

National Curriculum for Psychological Wellbeing Practitioner (PWP) Programmes



Fourth Edition (updated and revised July 2022)

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Key Changes to the Fourth Edition:

1. Greater emphasis on anti-discriminatory and anti-racist practice
2. Requirement to have meaningful involvement of experts by experience in all programmes
3. Requirement for all programmes to offer an adapted route for part-time trainees
4. Specification of a minimum of 15 days of in person teaching time (when safe to offer this), with commitment to a review of evidence in relation to the effectiveness of this blend.
5. Specification of a minimum of 30 days of synchronous teaching (was 25-30)
6. Increased focus on assessment skills including:
 - a. Understanding the patient's cognitions / world view as relevant to Step 2 work (with focus on here and now)
 - b. Identification of primary problem in context of co-morbidity (mental and physical health)
 - c. Evidence based selection of intervention/stepping up/signposting/onward referral
7. Naming of specific exclusions from PWP work including PTSD and social anxiety disorder
8. Recognition of learning opportunity under supervision to deliver evidence-based guided self-help groups, and that these can count towards up to 10 practice hours.
9. Requirement to develop competence across modes of delivery including in person, video, telephone
10. Increased emphasis on effective use of patient reported outcome measures to select and guide interventions
11. Requirement for trainees to understand the purpose and meaning of NHS Talking Therapies metrics
12. Specification of clinical skills supervision groups being no larger than 12 participants, and that there should also be opportunities to observe experienced PWPs in practice.
13. Specification of a minimum of 10 days self-directed study time (pro rata for part time trainees).
14. Specification of included PWP interventions (with greater emphasis on guided self-help as the defining feature) addition of reference to behavioural experiments as a component of cognitive restructuring, addition of reference to worry management, and to specifically include GSH interventions for OCD and panic disorder. Explicit inclusion of multiple "strands" with one patient which are linked to the patient's goals.
15. Specification that Module 2 should be assessed by an audio or video recorded session with a real patient.
16. Addition of M3 Learning Outcome on awareness of VCSE organisations in the community
17. Proposed addition of a further recording of a part-session in M3
18. More detail on supervision requirements incorporated from the NHS Talking Therapies Manual
19. Reference to the post-qualification preceptorship guidance
20. Reference to the need to complete Long Term Conditions top-up training within two years after qualification
21. Specification of accepted PWP competence assessment scales

1. Introduction

1.1 NHS Talking Therapies for Anxiety and Depression

The NHS Talking Therapies for Anxiety and Depression (formerly Improving Access to Psychological Therapies; IAPT) programme was established across England in 2008 with the aim of creating psychological therapy services to enable many more people to receive evidence-based, NICE approved psychological therapies and interventions for common mental health problems. NICE recommends a stepped care approach to the management of many cases of depression and to some, but not all, anxiety disorders. A key objective of the NHS Talking Therapies programme is to develop a competent workforce to deliver the stepped care model, with Psychological Wellbeing Practitioners (PWPs) vital to delivery.

The NHS Talking Therapies service delivery model is predicated on a stepped care model with PWPs supporting low-intensity interventions and high-intensity workers delivering CBT or one of the other NHS Talking Therapies approved modalities: Brief Dynamic Interpersonal Therapy for Depression (DIT), Counselling for Depression (CfD), Interpersonal Psychotherapy for Depression (IPT), Couples Therapy for Depression (CTfD), Behavioural Couples Therapy for Depression (BCT), Eye Movement Desensitisation and Reprocessing (EMDR) for PTSD and Mindfulness Based Cognitive Therapy (MBCT) as a relapse prevention intervention for recurrent depression currently in remission. It is important that PWPs have an understanding of the other modalities and how their work differs from high-intensity interventions. More information about the other modalities can be found in the [NHS Talking Therapies Manual](#).

PWPs assess and support patients with depression and/or anxiety disorders that can benefit from brief, standalone psychological interventions. Certain disorders (notably post-traumatic stress disorder and social anxiety disorder) should always be treated with high intensity interventions at Step 3 and so should not be treated at Step 2 by PWPs¹. The evidence-based low-intensity psychological interventions used by PWPs are informed by cognitive behavioral principles but also include physical activity and supporting medication adherence. PWPs also use interventions based on the COM-B behavior change model.

PWPs work in NHS Talking Therapies services providing the low-intensity (Step 2) component of the stepped care model through a range of modes of delivery linked to service user choice. Delivery modes include one-to-one treatment and guided self-help groups both of which can be in person and via video consultation. One-to-one sessions can also be delivered via telephone, interactive text or computerised cognitive behavioural therapy (cCBT).

Trainees will need to be competent in delivering low-intensity interventions via all of these modes. In working digitally with patients, it is important that PWPs adhere to the usual professional and ethical guidelines that guide their practice. PWPs should pay particular attention to issues of client consent and participation, equity of access and choice. [HEE's Health and Care Digital capabilities framework](#), and [Digital Health Skills' digital competency framework](#), which is specific to PWPs, should be consulted.

