THIRD SCHEDULE

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The competences required to deliver effective Systemic Therapies

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The full listing of competences in systemic therapies described in this report is available online at www.ucl.ac.uk/CORE

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Short summary (reader box)
This document identifies the activities associated with the delivery of high-quality systemic therapies and the competences required to achieve these. It describes a model of the relevant competences, and discusses how this should be applied by practitioners, its advantages for clinicians, trainers and commissioners, and the uses to which it can be put.

Acknowledgements
This work described in this report was commissioned by Skills for Health. The project team was headed by Anthony Roth and Stephen Pilling. Peter Stratton chaired the expert advisory group. Emma Silver and Isabelle Ekdawi identified source materials, extracting competences and producing drafts for discussion.

The work was overseen by Expert Reference Group (ERG) whose invaluable advice and collegial approach contributed enormously to the development of the work. The ERG comprised Peter Stratton, Eia Asen, Charlotte Burck, Frank Burbach, Judith Lask, Isobel Reilly, Rudy Dallos, Janet Reibstein, Ivan Eisler, Graham Bryce, Tom Sexton and Helen Pote. (Appendix A shows the professional affiliations of members of the ERG.)

We are also grateful to Dr Eia Asen, Professor Ivan Eisler, Professor Howard Liddle, Professor Scott Henggeler and colleagues, Professor Tom Sexton and Professor Jose Szapocnik for their peer-review of the problem specific competences.

Who can apply the competence framework?
All the modality competence frameworks describe *what* a therapist might do; they do not identify *who* can implement them. The standards set by the framework can be met by therapists with a range of professional backgrounds, on the basis that they have received a training which equips them to carry out the therapy competently. The issue of competence and of relevant training is the critical factor, rather than the title of the person offering the therapy.

Relationship between the competence frameworks and the development of National Occupational Standards

The competence frameworks and National Occupational Standards are constituent parts of a programme overseen by the Department of Health. This has the objective of specifying occupational standards for the practice and training of psychological therapists, initially in four modalities (CBT, psychoanalytic/psychodynamic, systemic and humanistic).

The two pieces of work are closely linked, but are intended to have somewhat different applications, and are published independently.

How competence frameworks/NOS are developed

Competence frameworks: The competence frameworks for each modality are commissioned by Skills for Health (and, in the case of the supervision competence framework, also by Care Services Improvement Partnership and NHS Education for Scotland). For the purposes of the National Occupational Standards project these competences are referred to as Statements of Evidence. They are developed by a team at UCL, a process which is overseen by an Expert Reference Group constituted of researchers and trainers selected for their expertise in the relevant therapy modality. Competences are identified using an evidence-based methodology (described in detail in the documentation which accompanies each framework). These are clustered according to a 'map' of the activities through which therapists carry out the therapy. This process is subject to careful review from the Expert Reference Group. When completed, this work is published by the Department of Health, and made available through the UCL website (www.ucl.ac.uk/CORE/). This work also constitutes the first phase of the Psychological Therapies National Occupational Standards development project undertaken by Skills for Health.

National Occupational Standards: Skills for Health convene a Modality Working Group to review and develop the UCL competence frameworks into National Occupational Standards for the psychological therapies. This group comprises senior clinicians with expertise in the relevant modality. These individuals are nominated by professional organisations with an interest in the standard of professional practice.

Consultants contracted by Skills for Health work with the Modality Working Group to translate the UCL competence framework into the formats used for National Occupational Standards and to ensure that the realities of day to day practice are taken account of in the standards. Expert readers are asked to review the drafts and they subsequently go to wider consultation and testing in practice. A National Reference Group, consisting of representatives from the professional organisations, is responsible for the quality of the draft standards that are submitted for accreditation as National Occupational Standards and publication on the Skills for Health website.

More information regarding this project can be found at:
www.skillsforhealth.org.uk/page/competences/competences-in-development/psychological-therapies

What are the similarities and differences between the competence frameworks and the NOS, and how can they each be used?

The competence frameworks are stand-alone, detailed representations of the competences needed to deliver and supervise the various modalities of therapy, and the ways in which these modalities can be applied in relation to specific psychological disorders, or how these modalities are adapted to form distinctive therapeutic interventions. They are already being used, for example, to develop training curricula and training materials, are being applied in research, and are being used as a basis for quality assuring courses.

