnosis of ‘personalitydisorder’ can often be seen as understandable reactions to adverse life experiences.

Similarly, many ‘symptoms’ can be understood as survival strategies that a person may have developed consciously or unconsciously to deal with adversity and overwhelming feelings associated with this. This fundamental change in perspective has led to the trauma informed adage: “Don’t ask what’s wrong with me; ask what’s happened to me”.

Whereas services that are aimed at clinical recovery focus on alleviating symptoms, personal recovery-orientated services aim to understand and meet the personal needs of individuals to help them thrive and live the best possible life, with or without a diagnosis and related symptoms. Positive Psychology is the scientific study of wellbeing: it identifies core human needs that need to be met for us to thrive.

Abraham Maslow’s 1943 Hierarchy of Needs identifies the range of needs a person needs to have to achieve ‘self-actualisation’. Fundamental biological needs such as food, water, warmth, and safety being at the bottom of the pyramid with higher level, secondary ‘self-fulfilment’ needs at the top.

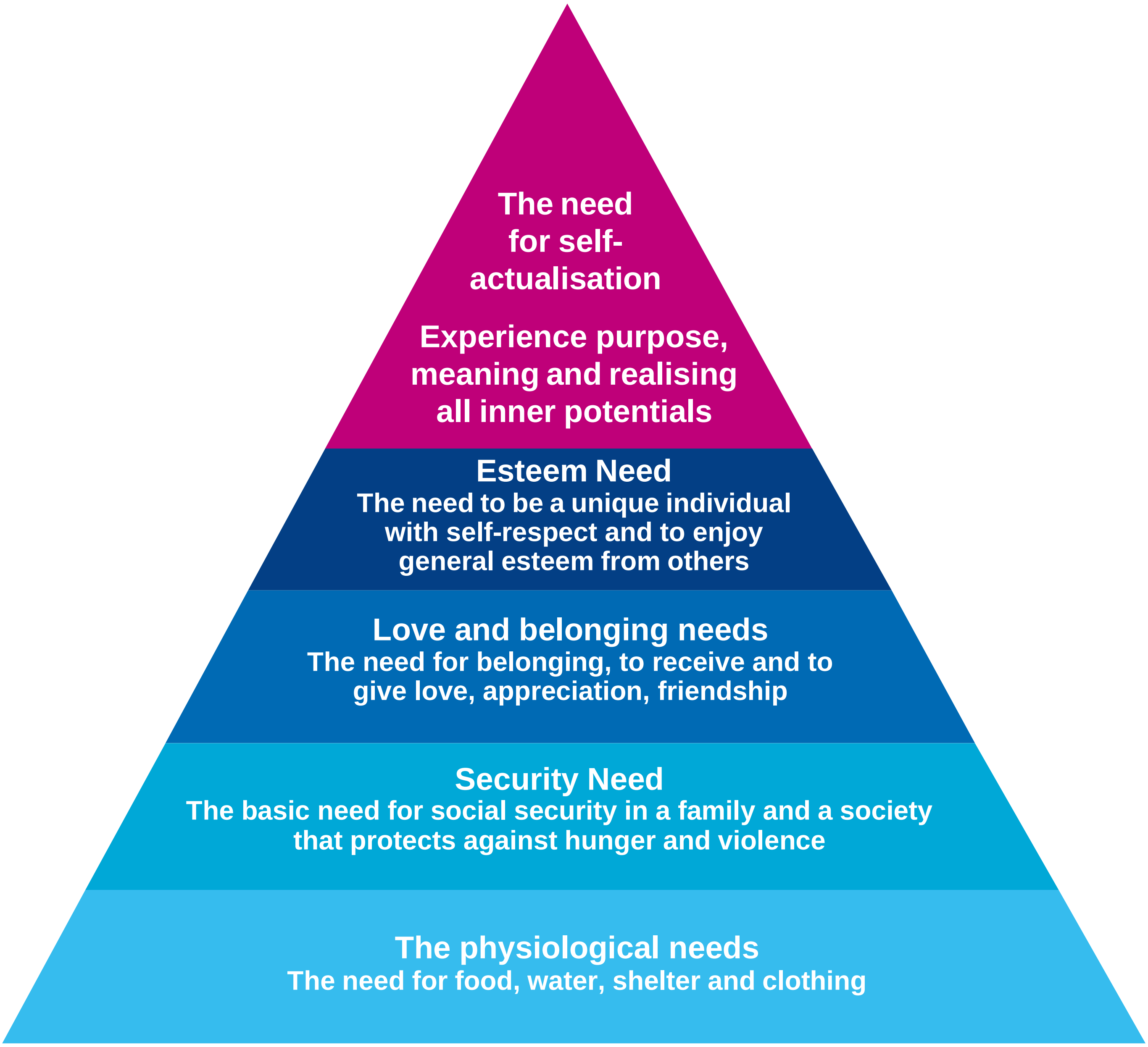


Figure 1. Abraham Maslow’s 1943 Hierarchy of Needs

Maslow’s Hierarchy can serve as a useful prompt when assessing a person’s needs and developing a care plan that prioritises appropriate interventions. For example, it is unlikely a person will want to work on building confidence if they are homeless or are unable to afford to eat or keep warm.

CHIME

Recently a team of researchers at Kings College in London, led by Mary Loamy, carried out a review of the recovery literature to determine what people with severe mental health problems considered to be the key processes required for personal recovery.

Five key themes emerged from this review:

- Connectedness
- Hope, and optimism about the future
- Identity
- Meaning (meaning in life and making sense of mental health issues), and
- Empowerment

These five processes are known by the acronym CHIME.

When supporting someone, it is vital that you take these five factors into account, assessing where there is a need and ensuring these needs are addressed.

One of the Patient Reported Outcome Measures (PROMs) that MHWPs use to look at recovery, namely ReQoL (Recovering Quality of Life Questionnaire), asks about the five CHIME factors.

Quality of life, although related to recovery, is a separate construct. However, responses to questions on a certain quality of life PROMs, such as DIALOG, may prove helpful when consideringa person’s needs.

Table 1: lists several potentially presenting problems that might highlight recovery-related needs, as well as some possible approaches that could be usedto address them.

CHIME Factor	Potential Related Presenting Problem	What might help address this?
Connectedness	• Feeling lonely • Not feeling part of wider group or community • Spiritual disconnection • Feeling different	• Peer support • Joining a community group (e.g. sports group, local choir, art group etc) • Joining a college or recovery college group • Being part of a faith community and having a religious affiliation
Hope and optimism about the future	• Belief that nothing will or can get better • Belief that it is impossible to recover from severe mental health problems • No or little hope of finding a partner or getting a job • No dreams or aspirations • Low levels of motivation	• Meeting others who have recovered e.g. Peer support • Provide information on recovery(incl. internet resources etc) • Goal setting and behavioural activation
Identity	• Identifies with and can't see self beyond a diagnosis e.g. I'm a schizophrenic • Stigma and self-stigma	• Recognise strengths and dimensions of identity and build on these e.g. dog owner, brother, guitarist • Work on self-stigma and self-esteem
Meaning (meaning in life and making sense of mental health issues)	• Poor quality of life – doing very little • Limited social roles • Limited social goals	• Consider how person spends their time • Behavioural activation • Shared formulation of presenting problems (in addition to or potentially instead of diagnosis) • Trauma Informed Approach
Empowerment	• Perceived lack of control over life • Limited personal responsibility	• Shared decision making • Collaborative approach to care planning and goal setting • Focus on personal strengths

Table 1. CHIME factors

References:

Leamy, M., Bird, V., Le Boutillier, C., Williams, J., & Slade, M. (2011). Conceptual framework for personal recovery in mental health: Systematic review and narrative synthesis. British Journal of Psychiatry, 199(6), 445–452.

Section 2E: Trauma Informed Care in Adult Mental Health

Trauma informed care is an organisational approach that involves realising, recognising, and responding to trauma, and preventing re-traumatisation (SAMHSA, 2014). Trauma is viewed as 'everyone's business' – we all need support to notice and address traumatic experiences and their effects, including in ourselves. Having safe, collaborative, trustworthy, and empowering relationships with colleagues and people using our services can assist healing from trauma and recovery.

Trauma informed care is a response to evidence of the widespread occurrence and impact of trauma, and the lived experience of trauma survivors about what can help or hinder their recovery. The NHS Long Term Plan (2019) recommends integrating trauma informed care into services for severe mental health problems. Transforming organisations to be trauma-informed is challenging, requiring support from everyone involved.

The 4 Rs of Trauma informed Care

In the USA, the Substance Abuse and Mental Health Services Administration (SAMHSA, 2014) have proposed a framework to support the implementation of trauma informed practice, underpinned by four key assumptions (the '4 Rs'). You can make a valuable contribution by understanding and integrating the 4 Rs into your role:

1. **Realising** what trauma is and how it affects us,
2. **Recognising** traumatic events and their effects,
3. **Responding** to traumatic events and their consequences and
4. **Resisting** re-traumatisation.

1. REALISING what trauma is and how it affects us

Understandings of trauma vary across cultures and have changed and developed over time. SAMHSA (2014) provide a broad definition of trauma that includes the 3 Es:

- the **event**, the **experience** and the **effects**

Traumatic events

Traumatic events are sadly common in our society and involve experiencing or witnessing actual or threatened psychological or physical harm. This means that whether an event is traumatic depends on the person's subjective perception of threat; not everyone will respond to the same event in the same way, and tolerance for what is bearable will vary between different people.

Traumatic events include physical, sexual, and emotional abuse; physical and emotional neglect; and serious illnesses and accidents. They also include other types of threatening experiences such as loss, stigma, discrimination (including racism), and societal inequalities. Events may happen once, occur repeatedly, or persist for a long period of time.

Experiencing mental health problems and contact with services can also be traumatic. Family members and carers can also experience trauma as a result of their caring role, and it is important to be aware that as a healthcare practitioner you may experience trauma as part of your work.

Mental health service users, their families and carers and mental health practitioners are more likely to experience traumatic events compared to the general population, including events where others intend to cause them harm. Rates of childhood abuse have been compared across diagnoses, with studies indicating the highest rates in PTSD and dissociative disorders, with comparable rates in schizophrenia-spectrum, personality disorder and depression diagnoses, followed by other types of anxiety disorders (Matheson et al, 2013).

The experience of traumatic events

Individuals may react differently to events, although emotions like fear, anger, sadness, shame, and guilt are common. People can also feel numb or detached. In the moment of trauma itself, certain responses are often triggered as our minds and bodies attempt to protect us from what is happening. We may become angry or violent or want to avoid or escape. We could freeze and not know how to respond. Or we may submit to those hurting us. These are all understandable, automatic responses to feeling threatened. However, these survival strategies can become a routine way of coping with experiences, which may cause problems later in life.

Trauma effects

Experiencing or witnessing traumatic events may or may not have longer-term effects. People can recover, especially if they have support. But traumatic events can also have significant effects on mental and physical health, and a marked impact on life. Difficult feelings, memories, feeling on edge and on guard, avoidance, feeling numb and unreal, fears of harm from others, feeling bad about us, and relationship problems are all common trauma effects – and can be triggered by reminders of the original trauma.

Relational (attachment) patterns arising from trauma, particularly as result of parental abuse, may influence how we interact with each other and relate to ourselves. In turn, trauma-related fight, flight and freeze responses can potentially have a long-term effect on our relationships. An awareness of trauma effects can help you understand what may be getting in the way of a person's recovery, and how best to support them to move forward.

2. RECOGNISING traumatic events and their effects

A trauma-informed approach encourages us to consider 'what happened to you' not 'what's wrong with you'? (Bloom, 1997). This can help you make sense of how people's life experiences may affect them now.

Recognising trauma events

Evidence suggests people may not spontaneously disclose their trauma history unless specifically asked, highlighting the need for services to offer trauma assessments routinely.

You should provide a concise, normalising rationale for asking about trauma and must always seek informed consent (see Read, Morrison, & Waddingham, 2020 for further guidance). It is essential that the service user feels in control and knows it is their choice whether and what to share. If they do consent, your focus should be on whether certain events happened and if they are still affecting the person now, including any safety concerns.

The Trauma and Life Events Checklist (TALE and mini-TALE, Carr et al, 2018) assesses a broad range of traumatic events, in line with the principles of trauma informed care. This can be helpful to a conversation about trauma if introduced appropriately.

Recognising trauma responses

It is vital to recognise trauma responses, both in ourselves and others. Questionnaires are available to assess trauma reactions, including PTSD and complex PTSD symptoms. These can be used to begin conversations about the impact of trauma, including normalising its effects. It can also be helpful to recognise when trauma responses impact a person's way of relating to services. Forexample, people may miss appointments or seem very hostile or demanding. These responses could appear self-defeating or confusing but are often adaptive responses to feeling threatened. By recognising how trauma may influence a person's relationships, we can find more helpful ways of responding.

3. RESPONDING to traumatic events and their consequences

Because trauma can affect anyone, responding to trauma is 'everyone's business.' A person-centred, rights-based and anti-racist position supports this way of working.

You can view every interaction as an opportunity to support healing from trauma, through promoting trust, collaboration, choice, safety, and empowerment. People should be assisted to rebuild their lives and access specialist, evidence-based trauma-focused interventions (Trauma Focused Cognitive Behavioural Therapy: TF-CBT or Eye Movement Desensitisation and Reprocessing: EMDR) where required.

What is trauma-sensitive responding? Trauma-sensitive responding involves:

1: Noticing situations that could trigger trauma.

2: Noticing and addressing difficult trauma-related emotions, thoughts, and behaviours.

3: Being kind, warm, compassionate, and empowering.

4: Considering safety and taking steps to address it as needed.

5: Asking the person how you can help and supporting as far as possible.

4. RESISTING Re-traumatisation

Realising, recognising, and responding to trauma all contribute to preventing re-traumatisation. This includes an awareness of the historical and current inequalities in mental health care, and how these harm people. You will need to recognise how organisational practices may trigger trauma reactions and re-traumatise people and do what you can to respond helpfully to these. It is important that you should also feel supported in your role and receive supervision to assist you in managing the emotional impact of your work.

Suggested reading

- Bloom, S.L. (1997). Creating sanctuary: toward the evolution of sane societies. New York, NY: Routledge.
- Carr, S., Hardy, A. & Fornells-Ambrojo, M. (2018). The Trauma and Life Events (TALE) checklist: development of a tool for improving routine screening in people with psychosis, European Journal of Psychotraumatology, 9:1, DOI: 10.1080/20008198.2018.1512265
- Read, J., Morrison, T. and Waddingham, R. 2020. Traumas, Adversities, and Psychosis: Investigating Practical Implications. Psychiatric Times. 37 (7), pp. 48-51.
- Sweeney, A. & Taggart, D. (2018) (Mis)understanding trauma-informed approaches in mental health, Journal of Mental Health, 27:5, 383-387, DOI: 10.1080/09638237.2018.1520973

SECTION 2F: Addressing Mental Health Inequalities

As a Mental Health and Wellbeing Practitioner, you should at all times maintain a focus on:

1. Reducing inequity of access and outcome among those from minoritised groups accessing mental health services; and
2. Seeking to eliminate discrimination from the experience of mental health service users and practitioners.

Mental Health Inequalities

The NHS defines health inequalities as: "…preventable, unfair, and unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental and economic conditions within societies, which determine the risk of people getting ill, their ability to prevent sickness, or opportunities to take action and access treatment when ill health occurs."

Reducing inequalities is a defining feature of the NHS Long Term Plan, which acknowledges "…while we cannot treat our way out of inequalities, the NHS can ensure that action to drive down health inequalities is central to everything we do."

It is important to recognise that different groups have different likelihoods of developing a mental health problem as multiple personal, social and environmental factors influence this. For example, people with adverse childhood experiences are more likely to developmental health problems.

While the NHS cannot always solve the causal factors which increase the likelihood of developing a mental health problem, it has a duty to advance equalities in NHS services. This means accounting for the particular needs of groups at risk of, or already experiencing, inequalities, and ensuring our services meet their needs. It also means working with those groups to identify ways to reduce disparities in access, experience and outcomes.

Key examples of inequalities in access, experience and outcomes

- Different groups access services differently, with underrepresentation in some services and overrepresentation in others. This is an inequality in access. Examples include older people being underrepresented in receiving talking therapies and black-British men being overrepresented in mental health secure care

- Different groups report having different levels of satisfaction with the healthcare they receive.This is an inequality in experience. Examples include members of the LGBTQ communities reporting discrimination and poor experience of healthcare overall and ethnic minority individuals reporting poor levels of satisfaction with community mental health services compared to heterosexual and white British counterparts

- Different groups receiving the same treatment also have different recovery outcomes. This is an inequality in outcomes. For example, ethnic minority groups generally have poorer recovery rates in talking therapy services than white British groups

Challenging Inequalities

Tackling mental health inequalities is everyone's business – we all must take active steps to address them. Local services should co-produce local solutions with communities experiencing the adverse effects of mental health inequalities. They can draw on NHS-commissioned tools such as the Advancing Mental Health Equality Strategy resource developed by the National Collaborating Centre for Mental health (NCCMH).

You should examine your practice and any ways in which you may unwittingly be replicating or extending inequalities. Make sure you discuss this in supervision.

Helpful resources

- NHS England. Reducing health inequalities resources:
  - LGBT Health
  - Advancing Mental Health Equality
  - NHS Resources

Suggested reading:

- NHS Long-Term Plan
- NHS Mental Health Implementation Plan 2019/20–2023/24
- Mental Health Inequalities: Factsheet
- Advancing Mental Health Equalities Strategy
- NHS Mental Health
- National Vision for Psychological Professions
- See also Health and Social Care Act (2012) and Equality Act (2010)

Section 2G: Involving Families and Carers

As a Mental Health and Wellbeing Practitioner, it will often be important that you take a family-focused, as opposed to an individual/service user-focused approach. This requires you to understand the person in the context of their family and social network and recognise the impact their behaviour may have on their family members and carers. Within a family-inclusive approach, it is important to recognise the needs and strengths of carers alongside those of the service user.

Although it may seem more straightforward to focus on the person, in most cases, it is not particularly difficult to involve family members in the person's care. Some family members and carers may initially be reluctant to engage. Still, the extra effort involved early on will save much time, help to ensure the whole family's wellbeing and support the service user's recovery.

There are multiple benefits to routinely involving family members and carers in mental healthcare, including:

- Improved clinical outcomes (symptoms, functioning and wellbeing) for the service user
- Reduced stress levels in the family
- Better mental health for family members

What do families and carers need?

- To be listened to, and to be heard
- Relevant information about the service user's care, including information on assessment; diagnosis; formulation; intervention; services; benefits and employment services (where relevant) and who to contact in an emergency
- To be involved in planning their relative's care where possible
- Emotional and practical support to help them cope with the demands of caring for their relative (including respite care in cases of severe and enduring mental health problems)
- Advice on ways to respond to and help their relative

Why is it so important to work with families and carers?

- Relatives can provide key information to guide assessment, formulation and intervention
- Relatives may know a significant amount of information and be caring for the patient in many ways unknown to services
- Relatives can be effective partners in care, and working together to ensure all parties get consistent messages lead to improved outcomes
- Whatever their viewpoint, family members and carers are often influential. Accepting and working with people with a range of views can help keep the service user on track to recovery

Are there times when it is inappropriate to work routinely with family members and carers?

In some cases, keeping family members or carers who are causing the patient distress or harm at a distance may be appropriate.

- Severely dysfunctional families may not be suitable for family inclusive practice. However, they may also need to be communicated with and potentially referred to a family intervention or family and systemic psychotherapy. You should seek supervision about this type of situation and be led by the service user

- It is generally inappropriate to include family members who have abused the patient in family sessions

In both of these cases, it would be appropriate for the family to be seen by an experienced systemic practitioner or family and systemic psychotherapist.

Tips for family-inclusive practice

1. You should aim to view the family members as potential allies/assets and recognise that all family members are doing their best. Take note of their strengths and resources.

2. Reach out and actively try to involve the family in the planning and delivery of care as soon as possible (partners in care). Try to get an agreement from the service user to involve the family as much as possible. If the person is reluctant, explain that services are required to listen to family members and support them. Do not simply exclude relatives from routine care or only refer them on to separate support for their role as carers.

3. If you can involve family member(s) in the initial assessment, make sure you also provide time to meet the service user and the main family members separately, as they may not feel able to share sensitive information within a family session.

4. Try to talk to as many family members as possible, empathise with the difficult situation each person finds themselves in and validate their experience. Feeling heard may make them more supportive of the service user's current difficulties.

5. Make sure you inquire about the wellbeing/coping of all family members and ask especially about children. Offer individual family members the opportunity for individual support and normalise the idea that the situation will affect everyone.

6. Always listen to family members and share as much information as possible. You should never disclose the service user's sensitive personal issues. Still, you can still engage with family members even if there are limits on what you can share due to your client's confidentiality agreement. Listen to their story and ask them if they have useful information to share. (See Section 2H: Working with family members and carers – sharing information).

7. Be curious about family members' experiences/ 'stories.' Encourage discussion of multiple and nuanced explanations (e.g. trauma, personality factors, family, coping styles and illness). Do not rush to reassure, oversimplify, or provide single explanations such as illness or genetics which is likely to close important helpful conversations.

8. Expect family members and carers to try to make sense of symptoms and unusual experiences and encourage them to express their ideas/hypotheses. Recognise that family members and carers may

also be experiencing feelings of guilt, fear, shame, or anger. This will ensure that you don't close conversations about psychosocial factors related to onset or relapse.

9. All mental health problems, including psychosis, should be normalised as 'an understandable reaction to stress' as part of the emerging 'shared understanding' (consider using the Stress Bucket metaphor to facilitate this – see Section 3F). Ensure that you remain hopeful about recovery; do not describe symptoms as severe, enduring, and involving long-term disability.

10. Answer questions openly and honestly, acknowledge uncertainty, and emphasize the importance of the patient and family members' expertise. Especially don't be tempted to give simple 'expert' advice which conveys certainty where this is not warranted.

11. Acknowledge people's strengths and competencies, pay attention to what works and encourage people to improve their coping strategies. Don't focus exclusively on people's problems and difficulties.

12. Encourage a sense of hope and optimism (see CHIME, section 2D) whilst ensuring that neither the service user nor their family members or carers put themselves under too much pressure by expecting a rush back to previous levels of functioning.

13. Involve family members in goal setting and other interventions where appropriate - ask them to support the intervention strategies and encourage the patient to practice their new skills.

14. Encourage calm, positive communication. Do not ignore critical or hostile communication - stop these conversations, for example, by asking the family members or carers to reflect on how this is likely to make people feel. Make sure you stop any persistently critical or abusive conversations.

Helpful Resources

- The British Psychological Society (2021) Family Interventions in Psychosis: Guidelines for psychologists and practitioners supporting families and social networks
- Worthington, A., Rooney, P., & Hannan, R. (2013). The Triangle of Care: Carers Included: A guide to best practice in mental health Care in England. Carers Trust.

Section 2H: Working with Families and Carers: Sharing Information

In general, sharing relevant information between service users, health professionals, families,or carers can benefit everyone. However, it is essential to check with the person giving the information whether it can be shared with others.

Service users and carers have the right to keep the information they provide confidential. Sometimes carers find it difficult to understand why information cannot be shared about their loved one when they are clearly unwell. This needs sensitive handling and can be a constant balancing act.

Practitioners have a duty to both the service user and their family members or carers to keep the information they provide private. For good working relationships to develop it is essential that service users and their families can trust the clinical team. They need to feel confident that theirpersonal points of view will be heard and taken on board and that information will be used within the service team and more widely if appropriate for the benefit of the service user.

Family members or carers have important experiences and information about their loved one that they may want to share with you. Working with families wherever possible will help you deliver the most suitable, recovery-focused package of care.

Family members or carers should, where appropriate, be offered the opportunity for a meeting to discuss their own needs. This will also allow you to provide details of any services they may find useful.

Key points

Sometimes service users do not want professionals to talk to their family or carers. It may be helpful to explain that you also have a duty of care to family members but that no personal information will be shared about them.

Carers can give information to professionals even when a service user does not want personal information shared. In this instance it should be made clear that the carer may not get the answers they would like, but that the information they provide is invaluable and will support their relative's recovery.

Information known to carers or families can be talked about. If they know about it already, it is not confidential. Family members and carers can't be told any new personal information that a service user has shared with you, unless the service user provides their consent for you to do so – that would be a breach of confidentiality.

You can ask family members or carers for information about service users. Asking carers questions to understand their point of view, such as, "how do you think they are doing?" or "what would you like to see happen next?' is important. You are not sharing information or breaking confidences by doing this.

Sharing information is a complex process. It is often not black and white. In some instances, service users may say they do not want their family or carers involved but will themselves be talking to them about their treatment. It's worth checking out with service users what information they do share with their carer and family members. Equally, it's worth asking families and carers what information they want to know and asking the service user if they consent to this being shared.

It needs to be acknowledged that there are instances where family relations have been, and/or continue to be, difficult or abusive. This could be contributing to the service user's mental health problems. In these circumstances, it is understandable that service users may not want their family members to be contacted or have any personal information shared with them. If family members are in contact with services, then staff need to be clear about what information can be shared. Even if a service user has not provided consent for any personal information to be shared, in most instances, it should not prevent the team from:

- Engaging with family members
- Receiving information from families and carers
- Listening to the views of family members, and
- Giving general information, advice and support to families and carers

In some specific cases where domestic abuse or violence is suspected, safeguarding principles must be considered carefully and applied. This could mean that details, including the service user's whereabouts (which are indicated by whether they are a user of your service), would not be shared. If you are unclear or concerned about sharing information, seek advice from yoursupervisor or team manager.

General information

Providing families and carers with general information about mental health problems or offering emotional and practical support does not breach confidentiality.

Although personal information cannot be shared without consent, general information can be shared includes:

- Information about mental health conditions
- Background information on medication and possible side effects
- Information about the workings of the Mental Health Act
- Contact details of the local/national carer support organisations
- Contact details of health and social care professionals
- Discharge arrangements which directly impact on them
- Information about local care planning arrangements
- Any confidentiality restrictions requested by the service user
- Information about how the service generally works with service users
- The role of each professional involved in their loved one's care
- How to access help, including out of hours service contact details in the event of a crisis

Confidentiality principles

There are some details that the clinical team will not be able to share with families and carers unless their loved one has consented. This includes new information that the service user has shared with the team.

Whether a service user does or does not give consent to share confidential information with their carer, you must document this decision in the service user's records. This should be reviewed regularly and documented in the care records.

No consent is required to seek information about a service user, only to share it.

Sharing of information in exceptional circumstances

There are exceptional circumstances when confidential information can be disclosed, such as where a service user's, or someone else's, health and wellbeing is at serious risk, or where there is a public interest or legal reason for disclosure without consent.

Consent to share information

The use of Advance Statements (also known as advance directives or information sharing agreements) is a useful way of setting out in clear detail:

- A services user's wishes about what should happen; and
- Which family member(s) or carer(s) practitioners can contact should the service user become too unwell to engage in discussions about sharing confidential information

You should let family members or carers know:

- If such a statement has been prepared
- Where the statement is held, and
- How to access it

Decision not to provide consent to share information

If service users decide not to consent to share information with their family or carers, you must provide family members with enough information to enable them to provide appropriate care. Support for family members or carers can also still be provided. You should inform service usersabout what information has been shared.

Lack of capacity to consent

If a service user is unconscious or unable, due to a mental or physical condition, to give consent or to communicate a decision, the mental health practitioners concerned must take decisions about the use of information.

Sharing information with other organisations (e.g. the police)

Whilst the police have no general right of access to health records, there are several laws which make the sharing of confidential information a requirement. This means the disclosure of confidential information to the police can be lawful in some circumstances.

If in Doubt – Ask

Issues surrounding confidentiality can be complicated. If you need clarification about the rights of service users and/or their families in relation to what information can be shared, then it is important you seek advice from your supervisor or team manager. Each organisation will have their local protocols and policies in relation to confidentiality. Make sure you know these and keep up to date by attending associated training.

Acknowledgement

This information has been adapted from the Information for Carers guidance on the Tees, Esk and Wear Valleys NHS Trust website.

For more information, see https://www.tewv.nhs.uk/about-your-care/carers/.

Suggested reading

For full information, please refer to:

NHS Code of Practice

Tees, Esk and Wear Valleys NHS Foundation Trust (2021) Common Sense Confidentiality-
Guidance for carers on information sharing between staff, service users and carers

Section 2I: Working in Person, by Telephone and by Video Consultation

In your practice, you will need to be able to work with the service users in your caseload, and their families or carers, in several different ways – in person, by telephone and by video consultation. Which you use may be dictated by circumstances beyond your or the person's control (such as public health restrictions), or by a particular individual's situation, needs or preferences.

The choice of mode of contact should as much as possible be made by the service user, rather than the service. You'll need to be prepared to carry out consultations by any of these means and be aware of how to maintain a service user's confidentiality if you are speaking to them in another location and how digital poverty and disadvantage may affect them.

Delivering services in person

When you meet with service users, families or carers in person, this should be in a confidential and comfortable space, where you are not likely to be interrupted or distracted, for example by telephone calls or messages. Where possible, it can be helpful to have consistency over where youmeet too, so unfamiliar surroundings don't increase anxiety.

It is usually better to meet in the service base, although sometimes meeting at the service user's home may be necessary. You should take the service user's, family members' or carers' preference into consideration when agreeing a meeting space. If meeting at the service user's home, make sure this feels and is safe for both of you. Make sure you understand and follow your service's lone working policy.

Delivering services remotely

Emerging evidence suggests that when used well, you can achieve outcomes from some types of intervention via telephone or video interventions, at a level comparable to that with in person intervention. These modes can also be very convenient for service users.

However, they may make it harder to pick up subtle cues and information or to deliver certain types of intervention (e.g. involving actively doing things together such as a graded exposure task). You should consult the local guidelines for the latest advice, processes, and protocols for delivering via telephone or video, and discuss with your supervisor. Broadly, though, successful remote interaction with service users is based on the following principles:

1. Preparation

- Live test any remote technology before you start using it, whether based from home or in a clinical environment

- Make time to practise using the software by connecting with a colleague and testing the process. For video consultations make sure you look into the camera, not the screen

- Make sure you have a suitable space if working from home. If using video consultation, your background must be free of personal information, and your lighting needs to give a clear picture. You should also encourage the service user to have good lighting so you can more easilyread non-verbal cues. If they have a window or bright light source behind their heads, you will see them mainly in silhouette

- For both video and telephone, use headsets if this improves the sound quality; this promotes engagement and your ‘presence’ on the call

2. Communication

- Outline the potential communication options to service users, family members and carers, and ask them if they have a preference. Make it clear that you are not asking them to committo using a specific tool, simply identifying their preferences
- Provide service users, family members and carers with clear, reasonably adjusted information on interventions delivered remotely
- Refrain from assuming that digital delivery modes will be unsuitable for older adults
- Check with service users that they have a safe and secure space where sessions will be confidential and free from distractions
- Explain to the service user that sessions will always be scheduled, so they do not worry when the next contact will be. Emphasise that it is an appointment and ask them to prepare in advance (i.e. questions, feedback, diaries ready, etc.)
- Agree on a code-word for use when the service user cannot talk, e.g. ‘Mary’

3. During consultations

- At the start of the consultation, agree with the service user how you will proceed should the technology fail (e.g. arranging to try again in 5 minutes, rescheduling or switching from video to telephone)
- With telephone contact or if the person chooses to have their camera off, it can be challenging to read non-verbal cues. You need to pay careful attention to tone of voice (if possible), pace, inflection, and the use of silence/long pauses. Check regularly with the service user if there is agreement and mutual understanding in therapeutic discussions
- Explain to the service user that there will be pauses during the session (for notetaking and thinking)
- Elicit immediate feelings from the service user on the specific delivery mode of therapy (telephone/video) so you can address any concerns or fears, and regularly elicit feedback during the first few contacts
- More frequent reflection and clarification of understanding is important when using remote methods of communication
- Use written materials and diaries and give examples by email if this is possible

4. Working with those who may have a learning disability, autism or communication impairment

- Identify any alternative or augmentative means of communication that help the person understand or express themselves. This may require additional preparation with the service user or their family members/carers to identify the best means of communication and to ensure both you and they have access to it. For example, you may need to check what kind of vocabulary theperson uses and is familiar with and whether signs, symbols or picture resources cansupport interaction

- Consider how your language or specific vocabulary can be simplified, paraphrased or be represented by symbols or pictures to best support individuals' understanding and response

- The service user may need extra time to become familiar with and comfortable in using the technology. Guidance on its use needs to be supported by the identified alternative or augmentative means of communication

- Consider pacing the session according to the service user's needs and monitoring their concentration level. Using signs, symbols or pictures is likely to slow the pace of an assessment or intervention; this will need to be considered

Adapted from: MHLDA Covid-19 guidance IAPT

Section 3
Engagement and Assessment

Engagement and Assessment with People with Severe Mental Health Problems

Section 3A: Approaching Engagement: Warmth, Empathy and Collaboration

Throughout your contact with service users, carers and families, as a Mental Health and Wellbeing Practitioner you should be guided by the principle of engaging genuinely in these relationships, beginning with warmth, empathy for the person's experience and offering a collaborative stance. You and the service user become a team working together to agree on goals and tackle the problems they are experiencing.

You should quickly establish the expectation that you and the service user can work together in a trusting and warm relationship. You should make explicit your intentions to negotiate what the contacts between you and the service user are intended to achieve.

Your aim is to motivate them to feel committed; you need to be working to generate hope so that the service user (and their family members or carers if you are working with them (see [Section 2H on working with family members and carers](#)) have realistic expectations that they can be helped through contact with you.

Key engagement considerations:

- Always introduce yourself clearly to the service user

- Make sure they understand your expertise, and how it is relevant to their situation

- Maintain a positive, non-judgmental attitude in all your interactions with the service user, families, and carers

- Use a variety of verbal communication styles, paraphrasing, reflection, empathy, summarising, factually accurate and realistic reassurance

- Be aware of non-verbal communication and its impact. Make sure you maintain positive eyecontact, a non-judgmental facial expression and an open posture; along with (if you are meeting the service user in person) ensuring seating arrangements are informal, relaxed and non-confrontational

Recognising and managing your own responses

Even if you have difficult feelings about your work or in response to particular individuals, remember that you need to maintain a positive, warm and collaborative relationship. It is important for you to recognise the full range of your own thoughts and feelings, especially making use of supervision to understand and process them, but always behaving in ways that are in the best interests of the service user.

Section 3B: Working with Distress

Working as a Mental Health and Wellbeing Practitioner will often involve being with and responding to people in distress. Responding to distress in a way that manages the intensity of the emotion to a level that allows progress, rather than escalating it unhelpfully, is a core competence of your role.

Distress is a universal human experience and can manifest in many ways. For example:

- Tearfulness
- Anger
- Hopelessness
- Fear response
- Withdrawing from others
- Suicidal thoughts, urges or intent

Consider:

When your own emotional intensity is high, how able are you to:

- listen to others?
- think clearly?
- problem-solve?

Responding to distress

i. 'Being' and 'doing' responses

Some sources of distress have a potential solution, or solutions, that can be implemented to alleviate distress. Other sources of distress have no immediate solution that will change the way you feel. Different situations may call for different type of responses.

- 'Doing' responses are goal-oriented responses (e.g. advice giving, problem-solving, signposting to services)
- 'Being' responses focus on accepting or allowing (e.g. listening, summarising, reflecting, validating)

ii. Knowing when to use a 'doing' response and when to use a 'being' response

Sometimes you might feel under pressure to do something to alleviate a service user's distress, particularly when you are employed in a role to 'help'. This can lead you to take a task-focused or problem-solving approach, which can sometimes escalate the distress.

You will know when a 'doing' response is the incorrect response very quickly, as the person is likely to become more distressed.

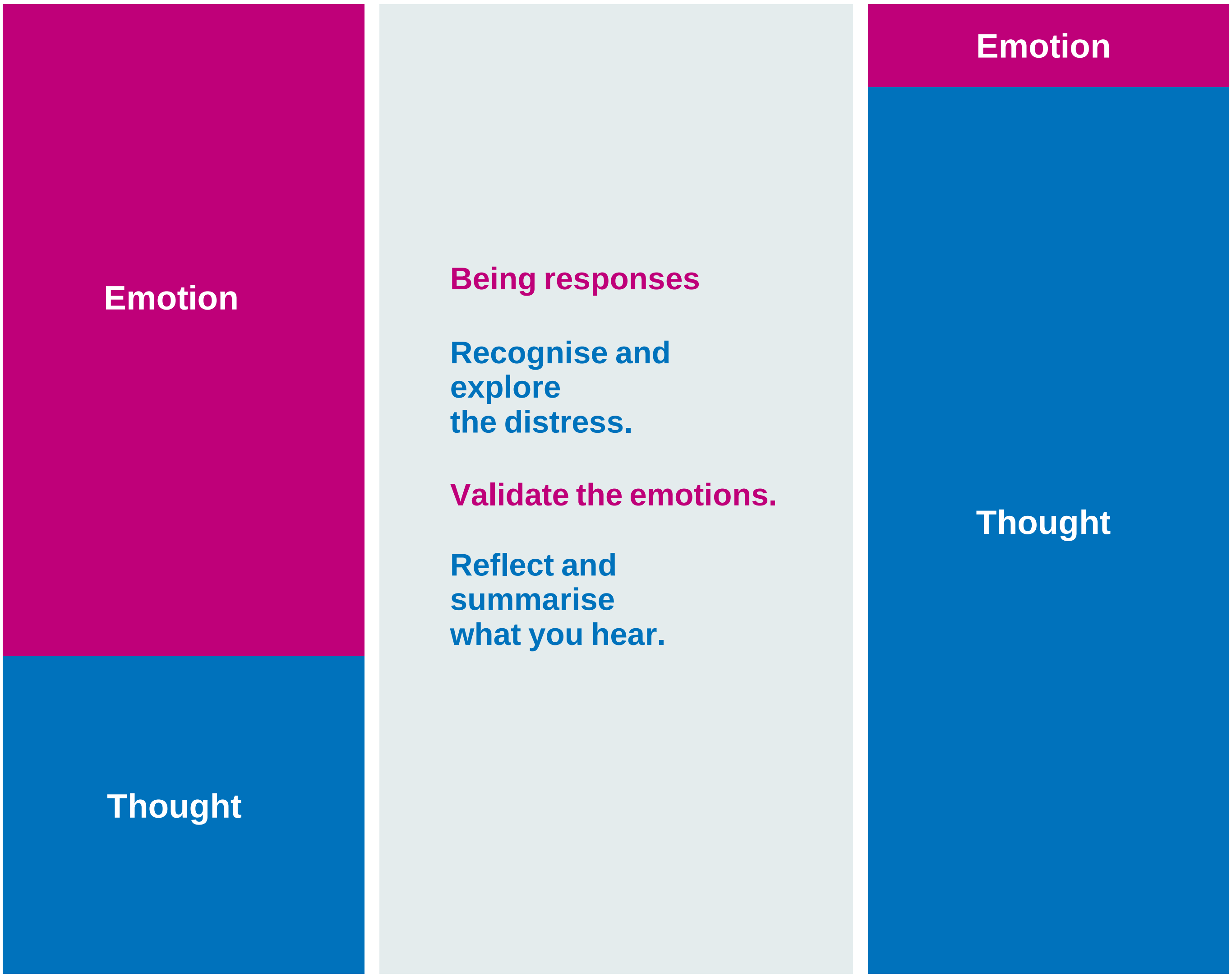
Sometimes, even when there are potential solutions, you might have to help a person to bring down the intensity of their emotional distress before they are able to look for or implement the solutions.

Think of 'headspace' as finite. If the majority is taken up with emotion, there is little room for clear thinking and problem solving (Figure 1). Often, when emotional intensity is at a manageable level, people are much more able to generate their own solutions.

