Doctorate in Clinical Psychology (DClinPsy)
Clinical Handbook

Year 2023-2026

Contents

Clinical Team

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Name & Email	Role	Profile	Working days
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	Clinical Tutor - Somerset		

For details of members of staff in each team, please refer to the staff page on the website: https://psychology.exeter.ac.uk/study/clinical/dclinpsy/team/

Important Roles and Responsibilities

This section aims to clarify the roles and expectations of the various parties involved in the clinical practicum placements.

Role of Clinical Tutor

The clinical tutor role is to monitor training on placement and to communicate between the trainee, the supervisors and the programme. Their tasks include: helping to ensure that the placement is planned to meet the trainee's training needs, taking into account trainees' strengths and learning needs; ensure supervisors are made aware of any particular issues that may affect the trainee's performance on placement; checking that the trainee is developing their clinical competencies and gaining relevant experiences on placement; checking that the placement is manageable for the trainee and the supervisors; liaising between the programme team and the supervisor so that the supervisors have all the information they require about the programme and the trainee; devising and monitoring an action plan if the supervisors and/or trainee experience difficulties; feeding back any problems with the placement to the clinical director.

Sharing of information between trainee and clinical tutor

In order to plan the placement, develop their strengths and meet their training needs, the **trainee shares with their supervisor**, at the start of each placement, relevant information about previous experiences.

At the start of subsequent placement periods, **the previous Clinical Competence Goals and Evaluation Form and Portfolio of Clinical Experience – or, at the beginning of training, relevant information about previous experiences and prior learning will also be shared.**

Furthermore, as we aim to facilitate an open learning environment in which information is shared appropriately and respectfully between programme staff, trainees and placement supervisors, to enable trainees' development and to ensure appropriate client care. Trainees should expect that information about day-to-day aspects of placement will be shared as appropriate. Clinical Tutors will provide feedback to line managers that contributes to trainees' appraisal. Assessment reports on continuous assessment work are also held on trainee files.

Role of Clinical Placement Supervisor

Supervisor Workshops & Placement Committee

We run supervisor training workshops for new and experienced supervisors each year. It is expected that supervisors attend workshops offered to them prior to taking a trainee so they can prepare for the trainee joining their service.
Supervisors are also invited to attend bi-annual placement committee meetings and CPD events, such as anti-racism in supervision, decolonisation of the curriculum, etc. In addition, supervisors are invited to attend relevant academic programme events in the teaching block.

Supervisor Database

Clinical supervisors are required to complete a database form indicating when they have attended training or refresher training as well as a description of what their service/placement offers for trainees (pre-placement audit). This is updated by the Programme Administrator once a year and is accessible for trainees when they come to plan their placements ahead of Year 3.

Employment with Taunton & Somerset NHS Foundation Trust

Trainees are employed by the Taunton & Somerset NHS Foundation Trust.

All issues regarding employment matters must be referred to their nominated line manager who is responsible for day-to-day employment issues including sickness, annual leave and travel expenses.

Whether on teaching, study or placement days, trainees are required to adhere to all regulations regarding their employment. This includes appropriate conduct, timekeeping and attendance. Trainees' attendance on placement will be monitored and line managers will be informed if any trainees are absent without having given appropriate notification (see Programme Handbook).

Requests for annual leave should be made in advance using the formal process outlined in the programme handbook.

Host Trusts

Each trainee is allocated to a geographical area and an NHS Trust taking into account availability of placements and where possible, trainee preference. This Trust becomes the host Trust for the trainee. Placement locations cannot always be guaranteed, but will usually be allocated within the host Trust. Trainees are strongly encouraged to live locally to their host Trust as this should reduce travel and time demands across the programme.

The Clinical Director, Clinical Tutors, Heads of Service and Trust-based placement coordinators jointly identify and agree placement availability. Trust-based liaison or placement coordinators are NHS clinical psychologists who take on their role in relation to the programmes in clinical psychology across most trusts in the Southwest. Some trusts do not have a named coordinator, and in these cases Heads of Service generally take on aspects of this role. The role of the coordinator is to act as a communicator between their trust and the programme.

Non-Host Trust Placements

Occasionally the course may be able to support a placement outside of commissioned regions, however this is the exception and in exceptional circumstances. This will be considered on a case by case basis. Trainees **must not** approach potential supervisors outside their base area without specific direction to do so by their clinical tutor.

The rationale for a placement outside of the host Trust (but within the commissioned Region, Devon, Somerset and Dorset) is:

- Learning needs cannot be met in host Trust, as evidenced by clinical tutor.
- Learning needs/performance would be impaired (through possible personal/coping/stress/difficulties). This needs evidencing from clinical tutor and line manager if this is the case.
- Insufficient placement numbers within the host Trust.
- Services elsewhere can accommodate the request.
- Services elsewhere provide unique learning experiences in line with the trainee's competency development needs and/or interests.

We have an agreement with liaison tutors in the host Trust (representing Service Heads' views) that this is acceptable. This is cost neutral and HR is in agreement. These criteria are in no particular order and all need to be met for a case to be agreed.

Employment in Taunton & Somerset NHS Foundation Trust

Clinical Mandatory E-Learning Training

Content List

- Basic life support (Level 1)
- Conflict Resolution/PMVA Module 1
- Counter Fraud
- Equality & Diversity
- Fire Safety Level 1
- Health, safety & welfare
- Infection prevention and control (Level 1)
- Information governance and data security
- Prevent (Level 3)
- Safeguarding adults (Levels 1&2)
- Safeguarding children (Levels 1&2)
- Moving & handling (Level 1)
- Dementia Awareness

- Freedom to Speak Up

The e-learning module requires the participant to read through the information supplied and it is followed by an assessment test whereupon the pass score must be higher than 80 %.

The Trainee Tariff System

As from April 2014 each organisation that provides a clinical placement will be paid per trainee. For further information see: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1064526/Education-and-Training-Tariff-Guidance-2022-23.pdf

Study Days

The DClinPsy programme is research-led in terms of teaching, clinical practice, and independent research. Trainees can use their study time for relevant reading, completing course assignments, working on the small-scale quality improvement project (QIP) and thesis research.

Trainees are able use the allocated study time in each year according to their own study demands.

In negotiation with the clinical supervisor and clinical tutor, some placement time can also be used for the QIP (in Years 1 and 2) and relevant clinical reading. The amount of time that can be used on placement is detailed at the end of the timetable. Details of study day arrangements can be found in the Programme handbook under study days.

Placement Bases

Trainees are allocated a placement base within either Devon, Somerset or Dorset. Generally, your placements will be within your placement base county. Placements may be across multiple sites and with community visits, within the county. It is the trainee's responsibility to get to their allocated placement and any required travel whilst on placement. With respect to remote/home working, we broadly expect the trainee to follow the stance of the service they are placed in. This can mean that remote/home working can vary from no opportunity to the whole placement being remo

Competency Development on Placements

Supervised clinical placements account for over half of the three years in training. In line with the British Psychological Society's (BPS; 2019) requirements for clinical psychology training (https://www.bps.org.uk/accreditation/education-providers) and the Health & Care Professions Council Standards of Education and Training Guidance (https://www.hcpc-uk.org/globalassets/resources/standards/standards-of-education-and-training.pdf?v=637660865080000000), we have a core competence model of training. Throughout the three years, three main areas are assessed: competence, experience and reflection.

Overview of BPS competencies

Competence:
Core competencies in clinical psychology are those areas of activity that are considered by the BPS and our regulatory body, the Health & Care Professions Council (HCPC), to be central to our identity and role in the public services. "Competence" is defined as the ability to perform the activities of an occupation to the standards expected in employment. In the NHS National Plan and workforce planning this translates into "fit for purpose" and "fitness to practise"

- HCPC Standards of Conduct, Performance and Ethics: https://www.hcpc-uk.org/standards/standards-of-conduct-performance-and-ethics/
- Guidance on Conduct and Ethics for Students: https://www.hcpc-uk.org/globalassets/resources/guidance/guidance-on-conduct-and-ethics-for-students.pdf
- Standards of Proficiency, Practitioner Psychologists: https://www.hcpc-uk.org/standards/standards-of-proficiency/practitioner-psychologists/

By the end of each placement year, trainees are expected to demonstrate they have met learning outcomes and they are progressing satisfactorily towards the competency level expected of a newly qualified clinical psychologist in that area of practice.
The required professional (BPS) competencies on the DClinPsy as outlined in the Standards for Doctoral Programmes in Clinical Psychology (2019) 2.1.3 are:

- Generalisable metacompetencies = GMC
- Psychological assessment = PA
- Psychological formulation = PF
- Psychological intervention = PI
- Evaluation = E
- Research = R
- Personal and professional skills and values = PPSV
- Communicating and teaching = CT

- Organisational and systemic influence and leadership = OSIL

Experience: Trainees are expected to develop their competence through a balanced range of experiences across settings and client groups. The BPS and HCPC specify the range of experience required in clinical psychology training:
Exposure to clients, carers and families with a range of presenting problems, resources and abilities across the life span, based in a range of service delivery systems or settings, working at a number of different levels (direct, indirect, and within multi-disciplinary teams) and using and integrating more than one psychological approach.

Reflection: Trainees are expected to engage in critical reflection on self and context as they develop their professional, practitioner, scientist/researcher and personal identities as clinical psychologists. Trainees are expected to draw upon this experience for supervision, appraisals and academic assessments.

Clinical Placement Structure

In years one and two (and possibly in year three), most trainees will have multiple supervisors from different specialisms in which the trainee will be gaining experience during the year. The balance of work across the specialisms over three days a week (Weds-Friday) will be individually negotiated between the trainee and supervisors, assisted by the clinical tutor where necessary. The work balance as far as possible will depend on trainees' previous strengths, prior experiences and current learning needs and service opportunities/needs. By the end of each year the trainee will need to meet learning outcomes in each specialism as specified in the competence and experience documentation. Trainees are expected to take on between 6-12 pieces of work over the course of the placement. A piece of work may be an assessment, client therapy, providing staff training, consultation for example.
During academic terms trainees spend Wednesday, Thursday and Friday on clinical placement. Outside of academic terms trainees are able to increase their working placement days. As this varies for each year of training, please refer to the academic timetable.

Placements are planned over the three years so that trainees can develop their core competencies within a life span, developmental and cultural contextual framework in which they can understand psychological well-being and distress.

In common with other DClinPsy Programmes, we are moving away from a "core specialty" approach towards a competency-based training model where trainees may be placed in a much wider variety of settings in order to develop a broad range of competences. Programme placements are currently broadly organised around the following specialities but as noted, trainees can expect to be placed in a variety of different settings at different stages in their journey through the programme,:

Year One placement usually involves work with children/ young people and their families and with people with learning disabilities, with an emphasis on community and systemic orientations. Competencies emphasised are Foundations of Assessment, Formulation and Intervention.

Year Two placement usually involves work in services with adults through the lifespan (working age and later life). Competencies are developed in Interventions and Working with Systems and Leadership. This is also a year for further specialisation (i.e. CBT, intermediate Family Therapy and CAT).
In both year one and two, trainees will have one or two supervisors, who may come from a number of different specialisms. Placements may be structured as two consecutive six month placements, or two year-long placements that run in parallel.

Year Three is a consolidation and specialisation, preparation for practice year in which trainees will gain more in-depth experience of applying and integrating psychological approaches, fill in any gaps and consolidate their acquisition of core competencies and experiences as they prepare for their first qualified post.

Core Competency Model Placement Structure

By providing a competency based training model, trainees have the opportunity to gain experience in a wide variety of settings, for example: charities, community interest companies, educational settings and social care, in order to develop a broad range of competences.

Trainees can expect to be placed in a variety of different settings at different stages in their journey through the programme.

Placements are as follows:

1. **Year One** Foundations of Assessment, Formulation and Intervention
2. **Year Two**: Interventions and Working with Systems and Leadership. This is also a year for further specialisation (i.e. CBT, intermediate Family Therapy and CAT).
   In both year one and two, trainees will have one or two supervisors, who may come from a number of different specialisms. Placements may be structured as two consecutive six month placement, or two year-long placements that run in parallel.
3. **Year Three** is a consolidation and specialisation, preparation for practice year in which trainees will gain more in-depth experience of applying and integrating psychological approaches, fill in any gaps and consolidate their acquisition of core competencies and experiences as they prepare for their first qualified post.

The programme allows for flexibility in consideration of a broad range of placement experiences that allow for the development of particular competencies. As such the programme recognises that there may be professionals outside of clinical psychology able to supervise some or all elements of particular placements.

Year One:

Theory-practice introductory placement days:	**1 day in October**
Placement start and end dates for year long placements:	**November - September**
Placement start and end dates for 6 month placements:	**November – April** **May - September**
Placement paperwork Submission dates:	**May and August**

Placement audit forms:	**May and August**

Year Two:

Theory-practice introductory placement days:	**2 Days in October**
Placement start and end dates for year long placements:	**November – September**
Placement start and end dates for 6 month placements:	**November – April** **May - September**
Placement paperwork Submission dates:	**May and August**
Placement audit forms:	**May and August**

Year Three:

Placement start and end dates:	**January - September**
Placement paperwork Submission dates (recommended 40 minimum placement days at point of assessment):	**August**
Placement audit forms:	**August**

Clinical Placement Attendance, Planning, and Allocation

Attendance at placements is mandatory. The BPS specifies that least **50%** of a trainee's time on the DClinPsy course is spent on clinical placement. Although this requirement is not specified in terms of an expected number of days in each placement, it is expected that the trainee will be in attendance on clinical placement between 60 to 65 days in any one 6 month placement or between 120 to 130 clinical days in a year long placement. If a trainee anticipates that they are unable to accrue this many days on placement due to illness, or other unforeseen circumstances, they need to inform their clinical tutor and line manager at the earliest possible opportunity, in order that an action plan can be discussed. Trainees should not have less than 55 days on placement, as an appropriate number of days on placement are required to assess whether the placement should be passed or failed.

If a trainee misses more than 10 days of a placement the clinical tutor will form an action plan around this absence and the line manager will be involved in this. An absenteeism form should be completed for any day of absence from placement.

Placement Planning

Placements in Year 1 and 2:	The clinical director and clinical tutors will arrange placements. Trainees will be informed of their placements in September for year 2 and September for year 1.
Placements in Year 3:	Planning for Year 3 takes place during the trainee's Year 2.
February	Clinical Tutors and Clinical Director meets with second year trainees to discuss the process of planning their third year placement.
March	The Regional Placement Database list is sent out to the cohort by the Programme Administrator.
April-May	Clinical Tutor and Trainee consider Year 3 options. The Clinical Tutor *will inform trainees when they can start to approach supervisors informally about one or two possible*

	*placements, bearing in mind that future Year 1 and 2 placements must take priority. However, trainees are **NOT** to agree placements with supervisors.*
June – August	Supervisors are agreed via programme team, liaison tutors and clinical tutors
August	Final confirmation of supervisor for Year 3.