The NOS are a broader description of the way in which each therapy modality is implemented. They focus on the generic, basic and specific competences identified in the competence framework. They do not provide the detail of disorder or problem specific practice found in the competence framework. Nevertheless they are also being used to review and refine training curricula. Instead of the finer detail, NOS have the benefit of being linked to the range of competence standards that Skills for Health have developed for interventions across the field of mental health care. National Occupational Standards are recognised across the UK and therefore support the transparency and transferability of qualifications. They are also mapped to the NHS Knowledge and Skills Framework. This enables them to be used as well in workforce planning and service specification, where they help to identify the standards expected of workers at each level of a multi-disciplinary team, from the generic skills required by all workers through to the more specialised skills needed by workers who are specialising in the delivery of psychological therapies. They are also used to develop job descriptions that in turn can build a career framework; this work is being undertaken through the New Ways of Working for Psychological Therapies programme of work. Lastly, they will provide one of the inputs to the content of the Standards of Proficiency which are being developed by the Health Professions Council for the regulation of Psychotherapists and Counsellors.

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The competences required to deliver effective Systemic Psychological Therapies

Executive summary

The report begins by briefly describing the background to the work on competences for psychological therapies. It then outlines an evidence-based method for identifying competences, and presents a competence model for systemic therapies. This organises the competences into five domains:

1. **Generic competences** - used in all psychological therapies

2. **Basic competences for systemic therapies -** techniques employed by most (though not all) forms of systemic therapies

3. **Specific systemic competences** – techniques employed by most (though not all) forms of systemic therapies

4. **Problem specific systemic competences** – adaptations of systemic interventions into discrete evidence-based approaches

5. **Metacompetences** – overarching, higher-order competences which practitioners need to use to guide the implementation of systemic therapies

The report then describes and comments on the type of competences found in each domain, before presenting a 'map' which shows how all the competences fit together and inter-relate.

Finally the report comments on issues which are relevant to the implementation of the competence framework, and considers some of the organisational issues around its application.

How to use this report

This report describes the model of competences for systemic therapies and (based broadly on empirical evidence of efficacy) indicates the various areas of activity that, taken together, represent good clinical practice. This report does not include the detailed descriptions of the competences associated with each of these activities: these can be downloaded from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE). They are available as pdf files, accessed directly or by navigating the map of competences (as represented by Figure 2 in this report).

Background

The Improving Access to Psychological Therapies (IAPT) programme, which was launched in May 2007, provided the backdrop for the first wave of work on the development of competences for the practice of psychological therapies. The IAPT programme has focused to date on delivering CBT for adults with common mental health problems because CBT has the most substantial evidence base supporting its

effectiveness in the treatment of depression and anxiety in particular (e.g. NICE, 2004a, 2004b, 2005a, 2005b). Consequently, the first wave of work was concerned to identify the competences needed to deliver good quality CBT. The CBT competence model was specifically developed to be a "prototype" for developing the competences associated with other psychological therapies. The work reported here is based on this model.

National Occupational Standards (NOS): The work undertaken in this report also needs to be seen in the context of the development of National Occupational Standards (NOS), which apply to all staff working in health and social care. There are a number of NOS which describe standards relevant to mental health workers, downloadable at the Skills for Health website (www.skillsforhealth.org.uk), and the work described in this report will be used to inform the development of standards for systemic therapies.

How the competences were identified

Oversight and peer-review: The work described in this project was overseen by an Expert Reference Group (ERG). Members of the group were identified on the basis of their expertise in systemic therapies – for example, their involvement in the development of systemic treatments, the evaluation of systemic therapy in formal trials, and the development and delivery of supervision and training models in systemic therapy. Membership of professional organisations was secondary to these considerations, since the frameworks aim to set out clinical practice rather than to describe professional affiliation. Nonetheless, the composition of the ERG ensured the representation of the Association for Family Therapy (AFT), the United Kingdom Council for Psychotherapy (UKCP), and a number of organisations involved in the training of systemic therapists.

The ERG ensured that the trials, manuals and basic texts most relevant to the modality were identified and that the process of extracting competences was appropriate and systematic. Additional peer review was provided by the researchers and clinicians who had developed the therapies contained in the framework. All this was designed to assure the fidelity of the framework in relation to the therapy it claimed to represent. Overall, this process of open peer-review ensured that the competence lists were subject to a very high level of scrutiny.

