MINDLER

Supervision Guide

A guide to clinical supervision, case management tasks, and support for Clinicians delivering Counselling for Depression at Mindler.

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Overview

The guide outlines the supervision available for clinicians at Mindler, focusing on professional development, support, and fostering reflective practice.

This course outlines the supervision available for clinicians at Mindler, focusing on professional development, support, and reflective practice. Key points include:

- Supervision Types: Access to individual and group sessions, case management, and clinical skills support, including case discussions, role-plays, and self-reflection.
- Support Structure: Dedicated supervisors offer tailored guidance through group, and text-based supervision tasks.
- Free and Structured: Supervision is provided free of charge to support professional development.
- Preparation: Clinicians submit case summaries and questions via Iaptus task centre, ensuring confidentiality.

This course highlights a comprehensive supervision model designed to support clinician growth and patient care.

1. Different Types of Supervision Available at Mindler

■ Different types of supervision available at Mindler

All Clinicians, regardless of their caseload, have access to a selection of support and development opportunities. Our Supervisors are committed to supporting your learning and development. They advocate reflective practice and encourage and support you to be the very best practitioner you can be. Supervisors have access to all live therapy material to support case management and supervision. Supervision follows the Roth and Pilling competency framework for supervision of psychological therapies.

From our enhanced model of clinical supervision, you can expect:

- A dedicated experienced Supervisor who wants to build a collaborative supervisory relationship with you
- A range of 1:1 and group supervision slots available throughout the week
- Option to join small-sized supervision groups with time to reflect on your work and learn with other Clinicians

- Ability to raise supervision questions via 'tasks' on our Therapy Platform for text-based supervision
- On call duty supervision for urgent risk 8am – 8pm every day (including weekends)
- Option to request a debrief after a difficult session
- Case Management and Clinical Skills supervision – may include a mix of case discussions, role-plays, and self-practice/self-reflection
- Smart tools to have an effective overview of your work and provide you with feedback to help you tailor and develop your clinical practice
- Option to request a 1:1 to discuss your skill development

Mindler patients should only be discussed with your Mindler Clinical Supervisor and not in supervision outside of Mindler.

In accordance with the Talking therapies supervision models:

CBT Therapists and Counselling for Depression Clinicians –have access to group or 1:1 supervision with their named Clinical Supervisor, as well as Case Management Support through text-based supervision tasks.

PWPs – should have Case Management Support delivered by their named Clinical Supervisor through the supervision task system. This is linked to the PWP best practice guidelines (IAPT Reach Out manual) case management approach to flagging and discussing new cases, non-response to treatment, 4 weekly reviews, DNAs, high risk, etc.

PWPs are also expected to attend monthly Clinical Skills supervision. This is a safe space where PWPs can discuss patient cases, interventions, processes, and contribute to discussions around Step 2 delivery with a Supervisor and fellow peers for support.

This supervision model is offered for free. We understand that what is offered will benefit your continued professional development, therefore, clinicians do not pay for attendance at these sessions.

Preparation for supervision and note taking

In preparation for your supervision please spend some time devising a brief case summary and stating a specific supervision question, then submitting this using the 'Task Centre' tool on iaptus.

Please do not email any patient formulations or supervision prep forms to your Supervisor. If you need your Supervisor to look at anything, please add it to the supervision task and inform them to check there, using the case reference but no other client identifying material.

2. How to Raise Supervision Tasks and Case Management Requests on the Platform

The supervision Tool/Task system on iaptus allows you to discuss patients and raise concerns for text-based support and case management. We use the Supervision Tool/tasks to have collaborative written discussions about the patients on your caseload. (Establishing suitability, extension requests, or onward referrals/referrals to secondary care, etc.) We aim to respond within 4 days.

Click here to view our full 'How to Create a Supervision Task' guide.

Although some guidance can be given, it is difficult to fully answer in depth clinical queries through non-live supervision. We provide free bookable video supervision which you can book with your allocated supervisor via The Hub. PWPs can request this via their Supervisor.

