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Brain Impairment

Supplementary Material

Developing consensus-based clinical competencies to guide stroke clinicians in the implementation of psychological care in aphasia rehabilitation

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Supplemental file S1

Link to information package for healthcare professional focus group

https://docs.google.com/presentation/d/1UUjznm3U6akK_9Uc5wUu91-4YS5AEbKQ/edit?usp=sharing&ouid=117006403433980857939&rtpof=true&sd=true

Link to information package for people with aphasia and family members focus group

https://docs.google.com/presentation/d/19Gzd_ZnEJmNzb9cKFTsV9Kz4MXAIprFV/edit?usp=sharing&ouid=117006403433980857939&rtpof=true&sd=true

Supplemental file S2 *Focus group qualitative content analysis*

Theme	Category	Meaning unit	Count
Communication support	The clinician uses personalised communication support strategies to support communication.	Communication support skills are important.	2
		To know the nature of the person with aphasia's communication disability (strengths and challenges).	
		Appropriate questions for people with aphasia (e.g., use yes/no questions).	3
		Use support and gesture.	2
		Avoid background noise.	2
		Stay on the one subject.	
		Use of mood cards.	
		Slowing rate of speech.	
		Increasing the confidence of psychologists to address communication support.	
		Recognising the communication strengths of the person with aphasia.	
	The clinician acknowledges the competence of the person with aphasia.	Understanding masked competence and revealing competence.	2
		Attitude that reveals competency (the clinician must develop skills to help the person with aphasia to reveal competency).	3
		I felt like I was back at school.	
		Make you feel normal again; I need to feel like a person.	
		Respecting of the expertise of the person with aphasia.	2
Assessment and therapy structure	The clinician takes a person-centred approach to goal setting	Skills for goal setting and ensuring it is person-centred.	
		Integration of level one therapies with other activities (e.g., goal setting).	
	The ability to identify mood difficulties through screening.	Screening for suicidal ideation and knowing how to respond/what to do.	
		Skills in mood screening.	7
		Knowledge of mood screening tools.	2
		Support to open up about feelings.	2
		To differentiate between grief/low mood and major depressive/anxiety disorder.	2
	The clinician makes appropriate referrals to and works with specialists to support the person with aphasia.	To know when to refer on and know the routes for referral.	2
		For non-psychologists to know who to turn to for their own support.	3
		Communicate with other health professionals to pass on information/ therapy goals.	2
		Knowledge about levels of support on entry to a service.	4
	The provision of psychoeducation regarding how psychological therapies can help.	Knowledge of counselling theories and their rationales.	
		Accepting of the evidence-based practice approach.	
		The clinician needs to understand the value of psychological therapy and how it	2

		should be prioritised.	
		To know the symptoms of depression (and when to escalate up the stepped care hierarchy).	
		Go to brainlink or enableme and get fact sheets.	
		Attitude that mental health is treatable.	
		Understanding of stigma around mental illness.	
	Adapting therapy sessions based on the personal factors of the person with aphasia.	A willingness to adapt therapy/support.	2
		Gearing therapy to likes/dislikes.	
		Fatigue can be a big issue – need to consider this.	3
		Consider memory problems – come up with strategies for this.	
		Managing outbursts, mood change and frustration.	
		Holistic approach.	
	The ability to address the psychological needs within the clinician's scope of practice.	A clinician needs to know their own scope of care.	3
	The session is structured and maintains a focus on treatment goals.	Repetition of activities is important.	
		It's important to recap or go over previous sessions at the start.	
		Explain what is going to happen/what is expected in the session.	
Interpersonal skills	Importance of the development of a therapeutic alliance.	Relationship-centred practice.	6
		Allow time to interact and share stories.	3
		Get to know the person, their background, their family, pets, interests- making a connection.	
		Be a person – use humour as appropriate.	
		Respect.	3
	Addressing a person's needs related to their social, cultural and language background.	Skills to work with CALD populations (interpreters etc.).	
		Cross cultural awareness and responsivity.	
		Social focus.	
	Non-verbal communication (e.g., facial expression, gesture, tone of voice and eye contact) is used by the clinician to build the therapeutic relationship.	Explore feelings through body language, gesture, facial expressions.	3

