NHS
Health Education England

Psychological interventions for people with eating disorders: A competence framework

Developing people
for health and
healthcare

www.hee.nhs.uk

THE NHS
CONSTITUTION
the NHS belongs to us all

Psychological interventions for people with eating disorders: A competence framework

The competences described in this report are designed to be accessed online andshould be downloaded from the University College London (UCL) website.

Authors

Professor Anthony Roth, Research Department of Clinical, Educational and Health Psychology, UCL

Professor Stephen Pilling, Director of CORE, Director of the National Collaborating Centre for Mental Health, Research Department of Clinical, Educational and Health Psychology, UCL

Expert reference group (ERG)

The work was overseen by an Expert Reference Group, whose invaluable advice, editorial comments and collegial approach contributed enormously to the development ofthe work. The ERG comprised:

Professor Ulrike Schmidt, Professor of Eating Disorders, Institute of Psychiatry,Psychology and Neuroscience, King's College London in London

Professor Lucy Serpell, Associate Professor in the Psychology of Eating Disorders, University College London

Professor Glen Waller, Professor of Clinical Psychology, University of Sheffield

Peer reviewers

We are very grateful to the following reviewers for their comments:

Professor Gini McIntosh, Associate Professor of Psychology, University of Canterbury, New Zealand

Professor Stephan Zipfel, Professor of Psychosomatic Medicine and Psychotherapy at the University of Tübingen

Psychological interventions for people with eating disorders: A competence framework

Contents

Authors 2
Expert reference group (ERG) 2
Peer reviewers 2
Executive summary 4
How to use this document 5
Scope of the Framework 5
The development of the Framework 5
Oversight and peer-review 5
Adopting an evidence-based approach to framework development 6
Inclusion and exclusion of specific interventions 6
Extracting competence descriptions 6
The competence model for psychological interventions for people with eating disorders 7
Organising the competence lists 7
Figure 1: Outline model for the framework 8
Specifying the competences needed to deliver assessments and interventions 9
The map of competences 9
Layout of the competence lists 9
Figure 2: The map of competences for working with people with eating disorder 11
Implementing the Framework 12
Do all clinicians need to be able to do everything specified in thecompetence list? 12
Is every competence in a competence list of equal importance? 12
Does this mean that clinicians can use their judgment to decidewhich elements of an intervention to include and which to ignore? 12
The impact of treatment formats on clinical effectiveness 13
The contribution of training and supervision to clinical outcomes 13
Applying the Framework 15
Commissioning 15
Service organisation – the management and delivery of services 15
Clinical governance 16
Supervision 16
Training 16
Research 16
Concluding comments 17
References 18

Executive summary

The report describes a method for identifying competences for staff working with people with eating disorders. It organises the competences into six domains.

The first domain ('Core professional competences for work with people with eating disorders') covers competences that should be demonstrated by all healthcare staff delivering psychological interventions.

The next domain ('Generic therapeutic competences') identifies the knowledge and skills needed for managing clinical sessions and any form of psychological intervention.

The third domain identifies the knowledge of eating disorders that would be needed by professional staff.

The fourth domain identifies competences relevant to assessment, formulation engagement and planning an intervention.

The penultimate domain identifies a number of specific interventions, subdivided into:

a) self-help interventions
b) face-to-face interventions
c) modes of working that are relevant across intervention models: working with families and carers, working with groups, and adapting interventions when working with young people.

The final domain identifies meta-competences – overarching, higher-order competences that practitioners need to use to guide the implementation of any assessment or intervention.

The report then describes how the competences are organised into a 'map', showing how the competences fit together and inter-relate. Finally, it addresses issues that are relevant to the implementation of the competence framework for people with eating disorders (referred to as 'the Framework), and considers some of the organisational issues around its application.

How to use this document

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

The report does not include the detailed descriptions of the competences associated with each of these activities. These are available to download as PDF files from the website of the Centre for Outcomes Research and Effectiveness (CORE) at UCL.