'Being' responses are a way of helping reduce emotional intensity to get to a point where people are likely to be more able to problem solve for themselves or be more receptive to a 'doing' response from you.

Figure 1: Emotional intensity and thinking space

Emotional intensity high = thinking space low



Being responses

Recognise and explore the distress.

Validate the emotions.

Reflect and summarise what you hear.

‘Being’ tips for when emotional intensity remains disruptively high:

1. Recognise and explore their distress. Be curious.

Try not to focus only on establishing the events. How did they feel about the events? What emotions did they experience? What was the meaning of the event to them?

Begin with open questions:

- How do you feel about that?
- What emotion did you feel at the time? If they are struggling with open questions:
- Could you reflect your observations on what you see? e.g. “You seem quite sad; I’m wondering if you’re feeling sad?”
- Could you ask them to look at an emotion wheel or a list of emotions to see if they would recognise feeling any of the emotions listed?
- Could you validate their confusion? Provide validation:
- Give your undivided attention. Listen. Accept what the person is saying as the truth without challenging or offering alternative perspectives
- Give good eye contact and non-verbal signs that you are listening and interested
- Recognise/normalise emotional responses that anyone would have
- Understand responses in terms of their personal history
- Be completely genuine in your willingness to accept how the person is thinking and feeling, even when you do not agree e.g. “I can see how angry this makes you,” even if you cannot validate their viewpoint

Reflect and summarise what you hear:

- Demonstrate that you understand what they are saying and accept how they think and feel by summarising what you have heard
- Paraphrase the words and feelings you have heard. This allows the speaker to hear their own thoughts, which may facilitate increased self-awareness
- Reflecting the content of what is being said helps to focus the conversation
- A skilled listener may be able to reflect what the speaker is feeling from non-verbal cues as well as from the verbal messages
- Reflecting and summarising demonstrates that you are interested and so encourages the individual to continue speaking e.g. “So, if I’m understanding you correctly, you’re saying that…”

Approaches to **AVOID** when distress/emotional intensity remains disruptively high:

- Suggesting solutions
- Challenging thoughts/beliefs
- Offering alternative perspectives
- Highlighting positives

‘Doing’ tips for when the person is ready to think about solutions

A doing response is not always necessary. Sometimes helping the person to bring down the intensity of their distress is enough intervention.

It is often impossible to implement a doing response when distress levels remain too high. The intensity of emotional distress can be reduced by staying with the being responses until it is apparent that the individual is much less distressed.

Examples of doing responses you might implement with the person include the psychologically informed interventions that Mental Health and Wellbeing Practitioners can offer (see section 5). Sometimes, these interventions will involve activities that can raise the ‘emotional temperature’, such as during graded exposure to feared situations.

There is a window of emotional intensity within which a doing intervention becomes possible, and helpful. Aim to keep working within these margins, lowering the emotional temperature when too high, but being willing to introduce doing interventions that raise it where these are helpful too.

Section 3C: Initial Information Gathering

The purpose of information gathering for Mental Health and Wellbeing Practitioners is to identify and respond to a service user'scurrent problems or issues. It is not to provide a diagnosis or undertake other assessments that would more appropriately be part of the role of another team member.

The method of gathering information used by Mental Health and Wellbeing Practitioners is known as 'person-centred interviewing'. It is designed to identify the person's primary concerns and ways forward in a way which acknowledges the service user as a unique individual. Person-centred interviewing accepts that a service user is an 'expert by experience' and uses their knowledge and experience of mental health challenges to guide the assessment.

The process of person-centred interviewing enables practitioners and service users to share power, negotiate the best care plan, work in an alliance, and personalise effective intervention strategies. This type of interview increases the chances of building a good therapeutic alliance. Properly established, developed, and maintained, such an alliance will reap dividends in effective helping.

Effective questioning – the funnelling technique

Funnelling is an essential technique for collecting information in a person-centred way. It places the service user's account at the centre of the interview (unlike a questionnaire-led interview where questions are asked in a pre-determined format and order). Using funnelling enables you to provide both structure and person-centredness in any interview.

Funnelling uses a mixture of open and closed questions.

Open and closed questions

Open questions:

- ask the service user to think and reflect
- encourage the service user to share their thoughts, opinions and feelings
- are likely to elicit long answers
- give control of the conversation to the service user

Closed questions:

- ask the service user to give you details or facts
- can be answered with either a single word or a short phrase
- are usually quick to answer
- keep control of the conversation with the interviewer

Funnelling begins with a general open question (for example, "What is the current problem?"), followed by specific open questions (for example, "Can you tell me more about…?") to find out more about the topic opened up by the service user's response.

You will probably need to use several specific open questions, but at some point, you will need to move to closed questions to get to specific details of the problem (e.g. “How often does this happen?” or “What triggers this problem?”) Be careful not to use too many closed questions too early in the interview, as this can restrict the service user from opening up, making the interview less person-centred.

The service user may outline a range of concerns in response to general open questions. You should treat each as a separate funnel. Once you have clarified one with closed questions, repeat the funnelling process by returning to another specific open question.

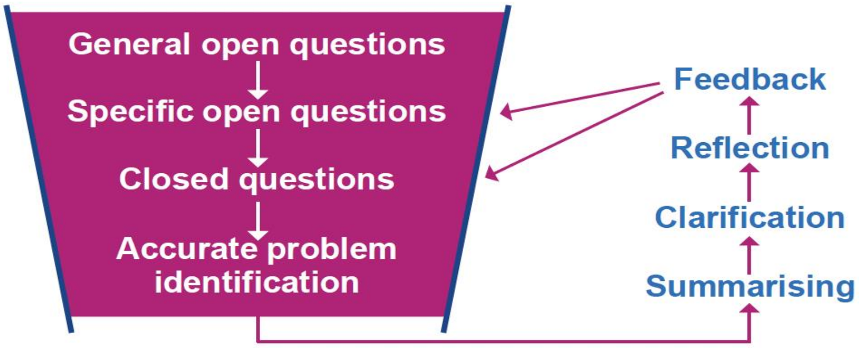


Figure 1: Funnelling

The content of the questions

Listed below are the specific questions which you should use to get a full picture of a service user’s main current concerns during an initial appointment.

Remember that you should always ask questions within the funnelling procedure and be flexible about when you ask them; you should not simply follow the rigid order presented below:

- The 5 ‘P’s

    1. The **Presenting** Issue - what is the current problem? The aim is to arrive at a problem statement incorporating CONTEXT, the PROBLEM, and IMPACT.

    2. **Precipitating** Factors - what has triggered the problem, why is the service user seeking help now?

    3. **Predisposing** Factors - What underlying issues (e.g. from the service user’s past or current situation) may have made this problem more likely?

    4. **Perpetuating** Factors - What is keeping the problem going?

    5. **Protective** Factors - What makes this problem better or helps the service user with it?

- What impact does the problem have on work, domestic activity, social leisure, private leisure, and intimate and family relationships (noting the connection between these impacts and CHIME factors)? (See CHIME factors, section 2D)

- Who are the most important people in the service user’s life – and how are they involved in supporting or not?

- Is the service user at risk of suicide, harm or neglect to themselves or others or at risk from others?

Other important issues to explore and consider with the service user:

- When did the current problem start?

- Has the service user had any previous episodes of a similar problem, and how have they been tackled?
- Is the service user receiving any current treatment or intervention for these problems?
- Is the service user using recreational drugs, or drinking alcohol? How much?
- Why has the service user sought help now?
- What does the service user want from seeking help?
- Is there any other important information that has not been covered?

Gathering Information from family members and carers

Family members and carers usually know the service user best, so will probably have noticed changes in their behaviour and will want to help. They know the person's strengths, skills and interests and can provide valuable information enabling you to work more effectively with them. Remember that family members and carers may also be dealing with their own feelings and may even feel they have failed the person somehow. (See Section 2F Working with families and carers) Even if the service user has had the problem for a while, this may be the first time their family or carers have had the opportunity to speak to anyone about their concerns. Remember that althoughyour main aim is to gather information about the service user, listening and hearing the family or carers' views cannot be overestimated. This is an opportunity to give them hope, gain their trust in working with the person and validate their experience and feelings, as well as recognising the importance of their place in the service user's life.

Using simple open questions allows the carer to explore what's been happening for them and give you the opportunity to gather information. Statements that allow the family member or carer to recognise how they feel can also be helpful. It is important to recognise and acknowledge their feelings, e.g. "this must be really hard/confusing/worrying for you."

Asking questions about their relative makes them feel valued and useful at a time when they may feel helpless and despairing.

Useful questions include:

- Can you tell me a little of what's been happening for you?
- What's changed in your relative's life that makes you concerned?
- This must be really hard/ confusing/ worrying for you?
- Can you tell me a bit about what they were like before you became concerned?
- When do you think things began to change?

This is not an exhaustive list of questions. Every carer and every family is different. The important thing is to empathise with their situation and ask questions accordingly to gather relevant information.

Suggested reading

Egan, G. and Reese, R. J. (2021). The Skilled Helper: A Client-Centred Approach. Third Edition. Cengage Learning EMEA.

Section 3D: Collecting Routine Outcome Measures

Collecting routine outcome measures

A key part of your responsibilities as a Mental Health and Wellbeing Practitioner is to collect and actively use service user-reported outcome measures to understand current problems and track progress through a service user's use of the service and any specific interventions.

This can help to guide effective helping. Comparing services can also identify ways that the most effective services achieve good outcomes for the service users so that all services can learn from this and become as effective as possible. Outcome measures should be an active guide to your unique work with each service user, never just used to gather service data. Interestingly practitioners often have greater reservations about using measures than service users.

Service users can find it very helpful to complete measures to enable fuller discovery of essential issues, including things that may need greater focus in your work together to unstick them. However, poorly delivered measures can be experienced as a burden or repetitive. They should always be integrated with coherent rationale. Completing measures outside of the session is beneficial, as this means there is more time in the sessions for discussion, including discussion of what they reveal.

You should use the following measures to inform collaborative work and track progress at every contact:

ReQoL-10

The ReQoL (Recovering Quality of Life) measure places service users at the heart of their recovery and provides you as a practitioner with a user-friendly, valid and reliable aid to clinical decision-making and outcomes monitoring.

1. ReQoL is an enabling tool for service users

- The quality of life of service users should have a central role in their recovery journey. One way to create a positive recovery environment is to provide a voice to service users, and this is the aim of ReQoL

- ReQoL enables service users to self-report on what matters most to them and provides them with the means to evaluate their progress on the recovery journey

- By doing so, ReQoL offers an opportunity for service users to feel in control of what happens with their services, interventions, and recovery

2. ReQoL is a clinical aid for practitioners

There are two versions of ReQoL: a short 10-item version (ReQoL-10) and a 20-item version(ReQoL-20).

The ReQol-10 questionnaire is included in resources. Please see the accompanying notes. You should use ReQoL-10 at the initial assessment and to review progress at every contact if you are undertaking a psychological intervention. This can help identify areas of collaborative work that would be beneficial to the service user.

Goal-based outcomes (GBO)

The goal-based outcomes (GBO) tool is a simple and effective method to measure progress and outcomes of an intervention.

It grew out of work with children, young people and their families in mental health and emotional wellbeing settings but can be used in any change-focused and goal-oriented setting – including adult community mental health contexts.

The GBO tool tracks what is arguably the most important thing to measure in any intervention: "Is this helping you make progress towards the things that you want help with?" The GBO tool should identify goals with service users at the initial assessment, then progress rated at every contact if you are providing a psychological intervention.

The GOAL progress chart is in Helpful Resources.

DIALOG

In addition, your service is likely to be using another measure (although not necessarily for every contact) called DIALOG, which examines satisfaction with several social determinants of mental health such as employment and relationships.

DIALOG is a scale of 11 questions. Service users rate their satisfaction with eight life domains and three treatment aspects on a 7-point scale.

DIALOG provides a score for subjective quality of life and treatment satisfaction.
You will find the DIALOG Scale in Helpful Resources.

Administering the measures

If possible, you should ensure that service users have a copy of each measure in front of them to help them answer the questions. Remember that your service users may find answering these questions quite demanding.

For sessional measures, tell the service user you will be running through this questionnaire each time you talk to each other. This is to help identify key issues at the outset and to give you both a measure of the service user's progress over the time that you will be helping them. For other measures, let them know the frequency of administration.

Some service users may be able to complete measures outside of the sessions (e.g. on the day they are going to meet you), either on paper or electronically if systems allow. This can save time in your meetings with them, but you should always review the measures together and use them to inform your work. You should give the service user as much choice as possible in the way that measures are completed.

You may find the following form of words helpful:

"I would like to ask you some standard questions from a questionnaire. This can help us identify key issues for you and to measure progress together and make sure we are on track and making as much progress as possible. I will return to these questions each time we speak/meet. Sometimes your responses will change, sometimes they won't, but we can always use them to help guide our work together".

How to use the questionnaire

- Run through the questions in order
- Give the service user feedback on what the scores mean and any changes
- Be honest with the scoring and ask, “How does this fit the way you are experiencing things?”
- Make sure you hand out spare paper copies of measures to the service user to help with any subsequent contacts, particularly if these are likely to be on the telephone/video consultation. Alternatively, explain how any electronic system for answering the questionnaires should be accessed

Helpful Resources

Note: Before using any of these tools it is important that your service has registered to use them with the National Clinical Content Repository. For guidance, see: National Clinical Content Repository (Copyright Licensing Service) - NHS Digital National Clinical Content Repository (Copyright Licensing Service) - NHS Digital.

Recovering Quality of Life (ReQoL) for Users of Mental Health Services

Goals and Goal-based outcomes

DIALOG

Section 3E: Diagnosis and Formulation

A fundamental difference between a psychological and a traditional medical approach is that a formulation, as opposed to a diagnosis, lies at the heart of the intervention. For this reason, it is important that you are clear on what is meant by ‘formulation’ and how this differs from a diagnostic-centred approach.

Diagnosis

A diagnosis is a fundamental component of a medical model. By examining the patient and determining symptoms, the physician can decide what the problem is and diagnose the illness. The diagnosis in turn provides clarification on what the course and outcome of the illness is likely to be and what types of treatments are most effective.

People who receive a mental health diagnosis, and their family and friends, may find this both helpful and (sometimes) unhelpful. Each person and family member will experience their relationship with a diagnosis differently. However, the diagnosis may well be received with an awareness that within our society there is still stigma attached to a mental health diagnosis.

Not everyone’s symptoms fall neatly into boxes within a diagnostic classification system. In such circumstances the diagnostic process is likely to be less helpful. In the UK, most services will use the International Classification of Diseases (ICD) to determine diagnoses.

Now in its eleventh revision ICD-11 was developed by the World Health Organisation and is the global standard for coding both physical and mental health conditions. You may also hear about Diagnostic and Statistical Manual of Mental Disorders or “DSM”. This manual is used by mental health professionals in the USA (as well as for some research trials in the UK) and is an alternative to ICD.

Formulation

Unlike a diagnosis, a formulation is an individualised explanation of why a person in a particular situation might have developed the problems they have and what might be keeping them going. Many psychological formulations are based on theoretical models:

- Psychodynamic psychotherapists base formulations on psychodynamic principles

- Systemic therapists’ base formulations on systemic theories

- Cognitive behavioural therapists base formulations on cognitive behavioural theory.

Other formulations are more generic and atheoretical.

Formulations come in different forms and can provide different depths of understanding.

Diagnosis	Formulation
Provides a description of symptoms. Not individualised in explaining “why”. Suggests the appropriate type of treatment. Fails to be helpful when symptoms don’t fit into discrete categories. As labels they can carry assumptions.	Provides explanations of why the problems have arisen and what is keeping them going. Is specific to the individual. Bridges the gap between theory and practice. Provides “hypotheses” which are modifiable. Determines treatment approaches. Predicts problems that could arise. Can be understood at different levels.

Table 2. Diagnosis vs Formulation

Formulations are not merely lay opinions but are based on psychological theories. You should work with the service user to develop a mutually agreed upon, shared formulation. This should help them to make sense of why their problems might have arisen and help you to plan the most appropriate intervention.

It is important to remember that formulations are hypotheses or ‘good guesses’, not facts. You should always be mindful that you could have the formulation wrong and should review it regularly, considering newly gathered information.

A good formulation is crucial to a psychological approach, as it provides information on what is causing the presenting problems and guides the entire therapeutic process.

Formulations should be collaboratively developed and should make sense for and resonate with the service user. They may enable understanding of the problem for both the service user and their family or carers.

As a Mental Health and Wellbeing Practitioner you will learn to collaboratively create two types of formulations:

1. A generic **5 ‘P’s formulation** that aims to understand the **problem** in terms of what has **precipitated** it, is **perpetuating** it, **predisposed** the person to develop it, and **protects** them from its worst effects. The 5 ‘P’s formulation is a comprehensive atheoretical model of the main factors behind a specific problem. It is a useful product of the first assessment (see Five ‘P’s Formulation, Section 3F).

2. A cognitive-behavioural **5-area formulation** aims to understand what may be perpetuating a problem in terms of vicious cycles of **thoughts**, **behaviour**, **emotion** and **physiology** in a particular **environment**. The 5-Areas formulation is a map of perpetuating cycles that can be addressed through some of the psychological interventions you will deliver. You will develop this type of formulation when you start to work with service users on a plan for one of these interventions (See Section 5).

Suggested reading:

Good Practice Guidelines on the use of psychological formulation, The British Psychological Society

Section 3F: The 5 Ps Formulation

The 5Ps Formulation is a widely used generic model that can be used to formulate a person's presenting problem: providing an explanation for what might have contributed to their problems arising and what might be keeping them going.

When making sense of a person's problems, you must work together with the service user to develop a mutual understanding of the problem. Remember that a formulation is a hypothesis or good guess using the information you have at the time. You may want to revisit the formulation as new information emerges.

The 5P Formulation looks at 5 particular factors (all beginning with 'P'!):

- The **P**resenting Problem
- **P**redisposing Factors
- **P**recipitating Factors
- **P**erpetuating Factors
- **P**rotective Factors

The Presenting Issue

This is a current problem that the person is wanting help with. It is best to define this in terms of the service user's experience, using their own words. The presenting issue should not be a simple diagnostic label, but a current problem such as "I sleep very little at night, and then doze all day", or "I feel very low and have no hope for the future", or "I binge on unhealthy food when I am stressed".

Predisposing Factors

Predisposing factors are those that may have made the person more susceptible or vulnerable to developing the current problem. These factors could be:

- Biological
- Social or
- Psychological

Although you may want to suggest a few things that we know could contribute to people developing mental health difficulties, it is important not to impose your own views.

Research shows that mental health professionals tend to emphasise bio-genetic causal factors more than psycho-social factors when it comes to severe mental health problems, particularly psychosis and bipolar.

It is important to inform service users that although genes can play a role, a wide range of psychosocial factors may also play a crucial role, including early adversity such as bullying (including racist abuse), neglect, sexual and physical abuse, being placed in care, lack of safe and secure attachments, losing a parent and so on.

We know that many people with severe mental health problems have multiple predisposing factors, and the more of these that are present the more susceptible they might be to developing mental health problems. However, although many people will have experienced adversity, there will be some people who cannot identify any predisposing factors for a current problem.

If this is the case, do not pressure the person to come up with something – it is not always possible!

Precipitating Factors

It can be difficult to differentiate Predisposing from Precipitating Factors.

Predisposing Factors tend to be longer term issues or events that occurred during childhood or adolescence.

Precipitating Factors tend to be the things that were going on immediately prior to the problem arising – these can be personal (such as the way the person was thinking, feeling, or behaving) or external (such as a particular event occurring including the end of a relationship, a bereavement, losing a job and so on).

We know that in many instances, sleep problems can play a key role, therefore it is worth asking about this specifically.

Perpetuating Factors

Perpetuating Factors are those things that keep the problem going once it has started. We know that sometimes the things that people do to cope can inadvertently maintain the problem. Examples of these may include:

- Drinking heavily
- Use of recreational drugs
- Isolating themselves and not sharing problems
- Avoidance and safety seeking behaviours

Once again, it is important not to impose your own views about what is helpful and unhelpful, but to explore ideas and potentially test things out (e.g. let’s find out if you do sleep better when you drink or not – and then monitor this over time).

It is also important to explore situational factors: for example, is the person in a relationship or situation where they don’t feel safe; are they worrying about debt or housing problems?

Protective Factors

Protective Factors are things that temper the problem or make it less likely to occur. These factors often equate to helpful personal coping strategies, such as:

- Practising mindfulness or relaxation
- Sharing problems with a friend
- Becoming more active

- Developing a routine
- Taking prescribed medication

Each person will have their own list of things that help. Just as some situational factors are crucial Perpetuating Factors, some can act as Protective Factors, and these need to be explored, too.

You should keep in mind the ‘5Ps’ when gathering information for your assessment as this should help you work with the service user to develop a meaningful shared formulation.

The 5Ps and The Stress Bucket

The Stress Bucket (see Section 3G) is a metaphor that can be used to structure your discussion around the 5Ps.

Next steps from the 5P Formulation

Once you and the service user have developed a personalised 5P Formulation, you can consider what the focus of your work together should be, either in supporting access to wider community and professional input, or in delivering an intervention yourself. It is unlikely you will be able to do anything to change Predisposing Factors. Still, you may want to explore the precipitating factors and think about anything can be done to reduce the likelihood of these happening again.

You may also want to consider how you can build on the identified Protective Factors and how best to address the Maintaining or Perpetuating Factors.

Worksheet: The 5 Ps: Making Sense of Problems

What is the presenting problem? A current problem, described using the service user's own words, in the form of their experience (not simply a diagnostic label)	
Predisposing Factors May include family history, early adversity etc.	
Precipitating (Triggering) Factor May include stressful life events including the end of a relationship, a bereavement, housing problems, physical health problems etc	
Perpetuating (Maintaining) Factors May include a range of personal and situational factors such as worry, avoidance, insomnia, housing issues, toxic relationships, debt, drinking/drug taking and so on.	
Protective Factors May include personal coping strategies such as relaxation, meeting with friends, taking medication, having a daily routine etc.	

Section 3G: The Stress Bucket

The Stress Bucket is often used as a metaphor to help explain why someone might experience symptoms of ‘psychosis’; however, it can be used more widely to explain why any of us could experience all forms of mental health problems more generally. You would use the Stress Bucket to find a shared understanding of why a current mental health problem has arisen and what might be keeping it going.

By acknowledging past and present trauma and adversity in the development and maintenance of problems, the bucket supports a trauma-informed approach (see section 2E) and should help you gather relevant information for a 5P Formulation (see section 3F). This metaphor has been used a lot to support conversations about psychotic experiences, which have often been considered “un-understandable” (a term that was once coined to define psychosis). However, there is no reason this metaphor cannot be used for other presenting problems.

The Stress Bucket Analogy

- the bucket represents Predisposing Factors
- the water coming into the bucketrepresents the Precipitating Factors
- blocked holes at the bottom of the bucket are Perpetuating Factors and
- open holes represent Protective Factors

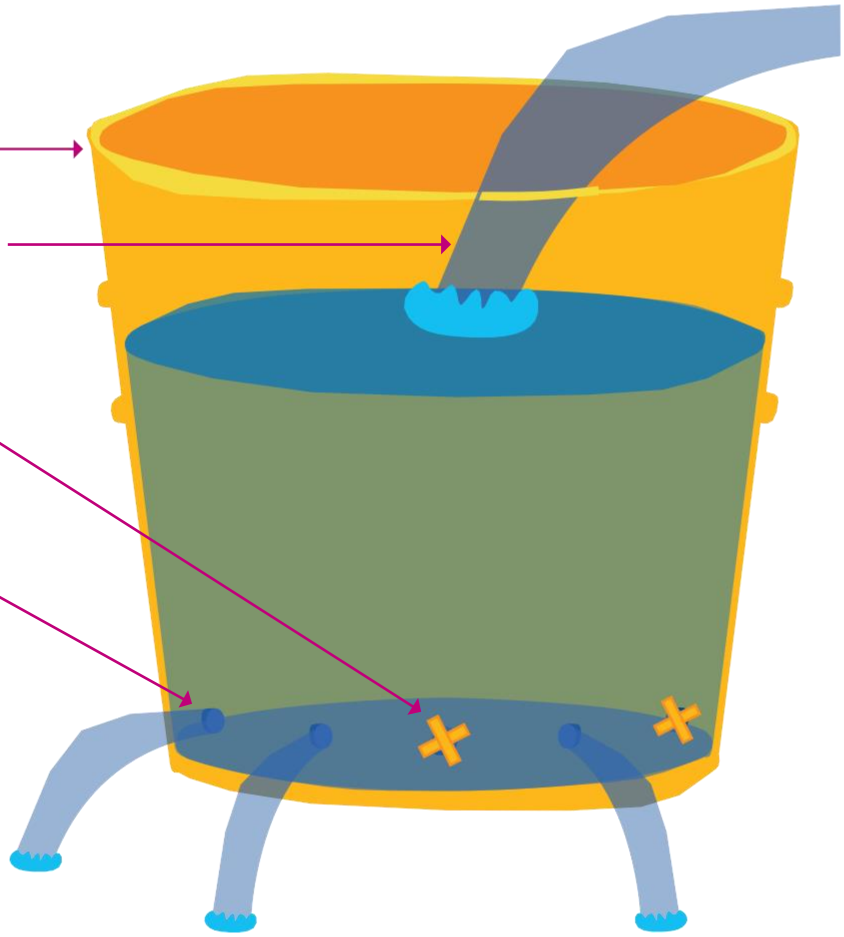


Figure 1. The Stress Bucket Analogy

When the bucket overflows, the Presenting Problem arises.

How Does the Stress Bucket Work?

The Bucket: Representing Predisposing (Vulnerability) Factors

Everyone has some level of vulnerability to developing mental health problems; some people are highly vulnerable, whilst for others, this susceptibility is minimal.

Using the bucket metaphor, vulnerability is represented by the bucket. People who are less sensitive to the stresses that life throws at them can be thought of as akin to large buckets and are able to deal with more water/stress pouring in before the bucket overflows. In contrast, those people who are more sensitive can be compared to small buckets with less volume to cope with lots of water/stress.

The size of the bucket, in other words, the level of vulnerability or sensitivity, is determined by a lot of different factors.

Genes play a part, but they are a relatively small part of the picture. We know that genes interact with a few other personal and social factors to determine overall susceptibility to mental distress. Our childhood, where we lived, things that happened to us and the relationships we had all can play a part.

For example, we know that certain unpleasant experiences during childhood, including things such as bullying, abuse or being placed in care, can all increase the likelihood of developing psychotic experiences later in life.

Social factors are also important and growing up in an inner-city area, as part of a minority ethnic group, or as a member of the LGBTQ community, can also make a person more vulnerable (i.e. using the metaphor it might make the bucket smaller).

The bucket metaphor is based on research evidence that demonstrates that there is a ‘dose effect’ between early adversity and the development of psychosis. The greater the number or extremity of adverse childhood events, the more likely a person can experience mental health problems.

We should be clear, however, that some people experience high levels of trauma and adversity and never experience psychosis or indeed any mental health problems. Similarly, some people may develop mental health problems without ever having experienced any significant adversity.

When working with service users to consider what life events might have influenced the size and shape of their bucket, it’s also important to consider positive events or aspects of childhood which could have made a person more resilient and expanded the bucket. These could include supportive and secure trusting relationships and happy memories.

Water: Represents Precipitating (Stress) Factors

The level of vulnerability is only one factor in explaining why people experience mental health problems. The level of stress a person is experiencing when their problems began can also play a part.

With the stress bucket, stress is compared to water coming into the bucket. If a lot of water comes into the bucket, in other words, if a person experiences a great deal of stress, then the bucket can overflow, which is when a person can experience mental health problems.

People who have a low level of vulnerability, and have often not experienced so much adversity, can be compared to 'big buckets' that are able to cope with more stress (water) than those who have a high level of susceptibility or sensitivity – the equivalent of a small bucket.

Stress comes in lots of forms; losing a job, a relationship split, bereavements, being assaulted, financial difficulties, housing problems, the list is endless.

Sometimes things that people see as exciting can still cause a lot of stress, such as getting married, leaving home, or going on holiday.

Figure 2. The Stress Bucket Analogy

Holes in the Bucket: Represent Protective (Coping) Factors

Finally, certain things make it more or less likely that the bucket will overflow. This can be thought of as akin to holes in the bottom of the bucket.

The holes are like a plughole in a bath. As long as the plughole is unblocked and the water isn't pouring in too fast, then the bath won't overflow. However, if the plughole gets blocked then it is much more likely that if the tap is running, even slowly, then a flood will ensue.

The holes in the bottom of the bucket are the equivalent of helpful and unhelpful coping strategies. Positive coping strategies allow most of us to deal with the everyday stresses and strains of day- to-day life without them getting too much for us. Unfortunately, some things we do to cope have the effect of 'blocking the holes' whilst other behaviours seem to 'clear the holes'.

As an example, a common thing that has the impact of blocking the holes and making it likely that the bucket will overflow is lack of sleep. Most people who are sufficiently sleep deprived will experience psychotic type experiences such as hearing voices or feeling more paranoid.

Certain drugs such as amphetamine and cannabis can also have the effect of 'blocking the holes'. However, just as some things can make it more likely that the bucket will overflow so some things open the holes and seem to help us cope with the stress: medication, sharing problems, relaxation and writing down feelings are examples of things that might help.

Every Stress Bucket is different

How, then, do we explain why for some people, these symptoms aren’t a temporary thing but last for a long time? If someone has a very high vulnerability, then even the general stress of living will be enough to keep the bucket overflowing.

Also, once a person starts experiencing strange psychotic-type experiences, then these in themselves can be scary and stressful for the person experiencing them. This added stress can keep the bucket spilling over.

We also know that some treatments and interventions, although intended to keep people safe in the long term, can be traumatic. This could include being detained in hospital under the Mental Health Act. Each person’s bucket will look different and it’s important that this is put together in collaboration with the service user, and they agree on important events and experiences.

Once you have a shared understanding, you can work to reduce the stress sufficiently or to help the person to cope with the stress in their life (opening the holes in the bucket). The bucket can stop overflowing and the current problematic experiences may diminish or disappear altogether.

Suggested reading:

The Stress Bucket, Mental Health UK

The Stress Vulnerability Bucket

Section 3H: Producing a Problem Statement and Identifying Goals

Summarising

The information gathering process provides you and the service user with a structure to their current concerns. As you complete the information gathering aspect of an initial contact interview, you need to move on to the information giving and shared decision-making aspects of the contact. To do this you need a bridge. Stating the problem and setting goals provides this bridge.

Stating the problem

A problem statement has three functions:

1. It draws a line underneath the information gathering section of the interview and allows you to move the interview on

2. It allows you to model shared decision-making and shift the culture of the interview from one of fact-finding by you to one of collaboration between you and the service user

3. It provides a reference point for future contacts between you and the service user and can be checked in subsequent sessions to determine whether the problems identified in the initial session are still current. The process of drawing up a problem statement should be collaborative, using information gathered in the previous information gathering section of the interview

There are three elements to a problem statement:

1. **Context** – what provokes the problem, including the context of situations, time and other people (if appropriate).

2. **Problem** – a description of the problem including autonomic, behavioural, cognitive elements and emotional elements, and

3. **Impact** – the consequences of the problem for the service user. The problem statement should be written in the service user's own words. For example:

Example problem statements

EXAMPLE: "When I am tired and very busy, I feel overwhelmed by emotions and start doing things that make me feel worse, such as getting angry with my friends. This pushes them away and leaves me with less support."

This statement neatly summaries the problem (high level of emotion leading to counter-productive behaviours) in terms of contextual triggers (being busy and tired) and the impact it is having (becoming more isolated).

Importantly, it is written in the first person and in the service user's own words.

EXAMPLE: My main problem is a lack of interest every day in doing things I used to enjoy,I also experience lethargy, sleep problems, reduced activity and thoughts that I am a failure, with the consequence that I am finding it difficult to keep on top of looking after myself and daily chores.”

This summary includes, in the service user’s own words, his or her problem in terms of autonomic symptoms (poor sleep and lethargy), behavioural symptoms (reduced activity), and thoughts (a failure). This service user feels down all the time, so there are no specific contextual triggers other than ‘every day’, and the impact is difficulty in working, socialising and doing housework.

Setting goals

Goals are medium-term aspirations, not short-term achievements, derived from the problem statement.

Towards the end of the information gathering, you should have asked what the service user would like to achieve from seeking help. People will often say things like, ‘to be happy again’ or ‘to feel better’.

Collaborative goal-setting is a process by which you can ask a service user to identify indicators of feeling better; these are often things the person is not doing at the moment.

For example, in the first problem statement above, a good goal will be focused on managing being tired and busy and managing emotions differently: “To be able to manage my emotions by doing calming activities so that I don’t take it out on my friends when I feel overwhelmed.”

The goal is specific, targeting the current problem, includes an indicator of the problem being reduced, has some important context (when I feel overwhelmed). It is achievable, specific and written in the service user’s own words.

A goal associated with the second problem above might be: “To be able to cook a meal for myself daily.’ Another could be: ‘To do my daily chores each day without thinking I am a failure.”

In these cases, you will have helped the service user translate a vague desire to ‘feel better’ into something explicit, realistic, concrete and achievable. Behavioural goals are usually the most effective, because they are easy to demonstrate or measure: ‘go for a meal once a week with friends’ is a much clearer goal than ‘do normal things again’.

Information gathering in subsequent sessions

Each time you speak to a service user, your contact should build on the previous one, continuing the conversation between you. Continuation sessions are generally short unless the service user’s state has deteriorated markedly.

After you have introduced yourself, you should:

- Feedback the problem statement you have previously agreed

- Ascertain from the service user that this is still an accurate reflection of their difficulties. If not, clarify and adjust the summary with them

- Assess risk – this is an essential part of ALL interviews, and you can approach it in the following way: “Last time we talked, I mentioned that sometimes when people are struggling, they can feel so despondent that they feel like taking their own lives. You said that [insert summary of last risk assessment]. Can you tell me if there has been any change in this?”

- Gather information and review the service user’s understanding of any information or materials that you gave them in the previous sessions

- Gather information and check the service user’s understanding of the agreed programme of interventions

- Gather information and review the progress of any therapeutic activities which had been planned at the last contact session, including reviewing any diaries or worksheets

Section 3I: Shared Decision-making

Shared decision-making is the process by which you help service users to make and act on informed decisions about the service they receive. Shared decision-making means that you must help service users come to informed decisions, make choices and decide how to implement their own interventions or plans.

Even taking medication requires service users to act with the aim of producing a positive therapeutic outcome. Psychological interventions place an even more significant burden on service users and require much positive activity from them.

Non-collaborative prescription of tasks or activity – telling the service user what to do – is inappropriate. Both you and they must have a stake in the outcome of the decisions made.

The process of negotiation naturally follows on from information gathering and information giving. You should:

- Present choices
- Help the service user to weigh up the pros and cons of the various options, and
- Come to a shared decision about which way forward to implement

In all stages of this process, the key is to for you and the service user to collaborate and come to a truly informed and shared decision.

Content of shared decision-making

The content of shared decision making will be focused on:

- How contacts between you and service users will be managed
- How the service user will proceed with any psychological interventions
- How the service user will proceed with any other options available to them. Each of these areas requires you to negotiate:
- What you and the service user will do
- How you will do it
- Where you will do it
- When you will do it
- If anyone else will be involved

Making decisions about further contact

Both you and service users have limits to your availability. Service users may have jobs and childcare commitments, and you will be limited to certain working hours. You need to negotiate how often you will contact them, when this will happen, how this will happen (face-to-face, on the phone, by video or by email), where it will happen and whether anyone else (e.g. family members or carers) will be involved in further contacts.

The next stages in co-ordinating care

Once satisfied that a service user has all the information required to decide on options for accessing additional professional or community resources, you should clarify what they have decided to do in an explicit and detailed manner.

You should give information on their options to assist them in their decision making. This should include any rationale for recommending a particular option e.g., that it is an intervention recommended by the National Institute for Health and Care Excellence (NICE).

Service users should be offered one or more NICE-recommended interventions for specific problems where possible. At all times, you should respect decisions the service user makes. If their informed decision is not to go ahead with a particular option, this should be respected.

The next stages in any psychological interventions

In many cases, you will be taking an active role in supporting service users to use psychological interventions. Where your assessment indicates that a different intervention to one that you can offer is more appropriate, this should be offered either instead of or as well as your psychological intervention options.

It is very important to ensure that service users understand why an intervention is appropriate, and how it is supposed to work, before deciding to start it. You will ensure this understanding by giving accurate information and discussing the matter with them to arrive at an informed shared decision.

You should present appropriate choices and discuss them with the service user. Many service users will look to you, as the practitioner, to give them some guidance. In doing so, you must always act responsibly and in the service user’s best interests (See Section 2B Professional and Ethical Practice).

As a Mental Health and Wellbeing Practitioner, you have experience and training in the methods that work for certain problems. Whilst it is impossible to predict how any individual will respond to a particular intervention, you should direct service users to those options that are evidence-based and promise the greatest chance of recovery.

Once the service user makes a choice, you should support their decision by undertaking the practical steps in the implementation of their chosen strategy.

Most structured psychological interventions require service users to undertake exercises in their own time. You will review the progress of these activities at the beginning of each subsequent contact session. Therefore, you should be very explicit in agreeing what service users will do, how they will do it, where they will do it, when they will do it and if anyone else will be involved.

Appendix 4: Example Interview Schedules

Each interview in a programme of structured psychological interventions takes the form of three sections:

1. information gathering.

2. information giving.

3. shared decision-making.

You can use the following interview schedule to guide the initial assessment between you and a service user.

The objectives of the initial assessment:

1. find out the main difficulties being experienced by the service user.
2. assess their level of risk.
3. determine their attitudes to their difficulties.
4. come to a shared understanding of the current problem.

The objectives of subsequent interviews:

1. Complete the assessment and formulation process.

2. Review progress with goals and uptake and impact of intervention/plans.

3. Agree on next steps with intervention or other professional input or community support.

Pacing the assessment

With people with severe mental health problems, pacing will be crucial. You should allow enough time to listen well and try to understand. This can be a helpful intervention in itself. You should not rush or pack in too much into each appointment. Sometimes an initial assessment can be completed in a single meeting, but for others it may take 2-3 meetings.

If spreading your assessment over more than one meeting, the first meeting should still end with a greater shared understanding of why the service user is seeking help, a summary of what has been discussed, and the aims for the next meeting. It is important that the service user goes away from the first meeting with an understanding of what will happen next, with the sense that you understand them and that there is some hope for helpful next steps.

The interview process

You will use a well-tried question process, but it is important that this is used in a non-dogmatic, service-user-centred and flexible manner. The key skill is to ensure that information is gathered using a funnelling technique (see Section 3C), whereby general open questions are followed by specific open and then closed questions. This funnelling process will often be used in an information-gathering interview as service users divulge information about their problems.

In contrast, checklist-driven interviews are the antithesis of service user-centredness.

Completing the assessment

Following successful information gathering, you will generally complete the assessment by:

- Agreeing on a problem statement
- Identifying some service user-centred goals, and
- Giving information about intervention or other support options

The options you will offer, depend on what problems the service user has identified and on what resources are available locally. They may include:

- Referral within the team for psychological therapy recommended by NICE for a particular condition
- Referral on within the team for a medication review or occupational or employment support
- Signposting to a specific community organisation (e.g. for peer support)
- Signposting to recovery college or other educational opportunities
- Offering a brief psychological intervention that targets the current problem e.g. behavioural activation for problems linked to low mood and withdrawal, improving sleep intervention for problems linked to poor sleep, guided self-help for binge eating or bulimia

Shared decision-making

Although shared decisions can be made at the initial session, many service users will prefer to read written information about these choices before making a decision. In that case, the main focus of your next session becomes supporting them to decide which plan or intervention suits them best through a process of collaborative, informed, shared decision-making.