See the Appendix 13: Planning Your Third Year Placement (second years only).

Process of allocating clinical placements

The Programme maintains a database of supervisors in the region who meet the relevant HCPC, BPS or other professional accreditation criteria to act as practice placement supervisors.

New supervisors and new placements are added to this following a robust process of assessment and approval and the quality of practice placement provision is audited using clear processes that emphasise the role of trainee feedback.

The process of allocating trainees to placements begins each year around May/June where supervisors are contacted by placement liaison or clinical tutor.

Placements are allocated bearing in mind the following considerations:

- Trainee assigned placement county
- Competency area / client group required by trainee / offered by service
- Existing competencies developed in practice placements (and to a lesser extent, prior to training)
- Service demands and requirements
- Reasonable Adjustments requested by a trainee in relation to a disability, or significant personal circumstances that are brought to the attention of the clinical team and line manager.

All allocations are made with the aim of providing the trainee with a set of different experiences across training, to ensure the trainee can develop the required range of core clinical competencies across practice placements, required for accreditation.

To aid this, prior to allocating first year placements, the admin team will request a summary of previous experience that is reviewed by the clinical team and the information will be used to inform first placement.

In the second year, the clinical tutor will review the placements completed in the first year; prior to the third year, the clinical tutor will review gaps in individual trainee's development in line with the competency model.

How much choice do trainees have in their placements?

For Placements in year 1 and 2:

Considering the range of factors that are weighed and balanced in making decisions about placements, for Placements in year 1 and 2 trainees are not given a specific opportunity to make choices about specific services or supervisors they would wish to work with.

For placements in year 3 trainee choice and preference are considered alongside the other factors above, as well as the requests of the whole cohort. Placement database will be available to trainees to highlight the possible placement opportunities.

N.B. In all cases, however, service demands, competency needs and other factors may mean that trainees' ability to choose placements is limited or removed entirely.

Travel whilst on placement

The commissioned geographical area of the Exeter DClinPsy is large, with several large rural areas with poor public transport infrastructure. It is the trainee's responsibility to get to their allocated placements whilst on training. There is often significant need to travel on placement and we therefore expect trainees to have access to a car during their placements.

In all cases, trainees should not use their own car for transporting patients.

How Trainees are prepared for Placements

Clinical Tutorials

Clinical tutorials have the broad remit of supporting trainees in achieving the programme's learning outcomes in all the clinical module. They complement the clinical placements by providing clinical tutor and peer support to facilitate learning and reflections from placements. Trainees are allocated their clinical tutorial group on the basis of their geographical placement base. Tutorials normally occur monthly in the first year, twice a term in the second year and once a term in the final year. The clinical tutorials are timetabled to occur during placement days and are coordinated by your clinical tutor, with all trainees expected to attend. Trainees are encouraged to contribute to and bring material for discussions.

Pre-Placement planning

A month prior to the placement start date, trainees should make contact with their supervisor to facilitate the planning of the placement experience. The emphasis is on encouraging a dialogue with the next supervisor early enough to allow a placement to be adapted to meet an individual's training needs. **It is the trainee's responsibility to arrange this contact.**

Suggested Clinical Placement Induction

Trainees are employed by NHS Trusts. As such they have completed all the checks and have undertaken a general induction which is sufficient to enable trainees to work safely in NHS (or equivalent) placement setting. See Clinical Mandatory E-Learning Training in Employment with Taunton & Somerset NHS Foundation. Upon starting placement trainees will need to undertake a local induction, which we suggest covers the following:

- A tour of the building and introduction to staff
- Showing where the trainee will be working and how to access relevant resources.
- Computer systems and guidance on record keeping
- Over-view any relevant safety procedures (fire exits, panic buttons in clinic rooms etc.)
- Location of policies
- Parking and local amenities

The sample induction programme and sample induction checklist can be used to guide discussions with your clinical placement supervisor.

Some Trusts do require Trainees to undertake additional training during their placement. Ideally this training should be done on placement days. If the Trust require the training to be completed prior to the Trainee being allowed to do any clinical work, then it is permissible to do this during academic teaching time. However, this should be avoided where possible, and this needs to be discussed and agreed with the Clinical Tutor/Director and Academic Director prior to attending.

Please watch this video, in which two trainees reflect on their experience of induction to placements, and share their thoughts on what is useful to discuss with supervisors at the beginning of placement. https://www.youtube.com/watch?v=cgihdgcMgQU

Starting your clinical placement

Supervisors will be inducting their trainees in the placement induction days preceding each placement. The first induction day is timetabled in the autumn term and the second induction is negotiated between trainee and supervisor before the trainee transfers to their next placement, if it is a 6 month placement.

During these days, trainees would normally:

1. Meet the supervisors and begin to discuss trainee's strengths and learning needs so as to set up goals for the placement (taking into account feedback from previous placement periods if this is not the first placement);
2. Find out from the supervisors about possible experiences available and discuss the supervision agreement;
3. Begin an induction into the service, work teams, to include introductions to key team members, team policy/trust policy (e.g., on diversity, equal opportunities and risk assessments) and to trainees from other professional groups within the service; clarification of the resources for the placement (e.g., desk, phone, secretarial support, filing cabinet space etc); practicalities such as parking permits if needed, plan the general placement outline;
4. Spend time with, alongside or shadowing service users and carers;
5. Observe and shadow the supervisor/s at work;
6. Begin work on setting up a case load;
7. Engage in activities related to the Problem-Based Learning (PBL) exercise for the academic component of the programme as required and the QIP for the research component.

Expectations common to all placements

It is expected that whilst on placement trainees will make the most of the learning opportunities they are offered and demonstrate behaviour consistent with the values

of the programme and the NHS. Whilst under the overall direction of a clinical supervisor, trainees need to be able to operate safely with an appropriate level of independence and autonomy.
Trainees are expected to adhere to the core values of the profession, policies relating to appropriate professional conduct, employment and academic policies, codes of conduct and guidelines. The range of policies relevant to these matters includes, but is not limited to, the following:

- Employment policies of the host employer Taunton & Somerset NHS Foundation Trust
- Specific policies of any organisation hosting a placement
- University specific regulations
- HCPC guidance (this is particularly outlined in the HCPC Guidance on Conduct and Ethics for Students, but also in the HCPC's Standards of Conduct Performance and Ethics - SCPEs)
- BPS guidance (e.g. BPS Code of Ethics and Conduct: https://www.bps.org.uk/guideline/code-ethics-and-conduct; BPS Practice Guidelines: https://www.bps.org.uk/guideline/bps-practice-guidelines-2017)
- Relevant legislation and associated guidance (e.g. Mental Capacity Act 2005 and Code of Practice)

It is worth noting that many of these policies also consider the professional role and identity to extend beyond the workplace. This has implications, for instance, for a trainee's use of social media and wider behaviour in public settings. Please consult these guidelines for more specific information about what this means in practice.
Any breaches of these policies or guidelines are viewed seriously by the Programme. Our response will depend on the nature of the breach, and will always be proportionate, but may include action taken through one or more of the following routes, *either separately or in parallel*

- University policies, e.g. action under university disciplinary procedures, fitness to practice/professionalism statues, or other relevant statues
- HCPC processes, particularly if issues or concerns are raised prior to or around the point of registration
- Adverse placement outcomes (e.g. failing a placement)
- Employment policies, e.g. warnings; suspension; dismissal

The programme must prioritise client and clinical safety above individual student's welfare or preference. The programme therefore is likely to progress formal action against a trainee where it is perceived that the behaviour or wider concern could lead to an impairment in client and/or clinical safety.

Fitness to Practice Guide for trainees

The reason we think this is so important, relates to the specific role of the Clinical Psychologist in having a position of power with vulnerable members of society. We expect all trainees to read this in full, even if you don't think it could possibly apply to you. The fact is that most activities of the Clinical Psychologist go on 'behind closed doors', and many members of the public do not have a 'template' for what a good psychological intervention looks like. Therefore, it is *far* easier for professional standards to lapse in our profession and go undetected than in many others. Ultimately, this section is all about how we ensure we maintain the *safety* and *effectiveness* of our practice. So…

Trainees must be fit to practice in the work in which they engage. This is an important principle outlined within the HCPC Standards of Conduct, Performance and Ethics (SCPEs) and explained in application to trainees within the HCPC's 'Guidelines for Conduct and Ethics for Students' document. The requirement applies equally to qualified psychologists and the ability to learn to apply 'professional self-regulation' is an important professional skill.

The HCPC use the term 'fit to practice' to mean 'that they have the skills, knowledge, character and health to practise their profession safely and effectively. We also mean that we trust them to act legally' (HCPC Document - Managing Fitness to Practice). It will be noted that a range of factors could lead to somebody being not fit to practice, including but not limited to the following:

- Physical or mental health difficulties
- A lack of relevant knowledge or skills in the relevant subject area
- Demonstrating a character or values that are not aligned with the core values of the profession

It is notable that these factors, in turn, could have a wide range of causes. For instance, a mental health concern (e.g. low mood) could be caused by personal loss or bereavement and a lack of knowledge could be caused by repeated teaching non-attendance. Demonstrating non-alignment with values could be caused by inappropriate posts on social media, or behaviour in public that risks bringing the profession into disrepute. It follows, therefore, that some impairments in Fitness to Practice could be temporary, whilst others might be long term.

Whatever causes a potential Fitness to Practice concern, the relevance of the concern will be judged primarily by the impact *or potential impact* on the **confidence in the ability of the trainee to practice with appropriate safety and effectiveness**. This may be of most immediate concern within the placement environment, but all aspects of a trainee's practice are potentially relevant. Concerns about a trainee's fitness to practice may be brought to the Programme's attention through a number of sources, for example: the placement supervisor, clinical tutor, programme staff or even other

trainees. Please refer to the University of Exeter's and Taunton & Somerset Foundation NHS Trust Fitness to Practice policies and guidelines.

Clinical Placement Guidelines & Contracts

Clinical Governance and Learning Status

Trainees must always use the term Trainee Clinical Psychologist when introducing themselves to clients.

Trainees must also ensure that all letters and reports are signed appropriately. The British Psychological Society requires the following: **"Trainee Clinical Psychologist working under the supervision of ….(name of supervisor)"**. Exeter trainees may add: "studying Doctorate in Clinical Psychology".

Trainees are required to explain their learning status to service users. This entails seeking consent for writing up any placement work for academic purposes. This should be undertaken at the beginning of any clinical work with service users, carers or staff teams.

Supervisors retain clinical responsibility for the work undertaken by trainees, but trainees should check with supervisors what is the expected practice within the Trust or organisation that they are working in.

Setting up and managing placements

Clinical practice placement supervision

The Programme adheres to the BPS requirements for practice placement supervisors. In terms of the core requirements for supervisors, these are:

- Supervisors must be appropriately registered, trained and suitably experienced for the role. In most cases, appropriate registration means that supervisors are Clinical Psychologists registered with the HCPC (this applies to over 95% of supervisors). Practitioner Psychologists registered in another modality (e.g. Counselling Psychologists, Forensic Psychologists) or another accredited professional can also act as supervisors. The Programme would expect that a trainee receiving supervision from a psychologist who is not a Clinical Psychologist should have a named contact who is a Clinical Psychologist who is able to provide any specific support around learning needs which are not able to be addressed by the placement supervisor.

- Supervisors must receive appropriate training delivered by University of Exeter DClinPsy on the requirements of providing supervision on the Programme, e.g. on the process of competency evaluation and assessment of placement outcome. This will ordinarily come through attendance at the supervisors' workshops delivered by the DClinPsy clinical team.
- This training must be undertaken by all new supervisors and should be updated every five years for existing supervisors for the programme.
- Supervisors must be aware of their responsibilities and agree to provide supervision in line with the BPS Guidelines on Clinical Supervision (https://cms.bps.org.uk/sites/default/files/2022-07/Guidelines%20on%20clinical%20supervision.pdf)
- The main supervisor of a trainee shall normally be a clinical psychologist who has at least two years' experience after gaining the qualification and eligibility for Registration as a Chartered Clinical Psychologist. Alternatively, it could be an experienced Clinical Psychologist with at least two years' practice who has recently gained a Statement of Equivalence and eligibility for Chartered Status. In certain circumstances, the main supervision may, at the discretion of the Clinical Director or Clinical Tutor, be carried out by a Clinical Psychologist who has at least one year's experience after gaining the qualification and eligibility for Registration as a Chartered Clinical Psychologist. When this occurs, the quality and quantity of supervision that is received by the trainee must be monitored carefully by the Clinical Director or Clinical Tutor. At the discretion of the Clinical Director or Clinical Tutor, the supervision of specific aspects of the trainee's work can be formally delegated to an appropriately qualified and experienced Psychologist who is eligible for Registration as a Chartered Psychologist or an appropriately qualified and experienced member of another profession, either in one-to-one supervision, as part of a supervisory team or group supervision. When this occurs, the quality and quantity of supervision that is received by the trainee must be monitored carefully by the Clinical Director or Clinical Tutor.

- All new supervisors should have a process of appropriate managerial support in place and must complete a 'new supervisor' workshop before supervising our trainees. We would expect new supervisors to identify a more experienced colleague to provide support and mentoring in development as a supervisor.

Placement supervision contract

At the beginning of placement, supervisors and trainees draw up a Supervision Contract and are encouraged to reflect on how to develop and maintain a positive supervisory relationship. This may include consideration of previous supervisory experiences, a clarification of expectations of trainee and supervisor, and how best to give feedback and address any difficulties should they arise. The supervisor and

trainee will then sign the Supervision Agreement, which will be reviewed with the clinical tutor at the placement meeting.

In terms of supervision requirements, the following are required:

- A placement supervision contract must be developed. The Programme has a standard template for this which provides key aims and objectives, planned pieces of work, planned competency areas that will be developed by the placement, and ensures both trainee and supervisor are aware of their responsibilities. This must be signed and forwarded to the DClinPsy admin (and copied to their Clinical Tutor) after signing to be stored in the trainees electronic file, within two weeks of starting placement.
- Supervision should occur weekly with *at least* one-hour of supervisory time made available. In line with BPS guidelines, the Programme recommends that 90 minutes of weekly supervision is provided pro rota.
- The supervisor must have at least 3 hours of total contact time with the trainee each week (including supervision). This can include observations, joint working for example.
- Arrangements should be made for cover of supervision in cases of planned leave or other absences of the supervisor. Trainees should also be made aware of emergency arrangements for supervision and escalation of clinical concerns in an urgent or time critical situation where the primary supervisor is unavailable.
- Supervision can be group or individual supervision.