Clinical supervision can be delivered via live video conferencing, or via the tasks. If you choose to use the tasks to access clinical supervision, be prepared to reflect, enter into dialogue with your Supervisor, share hypotheses around formulation, and have more information to uncover. If you are unsure which modality is for you, we encourage you to use both and see. Many people use a combination of the two.

3. Specific Types of Supervision Case Management Tasks

■ Specific types of supervision case management tasks

There are a range of 'Supervision tasks' that you can raise for on demand supervision queries.

Step 2 Supervision tasks:

- Step 2 New patient
- Step 2 4 weekly review
- Step 2 Step up reallocate and rebook
- Step 2 High scores

Step 2 and 3 Supervision tasks

Step 3 Supervision tasks:

In line with best practice guidelines as part of the national PWP role, every PWP should submit 'Case management supervision' tasks for the following:

- Every new patient assessed or reallocated to them
- Every patient following x1 assessment/mini assessment and x3 treatment sessions- known as a 4-weekly review
- Support if required
- High scores

See below a description of each task, and some examples of what to include to help your Supervisor answer your questions.

■ General tips on what to include in your supervision tasks

- Supervisors may not have time to read clinical notes or session transcripts. It is therefore important that you provide sufficient detail. Make sure that reading your request alone will help the Supervisor understand the problem/ question fully. Although this can take a little longer, ultimately it will save time by reducing the likelihood the Supervisor will need to reply to seek clarification
- We aim to respond to supervision tasks within 4 days (except 'Urgent tasks', which are responded to within an hour)

- If your Supervisor is on holiday, another supervisor may get back to you. It may be responses are slower during your Supervisor's leave, but they will email ahead to let you know

4. Specific Task Guidance

Step 2 'New patient' task

Purpose: For PWPs – allows case management of every new patient in line with best practice guidelines for PWP role.

Information required: Please try to avoid copy and pasting your entire assessment notes, as all Supervisors have access to notes and transcripts. Please lay out the supervision task with a clear summary, which includes:

- MDS/ADSM (e.g., PHQ9 – 10/ GAD – 13)
- Presenting problem and symptoms (e.g., Anxiety: worrying, feeling on edge, unable to relax, avoidance.)
- Patient's risk (e.g., Low – scoring 1 on PHQ question 9, Fleeting thoughts, no plans or intent, protective factor – Kids)
- Patients goals (e.g., 'To reduce my worrying thoughts and relax')
- Your proposed treatment plan (e.g., worry management with relaxation techniques)
- Any questions (e.g., Do you have any resources on PMR?)
- Any other useful factors (e.g., Patient does mention that they do suffer with some health worries – should I provide an ADSM?)

Step 2 '4 weekly review' task

Purpose: For PWPs – allows case management of all patients at the point of review in line with best practice guidelines for PWPs.

Information required: When raising a '4 weekly review' task it can be helpful to provide your supervisor with a clear overview based on the current treatment plan

- Presenting problem (e.g., Depression, loss of energy and motivation, no longer doing usual activities)

- MDS/ADSM (e.g., PHQ was 14 now 6/ GAD was 9 now 3)
- Patient initial goal (e.g., 'To improve my motivation to tidy the house and meet my friends at the gym again')
- Treatment plan (e.g., Behavioural Activation with procrastination tips)
- Engagement (e.g., attending session regularly and completing tasks in between sessions)
- Sessions (e.g., completed 1 assessment and 3 treatments)
- Plan (e.g., 'To complete treatment in final session and go through relapse prevention')

Step 2 'Step up and reallocate' Task

Purpose: where a patient's difficulties would be more suited for formulation and treatment at step 3.

Information required: please provide a hand over summary for the step 3 clinician.