NICE guidance for each of the anxiety disorders and depression sets out the range of different types of low-intensity evidence-based interventions appropriate for delivery by PWPs. These include behavioural activation, graded exposure, cognitive restructuring, managing panic,

¹ See the [NHS Talking Therapies Manual](#) for the full list of disorders which should be treated at different levels of the stepped care model

problem solving, sleep hygiene, worry management and supporting physical activity and medication adherence. Typically, the PWP supports the use of guided self-help materials which can be provided in written or digital form. Low-intensity psychological treatments place a greater emphasis on patient self-management than traditional psychological treatments. Support is specifically designed to enable patients to optimise their use of self-management recovery information and may be delivered through a range of methods (as described above).

PWP training should ensure that all trainees reach a level of competence that would enable them to deliver Step 2 treatment as recommended in the relevant NICE Guidelines for anxiety and depression. It will also be necessary for trainees to be familiar with the management of issues that are commonly co-morbid with depression and anxiety, such as substance misuse and physical health co-morbidities.

PWP interventions aim to have a meaningful impact on patients' lives, improving social inclusion, employment and community connection, as well as symptoms. Trainees will therefore need to be able to assess individual's employment needs and develop close working relationships with employment advisors in order to maximise the chance that patients will be able to return to work where appropriate.

PWPs operate within the NHS Talking Therapies service delivery model which requires the routine sessional collection of clinical, social and employment outcomes as part of a national outcome monitoring system. The performance of PWPs will, therefore, be measured through these outcomes.

Trainees will need to understand the patient benefits of the NHS Talking Therapies metrics and be able to use the NHS Talking Therapies national outcomes monitoring system (which includes session-by-session symptom measures). Teaching should also include how to use anxiety disorder specific measures to support correct problem identification, assess outcome and guide therapy and why the use of these outcome measures is important. Teaching should focus on taking a broad perspective when it comes to the use of NHS Talking Therapies metrics to gain a holistic picture of the client². Knowledge of NHS Talking Therapies services including the stepped care model of service delivery, regular and routine clinical outcomes measurement, case management and supervision are generic competencies that all PWPs require for the satisfactory performance of their duties. Trainees will need to be familiar with all aspects of the [NHS Talking Therapies Manual](#), paying close attention to those that relate directly to the PWP role. The [UCL competency framework for cognitive and behavioural therapy](#) should also be consulted.

1.2 The Role of Supervision

PWPs should operate at all times within the stepped care model of service delivery in which the NHS Talking Therapies minimum levels of PWP supervision are provided, in line with the [NHS Talking Therapies Manual](#). Training courses should accordingly have systems in place for monitoring the supervision that trainees receive and the training and experience of their supervisors in the NHS Talking Therapies services where they are employed. Supervisors of trainee PWPs should all have undertaken appropriate training (and refresher training) on PWP supervision and receive supervision of supervision. Guidance on NHS Talking Therapies supervision is available in the [NHS Talking Therapies Manual](#): PWP trainees should receive both case management supervision (individual, 1 hour per week) and clinical skills supervision (at least 1 hour per fortnight).

Small group supervision that is proportionally longer in duration can also be effective for clinical skills supervision.

- Case discussion should be informed by outcome measures.
- Regular live or recorded observation should take place within supervision to allow detailed

² See the [NHS Talking Therapies Manual](#) for more details

feedback on practice issues and fidelity to the model, including the use of fidelity/competence rating scales. A minimum of two live observations with a PWP competence rating scale should be conducted per year.

- Discussion of clinical cases should be prioritised according to need as determined by trainees and supervisors.
- Cultural competence and reasonable adjustments should be considered, as well as how supervision can support the supervisee to meet individual need.

1.3 Course Structure and Accreditation

Training providers need to work in close liaison with the service providers and this needs to be built into the course structure, for example, through integrated plans for supervision, visits to place of employment by course staff, etc. Quality standards for services are set out in detail in the [NHS Talking Therapies Manual](#).

Course accreditation standards for PWP Education have been developed and are linked to the National PWP curriculum. [Courses must be accredited by the British Psychological Society \(BPS\)](#). This supports fidelity to the curriculum and ensures that national minimum levels of competency in the provision of low-intensity interventions are maintained.

The curriculum is designed so that it can be available at both undergraduate (level 6) and postgraduate certificate level (level 7), based on three modules (see below) delivered over 45 days in total. This number of days is essential to meet the learning objectives specified within the curriculum. Although each module has a specific set of foci and learning outcomes, the clinical competences build on each other and courses are expected to focus the majority of their teaching activity on clinical competence development in all modes of delivery (in person, by telephone and by video platform) through clinical simulation/role play. Courses need to ensure trainees have the opportunity to gain and develop clinical competences prior to these being assessed. Assessment focuses primarily on trainees' practical demonstration of competencies. Skills based competency assessments are independent of academic level and must be passed. Participants may not necessarily possess previous clinical or professional expertise in mental health and can undertake academic assessments at either undergraduate or postgraduate level, depending on their prior academic attainment.

Most courses are likely to run as a one-year course (if full time) or up to two years (if part-time). The curriculum includes both theoretical learning and skills practice within the Higher Education Institute and practice-based learning directed by the education provider that extends learning into practice. Over the 3 modules totaling 45 days, at least 30 days are delivered as synchronous theoretical learning and skills practice and up to 15 days as directed practice-based learning.

A minimum of 15 days (including a minimum of 5 days for Module 1 and 5 days for Module 2) should be provided via in person classroom learning³. Directed practice-based learning tasks include shadowing/observation, role play/practice with peers/colleagues of assessment and interventions, self-practice of interventions with reflection (i.e., applying techniques to issues from own life) and directed problem-based learning.