Mid Placement Review Process and Structure for trainees and supervisors

The placement review meeting has two main functions:

- To encourage formative feedback for the trainee, which includes the clinical experiences available to the trainee and which competencies these address, the trainee's progress on the placement, with any areas of development, supervision arrangements and quality.
- Establishing whether the trainee is on track to pass the placement.

Trainees should ensure that they have sent the completed Clinical Competence Goals and Evaluation Form and the Log of Clinical Activity to the clinical tutor prior to the mid placement review.

Conditional pass or previous fail: Additionally, for those trainees who were given a conditional pass or a fail rating for the previous placement period, by the end of the second week on placement the trainee must send the clinical tutor a first draft of the general placement outline from the Clinical Competence Goals and Evaluation Form,

including initial consideration of how those issues identified as requiring particular attention from the previous placement will be addressed.

Supervisor and Trainee - preparation for the meeting

Trainees and supervisors complete the Mid Placement Review form and send it to the clinical tutor a week prior to the meeting. Please note, there are two versions of the form – one for 6 month placements and one for year long placements. Please use the form that is relevant for the length of the placement. Before the mid placement review, it is helpful for the supervisor and trainee to review progress to date, guided by the supervision contract, the log of clinical activity, the Clinical Competence Goals and evaluation form.

Format of the Mid Placement Review

Normally the clinical tutor arranges a placement review meeting with the trainee and their placement supervisor(s) twice a year (or more if required) in the first two years and once in the third year. These usually take place in the middle of a six-month placement or at two points in a year-long placement for years 1 and 2.
These meetings will normally be conducted online except in the circumstances outlined in our Guidance around face to face and online placement visits document. Please see Appendix- 10 Placement Visit Checklist (for clinical tutor).

At each visit the clinical tutor will meet the supervisors and trainee with individual time for each as well as some joint time. In the meeting with the supervisor(s) and trainee discussion will be based on the supervision contract, the trainee's log of clinical activity and the clinical competence goals and evaluation form. This is helpful to establish the range of clinical and competency experiences available to, and undertaken by, the trainee. As well as gaining an overall sense of the work being undertaken and basic placement arrangements. Clinical tutors will also ask about arrangements for observations of both supervisor and other professionals, joint working and for direct observation/recording of the trainee's work by the supervisor.

When the clinical tutor meets with the trainee, they will ask overall how the placement is progressing and further discussions about supervision arrangements, workload, range of experience for example.

When the clinical tutor meets with the supervisor, they will also ask overall how they perceive the placement progressing, whether there has been appropriate support from the course and any feedback on the relationship between the course and the placement. They will also discuss the trainee's progress on their placement goals and competency development.

The clinical tutor will record the agreed goals, as well as any additional issues / concerns that were raised in the meeting. Where there are these additional issues, they are recorded on the placement visit form and a copy is shared with the trainee's line manager. If serious concerns about trainee performance or about the adequacy of the placement emerge at the Mid-Placement Review (or indeed at other points in the placement cycle) the clinical tutor will document these and an action plan must be drawn up, indicating what needs to be done for the trainee's clinical competence and experience to be evaluated as reaching a level for the supervisor to pass the trainee. Clear arrangements must be set up to monitor the action plan and the trainee's progress, including if necessary another placement visit. The action plan will be shared with the trainee, their line manager, Clinical Director and supervisor.
In addition, further visits can be triggered by issues/concerns/requests from supervisors/trainees/clinical tutors.

Peer review between clinical tutors occurs annually. There may be visits where two clinical tutors are present in order for peer review to occur. Naturally, this will be negotiated with supervisors and trainees when this is to occur.

Observations whilst on clinical placement
One of the best ways of learning is through being observed and receiving feedback and reflecting on this in supervision. It is an essential skill as a clinical psychologist to be able to learn from our practice whilst on training and into qualified practice. We also encourage trainees to observe their supervisors and other professionals, to enable a rich learning environment.

- Observations include both direct and indirect observations.
- Observations should be planned, so that the trainee and supervisor know when the observation will occur, know specifically what they are being observed on and how feedback will occur.
- Observations can be virtual or face to face.

In order to ensure that trainees have sufficient opportunities for observation of their practice, as a minimum within each placement there needs to be for each placement:

- **1 formative observation:- this is used** for feedback and development purposes and does not count towards module grade
- **1 summative observation:- all work is marked as pass; conditional pass; fail and contributes to the placement grading.**

The trainee is required to submit the appropriate observation forms with their clinical placement paperwork. Trainees will need to submit a CBT observation within either year 1 or 2. Please see Appendix 26 - Observation tool for indirect clinical work.

Supervisors' evaluation of clinical competence

End of Placement Assessment

Supervisor Role in Trainee Evaluation

Supervisors evaluate trainees' competencies, evaluate their portfolio of experiences and observe their trainees at least twice on each placement during Years 1, 2 & 3. They also sign off attendance at placement, sick leave, study leave and annual leave. They also complete a placement audit survey at the end of each placement to evaluate the quality of placement. It is also expected that supervisors will have read the clinical case report written on the client within their placement and will be required to sign a form indicating that this has occurred.

Assessment of clinical skills

Trainee **competence** and **experience** are evaluated by the supervisors twice in each of the first two years of training and once towards the middle of the final year of training (with a final evaluation at the end of training if needed). The forms need to be submitted electronically before the submission deadline. Following this, the trainee's line manager reads this evaluation and it feeds into the annual appraisal meetings (outlined in more detail in section of the website) that generally function as a gateway to the following year of training or final qualification.

Reflection is monitored through feedback on reflexivity from clinical supervisors, which feeds trainees` annual appraisals (further reflective feedback comes from the programme team generally, and more specifically from the academic and research team).

Evaluation of Trainee's Placement Performance – Guidance of Completion of Clinical Paperwork.

Trainees are required to submit **electronic copies** of the Log of Clinical Activity and the observation (see observation tools in Supervisors' evaluation). *Trainees should keep a copy of these documents for their own records and send a copy to the relevant Clinical Tutor.*

These documents are completed by the trainee and signed and agreed by the supervisors as an accurate record. Trainees must ensure their submissions are complete and submitted by the deadline. If paperwork is submitted incomplete or late it will be marked as late, noted at examination board and discussed with the trainee's line manager. Plenty of time should be allowed to gain supervisors' input to this assessment. Being unable to access this because of time is not a valid reason for paperwork to be submitted late. Late submissions will automatically be marked as a 'conditional pass' as this is deemed to be a professional issue.
It is essential, as with all continuously assessed work that these evaluations are submitted by the required deadlines; if not, the trainee risks the paperwork being

marked as late, not progressing through to the next year, or completing the course in time. If the clinical paperwork is late this will be reported to the external examiners. **If the paperwork is more than two weeks late, this would normally constitute a fail.**
Clinical work undertaken after the September deadline should be mostly finishing work, completing reports etc rather than taking on any new work. Any new work undertaken after the September deadline would not normally be included in the assessment.

Should an incomplete or incorrect set of paperwork be submitted it is the trainees' responsibility to make any amendments or additions and re-organise their paperwork accordingly. Trainees must also keep their own copies as a cumulative record of all their placement reports to share with subsequent supervisors and at annual appraisal meetings. The clinical director moderates the ratings, prior to exam board where they are agreed .

Forms to be submitted:

At each clinical assessment deadline the following four documents need to be completed and submitted. These are:

- Clinical Assessment Front sheet
- Clinical Competence Goals and Evaluation Form
- Portfolio of Clinical Experience (Log of Clinical Activity and the Cumulative Record)
- Observation Forms

1. **Clinical Assessment Front sheet** (Appendix 15- Clinical Assessment Frontsheet)

One front sheet needs to be completed and signed by the trainee and all supervisors for each individual placement prior to submission before the deadline. This form records your overall placement grades for the Clinical Goals & Evaluation form and the Portfolio of Clinical Experience form.

2. **Clinical Competence Goals and Evaluation Form** (found in appendices 17, 18 &19)

This form is for trainees to record their clinical competency goals for every placement. At the beginning of placement you will identify goals, and these form the basis of the clinical assessment. Some of you will be on six month placements, and others will be on a year-long. If you are on a year-long placement you need identify goals for the first six month period, and these will be assessed by the supervisor as usual. For the second six month period these goals can either be added to, or new goals developed and these will form part of a new assessment at the end of the

placement year. If you have any further queries please discuss with your clinical tutor. Each form comes with a set of guidance notes.

There are two versions of the forms, one has been designed for use in a six month placement (with one supervisor) and one is for a long thin placement with two supervisors. However, trainees are free to use whichever they feel is more suited to their placement/s.

There are some suggestions for appropriate first placement goals in the Year 1 Guidance with Goals & Evaluation Form but these are suggestions only and you are not required to include them.

There is also a completed goals form from a second year placement by the way of example (provided here with permission of trainee and supervisor) called Example - Goals and Evaluation Form.

3. **Portfolio of Clinical Experience**

These documents are a record of the trainee's experience across training, and comprise two components; the log of clinical activity and the cumulative record of activity. It will be likely that trainees will not gain experience in each therapy domain in every placement, and therefore just leave the appropriate area blank.

Log of Clinical Activity: This log provides summary information of all clinical and professional activities undertaken during each placement period. This is kept as a running record by the trainee throughout each placement period; ideally updated every week. An example of this form is called: Example - Log of Clinical Activity

Cumulative Record of Experience: Trainee experiences are gathered cumulatively across placements. No one placement can provide all the competencies that a trainee needs to gain through training. The cumulative record is divided into 3 broad areas of experience: clients, service settings and modes of clinical work. The modes of clinical work are expanded upon in three further psychological therapy logs to evidence CBT, Systemic, and CAT experiences. Supervisors **do not** have to be accredited in order to sign off these logs.
An example of this record is called (please note this uses an older version of the cumulative record): Example - Cumulative Record of Experience

4. **Observational Tools** (Appendix 26- Observation tool for indirect clinical work)

Trainees **must complete** at least ten observations during their training, at least one formative and one summative per clinical placement. A number of observation tools (see below) are provided for trainees and supervisors to use to record supervisor

observation of trainee's clinical practice. These should be used formatively and developmentally and summatively and can be completed by any supervisor. The supervisor is not expected to be accredited in any particular therapy to be able to use these tools. Please see Appendix 21 - Observation guidance).

During Year 1 or Year 2 one of the observations **must** be the Child Assessment Tool (CAPS), CAPS 'PRECISE' – Scoring / Feedback Sheet or Cognitive Therapy Scale (CTS-R,) CTS R form for rating 17 01 12, CTS R Marking Feedback Formative Template or CTSR Feedback Form

Any of the following observation tools may be used:

- **Child Assessment Tool - CAPS-CBT Child assessment document**, **CAPS 'PRECISE' – Scoring / Feedback Sheet**
- **Cognitive Therapy Scale - CTS R form for rating 17 01 12, CTS R Marking Feedback Formative Template and CTSR Feedback Form**
- **Measure of Cognitive Analytic Therapy Competence (C-CAT)** for cognitive analytic therapy
- **The Clinical Skills Assessment – Rating Form (CSA-RF)** is a tool which was specifically developed for use by trainee psychologists and their supervisors and may also be useful for rating the observation of individual therapy work. This tool invites the supervisor to grade the trainee's performance (by rating the skill as 'Good Pass' 'Pass' 'Borderline' 'Fail'), please ignore this part of the form.
- **Exeter Observation tool for Indirect clinical work**
- **Exeter Observation tool for direct clinical work** (including performance-based psychometrics)
- **Systemic Family Practice Rating Scale** is a scale that has been devised to provide a structure for the assessment of Systemic Family Practice (SFP) skills. It is designed to evaluate a whole session but in addition can be used as a training and supervision tool and the focus may then be on particular areas of competence.

If you are in any doubt about the appropriateness of an observational tool, please consult with your clinical tutor. Moreover, if you are aware of another observation tool that you would like to use as an alternative, please consult with your clinical tutor.

Evaluation of Clinical Placements

Criteria for failing a clinical practice placement

As a course we need to ensure that trainees are able to develop the BPS competencies over the 3 years of training to a level that enables them to practice as a qualified clinical psychologist. This ensures that these competencies are achieved for safe and effective practice. Therefore, placements can be failed if any one of workload, competency, attendance or professionalism requirements are not fully met by the end of a placement. If a placement is not progressing well this should be identified and noted as early as possible, ideally prior to the Mid Placement Review. Once concerns are noted by a supervisor, it is expected that the supervisor would provide the trainee with clear feedback about their concerns and then, wherever possible, work with the clinical tutor and trainee to develop an action plan which would allow the trainee to remedy the stated concerns within the remainder of the placement. The action plan should contain clear learning objectives as well as specific timescales. The clinical tutor and line manager may need to consider whether additional support, at least within the scope of the placement/service, is required. Early reporting allows trainees to make the best use of the remaining time in the placement to remedy the concerns. An end of placement meeting should be arranged which will assess progress against the action plan reviewed. If the trainee does not respond sufficiently to the action plan by the end of placement, or additional concerns develop, then the supervisor's Evaluation of Clinical Competency Goals and Evaluation form should be completed accordingly, making a recommendation to the examination board that the placement is failed. If after moderation it is still recommended a placement failure, clinical placement paperwork will be submitted to the External Examiners. Where a repeated placement occurs particular goals may be specified that are required to be attained.

A **conditional pass**:- One or two significant concerns on any of the competencies would normally lead to a conditional pass grading. On either of the two placement evaluations (Clinical Competence Goals and Assessment Form and/or Portfolio of Clinical Activity) will be upgraded to a pass on confirmation from the clinical tutor that the issues identified have been attended to through the general placement outline for the next placement period. If the trainee receives a conditional pass at the mid-point of the final year placement, then the issue identified must be addressed in the planning for the next placement period and the trainee will be further evaluated at the end of the third year.
Paperwork submitted after the paperwork deadlines have passed will be noted as '*late*' and will automatically be marked as a conditional pass as this is considered a conditional issue.

Placement failure Three or more significant concerns on any of the competencies would normally lead to a fail grading and would ensue only after the procedures to address problems on placement had been exhausted without success as above. Any problems or concerns that could mean that the trainee may fail, should first be discussed by the trainee and supervisor together, and must be brought to the attention of the clinical tutor at the placement review visit (earlier if already identified, and

later if they emerge subsequently). If a trainee is failed on clinical placement, the host employer will be informed so that services from HR can be utilized as necessary (e.g., occupational health, employment support). This will prompt a letter from the employer registering confirmation/receipt of a clinical fail and commenting on any action plan. Notification will be given by the employer that if a trainee received another fail clinically, the trainee would normally fail the programme.