Identifying competences by looking at evidence of what works[1]: The approach taken across the suite of competence frameworks is to start by identifying clinical

1 An alternative strategy for identifying competences could be to examine what therapists actually do when they carry out a particular therapy, complementing observation with some form of commentary from the therapists in order to identify their intentions as well as their actions. The strength of this method – it is based on what people do when putting their competences into action – is also its weakness. Most psychological therapies set out a theoretical framework which purports to explain human distress, and this framework usually links to a specific set of therapist actions aimed at alleviating the client's problems. In practice these 'pure' forms of therapy are often modified as therapists exercise their judgment in relation to their sense of the client's need. Sometimes this is for good, sometimes for ill, but presumably always in ways which 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 does make it risky to base conclusions about competence on the work done by practitioners, since this could pick up good, bad and idiosyncratic practice.

approaches with the strongest claims for evidence of efficacy, based on the outcome in clinical controlled trials. Almost invariably the therapy delivered in these trials is based on a manual which describes the treatment model and associated treatment techniques. Treatment manuals are developed by research teams to improve the internal validity of research studies: they explicate the technical principles, strategies and techniques of particular models of therapy. In this sense the manual represents best practice for the fully competent therapist – the things that a therapist *should* be doing in order to demonstrate adherence to the model and to achieve the best outcomes for the client. Because research trials monitor therapist performance (usually by inspecting audio or video recordings) we know that therapists adhered to the manual. This makes it possible to be reasonably confident that if the procedures set out in the manual are followed there should be better outcomes for clients.

Once the decision is taken to focus on the evidence base of clinical trials and their associated manuals, the procedure for identifying competences falls out logically. The first step is to review the outcome literature, which identifies effective therapeutic approaches. The procedure for identifying relevant trials began with a search of a search of databases held by CORE (originally as part of NICE guideline development) and other high quality evidence reviews such as Roth and Fonagy (2005) where no specific NICE database existed. The list of trials identified by this were discussed with the ERG members to determine both the identified trials appropriateness for inclusion and if further, usually recently published trials, should be included.. This resulted in a final list of trials which met, or came close to meeting, NICE standards of evidence. (It should be noted that in relation to the criteria applied by the ERG, the evidence base for the efficacy of systemic therapies is not especially extensive, particularly with adults). Following identification of the key trials the manuals associated with these successful approaches are identified. Finally the manuals were examined in order to extract and to collate therapist competences. A major advantage of using the manuals to extract competences is that by using the evidence base to narrow the focus it sets clear limits on debates about what competences should or should not be included. This is in line with the method adopted with other competence frameworks (Roth and Pilling, 2008).

Selection of manuals

As described in the preceding section the selection of the manuals follows from the identification of the relevant trial(s). One issue that arose early in the development of the competence framework was the definition of systemic therapy and the implications of this for the overall scope of the framework. For example, a number of the manuals reviewed, in particular those for children with conduct disorder, made reference to and suggested as part of the overall intervention the provision of interventions such as contingency management for the management of child behavioural problems or individual cognitive behavioural therapy (CBT) for children and adolescents that are clearly not systemic in approach. As these were key components of a number of systemic approaches to treatment identified in this framework (for example, the use of CBT in multi-systemic therapy (Henggeler et al, 1998)) these competences were identified but they are not detailed as they are covered in other frameworks. It is expected that readers using this competence frameworks will refer to other competence frameworks (for example the CBT framework) where

they exist but to other manuals and relevant texts where competence frameworks do not currently exist (for example, parent training programmes).

Two areas of systemic practice were identified has having the most substantial evidence base; these are interventions for eating disorders (specifically anorexia nervosa) and for children and adolescents with conduct disorder, where a range of interventions have been developed and subject to extensive evaluation. Initial identification of the manuals which set out the specifics of the interventions for eating disorders, conduct disorders and couples therapy (which also had a reasonable evidence base) did not prove difficult. As well providing a source for the disorder specific competences, it had been assumed that these manuals would provide a source for the basic and specific competences essential to the development of the overall competence framework. However, following an initial review of these manuals it became apparent that a number of widely accepted basic and specific competences were assumed (that is, not explicitly described) rather than specified in the manuals. This was discussed with the ERG and following this discussion it was decided to use a number of established core texts to support the development of the basic and specific competences The ERG identified these core texts (listed in Appendix B) which were considered to be representative of systemic practice, in that many training programmes in the field make use of them. The use of these core texts to support the development of the basic and specific competences was supplemented by a careful and detailed discussion of the basic and specific competences as they emerged by the ERG.