Example interview schedule prompt sheet: initial contact

See section 3C for examples of the specific questions you can use at each stage of the interview.

Introductions

- Practitioner name and role
- Ask service user’s preferred name
- Purpose and format of interview
- Confidentiality
- Timescale

Information Gathering

- Current Problem - including context, problem and CHIME impact
- Routine Outcome Measure - ReQoL-10
- Stress Bucket
  - Precipitating factors: Why now?
  - Perpetuating Factors: What is keeping it going?
  - Predisposing Factors: What set you up for this problem?
  - Protective Factors: What helps?
- Wider impacts e.g. work, home management, social leisure, private leisure, family life and intimate relationships.
  - Past episodes and treatments
  - Drugs and alcohol
  - Current medication and attitude to this
  - Other treatment being provided
- Assessment of risk (to self, to others, from others)
  - Intent: suicidal thoughts
  - Plans: specific action plans
  - Actions: current / past; access to the means
  - Prevention: social network, services
  - Risk to others
  - Neglect of self or others
- Anything else that has not been covered in the assessment that is relevant from both perspectives

Information Giving and Shared Decision-Making

- Problem statement (Context, Problem, Impact)
  - Check with service user
- Identify Goals using Goal Based Outcome tool
- Agree next steps

Example interview schedule prompt sheet: subsequent contacts

Information gathering

- Feedback of previous problem statement
- Checking that problem statement is an accurate reflection of the service user's difficulties
- Further funnelled information gathering if necessary
- Clarification and adjustment of problem statement
    - **Routine Outcome Measure - ReQoL-10**
    - Check goals and rate using GBO

Assessment of risk

- Feedback from previous risk assessment
- Checking that risk assessment is still accurate
- If any changes, re-assess:
- Intent: suicidal thoughts
- Plans: specific action plans
- Actions: current/past; access to the means
- Prevention: social network, services
- Risk to others
- Self-Neglect or of others

Information review

- Understanding of information given previously:
- Options for other professional or community support
- Options for psychological interventions
- Mental health condition information

Psychological interventions

- Understanding of options discussed
- Review of interventions implementation
- Review of diaries and worksheets
- Next steps for intervention

Shared decision-making

- Choices discussed
- Options selected
- Interventions continued revised or initiated
- Diaries and worksheets organised

Ending

- Session summarised
- Next steps agreed and understood

Section 4

Care Planning in partnership

Section 4A: Collaborative Care Planning within the Multi-disciplinary Team

Being able to plan care is an essential skill needed by all mental health practitioners. Care planning is a process that involves information gathering, information giving, developing a shared understanding of what is important to the service user, and then setting goals and making shared decisions about how to improve the service user's wellbeing.

The care plan is the written record reflecting the outcome of this process. As a Mental Health and Wellbeing Practitioner, a significant part of your role will be to support service users, families and carers in planning appropriate care to access the most helpful community and professional resources available.

Regulatory background to care planning

Care planning for those with a severe mental health problem (SMHP) has been an essential component of care and treatment since a mandate that there must be a care plan developed for anyone leaving a psychiatric hospital in 1989 (DHSS). This was followed by the introduction of the Care Programme Approach (CPA) in 1991.

The Care Programme Approach was a system for ensuring that service users with the greatest needs had a formal plan of their care that was regularly reviewed, by an allocated 'care co-ordinator'. As the CPA recedes and the Community Mental Health Framework (CMHF) is introduced, there is an increasing emphasis on personalising the care planning process for those with severe mental health problems, rather than relying on a specific care planning technology.

Regulation 9 of the Health and Social Care Act (2008) makes personalised care legally binding for providers of mental health and learning disability services, noting that each service user must receive appropriate person-centred care and treatment.
More useful information and links to resources on person-centred care planning can be found in the Professional Record Standards Body (PRSB) Community Mental Health Planning Report.

Collaboration

The care planning process is aided by positive therapeutic relationships between the professional and the service user. In an ideal world, service users would sit with clinicians and talk candidly about what is important to them and their goals for improving their wellbeing.

However, this is not always initially possible for several reasons, such as levels of distress, trust in a new practitioner or difficulty with thought processes. Collaboration with the service user's family, carers or close friends can be transformational in developing a care plan that is personalised and meaningful, both in challenging circumstances and more generally.

Sharing information

A cornerstone of all good practice in mental health services is sharing the right information with the right people at the right time to ensure that the service user and others are safe.

Sharing care plans also make sure that all agencies involved in the service user's care and treatment know what they are supposed to be doing, ensuring continuity when named people are unavailable at any given time, for example, because of annual leave or sickness absence. Unfortunately, exemplary sharing practices do not make the headlines, but there are numerous instances of poor sharing arrangements in mental health services having catastrophic results. See for example, The University of Manchester's National Confidential Inquiry into Suicide and safety in Mental Health.

Key elements of care planning

There are six elements (or steps) of care planning, and whilst they are important to consider individually, in practice, they may not be as sequential as recorded here.

Step 1: Assessment

This manual covers assessment of need in detail (see Section 3), and it must be the starting point of any care planning. For an initial assessment, we usually try to find out the most pressing problems, and we try to establish this as close to the point of referral as possible. Taking precedence in all initial assessments and subsequent reviews is safety. There may be a need to act quickly to keep the service user or others safe; thus, the first plans are likely to be safety focused.

Step 2: Identifying needs

The information gathered in the assessment now needs to become more focused. Together with the service user, and sometimes with relevant others, we need to start making sense of the service user's circumstances and reality. Your 5 Ps formulation will be useful to start this process.

Before setting any goals, we must aim to be on the same page with the service user in terms of what is important to them, and what they think they need help with. Outcome tools such ReQoL-10 and DIALOG (see Section 3D Collecting routine outcome measures) are useful in giving structure and consistency to these questions, which then allows further distillation of the identified need into measurable and meaningful goals.

Step 3: Setting goals

This step is the linchpin of the care planning process. If the care plan does not record what changes are desired over an agreed timescale, then the care plan will lack direction and could slip away into administrative oblivion. The goal-setting part of the care planning process allows the tailoring of a plan to work for the service user, especially in terms of what the service user thinks is achievable.

Agreed goals should be noted using the Goal Based Outcome Tool (see Section 3D Collecting routine outcome measures) so that progress with these can be tracked over time.

Step 4: Exploring options and actions

Once the goals are set, there is often more than one way to achieve them. The ways of achieving these goals need to be given more thought at this step, and in particular, who can help. This should be beyond service provision, and should also explore what the person can do, what those closest to them can do, and what the local community can do. See Section 3I Shared-decision-making

Step 5: Recording the care plan

Once the goals are set, and decisions have been made about the best way to achieve them, you should record them in the care plan. There is no nationally-set format for what a care plan should look like, but they should always contain ‘needs’, ‘goals’ and ‘actions’ as a reflection of the care planning process. Your supervisor can advise you regarding local procedures and guidelines for writing the care plan. You will also need to consider accessibility when drawing up any care plan, e.g. language to use, use of symbols or pictures, font size, etc.

Step 6: Reviewing the care plan

To review a care plan’s success in meeting the service user's needs, there must be a way of measuring it. This is why a care plan with direction and purpose, particularly measurable goals set out in the Goal Based Outcome tool, is so essential and must be rooted in your everyday practice, alongside outcome monitoring using ReQol-10 to assess a broader range of recovery-focused outcomes. (See **Section 3D Collecting routine outcome measures**)

Reviews are often described as ‘formal’ and ‘informal’. Formal reviews usually mean a meeting between all parties involved with the service user and the service user themselves. Informal reviews are the everyday contacts practitioners have with the service user, either as a coordinator or provider of a specific intervention.

Section 4B: Risk Assessment, Safety Planning and Safeguarding

As a Mental Health and Wellbeing Practitioner you have a critical role in supporting the safety of service users, families and carers. You should always be mindful of the risks of harm to service users by others, by themselves, or by service users to others.

When working with acutely unwell people, they may be vulnerable to various harms. More usually, people's vulnerability means they're at risk of harm to themselves because their ability to take care of themselves or their judgement's impaired or they're at risk of harm or exploitation from someone else. Rarely they can present a risk to other people because of similar vulnerabilities, or how they think or feel.

As a care team member, you have an immediate professional duty to 'act in the public interest' to prevent anyone from coming to harm. The NHS Constitution outlines some of your legal responsibilities.

If you ever feel unsure or think that anyone (including you!) may be at risk in immediacy, you must follow your organisation's policies and procedures for keeping everyone safe and reporting the situation promptly and appropriately.

Risk assessment and management

Making an 'assessment of risk' is a live process involving an examination of what it happening now, what has occurred in the past, and taking a holistic view of the situation to then articulate and document risks to the service user, their family, the care team, and the broader public at large; considering not only the risk of what might happen if an intervention occurs but also the risk potentially if something is NOT done.

The **Community Mental Health Framework principles** state that any plans to mitigate risks should be integral to the care planning. The reality is that risk assessment and management often have distinct formats within the electronic service user record, and whilst they may be aligned to the care planning, they are usually separate.

Therefore, whilst many organisations use specific tools and templates to assess and manage risk, it is vitally important that we open up dialogue about risk and collaborate with the service user to address these risks (where possible).

A lack of collaboration when identifying and managing risks can stifle the opportunities for the service user to take positive risks and self-manage.

The risk assessment and management process can be covered by the analysis and planning around the following three questions:

1. What has happened or is happening now? (Facts)

2. Why do we think it has happened or is happening now? (Risk formulation)

3. What do we need to do about it? (Mitigation)

1. Facts

This starts with information gathering, usually via discussion and written records, and then organising this information so that the current and historic risks become evident. (See Section 3C for more details about information gathering). One item from the ReQoL-10 “I thought my life was not worth living” should be watched closely at each contact to identify one factor relevant to risk.

You should usually aim to organise this information under the following domains (or similar) often sub-dividing it into historical and current information:

- Risk to self from self
- Risk from others to self
- Risk to others
- Other risks

To elicit the information needed to formulate and mitigate risks of harm, you will need to explore the nature and degree of these risks. Enquiry about suicide is critical, and there are a range of tools to support the questioning of a service user in this area.

Questions to explore suicide risk

- In the last few weeks have you wished you were dead or wished you could go to sleep and not wake up?
- In the last few weeks have you had any thoughts about ending your life?
- In the last few weeks have you made any plans and preparations to end your life (you may want to give some examples, such as written a suicide note, given away valuables, bought or collected pills)
- Do you have what you would need to carry out these plans?
- Have you ever tried to kill yourself? What did you do?
- What stopped you from ending your life?

However, it is also worth noting some caution in their use, as a national study by Hunt et al. (2020) found an over-reliance on tools to make decisions, variance in use, and a need for more adequate training on the proper use of these tools.

2. Risk formulation

As with other clinical formulations, the risk formulation is ideally a product of team discussion and agreement by the multi-disciplinary team. The aim is to further understand what we think is driving, and protecting against, the risks identified – this is the ‘understanding’ part of the risk assessment.

Teams have different approaches to risk formulation, and you should seek local guidance and supervision. Some teams use the 5 Ps Formulation as a method of formulating risk, or support a range of approaches. The 5 P Formulation (see Section 3F) provides one method that you can use to formulate risk if local protocols support it. Again, this is where the service user, family members, carers and others close to them can be instrumental in really understanding the causal and contributory factors. (See Section 2G)

3. Mitigation

Based on the risks identified and the associated causal and contributory factors, the next step is to try and mitigate those risks that are unacceptable in terms of likelihood and/or severity to the service user and others. This is often referred to as the risk management plan, and as with care planning, a copy of this plan should always be made available to the service user.

Once the facts have been established, and there is a reasonable understanding of what is driving and protecting against the identified harms, it is important to take a solution focused approach to managing these risks. Endless discussions about the risks, and what causes or contributes to these, is not helpful. In fact, it may be counterproductive by retraumatising the service user.

Therefore, the records around risks of harm must be accurate, accessible, and easy to read. Before contacting the service user, you need to know the documented risk landscape and focus energy and time on developing realistic and achievable interventions to mitigate these risks.

4. Managing immediate risk

When planning actions to remove or reduce harm, there needs to be consideration of the urgency and immediacy of a situation, whereby actions run ahead of record keeping. For example, if you are with someone and feel concerned about their immediate intentions and the consequences of acting on these (such as suicide, self-harm, and violence toward others), then prioritising writing a plan will not keep people safe.

Questions

- Do I need to stay with this person until we have increased their immediate safety?
- Is it safe to stay with this person?
- Do I need immediate support from colleagues or others, e.g. crisis team, GP?
- Do any other agencies need to be informed immediately, e.g. police, local authority, A&E?
- Might the person potentially need to be subject to legal restrictions to manage the immediate risks of harm, e.g. under the Mental Health Act (1983) or Mental Capacity Act (2005)?

As already noted, the responsibilities involved with risk management should not be carried by any one individual practitioner. Knowledge of the support structures for you as a practitioner will make for more effective plans and practical responses, increasing the safety of the service user and/or others.

Every local authority and health organisation has a safeguarding team available for advice and support. Regular clinical supervision, with safety discussions as a core strand, will strengthen the knowledge and skills developed through induction and mandatory training packages covering risk and safeguarding.

When considering the record-keeping aspect of risk assessment and management, think about who will access this out of hours or when you are unavailable. Would a duty team worker or crisis team employee be able to make sense of the information presented and action a plan based on this?

As organisations increase their IT interoperability capabilities, you will also need to consider whether the records will help the response of services that would traditionally not have access to this information, e.g. ambulance services, police and the voluntary sector.

Safeguarding adults and children

Helping to keep service users, their families and local communities safe from violence, abuse or neglect is essential when providing care for people with mental health problems.

Those most in need of protection include:

- Adults at risk, such as those receiving care in their own homes, people with physical, sensory, and mental impairments, and those with learning disabilities
- Children and young people

The Care Act 2014 sets out statutory responsibility for integrating care and support between health and local authorities. Local Authorities have statutory responsibility for safeguarding.

Safeguarding adults

The aims of safeguarding adults are to:

- Prevent harm and reduce the risk of abuse or neglect to adults with care and support needs
- Safeguard individuals in a way that supports them in making choices and having control over how they choose to live their lives "Making Safeguarding Personal."
- Promote an outcomes approach in safeguarding that works for people resulting in the best experience possible
- Raise public awareness so that professionals, other staff and communities as a whole play their part in preventing, identifying and responding to abuse and neglect

All staff within health services have a responsibility for the safety and wellbeing of service users and colleagues.

You should read the Pocket Guide to Safeguarding Adults.

This pocket guide provides further guidance on safeguarding adults, including details on:

- Your duty of care
- The 6 Safeguarding Principles enshrined in the Care Act 2014
- Your role as the person raising concern
- Information-sharing
- The Mental Capacity Act
- Domestic violence and abuse
- Deprivation of liberty safeguards

Safeguarding children

Safeguarding and promoting the welfare of children is defined in Working Together (2018) as:

- Protecting children from maltreatment
- Preventing impairment of children's health or development
- Ensuring that children are growing up in circumstances consistent with the provision of safe and effective care
- Taking action to enable all children to have the best outcomes

As a Mental Health and Wellbeing Practitioner you have a duty to report any concerns that you may have that a child may be at risk; this includes the children of service users you may be working with.

Your employer will have their own local policies and procedures in relation to Safeguarding Adults and Children that you will need to be aware of and follow. This will include guidelines you must follow if you suspect a safeguarding issue. Local training in 'Safeguarding Adults' and 'Safeguarding Children' is mandatory.

Find out how to access this and how frequently you must complete it. If you have any concerns about adult or child safeguarding issues, always talk to your supervisor or team leader to understand your duty of care.

Helpful Resources

Safeguarding Children - Government Guidance

Child Abuse Concerns - Government Guidance for Practitioners

Study of the Assessment of Risk in Mental Health

Section 5

Wellbeing-focused Psychologically Informed Interventions for Severe Mental Health Problems

Section 5A: Matching and Shaping Interventions to People’s Needs

This section includes details of the core interventions in the Mental Health and Wellbeing Practitioner (MHWP) role, with consideration of how they work and the steps for implementation. It is crucial that the use of any intervention is decided collaboratively with the service user, so that both you and the service user are clear on why this may be helpful for the presenting problems you have explored with them in the assessment.

Shared decision-making to choose an intervention

The initial shared decision about which intervention should be based on choosing the best intervention to address:

- Goals that you and the service user have collaboratively identified
- The problem and its impact, as set out in the problem statement, developed together through the assessment process
- Processes that may be keeping the problem going identified through your 5 Ps formulation

You should discuss initial choice of intervention in case management supervision and where appropriate clinical skills supervision.

Some problems will lend themselves better to an intervention from another practitioner (e.g. a CBT therapist, psychologist, psychiatrist, occupational therapist, nurse or employment specialist). It is important to have a good understanding of all roles in the team and a good understanding of NICE guidance, to support decision-making.

Interventions based on cognitive behavioural principles: developing a Five-Areas Formulation

The following interventions in your repertoire are all based on cognitive-behavioural principles:

a. Behavioural Activation

b. Graded Exposure

c. Teaching problem-solving skills

d. Improving sleep

e. Recognising and managing emotions

f. Guided self-help for bulimia and binge-eating

g. Building confidence

The first step in introducing an intervention based on cognitive-behavioural principles will be to develop a Five-Areas cognitive-behavioural formulation of how (1) cognitions, (2) behaviours, (3) physiology and (4) emotions are interacting, in the particular (5) environment, to keep the problem going.

This will guide both the choice of the right cognitive-behavioural intervention and the most effective emphasis within and tailoring of an intervention. Evidence shows this approach can increase the service user’s willingness and motivation to engage in the intervention, which in turn makes the intervention more likely to be successful. For providing medication support there is no need to develop a Five-Areas formulation.

Using supervision to tailor interventions

Your work as a MHWP will be supported through case management supervision and clinical skills supervision. Both of these forms of supervision can support your use of these interventions with individual service users, ensuring individual adaptations are effective and maintain fidelity to the model.

Case management supervision supports the regular review of a service user’s treatment plan, to ensure it is still the best plan to meet their needs. Reviewing their engagement with, and progress with an intervention through this process, including in relation to regular review of outcome measures and progress against goals and their problem statement, can help to support decisions including:

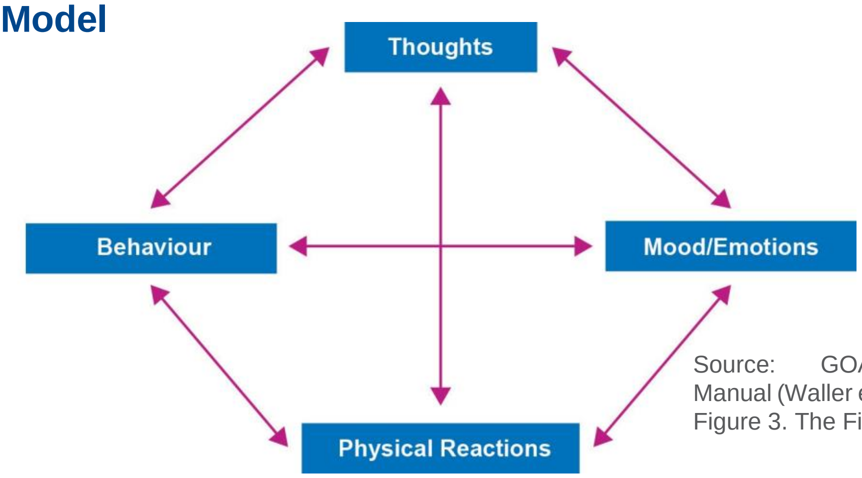
- Adaptations to the intervention’s implementation
- Considering an alternative intervention
- Successfully meeting goals and agreeing endings
- Identifying further needs and agreeing referral onwards to different therapy approaches or services

Section 5B: Developing a Five-Areas Cognitive-Behavioural Formulation

The Five-Areas Model can be used to guide the development of a simple, here and now, cognitive-behavioural formulation. This model, sometimes referred to as the ‘hot cross bun’, can be used with service users to demonstrate the connections between **thoughts, emotions, behaviours** and **physical aspects** within the context of a specific trigger **(situation/ environment)**.

The Five-Areas Model

Situation / Environment



Source: GOALS Therapy Manual (Waller et al. 2018)
Figure 3. The Five-Areas Model

What are the Five Areas?

The Situation of Environment: this pertains to information related to the person’s current circumstances or to a triggering event. Examples of these include family issues, job, life stresses and support networks as well as past experiences such as success, losses, and criticisms etc.

Linked to the trigger or situation are 4 inter-connected areas:

1. Thoughts/Cognitions: these are thoughts that the person has in relation to the specific issue. Often these are thoughts about the situation/trigger, but they can also be thoughts about the emotions, behaviours, or physiological aspects within the model. Some people are more visual and will describe images rather than verbal thoughts. You may want to ask the person “what went through your mind at the time?”, or “how did you make sense of what was going on?”

2. Moods/Emotions: Emotions include anxiety, sadness, anger, shame – they can often be described in a single word.

3. Behaviours: This reflects what the person did in relation to the problem being described. You may want to ask what the person did to cope with the situation or get through it. Did they stop or avoid doing something? What would other people have observed?

4. Physical Experiences: to understand this area, it may be helpful to ask what the person noticed happening in their body.

Sometimes service users have been told that their problems are ‘purely’ biological in nature or caused by a chemical imbalance. The Five-Areas model can help introduce a more holistic bio- psychosocial understanding of mental illness, including severe mental health problems.

The model acknowledges the physiological aspect of presenting problems, but it also illustrates how the other four areas play a role. For example, if someone is feeling sad, then there will be something happening neurologically that relates to this emotion, similarly if someone is happy, jealous or experiencing any other emotion, there will be a neurological correlate.

This does not mean that the problem is caused by the neurological reaction or chemical imbalance (we wouldn't say happiness is caused by a chemical imbalance, even if there is a neurological component). The model acknowledges that we can't separate out the biological/physical aspects from the other domains: they all play a role and interact with one another.

Using the model as a problem summary

The Five-Areas CBT model can be used to summarise a person's presenting problem. The problem is broken down into the five separate factors with links made between them to help both the therapist and service user see the connections and influences that each area has on the other. The model can guide what you ask about when gathering information and it should help you to pull together, summarise and make sense of the information you have.

Using the Five-Areas model to formulate a specific incident and guide the intervention

The model is particularly useful when trying to make sense or 'formulate' a specific problem experienced by the service user. The person may focus on any one of the five areas initially such as the situation or trigger: (e.g. "I've lost my job"); then you can link this to related thoughts (e.g. "I'm a complete failure"; "I'll never get another job"); to related moods and emotions; (feeling hopeless, sad and ashamed); to related behaviour (drinking heavily, isolating self; doing very little); to related physiological issues: problems sleeping, no appetite.

You can use any one of these areas as a starting point to make sense of a specific problematic issue and the effect it has on the other areas or domains to produce a 'here and now' formulation of the person's difficulties.

The Five-Areas formulation can also help you to identify specific areas to focus on to alleviate the distress the person is experiencing. You might want to target certain behaviours (e.g. increasing mood-enhancing activities), tackle physiological impacts (e.g. by improving strategies for managing sleep), or address the situation (e.g. by introducing skills for problem-solving).

Differentiating between the domains

Sometimes it can be confusing as to which domain a particular symptom/experience falls under. For example, does 'tearfulness' fall under physical, emotional or behaviour? Does 'feeling slowed down' fall under behaviour or physical? Does 'feeling on edge' fall under mood/emotions or physical? Some people may argue the importance of labelling the symptom/experience correctly but in reality, it is what the service user understands it to fall under that is most important.

However, it is crucial that service users learn to differentiate between thoughts and emotions. We often express our thoughts as feelings which can make things confusing such as, "I feel I made a right mess of that" or, "I feel I'm such a failure."

To illustrate this: "I feel he doesn't like me," is not a feeling despite it being expressed as such. Unless the person referred to has actually stated that he does not like the service user, then this would be classed as a thought rather than a fact and it is definitely not an emotion.

There is no ‘doesn’t like me’ emotion. The emotion is likely to be ‘sadness’ as a result of believing they are not liked. Therefore, stated correctly, we would have “he doesn’t like me” as the thought and sadness as the emotion. Emotions are usually easy to differentiate from thoughts because they can often be described by a single word (e.g. guilt, anger, sadness, fear, embarrassment, jealousy).

As with all formulations, it is important that a Five-Areas formulation is developed collaboratively, using their words so that it makes sense and resonates for the service user. Always check back with the service user what they make of it and whether it seems to fit. The diagram should be drawn out on paper together or on a whiteboard (remotely or in person) so that the service user can take away a photo/copy if they want.

Helpful resources:

Examples of Five-Areas Formulations and how they can guide interventions:

CBT 5 Factor Model. Hot Cross Bun Formulation in CBT

Fundamentals of CBT: An Introduction to the CBT Model

Presenting the Cognitive Model: Clinical Tip by Padesky and Mooney

Section 5C: Behavioural Activation Using the GOALS Programme

Behavioural activation is an effective treatment for depression. It is focused on activities to help people establish daily routines, increase pleasurable activities, and manage chores and self-care. It can be a very helpful intervention for people who have identified problems with motivation, mood or withdrawal from activities, or whose goals are focused on increasing enjoyable or rewarding activities.

How does behavioural activation work?

Service users with severe mental health problems frequently present with depression, although they may not always label this as ‘feeling depressed’.

Instead, they may talk about their feelings (‘sad’, ‘low’, ‘fed up’, ‘lonely’), physiological symptoms (having poor motivation, lethargy, problems with memory and concentration), negative thoughts (about themselves, their future, and the world) and/or voices and report limited routine and activities.

They may have limited social contact and appear to make little effort to engage in things that they may have previously enjoyed, and they may struggle to keep on top of household chores and self-care. In the short term, this tends to provide people with relief from burdensome activity and so becomes negatively reinforced.

In the longer-term, this reduction in activity maintains depression. As people avoid, they also reduce their opportunity for social and personal activities which could bring them a sense of pleasure and achievement. They therefore experience less positive reinforcement and thus these activities reduce further.

Depression is, therefore, a vicious circle of negatively reinforced avoidance and reduced opportunity for positive reinforcement. Both forces lead to reductions in usual activity for people who are depressed.

The vicious circle of reduced activity

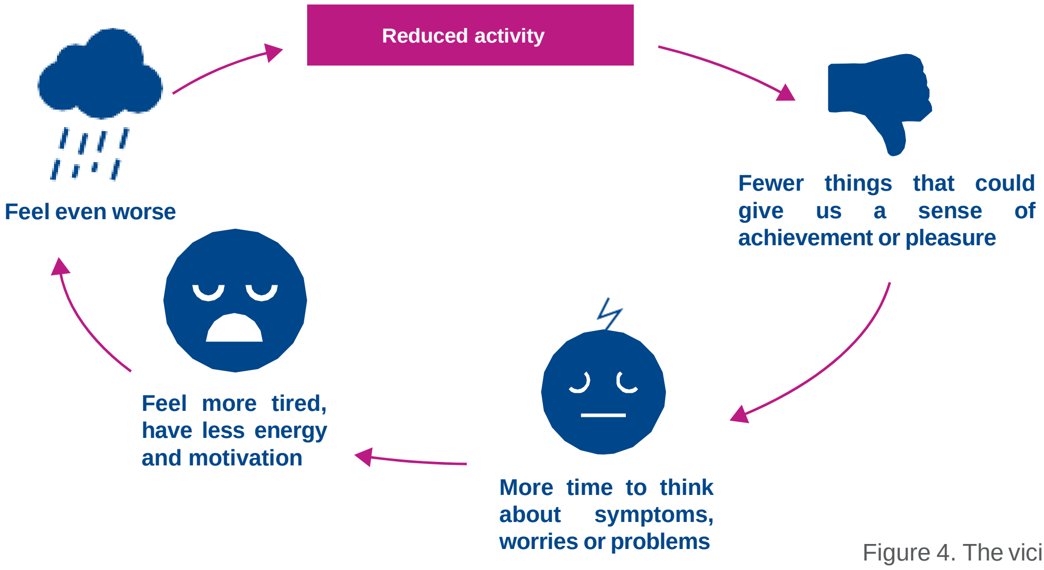
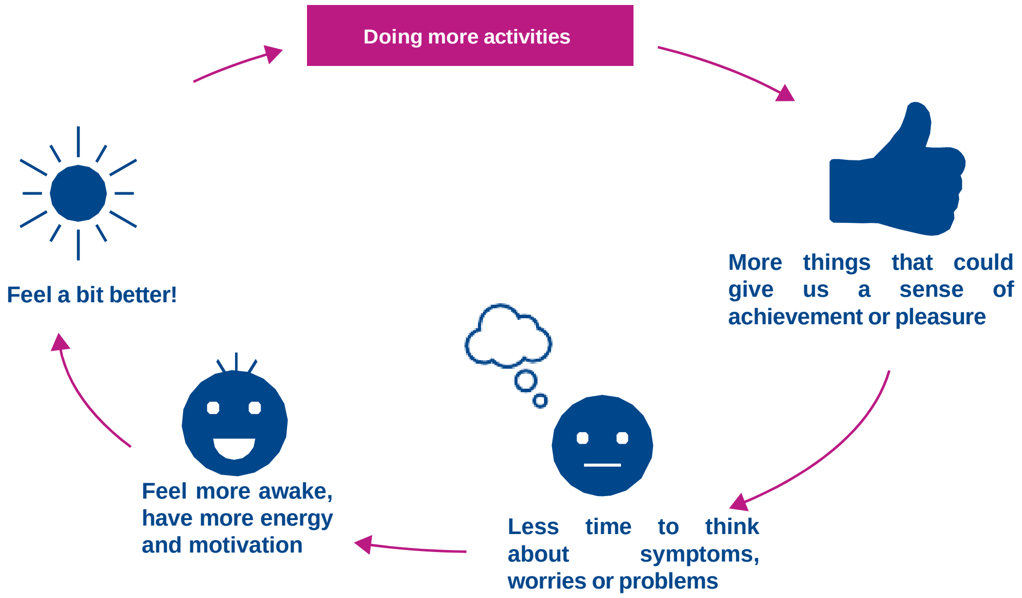


Figure 4. The vicious circle of reduced activity

How can I break the vicious circle?

- The good news is that vicious circles can be broken!
- If we gradually start to do more activities, we will have less time to focus on distressing thoughts and situations and have more opportunity to gain pleasure and a sense of achievements and therefore be more likely to feel motivated and energized. All of these things can help us to feel a little bit better



Source: GOALS Therapy Manual (Waller et al. 2018)

Figure 5. Breaking the vicious circle of reduced activity

The stages of behavioural activation

The following protocol for Behavioural Activation is taken from the GOALS Trial therapy manual and associated client information pack (see Waller et al. 2018). It is based on the clinical method described by Martell et al (2001) and Hopko et al (2003), but designed specifically for use with people with psychosis, and has subsequently been used in clinical practice in a range of settings for people with severe mental health problems.

Although recommended for clients with bipolar and depression, proceed with caution after discussing in supervision and provide psychoeducation around the potential to tip into high mood. You should help the service user make a plan for managing this in advance.

Step 1: Understanding how depression can impact personal goals

Mental Health and Wellbeing Practitioners should provide psycho education around:

- The symptoms of depression (common changes, plus personal impact on thoughts, feelings, physiological changes and behaviours), and
- The links between depression and reduced activity levels (see GOALS material introducing vicious and virtuous cycles; and completion of mood and activity diaries)

Remember: You will need to listen carefully and reflect the service user's own terminology when talking about depression (e.g. 'feeling rubbish' rather than depression).

It can take some time for service users to understand and buy into the relationship between low mood and reduced activity levels, and therefore the rationale for gradually trying to increase activity.

Doing more when we are feeling terrible often feels counterintuitive and can lead people to avoid this until a hypothetical time when they are feeling better physically and/or mentally.

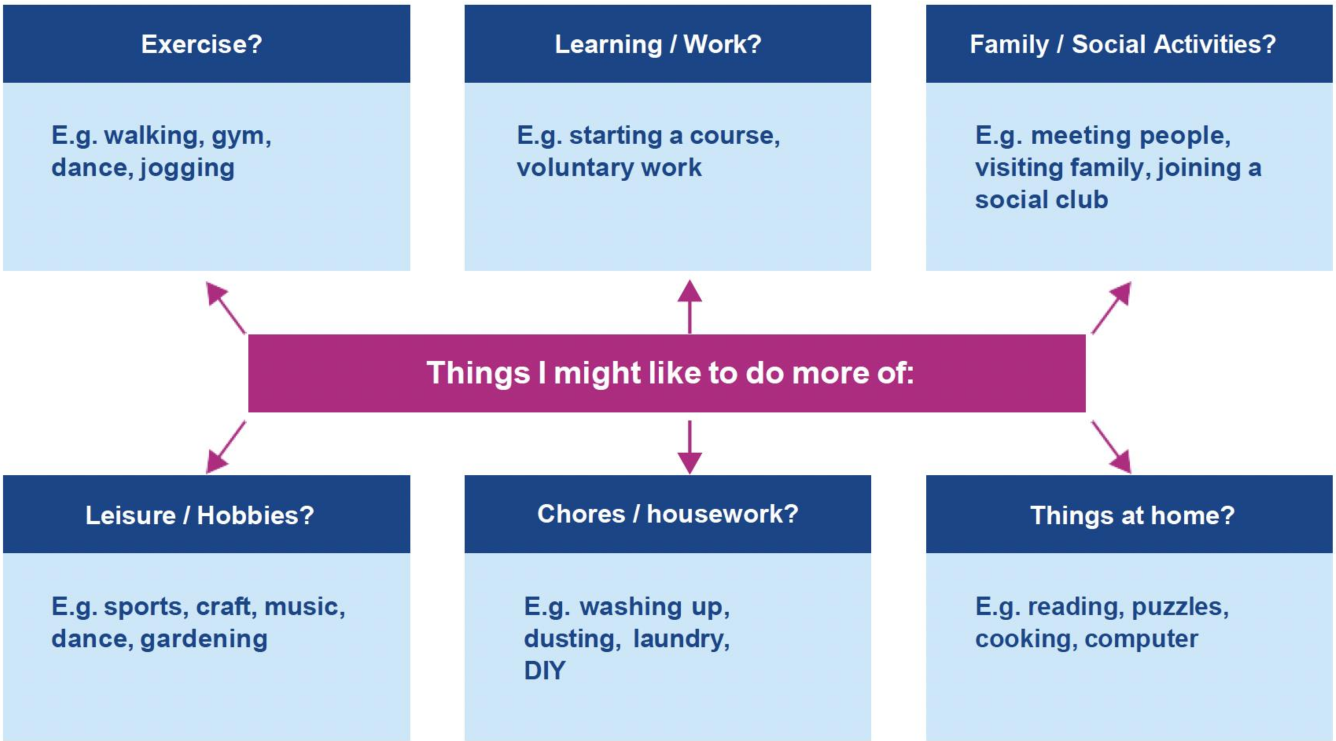
Using a motivational interviewing approach can be helpful, discussing the pros and cons of becoming more active and looking out for any signs that the service user might wish to change. Throughout the intervention be vigilant to changes in mood (however small), ask questions, and look out for opportunities to reinforce links with what they were doing at the time, and vice versa.

Step 2: Setting personal goals for this intervention

Aim to come up with a range of possible activities that service users may find pleasurable and/or provide a sense of achievement. This can be challenging, particularly when people have been struggling for many years, with little opportunity to consider what they might want to do differently.

Try to use prompts (see handout from the GOALS materials, below), including categories to discuss e.g. the Five Ways to Wellbeing. Activity Checklists can also be helpful prompts where service users are struggling to come up with ideas. Work together to narrow down this list of possible activities – aim to list a range of smaller goals which wouldn't need much planning and one larger goal to complete over the course of your sessions (approx. 10).

Take time to ensure that these goals are personal (and not something the service user feels they should be doing), linked primarily with depression rather than other barriers (e.g. more practical issues) and follow the SMART rule (specific, measurable, achievable, relevant, time-based).



Source: GOALS Therapy Manual (Waller et al. 2018). Figure 3. Setting up Personal Goals

Step 3: Breaking the goal down into smaller steps

When goals feel too big and unmanageable, they are typically much harder to achieve and therefore we are more likely to give up or put them off, particularly if we are feeling low in mood. Working together to teach the service user the rationale and skills to break down goals into smaller, more manageable steps can therefore help them to develop a valuable and transferable life skill.

Work together to break down the longer-term goal into smaller steps, making sure each step also follows the SMART rule, ideally so that they can be completed a step per week.

Possible steps could include:

- Further information gathering (to aid the development of steps)
- Skills development
- Gathering equipment
- Considering things that could make the activity easier initially (e.g. going with a friend)

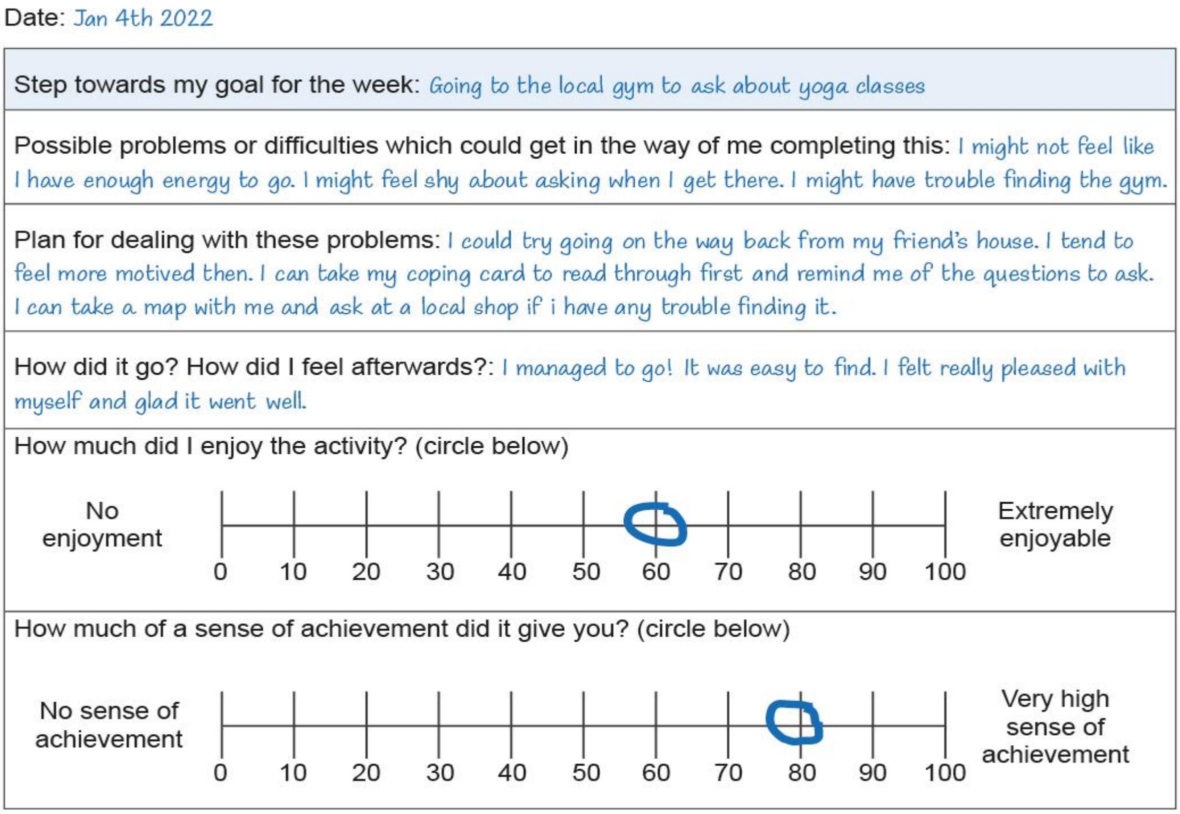
Step 4: Completing the Steps

Discuss the next step towards the longer-term goal at each session and aim to set at least one new smaller goal, ideally building activity levels over time, including a range of achievement-based and pleasurable activities (it can help to use a weekly planner to build structure).