Shadowing opportunities can be provided in different ways, including live shadowing of

³ Unless exceptional arrangements are required because of public health restrictions.

practitioner or supervisors recording sessions and making these available to trainees for learning purposes. Self-directed study is not counted within the 45 days allocated for the three modules and should be provided by employers in addition. Full time trainees would be expected to have a minimum of 10 additional days for course-related work across the calendar year. Part time trainees would be subject to suitably adapted arrangements.

The training programme requires trainees to learn from observation and skills practice under supervision while working in fully functioning NHS Talking Therapies for Anxiety and Depression services, as well as through the theoretical teaching, skills practice and practice-based learning directed by the Higher Education Institute. Trainees should complete a minimum total of 80 clinical contact hours with patients (in person, by telephone or by video platform; including a good spread of both assessment hours and a range of intervention hours) within an NHS Talking Therapies service as a requirement of their training. Trainees should complete a minimum of 40 hours of clinical contact time dedicated to assessment. Up to 10 of the intervention hours may be guided self-help group work.

They should undertake a minimum of 40 hours of supervision of which at least 20 hours should be case management supervision and at least 20 hours should be clinical skills supervision. These 80 clinical contact hours and 40 supervision hours are in addition to the 15-20 practice-based learning days directed by education providers. Where clinical skills supervision is provided in groups these should be no larger than 12 trainees per group. In addition, trainees should have the opportunity to observe or undertake joint interventions with experienced PWPs in practice.

The training provider and NHS Talking Therapies clinical sites need to work closely together to ensure an integrated learning experience and to facilitate generalisation of skills into practice. This includes the need for transparent information sharing between course and employer. Regular placement reviews will be carried out between members of the course team, trainees and relevant staff on the clinical site.

On-site supervisors will provide place of employment reports outlining trainee competences in relation to course learning outcomes. Once signed off by the course as competent to start seeing patients, trainees will be expected to carry out an average of 3 to 4 days per week of related clinical application of low-intensity interventions in their workplace to ensure generalisation of skills into routine work. This would be 2 to 3 days if undertaking part-time training.

The training programme will provide trainees with all of the competences and experience required to be able to register as a PWP with either the British Psychological Society (BPS) or the British Association for Behavioural and Cognitive Psychotherapies (BABCP). Qualified PWPs will be required to join one of these equivalent registers in order to practice.

2. Equality, Diversity and Inclusion

Courses must align their programmes to statutory duties under the Equality Act (2010), requiring public authorities who exercise public functions, and organisations carrying out public functions on behalf of a public authority, to advance equality of opportunity, eliminate unlawful discrimination and foster good relations between people across protected characteristics.

Trainees need to be equipped with understanding of equality and diversity in a broader sense too, in that individuals can experience disadvantage due to a wide range of factors, such as

geographic location, educational opportunities and economic factors. Structural and organisational practice needs to actively address inequity of access and strive for equality and cultural competence⁴.

Courses should include equality, diversity and inclusion issues within all teaching, with a specific focus on:

- 1) Reducing inequity of access to and outcomes of mental health services, across all protected characteristics and other characteristics associated with inequity.
- 2) Deploying reasonable adjustments to support access to and effectiveness of services where patients are disadvantaged for reasons of protected characteristics, autism, learning disability or other intersecting factors.
- 3) Seeking to eliminate all forms of discrimination from the experience of the mental health patients and staff.
- 4) Achieving cultural competence in order to provide culturally informed interventions.

Cultural competence for PWP's means developing the trainees' ability to recognise their own reaction to people who are perceived to be different and their own values and beliefs about the issue of difference, so as to be able to work effectively with them. In developing course assessment criteria, consideration should be given to the inclusion of:

1. Developing an ability to recognise one's own reaction to people who are perceived to be different and one's own values and beliefs about the issue of difference. Awareness of one's own bias, prejudice and assumptions, making good use of supervision and reflective spaces to examine these.
2. Understanding a definition of culture, related values and factors affecting culture
3. including (but not limited to) age, disability, marital status, ethnicity, parental status, sexual orientation, gender, education, language, socio-economic status, and religion or belief.
4. Being capable of taking responsibility for responses and actions taken with people who are different or are perceived to be different
5. Developing ability to accept ambiguity of not knowing what to expect or what to do initially during an encounter impacted by perceived difference.
6. Developing effective communication skills to work with people from diverse backgrounds and cultures and be able to respond to needs sensitively and with regard to all aspects of diversity.
7. Working effectively with interpreters, establishing ways of working together and considering clinical implications.
8. Having raised awareness of one's reaction to people who are different and the implications of these reactions during sessions.
9. Commitment to learning about anti-discriminatory (including anti-racist) clinical practice and implementing and reviewing learning in supervision.
10. Knowledge of research on low intensity interventions within different minoritised groups, with specific reference to evidence on cultural adaptations both broadly and clinical implications for working with the specific disorder.
11. Understanding of limitations on generalisability of research to the population where there may be small sample sizes of minoritised groups.

⁴ See the [NHS Talking Therapies Black, Asian and Minority Ethnic Service User Positive Practice Guide](#) for more detail

3. Ethics and Professionalism

All courses should ensure that teaching includes supporting trainees to understand and adhere to the [UCL CBT Competency Framework](#), specifically in relation to the [Generic Therapeutic Competences](#) section: '[Knowledge of, and ability to operate within, professional and ethical guidelines](#)' section on page 2.