	The clinician is empathetic and non-judgmental of the emotions expressed by the person with aphasia.	Therapist is non-judgmental.	
		To acknowledge and validate the person's experience.	3
		Support with grief around employment changes.	
		Empathy and having a compassionate approach.	
Significant others' (friend or family member) considerations	The clinician supports and communicates with significant others' as appropriate.	Understanding the role of the family.	
		Family-centred practice.	2
		Family members don't understand brain injuries and implications – dot point messages.	
	The clinician involves significant others in goal setting and therapy as appropriate (e.g., support in therapy tasks; observation/monitoring of mood changes).	Where appropriate, engagement of family members in therapy (flexibility and responsiveness and seeing the person with aphasia in the context of their family).	2
	The clinician provides information, resources and supports for significant others to seek help as needed (e.g., General Practitioner visit, counselling services, stroke and/or aphasia group supports).	Allow time to talk with the family.	
		Need support for family members.	
		Change of role from mother/wife to helper – support of this.	
		Resources for family members.	2
	The clinician shows concern for significant others' emotional difficulties.	Recognise that it's a long and hard journey for family members – we need someone to openly talk to and trust.	
		Change of role from mother/wife to helper – support of this.	
		Skills to support family members.	2

Supplemental file S3

Round 1 e-Delphi Survey Results

#	Competencies	% participants			Qualitative comments
	Self-rated items	**Essential**	**Important, but not essential**	**Not important**	**Suggestions regarding wording and/or appropriateness of the competency**
1	I can address the psychological care for people with aphasia within my scope of practice (Baker, Worrall, Rose & Ryan., 2020; Kneebone, 2016; Simmons-Mackie, 2018).	91%	9%	0%	• Replace 'care' with 'needs' • Insert 'level one of stepped psychological care' in this competency
2	I can identify mood difficulties appropriately (Baker, Worrall, Rose & Ryan., 2020; Kneebone, 2016; Simmons-Mackie, 2018).	91%	9%	0%	• Be more specific- acute mood difficulties, chronic, severe etc. • Mention screening
3	I can address the person's needs related to their social and cultural background (Grandpierre, Milloy, Sikora, Fitzpatrick, Thomas & Potter, 2018; Perry, 2012).	82%	18%	0%	• Include language background • Add examples
4	I can change the physical space depending on the person's goals and type of therapy (e.g., background noise; opportunities for socialisation; privacy) (Baker, Rose, Ryan & Worrall., 2020; Kneebone, 2016).	73%	18%	9%	• This may not be relevant to an aphasia specific mood measure; • Clinicians can reflect but not be able to do much about their reflections.
5	I can adapt therapy sessions based on the personal factors of the person with aphasia (e.g., fatigue, frustration etc.) (Lawton et al., 2017).	100%	0%	0%	
6	I can make appropriate referrals to and work with specialists to support the person with aphasia as needed (Kneebone, 2016; Mapanga, Casteleijn, Ramiah, Odendaal, Metu, Robertson, et al., 2019).	100%	0%	0%	