For each goal (or step) ensure that you set aside time to make a clear plan, anticipating possible problems and ways to manage them. For any tasks set as homework, encourage service users to record how it went and to rate the sense of pleasure/achievement as soon as possible after completing the task.

For service users with severe mental health problems, particularly those needing more of an outreach approach, it can be helpful to complete one or more steps together, in order to provide support and build confidence. This also allows you to highlight links in-vivo between mood and activity levels. Ensure you set aside time for planning and debrief.

Example 1. Step towards my goal of the week



Date: Jan 4th 2022

Step towards my goal for the week: Going to the local gym to ask about yoga classes

Possible problems or difficulties which could get in the way of me completing this: I might not feel like I have enough energy to go. I might feel shy about asking when I get there. I might have trouble finding the gym.

Plan for dealing with these problems: I could try going on the way back from my friend's house. I tend to feel more motived then. I can take my coping card to read through first and remind me of the questions to ask. I can take a map with me and ask at a local shop if i have any trouble finding it.

How did it go? How did I feel afterwards?: I managed to go! It was easy to find. I felt really pleased with myself and glad it went well.

How much did I enjoy the activity? (circle below)

No enjoyment 0 10 20 30 40 50 [✓ 60] 70 80 90 100 Extremely enjoyable

How much of a sense of achievement did it give you? (circle below)

No sense of achievement 0 10 20 30 40 50 60 70 [✓ 80] 90 100 Very high sense of achievement

Date ....

Step towards my goal for the week:

Possible problems or difficulties which could get in the way of me completing this:

Plan for dealing with these problems:

How did it go? How did I feel afterwards?

How much did I enjoy the activity? (Circle below)

No enjoyment 0 10 20 30 40 50 60 70 80 90 100 Extremely enjoyable

How much of a sense of achievement did it give me? (circle below)

No sense of achievement 0. 10 20 30 40 50 60 70 80 90 100 High sense of achievement

Source: GOALS Therapy Manual (Waller et al. 2018)

Step 5: Reviewing progress

You should review weekly activity plans during subsequent clinical contacts, enabling service users to reflect on their progress, receive feedback and problem-solve any difficulties experienced in implementation.

As well as recognising positive steps and strengths, encourage discussion of any difficulties so that you can try to resolve them collaboratively – view this as a learning exercise, teaching coping skills, emphasising that it's OK not to manage at first and that they can try it again.

Consider helpful tools and coping strategies for managing any difficulties which may arise. Common difficulties include:

- Forgetfulness (consider memory prompts)
- Lack of confidence (consider role playing these skills, joint sessions, linking with carers/trusted friends)
- Negative predictions/putting off (reinforcing psychoeducation linking mood and activity levels – message around 'following your action plan and not your feelings')

Tools such as 'coping cards' or 'flashcards' can also be helpful, for example reminding people of the reasons why they want to complete the step (rather than putting off, for example).

Table 3. Monitoring my mood & activity levels

- It can be helpful to find out a bit more about how you are feeling over the next week
- Sometimes this can help us to see patterns, such as what you were doing when you felt a bit better or worse. This can help when thinking about ideas for goals that might lift your mood

Day	What was I doing?	Rate your enjoyment	Rate your sense of achievement
Monday: Morning			
Afternoon			
Evening			
Tuesday: Morning			
Afternoon			
Evening			
Wednesday: Morning			
Afternoon			
Evening			
Thursday: Morning			
Afternoon			
Evening			
Friday: Morning			
Afternoon			
Evening			
Saturday: Morning			
Afternoon			
Evening			
Sunday: Morning			
Afternoon			
Evening			

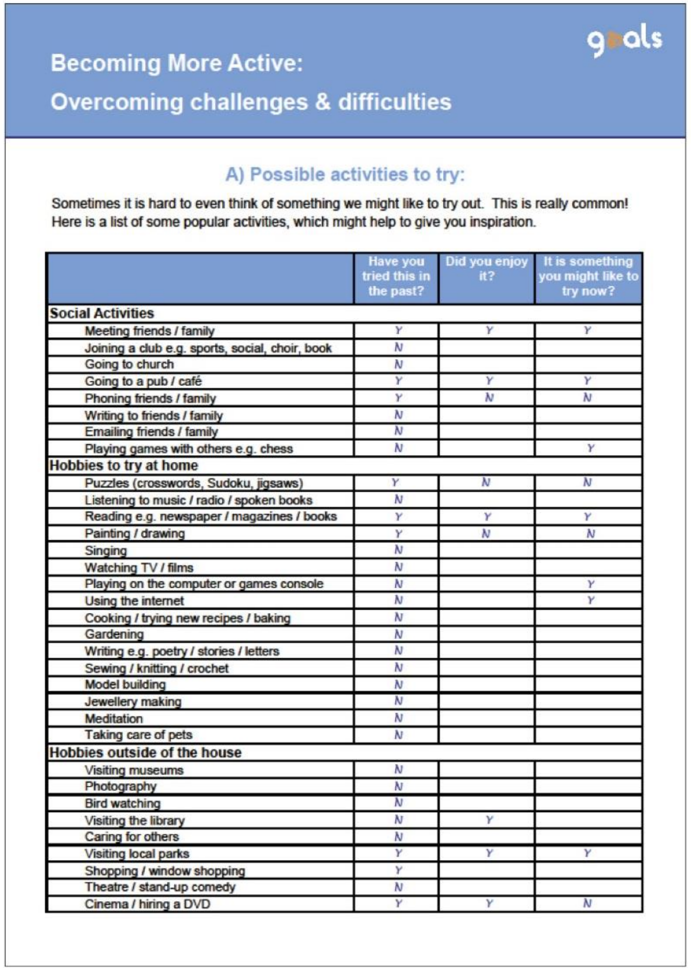
Source: GOALS Therapy Manual (Waller et al. 2018)

GOALS Handout 1: Becoming more active

Overcoming challenges & difficulties:

Difficulty setting a goal

Handout example:
'A) Possible activities to try'



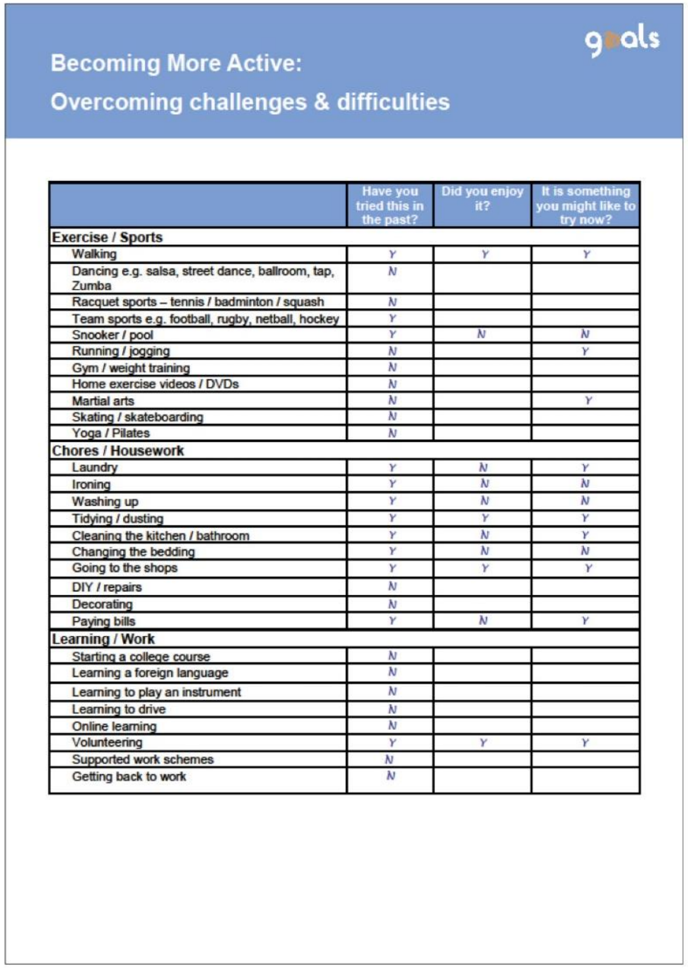
Becoming More Active:
Overcoming challenges & difficulties

goals

A) Possible activities to try:

Sometimes it is hard to even think of something we might like to try out. This is really common! Here is a list of some popular activities, which might help to give you inspiration.

	Have you tried this in the past?	Did you enjoy it?	It is something you might like to try now?
Social Activities			
Meeting friends / family	Y	Y	Y
Joining a club e.g. sports, social, choir, book	N		
Going to church	N		
Going to a pub / café	Y	Y	Y
Phoning friends / family	Y	N	N
Writing to friends / family	N		
Emailing friends / family	N		
Playing games with others e.g. chess	N		Y
Hobbies to try at home			
Puzzles (crosswords, Sudoku, jigsaws)	Y	N	N
Listening to music / radio / spoken books	N		
Reading e.g. newspaper / magazines / books	Y	Y	Y
Painting / drawing	Y	N	N
Singing	N		
Watching TV / films	N		
Playing on the computer or games console	N		Y
Using the internet	N		Y
Cooking / trying new recipes / baking	N		
Gardening	N		
Writing e.g. poetry / stories / letters	N		
Sewing / knitting / crochet	N		
Model building	N		
Jewellery making	N		
Meditation	N		
Taking care of pets	N		
Hobbies outside of the house			
Visiting museums	N		
Photography	N		
Bird watching	N		
Visiting the library	N	Y	
Caring for others	N		
Visiting local parks	Y	Y	Y
Shopping / window shopping	Y		
Theatre / stand-up comedy	N		
Cinema / hiring a DVD	Y	Y	N

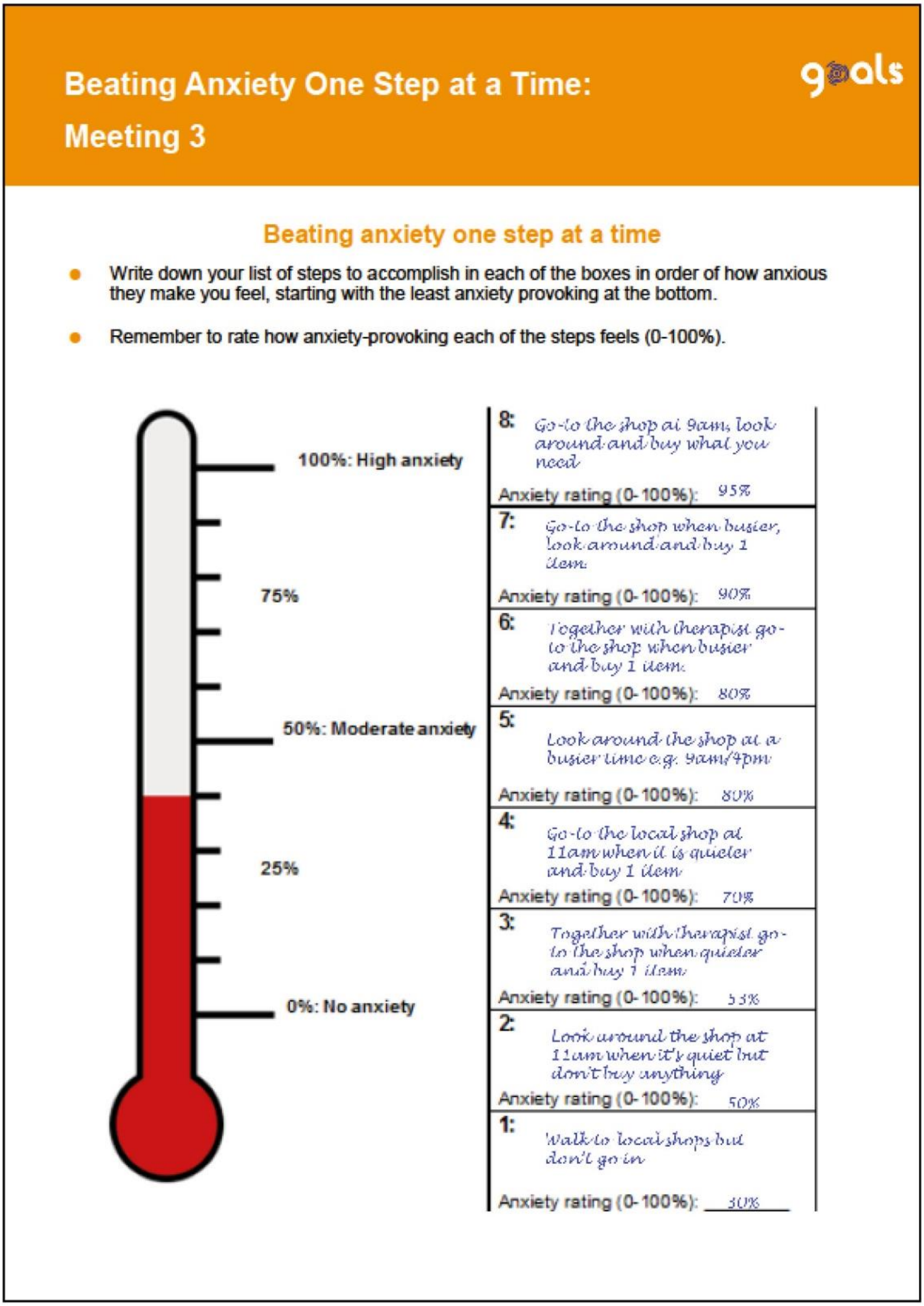


Becoming More Active:
Overcoming challenges & difficulties

goals

	Have you tried this in the past?	Did you enjoy it?	It is something you might like to try now?
Exercise / Sports			
Walking	Y	Y	Y
Dancing e.g. salsa, street dance, ballroom, tap, Zumba	N		
Racquet sports – tennis / badminton / squash	N		
Team sports e.g. football, rugby, netball, hockey	Y		
Snooker / pool	Y	N	N
Running / jogging	N		Y
Gym / weight training	N		
Home exercise videos / DVDs	N		
Martial arts	N		Y
Skating / skateboarding	N		
Yoga / Pilates	N		
Chores / Housework			
Laundry	Y	N	Y
Ironing	Y	N	N
Washing up	Y	N	N
Tidying / dusting	Y	Y	Y
Cleaning the kitchen / bathroom	Y	N	Y
Changing the bedding	Y	N	N
Going to the shops	Y	Y	Y
DIY / repairs	N		
Decorating	N		
Paying bills	Y	N	Y
Learning / Work			
Starting a college course	N		
Learning a foreign language	N		
Learning to play an instrument	N		
Learning to drive	N		
Online learning	N		
Volunteering	Y	Y	Y
Supported work schemes	N		
Getting back to work	N		

GOALS Handout 2: Beating Anxiety



Beating Anxiety One Step at a Time:
Meeting 3

Beating anxiety one step at a time

- Write down your list of steps to accomplish in each of the boxes in order of how anxious they make you feel, starting with the least anxiety provoking at the bottom.
- Remember to rate how anxiety-provoking each of the steps feels (0-100%).

100%: High anxiety
75%
50%: Moderate anxiety
25%
0%: No anxiety

8: Go-to the shop at 9am, look around and buy what you need
Anxiety rating (0-100%): 95%

7: Go-to the shop when busier, look around and buy 1 item.
Anxiety rating (0-100%): 90%

6: Together with therapist go-to the shop when busier and buy 1 item.
Anxiety rating (0-100%): 80%

5: Look around the shop at a busier time e.g. 9am/4pm
Anxiety rating (0-100%): 80%

4: Go-to the local shop at 11am when it is quieter and buy 1 item
Anxiety rating (0-100%): 70%

3: Together with therapist go-to the shop when quieter and buy 1 item.
Anxiety rating (0-100%): 55%

2: Look around the shop at 11am when it's quiet but don't buy anything
Anxiety rating (0-100%): 50%

1: Walk to local shops but don't go in
Anxiety rating (0-100%): 30%

Section 5D: Graded Exposure Using the GOALS Programme

People will often try to avoid situations or objects they fear, and this avoidance does indeed successfully relieve anxiety in the short term. However, the more people avoid, the more they will continue to use it as a coping strategy. This leads to long-term difficulties as people find it more and more difficult to face their fears, even when this is restricting life significantly.

Exposure is the planned therapeutic confrontation to a feared situation, object, or memory. By staying with situations until the anxiety subsides, future similar situations don't lead to the same level of anxiety. Graded exposure can be a helpful intervention with service user who have identified problems with avoidance and some forms of anxiety, or goals focused on
overcoming fears.

How does graded exposure work?

Graded exposure therapy works through a process known as habituation. This is the natural reduction in arousal that occurs when people allow themselves to remain in the presence of a feared situation or object for a prolonged period.

Over time, anxiety reduces gradually whilst the person remains in contact with the feared stimulus. This is very different from avoidance. In avoidance, arousal reduces sharply but only when the person escapes from the feared situation or object. The problem with escape and avoidance is that the fear remains. The next time a person comes across their feared stimulus, their arousal levels will be the same as before.

In exposure, habituation means that subsequent exposure sessions provoke less anxiety than previously. The graph below represents the difference.

Graded exposure vs avoidance

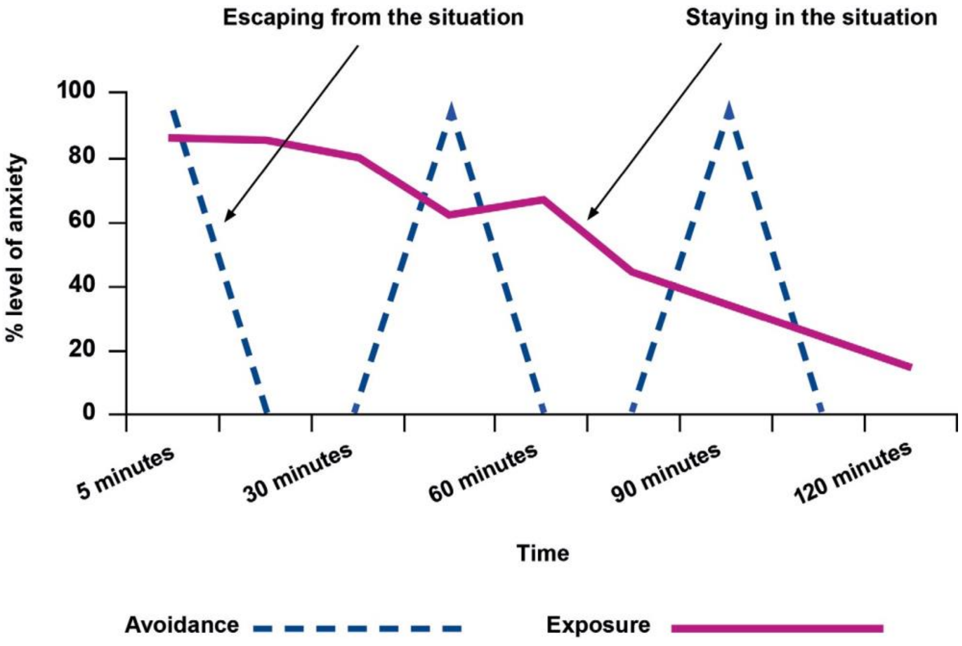


Figure 7. Graded exposure vs avoidance

Source: Reach Out. 3rd Edition. David Richards and Mark Whyte

Implementing graded exposure as an intervention

The following protocol for graded exposure therapy is taken from the GOALS Trial therapy manual and associated client information pack (see Waller et al. 2018). Similar to the methods described under Behavioural Activation, it is based on evidence-based treatment protocols for anxious avoidance, adapted for use in people with psychosis and subsequently used in clinical practice in a range of settings for people with severe mental health problems.

Goals and steps may be smaller and taken at a slightly slower pace to avoid triggering high levels of anxiety which can be associated with relapse in severe mental health problems.

Step 1: Understanding the relationship between anxiety and avoidance

You should first provide information on common symptoms of anxiety (including thoughts, feelings, physiological symptoms, and behaviours) and discuss how this relates to the service user's personal experience.

You should also discuss the relationship between anxiety and avoidance. Aim to normalise avoidance as a common way of managing anxiety, discussing how it typically provides relief from discomfort in anxiety-provoking situations, but when used as a longer-term strategy becomes a key maintenance factor in continuing anxiety.

To reinforce this message, encourage discussion around times when the service user has avoided versus approached anxiety-provoking situations and the impact on their mood in both the short and longer-term.

Step 2: Setting a goal to work on

Work together to compose a list of fearful objects or situations and to consider the impact of avoiding these things on the service user's mood and functioning.

Choose one of these avoided situations to work towards as the goal for your sessions. Encourage them to choose something that, when overcome:

- Is likely to enable them to work towards a valued goal of interest
- Overcomes restrictions in life without necessarily needing to go beyond this (e.g., if afraid of heights, to be able to go on trips to a variety of places with family, but not necessarily to go sky-diving)
- Is something that they are motivated to work on, and
- Feels manageable with support

Provide validation that you have heard how anxiety-provoking this situation feels and how important it would be to achieve this goal – emphasise that you will be working collaboratively and will work towards the goal gradually, in small steps.

See Graded Exposure handout 1 Deciding which fearful situation to work on.

Step 3: Building an anxiety ladder or hierarchy

Next, you should work together with the service user to create a list of steps to reach the goal, in order of anticipated anxiety levels (see example handout below).

Before doing this, find out more information to establish what might make the situation more or less anxiety-provoking, for example:

- Which aspects of the situation they find most anxiety-provoking
- Their last experience of going into the feared situation
- What they are already able to do

Think about what might make the situation easier, for example:

- Going alone versus accompanied
- Quieter versus busier times of day
- Time spent in the situation
- Using versus dropping safety behaviours (see below)

Using the information gathered, start to think about possible steps on the anxiety ladder – it can help to use sticky notes initially so you can re-order the steps, asking the service user to estimate their anticipated anxiety levels.

See Graded Exposure handout 2 The Anxiety Ladder.

Step 4: Completing the steps

During each session, aim to discuss and set a step on the ladder as a goal. As with behavioural activation, ensure you set aside enough time to write down a clear plan, anticipating possible problems and how to deal with them. Decide which steps will be completed together and which as homework. It is useful to have a mixture of both and to complete at least one joint exposure session together as an observation.

For any tasks completed together, ensure that you set aside time before and after to remind the service user of the plan and to reflect and debrief afterwards. When planning, consider your own role in the task –be careful that you do not become a form of avoidance – you want the person to work towards being able to reach the goal alone, not only when you are present.

For exposure to be effective it should be:

- **prolonged: There must be sufficient time for arousal levels to reduce in the presence of the feared object or situation. Ideally, exposure sessions should continue until anxiety has reduced by at least 50%. If this feels too much for one session, the step can be continued until this reduction in anxiety is felt.**
- **repeated: Additional exposure is necessary to cement improvement. The optimum number of repetitions should be balanced by the physical demands of feeling regularly fearful.**
- **without distraction: To experience a reduction in anxiety, people must feel some fear at first in order to experience and thus learn that fear reduces naturally in the presence of the feared object or situation.**

Source: GOALS Therapy Manual (Waller et al. 2018)

Step 5: Reviewing progress

The review process should follow the same structure as noted in the Behavioural Activation section, setting aside time to review homework tasks and problem solve any issues which have arisen.

Common difficulties include anxious thoughts leading to ongoing avoidance patterns: consider helpful tools and coping strategies, for example positive self-talk, reminders of how well they have done previously or how pleased they will feel afterwards, relaxation skills and plans for managing physiological symptoms of anxiety.

Another common difficulty arises when service users complete tasks, but do not report a reduction in anxiety levels. In this case, it is likely that the service user may be using ‘safety seeking behaviours’: behaviours carried out to ‘cope’ or prevent harm.

For example:

- Avoidance
- Escape (not staying in the situation to notice anxiety dropping)
- Distraction
- Self-medicating
- Strategies such as carrying medications ‘just in case’, wearing dark glasses, looking down when out or leaning on a wall to prevent from fainting

These behaviours maintain anxiety because they stop people from discovering whether the worst will really happen if they do nothing to prevent it. As a result, they continue to feel under threat and their ideas that they cannot accomplish their goals are reinforced.

Joint exposure sessions where you accompany the service user can be very helpful to look out for potential safety-seeking behaviours. Once they have been identified and are maintaining the anxiety and avoidance, provide the service user with psychoeducation on these behaviours and the need to quit them.

It is likely that you will need to go back to the anxiety ladder at this stage, to either build in the dropping of safety behaviours, as this is likely to impact on anticipated anxiety levels.

Helpful resources

Table 4. Weekly action plan. Completing the steps

Step towards my goal for the week:
Action plan: (Where? When? With whom?)
Possible problems or difficulties
Plan for dealing with these problems:

Each time you try out the plan, fill in the details below: before you start it, just after you start and at the end of it. Any comments you want to discuss at the next meeting.

Table 5. Reviewing the weekly action plan

Date & time	How long?	Anxiety rating (0-100%)			Comments:
		Before	Start of exercise	End of exercise	

Source: GOALS Therapy Manual (Waller et al. 2018)

Graded Exposure handout 1: Deciding which fearful situation to work on

Table 6. Avoidance situations

- Write down some of the situations you avoid in the table below and think about what avoiding these things might stop you doing

Things that I avoid	What this stops me doing

- Deciding which avoided situation to work on is very important
- The situation should be one that:
    - When overcome, will help you to work towards achieving a valued goal of interest
    - You are motivated to work towards
    - Feels manageable and achievable

Table 7. Avoidance situations plan

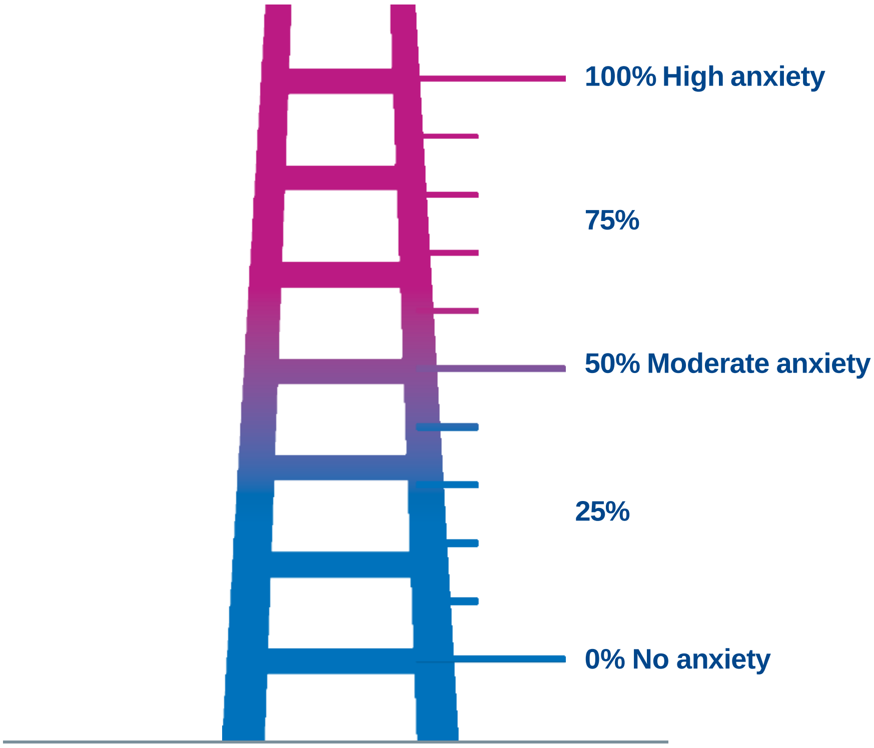
The situation I plan to work on is:
At the moment, this is difficult because:
Achieving this goal will be a positive step because:

Source: GOALS Therapy Manual (Waller et al. 2018)

Graded Exposure handout 2: The anxiety ladder

Beating anxiety one step at a time:

- Write down your list of steps to accomplish in each of the boxes in order of how anxious they make you feel, starting with the least anxiety provoking at the bottom
- Remember to rate how anxiety-provoking each of the steps feels (0-100%)



8:
Anxiety rating (0-100%)
7:
Anxiety rating (0-100%)
6:
Anxiety rating (0-100%)
5:
Anxiety rating (0-100%)
4:
Anxiety rating (0-100%)
3:
Anxiety rating (0-100%)
2:
Anxiety rating (0-100%)
1:
Anxiety rating (0-100%)

Figure 8. The anxiety ladder

GOALS
See Section 5C GOALS handout 1: Becoming more Active
See Section 5C GOALS handout 2: Beating Anxiety

Section 5E: Teaching Problem-solving Skills

Problem-solving is a straightforward and effective low-intensity intervention that focuses on finding effective solutions to everyday life situations that are considered problematic. It is a particularly useful intervention for tackling practical aspects of a problem, and focuses on the here and now.

Teaching problem-solving skills can be a helpful intervention for service users who have identified problems with worry, or with making decisions about how to move forward in life.

When someone feels overwhelmed by life problems, it is often difficult to see a way of addressing these difficulties satisfactorily. It can feel impossible even to know where to start. Using a problem-solving approach enables a person to take a step back from the problem and consider what solutions exist.

You should take a step-by-step approach with the service user to identify the problem, then consider the potential solutions and the steps required to overcome it. This intervention can teach the skills needed to overcome problems that the service user has put off dealing with as they seem too overwhelming or burdensome.

The 7 steps of problem-solving:

Step 1 Problem definition and formulation - Identify the problem

The first step in problem-solving is to identify the issue as clearly and precisely as possible.

This can be straightforward, but sometimes it can be difficult to pinpoint exactly what the issue is. If a person has this difficulty, it can be helpful to discuss it with a trusted person. Once they have accurately identified the problem, they should write it down. You should then break down each problem into its constituent parts.

For example, a financial problem may be broken down into debt, income, and expenditure.

Step 2 Generation of alternatives - Write down as many solutions as possible

At this point, you should encourage the service user to identify as many potential solutions as possible. No solutions should be rejected, no matter how ridiculous they may seem. It can be helpful to include outlandish solutions on the list as this can help foster a more flexible approach to dealing with problems.

It can also be helpful to consider what ideas other people in the service user’s life would suggest. The more ideas that are generated, the more likely it is that you and the service user will find an acceptable solution.

Step 3: Decision-making - Consider the pros and cons of each possible solution

Next you should consider each potential solution in terms of its pros and cons, to establish the main advantages and disadvantages of each. It can be helpful to consider each solution in terms of:

- Likelihood of success
- How possible it is to implement

- The resources required (time, money etc.)
- Any support needed from others – by example family members or carers

Step 4: Select the best or most promising solution

Based on the outcome of Step 3, the next step is to choose the solution that can be carried out most easily with present resources (e.g. time, money etc) and is most likely to result in a positive outcome.

Sometimes the preferred solution might turn out to be a combination of two or more of the proposals that were generated in Step 2.

Step 5: Plan how to carry out the chosen solution

It is likely that the selected solution will need careful planning. This step involves listing the resources needed, the main problems that need to be overcome and the steps that need to be taken. You can encourage the service user to practice difficult steps and make notes of what information is needed.

The steps should be specific and realistic, including:

- What will the service user do?
- Where will they do it?
- When will they do it?
- With whom – if another person is involved?

It should be clear what steps the service user is going to take and when they will be carried out.

Step 6: Solution implementation and verification – put the plan into action

The service user puts the plan into action, following the steps identified at Step 5, and records what happens.

Step 7: Review what happens

The solution chosen may work perfectly, or it may not. If it is not successful, you should encourage the service user to go back to their list of solutions and try something else.

Many solutions are helpful, but without necessarily providing the complete answer.

Important: Whether the service user's solution has worked completely, partially, or not at all, you should encourage them to give themselves credit for their efforts.

They may need to revise their plans, but you should encourage them to continue with the problem-solving process until they have resolved their problem or achieved their goal.

Summary

- A problem-solving approach is helpful for practical life problems
- Problem-solving is a step-by-step approach based on dealing with one problem at a time
- Problem-solving comprises seven key steps:
    1. Identify the problem.
    2. Write down as many solutions as possible.
    3. Consider the pros and cons of each possible solution.
    4. Select the best or most promising solution.
    5. Plan how to carry out the chosen solution.
    6. Put the plan into action.
    7. Review what happens.

Helpful resources

Problem-solving worksheet 1: Problem-solving

Step 1

Identify the problem
Identify the problem as clearly and precisely as possible.

Step 2

Write down as many solutions as possible
As many potential solutions as possible should be identified. At this step, remember not to reject any solutions no matter how ridiculous they may seem. **1.** **2.** **3.** **4.** **5.** **6.** **7.** **8.** **9.** **10.**

Step 3

Consider the pros and cons of each possible solution
Consider each potential solution in terms of its pros and cons. Take into account each potential solution's likelihood of success, how possible it is to implement, the resources required etc. **Solution 1** • **Pros** • **Cons**

Solution 2

- Pros
- Cons

Solution 3

- Pros
- Cons

Solution 4

- Pros
- Cons

Solution 5

- Pros
- Cons

Solution 6

- Pros
- Cons

Solution 7

- Pros
- Cons

Solution 8

- Pros
- Cons

Solution 9

- Pros
- Cons

Solution 10

- Pros
- Cons

Step 4

Select the best or most promising solution
Pick the best solution from Step 3 (this may be a combination of more than one proposal). Remember to consider what is needed to put the solution into action. **Solution no:**

Step 5

Plan how to carry out the chosen solution
Careful planning is key to effective problem-solving. **Resources needed** List the resources needed. **Main problems to be overcome** Identify any problems that will need to be overcome and any steps needed. **Steps to be undertaken** Steps should be specific and realistic include specific information on what, where, when, and with whom.

Step 6

Put the plan into action
Put the plan identified in Step 5 into action and make a record of what happens.

Step 7

Review what happens
Solution worked: depending on the outcome, no further action needed or ongoing implementation and review. Solution not worked or not worked completely: select another solution and go through Steps 5-7.

Additional Reading

Miles, G. (2020). ‘Problem-Solving: Doing What It Says on the Tin’ in Farrand, P. (ed), Low-Intensity CBT Skills & Interventions: A practitioner’s manual. London: Sage, pp 255-269.

Mynors-Wallis, L. & Lau, M.A. (2010). ‘Problem-solving as a low intensity intervention’ in Bennett-Levy, Richards, D.A., Farrand, P., Christensen, H., Griffiths, K.M., Kavanagh, D.J., Klein, B., Lau, M.A., Proudfoot, J., Ritterband, L., White, J. and Williams, C. (eds). Low Intensity CBT Interventions. London: Oxford University Press, pp 151-158.

Nezu, A.M., Nezu, C.M. & D’Zurilla, T.J. (2012). Problem-Solving Therapy: A Treatment Manual. New York: Springer.

Richards, D. & Whyte, M. (2011). ‘Problem-solving’ in Reach Out (third edition). London: Rethink, pp 41-42.

Section 5F: Encouraging Good Sleep

Sleep is essential to our health and wellbeing. Yet sleep disruption is common. Sleep problems include difficulty getting to sleep, staying asleep, or sleeping too much. Here we focus on the basics of getting good sleep.

To do this we need to understand the three factors that promote good sleep: consistent timing, building up the pressure for sleep, and feeling calm and relaxed before bed. Encouraging good sleep can be a helpful intervention with service users who have identified problems with sleep or where their Five-Areas formulation shows that poor sleep may be a maintaining factor for a problem.

The foundations of good sleep

Sleep is one of life's essentials. Typically, adults have 7-9 hours sleep each night. Yet almost everyone has experienced sleep difficulties at some point in their lives. There are many things that can disrupt sleep: experiencing a stressful event, low mood, physical illness, disrupted routines, not doing much in the day, and feeling stressed, worried, or frustrated.

When we don't sleep well, we notice the effects the next day – feeling exhausted, irritable, anxious, and having difficulty concentrating. This means that sleep disruption is actually a 24-hour problem and requires a 24-hour solution.

The three factors involved in getting good sleep

To get sleep back on track there are three key factors we need to consider:

1. Timing

We sleep best when our sleep pattern is aligned with the day/night cycle: activity in the daylight and sleeping when it is dark. For good sleep, we also need a consistent pattern – going to sleep and getting up at the same time each day.

2. Sleep pressure

If we have been active in the day, we build up our need for sleep, known as sleep pressure. If we are inactive or napping during the day this makes it harder to sleep at night as the sleep pressure is not high enough.

3. Feeling relaxed and calm

We need to feel calm in order to drift off to sleep. Stress, worry, and frustration can make it hard to sleep. We can even feel stressed and frustrated about not sleeping. Relaxing before bed makes it easier for us to get to sleep and stay asleep.

To improve sleep, we need to align the time we sleep (known as the sleep window) with the day/night cycle, build up sleep pressure by being active in the daytime, and ensure we feel calm and relaxed before bedtime in order to drift off to sleep.

The stages of improving sleep

The following protocol for techniques to improve sleep is drawn from two UK clinical trials using full treatment programmes with people with serious mental health difficulties (Freeman et al, 2015; Freeman et al, 2021). It was developed from CBT for insomnia (see Espie, 2006), with adaptations for people with serious mental health problems (Waite et al., 2016; Sheaves et al., 2018).

Step 1: Assessing sleep

It is recommended that you make an initial assessment of the service user's sleep problems, and then briefly re-assess each week to monitor change. The Insomnia Severity Index (Worksheet 1: Encouraging Good Sleep) is a 7-item self-report assessment of the key features of insomnia (difficulties getting to sleep, staying asleep, or waking too early) as well as impact on daytime functioning and satisfaction with current sleep patterns.

Step 2: Identifying factors that disrupt sleep

Use Worksheet 2: Encouraging Good Sleep - What stops me sleeping? to help service users identify what might be getting in the way of good sleep. The items align with the three factors underpinning good sleep. There are also practical items related to the sleep environment which often need addressing first for example, getting curtains or a bed.

Each item can be discussed with the service user and, using the relevant suggested solutions, a personalised plan put in place.

If the individual experiences nightmares or heavy snoring these are indications that you may need to refer them to a relevant professional for further assessment of specific sleep disorders, including nightmare disorder and sleep apnoea, which have specific treatments.

Step 3: Setting the sleep window

The next step is to identify the optimal sleep timing and duration for the individual. This means setting an ideal bedtime and ideal rise time. The sleep window needs to be at the same time each night of the week – including the weekends.

We need to work out the 'right fit' in terms of amount and timing of sleep for each individual. We all need a different amount of sleep. On average it is around 7-9 hours for adults. Preference for sleep timing also varies – some people are 'morning larks' (most alert in the morning) and others 'night owls' (most alert in the evening).

The aim is to help the service user to set realistic, achievable, regular waking and bedtimes.

Step 4: Building sleep pressure

To build sleep pressure and align the body clock with the night/day cycle, we need to keep active in the daytime.

Encourage the service user to plan activities using a regular schedule that includes morning daylight (which helps alert the body to the daytime and align the body clock) and a range of activities throughout the day. Suggest they use mealtimes as anchor points throughout the day and add activities between each meal. Worksheet '3: Encouraging Good Sleep – Activity planning' provides a framework for activity planning.

If the person tends to nap, then plan an activity to start just before the usual nap time to help them to stay awake in the day and build the sleep pressure for night.

Step 5: Feeling calm and relaxed for sleep

To transition from wakefulness to sleep, you should help the service user plan a wind-down routine for 60-90 minutes before bedtime. The wind-down routine includes slowing down, switching to relaxing activities, and starting a pre-bed routine, for example, cleaning their teeth.

Identify relaxing activities to include in the wind-down routine, such as having a warm bath, reading, watching TV, having a light snack or decaffeinated drink.