Scope of the work

Representation of different approaches within the field of systemic therapies

The field of systemic therapy has developed significantly over the past 50 years. Its origins lie in a reaction against locating all psychological difficulties within an individual or their specific psychopathology. The work originally developed in the context of family or couple therapy and was initially influenced by psychoanalytic ideas. However, in the mid 1950s the work of Gregory Bateson (Bateson, 1972) and others introduced ideas from cybernetics and systems theory into both social psychology and psychotherapy and from this began to emerge a distinct systemic approach to the treatment and management of psychological difficulties. From this initial work a number of separate schools emerged which focused predominantly on work with families, principally strategic family therapy (Haley & Hoffman, 1994) and structural family therapy (Minuchin, 1974) In addition to developments in structural and strategic models, a number of other approaches have emerged including the progressive elaboration of the family systems approach (Boscolo et al; 1987), the constructivist (Maturana, 1988) transgenerational (Bowen, 1978) and collaborative/dialogical (Anderson & Gehart, 2007) approaches. More recent introductions have included social constructionist and narrative approaches (White, 2007) and solution focused therapy (de Shazer, 1985). All share a common approach, seeing both the origin of the problem(s) and the potential solutions to them as located not in any one individual but with a system of which the individual and those in relationship with the individual are all members. Some approaches to working with families (while influenced by systemic ideas) specifically eschew a systemic label.

These include psychodynamic family or couples therapy (Ackerman, 1996; behavioural couples therapy (for example, the work of Neil Jacobson (Jacobson et al, 1998) on depression and domestic violence) and behavioural family therapy (for example, the work of Ian Fallon in schizophrenia (Falloon et al; 1987)).

The ERG spent considerable time debating the focus of the systemic competence framework and was influenced by a number of factors. These included the wish to stay within broadly the same structure and process that has been adopted for other competence frameworks. Perhaps more importantly there was agreement about the utility of arriving at a shared conceptualisation of systemic therapy which would encompass the variety of systemic interventions that have been developed and formally evaluated and which retain a focus on the system(s) and not the individual as the primary area for intervention. This meant that some interventions which involve working with families or couples were outside of the framework. An example is behavioural couples therapy for depression, which was excluded because the focus of the intervention and the underpinning theory (largely behavioural theory) has a base in individual psychological difficulties.

As noted above a key factor which influenced the inclusion of a particular systemic approach in the framework was the existence of an evidence base for its use (including RCT level evidence). This meant that some recent developments in systemic therapy (such as narrative therapy or solution focussed therapy) were not included as specific interventions. However, the principles associated with these approaches did influence the development of the framework, and are reflected at points in the Basic and Specific systemic competences.

The competence model for Systemic Therapies

Organising the competence lists

Competence lists need to be of practical use. The danger is that they either provide too much structure and hence risk being too rigid or they are too vague to be of use. The aim has been to develop competence lists structured in a way which reflects the practice they describe, set out in a framework that is both understandable (in other words, is easily grasped) and valid (recognisable to practitioners as something which accurately represents the approach, both as a theoretical model and in terms of its clinical application).

Figure 1 shows the way in which competences have been organised into five domains: the components are as follows:

Generic competences

Generic competences are those employed in any psychological therapy, reflecting the fact that all psychological therapies, including systemic therapy, share some common features. For example, therapists using any accepted theoretical model would be expected to demonstrate an ability to build a trusting relationship with their clients, relating to them in a manner which is warm, encouraging and accepting. Without building a good therapist-client relationship technical interventions are unlikely to succeed. Often referred to as ‘common factors’ in therapy, it is important that the competences in this domain are not overlooked or treated as an afterthought.

Basic competences for systemic therapies

Basic competences establish the underpinning structure for systemic therapies, and form the context for the implementation of a range of more specific systemic approaches and methods. Although (as noted above) there are some variations in practice across the field, the basic competences set out a range of activities that almost all systemically-oriented therapists should be able to acknowledge as fundamental to their practice. Systemic approaches privilege a focus on the relationships within a system, based on the proposition that difficulties in relationships are the appropriate focus of the problems (not the individual) and are also the primary vehicle for change and for the maintenance of therapeutic gains.

Insert Figure 1 about here

Distinguishing "Basic competences for systemic therapies" from "Specific systemic therapies competences"

As should be clear from the foregoing discussion, the framework needs to accommodate traditions that are somewhat distinct in their approach to clinical work. This is reflected in the structure of the framework. While the competences listed in the basic domain are assumed to be ubiquitous, it is also assumed that practitioners will select only those techniques from the specific competences domain that are consistent with the particular approach to systemic therapy that they are taking and adapting for each case. This is an important point; the framework assumes that some specific interventions will be central to some individuals' practice but peripheral or not present in the practice of others

Specific systemic competences
These are the specific approaches and methods employed by the various sub-orientations of systemic therapies.