- Rationale for referral step up (Presenting with symptoms consistent with social anxiety)
- Confirmation that the step up has been discussed and agreed with the patient
- Recent MDS and any ADSM's (e.g. PHQ9-10, GAD7-14, SPIN-32)
- Risk summary (e.g., Low – scoring 1 on PHQ question 9, Fleeting thoughts, no plans or intent, protective factor identified)
- Goals of patient (e.g. Patient would like to be able to feel less anxious in social situations and stop avoiding them)
- Any treatment completed at step 2 (e.g. Completed 2 sessions at step 2, these mainly focussed on assessing the patient's current difficulties and introducing them to the CBT model)

'Live clinical supervision' task

Purpose: To formulate a supervision question ahead of a booked live supervision session and log that a patient's treatment has been reviewed and discussed in relation to best practice.

Information required: The patient will likely be described verbally, but anything you feel might be helpful for the Supervisor to know ahead of time (such as number of sessions, MDS, risk, presenting problem, protocol, response to treatment, and supervision question, etc.).

If a particular type of supervision input would be helpful (such as role-play, review excerpt from session, review message etc.) you could also specify this in the task.

Possible action points: After the supervision session, you and your supervisor can log the discussion with the key points you'd want to remember and any action points for the patient's ongoing treatment.

Action required by Clinician: After your supervision session, please update the supervision task with key reflective points that will be most helpful to guide the next steps of treatment. Your Supervisor may also add some notes.

> *Group supervision booked 10/10/22*:
>
> *Number of sessions*: *7*
>
> *MDS*: *Their PHQ at intake was 18, now 12; GAD-7 16, now 15*
>
> *Risk*: *There is no risk present (0 PHQ9 question 9)*
>
> *Main presenting problem*: *Patient presents with OCD (OCI= 52). Patient checks windows, doors & appliances, as well as work tasks*
>
> *Goals*: *The patient's goals are to reduce checking to 1-2 times; to go back to the gym twice a week; to feel more confident at work*
>
> *Protocol/ techniques so far*: *Protocol*: *ERP. Techniques*: *psycho-ed, formulation, hierarchy*
>
> *Supervision question*: *Patient is struggling with ERP tasks/ not completing them. What can I do next?*

Risk: Non- Urgent' task

Purpose: To share a patient's risk, the management of it so far, and ask for additional guidance as needed. This includes risk to self (self-harm/neglect/thoughts of suicide), risk from others (adult safeguarding/a crime), or risk to someone else identified (child safeguarding). This is for routine enquiries which do not need an immediate response from Mindler. If the risk is urgent (the patient or someone else is at imminent risk of harm), please follow the guidance on the role of the Supervisor in responding to risks role of the supervisor in responding to risk and raise a 'Risk: Urgent' task, which will be responded to within an hour. It's always good practice to log that risk has been discussed and seek support as needed.

In the first instance, please refer to Risk Management Guidance in section 6; and once actioned, always feel free to seek further guidance. Although we advocate clinical judgement and taking appropriate action before asking for help, your supervisor team will be happy to answer further questions, so you are not alone when making risk decisions.

Information required: See example below for an advised template.

Possible action points: Your Supervisor might review your assessment so far and ask for additional information, make further suggestions (such as additions to a safety plan), or ask for further risk actions to be taken (e.g., writing to the GP to update on changes in risk).

> *PHQ 9 Q 9: 2 (more than half the days) Nature/ content of thoughts: Patient has thoughts of 'Everyone would be better off without me' more than half the days*
>
> *Current plans/ preparations: Has thoughts of falling asleep and not waking up again to avoid the pain/sadness of the day. No thoughts of means, preparations, or access to means*
>
> *Current intent to act (0-10: 0 = I definitely won't, 10= I'm certain I will): 2/10. Patient states on some days they think about how they could make it happen, but immediately think 'I couldn't do that' and distract themselves*
>
> *Historical risk: No previous acts towards life, no current or historical DSH*
>
> *Current exacerbating factors: Patient has had difficulties at work and feels hopeless that the situation will resolve*
>
> *Current protective factors: Patient has a very supportive partner and wishes to live; has some hope for the future and wants things to improve*
>
> *Risk Management Plan (RMP): I have sent the 'managing suicidal thoughts' booklet, given emergency numbers and completed risk management plan. Patient has no access to means, talks to partner regularly and has good rapport with their GP*
>
> *Supervision question: Any further action needed by the Clinician? Should I write separately to the GP?*

'Risk (Urgent/ secondary Care)' task

Purpose: For urgent, same-day support around a risk issue that has arisen with a patient.