A trainee may be **failed** due to unsatisfactory clinical competence and/or unsatisfactory clinical experience. Both supervisor and clinical tutor make the judgement, after discussion, which is agreed. All cases where the trainee's placement performance is evaluated as conditional pass or fail, or where there is disagreement between supervisors, are moderated by the clinical director who liaises with the clinical tutor, line manager and supervisors as necessary. In any case where, following moderation by the clinical director, there continues to be a recommendation of a placement fail, all relevant paperwork is sent to the external examiner. The external examiner will always be involved in all cases where the evaluation of the trainee's placement performance is categorised as **failed**. The external examiner may take advice from the clinical tutor, the clinical director and, if necessary, the head of service in the trust in which the placement was based. The decision of the external examiner, when ratified by the Board of Examiners, is **final**.

If the trainee is **failed** on placement evaluations, they would be required to repeat the placement to address the issues of concern. An action plan would be devised with the clinical tutor. In order to successfully complete the programme, normally all subsequent placement evaluations must be passed. If the trainee is failed again *on any subsequent placement*, then they would normally fail the programme. If the first fail is at the review point of the final year placement, the action plan would be set up within the remaining placement period to attempt to address the issue of concern within that time if possible. In this case the trainee will be further evaluated at the end of the third year. If at that point they are failed again they would normally fail the programme. If at that time the trainee receives a fail for the first time, then they will need to extend training (at their own expense) and be finally evaluated at the end of that period. If at that point they are failed again they would normally fail the programme.

If at any point a trainee is found, following appropriate enquiry and due process, to have engaged in serious professional misconduct, i.e. conduct that seriously infringes the current BPS Code of Ethics and Conduct and/or HCPC (Standards of Conduct, Performance and Ethics) or the DCP Professional Practice Guidelines, then they would fail the placement and, normally, the Programme.

Clinical Placement Governance

Ensuring Quality of Placements

Placements are audited prior to trainees arriving in placement setting and are continually audited.
A database entry is recorded for every supervisor or placement setting, which gives a record of the training of each supervisor and shows that each service has appropriate induction policies for trainees.
A self-assessment tool is carried out with the placement provider/supervisor prior to the trainee going to the placement. The clinical tutor reviews this in order to report on any difficulties to ensure that the trainees enter safe and supportive environments when in a placement setting, reporting using the Placement Provider Quality Assessment Document.

Minimum standards for supervisors/heads of services in providing a placement:

- Confirmation in Trusts of the equality and diversity policies
- Health and safety policies
- Risk assessments
- Supervision contract – feasibility on hours that supervisors work
- Practical resources available for trainees
- Lone working policy
- Fitness to practice guidelines
- Supervisor training undertaken

Procedures for monitoring clinical placements

Placements are accredited as follows:

- Trust coordinators/ service heads identify supervisors whose qualifications meet the current criteria of the BPS Guidelines on Clinical Supervision (https://cms.bps.org.uk/sites/default/files/2022-07/Guidelines%20on%20clinical%20supervision.pdf) and Standards for Doctoral Programmes in Clinical Psychology (https://cms.bps.org.uk/sites/default/files/2022-07/Clinical%20Accreditation%20Handbook%202019.pdf)
- Liaison tutors/ clinical director/clinical tutor also ascertain through communication with the supervisor and head of service (and other service managers as required) that minimum resources are available: a desk in (at least) a shared office with access to telephone and secretarial support.
- Individual supervisors are accredited through attendance at the pre-placement meeting or, when this is not possible, through receiving the relevant placement and supervision documentation, with, if necessary, a meeting or telephone

contact with the clinical tutor or clinical director at which the placement procedures are outlined and documentation clarified.

Placements are assessed by the course in two ways:

- the supervisor completes a Self Assessment Document prior to a trainee starting on a placement
- and the audit tool at the end of every placement. The clinical director then signs off the placement as meeting necessary and required standards.

Ongoing individual placement quality is monitored through clinical tutor observation and trainee and supervisor feedback at placement visits.
The trainee and each supervisor separately complete a placement survey online at the end of each placement. The programme collates placement audit data across placements in the South West annually. Relevant data are forwarded for action as appropriate to individual supervisors and, where appropriate and with agreement, heads of service or specialism. Collective anonymised data are circulated to the Placement Committee and to placement providers via heads of service and this information is also provided at contract management meetings, as appropriate.

Managing concerns on clinical placement

We take any concerns very seriously that trainees may have about practice placements, placement providers and the services in which you train. Concerns may relate to various aspects of the placement including (but not limited to) the quality of

care being provided by an individual, or behaviour towards a trainee within the placement setting. The programme has developed policies and procedures to support trainees in this situation. Please refer the Support Map (found on ELE2 and the website: https://psychology.exeter.ac.uk/study/clinical/dclinpsy/) for further information.

We are aware of the role of Care Quality Commission monitoring in the quality of services and also of local procedures regarding serious untoward incidents or never events in placement providers. Trainees should orientate themselves to these policies and have awareness of any procedures that need to be followed.

Principles of Action:

1. The person raising the concern should prepare a written report outlining the concerns and relevant dates. It would also be helpful, although not vital, if others who could corroborate the allegation were prepared to be identified at this stage. The trainee should seek the advice of their placement supervisor and/or clinical tutor in the preparation of this report.
2. The report should then be submitted to the Clinical Director who will decide most appropriate course of action with the Programme Director.
3. Where the concern relates to the practice placement, the Head of Service would be informed and it would be expected that the placement provider would use their own whistleblowing procedures reporting the findings and outcomes at the end of the process. If the University is satisfied that the service is fulfilling its responsibilities then the matter will rest there. Where this is not the case however, the University will take further action to fulfil its own responsibilities towards trainees (e.g. by withdrawing trainees from that setting and no longer using it as a suitable setting for practice learning) and to the public (e.g. by referring its concerns to the HCPC or other appropriate authority)
4. Where the investigation identifies a breach of HCPC Standards of Education and Training in respect of Practice Learning (SET5), the University undertakes not to place trainees in this setting until the matter is resolved and the University can be assured of the quality of the practice and/or service provision in that setting. In such cases a full placement pre audit would be undertaken and the context/service assessed again for its suitability to provide trainee placements.
5. In all cases the Clinical Director and Programme Director will be informed of the process and outcome of any investigation and, the person making the initial complaint will be informed of the outcome.

Please see the following link for additional information: https://www.england.nhs.uk/ourwork/freedom-to-speak-up/

Policy for raising placement concerns related to discrimination, bullying, harassment, abuse (BHA) and racism

1. A trainee has concern about their clinical supervisor on placement due to experiences of discrimination, BHA and/or racism.
2. Clinical tutor will raise with trainee line manager and speak with the placement supervisor.
    a. If placement supervisor demonstrates concern over behaviour and is open to learning and repairing their supervisory relationship step 3 is taken.
    b. If placement supervisor is not open to feedback and does not take on the concerns. The clinical tutor will escalate it to the Clinical Practice Director. Refer to step 4.
3. A three-way meeting with the trainee, the clinical tutor, and the placement supervisor is arranged. At the meeting an action plan is agreed, and a review date is established. Regular check-in with the trainee by the clinical tutor is organized. The clinical tutor will notify the line manager of the processes taken.
4. Clinical Practice Director raises concerns with the placement supervisors line manager.

If the behaviour of the placement supervisor is deemed inappropriate, unprofessional, or harmful, the trainee will be removed from the placement and a review of the placement provider with take place

University of Exeter Regulations Regarding Placement

This link gives details of the University Regulations and Code of Practice for Placements both in the UK and overseas which you should find useful and read for your information: https://as.exeter.ac.uk/academic-policy-standards/tqa-manual/lts/placements/

Auditing of clinical placements

The DClinPsy programme uses a Placement Quality Form (Appendix 7- Placement Provider Quality Assessment Document). Trainees and supervisors offer feedback on placement quality at the end of placement. Each time a placement is used both supervisor and trainee comment on placement resources, supervision quality, learning opportunities etc., and we use this feedback to assess the placement quality against the HEE placement quality standards. By evaluating placement feedback

routinely and feeding back to the placement committee we are able to highlight not only good practice but where there are difficulties and work with our placement providers to ensure a good quality of placements and experiences.

Appendices (Clinical Documents)

Contents

* this is a provisional copy of a document under review with an external examiner, it may change once reviewed

Appendix 1 Clinical Module Descriptor

UNIVERSITY OF EXETER

MODULE TITLE	Clinical Skills in Clinical Psychology Year 1	**CREDIT VALUE**	45 credits

MODULE CODE	PSYD058		MODULE CONVENOR	Clinical Director	
DURATION *Clinical placements continue throughout the year and are not contained within semesters	TERM	1	2	3	Number Students Taking Module (anticipated) 30
	WEEKS	10*	10*	10*	

DESCRIPTION – summary of the module content (100 words)

This module is the first of the three that comprise the clinical component of the professional Doctorate in Clinical Psychology (DClinPsy). Taken together the three components, academic, clinical and research, form the basis for the knowledge, skills values and competences required to practise as clinical psychologists, to meet the requirements for the award of DClinPsy and to be eligible for registration with the HCPC. The regulations that apply to these PGR Programme modules can be found here http://admin.exeter.ac.uk/academic/tls/tqa/Part%207/7Mprofdocs.pdf .

Overall, the clinical module aims to enable trainees to apply in practice the

- Theoretical and empirical knowledge,
- Critical, analytical and integrative skills and
- Professional, ethical and client-centred values needed to work effectively to enhance and promote psychological well-being.

The module provides trainees with opportunities to develop and demonstrate competencies in line with the HCPC Standards of Education and Guidance, the HCPC Standards of Proficiency and the HCPC Standards of Conduct, Performance and Ethics and the nine BPS core competencies for Clinical Psychology (BPS, 2019).

- **Generalisable metacompetencies = GMC**
  The generalisable meta-competencies are applicable in different contexts with different people at different life stages, drawing on any relevant areas of psychological knowledge, guidelines, and frameworks. These skills include the ability to critically synthesise evidence and apply it in ways that fit the context which may be complex or novel and draw on a variety of models of practice. Furthermore, to be able to exercise these approaches in an autonomous way, collaborating and communicating effectively, where appropriate with service users and others in a reflective and ethical manner.

- **Psychological assessment = PA**
  The ability to choose, use and interpret a broad range of methods of assessment encompassing individual, group, social context and organisational and approaches, with a good understanding of psychometric principles and practice, including the assessment of risk.

- **Psychological formulation = PF**
  On the basis of assessment being able to co-produce and lead on formulations addressing individual, systemic, cultural and biological factors which may be related to but are not premised on formal diagnostic frameworks and that are aimed at helping the client, team or organisation better understand their experience. Ability to choose the most appropriate format and complexity of the formulation to match the issues concerned and to guide interventions in a manner consistent with equality diversity and inclusion.

- **Psychological intervention = PI**
  On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner. Ability to use evidence-based psychotherapeutic models and other approaches for interventions that address the complexity of the presentation and context, including prevention and promotion of wellbeing, that promotes recovery that is informed by service users' values and goals. Ability to take into account psychopharmacological and other multidisciplinary methods. Are mindful of social constructivist, community and critical psychology approaches to intervention. Be aware of and able to communicate when intervention is not helpful or appropriate

- **Evaluation = E**
  Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning; devising innovative approaches to evaluation, with wide knowledge and critical appreciation of the main evaluation methods in use across the health and welfare system and effective use of supervision to evaluate own work.

- **Research = R**
  Being a critical and effective producer, consumer, interpreter, and disseminator of the research evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

- **Personal and professional skills and values = PPSV**
  Ability to, in a reflective and reflexive manner, recognise ethical issues, be able to reason about them and take action to address them in various contexts including complex clinical and self-care contexts; ensuring that informed consent underpins all contact with clients and research participants.

- **Communicating and teaching = CT**
  The ability to communicate effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences, as necessary. Using these skills in teaching, supervision, expert opinion, with interpreters and supporting other's learning.

- **Organisational and systemic influence and leadership = OSIL**
  Awareness of the legislative and national planning contexts for service delivery and clinical practice and the capacity to adapt practice in light of this. Ability to practice and in a variety of contexts and understand how these contexts function from an organisational perspective. Knowledge of and ability to supervise; provide consultancy and leadership, in collaborating with others, including service users and other experts by experience. Be able to promote psychological mindedness in services, alongside the implementation of quality improvement systems. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.

MODULE AIMS – intentions of the module

The module aims to develop trainees understanding of the main elements of theory, evidence-base and practice pertaining to core knowledge, skills, values and competence to draw upon for the clinical psychologist working with clients across the life span with special reference to five approaches: systemic, cognitive analytic therapy, cognitive behavioural therapy, neuropsychology, and Reflexive Organisational Practice (GMC, PA, PF, PI, E, R, PPSV, CT, OSIL). These approaches inform learning and practice with adult, older adult, children, people with intellectual disabilities, public health approaches, and clients in health settings.

Specific aims (abbreviations are BPS competencies for clinical psychologists) are to develop trainees'

1. Core clinical competencies in working directly and indirectly with individuals, carers, services and community systems (PA, PF, PI, E, R, PPSV, OSIL, CT, GMC)
2. Direct and indirect application of clinical competencies within a range of experiences: in a range of service delivery settings with clients with a representative range of problems and abilities from across the life span (PA, PF, PI, E, PPSV, OSIL, CT, GMC)
3. Application of clinical competencies with clients from a range of backgrounds taking into account social inequalities and diversity (PA, PF, PI, E, PPSV, OSIL, CT, GMC)
4. Integration of psychological theory, evidence and experience (PA, PF, PI, E, PPSV, OSIL, CT, GMC)
5. Commitment to working collaboratively, compassionately and respectfully with clients and colleagues, sharing essential capabilities and working as part of multi-disciplinary teams (PA, PF, PI, PPSV, OSIL, CT, GMC)
6. Competence to work within professional and regulatory codes of practice and ethics (PA,PF,PI, PPSV, OSIL, CT, GMC,)

7. Ability to conceptualise and adapt their practice in the light of current service policies and priorities (PA, PF, PI, E, CT, PPSV, OSIL, CT, GMC,)
8. Readiness to approach their work with critical reflection and self-awareness (PA, PF, PI, E, R, PPSV, OSIL, CT, GMC)
9. Capacity to nurture their own particular clinical strengths and interests so that they can make a contribution to the development of psychological skills, knowledge and the profession (PA, PF, PI, E, CT, R, PPSV, OSIL, CT, GMC)

Specifically, the BPS requires that by the end of the module (and the Programme more generally), it is expected that trainees will have:

1. A value driven commitment to reducing psychological distress and enhancing and promoting psychological wellbeing through the systematic application of knowledge derived from psychological theory and evidence. Work should be based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals.
2. The skills, knowledge and values to develop working alliances with clients, including individuals, carers and/or services, in order to carry out psychological assessment, develop a formulation based on psychological theories and knowledge, carry out psychological interventions, evaluate their work and communicate effectively with clients, referrers and others, orally, electronically and in writing.
3. Knowledge and understanding of psychological (and other relevant) theory and evidence, related to specific client groups, presentations, psychological therapies, psychological testing, assessment, intervention and secondary prevention required to underpin clinical practice.
4. The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives. Awareness of the clinical, professional and social contexts within which work is undertaken and impact therein.
5. Clinical and research skills that demonstrate work with clients and systems based on a reflective scientist-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation and that draws from across theory and therapy evidence bases as appropriate.
6. The skills, knowledge and values to work effectively with systems relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.
7. The skills, knowledge and values to work in a range of indirect ways to improve psychological aspects of health and healthcare. This includes leadership skills and competencies in consultancy, supervision, teaching and training, working collaboratively and influencing psychological mindedness and practices of teams.
8. The skills, knowledge and values to conduct research and reflect upon outcomes in a way that enables the profession to develop its knowledge base and to monitor and improve the effectiveness of its work.