Problem specific competences
In common with frameworks for other modalities this domain is restricted to the specific adaptations for which there is good evidence of efficacy.

In relation to anorexia nervosa two treatment manuals (authored by Ivan Eisler and colleagues (Eisler et al; 2003) and Jim Lock and colleagues (Lock et al; 2001) were identified and reviewed. The original intention was to develop separate competence descriptions for these two approaches, but a review of the manuals identified marked overlap in content. As a consequence (and in consultation with the ERG) the two approaches have been combined into a single description of systemic work with people with anorexia. On the rare occasions where significant differences in approach emerged the decision was taken to include the specific competence and hence, allow clinicians to determine which option to take up. An example of this is the use of the family meal, a feature highlighted by the Lock manual but which is not included in the Eisler manual.

There has been significant development and evaluation of specific systemic interventions for the treatment of conduct disorder and related problems in children

and adolescents. These include functional family therapy (Sexton and Alexander, 2004), brief strategic family therapy (Szapocnik et al; 2003), multi-dimensional family therapy (Liddle, 2002) and multi-systemic therapy (Henggeler et al; 1998). The ERG considered the possibility in combining these approaches but decided against this on the basis that they represent distinct models.

The final problem specific intervention is the approach to couples therapy for depression developed by Jones and Asen (1999).

Metacompetences

A common observation is that carrying out a skilled task requires the person to be aware of why and when to do something (and just as important, when not to do it!). This is a critical skill which needs to be recognised in any competence model. Reducing psychological therapy to a series of rote operations would make little sense, because competent practitioners need to be able to implement higher-order links between theory and practice in order to plan and where necessary to adapt therapy to the needs of individual clients. These are referred to as metacompetences in this framework: the procedures used by therapists to guide practice, and operate across all levels of the model. These competences are more abstract than those in other domains because they usually reflect the intentions of the therapist. These can be difficult to observe directly but can be inferred from therapists' actions, and may form an important part of discussions in supervision.

Specifying the competences needed to deliver Systemic Therapies

Integrating knowledge, skills and attitudes

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

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 therapist's attitude and stance to therapy is also critical – not just their attitude to the relationship with the client, but also to the organisation in which therapy is offered, and the many cultural contexts within which the organisation is located (which includes a professional and ethical context, as well as a societal one). All of these need to be held in mind by the therapist, since all have bearing on the capacity to deliver a therapy that is ethical, conforms to professional standards, and which is appropriately adapted to the client's needs and cultural contexts.

The map of competences in Systemic Therapies

Using the map

The map of competences in systemic therapies is shown in Figure 2. It organises the competences into the five domains outlined above and shows the different activities

which, taken together, constitute each domain. Each activity is made up of a set of more detailed competences. The details of these competences are not included in this report; they can be downloaded from the website of the Centre for Outcomes Research and Effectiveness (CORE) (www.ucl.ac.uk/CORE).

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

Figure 2

The map of competences in systemic therapies

Generic therapeutic competences

Knowledge: Knowledge of mental health problems, of professional and ethical guidelines and of the model of therapy being employed forms a basic underpinning to any intervention, not just for systemic therapies. Being able to draw on and apply this knowledge is critical to the delivery of effective therapy.

The ability to operate within professional and ethical guidelines encompasses a large set of competences, many of which have already been identified and published elsewhere (for example, profession-specific standards, or national standards (such as the Shared Capabilities (Hope, 2004)) and the suites of National Occupational Standards relevant to mental health (available on the Skills for Health website (www.skillsforhealth.org.uk)). Embedded in these frameworks is the notion of "cultural competence", or the ability to work with individuals from a diverse range of backgrounds, a skill which is important to highlight because it can directly influence the perceived relevance (and hence the likely efficacy) of an intervention.

Building a therapeutic alliance: The next set of competences is concerned with the capacity to build and to maintain a therapeutic relationship. Successfully engaging the client and building a positive therapeutic alliance is associated with better outcomes across all therapies. Just as important is the capacity to manage the end of treatment; which can be difficult for clients and for therapists. Because disengaging from therapy is often as significant as engaging with it, this process is an integral part of the 'management' of the therapeutic relationship.

Assessment: The ability to make a generic assessment is crucial if the therapist is to begin understanding the difficulties which concern the client. A generic assessment is intended to gain an overview of the client's history, their perspectives, their needs and their resources, their motivation for a psychological intervention and (based on the foregoing) a discussion of treatment options.