Information required/actions: See 'Urgent risk' and the role of the Supervisor in responding to risk

For secondary care referrals Purpose: For urgent secondary care referrals/ cases where an urgent screening and intervention are needed. Examples include: symptoms of an active psychosis; high distress and volatile behaviour requiring a response time quicker than a routine referral.

Information required: It is helpful to provide as much detail about the presentation in the supervision task as possible to help your Supervisor support decisions about onward referral. This information can be used in any referral forms or rationales sent to the service.

Possible action points: If the secondary care referral is supported by your Supervisor, and enough information is provided, please check the site protocol to see whether the protocol is to complete a referral form, or to add the rationale in the form of a 'Referral letter'. Once the information required is in the 'Referral letter', your Supervisor will approve this, close the task, and the Patient Services Team will send the referral. You can discharge the patient once we have confirmation that the referral has been accepted.

> *I have had two sessions with this patient.*
>
> *They score 24 on PHQ 9 (severed depression), Qu9 was 2 and 21 on GAD 7 (severe GAD)*
>
> *During our first appointment the patient reported hearing voices. The patient told me they regularly hear voices and have been managing these until recently when they have suddenly become worse. They reported they have had these experiences before but have recently stopped taking the medication prescribed. They no longer have contact with secondary care services. Reports voices are getting more aggressive and is not sure what is real and what is not. Has not yet acted on any command from voices.*
>
> *Risk: Scored 2 on question 9, no immediate concerns to harm themselves, but recognises symptoms have returned. Safety plan in place and is willing to tell family and friends of the current situation to gain support.*

'Engagement queries' Task

Purpose: This could be if a patient has surpassed the number of allowed late cancellations/DNAs and you wish to run this past a supervisor, if there's difficulties attending sessions, or if there has been non-engagement with CBT between session tasks. Please be aware the 2 late cancellations or DNAs are per patient episode, not by Clinician or Step.

Information required: What is the engagement difficulty? What attempts to overcome any difficulties so far and patient's response to it? Is the patient aware of Mindler policies/attendance expectations (this will need to have been messaged to the patient at each breach using templates on The Hub)?

Possible action points:

- If the patient has surpassed the number of DNAs/cancellations but with a very good mitigating circumstance, there may be flexibility to continue with sessions (to be agreed case by case)
- If the patient has not booked in a session within the agreed timeframe your Supervisor might help you to devise a clear, boundaried message to encourage engagement.
- If the patient is not engaging with homework, you might discuss with your Supervisor how to encourage this in a supportive manner or bring non-engagement into the patient's formulation. This could be booked as a live video discussion.

Patient presentation: depression

MDS: PHQ 9: 17; GAD 7: 12

Risk: Low. PHQ 9 Q9: 1. Fleeting thoughts of being better off not here- no intent (0/10).
Work so far: Assessment, 5 areas, baseline BA diary

Engagement difficulty: Patient has now not attended two sessions (DNA). The first time they forgot, the second time they slept in. After the first DNA <date> I sent a reminder of the policy. We talked about ways to prevent them forgetting (alarm on phone).
Following the second DNA the patient was apologetic. Engagement with homework has been OK - they completed 3 days of the baseline diary and did find the 5 areas difficult to do.

Supervision question: I am unsure of what to do, as the reasons for not attending are part of the depression. Please advise.

Top tip

If a patient has breached the DNA policy, however you have concerns regarding discharge, please reach out to your Clinical Supervisor to discuss.