9. A professional and ethical value base, including that set out in the BPS Code of Ethics and Conduct, the DCP statement of the Core Purpose and Philosophy of the profession and the DCP Professional Practice Guidelines.
10. High level skills in managing a personal learning agenda and self-care, in critical reflection and self-awareness that enable transfer of knowledge and skills to new settings and problems and professional standards of behaviour as might be expected by the public, employers and colleagues.

INTENDED LEARNING OUTCOMES (ILOs) (see assessment section below for how ILOs will be assessed)

On successful completion of this module you should be able to:

Module Specific Skills and Knowledge	
1	Explicitly underpin clinical work with theory, evidence and techniques drawn from two or more of the following psychological approaches (CAT, CBT, Systemic), of which one must be cognitive-behavioural therapy; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
2	Critically and autonomously evaluate and integrate theories in light of new information so as to develop new clinical approaches appropriate to the context (i.e. taking into account the complex and unpredictable nature of real world settings and recognizing complexities/deficiencies and/or contradictions in knowledge; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
3	Search and appraise relevant evidence bases and literature when planning interventions; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
4	Use clinical judgment, reflection and awareness of clients' views in applying evidence in practice; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
5	Justify, reflect on, evaluate, report and monitor own and others' work, and implement changes or acquire further knowledge when appropriate through a process of supervision and personal reflection; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
6	Develop skills, knowledge and values to build working alliances with clients, carers and services (CT, PPSV, GMC, OSIL)
Discipline Specific Skills and Knowledge:	
7	Demonstrate the core competencies of a clinical psychologist: generalisable meta competencies, psychological assessment, psychological formulation, psychological intervention, evaluation, research, personal development, professional skills and values, communication and teaching and organisational and systemic influence and leadership; (GMC, PA, PF, PI, E, R, PPSV, OSIL, CT)

8	Demonstrate the core competencies within a range of experiences: in a range of service delivery settings with clients (individuals, carers, families and groups) with a representative range of problems and abilities from across the life span; (PA, PF, E, R, PPSV, OSIL, CT GMC)
9	Demonstrate the essential shared capabilities for mental health practice: working in partnership, respecting diversity, cultural competency, practicing ethically, challenging inequality, promoting recovery, identifying peoples' needs and strengths, providing service user centred care, making a difference, promoting safety and positive risk taking, personal development and learning; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
10	Work effectively in consultation or in team work with professional colleagues across disciplines and across agencies, showing respect for knowledge and theories held by other professional groups including medical model diagnostic systems; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
11	Disseminate psychological skills and knowledge to others through formal or informal teaching; information provision; consultancy; supervision; (PA, PF, E, R, CT, PPSV, OSIL, GMC)
12	Document clinical work appropriately through notes, reports and letter writing for clients and referrers; (PA, PF, PI, E, CT, SD, R, OSIL, PPSV, GMC)
Personal and Key Transferable/ Employment Skills and Knowledge:	
13	Recognize and work within the limits of own professional and personal competence; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
14	Accept high levels of responsibility for self and others; (PA, PF, E, R, PPS, CT, PPSV, OSIL, CT, GMC)
15	Recognize and analyse professional and ethical dilemmas and act in accordance with professional guidelines and clinical governance; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
16	Understand, work within and influence the wider political, legal, organisational and systemic frameworks within which clinical psychologists operate; (PA, PF, E, R, CT, SD, PPSV, OSIL, CT, GMC)
17	Manage workload and deal pro-actively with stress and the impact of clinical work; (PA, PF, E, R, CT, PPSV, OSIL, GMC,)
18	Demonstrate critical reflection and self-awareness; (PA, PF, E, R, SD, PPSV, OSIL, CT, GMC)

19	Identify own professional development needs and implement learning in practice as part of a process of life-long learning. (PA, PF, E, R, PPSV, OSIL, CT GMC)

SYLLABUS PLAN – summary of the structure and academic content of the module

Learning will be through supervised practice via experience with a range of clients and across a range of settings e.g. health, social care, education, third sector and private provider settings. More than 50 percent of the three-year doctorate is spent in clinical psychology practice settings. A number of methods will be used including;

- Feedback based on supervision of trainee from placement supervisor
- Direct and indirect observation of clinical practice
- Feedback from service users and colleagues
- Literature searches
- Clinical tutorials
- Assigned reading.

A number of systems have been developed to ensure good links between theory and practice: as far as possible, the broad correspondence between the timing of academic teaching on the programme and placement experience, trainees writing practical reports on the basis of their placement experience, and mid-placement reviews, are all examples.

For trainees' learning to be maximised, and for them to feel that their academic and placement experience is integrated, it is important that they link their clinical work to literature in the field. Supervisors have a vital role in this, and need not feel that they have to be up to date in every area in order to be helpful. The trainee may be able to inform the supervisor at times, and both may need to extend their knowledge base in order to tackle particular problems. Making links between theory and practice should be a collaborative venture.

Year 1 Placement Overview

We take a life-span development model covering the challenges people face which can be addressed by psychological approaches. Core skills include therapeutic relationships, assessment, formulation, intervention and evaluation – working with individuals, families and communities. Students complete two 6 month or one 12 month clinical placement(s) within our placement provider settings, working with psychological presentations in children and families, neurodiversity and/or psychological presentations in working aged adults, older adults, health, social care & education settings, and/or groups, teams & systems.

Assessment is by 100% coursework.

All summative assessments must receive a pass mark for progression through the programme and successful module completion as detailed in the programme handbook:
(see TQA manual http://admin.exeter.ac.uk/academic/tls/tqa/Part%207/7Mprofdocs.pdf for details)

All summative assessments are graded as follows – pass, conditional pass or fail. Each assignment will include an assessment of a range of competences depending on the specific area covered.

3 Clinical tutorials, one per term Weekly supervision with placement supervisor					
LEARNING AND TEACHING					
LEARNING ACTIVITIES AND TEACHING METHODS (given in hours of study time)**					
Scheduled Learning & Teaching activities	240	Guided independent study	60	Placement/study abroad	0
***50% of the overall time on the programme is in practice based placements*					
DETAILS OF LEARNING ACTIVITIES AND TEACHING METHODS					
Category		Hours of study time	Description		
2 practice-based placements		Trainees employed as Band 6 practitioners-full-time employees of the NHS	Clinical practice undertaken in a range of clinical settings under the supervision of a HCPC regulated clinical psychologist. Settings may include child, older people, working age adults, learning disability, forensic and health. Placement providers may be NHS Trusts, education, charities, CICs, third and private sector.		
ASSESSMENT					
FORMATIVE ASSESSMENT - for feedback and development purposes; does not count towards module grade					
Form of Assessment		Size of the assessment e.g. duration/length	ILOs assessed	Feedback method	
1. Observation Tool x 2 (relates to Reflection 1,2,3 subject specific skills), at least one per placement. One is a CBT competency assessment e.g Child or Adolescent Practice Scale (CAPS-CBT), Revised Cognitive Therapy Scale (CTSr) (relates to subject specific skills 1-6)		Observational tool: 1 hour observation and followed by discussion	1-19 as defined above	Written and discussion	
2. Preparatory reading and literature searches for clinical work (relates to core academic skills 6 and 7)		Assessed through evaluation of clinical competence and supervision.	1-19 as defined above	Written and discussion	

3. Presentations of clinical work in tutorials and supervision (relates to subject specific skills 5)	Min of 43 hours (1hour weekly supervision and 3 clinical tutorials across the year)	1-19 as defined above	Written and discussion
4. Self-evaluation of Clinical Competence x 2 (relates to personal and key competencies)	(11 pages)	1-19 as defined above	Written and discussion

SUMMATIVE ASSESSMENT (% of credit) Summative assessment: all work is marked as pass; conditional pass; referred; fail.
If a trainee is referred twice on clinical assessment, they would normally fail the programme (C6)

Coursework	100	Written exams	0	Practical exams	0

DETAILS OF SUMMATIVE ASSESSMENT

Form of Assessment	% of credit	Size of the assessment e.g. duration/length	ILOs assessed	Feedback method
YEAR 1		Clinical placement 1& 2: (130 days – including clinical tutorials, theory practice days and annual leave).		
1. Supervisor Evaluation of Clinical Competence: end of placement 1 if 2 x six month placements or mid placement if 2 x year long placements (Deadline hand in May) (assesses core academic skills 1-5; subject specific skills 1, 3 -	16.67 16.67	**1.** Evaluation of Clinical Competence, end of placement 1 if 2 x six month placements or mid of placements if 2 x year long placements (Deadline hand in May) (11 pages per placement)	1-19 as defined above	Discussion and written feedback Discussion and written feedback

6; personal & key skills 1-7) **2.** Supervisor Evaluation of Clinical Competence: end of placement 2 if 2 x six month placements or end of placements if 2 x year long placements (Deadline hand in August) (assesses core academic skills 1-5; subject specific skills 1, 3 - 6; personal & key skills 1-7) **3.** Portfolio of Clinical Experience: end of placement 1 if 2x six month placements or mid of placements if 2 x year long placements (Deadline hand in May) (assesses subject specific skills 2) **4.** Portfolio of Clinical Experience: end of placement 2 if 2x six month placements or end of placements if 2 x year long	16.67 16.67 33.34	**2.** Evaluation of Clinical Competence, end of placement 1 if 2 x six month placements or mid of placements if 2 x year long placements (Deadline hand in August) (11 pages per placement) **3.** Portfolio of Clinical Experience, end of placement 1 if 2 x six month placements or mid of placements if 2 x year long placements (Deadline hand in May) (7 pages with appendices per placement) **4.** Portfolio of Clinical Experience, end of placement 2 if 2 x six month placements or end of placements if 2 x year long placements	1-19 as defined above 1-19 as defined above 1-19 as defined above	Discussion and written feedback Discussion and written feedback Discussion and written feedback

placements (Deadline hand in August) (assesses subject specific skills 2) **5.** Observation Tool x 2 (relates to Reflection 1,2,3 subject specific skills), at least one per placement. One is a CBT competency assessment (relates to subject specific skills 1-6)		(Deadline hand in August) (7 pages with appendices per placement) **5.** Clinical Placements 1 & 2, to include two observations (one per placement), with one being a Child and Adolescent Practice Scale (CAPS-CBT) or CTSr. Observational tool: 1 hour observation and followed by discussion.	1-19 as defined above	

DETAILS OF RE-ASSESSMENT (where required by referral or deferral)

Original form of assessment	Form of re-assessment	ILOs re-assessed	Time scale for re-assessment
Clinical assessment, Supervisor evaluation of clinical competence	Clinical assessment by Supervisor evaluation of clinical competence	1-19 as defined above	6 months
Portfolio of Clinical experience	Portfolio of clinical experience (7 pages with appendices)	1-19 as defined above	6 months
Observation Tool	Clinical placement assessment	1-19 as defined above	6 months

RE-ASSESSMENT NOTES – give details of how re-assessment will be calculated. This section can also be used to indicate where re-assessment is not available

Trainees will be required to undertake a further clinical practice placement with the same client group if they fail a placement. Two fails would normally lead to programme failure.

RESOURCES

INDICATIVE LEARNING RESOURCES - The following list is offered as an indication of the type & level of information that you are expected to consult. Further guidance will be provided by the Module Convener.

Basic reading:

ELE – http://vle.exeter.ac.uk/

Clinical Handbook - https://cedar.exeter.ac.uk/handbook/clinical/

Other resources:

British Psychological Society

- Electronic records guidance (2019)
- Record Keeping: Guidance on Good Practice, (2013)
- Code of Human Research Ethics (2021)
- Code of Ethics and Conduct. (2018)
- Conducting research with human participants during Covid-19 (2020)
- Division of Clinical Psychology: Policy on supervision (2014)
- Ethics guidelines for internet-mediated research (2021)
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- Standards for the accreditation of Doctoral Programmes in Clinical Psychology (2019)
- Practice Guidelines (2017)
- Guidelines for Clinical Psychology Services (July 2011)
- New ways of working for applied psychologists in Health and Social care: Working psychologically in Teams (2007)

Health and Care Professions Council

- Standards of Education and Training guidance (2017)
- Standards of Proficiency for Practitioner psychologists (2015)
- Standards of conduct, performance and Ethics (2016)
- Guidance on conduct and ethics for students (2016)
- Practitioner psychologists (2018)

Department of Health

Department of Health (1999) A National Service Framework for Mental Health. London: Department of Health.

Department of Health (2001) A National Service Framework for Older People. London: Department of Health.

Department of Health (2001) Valuing People: A New Strategy for Learning Disability for the 21st Century: a White Paper. London: The Stationery Office.

Department of Health (2004) A National Service Framework: children, young people and maternity services. London: Department of Health.

Department of Health (2004) Every Child Matters: Next Steps.

Department of Health (2005). A National Service Framework: Long Term Conditions. London: Department of Health.
House of Commons Health Committee (2007): Patient and Public Involvement in the NHS: a Brief Overview.
Department of Health (2004). The Ten Essential Shared Capabilities: a Framework for the Whole of the Mental Health Workforce.
Department of Health (2019). The NHS Long Term Plan. London: Department of Health.