Assessment also includes an appraisal of any risk to the client or to others. This can be a challenging task, especially if the person undertaking the assessment is a junior or relatively inexperienced member of staff. Bearing this in mind, the ability for workers to know the limits of their competence and when to make use of support and supervision, will be crucial.

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

Basic competences for Systemic Therapies

This domain contains a range of activities that are basic in the sense of being fundamental areas of skill and knowledge; they represent practices that underpin any systemic intervention.

Knowledge of the rationale for the systematic approach includes three areas. These are **knowledge of the systematic principles** that inform the therapeutic approach (locating an individual and their difficulties within the wider system, composed typically of family, the social community settings, personal networks, cultural and the wider socio-political environment). The second areas concerns **knowledge of systemic theories of psychological problems, of resilience and of change** and sets out the role that systems play in the development, maintenance of psychological problems, along with an understanding of why change in systems is needed to support improvement in psychological problems. The third areas concerns **knowledge of the systemic approaches that enable therapeutic change** and focuses on the importance of understanding the patterns of relationships in a system and their relationship to the presenting problem; the importance of historical or transgenerational factors; and the resources of the system to promote change and the role of the wider system including the therapist(s) in promoting change.

The **ability to initiate systemic therapy** includes a number of areas of competence. The initial set focus on the **ability to initiate and undertake a systemic assessment**, taking into account not only the problems and the context in which they present but also the process of referral and the ability to involve the wider system so as to provide information for a comprehensive assessment. The **ability to develop and maintain engagement** means working not only with the person and/or family presenting the problem, but with the wider system. It also includes presenting the rationale for a systemic approach to the problems and helping individuals to identify goals and objectives. The **ability to develop systemic formulations and also to help clients to formulate appropriate goals** for the therapy emphasises formulating the problem within the wider context and involving the family and the wider system in the development and revision of any formulation of the problems that emerge. The **ability to establish the context for a systemic intervention** focuses on the involvement of appropriate individuals and wider social and professional networks in order to support the implementation of the intervention. It is also concerned with clarifying the role of the therapist and wider team and ensuring that a collaborative approach to treatment is developed. Finally, this section looks at the therapeutic alliance and a number of factors when which need to be considered in establishing a systemic intervention: these include historical patterns of relationships; contextual factors such as class and gender and ethnicity; factors which might limit clients participation (e.g. developmental problems); and the ability to maintain an even-handed stance on the part of the therapist.

The **ability to maintain and develop the systemic approach** includes the therapist to be able to **work in a reflexive manner** using discussion with clients and feedback from colleagues to collaboratively promote therapeutic change and to reflect on one's own performance as a result of the feedback. The ability to **monitor progress** involves using a variety of strategies to support change, including the use of outcome measures. Consistent with the systemic approach is the importance of **facilitating communication** across all levels of the system. Finally the **ability to manage endings** focuses on the capacity to identify the appropriate time for an ending, to review the change that has been developed and to focus on strategies to both maintain positive change and prevent relapse.

Specific systemic competences

This domain sets out the specific interventions employed by systemic therapists, but it should be borne in mind that a number of different approaches are covered in this section such that not all will be taken up by all systemic therapists. The section includes seven different systemic competences.

The **ability to use systemic hypotheses** includes the ability to initially develop (and subsequently to revise) systemic hypotheses covering a broad range of issues, from the reason for referral through to factors concerned with the development and maintenance of the problem. It goes on to set out how systemic hypotheses can be used to both promote inquiry and develop the clients' understanding of the problems and promote the development of new perspectives.

The ability to use circular interviewing is a central feature of systemic approaches, helping to explore different views, beliefs and feelings about the nature of the relationships in the system and to draw out differences. This section sets out the competences to deliver different types of questions and the ability to phrase and adapt questions to the benefit of all individuals in the system.

The use of **systemic techniques to promote change** focuses on competences which aim to promote increased understanding through the use of a range of techniques such as externalising, reframing, the use of experiential techniques such as role play or sculpting or the development of new narratives. This section also emphasises the importance of identifying the strengths of the individual and of family members to support positive change.

Working towards resolving problems starts with the identification and analysis of problems, followed by the use a range of strategies for problem resolution - for example through using techniques such as brain storming possible solutions, agreeing and defining goals and speculating on the consequences of developing a specific plan or approach to a problem.

The **ability to map systems** includes the use of genograms and visual techniques such as role plays, sculpting or structural maps, with the aim of encouraging families to develop new representations of their past, present or future achievements and difficulties.