Scope of the Framework

The Framework is relevant to professionals working with people with eating disorders. It is not an exhaustive list of all the activities undertaken by clinicians; it is primarily focused on clinical work, and excludes service management and development skills.
Audit and research skills are not specified, though the ability to make use of measures (and to monitor outcomes) is identified as a core clinical skill, as is the ability to make informed use of the evidence base relating to therapeutic models.

The face-to-face interventions included in the Framework cover a number of modalities, and clinicians will need appropriate training in these modalities in order to adapt them for work with people with eating disorders. Separate frameworks identify these competences – specifically, the frameworks for CBT, for Psychodynamic Therapy and for Systemic Therapy (all available at the UCL website).

Supervision clearly plays a critical role in supporting the development of competences, and the ability to make use of supervision is included in the Framework. Competences associated with the delivery of supervision are detailed in a separate framework, also available at the UCL website.

The development of the Framework

Oversight and peer-review

The work described in this project was overseen by an expert reference group (ERG) comprising experts in working with people with eating disorders, selected for their expertise in research, training and service delivery. As well as a face-to face meeting, the ERG advised on process, and debated and reviewed materials as they emerged.

In addition to review by the ERG, competence lists for specific interventions were reviewed by individuals with particular expertise in that intervention. This process of open and iterative peer-review ensured that the competence lists were subject to a high level of scrutiny.

Psychological interventions for people with eating disorders: A competence framework

Adopting an evidence-based approach to framework development[1]

A guiding principle for the development of previous frameworks (Roth and Pilling, 2008) has been a commitment to staying close to the evidence-base for the efficacy of therapies, focusing on those competences for which there is either good research evidence or strong expert professional consensus about their probable efficacy.

Inclusion and exclusion of specific interventions

An initial task for the ERG was to identify those interventions with evidence of efficacy, based on outcomes obtained in clinical controlled trials. This scoping exercise was based on extant clinical guidelines and reviews of the available evidence, in particular of relevant National Institute for Health and Care Excellence (NICE) and Scottish Intercollegiate Guidelines Network (SIGN) clinical guidelines. This exercise identified the interventions for which there was good evidence of efficacy.

Extracting competence descriptions

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

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

The competence model for psychological interventions for people with eating disorders

Organising the competence lists

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

Figure 1 shows the six domains into which the competences have been organised.

The first domain identifies **core professional competences for work with people with eating disorders** – the knowledge and skills needed by staff to operate in a professional context.

The second domain (**generic therapeutic competences**) identifies the competences required to manage clinical sessions and any form of psychological intervention.

The third domain identifies the areas of **knowledge of eating disorders** that professionals will need when working with these presentations.

The penultimate domain relates to psychological **interventions** for eating disorders, and is subdivided into three sections. The first identifies skills and knowledge relevant to instituting self-help interventions. The second identifies specific face-to-face psychological interventions for people with eating disorders (all of which assume prior training in the relevant modalities). The final subsection identifies modes of working that commonly arise in this area – working with groups, working with families and carers, and adapting interventions for work with young people.

The final domain in the model focuses on **meta-competences**, so-called because they permeate all areas of practice, from 'underpinning' skills through to specific interventions. Meta-competences involve making procedural judgments – for example, judging if and when something needs to be done, or judging the ways in which an action needs to be taken or to be modified. They are important because these sorts of judgments are seen by most clinicians as critical to the fluent delivery of an intervention; effective implementation requires more than the rote application of a simple set of 'rules': meta-competences attempt to spell out some of the more important areas of judgment being made.