'Reallocation' task

Purpose: If a patient or the Clinician requests to be reallocated to a new Clinician, within the same modality due to a rupture conflict, If the patient has requested this via patient services, your Supervisor will be informed and you will be asked to create a reallocation request via the supervision task centre in iaptus.

When all the actions above have been completed, your Supervisor will close the task and the case will be reallocated.

> *John and I have had a rupture to the therapeutic relationship which is making treatment difficult. John has requested a new therapist at the end of our last session.*
>
> *During the appointment on XX date, we appeared to have a communication difficulty about the homework and compliance to complete it. This has been an ongoing theme throughout treatment. I would like to consider having this patient reallocated to a new therapist. I will book some time with you to reflect on this case and identify any learning points. John has now requested a new Clinician.*

Other task

If your query doesn't quite fit with the suggested categories and you are unsure, feel free to raise an 'Other' task, give the task a more specific title in the title section and together you and your Supervisor will agree the appropriate heading before closing the task.

'Onward referral' task

Purpose: For routine onward referrals to other services, such as IAPT or secondary care. Cases where a non-urgent screening and intervention are needed. Examples include: diagnosis indicated not worked with within Mindler (Axis II); highly impaired functioning not responding to primary care intervention; complex/type II trauma indicated.

Information required: It is helpful to provide as much detail about the presentation in the supervision task as possible to help your Supervisor support decisions about onward referral. This information can be used in any referral forms or rationales sent to the service

Possible action:

Please follow these steps before completing a clinical contact for an onward referral:

1. Create a supervision task with a summary of patients' support needs.

2. Once agreed to refer on, establish a detailed rationale by creating a Non MDS clinical contact.

3. Notify your supervisor again through the ticket to prompt referral to the Patient Services Team.

> *I have had two sessions with this patient.*
>
> *They score 24 on PHQ 9 (severed depression) and 21 on GAD 7 (severe GAD).*
>
> *During our second appointment the patient shared childhood trauma, that was prolonged and repeated. The patient described not having a sense of safety since this*



point. During their teen years, they regularly self-harmed and had CAMHS input. In adulthood, they have experienced abusive relationships. They are currently safe from harm, but they continue to feel depressed, have low sense of trust in others, relationship difficulties, and describe frequent flashbacks to childhood events. Although they currently do not self-harm, they do describe dissociation and feeling detached regularly. They are struggling to work and have limited social support. Their GP has suggested EUPD diagnosis, but this has not been confirmed. I wonder if this patient's needs might be better met in secondary care services due to multiple traumas, severe depression, history of CAMHS input, isolation, and frequent dissociative symptoms.

Information required: See referral to service rationale in 'How to write a referral back to service'.

'Session extension' task

Purpose: Although the average number of sessions for Step 3 is 6, and Step 3+ is 9, this is not a limit. We ask for session extension requests before session 6 and every 4 sessions thereafter for both Step 3 and Step 3+.

This is a valuable exercise to pause and reflect on sessions so far, what has been covered, and where you and the patient are 'on track'.

Information required: See example below, but we will need enough information about treatment so far, how many sessions are being requested, and a proposal for further sessions.

Possible action points: Additional sessions approved, less than requested sessions approved, more information requested.

Presenting problem: GAD

MDS: PHQ 9: 12; GAD 7: 12

Number of sessions so far: 5

Protocol (if appropriate) or treatment so far: Formulated using Dugas; worry awareness training; hypothetical vs practical problems; problem solving.

Engagement: Engagement is good, patient completes homework and reports sessions have been helpful. No further supervision questions due to treatment going well do far.

Number of sessions requested: 4 (taking to 10)

> *Proposed content of sessions: Continuation with Dugas protocol (challenging positive beliefs about worry; behavioural experiments re. tolerating uncertainty and, if appropriate, worry exposure).*

'Step up to Step 3+' task

Purpose: Patient is meeting criteria for Step 3+, and request is for step to be changed from 3 to 3+.