The **ability to make use of enactments** focuses on the use of enactment techniques to help develop alternative perspectives or ways of behaving, for example asking parents and children to enact familiar arguments, or making use of (and developing) spontaneous exchanges that emerge during the course of treatment.

The **ability to work with a systemic team** includes the capacity to work with different forms of reflection – for example when working as part of a reflecting team or the use of live commentary during therapy sessions, It also includes the ability to explain to clients the rationale for a team's involvement and agreeing with the client the most appropriate way in the team may be involved.

Specific adaptations of systemic therapies

This domain contains a number of problem specific interventions. The largest group is interventions for conduct disorder in children and adolescents, and include functional family therapy (Sexton and Alexander, 2004), multisystemic therapy (Henggeler et al; 1998), brief strategic family therapy (Szapocnik et al; 2003) and multi-dimensional family therapy (Liddle, 2002). The second area concerns the treatment of anorexia nervosa, drawing on the work of Eisler and Lock (Eisler et al; 2003; Lock et al; 2001). The final area is systemic couples therapy for depression Jones and Asen (1999).

Each of these problem-specific descriptions provides a coherent account of the key elements and pathways required to provide the intervention effectively. However, given the structure of some of the manuals and the broad range of interventions described within some of these interventions (for example, in multisystemic therapy) it is important that readers refer to the basic systemic competences previously covered in this framework. Use of the specific systemic competences will vary both according to the nature of the difficulties presented and the particular approach that is being adopted. As with all problem specific approaches the effective delivery of any intervention rests on a judicious use of generic, basic, specific and metacompetences.

Metacompetences

Therapy cannot be delivered in a 'cook-book' manner; by analogy, following a recipe is helpful, but it doesn't necessarily make for a good cook. This domain describes some of the procedural rules (e.g. Bennett-Levy, 2005) which enable therapists to implement therapy in a coherent and informed manner.

Therapeutic flexibility - the ability to respond to the individual needs of a client at a given moment in time - is an important hallmark of competent therapists. The interaction of a particular therapist and a particular client also produces dynamics unique to that therapeutic relationship, resulting in context-dependent challenges for the therapist. In other words, in psychological therapy the problems to be addressed can present differently at different times. The contextual meanings of the therapist and the client's actions change and the therapist is engaged in a highly charged relationship that needs to be managed. What is required therefore are a range of methods and approaches and complex interpersonal skills, under the guidance of very sophisticated mental activities.

On the whole these are more abstract competences than are described elsewhere, and as a result there is less direct evidence for their importance. Nonetheless, there is clear expert consensus that metacompetences are relevant to effective practice. Most of the list has been extracted from manuals, with some based more on expert consensus[2] and some on research-based evidence (for example, "an ability to maintain adherence to a therapy without inappropriate switching between modalities when minor difficulties arise", or "an ability to implement models flexibly, balancing adherence to a model against the need to attend to any relational issues which present themselves"). The

2 Through discussion and review of metacompetences by the Expert Reference Group

lists are divided into two areas. Generic metacompetences are common to all therapies, and broadly reflect the ability to implement an intervention in a manner which is flexible and responsive. Systemic metacompetences refer to the implementation of this therapy in a manner which is consonant with its philosophy, as well as the way in which specific techniques are applied. As is the case in other parts of the model, this division is pragmatically useful, but it is the case that many of the competences described as 'therapy-specific' could easily be adapted and apply to other interventions or techniques.

Implementing the competence framework

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

Do clinicians need to do everything specified in a competence list? The competence lists are based on manuals or descriptions of systemic techniques in therapy textbooks and manuals. Some of these techniques may be critical to outcome, but others may be less relevant, or on occasions irrelevant. Even where there is research evidence which suggests that specific "packages" of technique are associated with client improvement we cannot be certain about which components actually make for change, and exactly by what process. It needs to be accepted that the competences in the framework could represent both "wheat and chaff": as a set of practices they stand a good chance of achieving their purpose, but at this stage there is not enough empirical evidence to sift effective from potentially ineffective strategies. This means that competence lists may include therapeutic *cul de sacs* as well as critical elements.

A final point (raised earlier in this document) relates to the fact that because the systemic field contains some significant variations in practice, clinicians will necessarily be selecting primarily from those areas of the specific competence domain that fit to their model of practice.. Although this means that it is completely legitimate for therapists to be selective about which areas of the framework they adhere to, *within* each area the expectation is that all competences are probably relevant to practice.