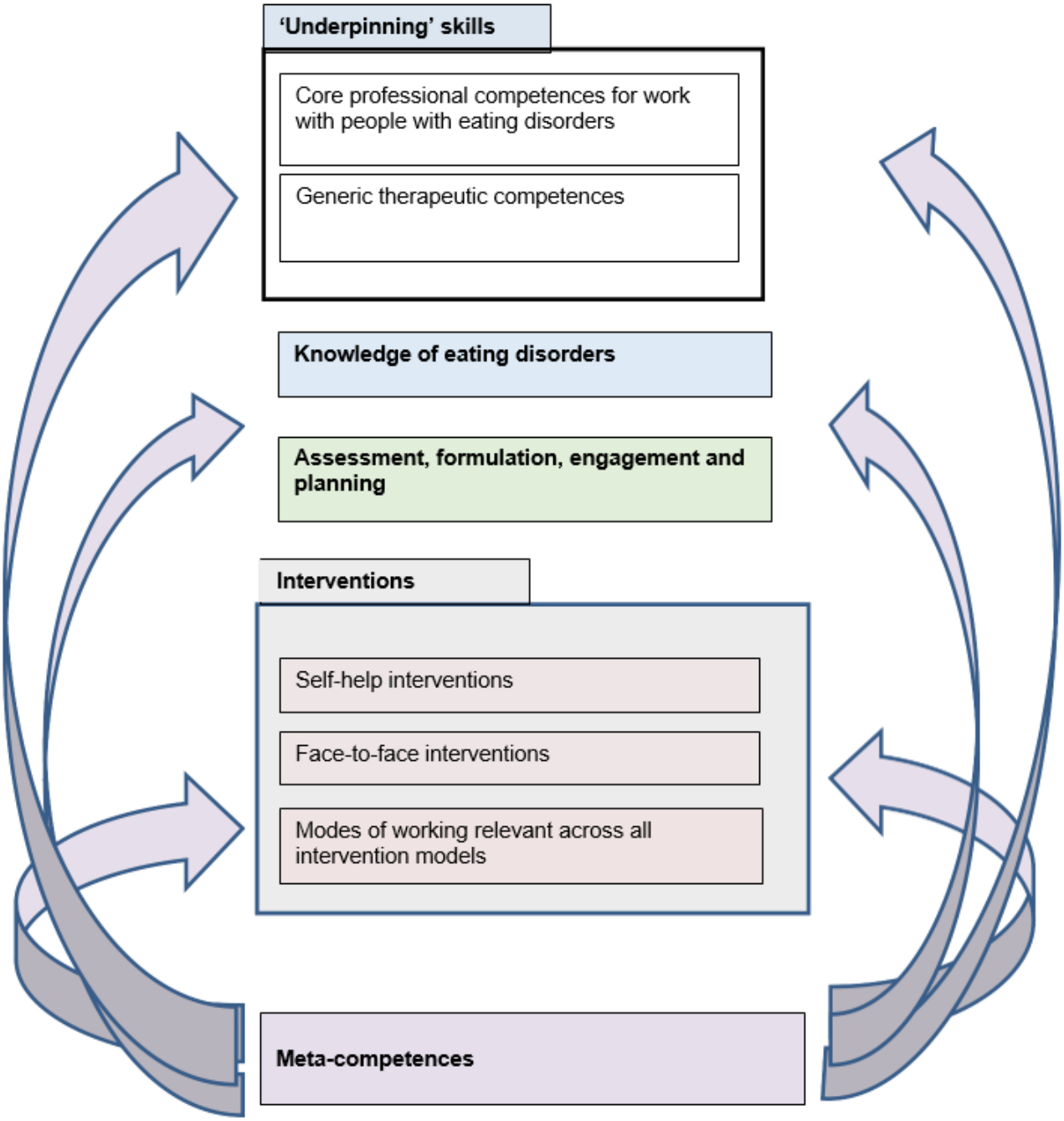

Figure 1: Outline model for the framework

Specifying the competences needed to deliver assessments and interventions

Integrating knowledge, skills and attitudes

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

Clinicians need background knowledge relevant to their practice, but it is the ability to draw on and apply this knowledge in clinical situations that marks out competence.
Knowledge helps the practitioner understand the rationale for applying their skills, to think not just about how to implement their skills, but also why they are implementing them. Beyond knowledge and skills, the clinician's attitude to and stance on an intervention is also critical – not just their attitude to the relationship with the client but also to the organisation in which the intervention is offered, and the many cultural contexts within which the organisation is located (including a professional and ethical, as well as societal, context). All of these need to be held in mind because all have a bearing on the capacity to deliver interventions that are ethical, conform to professional standards, and that are appropriately adapted to the client's needs and cultural contexts.

The map of competences

Using the map

The map of competences is shown in Figure 2. In the map, the competences have been organised into the six domains outlined above and in Figure 1, and shows the different activities which, taken together, constitute each domain. Each activity is made up of a set of specific competences. The details of these competences are not included in this report, but can be downloaded from the UCL website.

The map shows how the activities fit together and how they need to be 'assembled' for practice to be proficient. The orange dotted 'box' indicates the domains or competences that are specific to working with people with eating disorders.

Layout of the competence lists

Specific competences are set out in boxes.

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

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

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

Some of the boxes are indented, when a high-level skill is introduced and needs to be 'unpacked'. In the example below, the high-level skill is the notion of being 'collaborative and

empowering'; the indented boxes that follow are concrete examples of what the clinician needs to do to achieve this.

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

The competences in indented boxes will make most sense if the clinician holds in mind the high-level skill that precedes them. So, with the above example, although using plain language is always a sensible thing to do, there is a very good conceptual reason for emphasising its use here: it will impact on (and, therefore, contribute to) clients' sense of collaboration in and engagement with the therapy process. Bearing in mind that the conceptual idea behind an action should give the clinician a 'road map', and reduce the likelihood that they apply techniques by rote.

Psychological interventions for people with eating disorders: A competence framework