Plan when to switch off tech devices – this is important as the light from screens can disrupt the body clock and make it harder to fall asleep. Relaxation exercises can also be used before bed to help increase feelings of calm.

Plan out each step of the wind-down routine with the service user in detail.

Step 6: Reviewing progress

You can use the Insomnia Severity Index to assess improvement in sleep. You should also ask the service user if their sleep pattern is more consistent and if they are getting about the right amount of sleep for them. To help them maintain good sleep, reflect together to identify the top three strategies they found helpful for improving their sleep, and plan how these can be used in the long term.

Helpful resources

Encouraging good sleep worksheet 1: Insomnia Severity Index

How has your sleep been over the last week?

Each time you meet with your therapist you will be asked to fill in the following about your sleep over the last week so that you can discuss changes in your sleep and see improvements to your sleep.

Please rate the following in relation to your **CURRENT** sleep (in the past week) For each question please **CIRCLE** the number that best describes your answer.

Sleep problem	None	Mild	Moderate	Severe	Very severe
1. Difficulty falling asleep	0	1	2	3	4
2. Difficulty staying asleep	0	1	2	3	4
3. Problem waking up too early	0	1	2	3	4

4. How satisfied/dissatisfied are you with your current sleep pattern?

Very satisfied — Very dissatisfied

0	1	2	3	4

5. To what extend do you consider your sleep problem to interfere with your daily functioning (e.g. daytime fatigue, mood, ability to function at work/daily chores, concentration, memory, mood etc.)

Very satisfied — Very much interfering

0	1	2	3	4

6. How noticeable to others do you think your sleep problem is in terms of impairing the quality of your life?

Very satisfied — Very much noticeable

0	1	2	3	4

7. How worried/distressed are you about your current sleep problem?

Very satisfied — Very much worried

0	1	2	3	4

Source: Bastien, C. H., Vallieres, A. & Morin, C. M. (2001). Validation of the insomnia severity index as an outcome measure for insomnia research. Sleep Medicine, 2, 297-307.

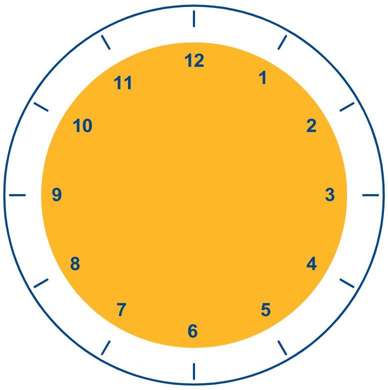
Encouraging good sleep worksheet 2: What stops me sleeping?

	What stops me sleeping?	Y/N	If yes – potential solutions
1	My room is too light at night-time.		Make sure there are curtains or blinds that keep the room dark at night-time.
2	I don't have a comfortable bed or bedding.		Create a place to sleep – this might mean getting a bed or new bedding.
3	I use my phone, laptop, or TV at night.		Set a time to switch off from tech devices – the light from screens can disrupt the body clock, making us feel awake in the evening and making it harder to sleep.
4	I don't have a regular bedtime or wake time.		Set a regular bedtime and wake time for each day of the week – including the weekends – this helps regulate our body clock.
5	I lie-in in the mornings and can't sleep the following night.		Plan a rise up routine that includes morning daylight and activity – light helps tell the body it is time to wake up.
6	Sometimes I wake up early, other days I wake up late.		Get up at the same time each day – the body will get used to the pattern.
7	I don't do much during the day, so I am not tired enough to sleep well.		Plan enjoyable activities in the morning and afternoon – use mealtimes to create a regular pattern throughout the day.
8	I nap during the day (which decreases my 'sleep pressure').		Schedule an activity for just before the usual nap time – try going for a walk, or listening to upbeat music.
9	I do things in the evening that leave me feeling alert rather than sleepy.		Do high energy activities in the morning and try relaxation exercises in the evening.
10	I don't have a regular pre-bed routine that helps me unwind.		Plan a regular wind-down routine to help transition from wake to sleep.
11	I don't feel relaxed when I go to bed.		Try relaxation exercises as part of the wind-down routine.
12	Thoughts go through my head and keep me awake.		Give a relaxation exercise a try just before switching the light off.
13	I have nightmares or frightening dreams.		Speak with a psychologist or member of the mental health team about treatments for nightmares.
14	I snore heavily.		Arrange a GP to check for sleep apnoea – another type of sleep problem.

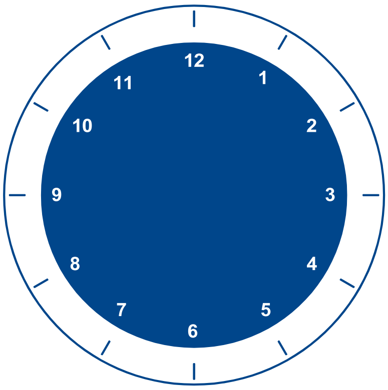
Source: Adapted from Freeman et al (2021). Comparison of a theoretically driven cognitive therapy (the Feeling Safe Programme) with befriending for the treatment of persistent persecutory delusions: a parallel, single-blind, randomised controlled trial. Lancet Psychiatry, 8: 696–707.

Encouraging good sleep Worksheet 3: Activity Planning

Ideal rise time



Ideal bedtime



Breakfast: ________________

Morning activity:

Lunch: ________________

Afternoon activity:

Dinner: ________________

Relaxation activity:

Source: Freeman et al (2021). Comparison of a theoretically driven cognitive therapy (the Feeling Safe Programme) with befriending for the treatment of persistent persecutory delusions: a parallel, single-blind, randomised controlled trial. Lancet Psychiatry, 8: 696–707.

References

Bastien, C.H., Vallières, a, Morin, C.M., (2001). Validation of the Insomnia Severity Index as an outcome measure for insomnia research. Sleep Med,. 2: 297–307.

Espie, C.A., 2006. Overcoming Insomnia and Sleep Problems: A Self-Help Guide Using Cognitive Behavioural Techniques. Constable and Robinson, London.

Freeman, D., Waite, F., Startup, H., Myers, E., Lister, R., McInerney, J., Harvey, A.G., Geddes, J., Zaiwalla, Z., Luengo-Fernandez, R., Foster, R., Clifton, L., Yu, L.M., (2015). Efficacy of cognitive behavioural therapy for sleep improvement in patients with persistent delusions and hallucinations (BEST): A prospective, assessor-blind, randomised controlled pilot trial. Lancet Psychiatry, 2: 975–983.

Freeman, D., Emsley, R., Diamond, R., Collett, N., Bold, E., Chadwick, E., Isham, L., Bird, J.C., Edwards, D., Kingdon, D., Fitzpatrick, R., Kabir, T., & Waite, F. (2021). Comparison of a theoretically driven cognitive therapy (the Feeling Safe Programme) with befriending for the treatment of persistent persecutory delusions: a parallel, single-blind, randomised controlled trial. Lancet Psychiatry, 8: 696–707.

Sheaves, B, Isham, L., Bradley, J., Espie, C., Barrera, A., Waite, F., Harvey, A.G., Attard, C., & Freeman, D. (2018). Adapted CBT to Stabilize Sleep on Psychiatric Wards: A Transdiagnostic Treatment Approach. Behavioural and Cognitive Psychotherapy 46:661-675.

Waite, F., Myers, E., Harvey, A.G., Espie, C.A., Startup, H., Sheaves, B., Freeman, D., (2016). Treating Sleep Problems in Patients with Schizophrenia. Behavioural and Cognitive Psychotherapy,. 44: 273–287.

Waite, F., & Sheaves, B. (2020). Better Sleep: Evidence-Based Interventions. J.C. Badcock, G. Paulik (Eds.), A Clinical Introduction to Psychosis. Elsevier: London.

Section 5G: Recognising and Managing Emotions

Emotions are an important part of life but can also be troublesome and hard to understand and manage. The recognising and managing emotions intervention aims to encourage service users to re-establish a more positive relationship with their emotions. This can be achieved by:

1. helping the service user to name emotions.

2. teaching them to understand the function of each emotion.

3. teaching them how to check whether the emotion itself is appropriate to the situation.

4. teaching them how to check if the level of intensity is appropriate to the situation.

5. teaching them how to increase or decrease the intensity of the emotion.

This intervention is in two parts: (1) Recognising Emotions and (2) Regulating Emotions. Only work on regulating emotions at the service user’s invitation. The intervention can be a helpful intervention with service users who have identified problems with understanding emotions, or with emotions that don’t seem to fit the situations where they arise.

Part 1: Recognising Emotions

What are emotions?

Emotions are complex full-body reactions that activate our behaviour - they Elicit Motion. They are different from each other and context-specific. This means some situations lead to sadness, others joy.

Emotions make themselves known to us through physical changes in the body, including temperature, muscle changes, breathing and heart rate. They are influenced by our hormones, diet, sleep, and fitness.

Our ancestors needed emotions to aid their survival. For example, anxiety would have activated our ancestors to run away from or avoid predator attacks. They have evolved in complexity and are still needed to guide our actions today, even though life-threatening dangers are fewer.

Although we imagine feeling many emotions at once, we actually move quickly from one to another. This is why If you try to do the facial expression for tragic sadness and simultaneous rage, you can’t do it.

What problems do emotions cause?

Specific past experiences, biological sensitivity and physical health problems can result in intense, volatile or painful emotions.

Some commonly reported problems:

- Emotions are experienced as painful

- Lots of emotions seem to occur at once and overwhelm the person

- One particular emotion, such as sadness or shame, fires up too frequently
- In a current situation the person feels emotions associated with the past
- The action urge for an emotion seems too powerful to resist (for example lashing out when angry)

The person feels no emotion, which is experienced as emptiness or numbness.

To reduce emotional discomfort service users may isolate themselves, over-medicate, restrict their food intake, use drugs or alcohol, self-harm or even attempt suicide.

Each strategy will reduce the emotion in the short term but cause it to increase in intensity over time. This is because emotions are too important to be ignored. When they are invalidated nature increases their volume to ram their message home.

Naming emotions

When people cannot name their emotions we call this Alexithymia.

We discourage service users from using the word ‘feeling,’ because it is too vague. For example, if someone says, “I feel left out,” it is a description of a thought, but the emotion could be sadness, anger, or shame.

To make the task easier we break down the emotions into ‘family’ groups. So, annoyance, frustration, irritation would go in the Anger family, disappointment, misery and gloom go in the Sadness family. Being able to name an emotion creates activity in the cortex area of the brain, which acts to dampen down the amygdala, a brain area associated with emotional intensity.

You can use the table in Recognising Emotions Handout 1. The functions of emotions with service users to help them understand the function of each emotion, and the situation in which it is likely to occur.

If they are still unable to identify their emotion the signature features of each one is described in Recognising Emotions Handout 2: Emotions crib sheet.

Being able to differentiate between emotions helps with the sense of being overwhelmed.

What is emotion regulation?

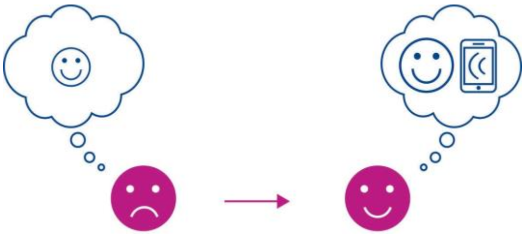
If the emotion is the correct type and intensity for the situation, we call it **regulated**. An emotion can be very strong and still be regulated. For example, extreme fear if you’re in a housefire, or intense sadness if a close friend dies.

A **dysregulated** emotion is one that;

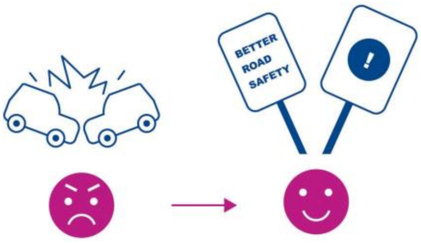
- Does not fit the situation – e.g. being sad when you are praised, feeling afraid in the supermarket, feeling guilty for leaving work on time, or
- Fits the situation but is too intense – e.g. being furious at yourself for a tiny mistake, feeling heartbroken if your friend is late arriving, or
- Is associated with a previous situation – e.g. being ashamed of your appearance because you were bullied at school, or
- Is absent where it would normally be – e.g. feeling no anger if someone is stealing from you

All emotions are **understandable**. If we have been assaulted near a bridge, we might feel afraid walking past bridges. If we have lost our pet dog, we might be sad during a meeting at work. If we have been abused as a child and told, we must keep it secret we may feel intense shame a lot of the time. Being able to say why you are feeling an emotion is called emotion validation.
Service users may naturally assume that every strong emotion is bad.

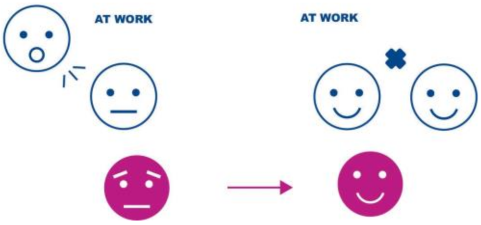
Example 1. Strong emotions being useful



- Someone feels sad at losing contact with a friend and is motivated to get back in touch



- Someone feels angry about a local traffic accident and campaigns for better road safety



- Someone feels guilty for snapping at a colleague and is prompted to repair the relationship

Mindfulness of emotions

We want to encourage people to pay attention to the body sensations that are associated with emotions.

Recognising Emotions Handout 2: Emotions crib sheet. is aa useful tool to help service users become more familiar with what they feel. They can then refer to Recognising Emotions Handout 1. The Functions of Emotions with your help- to find out if the emotion matched the facts.

Teaching service users to pause mindfully and reflect is ‘putting a space between the itch and the scratch’ so they realise they can learn to read emotions before acting on them.

Use of Multimedia

Emojis and gifs are extremely helpful in psychoeducation about emotion. They are readily accessible on people’s smartphones and add a touch of humour to the process.

Summary

Identifying emotions is important to give people mastery over their bodily sensations and equip them to use emotions effectively. People who have had intense emotional experiences can fear their internal responses. Whatever their past experiences, as a Mental Health and Wellbeing Practitioner you can help the service user have a better understanding of their emotions going forward.

In Part 2 we are going to look at ways to regulate problematic emotional responses.

Helpful Resources Part 1

Recognising Emotions handout 1. The functions of emotions

Emotion	**Situation**	**How is it trying to help (emotion function)**	**What is the action urge?**
Anger	Happens when we are blocked from trying to reach a goal, or when we are under threat.	Gives us a powerful surge of energy so that we can repel the threat or burst through the obstacle	To Attack – physically, verbally or by criticising in our mind. We might have the urge to lash out.
Anxiety	When there is a danger coming up in our future. A serious threat to our life, health or wellbeing	To get us to solve the problem, and escape from any danger	To stop whatever is threatening us from getting closer, to run away or avoid
Fear	When there is an immediate threat to our life, health, or wellbeing	To keep us safe	Fight, flight, or freeze
Sadness	When we have lost something	To inhibit our actions so that we don't lose any more. To alert others to come and help us find or replace what has been lost	To withdraw, to keep reminders of the lost item, to pine for it and seek it out.
Joy	When there is something that is of benefit to us	To maximise any gains that there might be from doing this action	To repeat the thing that gives us benefits, to increase the amount of it that we do
Guilt	When we have done something that our social group would disapprove of	To make sure we maintain the protection of the tribe. To stay friends with our peers.	To make a repair, put right what we have done wrong
Shame	When if the group found out what we had done wrong they would be more likely to throw us out than forgive us	To make sure we retain the benefits of being in the group. To allow the problem to blow over, so people will forget about it.	To hide ourselves or whatever we have done wrong
Disgust	When there is a risk of us being contaminated by something poisonous or being party to an horrific action	To keep us free from toxins or from doing terrible things	To twist away from the substance or action, to repel it away from us

Recognising Emotions handout 2: Emotions crib sheet.

Put a tally-mark or cross close to the appropriate box whenever you notice that emotion.

These are the average signature features of each emotion. Every person is slightly different, so don’t worry if this is not exactly what you experience. If you have difficulty check handout 1 and see if the emotion matches the situation. Your MHWP can help you.

Emotion		**X or I**
	Fear: Cold, frozen posture, eyes staring or tight shut, urge to curl up or freeze, hard to talk.	
	Anxiety: Hot, eyes wide, breathing fast and shallow, mouth open, muscles tense, voice tone high. Urge to run away.	
	Anger: Hot, frowning, clenched jaw, tense muscles, jagged breathing, finger jabbing, voice loud, shouting. Urge to attack.	
	Shame: Hot, head down, eyes averted, muscles weak, shrinking posture, covering face. Voice tone quiet. Urge to hide.	
	Sadness: Cold, muscles floppy, face droopy, jaw loose. Breathing halting in breath and long sighs. Voice tone in outer ranges higher or lower than normal. Movements slow. Posture slumped. Lump in the throat, pricking behind the eyes. Urge to withdraw, and pine for what is lost.	
	Guilt: Temperature rising, shoulders up, palms open, looking down or away but with a lift in the centre of your brow. Voice tone pleading. (When we feel guilty and defend against it we can get snappy) Urge to repair (Sometimes there is an urge to punish yourself).	
	Disgust: Upper body warm, curled upper lip, voice tone sneering, posture recoiling or turning away, eyes narrow.	

Part 2: Managing Emotions

What is emotion dysregulation?

In the previous part we saw how a dysregulated emotion is one that does not match the situation. These examples can be used with service users.

- You forget to return a friend's call and feel riddled with guilt
- You accidently drop your car keys in a muddy puddle and feel furious with yourself
- You are scared to say no to people because at school you were always left out
- You are told you are to lose your job through redundancy, and you feel nothing

In each example there is either too much or too little emotion to be effective.

What is emotion regulation?

Emotion regulation is the ability to increase or decrease an emotion when you want to. You can help service users to develop this skill.

We only do this at the service user's invitation, working on emotions they want to change. We do not tell people how to feel about anything; instead, we ask if their emotion is at the right level to be useful, and if not, how much of the emotion they want to keep. Then we help them regulate to that amount.

The steps in emotion regulation are to:

1. Identify the emotion
2. Work out the action urge
3. Work out if the emotion is too intense or not intense enough to match the situation
4. Problem-solve the valid part of the emotion
5. Increase the intensity of the emotion if you need more
6. Decrease the intensity if it is too big for the situation

How do we increase or decrease emotion?

Every emotion plays out in the body through a set of signature features (See Recognising Emotions Handout 2 Emotions crib sheet).

These are:

- temperature
- facial expression
- posture
- gesture
- breathing
- muscle tone
- voice tone
- actions

Every emotion is different so there is no ‘one-size fits all’. If we act opposite to the specific signature features of an emotion it will start to come down. For example, if the emotion is hot – such as anger - the opposite action is to cool down. If the emotion prompts you to withdraw, the opposite action would be to go out and meet people.

See Managing Emotions Handout 2 Opposite actions for when the emotion is totally inappropriate or too big for the situation for a list of opposite actions.

Exercise: Try saying in an angry voice tone, “I am NOT very happy about THAT.” Now say the words again in a kindly voice. You will immediately sense a difference.

Will an emotion go away if we just act opposite?

No. If an emotion is telling us something very important it will not just go away. So, if our house is on fire and we feel anxious, opposite action will not help. We need to get away from the fire. Our go-to skill for regulating emotion is to problem-solve what is highlighting to us.

For example:

- Feeling sad because we have ripped our favourite top: Repair it or get a new one
- Feeling angry that a neighbour parks across our drive: Have a word with the neighbour
- Feeling guilty that we shouted at our partner: Apologise and be kind

The importance of problem-solving. (See section 5E)

If we ignore the valid part of an emotion it will continue to grow stronger.

Sometimes people find problem-solving very hard. If they feel lonely (in the sadness family) it can be challenging for them to make new friends. However, this emotion is too important to ignore, and distracting them from their loneliness with breathing techniques or mindful colouring will make the situation worse. As a Mental Health and Wellbeing Practitioner you need to support as much problem-solving activity as you can, always highlighting how the emotion is helping.

Example: Henryk is repeatedly sad and contemplates suicide. He and his wife have separate rooms, and do not communicate. Henryk feels trapped in the marriage because of the children. Even when distracted from his situation during the day, at night Henryk feels painfully sad again and his risk rises.

Helping him to seek couple therapy to improve or end the marriage while remaining a parent is an emotion regulation intervention. Henryk’s sadness is helping him by highlighting that he should not settle for this poor quality of relationship.

Opposite action

Where an emotion is too big to be useful, opposite actions (see Managing Emotions Handout 2 Opposite actions for when the emotion is totally inappropriate or too big for the situation) bring it down to size.

Example: Indira offered Sally a lift to her doctor’s appointment, but Sally forgot to tell her that it was cancelled, resulting in a wasted journey. Indira was so angry she went home in a huff. Using her emotion regulations skills, she worked out that some crossness was valid. However, the amount of anger she had was risking the whole friendship, which she did not want to do.

So, she took some opposite actions;

- She elongated her outbreath as though blowing up a balloon
- She drank a glass of ice-cold water
- She sat down and leaned back in her chair, dropping her shoulders
- She smoothed out the frown-lines on her face and loosened her jaw
- She shook out her fingers to relax them and laid her hands in her lap
- She noticed her judgments of Sally and softened the tone of those thoughts

Indira did not regulate her anger all the way down to zero. She kept a little irritation to validate herself, and to allow her to say to Sally, “It was a long way for me to go to pick you up, so it would have been nice to let me know it was cancelled.”

Where an expected emotion is absent, the service user can add in the signature features. Although this does help them to feel slightly different, they should expect that the effects are much slower than down-regulating. It sometimes takes months of practice to start to feel something again if your emotions have been routinely numbed.

Summary: Managing Emotions Handout 3 Regulating an emotion step by step is a sheet for you to use with service users that will walk through the steps of regulating an emotion they want to change.

Suggested reading: Regulating Emotion the DBT Way. Dunkley, C., Routledge, 2020.

Helpful Resources part 2

Managing Emotions handout 1: Why are my emotions so hard to handle?

- Emotions are hard-wired survival mechanisms designed to keep us safe and healthy
- They are felt in the body, and they prompt us to take actions
- If you have had traumatic experiences, if you have a particularly sensitive nervous system or if you have been taught to ignore your emotions then they tend to get stronger over time
- The stronger they get, the more you might try to avoid them
- This sets up a vicious circle
- Eventually, you may find your emotions are different to your peers; they might flare up quicker, rise to a more intense level and take longer to go away
- You might find that emotions arise that are not even relevant in the current context, but would have been valid in the past
- This can give the impression that you are ‘always’ in an emotional state
- In fact, emotions can come and go very quickly
- But if you have a lot of emotions over a short time it can feel overwhelming

Take heart – this cycle can be reversed:

- The first step is learning to identify each emotion and what it can do for you -your MHWP can help you with this
- You can learn to disentangle emotions that relate to the immediate situation from those arising because of your past experiences
- You need to do this because it reduces the amount of discomfort you have at any one time. It is not fair to you if you have to endure more emotion than other people in the same situation
- Later on, when you can regulate your emotions, you may want to have therapy for those past experiences. This choice will be up to you, rather than feeling you are being pushed around by your emotions

Managing Emotions handout 2: Opposite actions for when the emotion is totally inappropriate or too big for the situation

Anger

- temperature – cool down
- facial expression – relax jaw and smooth frown lines, half smile
- posture – lay back, recline
- gesture – drop hands, unclench fists,
- breathing – elongate the out-breath
- muscle tone – relax muscles in your shoulders and stomach
- voice tone – soften, lower the volume
- actions – walk away instead of towards

Anxiety

- temperature -cool down
- facial expression – waggle your eyebrows, relax your mouth
- posture – drop your shoulders
- gesture – open hands, no finger chewing
- breathing – take a deep in-breath, breathe out slowly
- muscle tone – relax
- voice tone lower, speak clearly, no rushing
- actions – no pacing or rushing

Guilt

- temperature – cool down
- facial expression – drop your brows, relax your mouth
- posture -keep upright, lower shoulders,
- gesture – keep palms down, link fingers together
- breathing – keep even breaths
- muscle tone – relax stomach muscles
- voice tone – avoid pleading tone, firm up your voice, no apologies
- actions do the thing that makes you feel inappropriate guilt

Disgust

- temperature – cool down
- facial expression – keep lips straight, no sneering, open eyes, open mouth
- posture – keep straight looking forward, no twisting away or recoiling
- gesture – keep hands low, no dismissive gestures
- breathing - deep
- muscle tone - relax
- voice tone – no sneering or dismissive tone, describe matter of fact without judgment
- actions – approach and talk kindly about what disgusts you

Sadness

- temperature – warm yourself up
- facial expression – press lips together, open eyes wider
- posture – firm up shoulders, tense stomach a little, stay upright
- gesture – no handwringing
- breathing - shorten the out-breath
- muscle tone – firm up muscles
- voice tone – use matter of fact tone in the mid-range
- actions – don't isolate. Eat. Call people

Fear

- temperature – warm yourself up
- facial expression – relax your eyes
- posture – open up your posture, no curling
- gesture – move freely, no freezing
- breathing – breathe evenly
- muscle tone - relax
- voice tone – talk instead of remaining silent
- actions approach what you fear

Shame

- temperature – cool down
- facial expression – relax face, open lips slightly,
- posture – head up, shoulders down, meet people's gaze
- gesture - keep hands away from face, no hiding
- breathing - regular
- muscle tone -firm but not too tense
- voice tone – even paced, raise volume
- actions – avoid isolating, be seen, approach people

Managing Emotions handout 3: Regulating an emotion step by step

1. What emotion are you feeling? (Use handout 1 to help)

2. What is the situation that has set off this emotion? Does the emotion seem to be the right one in this current context, ignoring what has happened in the past? What intensity of emotion 0-100 do you have?

3. 0-100 How much of the emotion do you want to keep around to be useful? For example, if you are angry with someone, how much crossness do you need to make clear your position on it? Think about how much emotion would be too much and how much would not be enough.

4. What actions can you take to honour that valid part of the emotion? Don’t ignore any important messages. E.g. if guilty apologies and repair, if cross have your say, make a complaint. If sad, get some comfort, find or replace what you are missing.

5. If your emotion is too big, act OPPOSITE to the signature features of the emotion (see handout 2) until it comes down to your preferred level. If it is not high enough, you can add these features in. Write the actions you take in here.

Temperature -

Breathing -

Muscles -

Voice tone -

Posture -

Gesture -

Guided Self-Help for Bulimia Nervosa and Binge-Eating Disorder

Intervention training manual for MHWPs

(Reference 7e) Guided Self-Help for Bulimia Nervosa and Binge-Eating Disorder

Guided self-help based on cognitive-behavioural therapy principles is an effective treatment for bulimia nervosa and binge-eating disorder (including atypical cases). It targets the eating patterns, emotions and body image issues that maintain these eating disorders, establishing more helpful eating patterns and greater body image acceptance.

How does guided self-help work for eating disorders?

Understanding eating problems

Regardless of the origins of the eating disorder, by the time the person reaches treatment, their problems are largely maintained by avoidance and safety-seeking behaviours - people restrict their eating in an effort to control their weight, resulting in cravings that drive uncontrollable eating of very large amounts of food (binge eating). Those binges increase fear of weight gain, resulting in use of compensatory behaviours (e.g. more restriction, vomiting, taking laxatives). These behaviours form a vicious cycle, leaving the individual physically at risk and causing emotional, social, and quality of life issues.

It is also important to remember that some bulimic and binge-eating behaviours are primarily driven by emotional states rather than starvation, particularly in patients with binge-eating disorder and who are typically overweight.

Most people with eating disorders have a very negative body image, which increases restriction and maintains the restrict/binge/restrict cycle. Behaviours related to body checking and avoidance (e.g. of mirrors or socialising) serve to increase body dissatisfaction.

Elements in guided self-help for non-underweight eating disorders.

Guided self-help for eating disorders (GSH-ED) is recommended for bulimia nervosa and binge eating disorder (NICE, 2017). It addresses the following elements:

1. Motivation
Service users often have a degree of ambivalence about change, due to fear of what will happen if they give up their safety-seeking behaviours. GSH-ED encourages the service user to consider the pros and cons of their eating disorder, emphasising long-term negative impacts (e.g. poor quality of life) versus possible short-term positives (e.g. calmer after vomiting).

2. Addressing problematic eating behaviours Changing eating patterns is key to GSH-ED. This includes the need to move to a healthy eating pattern, with an adequate carbohydrate intake.
This requires:

- Helping the service user to understand how their eating pattern has become their core problem
- Encouraging the service user to face (rather than avoid) their anxiety when they change their eating pattern to meet their body’s needs

It is also important to manage emotional triggers.

3. Addressing body-related safety-seeking behaviours Reducing behaviours that maintain negative body image – particularly, such as body avoidance.

Guided self-help for eating disorders (GSH-ED) for bulimia nervosa and binge-eating disorder

The stages of Guided Self-Help for Eating Disorders (GSH-ED)

This protocol for GSH-ED for non-underweight service users reflects elements of different evidence-based self-help approaches that employ cognitive behaviour therapy for eating disorder (CBT-ED) (Cooper, 2009);

Fairburn, 2013; Wade et al., 2021).
The role of the MHWP is to be a coach, encouraging the service user to become their own therapist. The MHWP should identify risk management factors and review progress, to determine the need for a referral for more intensive individual/group CBT-ED (NICE, 2017).

The following should be delivered over 10 weekly or fortnightly meetings (in person or online) of approximately 30-40 minutes each. Focus on individual service user needs. Note that some service users (especially with binge-eating disorder) might have an adequate core dietary intake and lower restrictive characteristics and can move to emotional factors/body image (Stage 4) earlier, spending less time going through Stages 2 and 3.

Stage 1, Week 1:
Explain the rationale for GSH-ED and formulate behaviours

MHWPs should, during the first

- Explain that GSH-ED has a here-and-now focus, the need for early behavioural change, and key role of homework
- Assess risk management factors (particularly self-harm/suicidal; any abnormal blood results), acting accordingly
- Work through and complete Worksheet 1 (Energy Graphs) together and introduce Worksheet 2 (Food diary)
- Give the rationale for the service user weighing themselves openly at each session, and take the first weight reading to start a weekly weight
- Relevant psycho education material from Worksheet 3 (starvation effects; eating disorders and neurobiology; normal eating; why
- ED-15 (Worksheet 4), alongside other standard outcome measures

Homework

- Food diary, for the coming week (Worksheet 2)

Stage 2, Weeks 2-3:

Changes to eating

MHWPs should guide the patient

- Review learning from last time (including risks and starvation effects) and eating
- Identify pros and cons of having/giving up the eating disorder, and develop service user’s motivational statement (Worksheet 5)
- Review food diaries, highlight how these relate to the energy graphs (Worksheet 1), identify potential triggers to binges (diary)
- Complete Five Areas formulation of binge eating behaviours (see worked examples – Worksheet 6)
- Address therapy-interfering behaviours (e.g. not changing eating)
- Service user to weigh themself openly and chart weight
- Identify necessary dietary change (Healthy Eating Plan: Worksheet 7)

Homework

- Elaborate on Pros and Cons (Worksheet 5)
- ED-15
- Diary of eating, including own energy graphs
- Add carbohydrate where there are gaps (breakfast/first missing meal, then snacks)
- Identify specific feared foods (for Stage 3)

Stage 3, Weeks 4-5:

Expanding changes to eating

MHWPs should guide the service user

- Review eating patterns (diary/ED-15)
- Review benefits of change so far in eating (are the pros and cons of the eating disorder borne out?)
- Openly weigh themself, and chart weight
- Plan further normalisation of eating based on learning so far
- Negotiate adding specific feared foods into diet

Homework

- ED-15
- Diary of eating
- Level carbohydrate intake across the day
- Add first feared foods – start where anxiety is high but manageable
- Read material on body image avoidance, preparing for Step 4 (Worksheet 8)

Stage 4, Weeks 6-8:

Addressing emotional triggers to eating behaviours and body image issues

MHWPs should guide the patient

- Review eating (diary/ED-15)
- Openly weigh themself, and chart weight
- Maintain normalisation of carbohydrate intake, adding further feared foods
- Identify any emotional triggers for remaining bulimic/binge eating behaviours
- Identify body avoidance/checking if present

Homework

- ED-15
- Emotion diary, identifying emotional triggers of eating behaviours (Worksheet 9)
- Add further feared foods
- Undertake/plan exposure to overcome body avoidance/checking (Worksheet 8 - e.g. use mirror/screen exposure; change to more fitted
- If general self-esteem is an issue for the patient, then discuss how self-criticism might be holding them back and how a more self- compassionate approach would be helpful. Direct them to Worksheet 10 to support this

Stage 5, Week 9:

Relapse prevention

MHWPs should guide the service user

- Review eating/body image (diary, ED-15)
- Openly weigh themself, and chart
- Complete blueprint (Worksheet 11) for next steps to reinforce own role in producing change
- Plan 'self-help revisited' sessions using the blueprint

Homework

- Weekly 'self-help revisited'
- Food diary (Worksheet 2)
- Maintain healthy eating and body image challenges
- ED-15 weekly until follow-up
- Use blueprint to address slips immediately

Stage 6, Follow-up session (one month later):

Reviewing progress and planning for the future

MHWPs should address the following:

- Reviewing progress and use of the blueprint
- Trouble-shooting for any setbacks
- Attributing change to the service user's efforts
- Planning long-term progress (maintaining changes, until they are normal patterns)

Worksheets – see following pages

You might also benefit from the following resources:

Cooper, P. J. (2009). OVERCOMING BULIMIA NERVOSA AND BINGE-EATING
A self-help guide using Cognitive Behavioral Techniques. London: Robinson.

Cooper, P. J. (2009). Bulimia nervosa and binge eating.
A guide to recovery (2nd Edition). London: Robinson.

Schmidt, U., Treasure, J. (1993). Getting Better Bit(e) by Bit(e)
A Survival Kit for Sufferers of Bulimia Nervosa and Binge Eating Disorders. London and New York: Routledge

Waller, G., Mountford, V., Lawson, R., Gray, E., Cordery, H., & Hinrichsen, H. (2010). Beating your eating disorder:
A cognitive-behavioural self-help guide for sufferers and their carers. Cambridge, UK: Cambridge University Press.

Fairburn, C. (2013). Overcoming Binge Eating:
The Proven Program to Learn Why You Binge and How You Can Stop (2nd Edition). New York: Guilford Press

The My Transitions website has a range of additional psychoeducation resources if they are needed:
https://mytransitions.co.uk/

The Living Life to the Full (LLTTF) website has a range of additional psychoeducation resources, if they are needed:
https://llttf.com/

The Digital CBT-E website has a range of additional psychoeducation resources if they are needed:
https://www.cbte.co/self-help-programmes/digital-cbte/

The CCI website has a range of additional psychoeducation resources, if they are needed:
https://www.cci.health.wa.gov.au/Resources/For-Clinicians/Eating-Disorders

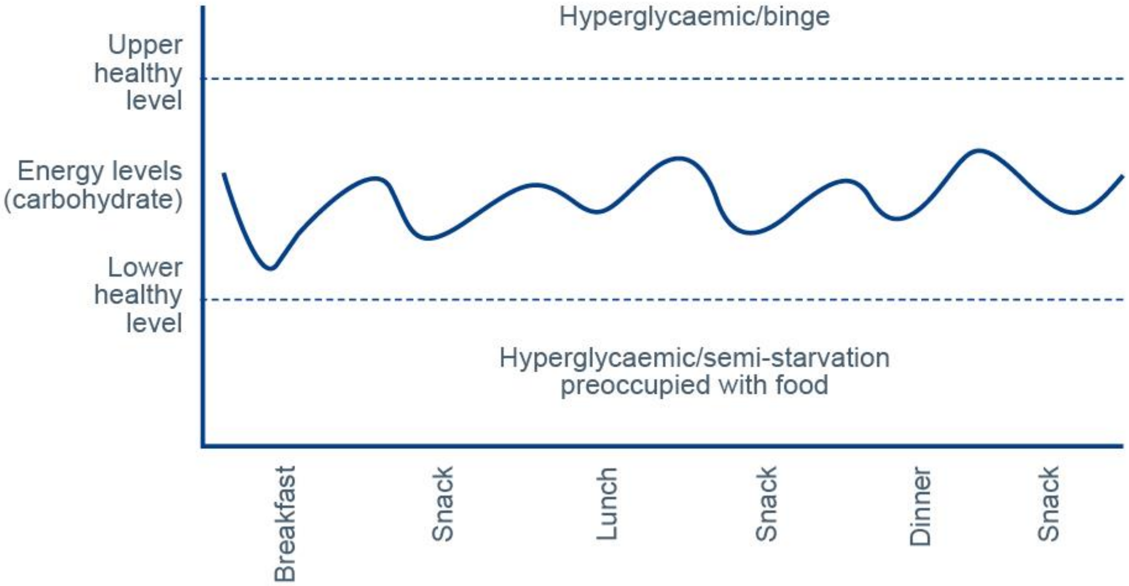
We would like to thank Dr Bronwyn Raykos and the team at the Centre for Clinical Interventions (CCI) of the North Metropolitan Health Service, Western Australia, for their kind permission to use some of the psychoeducation and self-help materials in this manual. Please note that copyright for those materials remains with CCI, and their materials should not be used for other purposes without express permission of the Director of CCI.

(7e) Worksheet 1

Energy Graphs – Understanding the Need for Carbohydrate in Your Diet

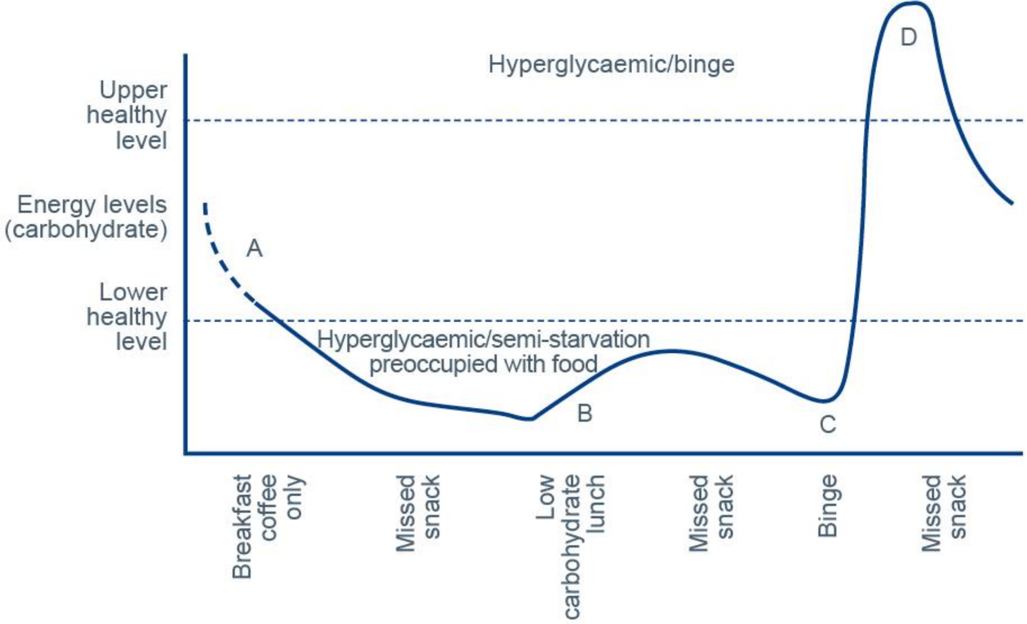
Healthy eating pattern

Most people eat regularly throughout the day, in response to hunger and routine. That includes regular carbohydrate intake, driven by internal signals. That means that their energy levels stay stable (within the dotted lines), so that they do not get the urge to binge on lots of food. That means that their weight stays relatively stable.