National Institute for Clinical Excellence: www.nice.org.uk
Beinart, H. and Kennedy, P. and Llewelyn, S, (2009) Clinical Psychology in Practice. Oxford Blackwell: British Psychological Society.
Fleming, I and Steen, L. (2011) Supervision and Clinical Psychology, 2nd Edition. Hove and New York: Brunner – Routledge.
Harvey, D (Ed). (2001) Core Purpose and Philosophy of the Profession. Leicester: British Psychological Society.
Hawkins, P. & Shohet, R. (2020) (5th Edn) Supervision in the Helping Professions. Milton Keynes: Open University Press.
Owusu-Bempah, K. & Howitt D. (2000) Psychology Beyond Western Perspectives. Leicester: British Psychological Society.
Scaife, J. (2019) Supervision in Clinical Practice. 3rd Edition. London: Taylor & Francis

CREDIT VALUE	45	**ECTS VALUE**	**22.5**
PRE-REQUISITE MODULES	None		
CO-REQUISITE MODULES	PSYD061 and PSYD064		
NQF LEVEL (FHEQ)	8	**AVAILABLE AS DISTANCE LEARNING**	NO *Some clinical placements are remote
ORIGIN DATE	**Feb 2015**	**LAST REVISION DATE**	**Sept 2023**
KEY WORDS SEARCH	**Clinical Psychology, Placement, Trainees**		

MODULE TITLE	Clinical Skills in Clinical Psychology Year 2				**CREDIT VALUE**	45 credits
MODULE CODE	PSYD059		**MODULE CONVENOR**		Clinical Director	
DURATION *Clinical placements continue throughout the year and are not contained within semesters	**TERM**	**1**	**2**	**3**	**Number Students Taking Module (anticipated)**	**30**
	WEEKS	10*	10*	10*		

DESCRIPTION – summary of the module content (100 words)

This module is the second of the three that comprise the clinical component of the professional Doctorate in Clinical Psychology (DClinPsy). Taken together the three components, academic, clinical and research, form the basis for the knowledge, skills values and competences required to practise as clinical psychologists, to meet the requirements for the award of DClinPsy and to be eligible for registration with the HCPC. The regulations that apply to these PGR Programme modules can be found here http://admin.exeter.ac.uk/academic/tls/tqa/Part%207/7Mprofdocs.pdf .

Overall, the clinical module aims to enable trainees to apply in practice the

- Theoretical and empirical knowledge,
- Critical, analytical and integrative skills and
- Professional, ethical and client-centred values needed to work effectively to enhance and promote psychological well-being.

The module provides trainees with opportunities to develop and demonstrate competencies in line with the HCPC Standards of Education and Guidance, the HCPC Standards of Proficiency and the HCPC Standards of Conduct, Performance and Ethics and the nine BPS core competencies for Clinical Psychology (BPS, 2019).

- **Generalisable metacompetencies = GMC**
  The generalisable meta-competencies are applicable in different contexts with different people at different life stages, drawing on any relevant areas of psychological knowledge, guidelines, and frameworks. These skills include the ability to critically synthesise evidence and apply it in ways that fit the context which may be complex or novel and draw on a variety of models of practice. Furthermore, to be able to exercise these

approaches in an autonomous way, collaborating and communicating effectively, where appropriate with service users and others in a reflective and ethical manner.

- **Psychological assessment = PA**
  The ability to choose, use and interpret a broad range of methods of assessment encompassing individual, group, social context and organisational and approaches, with a good understanding of psychometric principles and practice, including the assessment of risk.

- **Psychological formulation = PF**
  On the basis of assessment being able to co-produce and lead on formulations addressing individual, systemic, cultural and biological factors which may be related to but are not premised on formal diagnostic frameworks and that are aimed at helping the client, team or organisation better understand their experience. Ability to choose the most appropriate format and complexity of the formulation to match the issues concerned and to guide interventions in a manner consistent with equality diversity and inclusion.

- **Psychological intervention = PI**
  On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner. Ability to use evidence-based psychotherapeutic models and other approaches for interventions that address the complexity of the presentation and context, including prevention and promotion of wellbeing, that promotes recovery that is informed by service users' values and goals. Ability to take into account psychopharmacological and other multidisciplinary methods. Are mindful of social constructivist, community and critical psychology approaches to intervention. Be aware of and able to communicate when intervention is not helpful or appropriate

- **Evaluation = E**
  Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning; devising innovative approaches to evaluation, with wide knowledge and critical appreciation of the main evaluation methods in use across the health and welfare system and effective use of supervision to evaluate own work.

- **Research = R**
  Being a critical and effective producer, consumer, interpreter, and disseminator of the research evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

- **Personal and professional skills and values = PPSV**
  Ability to, in a reflective and reflexive manner, recognise ethical issues, be able to reason about them and take action to address them in various contexts including complex clinical

and self-care contexts; ensuring that informed consent underpins all contact with clients and research participants.

- **Communicating and teaching = CT**
  The ability to communicate effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences, as necessary. Using these skills in teaching, supervision, expert opinion, with interpreters and supporting other's learning.

- **Organisational and systemic influence and leadership = OSIL**
  Awareness of the legislative and national planning contexts for service delivery and clinical practice and the capacity to adapt practice in light of this. Ability to practice and in a variety of contexts and understand how these contexts function from an organisational perspective. Knowledge of and ability to supervise; provide consultancy and leadership, in collaborating with others, including service users and other experts by experience. Be able to promote psychological mindedness in services, alongside the implementation of quality improvement systems. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.

MODULE AIMS – intentions of the module

The module aims to develop trainees understanding of the main elements of theory, evidence-base and practice pertaining to core knowledge, skills, values and competence to draw upon for the clinical psychologist working with clients across the life span with special reference to five approaches: systemic, cognitive analytic therapy, cognitive behavioural therapy, neuropsychology, and Reflexive Organisational Practice (GMC, PA, PF, PI, E, R, PPSV, CT, OSIL). These approaches inform learning and practice with adult, older adult, children, people with intellectual disabilities, public health approaches, and clients in health settings.
Specific aims (abbreviations are BPS competencies for clinical psychologists) are to develop trainees'

10. Core clinical competencies in working directly and indirectly with individuals, carers, services and community systems (PA, PF, PI, E, R, PPSV, OSIL, CT, GMC)
11. Direct and indirect application of clinical competencies within a range of experiences: in a range of service delivery settings with clients with a representative range of problems and abilities from across the life span (PA, PF, PI, E, PPSV, OSIL, CT, GMC)
12. Application of clinical competencies with clients from a range of backgrounds taking into account social inequalities and diversity (PA, PF, PI, E, PPSV, OSIL, CT, GMC)
13. Integration of psychological theory, evidence and experience (PA, PF, PI, E, PPSV, OSIL, CT, GMC)

14. Commitment to working collaboratively, compassionately and respectfully with clients and colleagues, sharing essential capabilities and working as part of multi-disciplinary teams (PA, PF, PI, PPSV, OSIL, CT, GMC)
15. Competence to work within professional and regulatory codes of practice and ethics (PA,PF,PI, PPSV, OSIL, CT, GMC,)
16. Ability to conceptualise and adapt their practice in the light of current service policies and priorities (PA, PF, PI, E, CT, PPSV, OSIL, CT, GMC,)
17. Readiness to approach their work with critical reflection and self-awareness (PA, PF, PI, E, R, PPSV, OSIL, CT, GMC)
18. Capacity to nurture their own particular clinical strengths and interests so that they can make a contribution to the development of psychological skills, knowledge and the profession (PA, PF, PI, E, CT, R, PPSV, OSIL, CT, GMC)

Specifically, the BPS requires that by the end of the module (and the Programme more generally), it is expected that trainees will have:

1. A value driven commitment to reducing psychological distress and enhancing and promoting psychological wellbeing through the systematic application of knowledge derived from psychological theory and evidence. Work should be based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals.
2. The skills, knowledge and values to develop working alliances with clients, including individuals, carers and/or services, in order to carry out psychological assessment, develop a formulation based on psychological theories and knowledge, carry out psychological interventions, evaluate their work and communicate effectively with clients, referrers and others, orally, electronically and in writing.
3. Knowledge and understanding of psychological (and other relevant) theory and evidence, related to specific client groups, presentations, psychological therapies, psychological testing, assessment, intervention and secondary prevention required to underpin clinical practice.
4. The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives. Awareness of the clinical, professional and social contexts within which work is undertaken and impact therein.
5. Clinical and research skills that demonstrate work with clients and systems based on a reflective scientist-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation and that draws from across theory and therapy evidence bases as appropriate.
6. The skills, knowledge and values to work effectively with systems relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.
7. The skills, knowledge and values to work in a range of indirect ways to improve psychological aspects of health and healthcare. This includes leadership skills and

competencies in consultancy, supervision, teaching and training, working collaboratively and influencing psychological mindedness and practices of teams.

8. The skills, knowledge and values to conduct research and reflect upon outcomes in a way that enables the profession to develop its knowledge base and to monitor and improve the effectiveness of its work.
9. A professional and ethical value base, including that set out in the BPS Code of Ethics and Conduct, the DCP statement of the Core Purpose and Philosophy of the profession and the DCP Professional Practice Guidelines.
10. High level skills in managing a personal learning agenda and self-care, in critical reflection and self-awareness that enable transfer of knowledge and skills to new settings and problems and professional standards of behaviour as might be expected by the public, employers and colleagues.

INTENDED LEARNING OUTCOMES (ILOs) (see assessment section below for how ILOs will be assessed)

On successful completion of this module you should be able to:

Module Specific Skills and Knowledge	
1	Explicitly underpin clinical work with theory, evidence and techniques drawn from two or more of the following psychological approaches (CAT, CBT, Systemic), of which one must be cognitive-behavioural therapy; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
2	Critically and autonomously evaluate and integrate theories in light of new information so as to develop new clinical approaches appropriate to the context (i.e. taking into account the complex and unpredictable nature of real world settings and recognizing complexities/deficiencies and/or contradictions in knowledge; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
3	Search and appraise relevant evidence bases and literature when planning interventions; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
4	Use clinical judgment, reflection and awareness of clients' views in applying evidence in practice; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
5	Justify, reflect on, evaluate, report and monitor own and others' work, and implement changes or acquire further knowledge when appropriate through a process of supervision and personal reflection; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
6	Develop skills, knowledge and values to build working alliances with clients, carers and services (CT, PPSV, GMC, OSIL)
Discipline Specific Skills and Knowledge:	
7	Demonstrate the core competencies of a clinical psychologist: generalisable meta competencies, psychological assessment, psychological formulation, psychological

	intervention, evaluation, research, personal development, professional skills and values, communication and teaching and organisational and systemic influence and leadership; (GMC, PA, PF, PI, E, R, PPSV, OSIL, CT)
8	Demonstrate the core competencies within a range of experiences: in a range of service delivery settings with clients (individuals, carers, families and groups) with a representative range of problems and abilities from across the life span; (PA, PF, E, R, PPSV, OSIL, CT GMC)
9	Demonstrate the essential shared capabilities for mental health practice: working in partnership, respecting diversity, cultural competency, practicing ethically, challenging inequality, promoting recovery, identifying peoples' needs and strengths, providing service user centred care, making a difference, promoting safety and positive risk taking, personal development and learning; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
10	Work effectively in consultation or in team work with professional colleagues across disciplines and across agencies, showing respect for knowledge and theories held by other professional groups including medical model diagnostic systems; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
11	Disseminate psychological skills and knowledge to others through formal or informal teaching; information provision; consultancy; supervision; (PA, PF, E, R, CT, PPSV, OSIL, GMC)
12	Document clinical work appropriately through notes, reports and letter writing for clients and referrers; (PA, PF, PI, E, CT, SD, R, OSIL, PPSV, GMC)
Personal and Key Transferable/ Employment Skills and Knowledge:	
13	Recognize and work within the limits of own professional and personal competence; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
14	Accept high levels of responsibility for self and others; (PA, PF, E, R, PPS, CT, PPSV, OSIL, CT, GMC)
15	Recognize and analyse professional and ethical dilemmas and act in accordance with professional guidelines and clinical governance; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
16	Understand, work within and influence the wider political, legal, organisational and systemic frameworks within which clinical psychologists operate; (PA, PF, E, R, CT, SD, PPSV, OSIL, CT, GMC)
17	Manage workload and deal pro-actively with stress and the impact of clinical work; (PA, PF, E, R, CT, PPSV, OSIL, GMC,)

18	Demonstrate critical reflection and self-awareness; (PA, PF, E, R, SD, PPSV, OSIL, CT, GMC)
19	Identify own professional development needs and implement learning in practice as part of a process of life-long learning. (PA, PF, E, R, PPSV, OSIL, CT GMC)

SYLLABUS PLAN – summary of the structure and academic content of the module

Learning will be through supervised practice via experience with a range of clients and across a range of settings e.g. health, social care, education, third sector and private provider settings. More than 50 percent of the three-year doctorate is spent in clinical psychology practice settings.
A number of methods will be used including;

- Feedback based on supervision of trainee from placement supervisor
- Direct and indirect observation of clinical practice
- Feedback from service users and colleagues
- Literature searches
- Clinical tutorials
- Assigned reading.

A number of systems have been developed to ensure good links between theory and practice: as far as possible, the broad correspondence between the timing of academic teaching on the programme and placement experience, trainees writing practical reports on the basis of their placement experience, and mid-placement reviews, are all examples.
For trainees' learning to be maximised, and for them to feel that their academic and placement experience is integrated, it is important that they link their clinical work to literature in the field. Supervisors have a vital role in this, and need not feel that they have to be up to date in every area in order to be helpful. The trainee may be able to inform the supervisor at times, and both may need to extend their knowledge base in order to tackle particular problems. Making links between theory and practice should be a collaborative venture.

Year 2 Placement Overview

We take a life-span development model covering the challenges people face which can be addressed by psychological approaches . Core skills include therapeutic relationships, assessment, formulation, intervention and evaluation – working with individuals, families and communities. Students complete two 6 month or one 12 month clinical placement(s) within our placement provider settings, working with psychological presentations in children and families, neurodiversity and/or psychological presentations in working aged adults, older adults, health, social care & education settings, and/or groups, teams & systems.

Assessment is by 100% coursework.
All summative assessments must receive a pass mark for progression through the programme and successful module completion as detailed in the programme handbook:
(see TQA manual http://admin.exeter.ac.uk/academic/tls/tqa/Part%207/7Mprofdocs.pdf for details)

All summative assessments are graded as follows – pass, conditional pass or fail. Each assignment will include an assessment of a range of competences depending on the specific area covered.