New suggested items: Include a competency that allows the clinician to reflect on family systems/family centred practice. Include competencies that allows the clinician to reflect on the clinician being able to assist significant others' to use communication strategies.					
Observer-rated items					
Communication support					
7	The clinician uses personalised communication support strategies to support the person's understanding (receptive language skills, "message in") (e.g., uses short and simple messages; pictures, photos, objects, gesture, written key words; repeats information) (Baker, Worrall, Rose & Ryan., 2020, Baker, Rose, Ryan & Worrall., 2020).	100%	0%	0%	• Replace "message in" and "message out" terminology with definitions of receptive and expressive language strategies. • The double use of brackets is confusing.
8	The clinician uses personalised communication support strategies to support the person's talking (expressive language skills, "message out") (e.g., uses yes/no questions, provides extra time for the person to reply) (Baker, Worrall, Rose & Ryan., 2020, Baker, Rose, Ryan & Worrall., 2020).	100%	0%	0%	• Replace "message in" and "message out" terminology with definitions of receptive and expressive language strategies. • The double use of brackets is confusing.
9	The clinician acknowledges the communication competence of the person with aphasia (Baker, Worrall, Rose & Ryan., 2020, Baker, Rose, Ryan & Worrall., 2020).	91%	9%	0%	• Add examples.
Assessment and therapy structure					
10	The clinician provides psychoeducation regarding the prevalence of mood difficulties and how psychological intervention can help (e.g., provision of information about psychological supports and resources) (Northcott et al. 2018).	82%	18%	0%	• Add "personally tailored" before psychoeducation

11	The clinician takes a person-centred approach to goal setting, encouraging the person to participate in identifying goals for intervention (Thomas et al., 2012; Lawson et al., 2017; Lawton, Conroy, Sage & Haddock., 2019).	91%	9%	0%	• Could add family/support person where appropriate (e.g. "The clinician... encouraging the person (+/- support person where consent given and appropriate)…" • Include "goals are co-constructed with a person with aphasia" • Include mention of supporting people to reflect on what would be meaningful for them.
12	The person's goals and how therapy can help to achieve those goals are revised at the start of the session (Thomas et al., 2012; Lawson et al., 2017; Lawton, Conroy, Sage & Haddock., 2019).	27%	73%	0%	• Goal setting/revision should be flexible and open to the idea that goals can change.
13	The session is structured and maintains a focus on treatment goals (Lawton et al., 2017).	55%	27%	18%	• This competency may limit flexibility in sessions.
Suggested additional item: The clinician can explain psychological therapies in a format suitable for the person with aphasia.					
	Interpersonal skills				
14	The clinician shows building of trust and therapeutic relationship in various ways that are appropriate to the person and situation (e.g., sharing stories, conversation, news, humour) (Baker, Rose, Ryan & Worrall., 2020; Northcott et al. 2018; Simmons- Mackie and Damico 2011; Victorino and Hinkle, 2018; Carragher, 2020; Fourie, 2009).	100%	0%	0%	• Rephrase slightly to "The clinician pays attention to and facilitates the development of trust and the therapeutic relationship… • Situation could have negative connotations, remove this word.
15	The clinician shows empathy and attention towards the person's needs (Baker, Rose, Ryan & Worrall., 2020; Northcott et al. 2018; Simmons- Mackie and Damico 2011;	100%	0%	0%	• Merge competencies 15 and 17

	Victorino and Hinkle, 2018; Carragher, 2020; Fourie, 2009).				
16	The clinician uses active listening throughout the session (e.g., by orienting self physically toward the person or through repeating or rephrasing to confirm the meaning of what the person has communicated) (Baker, Rose, Ryan & Worrall., 2020; Northcott et al. 2018; Simmons- Mackie and Damico 2011; Victorino and Hinkle, 2018; Carragher, 2020; Fourie, 2009).	91%	9%	0%	• Revise the examples
17	The clinician is non-judgmental of the emotions expressed by the person (Baker, Rose, Ryan & Worrall., 2020; Northcott et al. 2018; Simmons- Mackie and Damico 2011; Victorino and Hinkle, 2018; Carragher, 2020; Fourie, 2009).	91%	9%	0%	• Merge competencies 15 and 17
18	Non-verbal communication (e.g., facial expression, gesture, tone of voice and eye contact) is used by the clinician to build the therapeutic relationship (Carragher, 2020).	100%	0%	0%	
Significant others considerations (e.g., family member)					• Include ‘friend’ in the brackets
19	The clinician communicates with and supports the significant other (Grawburg, Howe, Worrall, & Scarinci, 2013; Sekhon, Oates, Kneebone and Rose., 2019; Kneebone, 2016).	91%	9%	0%	• Communicates with and supports is too general, include: "includes/involves in session and updates"
20	The clinician shows concern for significant others’ emotional difficulties (Grawburg, Howe, Worrall, & Scarinci, 2013; Sekhon, Oates, Kneebone, & Rose, 2019; Kneebone, 2016).	91%	9%	0%	• Consider revising “concern”. It is important to be empathetic.
21	The clinician provides information regarding the high prevalence of mood difficulties significant others may experience (as appropriate) (Northcott et al. 2018).	82%	18%	0%	
22	The clinician provides information, resources and supports for significant others to seek help as needed (e.g., General	91%	9%	0%	