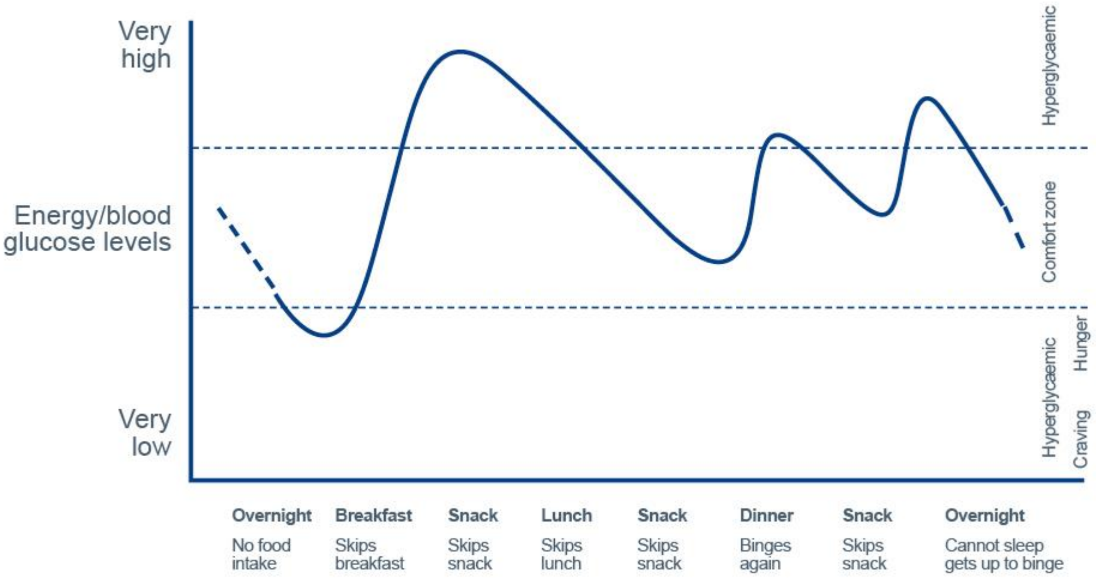
Bulimic/binge-eating pattern

People with bulimia nervosa or binge-eating disorder often restrict their intake in an attempt to lose weight or out of fear that if they eat then they will lose control. That means that they miss the carbohydrates that their bodies need (points A and B). Eventually, their body experiences cravings that take over (point C), and they binge on lots of food - mostly on the carbohydrates that their body needs. Even if they try to get rid of some of the food (e.g. vomiting at point D), they are very likely to lose control of their weight.



Emotionally driven binge-eating pattern

Emotions can also trigger people to overeat/binge eat- this explains eating problems in some (though not all) people with binge-eating disorder, especially where they are overweight. In such cases, people binge/overeat even though they are not starved or hungry. If your food diary does not indicate starvation (i.e., your energy graph shows you do not spend long in the lower part of the carbohydrate level), we will address the emotional triggers earlier in treatment. People with bulimia nervosa can sometimes experience this pattern of emotionally driven binge-eating, too.



So what is your eating/energy pattern?

Let’s consider your energy graph. With your guide’s help, pick a day when you binged, and draw out your pattern of eating on this template. Does it look more like the second graph? If so, that would explain a lot of your binges, and we can work on regularising your’ eating so that your body doesn’t drive you to overeat in the way that you have been. Doing this every day will help you to prevent daily binge-eating, by ensuring your energy levels follow the pattern in the top graph (healthy eating). You can monitor this on your daily food diary, filling in your levels as you go.

(7e) Worksheet 2

Diary of Food Intake

Please complete this diary daily, as you go along (i.e., when you eat, rather than at the end of the day). Please review your eating pattern before you meet with your guide, looking at your pattern of potential triggers for bingeing (diagram at top right) and drawing your own energy graph as you go along (bottom right). See if you can link the pattern to your energy graphs, and to any overeating or binges. Remember to include anything that you drink, too.

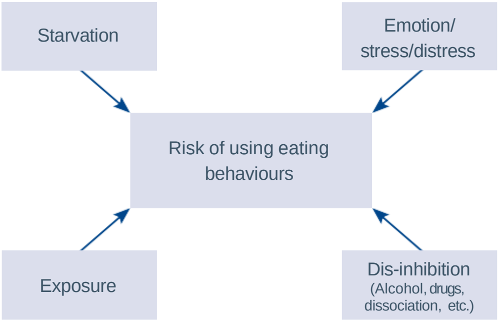
Food and drink diary

(Record of everything that you eat and drink across 24 hours)

Day: ....

Date: ....

Today's risk factors
(including those carried over from yesterday)

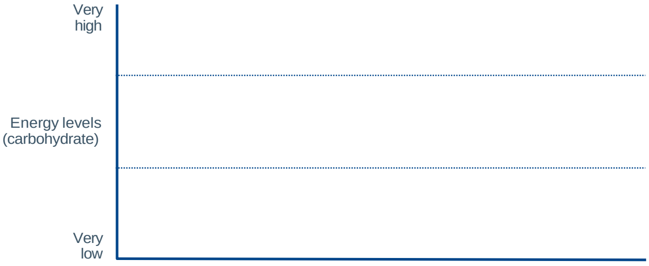


Time	Food and liquids consumed - type and amount - including alcohol	Objective binge	Subjective binge	Vomit (V) / Laxatives (L)	Context (*Where was I? Who was about? What was I doing? Emotional state?)*

Summary of day's intake

Carbohydrate intake

Meal/snack	B	S	L	S	D	S
Carbohydrate? (tick if you ate any complex carbohydrate)						



(7e) Worksheet 3 - Key psychoeducation topics

1. Starvation Syndrome

What is Starvation syndrome?

Starvation Syndrome

When starved of energy, the human body responds in a way known as "Starvation Syndrome". Starvation syndrome (or semi-starvation) refers to the physiological and psychological effects of prolonged dietary restriction. The effects of starvation syndrome are commonly observed in individuals with eating disorders, who often severely restrict their energy intake, eat irregularly, and engage in compensatory behaviours (e.g. purging), which reduce energy absorption. Many of the symptoms once thought to be primary symptoms of eating disorders are symptoms of starvation.

The Minnesota Starvation Experiment

The Minnesota Starvation Experiment is the best example of the wide-ranging physical, cognitive, social and behavioural effects of starvation. Between 1944 and 1945, the University of Minnesota studied the effects of dietary restriction and the effectiveness of dietary rehabilitation strategies. The study recruited 32 fit, young male volunteers, who were conscientious objectors to the military service. The study had three phases:

- 3-month control: participants ate normally
- 6-month semi-starvation period: caloric intake of each participant was reduced by 50%
- 3-month recovery: participants were re-nourished

During the semi-starvation period, men lost on average 25% of their baseline body weight. Unexpectedly, semi-starvation also had a dramatic impact on the physiological, psychological, cognitive, and social functioning of the men.

Physical Changes

- Heart muscle mass reduced by 25%
- Heart rate and blood pressure
- decreased Basal metabolic rate slowed
- down Feeling cold all the time
- Fluid retention (edema)
- Dizziness and blackouts
- Loss of strength, high fatigue
- Hair loss, dry skin
- Decreased hormone levels, causing lack of sexual desire and other changes

Emotional Changes

- Depression
- Anxiety
- Irritability
- Loss of interest in life

Changes in Thinking

- Impaired concentration, judgement and decision making
- Impaired comprehension
- Increased rigidity and obsessional thinking
- Reduced alertness

Social Changes

- Withdrawal and isolation
- Loss of sense of humour
- Feelings of social inadequacy
- Neglect of personal hygiene
- Strained relationship

Attitudes and Behaviour Relating to Eating

- Thinking about food all the time
- Meticulous planning of meals
- Eating very fast or very slowly
- Increased hunger, binge-eating
- Tendency to hoard (e.g. collecting recipes)
- Increased use of condiments (e.g. spices) for flavour

Symptoms of starvation syndrome are observed in any individual who has prolonged restricted access to food, no matter what the reason (e.g. prisoners of war or effects of an eating disorder). Physical re-nourishment and weight restoration is therefore essential to reverse these symptoms.

How is Starvation Syndrome Relevant to Eating Disorders?

The physiological and psychological effects of semi-starvation observed in the Minnesota Experiment mirror the experience of many individuals with eating disorders. Many eating disorder symptoms are actually a direct result of semi-starvation.

You may be thinking:
"This information isn't relevant to me because I'm in the average or overweight range." However, research shows that a person does not have to be underweight to experience symptoms of starvation. Starvation syndrome may be observed if a person's nutritional intake is poor, irregular, or unbalanced, or if they engage in compensatory behaviours that reduce energy absorption, irrespective of their weight. Individuals with anorexia nervosa, bulimia nervosa and binge eating disorder are therefore all vulnerable to experiencing symptoms of semi-starvation.

A crucial distinction between men in the Minnesota Study and individuals with eating disorders is that, in addition to experiencing symptoms of starvation, individuals with eating disorders have significant fears about their shape, weight, appearance and eating. When a person who is starving has the opportunity to eat, they will eat. A person with an eating disorder will continue to restrict what they are eating due to their fears. It is therefore crucial that eating disorder recovery focuses on physical re-nourishment as well as psychological treatment to address anxiety and fear about eating.

Reversing Symptoms of Starvation Participants in the Minnesota Experiment were re- nourished during a 3 month recovery phase. By normalising their eating through regular rations, the men recovered from many of the physiological and psychological effects of starvation. Rate of recovery varied among the men, with some taking longer than others to normalise their eating. Many also reported persistence of symptoms well into the re-nourishment phase (e.g. feeling ‘out of control’, experiencing low mood, inability to identify hunger/fullness cues, episodes of binge eating). Importantly, these symptoms subsided over time with consistent, adequate nutrition.

Recovery from an Eating Disorder

The good news is that the effects of semi-starvation are reversible. By consuming nutritionally balanced meals regularly throughout the day the body will return to normal physical and psychological functioning. (see Handout Regular Eating for Recovery for more information).

Remember, it takes time, and symptoms of semi-starvation may persist in the short-term during physical re-nourishment. When the brain is properly nourished, it can carry out vital processes such as perception, problem solving, planning, memory, decision making, and emotion regulation.

These processes are essential for a person to engage in psychological treatment for their eating disorder. This is why eating disorder treatment often begins with physical re-nourishment. Once semi-starvation has been corrected, an individual will be in a better position cognitively to address the underlying thoughts and feelings that keep disordered eating behaviours going.

You may need to consult a medical practitioner, psychologist, dietitian or other health professional for support with re-nourishment or to help you manage your anxiety while you are making changes. Remember, the effects of semi-starvation are reversible with consistent, adequate nutrition!

Science and Eating Disorders

Eating disorders are severe mental illnesses with the potential for serious medical consequences. Our current knowledge, thanks to a growing body of scientific evidence, is helping us to better understand the neurobiology of these disorders: how they develop and how we can best support people to recover.

People with eating disorders and their loved ones may wonder how the disorder developed or blame themselves. Science can help dispel harmful myths and improve our understanding of the complexity of eating disorders. Through research we have come to understand that there is no single cause of eating disorders-for example, you don't have to have other psychological problems or trauma. However, it is common for eating disorders to develop after a period of caloric restriction or inadequate nutritional intake {intentionally or through stress/illness).

The Role of Genetics in Eating Disorders Mood, personality, anxiety and impulse regulation, as well as appetite, body weight and metabolism have a strong genetic basis (i.e., are heritable). On average, about half the risk of developing an eating disorder comes from genetic influence, but this risk differs from person to person. People with higher heritability need only a slightly toxic environment for an eating disorder to manifest itself, while in a protected environment, may not go on to develop an eating disorder.

Consider an orchid and a dandelion - an orchid needs an optimal environment to flourish, whereas a dandelion survives in spite of environmental challenges. Similarly, people with a genetic vulnerability to developing an eating disorder can thrive in positive environments but are more vulnerable to harmful environments, such as those that might trigger weight loss or stress.

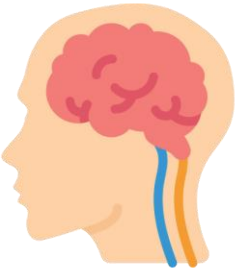
"Epigenetics" is the study of biological mechanisms that cause our underlying genetic predispositions to be "switched on" or "switched off'. In certain environments, especially where there is a lot of stress and/or inadequate nutrition, the risk is higher - the genes might get "switched on". As international eating disorders expert Professor Cynthia Bulik explains: "Genes load the gun, environment pulls the trigger".

The Gene-Environment Interaction

Western culture places a high value on thinness and muscularity and many people engage in dieting or excessive exercise to become thinner or more muscular. For some, these behaviours are only minimally harmful, For those who carry the genetic risk, these environmental influences can trigger their genes to "switch on" and result in an eating disorder. In another scenario, two individuals might get ill with a stomach bug resulting in modest weight loss. One person may naturally regain the lost weight with no long-term consequences, while in the other, the development of an eating disorder may be triggered. Thus, inadequate nutrition serves as the catalyst for the expression of an underlying genetic vulnerability.

How Eating Disorders Affect the Brain

Some people worry that eating disorders are caused by a chemical imbalance in the brain, but there is no evidence for this. However, research has shown that brain activity can be affected by even modest dieting, and a young person's developing brain is particularly vulnerable. When a person is malnourished, their brain is not adequately fueled, and this may mean they struggle to make decisions, solve problems and regulate their emotions. (See our handout on Starvation Syndrome). They may also experience perceptual disturbances in the way they see themselves; for example, looking in the mirror and see themselves as much larger than they actually are.



Also, although eating disorders aren't caused by a chemical imbalance in the brain, restricted eating, malnourishment, and excessive weight loss can result in problematic changes to our brain chemistry. For example, the brain produces less serotonin, which results in increased symptoms of depression.

What Does All This Mean For Recovery?

The good news is that the effects of starvation can be reversed with adequate re-nourishment. Brain-imaging studies show that brain activity in people with eating disorders can change. The brain, like a muscle, is constantly changing and adapting as a result of our environment and how it is used, or "exercised". It can be "exercised" through learning and practicing new ways of thinking and interacting with others. With practice, people with improved eating disorders. show brain activity that looks more like that of people who had never had an eating disorder.

However the brain needs to be adequately nourished in order to make these challenging changes. A starved brain won't function optimally so the first priority in treatment is nutritional rehabilitation. This can be challenging, as increasing food intake can be scary for someone with an eating disorder. Also the brain tends to "'lag behind" the body in terms of recovery and it can take time for people recovering from an eating disorder for their brain to "catch up", when they regain their capacity for abstract reasoning and rational thinking.

A particular challenge we face is that our society remains a potentially triggering environment, with images of unachievable bodies and inaccurate and conflicting messages about diets and exercise ever present. Therapy not only needs to address the person's genetic vulnerabilities, but also to help them develop skills to manage environmental influences (e.g. managing stress and avoiding dieting).

Recovery from an eating disorder is possible. With adequate re-nourishment and learning, the brain and body can return to healthy functioning. Adequate nutritional intake and supportive environments will promote thriving across all life domains.

(7e) Worksheet 3 - Key psychoeducation topics

3. Normal Eating vs. Disordered Eating

If you have an eating disorder, it's likely that you've been engaging in eating behaviours that are disordered and unhelpful, perhaps for quite some time. This can make it difficult to figure out what normal, balanced, non-disordered eating looks like. This is particularly confusing when we live in a society where, even amongst people who don't have eating disorders, there is often an abundance of disordered eating.

Here we will consider the key components of normal eating: regularity, variety, flexibility, and fun.

Frequency of Eating

Ideally, humans function best when we eat regularly throughout the day. Regular eating is such a fundamental component of overcoming an eating disorder that we have created a separate handout focusing on this topic (see Regular Eating for Recovery).

How Much to Eat

It can be difficult to know how much energy our body needs for the day and therefore what portions to aim for at our meals and snacks. The amount of food required will differ from person to person based on a number of factors including their base metabolic rate and level of activity, their height, weight, and overall build, their age, gender etc. Essentially, weight maintenance occurs when our energy input and energy output are balanced.

What Kinds of Foods to Eat

In terms of what we eat, it might help to consider your consumption across the whole day, as well as the content on your plate at each meal. There are six major food groups, and we need to get a balance of three main macronutrients: carbohydrates, proteins, and fats. Typically, the following ratios are recommended as a guideline for the amount of energy each of these should contribute to our diet:

- Carbohydrates: 50-60%
- Protein: I 0-20%
- Fats: 30%

If you want to know more about these macronutrients we have a handout on each of them!

Australian dietary guidelines recommend aiming to eat some food each day from the following 6 food groups, at least:

- 6-7 servings of grains e.g. rice, pasta, cereal, bread
- 5-7 servings of vegetables
- 2-3 servings of fruit
- 3 servings of dairy products, e.g. milk, cheese, yoghurt
- 2-3 servings of meat, poultry, fish, or alternatives e.g. eggs, tofu, nuts, seeds, beans
- 1-2 + servings of added fats e.g. avocado, olive oil, butter

It's also totally normal to include treat foods, purely for our enjoyment, like a slice of cake, some chocolate, or a packet of chips [crisps]. Sometimes these will be described as "occasional", "energy dense", "sometimes", or "discretionary" foods... the most important thing to remember is that it's absolutely okay to include some of these foods each day! That's what makes for normal, balanced, non-disordered eating. The key is having a balanced intake with many different foods from all the different food groups.

The Reason for Eating

Have you ever considered why we eat? In fact, there are many reasons! We eat to fuel our bodies and brains, but we also eat for pleasure-as part of our socialising as humans, celebrate certain occasions, perhaps in response to feeling tired, sad, anxious, or happy, or just because we feel like it! All of these are valid, normal reasons for eating.

Eating During Treatment vs. Recovered Eating While in treatment for your eating disorder eating may look a little different to the average non-eating disordered person. Perhaps you will have to monitor what you eat, be particularly vigilant about the timing of your meals and snacks or engage in more planning and preparation around your meals than other people you know. If you are underweight and need to regain weight as part of your treatment, you may need to eat more than normal for a while. This is a typical part of going through treatment for an eating disorder and is a away from disordered eating and towards normal, balanced, eating. Most people find that further into their recovery, their eating becomes more flexible and intuitive.

Flexible Eating

To be fully recovered from an eating disorder means having the freedom of flexibility and choice. To join your colleagues for an impromptu outing for cake and coffee, or attend a family celebration without anxiety around the uncertainty of not knowing what food will be served. Normal eating varies in response to your emotions, your schedule, your hunger, and your proximity to food. When in doubt, remember to consider regularity, variety, flexibility, and fun!

(7e) Worksheet 3 - Key Psychoeducation Topics

4.Why Diets Do Not Work

If you enter the word “diet” into internet search engines you will get nearly 200 million results instantly. Diets are often marketed as the answer to people’s problems, promising quick weight loss, body acceptance, physical health (e.g. detoxifying) and beauty. But if diets really work, then why do we need so many of them? In reality, the dieting industry is a multi- billion dollar industry that succeeds by making people feel bad about themselves. People quickly become stuck in a vicious cycle of dieting (and the dieting companies make even more money!).

What is a Diet?

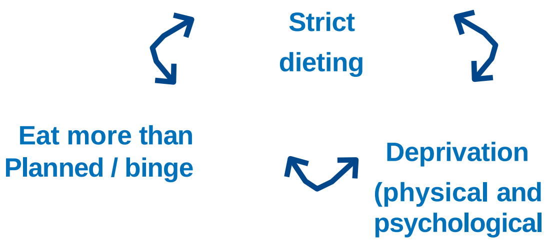
Diets typically prescribe that a person follows a rigid pattern of eating for a strict period of time. The time frame may be short (e.g. 8 hours, I week) or long (e.g. 6 months). Diets prescribe what to eat, when to eat and how much to eat. But all diets are different! And if we tried to follow all the rules prescribed by available diets you would soon find that there is nothing much left to eat at all! People usually follow diets for the purposes of weight loss, to avoid weight gain, or for the purposes of cleansing their body. However, in reality, diets have an extremely low success rate and persistent dieting behaviour can actually contribute to significant weight gain in the long-term.

Physical and Psychological Deprivation

Most diets prescribe far too little food. When we do not eat enough from all food groups the body tips into a state of semi-starvation and induces physical deprivation. If we do not respond to this hunger by eating, the physiological pressure to eat builds up until we are driven to eat. Patients with an eating disorder often say that they do not feel hungry, which can be true, because when a person ignores hunger signals for a long period of time, the body stops recognising hunger. Despite this, the body still craves and needs adequate nutrition.

Consequences of Deprivation

When a person is physically and psychologically driven to eat, they often eat more than they had planned, eat foods they had previously tried to avoid, or lose control to the point of binge eating. When this happens, people often worry about how this eating will impact on their weight. Such worries can lead a person to diet more strictly than ever to ‘make up’ for breaking the rules of their diet, which sets them up for a vicious cycle to overeat or binge again.



Rigid Rules

Diet language often includes words such as “good”, develop strict and rigid rules about what to eat, when to eat and how much to eat. Rigid rules are different to guidelines. Having some guidelines about what we eat can help us maintain healthy eating. For example, someone may have the guideline “I try not to eat too many sugary foods”. A rigid rule differs in that it is inflexible and ‘all or nothing’ in nature, for example, “I must never eat sugar at all”. The rule is either followed or broken so our actions can only be ‘right’ or ‘wrong’; we perceive ourselves to have ‘succeeded’ or ‘failed’.
This is problematic because if we try to follow rigid rules, psychological and physiological pressures to eat will build up until eventually we can’t help but “break” these rules in some way.

Consequently, people will then perceive that they have “failed” their diet, which can exacerbate feelings of low mood and low self-esteem. Additionally, after breaking a dietary rule a person may think something like, “I’ve blown it now, I may as well eat the whole bag" or, "I've ruined today, I'll start again tomorrow", which can lead them to go from a small 'slip' in eating to overeating or a binge eating episode, reinforcing the vicious cycle of dieting once more.

Escaping the Vicious Cycle of Dieting

Dieting behaviour increases the risk of overeating or binge eating from physical and psychological deprivation. To reduce this risk, we need to eat regularly throughout the day and include adequate amounts from all food groups (see our handouts, Regular Eating for Recovery and Normal Eating versus Disordered Eating). Undereating and eating infrequently can actually slow down a person's metabolism, so that their body burns energy from food more slowly, and will conserve energy by storing it as fat.

We also need to move away from any strict or rigid rules about what to eat, when to eat and how much to eat, and towards more flexible eating guidelines. Normal healthy eating involves daily consumption of foods from all food groups, including 'occasional foods' such as ice cream and chocolates. Remember, dieting will only keep the cycle of disordered eating going!

5.Regular Eating for Recovery

What Do We Mean By Regular Eating?

Establishing regular eating habits will form a fundamental part of overcoming your eating disorder. Regular eating is the foundation upon which other positive changes in your eating will be based.

If you have an eating disorder, it's likely that you've been engaging in eating behaviours that are disordered and unhelpful, perhaps for quite some time. One behaviour that is very common amongst people with eating disorders is irregular, infrequent, or delayed eating. For example, you may have a rule that you don't eat before midday, or perhaps you've become accustomed to having a small breakfast and then not eating again until dinner time, or maybe you find yourself snacking and grazing throughout the day without sitting down for a proper meal or snack.

Ideally, humans function best when we eat regularly throughout the day; this means eating every ~ 3 hours. For many people, regular eating involves eating 3 meals and 2-3 snacks, although sometimes it's helpful to think of it simply in terms of 5-6 eating occasions throughout the 16 or so hours you are awake.

For some people, the timing of their eating and how much they eat at each meal will vary depending on their daily patterns involving sleep, work, exercise, socialising etc. However, when you're first entering treatment for your eating disorder, you may need to pay special attention to when you're eating, and start out by "eating by the clock" in order to stay on track. When you're first getting started, regular eating may take the following form:

- Breakfast
- Morning tea
- Lunch
- Afternoon tea
- Dinner
- Evening snack/supper

A Word on Water ...

It's also important to make sure you are drinking an adequate amount of water-although not so much that you feel overly full and it discourages you to eat your next meal or snack! Water allows the body to absorb nutrients from food and transport them around the body. It also facilitates removal of waste products, and lowers our body temperature in warm weather. The human body uses approximately 4% of its body weight in water each day, and health professionals recommend adults drink about I.5-2L water daily. Failing to drink enough water can lead to dehydration, which can negatively impact our physical and mental functioning.

Why Eat Regularly?

There are lots of benefits to eating regularly, particularly during treatment for an eating disorder. Eating regularly:

- Gives structure to your eating habits, so that eating can start to become a regular, normalised part of your life.
- Keeps your blood sugar level steady, which minimises tiredness, irritability, and poor concentration
- Helps to combat delayed or infrequent eating
- Helps to combat unstructured eating, such as grazing or picking (which may increase vulnerability to binge eating)
- Establishes habits that will help prevent binge eating – when eating regularly, you are less likely to become overly hungry and feel out of control of your eating
- Improves metabolic functioning and prevents your body from going into "starvation mode" (see our handout on Starvation Syndrome)

Changing your eating habits can feel overwhelming, so regular eating is a great place to start! Once the routine of eating every ~3 hours is in place, you can then begin to modify your food choices and portion sizes.

Plan, Prepare, Prioritise!

When establishing your own system of regular eating be sure to remember the 3 Ps-Plan, Prepare, Prioritise! Early on in treatment it pays to plan out and prepare your meals and snacks in advance. You won't have to do this forever, and in future your eating can become more flexible, but for now, thinking several steps ahead will help to keep you on track!

Right now, regular eating must be a priority in your life, and may need to take precedence over other activities. This may mean temporarily reshuffling your work day, when you choose to socialise, or other commitments.

Tips for Regular Eating

- Aim not to miss a meal or snack - if you do, be sure to get 'back on track' as soon as you notice!
- Do not leave a gap of more than 4 hours between meals/snacks
- Avoid eating between your meals and snacks. If you consistently experience hunger between meals and snacks this may be a clue that you need to increase the size or density of your meals and snacks
- If you purge (i.e., vomit or use laxatives) the meal or snack doesn't count towards regular eating
- Consider carrying a snack (muesli bar, dried fruit, nuts) with you in the car or your handbag, in case you get caught out of the house/office at mealtimes.

6.Vomiting and Your Health

For many people, vomiting starts as part of an attempt to regain control after breaking dietary rules or eating more than planned. This can often lead to a vicious cycle of eating and vomiting. When vomiting occurs regularly, it can affect health in a number of ways.

Effects of Regular Vomiting

- Gastric acid enters the mouth and erodes tooth enamel, which leaves teeth vulnerable to erosion, brittleness, and thermal sensitivity. Expensive dental work can be needed to repair or replace the damaged tooth.
- Parotid (salivary) glands can swell up and cause the cheeks to look enlarged and puffy.
- Fingers and knuckles can become calloused and burned by gastric acid.
- Ruptures and bleeding can occur in the oesophagus as acid and food pieces are forcefully ejected.
- The digestive system can become dysregulated, so that even a small amount of food in the stomach feels uncomfortable.
- The ability to identify hunger and fullness is impaired.
- Imbalances in electrolytes, such as potassium and sodium, can result in fainting, fever, digestive problems, confusion, blood pressure changes, heart palpitations, seizures, cardiac arrest and even death.
- People sometimes try to hide their vomiting, which can involve actions such as lying or vomiting in odd places. This can impact social relationships as well as functioning at work and other responsibilities.
- People may feel guilt, shame, anxiety or depression - which can add to feeling worthless and out of control - and these feelings can trigger a binge. This can lead to additional vomiting, beginning the vicious cycle over again.

Minimising Dental Damage

While prevention is the best option, there are ways to minimise the damage caused by regular vomiting.

- Gently brush teeth and spit without rinsing the toothpaste away-this leaves fluoride to strengthen the tooth enamel.
- Alternatively, rinsing with a mixture of baking soda and water can help neutralise gastric acid.
- Chew sugar free gum-this promotes saliva production which helps protect against acid.

Challenging Myths About Vomiting

Often, vomiting can become a “safety net” because people think they can compensate for what they’ve eaten. Sometimes, people believe that if they vomit when they eat anything at all, they will lose weight. By challenging beliefs about vomiting, people can reverse the vicious cycle of eating and purging. This along with other strategies, can help minimise the physical and mental effects by vomiting.

Myth I: Vomiting gets rid of the calories I’ve consumed

FACT: Research has shown that vomiting cannot get rid of all calories ingested, even when done immediately after eating.

A vomit can only remove up to about half of the calories eaten - which means that, realistically, between half to two thirds of what is eaten is absorbed by the body. This is because absorption begins in the mouth (through the saliva), continues in the oesophagus, and then in the stomach.

Even if the entire stomach contents are vomited up, many of the calories will have already been ingested. This explains why many people with bulimia maintain an average weight, even if they restrict food outside of binges - they still ingest most of the binge.

Myth 2: Vomiting helps prevent weight gain

FACT: Vomiting tends to encourage overeating and weight gain.

Vomiting gives a false sense of security, because believing that it is a safety net can lead to larger and more frequent binges - people can think that if they are going to vomit anyway, they may as well eat more.

Believing that vomiting compensates for eating actually makes overeating more likely, and over time, increase the amount eaten during binges and greater calorie intake.

The eat and purge cycle also causes metabolic changes that accelerate weight gain. Due to the vomiting process, the body is primed to compensate for the loss of potential nutrients by preserving energy and slowing the metabolic rate. These changes can last a long time, and contribute to increased weight gain over time.

Regular check-ups with a GP and dentist can help monitor and minimise some of the negative effects of vomiting on your health. While it can sometimes be difficult tell people about vomiting, remember that they are there to help and not judge.

(7e) Worksheet 4

Weekly Measure of Eating Concerns and Behaviours

Complete this measure weekly, so that you can discuss with your Guide what beliefs and behaviours change as you progress through your self-help programme. Referring to it every time in your guided session will allow you and your Guide to see how you are progressing, and what targets it is time to move on to.
Don't worry about any overall scoring – just look at what items change each time, lower is always better.

ED-15: This questionnaire considers your eating attitudes and behaviours over the last week. Please complete this measure by ticking the appropriate answers for all items.

	Over the past week, how often have I:	Not at all	Rarely	Occasionally	Sometimes	Often	Most of the time	All the time
1	Worried about losing control over my eating.							
2	Avoided activities or people because of the way I look							
3	Been preoccupied with thoughts of food and eating							
4	Compared my body negatively with others'							
5	Avoided looking at my body (e.g. in mirrors; wearing baggy clothes) because of the way it makes me feel							
6	Felt distressed about my weight							
7	Checked my body to reassure myself about my appearance (e.g. weighing myself; using mirrors)							
8	Followed strict rules about my eating							
9	Felt distressed about my body shape							
10	Worried that other people were judging me as a person because of my weight and appearance.							

If you have never used any of the following behaviours, please respond with N/A.

	For those that you have used, over the past week, how many times have you:	**Number of times**
a	Binged (felt out of control of your eating, and eaten far more than a person normally would at one go)	
b	Vomited to control your weight (whether you had to make yourself sick or not) *	
	Finally, on how many days in the past week have you:	
c	Used laxatives to control your weight or shape	
d	Restricted or dieted in order to control your weight	
e	Exercised hard in order to control your weight	

** i.e., Using your fingers or medicines to make yourself sick, or vomiting without such aids*

(7e) Worksheet 5

Pros and Cons of Your Eating Disorder

What are the Pros and Cons of my Eating Disorder?

Eating disorders often seem negative to the person with the problem, and to those around you. However, it is important to remember that they have some positive value to the individual, as well as having long-term negative outcomes. The positives (‘pros’) are usually short-term, while the negatives (‘cons’) are usually longer-lasting, but individuals often think that they cannot avoid the negative outcomes.

Please use this sheet to help you work out whether your eating disorder is a benefit to you or a problem that you want to overcome. If you want to overcome your eating disorder, then you will need to think about what the benefits are of giving it up, both in the short and the long term.

First, please list all of the positives about your eating disorder in the left-hand box. Then list all the negatives in the right-hand box. A few have been filled in as suggestions to get you started, but delete them if they do not apply to you.

Good things about having my eating disorder (‘Pros’)	Bad things about having my eating disorder (‘Cons’)
• It calms me down sometimes if I don’t eat or if I make myself sick. • I have hope in the short-term that I can keep my weight stable and low. • I can cope with my feelings by starving myself.	• The calm feeling never lasts long, and I usually end up • My weight is not very stable, and is rising over time. • My emotions keep going even more haywire.

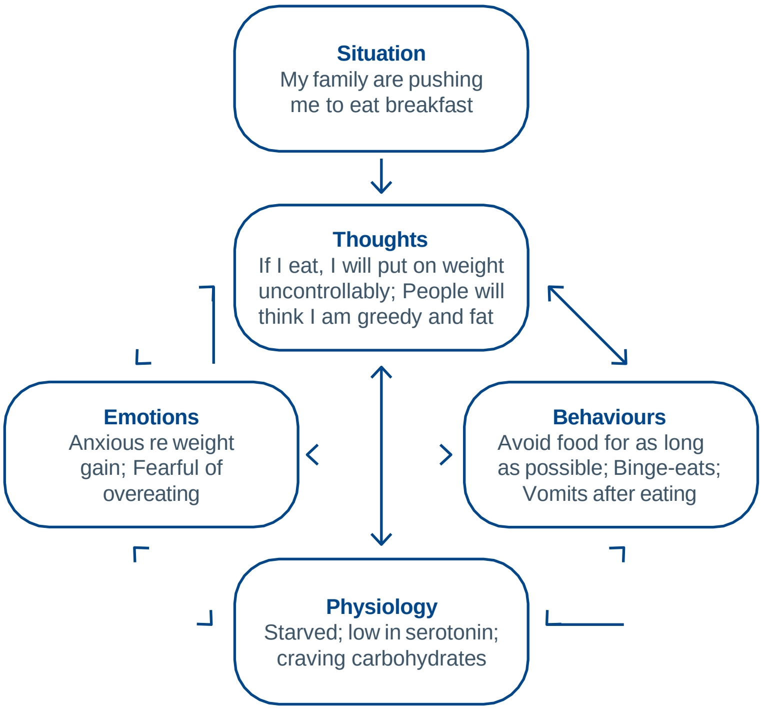
Now that you have done those lists, please write yourself a personal ‘motivational statement’ in the box below. Here you can say what you plan to do from now onwards, based on those pros and cons of your eating disorder. It might be something like: “I realise that my eating disorder is never going to ‘just go away’, and that it is ruining my life, so I am going to commit myself to what I need to do in therapy to give myself the best possible chance of getting well”, or it might be something else. The important thing is that it should be your own, personal statement, so please write what has meaning for you.

Personal motivational statement:

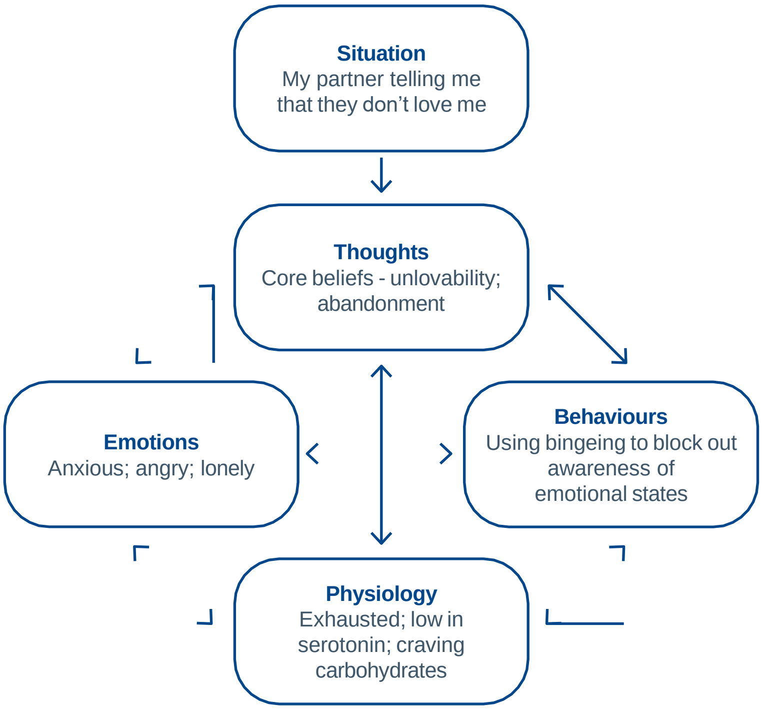
(7e) Worksheet 6

Formulating your Binge-eating Behaviour (Five Areas Models)

Example 1 Five Areas model showing the role of starvation in triggering bulimic behaviours (individual with bulimia nervosa):



Example 2 Five Areas model showing the role of emotions in triggering binge-eating (individual with binge-eating disorder):



(7e) Worksheet 7

Healthy Eating Plan

Bulimia Nervosa/ Binge Eating Disorder, Basic Eating Plan

DAILY	1/3 - 1/2 pint of milk for teas and coffees
BREAKFAST	Fruit Juice or fruit **6 Tablespoons of cereal (1oz/30g)*** Milk **1-2 Large slices of bread**** Butter or margarine Eggs/bacon/cheese/fish (if desired)
MID-MORNING	1 Portion of fresh fruit or 2 plain biscuits
LUNCH	**2-4 Large slices of bread**** Meat/fish/cheese/pulses/beans or eggs Vegetables or salad 1 Carton of yoghurt (not diet) and 1 Portion of fresh fruit
MID-AFTERNOON	1 Portion of fresh fruit or 2 plain biscuits or 1 cereal bar or 1 scone
EVENING	Meat/fish/cheese/pulses/beans or eggs **2-4 Large slices of bread**** Vegetables or salad **Dessert (if desired)***** or, if preferred, a larger portion of the meal may be taken including extra carbohydrate
SUPPER	1-2 Slices of bread/crumpet/muffin/or 2 plain biscuits or crackers plus a milky drink

An adequate amount of fluid is between 1.5 - 2 litres (8-10 cups) drunk throughout the day.

This plan is a simple menu guide for one day but can be used as a guide for eating over a longer period. It is important that you eat all those carbohydrate foods which are in bold. Wholegrain and higher fibre types may satisfy hunger better.

The differences in amounts relate to people's differing energy needs. Over time, you will be better able to judge The amounts you need.

Lunch and evening meals may be interchanged, as may meal items themselves. This list below gives alternative to the foods in bold and you can substitute the appropriate quantities as you wish.

Aim for a variety in your eating plan to help you achieve a balanced diet.

CEREAL*

= 6 tablespoons of non-diet cereal (1 oz/30g)
= 2 Weetabix
= 2 shredded wheat
= 3 tablespoons of muesli

2 LARGE SLICES OF BREAD**

= 1 bagel
= 3 small slices of bread
= 2 small bread rolls
= 3 small roast potatoes {7oz/200g)
= 3 tablespoons of potato boiled or mashed
= 18 small chips (3oz/90g)
= 4oz pizza {120g)
= 2oz/60g rice or pasta or noodles or couscous (dry weight)

DESSERT IDEAS***

= small slice of cake {plain or fruit) (2oz/60g)
= small tin of rice pudding (8oz/240g)
= individual dessert, e.g. trifle, chocolate mousse, yoghurt (not diet types)
= 5Og chocolate bar
= ice cream (2 scoops)

(7e) Worksheet 8

Reducing Body Avoidance | Module 12

Break Free from ED

An Active Guide to Recovering from Your Eating Disorder

Body image II: Body Avoidance

If you are restricting your food intake, using self-induced vomiting, over-exercising, laxatives or diuretics for weight- control, or have lost weight recently, it is important that you talk to your medical practitioner and get a full medical check-up, as there are many physical complications that can arise as a result.

(7e) Worksheet 8 - Break Free from ED

Introduction

In the previous module, we discussed body image and started tackling one of the behaviours that keeps poor body image going – body checking. While some people focus intensely and repeatedly on their body, others try to avoid looking at their body altogether. In this module we will tackle a second behaviour that keeps poor body image going, body avoidance. It is very common for people with eating disorders to swing between body checking and body avoidance.