3 Clinical tutorials, one per term
Weekly supervision with placement supervisor

LEARNING AND TEACHING					
LEARNING ACTIVITIES AND TEACHING METHODS (given in hours of study time)**					
Scheduled Learning & Teaching activities	240	Guided independent study	60	Placement/study abroad	
***50% of the overall time on the programme is in practice based placements*					

DETAILS OF LEARNING ACTIVITIES AND TEACHING METHODS		
Category	Hours of study time	Description
2 practice-based placements	Trainees employed as Band 6 practitioners-full-time employees of the NHS	Clinical practice undertaken in a range of clinical settings under the supervision of a HCPC regulated clinical psychologist and/or a recognised accredited clinician. Settings may include child, older people, working age adults, learning disability, forensic and health. Placement providers may be NHS Trusts, education, charities, CICs, third and private sector.

ASSESSMENT			
FORMATIVE ASSESSMENT - for feedback and development purposes; does not count towards module grade			
Form of Assessment	Size of the assessment e.g. duration/length	ILOs assessed	Feedback method
5. Observation Tool x 2 (relates to Reflection 1,2,3 subject specific skills), at least one per placement. One is a CBT competency assessment e.g. Child and Adolescent Practice Scale (CAPS-CBT), CTSr (relates to subject specific skills 1-6)	Observational tool: 1 hour observation and followed by discussion	1-19 as defined above	Written and discussion

6. Preparatory reading and literature searches for clinical work (relates to core academic skills 6 and 7)	Assessed through evaluation of clinical competence and supervision.	1-19 as defined above	Written and discussion
7. Presentations of clinical work in tutorials and supervision (relates to subject specific skills 5)	Min of 42 hours (1hour weekly supervision and 3 clinical tutorials across the year)	1-19 as defined above	Written and discussion
8. Self-evaluation of Clinical Competence x 2 (relates to personal and key competencies)	(11 pages)	1-19 as defined above	Written and discussion

SUMMATIVE ASSESSMENT (% of credit) Summative assessment: all work is marked as pass; conditional pass; referred; fail.
If a trainee is referred twice on clinical assessment, they would normally fail the programme (C6)

Coursework	100	Written exams	0	Practical exams	0

DETAILS OF SUMMATIVE ASSESSMENT

Form of Assessment	% of credit	Size of the assessment e.g. duration/length	ILOs assessed	Feedback method
YEAR 2		Clinical placement 1& 2: (130 days – including clinical tutorials, theory practice days and annual leave).		
6. Supervisor Evaluation of Clinical Competence: end of placement 1 if 2 x six month placements or mid placement if 2 x year long placements (Deadline hand in May) (assesses core academic	16.67	**6.** Evaluation of Clinical Competence, end of placement 1 if 2 x six month placements or mid of placements if 2 x year long placements (Deadline hand in May) (11 pages per placement)	1-19 as defined above	Discussion and written feedback

	skills 1-5; subject specific skills 1, 3 - 6; personal & key skills 1-7)	16.67		1-19 as defined above	Discussion and written feedback
7.	Supervisor Evaluation of Clinical Competence: end of placement 2 if 2 x six month placements or end of placements if 2 x year long placements (Deadline hand in August) (assesses core academic skills 1-5; subject specific skills 1, 3 - 6; personal & key skills 1-7)	16.67	**7.** Evaluation of Clinical Competence, end of placement 1 if 2 x six month placements or mid of placements if 2 x year long placements (Deadline hand in August) (11 pages per placement)	1-19 as defined above	Discussion and written feedback
8.	Portfolio of Clinical Experience: end of placement 1 if 2x six month placements or mid of placements if 2 x year long placements (Deadline hand in May) (assesses subject specific skills 2)	16.67	**8.** Portfolio of Clinical Experience, end of placement 1 if 2 x six month placements or mid of placements if 2 x year long placements (Deadline hand in May) (7 pages with appendices per placement)	1-19 as defined above	Discussion and written feedback
9.	Portfolio of Clinical Experience: end of placement 2 if 2x six month placements or end	33.34	**9.** Portfolio of Clinical Experience, end of placement 2 if 2 x six month placements or end		Discussion and written feedback

of placements if 2 x year long placements (Deadline hand in August) (assesses subject specific skills 2) **10.** Observation Tool x 2 (relates to Reflection 1,2,3 subject specific skills), at least one per placement. One is a CBT competency assessment (relates to subject specific skills 1-6)		of placements if 2 x year long placements (Deadline hand in August) (7 pages with appendices per placement) Clinical Placements 1 & 2, to include two observations (one per placement), with one being a Child and Adolescent Practice Scale (CAPS-CBT) or CTSr. Observational tool: 1 hour observation and followed by discussion.	1-19 as defined above	

DETAILS OF RE-ASSESSMENT (where required by referral or deferral)

Original form of assessment	Form of re-assessment	ILOs re-assessed	Time scale for re-assessment
Clinical assessment, Supervisor evaluation of clinical competence	Clinical assessment by Supervisor evaluation of clinical competence	1-19 as defined above	6 months
Portfolio of Clinical experience	Portfolio of clinical experience (7 pages with appendices)	1-19 as defined above	6 months
Observation Tool	Clinical placement assessment	1-19 as defined above	6 months

RE-ASSESSMENT NOTES – give details of how re-assessment will be calculated. This section can also be used to indicate where re-assessment is not available

Trainees will be required to undertake a further clinical practice placement with the same client group if they fail a placement. Two fails would normally lead to programme failure.

RESOURCES

INDICATIVE LEARNING RESOURCES - The following list is offered as an indication of the type & level of information that you are expected to consult. Further guidance will be provided by the Module Convener.

Basic reading:

ELE – http://vle.exeter.ac.uk/

Clinical Handbook - https://cedar.exeter.ac.uk/handbook/clinical/

Other resources:

British Psychological Society

- Electronic records guidance (2019)
- Record Keeping: Guidance on Good Practice, (2013)
- Code of Human Research Ethics (2021)
- Code of Ethics and Conduct. (2018)
- Conducting research with human participants during Covid-19 (2020)
- Division of Clinical Psychology: Policy on supervision (2014)
- Ethics guidelines for internet-mediated research (2021)
- Standards for the accreditation of Doctoral Programmes in Clinical Psychology (2019)
- Practice Guidelines (2017)
- Guidelines for Clinical Psychology Services (July 2011)
- New ways of working for applied psychologists in Health and Social care: Working psychologically in Teams (2007)

Health and Care Professions Council

- Standards of Education and Training guidance (2017)
- Standards of Proficiency for Practitioner psychologists (2015)
- Standards of conduct, performance and Ethics (2016)
- Guidance on conduct and ethics for students (2016)
- Practitioner psychologists (2018)

Department of Health

Department of Health (1999) A National Service Framework for Mental Health. London: Department of Health.

Department of Health (2001) A National Service Framework for Older People. London: Department of Health.

Department of Health (2001) Valuing People: A New Strategy for Learning Disability for the 21st Century: a White Paper. London: The Stationery Office.

Department of Health (2004) A National Service Framework: children, young people and maternity services. London: Department of Health.

Department of Health (2004) Every Child Matters: Next Steps.
Department of Health (2005). A National Service Framework: Long Term Conditions. London: Department of Health.
House of Commons Health Committee (2007): Patient and Public Involvement in the NHS: a Brief Overview.
Department of Health (2004). The Ten Essential Shared Capabilities: a Framework for the Whole of the Mental Health Workforce.
Department of Health (2019). The NHS Long Term Plan. London: Department of Health.

National Institute for Clinical Excellence: www.nice.org.uk
Beinart, H. and Kennedy, P. and Llewelyn, S, (2009) Clinical Psychology in Practice. Oxford Blackwell: British Psychological Society.
Fleming, I and Steen, L. (2011) Supervision and Clinical Psychology, 2nd Edition. Hove and New York: Brunner – Routledge.
Harvey, D (Ed). (2001) Core Purpose and Philosophy of the Profession. Leicester: British Psychological Society.
Hawkins, P. & Shohet, R. (2020) (5th Edn) Supervision in the Helping Professions. Milton Keynes: Open University Press.
Owusu-Bempah, K. & Howitt D. (2000) Psychology Beyond Western Perspectives. Leicester: British Psychological Society.
Scaife, J. (2019) Supervision in Clinical Practice. 3rd Edition. London: Taylor & Francis

CREDIT VALUE	45	**ECTS VALUE**	**22.5**
PRE-REQUISITE MODULES	None		
CO-REQUISITE MODULES	PSYD065 and PSYD062		
NQF LEVEL (FHEQ)	8	**AVAILABLE AS DISTANCE LEARNING**	NO *Some clinical placements are remote
ORIGIN DATE	**Feb 2015**	**LAST REVISION DATE**	**September 2023**
KEY WORDS SEARCH	**Clinical Psychology, Placement, Trainees**		

MODULE TITLE	Clinical Skills in Clinical Psychology Year 3				**CREDIT VALUE**	45 credits
MODULE CODE	PSYD060		**MODULE CONVENOR**		Clinical Director	
DURATION *Clinical placements continue throughout the year and are not contained within semesters	**TERM**	**1**	**2**	**3**	**Number Students Taking Module (anticipated)**	**30**
	WEEKS	10*	10*	10*		

DESCRIPTION – summary of the module content (100 words)

This module is the third of the three that comprise the clinical component of the professional Doctorate in Clinical Psychology (DClinPsy). Taken together the three components, academic, clinical and research, form the basis for the knowledge, skills values and competences required to practise as clinical psychologists, to meet the requirements for the award of DClinPsy and to be eligible for registration with the HCPC. The regulations that apply to these PGR Programme modules can be found here http://admin.exeter.ac.uk/academic/tls/tqa/Part%207/7Mprofdocs.pdf .

Overall, the clinical module aims to enable trainees to apply in practice the

- Theoretical and empirical knowledge,
- Critical, analytical and integrative skills and
- Professional, ethical and client-centred values needed to work effectively to enhance and promote psychological well-being.

The module provides trainees with opportunities to develop and demonstrate competencies in line with the HCPC Standards of Education and Guidance, the HCPC Standards of Proficiency and the HCPC Standards of Conduct, Performance and Ethics and the nine BPS core competencies for Clinical Psychology (BPS, 2019).

- **Generalisable metacompetencies = GMC**
  The generalisable meta-competencies are applicable in different contexts with different people at different life stages, drawing on any relevant areas of psychological knowledge,

guidelines, and frameworks. These skills include the ability to critically synthesise evidence and apply it in ways that fit the context which may be complex or novel and draw on a variety of models of practice. Furthermore, to be able to exercise these approaches in an autonomous way, collaborating and communicating effectively, where appropriate with service users and others in a reflective and ethical manner.

- **Psychological assessment = PA**
  The ability to choose, use and interpret a broad range of methods of assessment encompassing individual, group, social context and organisational and approaches, with a good understanding of psychometric principles and practice, including the assessment of risk.

- **Psychological formulation = PF**
  On the basis of assessment being able to co-produce and lead on formulations addressing individual, systemic, cultural and biological factors which may be related to but are not premised on formal diagnostic frameworks and that are aimed at helping the client, team or organisation better understand their experience. Ability to choose the most appropriate format and complexity of the formulation to match the issues concerned and to guide interventions in a manner consistent with equality diversity and inclusion.

- **Psychological intervention = PI**
  On the basis of a formulation, implementing psychological therapy or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner. Ability to use evidence-based psychotherapeutic models and other approaches for interventions that address the complexity of the presentation and context, including prevention and promotion of wellbeing, that promotes recovery that is informed by service users' values and goals. Ability to take into account psychopharmacological and other multidisciplinary methods. Are mindful of social constructivist, community and critical psychology approaches to intervention. Be aware of and able to communicate when intervention is not helpful or appropriate

- **Evaluation = E**
  Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning; devising innovative approaches to evaluation, with wide knowledge and critical appreciation of the main evaluation methods in use across the health and welfare system and effective use of supervision to evaluate own work.

- **Research = R**
  Being a critical and effective producer, consumer, interpreter, and disseminator of the research evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

- **Personal and professional skills and values = PPSV**
  Ability to, in a reflective and reflexive manner, recognise ethical issues, be able to reason about them and take action to address them in various contexts including complex clinical and self-care contexts; ensuring that informed consent underpins all contact with clients and research participants.

- **Communicating and teaching = CT**
  The ability to communicate effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences, as necessary. Using these skills in teaching, supervision, expert opinion, with interpreters and supporting other's learning.

- **Organisational and systemic influence and leadership = OSIL**
  Awareness of the legislative and national planning contexts for service delivery and clinical practice and the capacity to adapt practice in light of this. Ability to practice and in a variety of contexts and understand how these contexts function from an organisational perspective. Knowledge of and ability to supervise; provide consultancy and leadership, in collaborating with others, including service users and other experts by experience. Be able to promote psychological mindedness in services, alongside the implementation of quality improvement systems. Being able to recognise malpractice or unethical practice in systems and organisations and knowing how to respond to this, and being familiar with 'whistleblowing' policies and issues.

MODULE AIMS – intentions of the module

The module aims to develop trainees understanding of the main elements of theory, evidence-base and practice pertaining to core knowledge, skills, values and competence to draw upon for the clinical psychologist working with clients across the life span with special reference to five approaches: systemic, cognitive analytic therapy, cognitive behavioural therapy, neuropsychology, and Reflexive Organisational Practice (GMC, PA, PF, PI, E, R, PPSV, CT, OSIL). These approaches inform learning and practice with adult, older adult, children, people with intellectual disabilities, public health approaches, and clients in health settings.