	Practitioner visit, counselling services, stroke and/or aphasia group supports) (Grawburg, Howe, Worrall, & Scarinci, 2013; Sekhon, Oates, Kneebone, & Rose, 2019; Kneebone, 2016).				
23	The clinician involves family members in goal setting and therapy as appropriate (e.g., support in therapy tasks; observation/monitoring of mood changes) (Grawburg, Howe, Worrall, & Scarinci, 2013; Sekhon, Oates, Kneebone, & Rose, 2019; Kneebone, 2016).	45%	55%	0%	

Supplemental file S4

Round 1 e-Delphi Survey Results self-rated scale

Score	Self-rated items rating scale	Suggestions regarding wording and/or appropriateness of the rating scale
0	I'm not familiar with the concept	
1	Familiar, but not at all confident	
2	A little confident	• Reword to: 'not so confident'
3	Somewhat confident	• Change to moderately confident
4	Very confident	• The difference between 4 and 5 is unclear.
5	Completely confident	• Remove

Supplemental file S5 *Round 1 e-Delphi Survey Results observer-rated scale*

Score	Observer-rated items rating scale	Suggestions regarding wording and/or appropriateness of the rating scale
0	Not observed	
1	Observed – not done well	• Remove done • Reword to requires further training
2	Observed – done adequately	• Remove done
3	Observed – done well	• Remove done • Consider rewording all by looking at the UK Stroke Specific Educational Framework • Include space for qualitative comments

Supplemental file S6

Round 2 e-Delphi Survey Results

#	Competency	% of participants who rated:			Qualitative comments	
		Essential	**Important, but not essential**	**Not important**	**Suggestions regarding wording and/or appropriateness of the competency**	**Suggestions for a new competency**
Self-rated items						
1	I can address the psychological needs of people with aphasia within my scope of practice within stepped psychological care.	100%			• Too ambiguous/unclear	-
2	I can screen for depression in the person with aphasia.	100%			• Add "and refer appropriately" to end the of the competency. • Should include competency in screening the significant other for mood.	-
3	I can screen for suicidal ideas and refer on appropriately.	100%			• Should mention suicidal ideas, plans and intent. • Change ideas to ideation.	-

4	I can screen for anxiety in the person with aphasia.	100%			• Add "and refer appropriately" to the end of the competency.	-
5	I can address the person's needs related to their social, cultural and language background.	100%			• Reword to: In my work with the person with aphasia, I take into account their social, cultural and language background.	-
6	I can adapt therapy sessions based on the personal factors of the person with aphasia (e.g., fatigue, frustration).	100%				-
7*	I am able to reflect on a family-centred approach and factors that may impact the delivery of stepped psychological care. For example, considering the wellbeing of family members, the ability to provide practical assistance, a support person may consent as needed etc.	73%	27%		• Include 'managing conflict' as an example.	-
8	I can help significant others to use personalised communication support strategies to support the person with aphasia's understanding (receptive language skills, a person's	82%	18%		• Bold the key concept (i.e., understanding)	-