4. Digital Literacy

Digital technology is integrated into our lives. As technology is evolving rapidly, the NHS Talking Therapies workforce needs to be fully competent, confident and capable in its use in the workplace. Excellent digital capabilities are not just about technical skills but include a positive attitude towards technology and innovation and its potential to improve care and outcomes.

HEE's digital capability framework was developed to support the improvement of the digital capabilities of everyone working in health and care. It is intended as a developmental and supportive tool that can empower and enable all staff.

Courses should include [digital literacy](#) issues within all teaching, with a specific focus on:

- 1) **Clinical Information Governance** e.g., ability to obtain the client's informed consent to digital work throughout the course of their contact
- 2) **Assessment & Formulation** e.g., Knowledge of clinical safety issues (risk) associated with digital/remote therapeutic work
- 3) **Psychological Intervention** e.g., Ability to conduct interventions using digital technologies
- 4) **Evaluation and Research** e.g., Ability to manage outcome data collected digitally and integrate this into treatment planning
- 5) **Communication and Teaching** e.g., Ability to discuss the pros and cons of the digital modality with patients
- 6) **Leadership, Supervision & Consultation** e.g., Ability to engage in remote supervision through a digital platform.

5. Expert by Experience Involvement in Training

People with lived experience make a positive contribution to the learning, practice and work of mental health professionals. The involvement of those with lived experience highlights to professionals the importance of placing the goals, needs and strengths of patients, families, carers and the wider community at the centre of all they do.

The inclusion of people with lived experience in training programmes improves trainees understanding of the way in which patients, families and carers experience and understand their situation. Trainees should be equipped to provide compassionate, empathetic and effective care and understand the networks and systems in which patients live.

In addition to the lived experience of members of the public, it is also important that trainees have the opportunity to explore the relevance of their own lived experiences to their clinical practice.

Programmes should incorporate lived experience into the training. Informing, collaborating and co-production are all valuable contributions.

Courses should attend to:

- How the involvement of those with lived experience is co-ordinated.
- How lived experience contributors are selected to be representative of all backgrounds, cultures and ethnicities.
- How people with lived experience are rewarded for their contribution.
- Involvement in:
 - Course development
 - Trainee selection and interview panels
 - Teaching and learning
 - Assessment
 - Trainee mentoring
 - Recruitment of staff
 - Planning of programmes and quality assurance

6. Curriculum for the Education of Psychological Wellbeing Practitioners

The curriculum for the education of PWP is organised into three modules (see below). Modules and credit ratings can be adapted by institutions and training providers to comply with their academic timetable and tailored to suit local needs. Module 1 precedes Module 2. Module 3 can run across the whole period of training, interspersed across the Module 1 and 2 content.

The assessment of academic and clinical skills is detailed below. It is important that training precedes assessment in each area. All clinical skills should be assessed by practical tests of clinical competence. Because of the critical nature of clinical competence, there can be no compensation/condonement for a failed clinical competence assessment (after usual university mitigation and repeat procedures).

While the assessment strategies for assessing practical clinical skills are set out for each module, the assessment of academic skills and knowledge may be in the form of a written exam(s), course work (including seminars and presentations), case report or essay and will be expected to cover the academic content of all three modules. Learning outcomes for each module are assessed through a combination of academic assessments, formal competence assessments, and outcomes evidenced in practice through a portfolio.

Training and supervision is expected to be through a mixture of in-person attendance⁵ and remote synchronous interactive components. The in-person attendance component should include:

- The development of skills for in-person assessment and intervention methods through live role play feedback
- Peer and tutor support - The curriculum informs the [BPS accreditation process for PWP courses](#).

⁵ Where this is permitted and assessed as safe under prevailing public health advice

Module 1: Engagement and assessment of patients with common mental health problems

Aims for the module

PWPs assess and support people with common mental health problems in the self-management of their recovery. To do so they must be able to undertake a range of patient-centred assessments and be able to identify the main areas of concern relevant to the assessment undertaken. They need to have knowledge and competence to be able to apply these in a range of different assessment formats and settings as well as via a range of delivery methods.

These different elements or types of assessment include screening/triage assessment within an NHS Talking Therapies service; risk assessment; provisional diagnostic (problem descriptor) assessment; psychometric assessment (using the NHS Talking Therapies standardised symptom measures); problem focused assessment; and intervention planning assessment. In all these components of assessment they need to be able to engage patients and establish an appropriate relationship whilst gathering information in a collaborative manner.

PWPs must have knowledge of mental health disorders, including complex and severe presentations and the suitable care pathways for these in order to facilitate onward referral. PWPs must also have knowledge of the evidence-based therapeutic options available for common mental health disorders and be able to communicate this knowledge in a clear and unambiguous way so that people can make informed treatment choices, within and beyond NHS Talking Therapies services.

In addition, they must have knowledge of the COM-B behaviour change model and how this can inform choice of goals and interventions. This module will, therefore, equip PWPs with a good understanding of the incidence, prevalence and presentation of common mental health problems and evidence-based treatment choices. Skills teaching will develop PWPs' core 'common factors' competencies of active listening, engagement, alliance building, patient-centred information gathering, information giving and shared decision making.