Information required: Any information that will confirm whether the patient meets the following criteria for Step 3+: Step 3+:

- Depression (including that relating to antenatal and postnatal mental health)
- Severe Depression (DSM Criteria and/or PHQ9 20-27)

AND/OR

- Patients with common mental health problems (as listed in inclusions above) with additional psychosocial needs. They may present with co-morbid or historical difficulties (which will not be the focus of therapy) e.g., functional ASD, CFS, Chronic Pain etc.)
- Severe OCD

Possible action points: This will either be approved and changed by your Supervisor, or if criteria are not met, will be left as Step 3. If the case does not meet Step 3+ criteria, do not worry. If there are other factors not included in the criteria that will impact on the trajectory of treatment and amount of time needed for sessions, you can still extend sessions as needed using the 'Session extension' task.

> *I have assessed this patient and they score 19 on PHQ 9 question 9. They have also been diagnosed with Chronic Fatigue - which is impacting their energy and mood; and they become frustrated with themselves that that they can't do what they used to do. We are formulating using Beck, while acknowledging the impact of their condition on their depression/energy and activities. Would this patient meet Step 3+ criteria?*

'Modality change' task

Purpose: If a patient requests a modality Change, it is important that you check the site protocols to ensure that this is an option for the specific contract. 'If a patient is able to switch from typed to video, or vice versa, please request a modality change through your supervisor and follow the guidance below. Please do not continue with the patient sessions until the modality change has been agreed in supervision.



Information required: Provide details on the steps that have been taken to encourage engagement:

- Reflect on how the client has been engaging in a specific modality
- Adjustments that have been made to help engagement
- Patients feedback on modality
- Why you are recommending video sessions

Possible action points: This will be discussed with your supervisor and next steps will be agreed before resolving the task.

> *We've been using cognitive restructuring techniques to tackle their anxious thoughts, and they've been keeping track of their triggers and coping strategies between sessions.*
>
> *In our typed sessions, they've been engaged, but there have been moments where the lack of face-to-face interaction makes it hard to pick up on subtle cues and emotions.*
>
> *To address this, I've tried incorporating more visuals and interactive exercises to keep things lively and engaging.*
>
> *They've mentioned they like the structure of our typed sessions but feel like they're missing out on the personal connection that video sessions could offer. They're keen to have more real-time interaction and visual cues to enhance the therapy experience.*
>
> *I believe making the switch to video sessions could really ramp up the effectiveness of therapy. Being able to see each other in real-time may help build a stronger therapeutic rapport and delve deeper into their anxiety triggers and coping strategies.*

‘Step 3 Change of Treatment Type

Purpose: Following a full assessment, if your conclusion is the patient would benefit from switching from either CBT to CfD or vice versa, you can check the site protocols to determine if this is possible. If it is a switch we are able to do, raise this task with your supervisor to review.

Information required: You have checked the site protocols and changing therapy type is available on this contract. Please consider:

- Review the criteria to both CfD or CBT as per your training and Mindler inclusion and exclusion criteria.
- Reflect on the patients engagement and willingness to engage.

Possible action points: This will be discussed with your supervisor and next steps will be agreed before resolving the task.

> *We have engaged in a piece of work focussing on depression and the recent life events which the patient has been dealing with. In completing the initial assessment, it appears this patient has also be struggling with long term PSTD and is having symptoms which would need reviewing with CBT.*
>
> *The patient has engaged well up to this point and has not DNA'd or attended late.*
>
> *The patient feels this is the best route for them considering the level of difficulty they are expressing.*

Discharge Non recovered ' task

Purpose: The objective of this task is to comprehensively review the treatment journey, identify potential hurdles to progress, conduct a thorough risk assessment, explore the client's sentiments regarding the conclusion of treatment, and discuss the potential necessity for additional guidance or referrals with the clinical supervisor.