	understanding of language). For example, using short and simple sentences; pictures, photos, objects, gestures, written key words; repeating information.					
9	I can help significant others to use personalised communication support strategies to support the person with aphasia's talking (expressive language skills, the ability to use language). For example, using yes/no questions, providing extra time for the person to reply, providing opportunities for written, pictorial and/or technology-supported resources (e.g., iPad, audio recordings).	82%	18%		• Bold the key concept (i.e., talking)	-
10*	I can help significant others use strategies to acknowledge the communication competence of the person with aphasia. For example, taking responsibility for the communication breakdown, saying statements like "I	73%	27%		• Bold the key concept (i.e., competence)	-

	know you know what you want to say”					
11	I can make appropriate referrals to and work with specialists to support the person with aphasia as needed.	100%				-
Observer-rated items						
Communication support						
12	The clinician uses personalised communication support strategies to support the person’s understanding (receptive language skills, a person’s understanding of language). For example, Using short and simple sentences; pictures, photos, objects, gestures, written key words; repeating information.	100%			• Remove bracketed content. • Bold the key concept (i.e., understanding)	-
13	The clinician uses personalised communication support strategies to support the person’s talking (expressive language skills, the ability to use language). For example, Using yes/no	91%	9%		• Change ‘(e.g., iPad…) to ‘such as an iPad’. • Bold the key concept (i.e., talking)	-

	questions, providing extra time for the person to reply, providing opportunities for written, pictorial and/or technology-supported resources (e.g., iPad, audio recordings).					
14	The clinician acknowledges the communication competence of the person with aphasia. For example, the clinician takes responsibility for the communication breakdown, the clinician says "I know you know what you want to say".	82%	18%		• Bold the key concept (i.e., understanding). • Remove 'I know you know'. • 'Communication competence' may not be meaningful to non speech pathologists. However, a client-centred and collaborative approach may be more familiar. • Put competency 14 before expressive and receptive ones.	-
Assessment and therapy structure						
15	The clinician provides personally-tailored psychoeducation (e.g., the prevalence of mood difficulties, how psychological intervention can help, the provision of information regarding psychological supports and resources).	91%	9%			-

16	The clinician takes a person-centred approach to goal setting, encouraging the person to participate in identifying goals for intervention.	100%			• Add 'that matter to them' or 'are important to them'.	-
						Communicates clearly with other professionals appropriately, as required and with consent, regarding the psychological needs of the person with aphasia.
						Identifies concerns about the mental capacity of the person with aphasia to make specific decisions and provides or arranges for a capacity assessment as appropriate.
Interpersonal skills						
17	The clinician pays attention to and facilitates the development of trust and the therapeutic relationship in various ways that are appropriate to the person (e.g., sharing stories, conversation, news, humour).	91%	9%			-
18	The clinician shows empathy and attention	100%				

	towards the person's needs and is non-judgmental of the emotions expressed by the person.				• Reword to say '… is non-judgmental towards them.'	-
19	The clinician uses active listening skills tailored to the person's needs throughout the session.	100%			• Merge 19 into either competency 17,18 or 20.	-
20	Nonverbal communication (e.g., facial expression, gesture, tone of voice and eye contact) is used by the clinician to build the therapeutic relationship.	100%				-
Significant others' (friend or family member) considerations						
21*	The clinician communicates with and supports the significant other (e.g., involves and updates when appropriate).	73%	27%			-
22	The clinician shows empathy for significant others' emotional difficulties.	82%	18%		• Reword to: 'the clinician applies a person centred approach to support the significant other's emotional difficulties including showing positive regard, respect, empathy and being genuine'.	-
23*	The clinician provides personally-tailored psychoeducation for the significant other (e.g., the prevalence of mood difficulties, provision of	73%	27%		• In the examples emphasise this is about family/caregivers.	-

	information about psychological supports and resources such as General Practitioner visits, counselling services, stroke and/or aphasia group supports).					