Trainees will need to understand the benefits to patients of the NHS Talking Therapies metrics and be able to use the NHS Talking Therapies national outcomes monitoring system (which includes session-by-session symptom measures).

Teaching in module 1 should include how to use anxiety disorder specific measures to support correct problem identification, and why the use of these outcome measures is important. Teaching should focus on taking a broad perspective when it comes to the use of NHS Talking Therapies measures to gain a holistic picture of the client⁶.

Learning outcomes:

1. Demonstrate knowledge, understanding and critical awareness of concepts of mental health and mental illness, diagnostic category systems in mental health and a range of social, medical and psychological explanatory models.
2. Demonstrate knowledge of, and competence in applying the principles, purposes and different types of assessment undertaken with people with common mental health

⁶ See the [NHS Talking Therapies Manual](#) for more details

disorders (across in person, telephone and video-based modes of delivery).

3. Demonstrate knowledge of, and competence in using 'common factors' to engage patients; gather information; build a therapeutic alliance with people with common mental health problems; manage the emotional content of sessions and the impact of this on both themselves and the client and hold boundaries.
4. Demonstrate knowledge of, and competence in 'patient-centred' information gathering to arrive at a succinct and collaborative definition of the person's main mental health difficulties and the impact this has on their daily living.
5. Demonstrate competence in assessing and understanding the world view of patients, with a focus on the here and now, including cognitive patterns and biases that link to specific conditions and the implications of these to shape low-intensity working.
6. Demonstrate knowledge of, and competence in recognising patterns of symptoms consistent with diagnostic categories of mental disorders (according to ICD 11) from a patient-centred interview, and by doing so correctly identify the correct primary problem descriptor.
7. Demonstrate understanding of the complexity of mental disorders and competence in conceptualising comorbidity, including how to decide the primary target problem for intervention in the context of comorbidity of mental and physical health problems.
8. Demonstrate knowledge of, and competence in accurate risk assessment with patients or others to ensure practitioners can confidently manage this effectively in accordance with [NICE Guidance](#).
9. Demonstrate knowledge of, and competence in the use of standardised assessment tools including symptom and other psychometric instruments to aid problem recognition and definition and subsequent decision making.
10. Demonstrate knowledge, understanding and competence in using the COM-B behaviour change model to identify intervention goals and choice of appropriate interventions.
11. Demonstrate the ability to set agreed goals for treatment which are specific, measurable, achievable, realistic and timely (SMART).
12. Demonstrate knowledge of, and competence in giving evidence-based information about treatment choices and in making shared decisions with patients.
13. Demonstrate knowledge of, and competence in selecting an appropriate mode of delivery in partnership with patients. If digital modes of delivery are considered, competence to assess a service user's suitability for online interventions, revising this as necessary on an ongoing basis.
14. Demonstrate competence in understanding the service user's attitude to a range of mental health treatments including prescribed medication and evidence-based psychological treatments.
15. Demonstrate competence in clinical decision making in terms of choosing the appropriate pathway for a service user after assessment.
16. Demonstrate competence in identifying patients at assessment who do not fit the criteria for treatment at Step 2 (e.g. those with PTSD, social anxiety disorder or severe mental health problems) and facilitate appropriate stepping up or onward referral.

Learning and teaching strategy

Skills based competencies will be learnt through a combination of clinical simulation in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Self-directed study will include review of video library and web-based resources with examples of assessment sessions and clinical demonstrations of specific techniques.

Module assessment strategy

Standardised role-play scenario(s) where trainees are required to demonstrate skills in undertaking problem focused assessments. This will be video-recorded and assessed by teaching staff using specified standardised assessment measures (See Appendix).

Academic assignment: trainees should also provide a reflective commentary on their performance on the above, or an alternative academic assignment could be set e.g. an exam, case report or essay.

Successful completion of the following practice outcomes, to be assessed by means of a practice outcomes portfolio:

- Demonstrates competency in undertaking and recording a range of assessment formats. This should include both triage within an NHS Talking Therapies service and problem focused assessments.
- Demonstrates experience and competence in the assessment and correct identification of presenting problems across a range of problem descriptors including depression and two or more anxiety disorders.
- Demonstrates the common factor competencies necessary to engage patients across the range of assessment formats.
- Demonstrates understanding of the complexity of mental health difficulties, to conceptualise comorbidity of mental disorders and prioritise the appropriate primary problem in the context of both physical and mental health comorbidity.
- Demonstrate competence in accurate recording of interviews and questionnaire assessments using paper and electronic record keeping systems.
- Demonstrate competence in identifying patients at assessment who do not fit the criteria for treatment at Step 2 (e.g. those with PTSD, social anxiety disorder or severe mental health problems) and facilitate appropriate stepping up or onward referral.

Duration

The following structure is suggested for this module 15 days in total:

- At least ten days of theoretical teaching, skills practice in intensive workshops and clinical simulations, starting with an intensive module where trainees must be signed off by the course as competent to start work with patients.
- Up to five days undertaking directed practice-based learning.
- Practice-based learning days should be spread across the module so that they intersperse the university-based days (and may extend beyond the end of the module for part-time trainees).
- Self-directed study is not counted within these days and should be provided by employers in addition.