Information required: Provide rationale and reflection on the following:

- ADSM Scores: Review recent scores
- Recovery Discussion: Explore non-recovery reasons, address barriers.
- Patients Response: Assessment of discharge readiness.
- Signposting Opportunities: Explore resources, confirm awareness, capture concerns, consider input.
- Risk Assessment: Thorough assessment, identify risks, obtain consent for sharing with GP.

Possible action points: This will be discussed with your supervisor and next steps will be agreed before resolving the task.

> *I'm writing to discuss the potential discharge of a patient from our therapy services. Despite our efforts, the patient hasn't shown significant symptom improvement, as reflected in their recent ADSM scores. However, they've expressed a strong readiness to move forward from therapy, indicating a desire to explore alternative support options.*
>
> *In exploring the reasons for the limited progress, we've identified barriers that may have impeded the therapeutic process which includes external stressors relating to a recent house move. Despite addressing these barriers, the patient's symptoms persist.*

Nevertheless, their expressed readiness for discharge signals a shift in perspective and motivation to seek new approaches for managing their challenges.

To ensure the patient's safety post-therapy, I've conducted a thorough risk assessment. They've consented to sharing relevant information with their GP for ongoing care. While their symptom reduction may not meet our initial expectations, their agency in deciding to move forward is an important consideration.

Suitability Task

Purpose: Patients may present new information during their initial session/s, which can sometimes lead to questions about their suitability for our primary care services. To ensure we provide the best care possible, we encourage you to bring any patients to supervision as soon as possible if you have any concerns or queries regarding their suitability. Please remember that if your concerns are risk related that you should continue to use the non-urgent and urgent risk categories.

Information required: Provide details on the steps that have been taken to encourage engagement:

- What are your suitability concerns
- Why you feel Mindler is not the best service for this patient
- Any questions you might have around suitability and exclusion/inclusion criteria

Possible action points: This will be discussed with your supervisor and next steps will be agreed before resolving the task.

I have seen this patient for their first session today.

PHQ9 – 21, GAD7 – 18

They have reported to me that they have recently been assessed by the community mental health team (CMHT) and been giving a diagnosis of EUPD and is waiting for treatment with their service.

Their main presenting difficulties appear to be emotional dysregulation as well as periods of very low mood.

Risk: experiences intrusive thoughts around harming themselves,no plans to act, but has engaged in impulsive behaviours previously (not for 1 year), If struggling reaches out to partner and/or crisis support services.

Suggested Plan: I don't feel Mindler is the most appropriate service to meet this patients needs currently. I would suggest they continue to engage with the CMHT and wait for the treatment they are offering.

Please let me know your thoughts on this case and my suggested plan?

5. Using Data to Improve Outcomes at Step 3 for CBT Interventions

Clinicians working with us have proven themselves to be above standard in their ability to deliver evidence-based interventions with fidelity to the CBT model. Once you begin treating patients, Mindler begins to collect a wide range of data that is used to inform future continuing professional development. We feedback the data to you to help you learn via supervision and grow as a Clinician.

Our AI scientists have also developed an automated CTS-R, which we are calling the CTSRR. This is based on a model we call the Therapy Insight Model ("TIM"), which is our automated model based on the Cognitive Therapy Scale-Revised (CTS-R) Therapy Insight Model (TIM or CTSRR), as used in our published research papers. We use TIM in supervision and training to provide you with feedback on your work. Normally in CBT you might do a CTS-R a couple of times a year, and whilst we believe that this is a useful exercise, it does not give you the most effective overview of your work in real time. Imagine if you could have a CTS-R on every single therapy session you deliver. -That's what we do with TIM. You can access this information via supervision, just book in with your supervisor.

We really hope that this data can help you identify your strengths and reflect on areas you would like to improve. We recommend periodically booking in with your Clinical Supervisor for a 1:1 meeting to support your self-reflections on the data. Reflecting on patient feedback and outcome data is an important part of Continued Professional Development.

If you have any concerns or questions, please do not hesitate to contact your Clinical Supervisor who will be there to support you.