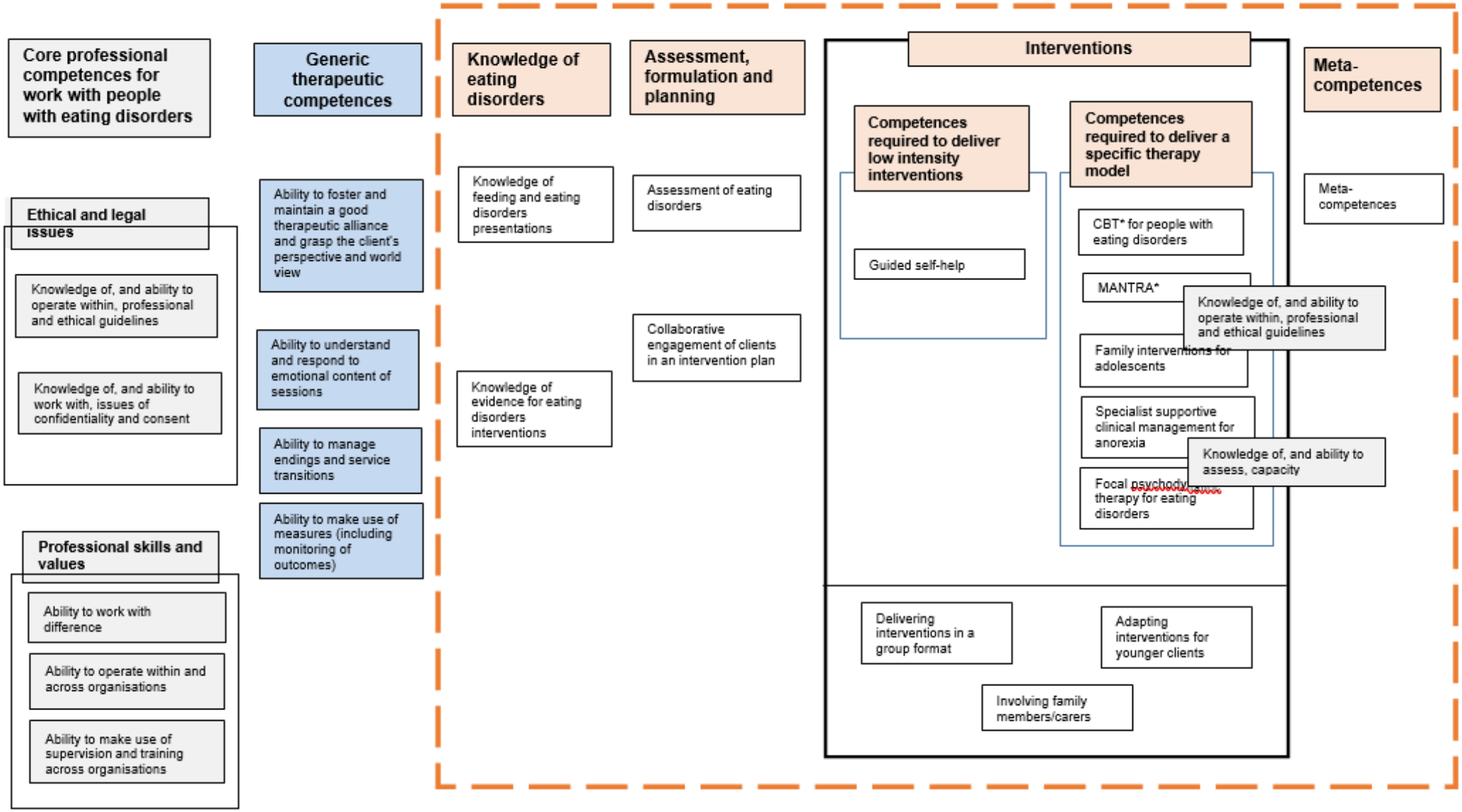

Figure 2: The map of competences for working with people with eating disorders

* Note: CBT = cognitive behavioural therapy; MANTRA = Maudsley Model of Anorexia Treatment in Adults

Implementing the Framework

A number of issues are relevant to the practical application of the Framework, and theseare discussed below.

Do all clinicians need to be able to do everything specified in the competence list?

All clinicians would be expected to be able to demonstrate 'underpinning' skills (core professional skills, generic therapeutic competences, and knowledge of eating disorders).

Whether or not an individual clinician will demonstrate competence in specific interventions will depend on their having had the appropriate training and supervision tocarry out the procedures and interventions that are listed in these sections.

Is every competence in a competence list of equal importance?

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

Does this mean that clinicians can use their judgment to decide which elements of an intervention to include and which to ignore?

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

Another factor is that most interventions evolve over time, especially as research helpsto identify the elements that make a difference and are associated with efficacy.
However, it can take some time before research validates the benefit of innovations, and, as a

consequence, there is often a lag between the emergence of new ideas and their inclusion in clinical guidelines. This means that intervention packages should not be viewed as tablets of stone – though equally this is not a reason for clinicians to adopt 'pick-and-mix' approach to the competences they incorporate into a 'standard' treatment.

The impact of treatment formats on clinical effectiveness

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

When implemented in routine services, treatment formats often deviate from the schedules used in research trials. This can be for a range of reasons, but it is reasonable to ask whether making significant changes to the format may impact on effectiveness. This is a difficult question to answer because, on the whole, there is little research evidence on which to draw. However, where research has been conducted – for example, in the area of parenting programmes – it suggests that better outcomes are achieved when therapists show greater fidelity to the procedures set out in the manuals (for example, Eames, Daley, Hutchings, Whitaker, Jones, Hughes, & Bywater, 2009). It is also the case that fidelity in parenting programmes is best conceived as adherence to a number of overarching areas of activity (for example, an ability to apply social learning theory, a capacity to work with group process while also attending to each individual parent, and an ability to assure access and active support to maintain the engagement and involvement of parents). As such, there is much that could be neglected if clinicians deliver bespoke programmes that include only some of these areas. Generalising this observation across all interventions, it suggests that when clinicians vary a 'standard' treatment procedure they should have a clear rationale for doing so, and that where procedures are varied there should be careful monitoring and benchmarking of clinical outcomes to detect whether this has a neutral or an adverse impact.