Module 2: Evidence-based low-intensity treatment for common mental health disorders

Aims of module

PWPs aid clinical improvement through the provision of information and support for evidence-based low-intensity psychological treatments and regularly used pharmacological treatments of common mental health problems. Low-intensity psychological treatments place a greater emphasis on patient self-management and are designed to be less burdensome for services to deliver than traditional psychological treatments.

The overall delivery of these interventions is informed by the COM-B behaviour change model and strategies. Interventions include a range of low-intensity self-help interventions (often with the use of written self-help materials), informed by cognitive-behavioural principles, such as behavioural activation, graded exposure, cognitive restructuring, worry management, problem solving, sleep hygiene, as well as recommending physical activity that raises heart rate and medication support. Support is specifically designed to enable people to optimise their use of self-management recovery information and pharmacological treatments.

PWP interventions can be delivered via one-to-one treatment and guided self-help groups both of which can be in person or via video consultation. Guided self-help groups should be interactive and support skill development and behavior change. They may include psychoeducation, but pure didactic presentation does not constitute a complete intervention.

One-to-one sessions can also be delivered via telephone, interactive text or computerised cognitive behavioural therapy (cCBT). Trainees must be competent in delivering all interventions via all of these methods. Furthermore, trainees must have the meta-competencies as outlined in the Digital Health Skills framework⁷ such as knowledge of psychological frameworks specific to the online therapeutic relationship (e.g., the online disinhibition effect, screen presence). There are specific interventions which should not be delivered by PWPs, for example transdiagnostic interventions or high intensity interventions.

Only interventions listed in the NHS Talking Therapies manual as being delivered by PWPs should be taught. This module will equip PWPs with a good understanding of the process of therapeutic support and the management of individuals and groups of patients and should include engagement where appropriate with families and carers. Skills teaching will develop PWPs general and disorder-defined 'specific factor' competencies in the delivery of low-intensity treatments informed by cognitive-behavioural principles and in the support of medication concordance. Where trainees deliver groups, these should be based on evidence-based guided self-help linked to the interventions listed in the NHS Talking Therapies Manual. Trainees running groups should though supervision be supported to develop facilitation skills. This includes involving everyone to generate a useful discussion, managing challenges to engagement such as someone monopolising the discussion or someone not talking at all, and responding flexibly to questions from the group.

PWPs must also be able to manage any change in risk status as introduced in Module 1 and in accordance with [NICE Guidance](#). Module 2 will further help trainees understand the benefits to the patient of the NHS Talking Therapies metrics and be able to use the NHS Talking Therapies national outcomes monitoring system (which includes session-by-session symptom measures). Teaching in this module should include how to use anxiety disorder specific measures to

assess outcome and guide therapy and why the use of these outcome measures is important. Teaching should focus on taking a broad perspective when it comes to the use of NHS Talking Therapies measures to gain a holistic picture of the client⁸.

⁷ <https://www.digitalhealthskills.com/digitalcompetencies>

⁸ See the [NHS Talking Therapies Manual](#) for more details

Learning outcomes:

1. Critically evaluate a range of evidence-based interventions and strategies to assist patients in managing their emotional distress and disturbance.
2. Demonstrate knowledge of, and competence in developing and maintaining a therapeutic alliance with patients during their treatment programme, including dealing with issues and events that threaten the alliance.
3. Demonstrate competence in planning a collaborative low-intensity psychological treatment programme for common mental health problems, including appropriate frequency of contacts, managing the ending of contact and development of relapse prevention strategies.
4. Demonstrate understanding of and competence in selection of appropriate cases for low-intensity treatment, aligned to NICE guidance and the NHS Talking Therapies Manual. For example, people whose primary problem is social anxiety disorder or PTSD should only be offered a high intensity intervention.
5. Demonstrate in-depth understanding of, and competence in, a range of low-intensity, evidence-based guided self-help psychological interventions where these are NICE recommended for anxiety disorders⁹ and depression, selecting one or more of these intervention strands¹⁰ delivered in an adequate dose for work with patients, linked to their goals:
 - Behavioural activation
 - Graded exposure
 - Cognitive restructuring (including behavioural experiments)
 - Worry management
 - Problem-solving
 - Promoting good Sleep
 - Promoting physical activity
 - Medication support
6. Demonstrate knowledge and understanding of, and competence in using the COM-B behaviour change model and strategies in the delivery of low-intensity interventions.
7. Critically evaluate the role of case management and stepped care approaches to managing common mental health problems in primary care including ongoing risk management appropriate to service protocols and [NICE guidance](#).
8. Demonstrate knowledge of, and competence in supporting people with medication for common mental health problems to help them optimise their use of pharmacological treatment and minimise any adverse effects.
9. Demonstrate competence in delivering low-intensity interventions using a range of methods including one-to-one treatment (in person, via video consultation, via telephone, interactive text or computerised cognitive behavioural therapy (cCBT)) and guided self-help groups (in person and via video).
10. Demonstrate competence in selecting and revising mode of delivery, as necessary on an ongoing basis depending on patient choice, suitability, etc.
11. Demonstrate knowledge and understanding to map core skills into text-based interventions.

9

Including guided self-help interventions for Obsessive Compulsive Disorder and Panic Disorder.

¹⁰ On occasions where a single strand guided self-help intervention is not bringing about recovery the first consideration should be given to step a patient up to a high intensity intervention. If it is felt it may be appropriate to offer a sequence of low-intensity interventions, this should be discussed first in supervision.