My Body Avoidance

If you hold negative beliefs about your body you may avoid certain situations where these beliefs are triggered, especially situations where your body is more exposed. Let's think about situations you avoid due to your body image concerns.

- Highlight any situations from the table below that are relevant to you, then add your own examples.
- For each situation, identify your negative body prediction. What do you think would happen if you approached this situation?
- Rate your anxiety about approaching the situation on a scale from 0-10.
  0 - Perfectly relaxed; I 0 - Overwhelming anxiety, you want to escape from the situation

Situations I avoid due to my body image concerns	**My negative body prediction** "What do I think would happen if I approached this situation?"	**Anxiety Rating (0-10)**
Going to an exercise class	e.g. people will notice my body wobbling and will laugh at me or call me fat	e.g. 9
Looking in the mirror/ window reflection		
Wearing swimwear at the beach/ pool		
Shopping for clothes		
Wearing tight fitting clothes		
Wearing clothes that expose body parts (e.g. shorts, singlets)		
Exercising		
Attending events with an increased focus on body (e.g. school dance)		
Socialising with particular people or groups		
Close physical contact with others e.g. dating, being intimate (e.g. hand holding, hugging, sexual intimacy)		
Self-care activities (e.g. applying sun-cream, washing face, shaving legs)		
Being photographed		
Being recorded on video		
Posting images of myself on social media		

Problems with Avoiding your Body

Avoiding situations due to body image concerns can help you feel calmer and more in control in the short term but makes body image concerns worse in the long-term. Body avoidance is problematic because...

My Body Avoidance

I. We never get to test our fears. If we approach the situations we fear, we might discover that our fears don't always come true, and that things can turn out better than expected.

2. Avoidance and anxiety can spread. As we avoid situations, we tend to lose confidence and our anxiety can start to spread to more and more areas of our life (e.g. you might notice yourself losing confidence in your social skills).

3. We miss out on opportunities for positive experiences: These experiences can build our confidence or allow us to participate in other valued areas of life. For example, swimming at the beach might be scary, but also involves the feeling of cold water on your body or laughing with your friends.

4. It is impossible to avoid our bodies altogether: Our bodies are the amazing, miraculous vehicles that we drive around in every day to get where we need to go in life. No matter how hard you try, you will end up catching your reflection in a window or having to pose for a photo. You may never fully like your body but accepting it for all that it does for you, and working with your body rather than against it, will help you get more out of life. This is true regardless of where your weight sits on the scale.

Note: Reducing body image concerns is not about loving your body all the time, but about developing body acceptance. You might hear this described as body neutrality because it's about caring less about how your body looks rather than having strong positive or negative feelings about your appearance.

My Body Avoidance and exposure

To tackle body avoidance, you need to experiment with approaching situations that you avoid because of your body image concerns. This is called exposure. In the short-term, exposure experiments can increase anxiety, but they also give you the opportunity to test your fears and build confidence in your coping skills, which helps reduce anxiety over time.

There are different ways to approach feared situations. You can jump in the deep end and tackle your biggest fears first or you can take a more gradual approach where you work towards the big goal step-by-step. Choose a step that is associated with the most anxiety you think you can handle - this will help you change more quickly.

One form of exposure shown to reduce distress, negative body beliefs, and body dissatisfaction is mirror exposure. Mirror exposure encourages you to focus on your body for a prolonged period of time so that you can get used to it without feeling distressed. The step-by-step guide to mirror exposure on the next page shows you how you can take a more neutral approach to looking at your body. Give it a go!

Mirror Exposure

Step I. Find a full-length mirror where you can conduct mirror exposure without interruption. This might take 30-40 minutes when you first start but will get quicker each time you practice.

Step 2. Observe your whole body in the mirror in tight-fitting clothing. It is important to keep your attention on your body throughout the exposure task. Keep redirecting your attention back to your body, even if you notice it feels upsetting or you have an urge to look away.

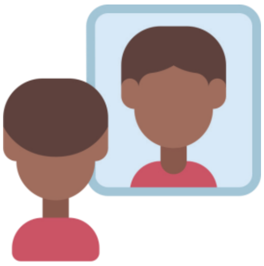
Step 3. Rate your anxiety before mirror exposure and then at 5-minute intervals on a scale from 0 (completely relaxed) to 10 (extremely anxious, urge to escape or look at away).

Step 4. Adopt a non-judgemental approach. Slowly scan your body from head to toe and describe your body as a neutral observer might, one who has just landed from Mars and has no preconception about body shape. Describe the texture, colour, and shape of your body parts in as much detail as you can. For example, instead of saying ‘my stomach is disgusting’, you might say ‘the skin protrudes slightly over the top of my fitted blue jeans’. When your gaze reaches your toes, work your way all the way back up to the top of your head, continuing to describe each part of your body non-judgementally.

Step 5. Congratulations on completing mirror exposure. What did you notice happened to your anxiety?

Tips

- Try to look at your entire body, paying equal attention to all areas rather than avoiding or focusing intently on certain areas as you may normally do.
- It is important to repeat mirror exposure regularly (e.g. several times a week) until seeing your body reflection no longer triggers strong negative emotions.
- You will learn more quickly if you practice across a range of reflective surfaces (e.g. other mirrors at home, shop mirrors, window reflections).
- If you find yourself getting bored this is a pretty good sign that you don’t need to continue, as you are no longer distressed by the image.



(7e) Worksheet 8 - Break Free from ED

Other Exposure Experiments

There are lots of ways you can experiment with approaching situations you avoid due to your body image concerns. Take a look at the table below for some ideas.

Situation I avoid due to my body image concerns	**Exposure experiment to approach this situation**
Going to an exercise class	Attend 2 x 45 minute gym classes this week
Looking in the mirror/ window reflection	Mirror exposure - see above
Wearing swimwear at the beach/ pool	Go to the pool in swimwear
Shopping for clothes	Go shopping for clothes with someone I trust and try on at least 5 items
Wearing tight fitting clothes	I will wear the fitted dress I bought at Christmas when I next go out
Wearing clothes that expose body parts (e.g. shorts, singlets)	Wear shorts this weekend for at least 2 hours in public
Attending events with an increased focus on body (e.g. school ball)	Say yes to the work dinner party that I have been avoiding
Socialising with particular people or groups	Visit my grandmother, even though I know she will comment on my weight
Close physical contact with others, such as dating or being intimate (e.g. hand holding, hugging, sexual intimacy)	Let my partner hug me
Self-care activities (e.g. applying sun-cream, washing face, shaving legs, get a massage)	Take time for self-care - I can use the new lotion I got for my birthday or go to a salon and get a pedicure
Being photographed/ recorded on video	Allow my friends to take photos of me when we go out
Posting images of myself on social media	Post a photo of myself that is not edited

Body Exposure Experiments: My Plan

Select 3 situations you avoid due to your body image concerns and plan some exposure experiments using the ideas listed above or your own ideas.

Situation I avoid due to my body image concerns	**Exposure experiment to approach this situation**
1.	
2.	
3.	

Step-by-step Approach to Exposure

Remember you can jump straight in with facing your biggest fears or you may prefer to take a step-by-step approach, as outlined in the example below.

GOAL: To swim at the beach in swimwear with my friends for at least I hour		**Anxiety 0-100**
		90
	STEP	
5	To wear swimwear at home on my own for at least I hour	75
4	To wear swimwear at home on my own for at least 30 minutes	65
3	To go to the beach in singlet and shorts with a friend for at least I hour	60
2	To go out with friends wearing a singlet and shorts (exposing my arms, shoulders and legs) for at least 30 minutes	50
1	To go out to the shops in a singlet that exposes my shoulders and arms for at least 30 minutes	30

You can use the blank exposure table below to develop your own step-by-step plan if you need to take a more gradual approach.

GOAL:		**Anxiety 0-100**
	STEP	
5		
4		
3		
2		
1		

TIP

Regardless of whether you jump straight in with exposure or take a more gradual approach, you will learn more quickly if you complete a behavioural experiment worksheet to identify and test out your fears. What do you predict will happen when you face the feared situation? Did your prediction come true?

(7e) Worksheet 8 - Break Free from ED

My Weekly Progress Review

First, complete your symptom tracker:

Eating disorder behaviour	**Frequency (days per week)**
Restrict or diet	
Binge (include# binge episodes)	
Vomit to control my weight (include# vomiting episodes)	
Exercise hard	
Use laxatives (include# laxatives taken on average)	

Second, reflect on your self-monitoring:

What did I learn from my self-monitoring this week? e.g. "*now that I have been eating regularly for a while, it feels less effortful and I have less negative thoughts about my meals*"; "*when I check more I fee/ more urges to restrict or binge*"

Third, review your homework from last week:

Eating disorder behaviour	**Frequency (days per week)**
Restrict or diet	
Binge (include# binge episodes)	
Vomit to control my weight (include# vomiting episodes)	
Exercise hard	
Use laxatives (include# laxatives taken on average)	

Finally, set some goals! What do you want to work on this week?
(e.g. mirror exposure, body image exposure experiments - go to the beach with my friends in swimwear).

(7e) Worksheet 8 - Break Free from ED

Module Summary

- If you hold negative body beliefs you may avoid certain situations where these beliefs are triggered, such as situations where your body is more exposed.
- Avoiding your body keeps body image concerns going and this avoidance can spread to other valued areas of life.
- It is important to experiment with approaching situations you have been avoiding due to your body image concerns, even though this feels uncomfortable. We call this body exposure.
- Mirror exposure is an effective way of reducing body dissatisfaction in people with eating disorders.
- You will need to conduct lots of exposure experiments to improve body image - such as, wearing swimwear or letting others hug you.
- It is okay to jump straight in and tackle your biggest fears first or you might prefer to take a step-by-step approach.

Module Summary

Contributors

Dr. Bronwyn Raykos (MPsych')
Senior Clinical Psychologist

Dr. Bruce Campbell (MPsych')
Consultant Clinical Psychologist

Dr. Olivia Carter (DPsych')
Clinical Psychologist

Samantha Bank (MPsych')
Clinical Psychologist

Katharina Targowski (MPsych')
Clinical Psychologist

References

These are some of the professional references used to create the modules in this

Cash, T. (1997). The Body Image Workbook. Oakland: New Harbinger Publications

Fairburn, C. G., Cooper, z.,S hafran, R., Murphy, R., & Hawker, D. M. (2008). Cognitive Behaviour Therapy and Eating Disorders Guilford Press.

Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., & Lawson, R., (2007). Cognitive Behavioural Therapy for Eating Disorders. Cambridge University Press.

Waller, G., Turner, H.M., Tatham, M., Mountford, V.A., & Wade, T.A. (2019). Brief Cognitive Behavioural Therapy Non-UnderweighPt atients: CBT-T for Eating Disorders Routledge.

(7e) Worksheet 8 - Break Free from ED

Acknowledgements

We would like to thank Professor Glenn Waller, Professor Tracey Wade and Dr. Louise Andony for their expert review of the modules. We would also like to acknowledge Dr. Sarah-Ashley Robbins from the Gaudiani Clinic for her review of select medical information and thank the entire Eating Disorders team at the Centre for Clinical Interventions.

Images

"Break Free From ED"

This module forms part of:

Targowski, Bank, Carter, Campbell & Raykos (2022). Break Free from ED. Perth, Western Australia: Centre for Clinical Interventions

ISBN: 978-0-9757995-2-9 Created: July, 2022

(7e) Worksheet 9

Diary of Emotional Triggers

Diary of potential triggers to using unhealthy eating behaviours

Day: ______________________________ **Date:** ______________________________

Every time you feel like overeating, bingeing, taking laxatives, restricting, being sick, etc., please complete this diary. Then decide whether you want to use that behaviour and make a note of the outcome.
Look at what you can learn, before going into your next therapy session.

Time	
What did I last eat? When?	
Context/trigger (Where was/? Who was about? What was I doing?)	
What eating behaviour(s) did I feel like using?	
What thoughts/ core beliefs can you identify that might be relevant?	
What emotions are you experiencing that you might be trying to block out?	
What do I want to do? (safety behaviour) What am I going to do, having thought about why?	

(7e) Worksheet 10

Building Self-Compassion | Module 5

Self-compassionate Thinking

Introduction

Ideally you have been practicing your compassionate image, and when you slow your breathing down and bring this image to mind you notice it triggers a shift in how you are feeling. You may notice some warmth within, and feelings of calm, kindness and strength start to arise. So, now what?

Essentially by using your breathing and compassionate image you can shift gears and activate the soothe system and calm the threat system whenever you need to. We now want to take this a step further, and deliberately allow these compassionate feelings to influence the way you think about any difficult situation you find yourself in.

This module will take you through two ways that you can do this (i.e., Compassionate Thought Diaries and Compassionate Letter Writing), showing you how to purposely bring a compassionate perspective or mindset to any specific struggle you face.

We will also finish this module by considering how you can train your attention in a manner that is a bit different to what you have already done in Module 3. That is, how you can train your attention to generally appreciate the positives in life. This can be a nice counterbalance to the threat system that is always on the lookout for the negatives, and hence might help us to spend more time in soothe mode.

The Thought-Feeling Connection

What you think, and the thoughts that go through your mind, are very important in determining how you feel. Stop for a moment and think: when you are feeling good, what sorts of thoughts roam around in your head? Conversely, when you are feeling bad, what sorts of thoughts are you having?

It makes sense to most people when we say that:
It is not the situation you are in that determines how you feel, but the thoughts, meanings, and interpretations you bring to that situation.

Here is an example of what we mean. Imagine you are told that you will have a pop quiz on Monday. Below are three different ways of thinking about this same situation and the different emotions, behaviours, and physical sensations that would result from thinking in these different ways.

Example event: *Being told I have a pop quiz*			
	Emotions	**Behaviour**	**Physical**
Thought 1: *I love quizzes! I know this stuff quite well so I think I will do fine.*	*Happy*	*Do a bit of revision*	*Quite relaxed*
Thought 2: *I am useless at quizzes. I am such an idiot. I don't know anything, I am going to fail for sure.*	*Anxious* *Sad*	*Try to study hard, but can't concentrate, give up don't get much done*	*Sick in stomach* *Tense*
Thought 3: *So what? I don't care. This subject isn't important anyway.*	*Neutral*	*Do not study*	*Quite relaxed*

(7e) Worksheet 10 - Building Self-Compassion

Can you see how what we think can be so important in determining how we feel emotionally and physically, and can influence what we do?

We have already discussed in Module 1 how self-critical thinking about any situation can leave us feeling a variety of uncomfortable emotions like anxiety, sadness, depression, guilt, shame or anger. Thought 2 ("*I am useless at quizzes. I am such an idiot. I don't know anything, I am going to fail for sure.")* is an example of what self-criticism can do to us, showing how it generates difficult emotions, and can lead to unhelpful behaviours and uncomfortable physical sensations too.

As we have said previously, with **self-critical thinking**, our internal self-talk is highly negative, disparaging and berating. The content of self-critical thoughts can be very cruel, but also the tone of our internal voice when we speak to ourselves is usually very cold, harsh, and attacking.

Now remembering the idea that how we think largely determines how we feel, then one way to lift uncomfortable emotions is to change the way we are thinking. This means that you don't just accept your self-critical thoughts as true, but instead use your breathing and compassionate image to shift your mindset into self-compassion gear. Once you are in this more helpful gear, start to question the way you are thinking and see if you can't bring a more compassionate perspective to the situation. Doing this can then have a positive impact on how you are feeling.

Compassionate Thought Diaries

We would like to introduce you to a Compassionate Thought Diary to guide you in developing more self-compassionate ways of thinking. If this way of thinking is new to you, then following a step-by- step guide can be useful. Even if you are familiar with this approach, putting pen to paper can free your mind, making it less cluttered so you are able to think more clearly and compassionately.

On page 44 is an example of how to complete a thought diary and following that is a blank copy for you to practice on. The diary guides you through how to put your self-critical thoughts out on paper, and how to bring a more compassionate perspective to whatever you are dealing with.

The diary will first ask you to write down information about your **Self-Critical Thinking**. For example:

- **What is the trigger?** The trigger can be a specific situation you are experiencing, or just thinking about something like a memory of the past or thinking about something in the future, or it could be a current emotion or physical sensation you are experiencing. The trigger is whatever you are struggling with.
- **What is the self-critical art of me saying?** This is where you list all the unhelpful or negative thoughts that might be running through your mind about the trigger. A number of these are likely to be unkind thoughts directed towards yourself.
- **What tone of voice is it using?** This acknowledges that it isn't just what we say to ourselves that can be hurtful, but the way we say it. The tone of our internal voice is important to recognise, because it has an effect on how we feel.
- **How much do I believe the self-critical thoughts?** Rate the strength of your belief between 0 and 100%. That is, how convincing the self-critical thoughts seem to you.

(7e) Worksheet 10 - Building Self-Compassion

- **What emotion(s) am I feeling?** And rate the intensity of the main emotion you are experiencing, between O and I 00%.
- **What physical sensations or behaviours go with these feelings?** This recognises that our thoughts don't

This section of the diary will just help you to become more aware of how you are thinking and feeling. At this point nothing changes, we just have more clarity about what is going on for us, and hence are in a better position to meet this struggle with some self-compassion.

The next part of the diary will be about shifting perspective and injecting some **Compassionate Thinking** into the mix. To do this, you must first call upon your Slow Breathing and Compassionate Image. Once doing this has helped to activate the soothe system and calm the threat system, you will be in a much better frame of mind to bring a compassionate perspective to whatever you are dealing with.

There are a number of questions listed in the diary to help you entertain more compassionate thinking. You don't necessarily have to use all the questions, but sometime the more options you have the better. Also, you may find that you answer a number of questions with the same sorts of ideas. This is not a problem, as repetition can be a good thing, especially when we are retraining our mind to think in more compassionate ways.

So with compassionate feelings of warmth, kindness, wisdom, and strength elicited within you, you can then ask yourself the following:

- **What does my compassionate image have to say about this?** If your compassionate image is your own fantasy creation of an ultimate compassionate being, what would it say to you about the problem you are struggling with? If instead your compassionate image involves imagining giving compassion to another person, then what would this side of yourself that can give such abundant compassion, have to say to you about your current difficulty?
- **What advice would I give to a friend I deeply care about who was thinking and feeling this way?** We have already seen how compassionate we can be to others. This question can help us draw out our compassionate side that we tend to reserve for others, and bring it to bear on our own difficulties.
- **What does the compassionate part of me want to say to the self critical part?** This is about giving voice to the compassionate side of you that may have been sidelined for too long. The compassionate side may recognise that the self-critical part might just be scared and is only trying to help, but is misguided and cruel and only leads to misery.
- **What are some other ways of viewing this situation that might be more realistic, kinder or more helpful to me?** This question is about tapping into compassionate thinking as being more balanced, reasonable, and wise in the advice it gives. Rather than hot headed and irrational as self-criticism can often be.
- **How will I feel about this in I week. or I month or I year?** (If it won't matter much then, can I let go of it now?) This question can sometimes bring some new balanced perspective about the true importance of what we are dealing with.
- **What can I do to cope and look after myself now?** A compassionate response is always geared at taking care of someone who is struggling, so it is important to shift our energy to doing this for ourselves, recognising the ways we can cope and the ways we can look after ourselves when we feel vulnerable as a way of rebuilding our strength.

(7e) Worksheet 10 - Building Self-Compassion

With all of these new compassionate ideas and thoughts available to us, the last step of the diary is to consider what new **Compassionate Conclusion** we might develop. Before making a conclusion, it is important to re-read all the compassionate thoughts you put down on paper, and be conscious of how you are reading these to yourself.

Ensure you haven't slipped from the warm and caring voice tone that goes with your compassionate image. If you have lost it momentarily, again just refocus on your slow breathing and compassionate image to kick-start your self-compassion mode again.

Having read through your compassionate thoughts then consider:

- What is a more compassionate and helpful conclusion to replace the self-criticism?
- How much do I believe the self-critical thoughts now? Re-rate 0-100%
- How intense is my initial main emotion now? Re-rate 0-100%

If you follow through with this strategy, it is likely that you will experience a decrease in your belief in the original self-critical thoughts and a decrease in the intensity of your original emotional reactions. If it has been useful in this way, then great, you can put your concerns to rest.

If instead you are still struggling, there are two things that can be helpful. Firstly, keep engaging your slow breathing and compassionate image, and re-reading the more compassionate thoughts to yourself. Bringing a compassionate perspective to things will be new and foreign to you, and may require quite a bit of practice to get used to.

Also, focus your energy on the question: *what can I do to cope and look after myself now?* Whatever you came up with as helpful ideas in this regard, make sure you are putting them into practice now. If you aren't able to change your thinking on a struggle you are facing, then taking care of yourself is the most important place to channel your attention and energy.

(7e) Worksheet 10 - Building Self-Compassion

Compassionate Thought Diary (example)

Self-critical Thinking

What is the trigger?
(i.e., a situation, thought - memory of past or thinking about future, emotion, physical sensation)
Feeling anxious about an upcoming work presentation

What is the self-critical part of me saying?

What is wrong with me? I am so useless and pathetic. I am going to stuff everything up Other people do presentations all the time with no problem. I am just so anxious and weak. Get it together or I'll lose my job.

What tone of voice is it using?

Aggressive, Shouty

How much do I believe the self-critical thoughts (0-100%)? *90%*

What emotion(s) am I feeling? (Rate intensity of main emotion 0-1 00%)

Anxious
Angry

What physical sensations or behaviours go with these feelings?

Tense, butterflies, hot Plan to call in sick to work

Compassionate Thinking

Slow Breathing and bring my Compassionate Image to mind, allowing compassionate feelings to arise, then...

What does my compassionate image have to say about this?
This sounds really hard. I'm sorry you are having to go through this. You are not alone, Everyone feels anxious at times. These are normal feelings. Just focus on what you need to do.

What advice would I give to a friend I deeply care about who was thinking and feeling this way?
It is OK. Everyone gets anxious about presentations. You are not alone in that. You can do this. It is just a presentation that will be over in a flash.

What does the compassionate part of me want to say to the self-critical part?
I know you are just scared for me and trying to prepare me for the worst and push me harder but you just make me more anxious and this doesn't help me to focus so I can do my best.

What are some other ways of viewing this situation that might be more realistic, kinder or more helpful to me?
I have done presentations before and they have mostly gone well. Even if it didn't go well, I won't lose my job over one presentation. I am valued for many other things I do at work.

How will I feel about this in I week, or I month, or I year? (If it won't matter much then, can I let go of it now)?
I may still think about this in a week, but probably not in a month and definitely not in a year. Maybe it isn't important in the big scheme of things.

What can I do to cope and look after myself now?
I can focus on preparing y slides for the presentation, plus go and do something relaxing and fun to give myself a break from constantly thinking about this.

Compassionate Conclusion

Re-read my compassionate thoughts, making sure I am using a compassionate tone of voice when I do this

What is a more compassionate and helpful conclusion to replace the self-criticism?
It is ok and normal to feel anxious. Balance my time between working and relaxing. It will probably go well. And who will care in a month anyway!

How much do I believe the self-critical thoughts now (0-100%) *30%*

How intense is my initial main emotion now (0-100%) *50%*

(7e) Worksheet 10 - Building Self-Compassion

Compassionate Thought Diary

Self-critical Thinking

What is the trigger?
(i.e., a situation, thought - memory of past or thinking about future, emotion, physical sensation)

What is the self-critical part of me saying?

What emotion(s) am I feeling? (Rate intensity of main emotion 0-1 00%)

What tone of voice is it using?

How much do I believe the self-critical thoughts (0-100%)?

What physical sensations or behaviours go with these feelings?

Compassionate Thinking

Slow Breathing and bring my Compassionate Image to mind, allowing compassionate feelings to arise, then...

What does my compassionate image have to say about this?

What advice would I give to a friend I deeply care about who was thinking and feeling this way?

What does the compassionate part of me want to say to the self-critical part?

What are some other ways of viewing this situation that might be more realistic, kinder or more helpful to me?

How will I feel about this in I week, or I month, or I year? (If it won’t matter much then, can I let go of it now)?

What can I do to cope and look after myself now?

Compassionate Conclusion

Re-read my compassionate thoughts, making sure I am using a compassionate tone of voice when I do this

What is a more compassionate and helpful conclusion to replace the self-criticism?

How much do I believe the self-critical thoughts now (0-100%)

How intense is my initial main emotion now (0-100%)

(7e) Worksheet 10 - Building Self-Compassion

Compassionate Letter Writing

A slightly different method of encouraging compassionate thinking when we are struggling with a problem, is by writing a compassionate letter to ourselves. This is really just a different way of doing the same thing that we did in our compassionate thought diary. That is, shifting our perspective from one that is self -critical to one that is self-compassionate.

You may find you prefer compassionate letter writing to using the compassionate thought diary, or vice versa. Everyone is different. It is a good idea to try both on for size and see which one seems to be more effective for you. To help with writing a compassionate letter to yourself, follow the suggested prompts below to guide you through the process.

The first step is to decide what the problem is that you are struggling with, which will become the focus of the letter. This is essentially the same as the trigger from your thought diary and can therefore be a difficult situation, thinking about a difficult past memory or some worries you have about the future, or a current uncomfortable emotion or physical sensation you might be struggling with. Once you know what the topic of your letter is, the next step is to use your Slow Breathing and Compassionate Image to shift yourself into self-compassion mode. Once this is achieved and you feel compassionate feelings arise within you, then you are ready to write a letter to yourself.

Really try to take the same stance you would if you were writing a deeply caring and kind letter to a friend who was having the same problem. If you notice yourself shift from this self-compassionate stance back into self-critical mode at any point while you are writing, just pause the letter writing, and use your Slow Breathing and compassionate Image again, and then proceed with the letter writing once you feel you can approach it again from a compassionate mindset.

So, if you want to hand write the letter, get out a blank piece of paper, maybe even some beautiful writing paper if you have it. If typing it up on your computer, tablet or phone is more your style, then do that. Either way, use the following prompts to get you started with your writing. Feel free to change the prompts as you see fit, they are only suggestions, and you can write as much or as little as you like for each prompt. Remember you are writing this letter to yourself and trying to bring a caring and kind perspective to whatever the problem is.

Dear **[yourself]**

I am writing to you because I understand that it is really hard for you at the moment.
I know you are struggling with **[the problem/trigger]**

I am so sorry you have to go through this...
I hope you know that it is ok to feel.....
I hope you know everyone experiences...
Human beings are imperfect and we all struggle, so I hope you know you are not alone in this...

I am wondering if you have thought about **[add any helpful perspectives about the problem]**

I really want your struggle to get easier. To help you feel better, address the problem and move on from it,
I am wondering if it would help to... **[add any behaviours that might bring comfort or help solve the problem].**
[Add anything else that needs to be said]

Please know I care about you and I am here for you whenever you need.

wishing you well,
... [sign off as yourself]

(7e) Worksheet 10 - Building Self-Compassion

Below is an example to give you a feel for what compassionate letter writing might sound like. But remember, there is no right or wrong as long as you are approaching writing the letter with a deeply caring and non-judgemental mindset in place.

Dear Lisa,

I am writing to you because I understand that it is really hard for you at the moment. I know you are struggling with this work presentation that is coming up on Monday, and I know you are feeling really anxious about this. I am sorry you have to go through this and I want to help you get through it.

I hope you know it's ok to feel anxious about the presentation. I hope you know that everyone experiences anxiety about all sorts of things in life, and anxiety about doing presentations is really common and normal Human beings are imperfect and we all struggle, so I hope you know you are not alone in this. Many people have struggled with this sort of anxiety and many people will again. People do understand, even if this understanding is unspoken.

I am wondering if you have thought about all the positives that you have going for you that you might be forgetting. You have done presentations before and they have usually gone well. I can't think of one that went really badly. Even if it wasn't the greatest presentation, it will be over in a flash and will probably stand out more in your mind than anyone else's. Others will move on from it really quickly to the next thing, so you should feel free to do that too. You don't need to hold onto it. And just remember all the things you are valued for at work. One presentation doesn't change that.

I really want your struggle to get easier. To help you feel better, address the problem and move on from it, I am wondering if it would help to take some chill out time for yourself. Do something really relaxing and enjoyable like watching a movie or taking a bath. You deserve a break from all this. Then when you are feeling a bit refreshed, just focus on preparing your presentation one small step at a time. I know you can do that, remember that you have done it before.

Please know I care about you and here for you whenever you need.

Wishing you well,

Lisa

(7e) Worksheet 10 - Building Self-Compassion

Appreciating the Positives

Compassionate Thought Diaries and Compassionate Letter Writing are both about bringing compassionate thinking to the forefront when we are dealing with a specific issue that is troubling us and is generating emotional pain.

However, we can also foster compassionate thinking more broadly when we are not struggling with a specific situation, by training our mind to see, appreciate, and savour the positives in life. This is something that should be done regularly. Just like if you were training your muscles you would exercise them regularly, so if you want to train your attention to appreciate the positives, then your attention needs regular exercise in doing this.

There are two ways you can train your attention to appreciate the positives. The first is through building on your Mundane Task Focusing from Module 3. This is about doing all the same things with your attention that were recommended for mundane task focusing (i.e., becoming aware of all the sensory aspects of the task at hand - touch, sight, sound, smell, or taste - and redirecting your attention back to these when your mind inevitably wanders). However, now we want to purposely choose pleasurable rather than mundane tasks as your focus (e.g. taking a bath, walking in nice scenery, eating a delicious meal, showing physical affection, listening to music, laughing, swimming, putting moisturiser on, etc.).

Now, what we find pleasurable in life will be different for each of us. This is about taking the small pleasures available to us in daily life, and not ignoring them, but maxing out our attention on these so we really appreciate them and all the sensory experiences that go with them. I guess we could call it **Pleasure Task Focusing**. List some of the common pleasurable tasks that you do, that from now on you can immerse your full attention in.

The second way of training our attention is by noting the positives that happen in daily life. This involves on a daily basis noticing acts of kindness by others, appreciating the small things others might do for us that we can often take for granted, and noticing any nice or positive things that happen.

Remember the threat system is always on the lookout for the negatives, so noticing the positives can be a good counterbalance to this bias we all have. People often say “if it’s not written down, then it didn’t happen”. This is certainly the case when it comes to our attention. To retrain our attention we have to almost force it to look at the good stuff, so writing it down or keeping an Appreciation Logbook is a good way to force our attention to sit up and take notice.

People usually get a nice pad or notebook to be their Appreciation Logbook, and the most common place people keep it is on their bedside table. Then at the end of each day before going to bed, they record at minimum one thing they appreciated from the day (e.g. a meal their partner made for them, a work colleague offering to buy them a coffee, someone standing up for them on the bus, someone giving way to them in traffic, receiving a compliment, a beautiful sunny day, etc.).

As with all things recommended throughout these modules, try Pleasure Task Focusing and the Appreciation Logbook on for size, and be curious about the impact over time that regularly appreciating the positives can have on your general outlook on life. This is not about pretending that bad or negative stuff doesn’t happen, but instead allowing some of the good stuff to filter through too.

(7e) Worksheet 10 - Building Self-Compassion

Module Summary

- How we think can be so important in determining how we feel emotionally and physically and can influence what we do. Self-critical thinking will tend to generate difficult emotions and can lead to unhelpful behaviours and uncomfortable physical sensations too.
- Rather than just accept self-critical thoughts as true, instead use your breathing and compassionate image to shift your mindset into self-compassion gear, and once you are in this more helpful gear, you are then in a good position to start thinking in more compassionate ways. Doing this can then have a positive impact on how you are feeling.
- There are two ways to bring a more compassionate perspective and tone to the way you are thinking about a specific problem: 1) Compassionate Thought Diaries, and 2) Compassionate Letter Writing. Both are different methods of achieving the same thing, that is, a kinder, more balanced, and helpful perspective on whatever is troubling you in life.
- Appreciating the positives more generally in day to day life can be a great way to nurture a more compassionate way of seeing the world. Pleasure Task Focusing and an Appreciation Logbook done on a daily basis can help you with this.

About the Modules

Contributors

Dr Lisa Saulsman (MPsych1; PhD2)
Centre for Clinical Interventions

Dr. Bruce Campbell (MPsych’)
Centre for Clinical Interventions

Dr Adelln Sng (MPsych1; PhD2)
Centre for Clinical Interventions

[1]*Masters of Psychology Clinical Psychology* [2]*Doctor of Philosophy (Clinical Psychology)*

Background

The concepts and strategies in these modules have been developed from evidence based psychological practice, primarily Compassion Focused Therapy, which is an extension of and adjunct to Cognitive Behaviour Therapy. These modules particularly draw on the work of Paul Gilbert and Kristen Neff.

(7e) Worksheet 10 - Building Self-Compassion

References

These are some of the professional references that informed the development of modules in this

Gilbert, P. (2009). The Compassionate Mind. Constable: London, UK.

Gilbert. P. (20 I 0). Compassion Focused Therapy: Distinctive Features. Routledge: East Sussex, UK

Gilbert, P. & Choden. (2015). Mindful Compassion: U sing the Power of Mindfulness and Compassion to Transform

Hackmann, A, Bennett-Levy, J.,& Holmes, E. A (20 I I). Oxford Guide to Imagery in Cognitive Therapy. New

Leaviss, J. & Uttley, L. (2015). Psychotherapeutic benefits of compassion-focused therapy: An early systematic review. Psychological Medicine,4 5, 927-945

Linehan, M. M. (1993). Skills Training Manual For Treating Borderline Personality Disorder. New York: Guilford

Mac Beth, A & Gumley, A (2012). Exploring compassion: A meta-analysis of the association between self compassion and psychopathology. Clinical Psychology Review,3 2, 545-552.

Neff, K. (20 I I). Self-Compassion: The Proven Power of Being kind to Yourself William Morrow: NY.

“BUILDING SELF-COMPASSION”

This module forms part of:
Saulsman,L ., Campbell, B., & Sng,A (2017). BuildingS elf-CompassionF: romS elf-Criticismto Self-Kindness. Perth, Western Australia: Centre for Clinical Interventions.

ISBN: 9780987547903 Created: March 2017

(7e) Worksheet 11

End of Treatment Blueprint

Please complete this template document as well as you can. Then, you can discuss it with your Guide in your final main session and make any amendments that would be useful. Then use it to structure your own reflection and checking-in sessions before the follow-up, to reinforce the changes that you have made and to learn new ways of progressing.

When completing the blueprint, think about what worked for you in your self-help work, as well as anything that did not work well. Remember, the goal is to remind yourself in the future about what you have learned from guided self-help, so that you can make sure that you maintain your progress over the follow-up period and far beyond.

It might help if you imagine yourself now, giving advice to yourself a few months ago, when you were starting your guided self-help. What would your advice be then, and how would you talk to yourself to make sure that you keep taking that advice into the future.

1. What were my problems when I was first referred?

2. What did I do to change?

3. What changes do I still want to make and how will I achieve that?

4. What might lead to a setback in the future?

5. What will be the symptoms of a setback?

6. How will I overcome the setback?

7. What if that doesn't work?

Section 5I: Building Confidence

Confidence involves holding positive self-beliefs – that we are likeable, worthwhile, and have a purpose. When we have experienced knocks in life, it is common for a negative view of oneself to dominate thinking. Positive self-beliefs help to counter-balance negative self-beliefs. Positive psychology shows that to build our confidence we have to be aware of our strengths and values, use these strengths and values in our everyday life, and learn to savour positive experiences.

As a Mental Health Wellbeing Practitioner, one of the ways to support service users to improve their wellbeing is to help them to build their own self confidence. This section discusses ways in which we can build self-confidence. This can be a helpful intervention with service users who have identified problems with confidence, or for whom low confidence is a factor keeping other problems going.

How can we build self-confidence?

The way we think and feel about ourselves matters – it shapes all our interactions with the world. Walking into a room feels different when we are self-confident to when we are self-critical.

When people have had difficulties, it is easy for their views about themselves to be very negative. People can believe they are worthless, unlikeable, and of less value than other people. The consequence can be to retreat. Activities may fall by the wayside. Negative views become reinforced and positive qualities overlooked. Building up positive self-beliefs is way of providing a counter-weight to negative self-beliefs. A more rounded and realistic self-view becomes accessible. Having self-confidence means we are more likely to engage in meaningful activities and to feel happy.

We need to nurture our self-confidence. We need to build and maintain positive self-beliefs. We need to give more attention to our positive qualities than our negative ones.

- We need to connect with our strengths and values. Each of us has values and strengths. Signature values and strengths are the ones that are most important to us. We need to be able to bring these to mind as easily as we do the self-critical thoughts

- We need to use our values and strengths in everyday situations during the week. It helps to build up our self-confidence by including activities during the week that use our signature values and strengths. For example, we may want to help other people, or do something creative, or learn something new

- We need to pay attention to the positive moments in our lives. Positive experiences need to be noticed and savoured, and given at least as much attention as when negative things happen

The stages of building self-confidence

The following protocol for positive psychology techniques is drawn from a UK clinical trial with people with severe mental health problems. It was developed from the ideas described in books by Freeman & Freeman (2012) and Seligman (2017).

Step 1: Assessing psychological wellbeing

It is recommended to keep track of confidence and wider aspects of wellbeing to check that the techniques are working. Your session-by-session use of the ReQoL-10 and GBO measures will allow you to do this. The ReQoL-10 contains a specific item about confidence that can be useful in helping to track progress. (See Section 3D Collecting routine outcome measures)

Step 2: Identifying values and strengths

Use Building Confidence worksheet 1: The VIA Character Strengths Survey to help service users identify key values and strengths. Each item can be discussed with the person, typically completing the questionnaire in about half an hour.

Past and present values and strengths can be identified and the most important ones (‘signature’) to the person highlighted. Other values and strengths can be added from conversation with the service user. It is important for you to observe the person's positive qualities to feedback this information to them.

Step 3: Making an activities list

Using the person’s signature values and strengths, make a list of activities showing their use in action. The key question is: What is an example of this value/strength occurring in day-to-day life? The activities generated should have the potential to occur regularly and to be meaningful for the service user. They can be a mix of small things done fairly often and larger things done less frequently.

Step 4: Planning the use of the activities during the weeks

A clear plan needs to be made for the activities to be incorporated into the service user’s life. Activities need to be scheduled, and consideration given to how best to ensure they occur successfully. Small, regular, and achievable activities are excellent to introduce.

Step 5: Paying attention to the positive

At the end of each day encourage the service user to reflect on the things that have been good or gone well during the day. These can be very small things. They can complete a positive data log (see Building Confidence Worksheet 2 Savouring the positive).

The idea of a positive data-log is to shift attention onto aspects of life that evidence positive qualities, to counterbalance a tendency to attend to negative events. One of the key components of self-confidence is the ability to recognise and savour the good things in life, no matter how small. Agree with the service user whether to try to spot one, two, or three positive things a day.

Step 6: Reviewing progress

The ReQoL-10 and GBO tools (See Section 3D Collecting routine outcome measures) can be used to assess improvement in confidence. You can also ask the person whether they are more aware of their positive qualities and whether there has been an increase in positive activities during their week. The most important driver of building up confidence is positive activity, so if there are difficulties in implementation of positive activity during the week then this should be a focus of problem-solving.