*denotes competency item did not achieve consensus and was removed from the final version as shown in supplemental file 9

Supplemental file S7

Round 2 e-Delphi Survey Results self-rating scale

Score	Self-rated items rating scale	Suggestions regarding wording and/or appropriateness of the rating scale
1	I'm not familiar with the concept	• Reword to 'I don't have knowledge or experience with this competency yet'
2	Familiar, but not at all confident	• Reword to 'Some knowledge and experience, but not at all confident.'
3	A little confident	
4	Moderately confident	
5	Very confident	

Supplemental file S8

Round 2 e-Delphi Survey Results observer-rating scale

Score	Observer items rating scale	Suggestions regarding wording and/or appropriateness of the rating scale
0	Not observed	
1	Observed – Requires further development	
2	Observed – Adequate level	• Add 'proficiency' after level
3	Observed – High level of proficiency	

Supplemental file S9 *Final version of the provisional competency rating scale*

Psychological Care in Aphasia Rehabilitation Competency Scale

SELF-RATED ITEMS

	Examples	I'm not familiar with the concept (1 point)	Familiar, but not at all confident (2 points)	A little confident (3 points)	Moderately confident (4 points)	Very confident (5 points)	Score (points)
1. I can address the psychological needs of people with aphasia within my scope of practice within stepped psychological care.							
2. I can screen for depression in the person with aphasia and refer appropriately.							
3. I can screen for suicidal ideas and refer on appropriately.							
4. I can screen for anxiety in the person with aphasia and refer on appropriately.							
5. I can address the person's needs related to their social, cultural and language background.							
6. I can adapt therapy sessions based on the personal factors of the person with aphasia.	Fatigue, frustration.						
7. I can help significant others to use personalised communication support strategies to support the person with aphasia's **understanding** (receptive language skills, a person's understanding of language).	Using short and simple sentences; pictures, photos, objects, gestures, written key words; repeating information.						
8. I can help significant others to use personalised communication support strategies to support the person with	Using yes/no questions, providing extra time for the person to reply, providing						

aphasia's **talking** (expressive language skills, the ability to use language).	opportunities for written, pictorial and/or technology-supported resources such as an iPad, audio recordings.						
9. I can make appropriate referrals to and work with specialists to support the person with aphasia as needed.							
						Total score=	
Self-reflection comments:							

OBSERVER-RATED ITEMS						
Communication support	Examples	Not observed (0 points)	Observed – Requires further development (1 point)	Observed – Adequate level of proficiency (2 points)	Observed – High level of proficiency (3 points)	Score (points) Score (point)
10. The clinician acknowledges the communication **competence** of the person with aphasia.	The clinician takes responsibility for the communication breakdown.					
11. The clinician uses personalised communication support strategies to support the person's **talking** (expressive language skills, the ability to use language).	Using yes/no questions, providing extra time for the person to reply, providing opportunities for written, pictorial and/or technology-supported resources such as an iPad.					
12. The clinician uses personalised communication support strategies to support the person's **understanding** (receptive language skills, a person's understanding of language).	Using short and simple sentences; pictures, photos, objects, gestures, written key words; repeating information.					
Assessment and therapy structure						
13. The clinician provides personally-tailored psychoeducation.	The prevalence of mood difficulties, how psychological intervention can help, the provision of information regarding psychological supports and resources.					
14. The clinician takes a person-centred approach to goal setting, encouraging the person to						

participate in identifying goals for intervention.						
Interpersonal skills						
15. The clinician pays attention to and facilitates the development of trust and the therapeutic relationship in various ways that are appropriate to the person.	Sharing stories, conversation, news, humour.					
16. The clinician shows empathy and attention towards the person's needs and is non-judgmental of the emotions expressed by the person.						
17. The clinician uses active listening skills tailored to the person's needs throughout the session.						
18. Non-verbal communication is used by the clinician to build the therapeutic relationship.	Facial expression, gesture, tone of voice and eye contact.					
Significant others' (friend or family member) considerations						
19. The clinician shows empathy for the significant other's emotional difficulties.						
					Total score =	
Observation comments:						