12. Demonstrate competence in succinct and accurate note-taking skills.

Learning and teaching strategy

Skills based competencies will be learnt through a combination of clinical simulation and role plays in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Teaching will provide trainees with the opportunity to practice different modes of evidence-based treatment delivery. Group facilitation skills will be learnt through teaching on and feedback on experiential practice of group facilitation.

This approach could help trainees to learn how to present information in different ways e.g. designing PowerPoint slides, using an interactive white board, and to learn how to tailor information to different audiences including minoritised communities.

Self-directed study will include review of video library and web-based resources with examples of intervention sessions and clinical demonstrations of specific techniques.

Module assessment strategy

An audio or video recording of a real low-intensity treatment session with a patient treated by the trainee, in which the trainee is required to demonstrate skills in planning and implementing a low-intensity treatment. This recording will be assessed by teaching staff using a specified standardised assessment measure (see Appendix).

Academic assignment: trainees should also provide a reflective commentary on their performance on the above, or an alternative academic assignment could be set e.g. an exam, case report or essay.

Successful completion of the following practice outcomes, to be assessed by means of a practice outcomes portfolio:

1. Demonstrates experience and competence in the selection and delivery of treatment of a range of presenting problems using evidence-based low-intensity interventions across a range of problem descriptors, including depression and two or more anxiety disorders, and across all modes of intervention (in person, telephone, video platform).
2. Demonstrate an understanding of problems that should not be treated at Step 2, and where and how appropriate treatment should be accessed for these.
3. Demonstrate the ability to use common factor competencies to manage emotional distress and maintain therapeutic alliances to support patients using low-intensity interventions.
4. Demonstrate competence in delivering low-intensity interventions using a range of methods including one-to-one treatment (in person, via video consultation, via telephone, interactive text or computerised cognitive behavioural therapy (cCBT)) and where possible guided self-help groups (in person and via video).
5. Demonstrate competence in selecting and revising mode of delivery, as necessary on an ongoing basis depending on patient choice, suitability, etc.
6. Demonstrate knowledge and understanding to map core skills into text-based interventions.
7. Demonstrate high quality clinical note keeping and effective use of clinical outcome measures to shape and adapt low intensity interventions.

Duration

The following structure is suggested for this module 15 days in total:

- At least ten days of theoretical teaching, skills practice and clinical simulations.
- Up to five days undertaking directed practice-based learning.
- Service-based days should be spread across the module so that they intersperse the university-based days (and may extend beyond the end of the module for part-time trainees). Self-directed study is not counted within these days and should be provided by employers in addition.

Module 3: Values, diversity and context

Aims of module

PWPs operate at all times from an inclusive values base which promotes recovery and recognises and respects diversity. Diversity represents the range of cultural norms including personal, family, social and spiritual values held by the diverse communities served by the service within which the PWP is operating. PWPs must respect and value individual differences in age, sexuality, disability, gender, spirituality, race and culture. PWPs must also understand equality and diversity in a broader sense in that individuals can also experience disadvantage due to a wide range of factors, including geographic location, educational opportunities, and economic factors for example.

PWPs must also take into account any physical and sensory difficulties people may experience in accessing services and make provision in their work to ameliorate these. They must be able to respond to people's needs sensitively with regard to all aspects of diversity and protected characteristics.

They must demonstrate a commitment to equal opportunities for all and encourage people's active participation in every aspect of care and treatment. They must also demonstrate an understanding and awareness of the power issues in professional-patient relationships and take steps in their clinical practice to reduce any potential for negative impact this may have. They must also consider the impact of individuals' different backgrounds on the process of group work. This module will, therefore, expose PWPs to the concept of equality, diversity and inclusion and equip workers with the necessary knowledge, attitudes and competencies to operate in an inclusive value driven service.

PWPs are expected to operate in a stepped care, high-volume environment. During training, trainee PWPs should carry a reduced caseload, with the number of cases seen depending on their stage in training, building up to a maximum of 60-80% of a qualified PWP's caseload at the end of training (pro rata for part-time trainees).

PWPs must be able to manage caseloads, operate safely and to high standards and use supervision to aid their clinical decision-making. PWPs need to recognise the limitations to their competence and role and direct people to resources appropriate to their needs, including step-up to high-intensity therapy, when beyond their competence and role.

In addition, they must focus on social inclusion – including return to work and meaningful activity or other occupational activities – as well as clinical improvement. To do so they must have knowledge of a wide range of social and health resources available through statutory and community agencies. They must have a clear understanding of what constitutes the range of high-intensity psychological treatments, which includes CBT and the other NHS Talking Therapies approved high-intensity therapies and how high-intensity treatments differ from low-intensity working.

This module will, therefore, also equip PWPs with an understanding of the complexity of people's health, social and occupational needs and the services which can support people to recovery. It will develop PWPs decision making abilities and enable them to use supervision and to recognise when and where it is appropriate to seek further advice, a step-up or a signposted service. Skills teaching will develop PWPs clinical management, liaison and decision-making competencies in the delivery of support to patients, particularly where people

require intervention or advice outside the core low-intensity evidence-based interventions taught in Module 2.