The contribution of training and supervision to clinical outcomes

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

It may be unhelpful to see the treatment procedure alone as the evidence-based

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

Applying the Framework

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

Commissioning

The Framework can contribute to the effective use of healthcare resources by enabling commissioners to specify the appropriate levels and range of competences that need to be demonstrated by workers to meet identified local needs. It could also contribute to the development of more evidence-based systems for the quality monitoring of commissioned services by setting out a framework for competences that is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and delivery of services

The Framework represents a set of competences that (wherever possible) are evidence-based, and it aims to describe best practice for the activities that individuals and teams should follow to deliver interventions.

Although further work is required on their utility and on associated methods of measurement, the competences should enable:

- the identification of the key competences required by a practitioner
- the identification of the range of competences that a service or team would need to meet the needs of the populations with whom they work
- the likely training and supervision competences of people managing and delivering the service.

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

Clinical governance

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

The introduction of the Framework into clinical governance can be achieved through local implementation plans (including those for NICE/ SIGN guidance) and their monitoring through the local audits procedures as well as by the monitoring systems oforganisations such as the Care Quality Commission.

Supervision

Used in conjunction with the competence framework for supervision, the Framework is potentially a useful tool to improve the quality of supervision for psychological interventions. It does this by focusing the task of supervision on a set of competences that are known to be associated with the delivery of effective treatments. Supervision commonly has two aims – to improve outcomes for clients and to improve the performance of practitioners; the Framework will support both these through:

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

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

Training

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

- providing a clear set of competences that can guide and refine the structure andcurriculum of training programmes, including pre- and post-qualification professional training as well as the training offered by independent organisations
- providing a system for the evaluation of the outcome of training programmes.

Research

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

Concluding comments

This report describes a model that identifies the activities that characterise effective assessments and interventions with people with eating disorders, and locates them in a 'map' of competences.

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

Putting the model into practice – whether as an aid to curriculum development, training, supervision, quality monitoring or commissioning – will test its worth, and indicate the ways in which it needs to be developed and revised. However, implementation needs to be holistic: competences tend to operate in synchrony, and the model should not be seen as a cookbook. Delivering effective interventions involves the application of parallel sets of knowledge and skills, and any temptation to reduce it to a collection of disaggregated activities should be avoided. Clinicians need to operate using clinical judgment in combination with their technical and professional skills, interweaving technique with a consistent regard for the relationship between themselves and service users.

Setting out competences in a way that clarifies the activities associated with a skilled and effective practitioner should prove useful for clinicians working in services for people with eating disorders. The more stringent test is whether it results in more effective interventions and better outcomes for clients of these services.

References

Eames C, Daley D, Hutchings J, Whitaker CJ, Jones K, Hughes JC & Bywater T. Treatment fidelity as a predictor of behaviour change in parents attending group-based parent training. *Child: Care Health and Development.* 2009;*35*:603–12.

Elkin I. A major dilemma in psychotherapy outcome research: Disentangling therapists from therapies. *Clinical Psychology: Science and Practice*. 1999;*6*:10–32.

Roth AD & Pilling S. Using an evidence-based methodology to identify the competences required to deliver effective cognitive and behavioural therapy for depression and anxiety disorders. *Behavioural and Cognitive Psychotherapy*. 2008;*36*:129–47.

Roth AD, Pilling S & Turner J. Therapist Training and Supervision in Clinical Trials: Implications for Clinical Practice. *Behavioural and Cognitive Psychotherapy*. 2010;*38*:291–302.