Explanatory guide

Competency rating scale to facilitate psychological care for people with aphasia

Explanatory guide

Purpose:

The purpose of this preliminary list of items within the competency rating scale is to rate the competencies of clinicians in facilitating psychological care and support to people with aphasia after stroke (level one interventions of stepped psychological care after stroke). Stepped psychological care is an evidence-based service delivery framework which guides clinicians in triaging clients to one of four levels of increasing psychological treatment intensity, depending on symptom severity and responsiveness to treatment (Mendelson et al., 2012). Delivery of low-intensity level one psychological interventions such as behavioural activation, relaxation and problem-solving, can be facilitated by trained stroke clinicians (e.g., speech pathologists, psychologists, occupational therapists) (Kneebone, 2016). The competency rating scale is designed to be used by interdisciplinary clinicians who require foundational knowledge and skills in this area of practice (from allied health, nursing and medical backgrounds). Please note further consensus building of items and testing of the scale by stroke clinicians of varied disciplines is required in future research.

Directions for scoring the competency rating scale:

- The clinician conducting the session completes the self-rated items section of the rating scale.
- Another clinician observing the session completes the observer-rated sections (communication support, assessment and therapy structure, interpersonal skills and Significant others' [friend or family member] considerations). It is helpful for the observer to have a higher level of proficiency and/or experience to support the clinician.
- The clinician and observer score the items by ticking the appropriate box. Each rating scale item has a corresponding score (e.g., "Observed – Requires further development" = 1).
- Scores are totalled for each section.
- Open-text comment sections are available to promote further reflection and discussion between the clinician and observer.

Descriptions of each observer-rating score is provided below:

- Not observed – The clinician did not attempt the skill as the skill was not required/ there wasn't an opportunity to use it in the session. Alternatively, the opportunity could have been present, in which case a note in the open-text box should be made.
- *Observed – Requires further training* – The clinician did not attempt the skill, however errors were present, or very few features were present or it was delivered inconsistently.

- *Observed – Adequate level of proficiency* – The clinician demonstrates is competent in the skill, however it may be less sophisticated or not consistently applied.
- *Observed – High level of proficiency* – The clinician demonstrates demonstrates the skill in a comprehensive and sophisticated manner.

Descriptions of key terms within competency items:

- *Competency 1 "scope of practice"* – The scope of practice will be slightly different for each profession (allied health, nursing, medical practitioners). It is within each profession's scope of practice to deliver low intensity/ level one stepped psychological care. If a client presents with difficulties beyond level one, please refer onwards to a psychologist.
- *Competency 3 "suicidal ideas"* – This term encompasses suicidal ideation, planning and intent.
- *Competency 10 "communication competence"* – This term refers to using a strengths-based approach when communicating with the person with aphasia. It means that the clinician does not assume difficulties with certain aspects of the person's communication.
- *Competency 14 "Person-centred approach"* – This approach places the client and their family at the centre of the care being provided. It encompasses goal setting that is meaningful and personalized to the client to therefore tailor therapy to the unique needs of the client. A person-centred approach values partnership and choice in decision making. The clinician shows respect towards the client's decisions.

References:

Mendelson, T., Pas, E., Leis, J.A., Bradshaw, C.P., Rebok, G.W., & Mandell, W. (2012). Public Mental Health. In Eaton W, editor. *Public mental health.* (p. 1–69).

Kneebone, I. I. (2016). Stepped psychological care after stroke. *Disability and Rehabilitation*, 38(18), 1836–1843. https://doi.org/10.3109/09638288.2015.1107764