Learning outcomes:

1. Demonstrate knowledge of, and commitment to a non-discriminatory, recovery orientated values base to mental health care and to equal opportunities for all and encourage people's active participation in every aspect of care and treatment.
2. Demonstrate respect for and the value of individual differences in age, sexuality, disability, gender, spirituality, race and culture.
3. Demonstrate knowledge of, and competence in, responding to people's needs sensitively with regard to all aspects of diversity, including working with older people, the use of interpretation services and taking into account any cognitive, physical, or sensory difficulties patients may experience in accessing services.
4. Demonstrate awareness and understanding of the power issues in professional-patient relationships.
5. Demonstrate an awareness of voluntary, community and statutory organisations in their community that may be helpful to signpost/refer to.
6. Demonstrate competence in managing a large caseload of people with common mental health problems efficiently and safely.
7. Demonstrate knowledge of, and competence in using supervision to assist the PWP's delivery of low-intensity psychological treatment and/or medication support programmes for depression or anxiety disorders.
8. Demonstrate knowledge of, and competence in gathering patient-centred information on employment needs, wellbeing and social inclusion and in liaison and signposting to other agencies delivering employment, occupational and other advice and services.
9. Demonstrate an appreciation of the PWP's own level of competence and boundaries of competence and role, and an understanding of how to work within a team and with other agencies with additional specific roles which cannot be fulfilled by the PWP alone.
10. Demonstrate a clear understanding of what constitutes high-intensity psychological treatment and how this differs from low-intensity work.

Learning and teaching strategy

Skills based competencies will be learnt through a combination of clinical simulation in small groups working intensively under close supervision with peer and tutor feedback and supervised practice through supervised direct contact with patients in the workplace. Knowledge will be learnt through a combination of lectures, seminars, discussion groups, guided reading and independent study.

Self-directed study will include review of video library and web-based resources with examples of adaptations to delivery, supervision sessions and clinical demonstrations of specific methods.

Module assessment strategy

A recording of an assessment or treatment session, OR a presentation OR a written task in which trainees are required to demonstrate knowledge and skills in working with a person or people with a variety of needs from one or more of a range of diverse groups.

A case report, reflective commentary, essay or exam in which trainees are required to demonstrate knowledge and competence in using case management and clinical skills supervision.

Successful completion of the following practice outcomes, to be assessed by means of a practice outcomes portfolio:

- Demonstrates the ability to engage with people from diverse demographic, social and cultural backgrounds in assessment and delivery of low-intensity interventions. This could include adaptations to practice in line with positive practice guides¹¹, using interpretation services or self-help materials for people who are deaf or whose first language is not English, and/or adapting self-help materials for people with learning or literacy difficulties including as a result of cognitive or neurological conditions.
- Demonstrates the ability to effectively manage a large caseload efficiently and safely, including step-up within NHS Talking Therapies, onward referral to employment support and signposted services, or other referral beyond NHS Talking Therapies
- Demonstrates the ability to use supervision to the benefit of effective (a) case management and (b) clinical skills development.

This should include:

- a) a report on a case management supervision session demonstrating ability to review caseload, bring patients at agreed pre-determined thresholds and provide comprehensive and succinct case material
- b) a report on use of clinical skills supervision including details of clinical skills questions brought, learning and implementation.

Duration

The following structure is suggested for this module 15 days in total:

- At least ten days to be spent in class in theoretical teaching and clinical simulation,
- Up to five days undertaking directed practice-based learning.
- Service-based days should be spread across the module so that they intersperse the university-based days (and may extend beyond the end of the module for part-time trainees).
- Self-directed study is not counted within these days and should be provided by employers in addition.

¹¹ See [NHS Talking Therapies Manual](#) for details

7. Registration after Qualification

On qualification, graduates of PWP training, by continuing to practice within the specified system of care for registration (an NHS Talking Therapies service or equivalent) should meet all of the requirements for individual registration as a PWP with either BABCP or BPS (which are equivalent registers). All qualified PWPs working within NHS Talking Therapies services are required to be registered with one of these schemes.

8. Preceptorship Guidance

After PWPs have completed their BPS accredited PWP training programme there is an expectation for them to complete a structured preceptorship year. This is the responsibility of the employing service. It provides a co-ordinated approach to support, sustain and develop PWPs during their first year after qualifying. You can also read [HEE's preceptorship guidance](#).

9. Long Term Conditions Top-up Training

This is a compulsory top up module that all PWPs will normally be expected to complete within two years of qualification. Approximately 40% of entrants into NHS Talking Therapies have a long-term health condition¹².

Considering such a high proportion of those being seen at Step 2 will have a long-term condition, it is important that PWPs have a good understanding of long term conditions and how these should be considered at assessment and intervention.

The top up training provides PWPs with knowledge of the adverse impact of the long-term condition, key issues the practitioner should look to identify at assessment, adapted low-intensity treatments for depression and anxiety disorders in the context of a long term condition. This top up training is synchronous and interactive but accompanied by e-learning materials available on the [elearning for healthcare webpage](#).

¹² [improving-access-to-psychological-therapies-long-term-conditions-pathway.pdf \(england.nhs.uk\)](#)

Appendix: Accepted Competence Assessment Tools

Courses may choose to assess competence using the following range of assessment and intervention scales¹³

- [University College London](#) (assessment and intervention scales)
- [University of Exeter](#) (assessment and intervention scales)
- [University of Reading](#) (assessment and intervention scales)
- [University of Sheffield](#) (assessment and intervention scales)

¹³ . Future additions to this list would be subject to approval at future curriculum review