Helpful resources

Building Confidence worksheet 1: The VIA Character Strengths Survey

Strength	Signature strengths	What it means
Kindness		You are kind to other people, doing favours and good deeds for them. You enjoy helping people out and are often considering what other people would like
Honesty		You speak the truth about things. You present yourself in a genuine way without pretending to be something else
Love of learning		You love learning new skills or information. This could be something that you do as part of a class or on your own
Loyalty		If you are in a group or team you are loyal to them and do your best for the team
Creativity		You like thinking of new ways to think about things and do things. You don't follow the crowd to do what everyone else does, you like finding your own, better way
Modesty		You don't seek to be the centre of attention. You don't see yourself as special and let your accomplishments speak for themselves
Perspective		You have a way of looking at the world that you and others find helpful. People often come to you to help them solve their problems or look at things differently
Fairness		You try to treat people fairly and equally without letting personal feelings bias you.
Bravery		You're prepared to face difficult situations and challenges. You're able to take a stand for the things that you believe in, even if other people don't agree with you.
Appreciation of beauty and excellence		You appreciate beauty, excellence and skill in varied aspects of life- be it nature, a musician performing a piece of music, a well written book, or a clever piece of technology
Spirituality		You have a belief in a higher purpose and meaning in the world. This belief brings you comfort.
Vitality		You approach life with excitement and energy.
Hope		You expect the best for the future and you plan to try and make it happen.
Social and emotional intelligence		You understand yourself, your emotions and what makes you tick. You're able to judge the moods and needs of others and do what you can to help them.
Curiosity		You enjoy exploring and discovering the world around you. You are interested in new things and like to find out more about them
Love		You value your relationships with other people and care for others
Caution		You're a careful person who considers what they are going to say or do to make sure that you won't regret it later. You consider all options fully before you make any decisions and you avoid taking risks
Forgiveness		If someone does something mean to you, you are able to forgive them without seeking revenge. You feel people deserve a second chance
Self-control		You are able to keep your needs and desires in check when you need to
Persistence		You finish what you start, even in the face of challenges.
Open mindedness		You like to take the time to think things through and weigh up the evidence for something before reaching a decision
Gratitude		You are able to notice when something good happens to you, to appreciate it and not take it for granted. You take the time to thank people if they do something nice for you
Leadership		You are a good organiser, helping other people to get things done and still keeping a good relationship with them
Humour		You enjoy laughing at things that you find funny and making others laugh and smile

Source: Peterson, C. & Seligman, M. (2004). Character Strengths and Virtues: A Handbook and Classification. Washington, D.C. APA Press and Oxford University Press.

Building Confidence Worksheet 2: Savouring the positive

Record sheet

Day	Positive things	How I feel
Day 1		
Day 2		
Day 3		
Day 4		
Day 5		
Day 6		
Day 7		

Source: Freeman, D., & Freeman, J. (2012). You Can Be Happy: The Scientifically Proven Way to Change How You Feel. Pearson, Harlow.

References

Freeman D, Pugh K, Dunn G, Evans N, Sheaves B, Waite F, Cernis E, Lister R, Fowler D. An early Phase II randomised controlled trial testing the effect on persecutory delusions of using CBT to reduce negative cognitions about the self: the potential benefits of enhancing self-confidence. Schizophr Res. 2014 Dec;160(1-3):186-92. doi: 10.1016/j.schres.2014.10.038. Epub 2014 Nov 11. PMID: 25468186; PMCID: PMC4266450.

Freeman, D., & Freeman, J. (2012). You Can Be Happy: The Scientifically Proven Way to Change How You Feel. Pearson, Harlow.

Peterson, C. & Seligman, M. (2004). Character Strengths and Virtues: A Handbook and Classification. Washington, D.C. APA Press and Oxford University Press.

Section 5J: Medication support – Based on Information-giving

The language used to describe medicines and their effects can be a powerful tool to support a person to gain the best therapeutic outcome from taking medication.

Service users and their close carers may have strong feelings about the value or otherwise of taking medication. They may have understandable fears – or experiences of harmful/unpleasant adverse effects. On the other hand, there will also be people who have experienced benefit from taking medication – even though they may also experience side-effects – or problems.

As a Mental Health and Wellbeing Practitioner you can provide basic information to help service users, families and carers make sense of some medication issues, support effective use of medication, and decide when and how to seek further professional input. You should direct service users to a qualified medical practitioner or other independent prescriber before they make any change to their medication.

Getting the balance right between side-effects and therapeutic benefit for an individual is the cornerstone of good medication use (Also referred to as medicines optimisation - or medicines management).

More details on making the best use of medicines for individuals can be found in the guidance from **NICE on medicines optimisation** (NG5) **and shared decision making**

There may be times when medication use is challenged by people – simply on the basis that medicines are ‘chemicals’ and therefore ‘must’ be harmful. Overall, taking a dichotomous approach to medication use is probably unhelpful – for most people. Medicines, in and of themselves are neither ‘good’, nor ‘bad’; it is the way in which medicines are used that will most often determine the best therapeutic outcome.

Types of medication

Drug treatments for psychosis

As a group these medicines are referred to as ‘antipsychotics’. Other terms such as ‘neuroleptic’ and ‘major tranquiliser’ have also been used. Other words often associated with antipsychotic treatment include ‘atypical’, ‘typical’ and ‘first/second generation’.

Although there is a wide range of drugs that are described as antipsychotic, overall, there is no single drug that is any better – or any worse – for a patient in terms of benefits. However, there are differences in the range of side-effects that patients are likely to experience and the choice of treatment should take account of an individual’s concern to avoid a particular side-effect.

These drugs will commonly reduce the severity of symptoms. The range of side-effects/adverse effects associated with each antipsychotic is listed in the patient information leaflet that should be given to the patient when the drug is dispensed (or described by the health professional if given by injection).

Copies of these medication information leaflets are also available on line through the Electronic Medicines Compendium (EMC) and/or the Medicines and Healthcare Products Regulatory Agency (MHRA).

Clozapine

Of all the different antipsychotic drugs that are available, clozapine alone stands out as being different.

This is an antipsychotic drug that offers potential benefits over all the other antipsychotics if someone has not been helped by other antipsychotics (sometimes referred to as 'treatment resistant schizophrenia/psychosis').

Unfortunately, this drug is not without risks of side-effects, some of which may be severe or life-threatening.

Approximately 1 in 100 people taking clozapine may develop problems with their white blood cells – which, if continued, could result in a life-threatening risk of severe infection.

There are a number of other potentially serious side-effects – which, if overlooked and not managed appropriately, could be life threatening. These include constipation, heart problems and disturbances of blood sugar control. (See the British National Formulary (BNF), EMC or MHRA for more details).

There are strict protocols in place to ensure that anyone taking clozapine has regular blood tests. These blood tests are also linked to the specific brand of clozapine being taken which means that the same brand of clozapine should be used.

Tables or injection

Some antipsychotic medication is available in an injected form, which can replace the need for taking tablets/oral medication. These injections are often referred to as 'depots' or 'long-acting injections'. Depending on the particular medication the effects of these injections can last for several weeks – or longer – which means that injections are only required every few weeks. (One injection is available to last for three months).

These depot injections are commonly administered by mental health nurses, who should also be regularly assessing the patient for emergence of side-effects/problems as well as continued benefit from treatments.

Understanding the benefits of injection vs tablets/oral medication:

- Giving medication by injection does not make any difference to how effective the drug is – or how well tolerated it is – the effects of the medication are exactly the same as would occur if the drug was taken by mouth

- Some patients may prefer to take medication by injection as it avoids the need to keep remembering to take tablets

- From a service perspective the main advantage is the person who administers the drug will know whether or not medication has been taken regularly and in line with the prescribing guidelines

Drug treatments for bipolar disorder

a. Lithium

Although Lithium medication has been available for many years, it remains the best option for reducing the risks of relapse for most people with a diagnosis of bipolar disorder.

Patients who are taking lithium treatment should be regularly reviewed to ensure that the benefits of treatment continue to outweigh any emerging side-effects. Regular blood tests are important to ensure levels remain within the appropriate therapeutic range and renal (kidney) and thyroid functions are not affected by the drug.

Ensuring patients and their close carers are fully informed about the drug and potential signs of toxicity is an important factor in keeping people safe from harm with this drug.

b. Valproate (sodium Valproate)

Valproate is commonly prescribed to treat epilepsy. This drug may also be used as a second line alternative to lithium. The mechanism of action of valproate in bipolar disorder is unclear, but appears to be unrelated to its effects related to epilepsy treatments. Occasional blood tests may still be required, but unlike lithium there is no target “blood level” and the dose is determined on an individualised basis determined by tolerability and therapeutic benefit.

As valproate may cause damage to the foetus if taken by someone who is pregnant, special care is needed to ensure pregnancy is avoided if prescribed to a female. (See the pregnancy protect programme at: Valproate Pregnancy Prevention Programme: actions required now from GPs, specialists, and dispensers - GOV.UK (www.gov.uk)

Drug treatments for depression

These medicines are called antidepressants. In around two out of three people with moderate/severe depression antidepressants will reduce many of the unpleasant symptoms of depression. Although some helpful effects such as sedation/improved sleep may occur within the first few days of taking an antidepressant – the full beneficial effects are unlikely to be felt until the medicine has been taken regularly for 4 to 6 weeks.

Unfortunately, some of the unpleasant side-effects may start to appear soon after treatment is started – so it is important to take steps to address any emerging problems so that treatment can be continued until therapeutic benefit occurs.

Once the initial symptoms have responded antidepressants are normally continued for around six months to help prevent a premature relapse. After six months of treatment with antidepressant medication, a plan for gradual tapered withdrawal should be agreed between the service user and the prescriber.

In some cases, you may need to decide to continue treatment beyond 6 months, and, for a minority of patients, treatment may be continued for several years.

All antidepressant treatment should be regularly reviewed to ensure that the therapeutic benefits Continue to outweigh any problems or side-effects from treatment.

When the time comes to stop antidepressants, an individualised plan should be agreed between the patient and the prescriber. This should include details of the step-by-step reduction in dose and the rate at which withdrawal takes place. Antidepressants should not normally be stopped suddenly and without the opportunity to taper treatment.

Types of antidepressants

Various terms are used to describe different types of antidepressants:

- SSRI (Selective Serotonin Reuptake Inhibitor)
- SNRI (Serotonin Noradrenaline Reuptake Inhibitor)
- Tricyclic MAOI (Monoamine Oxidase Inhibitor)
- A selective MAOI

These terms simply relate either to the type of chemical structure of the drug – or to the action of the drug on the various cells and neurotransmitter chemicals within the brain and body.

How effective are the different types of antidepressants?

In general terms all of the above types or groups of antidepressants are equally effective.

However, different people may respond better (or worse) to different medications. Antidepressant medication within these groups may have differences in pharmacology (the action of the drug on body and brain cells) which may mean some types of side-effects are more common.

One major difference between these types of antidepressants is the likelihood of toxicity if taken in overdose. The SSRIs generally have a much better safety profile if taken in overdose which is why these drugs are most likely to be prescribed as first options. Other differences may include the risks of drug – or food interaction.

There is no blood test or other mechanism to test which antidepressant would help someone with symptoms of depression. Individualising treatment should be done in collaboration with the patient. Most people find that some side-effects, which occur early in treatment, subside after a short time, and they find that they are able to tolerate the medication. However, if side-effects become unbearable – or cause additional problems – such as gastro-intestinal bleeding with SSRIs, prescribers should switch to an alternative antidepressant carrying less risk of that particular side-effect.

When a prescription for an antidepressant is dispensed, patients should be given an information leaflet by the pharmacist, explaining in simple/plain English the common side-effects, and other useful information about the drug.

Making sure the patient has read and understood the details of this leaflet may be helpful.

Addressing common misconceptions about medicines

1) Chemical imbalances.

Patients/service users are often told that the medicines prescribed for mental health problems such as antipsychotics, antidepressants or mood stabilisers were needed to restore a chemical imbalance. The reality is more complex – we still don’t fully understand ‘how’ these medicines work.

But we do know that they can be incredibly helpful in reducing the distressing and unpleasant symptoms associated with disorders like schizophrenia/psychosis, depression and bipolar disorder and by continuing to take these treatments appropriately it will mean that the chances of relapse – or a return of symptoms can be significantly reduced.

Although we still don’t fully understand how the drugs work therapeutically, we do know the effects that these drugs can have on the individual cells in a person’s brain and the body.

This detailed knowledge helps us understand – and mitigate against many of the adverse – or side-effects of medication. It may sometimes be difficult for prescribers and others to explain the complex relationship between medicines and therapeutic outcomes – which is why this is often boiled down to a ‘bite-sized’ statement such as ‘restoring chemical imbalances’.

2) I will get addicted/they will stop working after a while.

It is not possible to address these concerns as a blanket response for all medicines – certainly there are some medicines that will cause dependence/addiction and some that may become less effective over time.

However, this is not the case for all medicines and we should take an individualised approach to address such concerns.

In general, the medicines used to treat the symptoms of psychosis, depression and bipolar disorder do not become less effective over time.

If/when these treatments are stopped some people can experience problems of withdrawal – and/or a relapse/return of symptoms - so it is very important to explain – and plan for stopping treatment in line with a recognised plan when/if the time comes for tapering/withdrawal of treatment.

For most people long term (years) treatment with medication may be beneficial to help manage the distressing symptoms of psychosis – and/or to reduce the risks of relapse/return of symptoms.

The same is also true of people who have a diagnosis of bipolar disorder and taking medication to reduce the risks of relapse. Everyone taking medication should be regularly reviewed by their prescriber to ensure that the benefits of taking medication continue to outweigh any risks from treatment. If side-effects or medicine related problems emerge these should be addressed in line with best practice guidance.

3) Taking medication makes you weaker – strong people don’t need to take medication.

This is not true. However, there are certain conditions such as mild depression where taking medication may not be the best option, as the balance between benefits and harms is likely to be low. For some people medication may be a crucial, first-line option. Prematurely stopping – or failing to take medication in line with the prescription – could have devastating consequences for an individual.

Suggested reading

Electronic Medicines Compendium (EMC)

Medicines and Healthcare Products Regulatory Agency (MHRA)

The British National Formulary (BNF)

NHS Website Content on Medications and Psychiatry

Royal College of Psychiatrists Information on Antidepressants

The charities Rethink Mental Illness and Mind also have a good selection of information about antidepressants and other commonly used treatments.

Section 6

Acknowledgements

Authors

Dr Adrian Whittington

National Clinical Lead for Psychological Professions, NHS England (NHSE)

Dr Alison Brabban

National Clinical Advisor to AMH Programme, NHSE, Clinical Lead for Community Transformation, Tees, Esk and Wear Valleys NHS Foundation Trust

Additional authors

Trauma informed care in adult mental health (Section 2E)

Dr Amy Hardy

Consultant Clinical Psychologist, South London & Maudsley NHS Foundation Trust

Dr Eleanor Longden

Postdoctoral Service-User Research Manager, Greater Manchester Mental Health NHS Foundation Trust

Involving families and carers (Section 2G)

Dr Frank Burbach

Head of Outcomes, Innovation & Research, Healios Limited. Hon Senior Lecturer, University of Exeter

Working with distress (Section 3B)

Dr Rachel Smith

Consultant Clinical Psychologist, Tees, Esk and Wear Valleys NHS Foundation Trust

Collaborative care planning within the multi-disciplinary team (Section 4A) and Risk assessment, safety planning and safeguarding (Section 4B)

Michael Cowan

Care Programme Approach Lead Officer, Nursing and Governance, Tees, Esk and Wear Valleys NHS Foundation Trust

Matching and shaping interventions to people’s needs (Section 5A)

Liz Kell

Principal Lecturer for Academic Development; Senior Lecturer in Counselling and Psychological Therapies; Course Lead Post Graduate Certificate / Graduate Certificate Promoting Psychological Wellbeing (NHS Talking Therapies for anxiety and depression)

Behavioural activation using the GOALS programme (Section 5C) and Graded exposure using the GOALS programme (Section 5D)

Dr Helen Harding (Nee Waller)

Clinical Psychologist, South London and Maudsley NHS Foundation Trust

Teaching problem-solving skills (Section 5E)

Pamela Myles-Hooton

Director, Bespoke Mental Health

Encouraging good sleep (Section 5F)

Dr Felicity Waite

Research Clinical Psychologist and NIHR Research Fellow

Recognising and managing emotions (Section 5G)

Dr Christine Dunkley

Consultant Trainer, British Isles DBT Training Team, Wrexham

Guided self-help for Bulimia Nervosa and Binge-Eating Disorder (Section 5H)

Professor Glenn Waller

Department of Psychology, University of Sheffield, Clinical and Applied Psychology Unit

Dr Hannah Turner

Consultant Lead Clinical Psychologist, Southern Health NHS Foundation Trust, Eating Disorders Service

Building confidence (Section 5I)

Professor Daniel Freeman

Professor of Clinical Psychology, Department of Psychiatry, University of Oxford

Dr Felicity Waite

Research Clinical Psychologist. NIHR Research Fellow

Medication (Section 5J)

Peter Pratt

National Speciality Advisor for Mental Health Pharmacy, NHSE

Matthew Elswood

National Speciality Advisor for Mental Health Pharmacy, NHSE and Chief Pharmacist, Nottinghamshire Healthcare NHS Foundation Trust

Editorial Board

Dr Alison Brabban	National Clinical Advisor, NHSE (Co-Chair)
Dr Adrian Whittington	National Clinical Lead for Psychological Professions, NHSE (Co-Chair)
Suzanne Farrell	Programme Manager, Adult Mental Health, NHSE National
Rebecca Burgess-Dawson	National Clinical Lead, Mental Health Programme, WT&E, NHSE
Peter Rolland	Programme Lead, National Mental Health Programme, WT&E, NHSE
Dr Nicole Jamani	Director of Portfolio for Adult HI NHS Talking Therapies for anxiety and depression/CBT and SMHP Programmes; Clinical Psychologist & BABCP-accredited CBT Therapist; CEDAR, Psychology, College of Life and Environmental Sciences
Liz Kell	Principal Lecturer for Academic Development; Senior Lecturer in Counselling and Psychological Therapies; Course Lead Post Graduate Certificate / Graduate Certificate Promoting Psychological Wellbeing (NHS Talking Therapies for anxiety and depression)
Bryan Dalgleish-Warburton	Course Lead, University of Central Lancashire
Laura Lea	National Lead for Expert by Experience Involvement: Psychological Professions, NHSE
Sheena Foster	Expert by Experience (Carer)

Additional Acknowledgements

David Richards and Mark Whyte. Reach out. National Programme Student Materials to Support the Delivery of Training for Psychological Wellbeing Practitioners Delivering Low Intensity Interventions

GOALS manual: Professors Philippa Garety and Tom Craig, based at the Institute of Psychiatry, Psychology and Neuroscience, King's College London.

Rights reserved

The content of the Mental Health and Wellbeing Practitioner Training Manual remains the property of NHS England and is copyrighted © with all rights reserved except as below:

- You may download/ use the material for educational purposes, for private research, study, or in-house use only
- Health care professionals may use the material for use by themselves and in the course of their work for the NHS, their patients, their families, or carers
- You must not copy, distribute, or publish any material from this document without prior permission
- Any other use of copyrighted material belonging to NHS England should be requested through the contact us webpage

Section 6
Appendices

Appendix 1: MHWP-1 Person-centred Assessment Competence Scale

Student number: ______________________ **Date:** ______________________

Instructions

Mental Health and Wellbeing Practitioners (MHWP) will complete a video recorded simulated assessment with an actor playing the part of the service user. This simulation is expected to be of a fairly straightforward assessment but split across two 30-minute segments (with a break in between) to simulate an assessment across two contacts. This will allow the practitioner to demonstrate their skills in all aspects of the person-centred assessment.

The simulated assessment is rated by examiners using version of the Dreyfus competence scale (Dreyfus, 1989), as adapted within other competence rating systems such as the Cognitive Therapy Scale - Revised (CTS-R) which is used to rate competence in cognitive behavioural therapy. The principles in these instructions are drawn from the CTS-R (Blackburn, James, Milne and Reichelt, 2000). However, the key features in the MHWP assessment scale are specific to this role.

The following components of the assessment simulation are rated for competence. Scores for each component are weighted as listed:

- Introduction to the session (10%)
- Interpersonal skills (30%)
- Information gathering (40%)
- Information giving and shared decision-making (20%)

Each element is rated for competence on a seven-point scale (i.e. a 0-6 Likert scale), which extends from 0 where the practitioner did not adhere to that aspect (non-adherence) to 6 where there is adherence and very high skill. Thus, the scale assesses both adherence to method and skill of the practitioner.

To aid with the rating of items of the scale, an outline of the key features of each item is provided at the top of each section. The evidence examples in the key features tables for each section are designed to highlight elements of adherence, whereas the 0-6 competence scale for each section measures both competence and adherence. In rating, consider not just whether features were present, but the competence with which the whole section was delivered.

Incompetent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced Beginner	2	Evidence of competence, but numerous problems and lack of consistency
	3	Competent, but numerous problems and/or inconsistencies
Competent	4	Good features, but minor problems and/or inconsistencies
Proficient	5	Very good features, minimal problems and/or inconsistencies
Expert	6	Excellent performance, even in the face of service user difficulties

The key features in each component describe the important features that need to be considered when scoring each item. When rating each, you must first identify whether and to what extent the features are present. You must then consider whether the practitioner should be regarded as competent with the features. If the practitioner includes most of the key features and uses them appropriately (i.e. misses few relevant opportunities to use them), the practitioner should be rated very highly.

Introduction to the session – weighting 10%

Key features

	Clear evidence demonstrated (The practitioner fully demonstrated the criteria)	**Some evidence demonstrated** (The practitioner demonstrates part of the skill or limited skill)	**Not demonstrated** (Not demonstrated)
Introduces self by name	(e.g., Clearly states own full name)	(e.g., States first name only)	(e.g., Does not introduce or just uses role e.g. “I am a mental health and wellbeing practitioner”)
Elicits service user’s full name	(Finds out service user’s full name / preferred name)	(Finds out part of name e.g., first name)	(Fails to discover name or ascertains later during interview)
Role of the practitioner made clear	(“I am a mental health and wellbeing practitioner, my job is….”)	(Finds out part of name e.g., first name)	(Fails to discover name or ascertains later during interview)
Describes purpose/ agenda of interview	(Purpose stated e.g. “I will be asking you to tell me what your current difficulties are, then we will look at what our next steps could be”)	(Vague statements e.g., “I am going to interview you”)	(No purpose stated)
Explains confidentiality and its limits	(Principle of confidentiality set out clearly e.g., “what we discuss will be confidential within the care team”, with limits explicit, e.g., “unless I am concerned that you or someone else may be at risk of severe harm, or unless we agree that information can be shared with others”. Checks agreement for information sharing with family or carers).	(Some coverage but key elements poorly covered)	(Problematic or inappropriate)
Defines time scale for the interview	(Explicitly states time) e.g., “we have 60 minutes”)	(Vague statement about time scale e.g., “we only have a short time”)	(Time not mentioned)

Competence level: Introduction to the session - weighting 10%

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

Interpersonal skills - weighting 30%

Key features

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Displays empathy by verbal communication skills, e.g. “I realise that this is very distressing for you”	(At most appropriate points)	(At some appropriate points but some inconsistencies)	(Numerous problems or inappropriate)
Displays engagement by non-verbal cues, e.g., eye contact, posture, nods, facial expression	(Displays all / most of the time)	(Some evidence, but inconsistent)	(Numerous problems or inappropriate)
Acknowledges the problem by reflection, using the service user’s own words, e.g. “So, you felt that you were really overwhelmed by your emotions” or “so you felt really down”	(At most appropriate points)	(Some evidence, but inconsistent)	(Numerous problems or inappropriate)
Acknowledges the problem by summarising, e.g. “You have told me you are finding it really difficult to leave the flat... is that correct?”	(At most appropriate points)	(Some evidence, but inconsistent)	(Numerous problems or inappropriate)
Appropriate pacing of the session	(Does not rush or put pressure on the service user, but does keep making forward progress)	(Some evidence, but inconsistent – rushes, or does not make sufficient progress)	(Numerous problems or inappropriate)

Competence level: Interpersonal skills - weighting 30%

Incompetent

Novice

Advanced Beginner

Competent

Proficient

Expert

0 Absence of feature, or highly inappropriate performance

1 Inappropriate performance, with major problems evident

2 Evidence of competence, but numerous problems and lack of consistency

3 Competent, but numerous problems and/or inconsistencies

4 Good features, but minor problems and/or inconsistencies

5 Very good features, minimal problems and/or inconsistencies

6 Excellent performance, even in the face of service user difficulties

Information gathering – weighting 40%

Key features

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Uses person-centred interviewing and clear information gathering Uses a funnelling process to elicit person-centred problem identification by: • General open questions • Specific open questions • Closed questions • Summarising and clarification	(Full elements of process demonstrated appropriately)	(Some evidence / not all appropriate use, e.g., general open questions leading too quickly to closed questions without intervening stage)	(Numerous problems or inappropriate, e.g., mainly closed questioning or interrogative style)
Determines the impact of the problem on broader aspects of life linked to CHIME factors	(Clearly enquires including family, domestic, work, social, leisure, identifying impact on at least one CHIME factor).	(Vague or incompletely enquires, or not linked to any CHIME factors)	(Inappropriate or lacking)
Use of routine outcome measures	(Collaborative introduction and use of the required clinical outcome measures and feeds back results appropriately)	(Required clinical outcome measures used but with problems of application)	(Inappropriate or lacking)
Elicits **predisposing** factors	(Asks specific questions and follows answers	(Asks vaguely and fails to follow cues / or asks specifically but fails to obtain thorough info)	(Does not obtain sufficient information)

Information gathering (continued)

Key features (continued)

Elicits **precipitating** factors	(Asks specific questions and follows answers up to gain thorough understanding)	(Asks vaguely and fails to follow cues / or asks specifically but fails to obtain thorough info)	(Does not obtain information)
Elicits **perpetuating** factors	(Asks specific questions and follows answers up to gain thorough understanding)	(Asks vaguely and fails to follow cues / or asks specifically but fails to obtain thorough info)	(Does not obtain sufficient information)
Elicits **protective** factors	(Asks specific questions and follows answers up to gain thorough understanding)	(Asks vaguely and fails to follow cues / or asks specifically but fails to obtain thorough info)	(Does not obtain sufficient information)
Includes initial evaluation of risk and safeguarding issues **Intent:** Thoughts of harming self or other **Plans:** specific action plans **Actions:** current / past; access to the means **Prevention:** social network, services **Safeguarding:** Risks to service user or to vulnerable others appropriately followed up if disclosed.	(Appropriate initial risk and safeguarding evaluation matched to risk level articulated by service user)	(Risk and safeguarding investigated but with problematic gaps, or overly preoccupied with risk and safeguarding issues preventing progress with broader goals of the assessment)	(Inappropriate or lacking any discussion of risk or safeguarding) **AUTOMATIC FAIL**
Asks about other important issues such as why do they **want help now**, service user **hopes, past episodes and treatments, drugs and alcohol, current medication and attitude to this, other treatment, anything else** that has not been covered in the assessment that is relevant from both perspectives	(Clearly enquires including follow up of important leads from service user)	(Vague or incompletely enquires)	(Inappropriate or lacking)

Competence level: Information gathering - weighting 40%

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

Information giving and shared decision making – weighting 20%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Summarises with a problem statement, using the framework: CONTEXT, PROBLEM, IMPACT	(All used with appropriate language in service user's words, covering CONTEXT, PROBLEM, and IMPACT)	(Some demonstrated and / or in appropriate language, or elements missing)	(Vague / absent / poorly demonstrated)
Seeks service user's affirmation of problem statement	(Gives opportunity to revise statement)	(Presents statement but limited opportunity to revise)	(Inadequate attempt to seek service user's view)
Identifies goals using the Goal Based Outcome (GBO) tool	(Collaboratively identifies up to 3 goals using GBO tool, phrased appropriately using service user's language, as far as possible SMART)	(Attempt made to define initial goals using GBO tool, but some problems apparent)	(Inadequate or no attempt to define initial goals using GBO tool)
Agreed ending, which should include the information giving and shared decision-making regarding the next step. For example, support accessing other service or community resources, or initiating a specific psychologically-informed intervention. At the very least, this should include an agreement on next steps in terms of next contact arrangements.	(Session summarized and next steps agreed collaboratively with service user)	(Ending with no collaborative action plan)	(Inadequate or absent)

Competence level: Information giving and shared decision-making - weighting 20%

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

Summary of scores

		A	B	C
		Score (Must score a minimum of 3 on sections 2, 3 and 4)	**Weighting**	**Weighted score** **(Column A score x Column B weighting)**
1	**Introduction to the session**		**1**	
2	**Interpersonal skills**		**3**	
3	**Information gathering**		**4**	
4	**Information giving and shared decision making**		**2**	
	TOTAL WEIGHTED SCORE (pass = 30/60)			

References

Blackburn, I, M., James, I.A., Milne, D.L. and Reichelt, F.K. (2000). Cognitive Therapy Scale - Revised (CTS-R).

Dreyfus, H. L. (1989). The Dreyfus Model of Skill Acquisition. In J. Burke (ed.) Competency based education and training. London: Falmer Press

Appendix 2: MHWP-2 Psychological Intervention Competence Scale

Student number: ______________________ **Date:** ______________________

Instructions

The simulated/recorded intervention is rated by examiners using version of the Dreyfus competence scale (Dreyfus, 1989), as adapted within other competence rating systems such as the Cognitive Therapy Scale - Revised (CTS-R) which is used to rate competence in cognitive behavioural therapy. The principles in these instructions are drawn from the CTS-R (Blackburn, James, Milne and Reichelt, 2000). However, the key features in the MHWP assessment scale are specific to this role.

The following components of the psychologically informed intervention simulation / recording are rated for competence. Scores for each component are weighted as listed:

- Introduction (10%)
- Interpersonal skills (20%)
- Information gathering (20%)
- Information giving (20%)
- Shared decision making (20%)
- Ending (10%)

Each element is rated for competence on a seven-point scale (i.e., a 0-6 Likert scale), which extends from 0 where the practitioner did not adhere to that aspect (non-adherence) to 6 where there is adherence and very high skill. Thus, the scale assesses both adherence to method and skill of the practitioner.

To aid with the rating of items of the scale, an outline of the key features of each item is provided at the top of each section. The evidence examples in the key features tables for each section are designed to highlight elements of adherence, whereas the 0-6 competence scale for each section measures both competence and adherence.

In rating, consider not just whether features were present, but the competence with which the whole section was delivered.

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

The key features in each component describe the important features that need to be considered when scoring each item. When rating the item, you must first identify whether and to what extent the features are present. You must then consider whether the practitioner should be regarded as competent with the features. If the practitioner includes most of the key features and uses them appropriately (i.e., misses few relevant opportunities to use them), the practitioner should be rated very highly.

Introduction to the session – weighting 10%

Key features

	Clear evidence demonstrated (The practitioner fully demonstrated the criteria)	**Some evidence demonstrated** (The practitioner demonstrates part of the skill or limited skill)	**Not demonstrated** (Not demonstrated)
Describes purpose/ agenda of session	(Purpose stated e.g. “We will be reviewing what we discussed the last time we met and then we will look to make a start on tackling the problems that you described”)	(Vague statements e.g., “We are going to have a discussion and I will try to help”)	(No purpose stated)
Defines time scale for the session	(Explicitly states time) e.g., “we have 60 minutes”)	(Vague statement about time scale e.g., “we only have a short time”)	(Time not mentioned)

Competence level: Introduction to the session - weighting 10%

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

Interpersonal skills - weighting 20%

Key features

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Displays empathy by verbal communication skills e.g. “I realise that this is very distressing for you”	(At most appropriate points)	(At some appropriate points but some inconsistencies)	(Numerous problems or inappropriate)
Displays engagement by non-verbal cues e.g., eye contact, posture, nods, facial expression	(Displays all / most of the time)	(Some evidence, but inconsistent)	(Numerous problems or inappropriate)
Acknowledges the problem by reflection, using the service user’s own words e.g. “So, you felt that you were really overwhelmed by your emotions” or “So you felt really down”	(At most appropriate points)	(Some evidence, but inconsistent)	(Numerous problems or inappropriate)
Acknowledges the problem by summarising e.g. “You have told me you are finding it really difficult to leave the flat... is that correct?”	(At most appropriate points)	(Some evidence, but inconsistent)	(Numerous problems or inappropriate)
Appropriate pacing of the session	(Does not rush or put pressure on the service user, but does keep making forward progress)	(Some evidence, but inconsistent – rushes, or does not make sufficient progress)	(Numerous problems or inappropriate)

Competence level: Interpersonal skills - weighting 20%

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

Information gathering – weighting 20%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
a. Reminds service user about the main problem statement agreed at the last contact and b. ascertains whether there has been any change since the last contact	(Both evident in depth)	(Insufficiently evident – aspects missing)	(None evident)
Use of routine outcome measures	(Collaborative introduction and use of the required clinical outcome measures and feeds back results appropriately)	(Required clinical outcome measures used but with problems of application)	(Inappropriate or lacking)
Includes screen for any change to risk and safeguarding issues.	Appropriate risk screen and safeguarding review matched to risk level articulated by service user)	(Risk and safeguarding investigated attended to but either over or under-emphasised in context of risk level articulated)	(Inappropriate or lacking any discussion of risk or safeguarding)
AUTOMATIC FAIL			
Reviews service user's use of psychological intervention agreed at previous contact	(Clearly enquires of use, including depth of understanding, attitudes to the intervention including doubts and sticking points, activities undertaken	(Vaguely or incompletely enquires; does not use handouts service user between contacts)	(No enquiry made)

Competence level: Information gathering - weighting 20%

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

Information giving – weighting 20%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Introduction of intervention(s)	(More than one option discussed and understanding checked with service-user)	(Only one option discussed or previously selected intervention re-introduced without checking understanding)	(No discussion of options or previously selected intervention)
Rationale based on a unique 5 Areas formulation	(Unique 5-Areas formulation developed collaboratively with this service user is used to make rationale for specific intervention options explicit)	(5 Areas formulation used but significant gaps or problems with this or with linking it to the rationale for the specific intervention options)	(Major problems with rationale for intervention or with links to formulation)
Appropriate use of specific intervention content and process (written material and discussion) as set out in the MHWP practice guide	(Material and discussion content provided in an accessible format appropriate to the service user's needs Material used includes information relevant to the service user's main current problems and the selected intervention All material is discussed collaboratively with the service user)	(Little breadth or depth to material and discussion content presented and small amount of collaboration around the information)	(No material presented, or material not discussed at all)

Competence level: Information giving - weighting 20%

Incompetent

Novice

Advanced Beginner

Competent

Proficient

Expert

0 Absence of feature, or highly inappropriate performance

1 Inappropriate performance, with major problems evident

2 Evidence of competence, but numerous problems and lack of consistency

3 Competent, but numerous problems and/or inconsistencies

4 Good features, but minor problems and/or inconsistencies

5 Very good features, minimal problems and/or inconsistencies

6 Excellent performance, even in the face of service user difficulties

Shared decision making – weighting 20%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Action plans appropriate to the chosen intervention (as set out in the MHWP practitioner guide)	(Collaborative action plan arrived at for appropriate next steps with the intervention. The service user's understanding and attitude towards the plan is	(Action plan agreed but no understanding or attitude checked)	(Either no action plan or plan imposed by practitioner without collaboration)
Method of implementation appropriate to the chosen intervention (as set out in the MHWP practitioner guide)	(Method progressed collaboratively with service user. Method includes an appropriate schedule of inter- sessional activity for the chosen intervention, by service user and/ or practitioner)	(Method incorrectly applied or problems evident)	(Major problems with identifying method for implementation)

Competence level: Shared decision making - weighting 20%

Incompetent
Novice
Advanced Beginner
Competent
Proficient
Expert

0 Absence of feature, or highly inappropriate performance
1 Inappropriate performance, with major problems evident
2 Evidence of competence, but numerous problems and lack of consistency
3 Competent, but numerous problems and/or inconsistencies
4 Good features, but minor problems and/or inconsistencies
5 Very good features, minimal problems and/or inconsistencies
6 Excellent performance, even in the face of service user difficulties

Ending – weighting 10%

	Clear evidence demonstrated	Some evidence demonstrated	Not demonstrated
Summary of session	(Practitioner summarises the whole session and seeks agreement from service user)	(Brief summary and/or no agreement from service user sought)	(No summary)
Next steps agreed	(Collaborative agreement of next step with feedback from service user to check understanding)	(Next steps agreed with no check of understanding)	(No next steps or very vague decision for the future)

Competence level: Ending - weighting 10%

Incompetent	0	Absence of feature, or highly inappropriate performance
Novice	1	Inappropriate performance, with major problems evident
Advanced Beginner	2	Evidence of competence, but numerous problems and lack of consistency
Competent	3	Competent, but numerous problems and/or inconsistencies
Proficient	4	Good features, but minor problems and/or inconsistencies
Expert	5	Very good features, minimal problems and/or inconsistencies
	6	Excellent performance, even in the face of service user difficulties

Summary of scores

		A	B	C
		Score (Must score a minimum of 3 on sections 2, 3, 4 and 5)	Weighting	Weighted score (Column A score x Column B weighting)
1	**Introduction to the session**		1	
2	**Interpersonal skills**		2	
3	**Information gathering**		2	
4	**Information giving**		2	
5	**Shared decision making**		2	
6	**Ending**		1	
	TOTAL WEIGHTED SCORE (pass = 30/60)			

References

Blackburn, I, M., James, I.A., Milne, D.L. and Reichelt, F.K. (2000). Cognitive Therapy Scale - Revised (CTS-R).

Dreyfus, H. L. (1989). The Dreyfus model of skill acquisition. In J. Burke (ed.) Competency-based Education and Training. London: Falmer Press

Appendix 3: Practice Portfolio

1.Trainee and site supervisor details

Trainee	
Name	
Job title	
Email address	

Site supervisor	
Name	
Job title	
Email address	

2. Practice outcomes

Component 1 practice outcomes	**Site supervisor signature to confirm**
1A Demonstrates the common factor competencies necessary to engage effectively and involve families and carers in line with the service user's and their family's needs	
1B Demonstrates competence in undertaking assessments across a range of presenting problems	
1C Demonstrates competence in the generation of 5 P formulations with clients (potentially using the Stress Bucket to do this)	
Component 2 practice outcomes	
2A Demonstrates competence in the mobilisation of appropriate resources with service users	
2B Demonstrates high-quality use of clinical information systems and effective correspondence	
2C Demonstrates effective use of clinical supervision and self-care	
Component 3 practice outcomes	
3A Demonstrates the ability to set appropriate goals for intervention collaboratively with service users	
3B Demonstrates competence to deliver all specified interventions in practice	

3B (i) Behavioural Activation and Graded Exposure using the “GOALS” programme

3B (ii) Teaching problem - solving skills

3B (iii) Improving sleep

3B (iv) Recognising and managing emotions

3B (v) Guided self - help for bulimia and binge - eating

3B (vi) Building confidence

3B (vii) Medication support – based on information - giving

3. Clinical contact hours

Service user ID (anonymised)	**Total clinical contact hours**	**Name of psychological intervention delivered if applicable** (from list of seven)	**Clinical contact hours delivering one of the seven psychological interventions**	**Paired scores on GBO obtained (must have paired scores for minimum of 36 intervention hours)** (please tick)	**Paired scores on ReQoL - 10 obtained (must have paired scores for minimum of 36 intervention hours)** (please tick)
	Total = **(Must be at least 80)**		**Total =** **(Must be at least 40)**		

3. Clinical supervision hours

Case management supervision (weekly, individual)
The entire caseload is reviewed and action agreed if there is current high risk, an increase in risk or a regular monthly review of the care plan is due. Supervisor to be any suitably qualified member of the team

Date	Hours	Supervisor name
	Total = **(Must be at least 20)**	

Clinical skills supervision (weekly or fortnightly, individual or group) Development of clinical skills - supervisor to be Health and Care Professions Council registered clinical psychologist, British Association for Behavioural & Cognitive Psychotherapies Accredited CBT Therapist, or MHWP with two years post - qualification experience

Date	Hours	Supervisor name
	Total = **(Must be at least 20)**	

5. Declaration

This practice portfolio is a true and accurate reflection of work undertake

Trainee signature

Site supervisor signature