Are some competences more critical than others? For many years researchers have tried to identify links between specific therapist actions and outcome. Broadly speaking better outcomes follow when therapists adhere to a model and deliver it competently (Roth and Pilling, in preparation), but this observation really applies to the model as a whole rather than its specific elements. Given the relative paucity of research on systemic therapies there is only very limited evidence on which to base judgments about the value of specific activities, and comment on the relative value of competences may well be premature.

The impact of treatment formats on clinical effectiveness: The competence lists in this report set out what a therapist should be able to do, but do not comment on the way in which therapy is organised and delivered – for example, the duration of each session, how sessions are spaced or whether the therapy is time-limited or longer term. Although such considerations will undoubtedly shape the clinical work that can be undertaken, the consensus of the ERG was that these variations do not necessarily have implications for the skills that therapists deploy.

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 (in preparation) reviewed the training and ongoing supervision associated with the delivery of therapy in the exemplar trials which contributed to this report. 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 which help to ensure the delivery of competent and effective practice. This means that claims to be implementing an evidence-based therapy could be undermined if the training and supervision associated with trials is neglected.

Applying the competence framework

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

Commissioning: The systemic psychological therapy framework can contribute to the effective use of health care resources by enabling commissioners to specify the appropriate levels and range of systemic therapies for 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 which is shared by both commissioners and providers, and which services could be expected to adhere to.

Service organisation – the management and development of psychological therapy services: The framework represents a set of evidence-based competences, and aims to describe best practice - the activities that individuals and teams should follow to deliver evidence-based treatments.

Although further work is required on the utility and associated method of measurement – they will enable:

- the identification of the key competences required by a practitioner to deliver systemic therapies interventions
- the identification of the range of competences that a service or team would need to meet the needs of an identified population
- the likely training and supervision competences of those managing the service

This level of specification carries the promise that the interventions delivered within NHS settings will be closer in form and content to that of the research trials on which claims

for efficacy 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 clients are to be assured optimum benefit. Monitoring the quality and outcomes of psychological therapies is a key clinical governance activity; the framework will allow providers to ensure that:

- Systemic therapies are provided at the level of competence that is most likely to bring real benefit by allowing for an objective assessment of therapist performance

- Clinical Governance systems in Trusts meet their requirement for service monitoring from the HCC and other similar bodies

Supervision: The systemic therapies competence framework potentially provides a useful tool to improve the quality of supervision by helping supervisors to focus on a set of competences which are known to be associated with the delivery of effective treatments. Used in conjunction with the supervision competence framework (available online at www.ucl.ac.uk/CORE/) it can:

- provide a structure which helps to identify the key components of effective practice in systemic therapies

- help in the process of identification and remediation of sub-optimal performance

Supervision commonly has two (linked) aims – to improve the performance of practitioners and to improve outcomes for clients. The systemic therapies framework could achieve these aims through its integration into professional training programmes and through the specification for the requirements for supervision in both local commissioning and clinical governance programmes.

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

- providing a clear set of competences which can guide and refine the structure and curriculum of training programmes (including pre- and post-qualification professional trainings as well as the training offered by independent organisations)

- providing a system for the evaluation of the outcome of training programmes

Registration: The registration of psychotherapists and counsellors is a key objective for the Department of Health. Although a clear set of competences associated with the key activities of these professionals groups may well contribute to the process of establishing a register, caution is that it represents only one aspect of a broad set of requirements that will inform a formal registration system.

Research: The competence framework can contribute to the field of psychological therapy research in a number of areas; these include the development and refinement of appropriate psychometric measures of therapist competence, the further exploration of the

relationship between therapy process and outcome, the development of new interventions and the evaluation of training programmes and supervision systems.

Concluding comments

This report describes a model which identifies the activities which characterise effective interventions in the field of systemic therapies, and locates them in a "map" of competences.

The work has been guided by two overarching principles. Firstly, it stays as close to the evidence-base as possible, 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 clients. Secondly, it aims to have utility for those who use it, clustering competences in a manner that reflects the way systemic therapy is actually negotiated and hence facilitates its 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 cook-book. Delivering effective therapy 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. Therapists of all persuasions need to operate using clinical judgment in combination with their technical skills, interweaving technique with a consistent regard for the relationship between themselves and their clients.
Setting out competences in a way which clarifies the activities associated with a skilled and effective practitioner should prove useful for workers in all parts of the care system. The more stringent test is whether it results in more effective therapy and better outcomes for clients.

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Appendix B – List of sources

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