Specific aims (abbreviations are BPS competencies for clinical psychologists) are to develop trainees'

19. Core clinical competencies in working directly and indirectly with individuals, carers, services and community systems (PA, PF, PI, E, R, PPSV, OSIL, CT, GMC)
20. Direct and indirect application of clinical competencies within a range of experiences: in a range of service delivery settings with clients with a representative range of problems and abilities from across the life span (PA, PF, PI, E, PPSV, OSIL, CT, GMC)
21. Application of clinical competencies with clients from a range of backgrounds taking into account social inequalities and diversity (PA, PF, PI, E, PPSV, OSIL, CT, GMC)

22. Integration of psychological theory, evidence and experience (PA, PF, PI, E, PPSV, OSIL, CT, GMC)
23. Commitment to working collaboratively, compassionately and respectfully with clients and colleagues, sharing essential capabilities and working as part of multi-disciplinary teams (PA, PF, PI, PPSV, OSIL, CT, GMC)
24. Competence to work within professional and regulatory codes of practice and ethics (PA,PF,PI, PPSV, OSIL, CT, GMC,)
25. Ability to conceptualise and adapt their practice in the light of current service policies and priorities (PA, PF, PI, E, CT, PPSV, OSIL, CT, GMC,)
26. Readiness to approach their work with critical reflection and self-awareness (PA, PF, PI, E, R, PPSV, OSIL, CT, GMC)
27. Capacity to nurture their own particular clinical strengths and interests so that they can make a contribution to the development of psychological skills, knowledge and the profession (PA, PF, PI, E, CT, R, PPSV, OSIL, CT, GMC)

Specifically, the BPS requires that by the end of the module (and the Programme more generally), it is expected that trainees will have:

1. A value driven commitment to reducing psychological distress and enhancing and promoting psychological wellbeing through the systematic application of knowledge derived from psychological theory and evidence. Work should be based on the fundamental acknowledgement that all people have the same human value and the right to be treated as unique individuals.
2. The skills, knowledge and values to develop working alliances with clients, including individuals, carers and/or services, in order to carry out psychological assessment, develop a formulation based on psychological theories and knowledge, carry out psychological interventions, evaluate their work and communicate effectively with clients, referrers and others, orally, electronically and in writing.
3. Knowledge and understanding of psychological (and other relevant) theory and evidence, related to specific client groups, presentations, psychological therapies, psychological testing, assessment, intervention and secondary prevention required to underpin clinical practice.
4. The skills, knowledge and values to work effectively with clients from a diverse range of backgrounds, understanding and respecting the impact of difference and diversity upon their lives. Awareness of the clinical, professional and social contexts within which work is undertaken and impact therein.
5. Clinical and research skills that demonstrate work with clients and systems based on a reflective scientist-practitioner model that incorporates a cycle of assessment, formulation, intervention and evaluation and that draws from across theory and therapy evidence bases as appropriate.
6. The skills, knowledge and values to work effectively with systems relevant to clients, including for example statutory and voluntary services, self-help and advocacy groups, user-led systems and other elements of the wider community.
7. The skills, knowledge and values to work in a range of indirect ways to improve psychological aspects of health and healthcare. This includes leadership skills and competencies in

consultancy, supervision, teaching and training, working collaboratively and influencing psychological mindedness and practices of teams.

8. The skills, knowledge and values to conduct research and reflect upon outcomes in a way that enables the profession to develop its knowledge base and to monitor and improve the effectiveness of its work.
9. A professional and ethical value base, including that set out in the BPS Code of Ethics and Conduct, the DCP statement of the Core Purpose and Philosophy of the profession and the DCP Professional Practice Guidelines.
10. High level skills in managing a personal learning agenda and self-care, in critical reflection and self-awareness that enable transfer of knowledge and skills to new settings and problems and professional standards of behaviour as might be expected by the public, employers and colleagues.

INTENDED LEARNING OUTCOMES (ILOs) (see assessment section below for how ILOs will be assessed)

On successful completion of this module you should be able to:

Module Specific Skills and Knowledge	
1	Explicitly underpin clinical work with theory, evidence and techniques drawn from two or more of the following psychological approaches (CAT, CBT, Systemic), of which one must be cognitive-behavioural therapy; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
2	Critically and autonomously evaluate and integrate theories in light of new information so as to develop new clinical approaches appropriate to the context (i.e. taking into account the complex and unpredictable nature of real world settings and recognizing complexities/deficiencies and/or contradictions in knowledge; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
3	Search and appraise relevant evidence bases and literature when planning interventions; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
4	Use clinical judgment, reflection and awareness of clients' views in applying evidence in practice; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
5	Justify, reflect on, evaluate, report and monitor own and others' work, and implement changes or acquire further knowledge when appropriate through a process of supervision and personal reflection; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
6	Develop skills, knowledge and values to build working alliances with clients, carers and services (CT, PPSV, GMC, OSIL)
Discipline Specific Skills and Knowledge:	
7	Demonstrate the core competencies of a clinical psychologist: generalisable meta competencies, psychological assessment, psychological formulation, psychological

	intervention, evaluation, research, personal development, professional skills and values, communication and teaching and organisational and systemic influence and leadership; (GMC, PA, PF, PI, E, R, PPSV, OSIL, CT)
8	Demonstrate the core competencies within a range of experiences: in a range of service delivery settings with clients (individuals, carers, families and groups) with a representative range of problems and abilities from across the life span; (PA, PF, E, R, PPSV, OSIL, CT GMC)
9	Demonstrate the essential shared capabilities for mental health practice: working in partnership, respecting diversity, cultural competency, practicing ethically, challenging inequality, promoting recovery, identifying peoples' needs and strengths, providing service user centred care, making a difference, promoting safety and positive risk taking, personal development and learning; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
10	Work effectively in consultation or in team work with professional colleagues across disciplines and across agencies, showing respect for knowledge and theories held by other professional groups including medical model diagnostic systems; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
11	Disseminate psychological skills and knowledge to others through formal or informal teaching; information provision; consultancy; supervision; (PA, PF, E, R, CT, PPSV, OSIL, GMC)
12	Document clinical work appropriately through notes, reports and letter writing for clients and referrers; (PA, PF, PI, E, CT, SD, R, OSIL, PPSV, GMC)
Personal and Key Transferable/ Employment Skills and Knowledge:	
13	Recognize and work within the limits of own professional and personal competence; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
14	Accept high levels of responsibility for self and others; (PA, PF, E, R, PPS, CT, PPSV, OSIL, CT, GMC)
15	Recognize and analyse professional and ethical dilemmas and act in accordance with professional guidelines and clinical governance; (PA, PF, E, R, PPSV, OSIL, CT, GMC)
16	Understand, work within and influence the wider political, legal, organisational and systemic frameworks within which clinical psychologists operate; (PA, PF, E, R, CT, SD, PPSV, OSIL, CT, GMC)
17	Manage workload and deal pro-actively with stress and the impact of clinical work; (PA, PF, E, R, CT, PPSV, OSIL, GMC,)

18	Demonstrate critical reflection and self-awareness; (PA, PF, E, R, SD, PPSV, OSIL, CT, GMC)
19	Identify own professional development needs and implement learning in practice as part of a process of life-long learning. (PA, PF, E, R, PPSV, OSIL, CT GMC)

SYLLABUS PLAN – summary of the structure and academic content of the module

Learning will be through supervised practice via experience with a range of clients and across a range of settings e.g. health, social care, education, third sector and private provider settings. More than 50 percent of the three-year doctorate is spent in clinical psychology practice settings. A number of methods will be used including;

- Feedback based on supervision of trainee from placement supervisor
- Direct and indirect observation of clinical practice
- Feedback from service users and colleagues
- Literature searches
- Clinical tutorials
- Assigned reading.

A number of systems have been developed to ensure good links between theory and practice: as far as possible, the broad correspondence between the timing of academic teaching on the programme and placement experience, trainees writing practical reports on the basis of their placement experience, and mid-placement reviews, are all examples.

For trainees' learning to be maximised, and for them to feel that their academic and placement experience is integrated, it is important that they link their clinical work to literature in the field. Supervisors have a vital role in this, and need not feel that they have to be up to date in every area in order to be helpful. The trainee may be able to inform the supervisor at times, and both may need to extend their knowledge base in order to tackle particular problems. Making links between theory and practice should be a collaborative venture.

Year 3 Placement Overview

We take a life-span development model covering the challenges people face which can be addressed by psychological approaches . Core skills include therapeutic relationships, assessment, formulation, intervention and evaluation – working with individuals, families and communities. Students complete two 6 month or one 12 month clinical placement(s) within our placement provider settings, working with psychological presentations in:

- Children and families,
- Neurodiversity
- Working aged adults, health,
- Social care & education settings,
- Advanced work with Groups, Teams & Systems,
- Specialist Clinical Services
- Community Psychology and Interventions

- Organisational Frameworks and Approaches

Within the final year trainees and clinical tutors review their competency development and any specific interest areas and then placement(s) are allocated accordingly.

Assessment is by 100% coursework.
All summative assessments must receive a pass mark for progression through the programme and successful module completion as detailed in the programme handbook:
(see TQA manual http://admin.exeter.ac.uk/academic/tls/tqa/Part%207/7Mprofdocs.pdf for details)

All summative assessments are graded as follows – pass, conditional pass or fail. Each assignment will include an assessment of a range of competences depending on the specific area covered.

One clinical tutorial

Weekly supervision with placement supervisor

LEARNING AND TEACHING

LEARNING ACTIVITIES AND TEACHING METHODS (given in hours of study time)**

Scheduled Learning & Teaching activities	240	Guided independent study	60	Placement/study abroad	

***50% of the overall time on the programme is in practice based placements*

DETAILS OF LEARNING ACTIVITIES AND TEACHING METHODS

Category	Hours of study time	Description
2 practice-based placements	Trainees employed as Band 6 practitioners-full-time employees of the NHS	Clinical practice undertaken in a range of clinical settings under the supervision of a HCPC regulated clinical psychologist. Settings may include child, older people, adult, learning disability, forensic and health. Placement providers may be NHS Trusts, education, charities, CICs, third and private sector.

ASSESSMENT

FORMATIVE ASSESSMENT - for feedback and development purposes; does not count towards module grade

Form of Assessment	Size of the assessment e.g. duration/length	ILOs assessed	Feedback method
9. Observation Tool x 1 (relates to Reflection 1,2,3 subject specific skills), at least one per placement. (relates to subject specific skills 1-6)	Observational tool: 1 hour observation and followed by discussion	1-19 as defined above	Written and discussion
10.Preparatory reading and literature searches for clinical work (relates to core academic skills 6 and 7)	Assessed through evaluation of clinical competence and supervision.	1-19 as defined above	Written and discussion
11.Presentations of clinical work in tutorials and supervision (relates to subject specific skills 5)	Min of 42 hours (1hour weekly supervision and 3 clinical tutorials across the year)	1-19 as defined above	Written and discussion
12.Self-evaluation of Clinical Competence x 2 (relates to personal and key competencies)	(11 pages)	1-19 as defined above	Written and discussion

SUMMATIVE ASSESSMENT (% of credit) Summative assessment: all work is marked as pass; conditional pass; referred; fail.
If a trainee is referred twice on clinical assessment, they would normally fail the programme (C6)

Coursework	100	Written exams	0	Practical exams	0

DETAILS OF SUMMATIVE ASSESSMENT

Form of Assessment	% of credit	Size of the assessment e.g. duration/length	ILOs assessed	Feedback method
YEAR 3		Clinical placement 3: (132 placement days, including theory practice days and annual leave)		
1. Supervisor Evaluation of Clinical Competence x 1:	33.3	1. Evaluation of Clinical Competence end of	1-19 as defined above	Discussion and written feedback

end of placement (assesses core academic skills 1-5; subject specific skills 1, 3 - 6; personal & key skills 1-7) **(11 pages)**	33.3	placement (11 pages)	1-19 as defined above	Discussion and written feedback
2. Portfolio of Clinical Experience x 1: end of placement (assesses subject specific skills 2) **(7 pages with appendices)**	33.3	2. Portfolio of Clinical Experience end of placement (7 pages with appendices)	1-19 as defined above	Discussion and written feedback
3. Observation Tool (relates to Reflection 1,2,3 subject specific skills)		3. Clinical Placement observation. Suitable observational tool: 1 hour observation and followed by discussion.		

DETAILS OF RE-ASSESSMENT (where required by referral or deferral)

Original form of assessment	Form of re-assessment	ILOs re-assessed	Time scale for re-assessment
Clinical assessment, Supervisor evaluation of clinical competence	Clinical assessment by Supervisor evaluation of clinical competence	1-19 as defined above	6 months
Portfolio of Clinical experience	Portfolio of clinical experience (7 pages with appendices)	1-19 as defined above	6 months
Observation Tool	Clinical placement assessment	1-19 as defined above	6 months

RE-ASSESSMENT NOTES – give details of how re-assessment will be calculated. This section can also be used to indicate where re-assessment is not available

Trainees will be required to undertake a further clinical practice placement with the same client group if they fail a placement. Two fails would normally lead to programme failure.

RESOURCES

INDICATIVE LEARNING RESOURCES - The following list is offered as an indication of the type & level of information that you are expected to consult. Further guidance will be provided by the Module Convener.

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Other resources:

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Code of Ethics and Conduct (2018)
Guidelines for Clinical Psychology Services (July 2011)
New ways of working for applied psychologists in Health and Social care: Working psychologically in Teams (2007)
Electronic records guidance (2019)
Record Keeping: Guidance on Good Practice, (2013)
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CREDIT VALUE	45	**ECTS VALUE**	**22.5**
PRE-REQUISITE MODULES	None		
CO-REQUISITE MODULES	PSYD063 and PSYD066		
NQF LEVEL (FHEQ)	8	**AVAILABLE AS DISTANCE LEARNING**	NO *Some clinical placements are remote
ORIGIN DATE	**Feb 2015**	**LAST REVISION DATE**	**September 2023**
KEY WORDS SEARCH	**Clinical Psychology, Placement, Trainees**		

Module Descriptor Template Revised April 2022

Appendix 2 New Supervisor Data Form 2021

New Supervisor Data Form / Information to be gathered

This form will ask questions regarding your professional information and the placement that you can offer to DClinPsy trainees at the University of Exeter so that trainees can make an informed decision when selecting their placement preferences.

SUPERVISOR INFORMATION	
Name:	**Service:**
Employee number:	

Workplace address (main base):	**Geographical area covered (Countrywide, Mendip, Sedgemoor, Somerset Coast, South Somerset. Poole, Bournemouth, Dorchester. North Devon, Mid Devon, East Devon, Devon; Other):**
	Specialism (CAMS, LD, older adult MH services, CMHS, neuropsychology, health psychology, forensic psychology, other): **If other, please specify:**
Normal working pattern (e.g. Full-time / Part-time and days of the week worked):	
Email OR your Trust's Liaison Tutor's email (required):	
Telephone (not required):	
Trust (Devon, Somerset, Dorset, Healios, Other - if other please specify):	
Clinical psychologist? (Yes/No)	
HCPC registered? (Yes/No)	
Other profession/ professional qualification (e.g. Counselling Psychologist, Family Therapist, RMHN and Cognitive Behavioural Practitioner):	
Year completed professional qualification:	
Other professional registration:	
Date supervisor data form last updated/reviewed (please enter today's date if completing for the first time):	

SUPERVISER AVAILABILITY	Y/N
Supervision available	
Individual supervision	
Individual supervision of more than one trainee	
Team / group supervision (more than one trainee to supervisor)	
If currently unable to supervise, please estimate when you may become available:	

PLACEMENT PREFERENCE	Y/N
Full placement only (on average 3-4 days / week)	
Split placement (1/2 days / week)	
Competency-based supervision experience (e.g. supervision of a few cases to supplement other placement experience: the programme clinical team is happy to think with you about how this might work in practice)	
5 to 6 months only (often described as "short fat" placements; usually November to May or May to September)	
Please note here if you prefer either first or second half placements (i.e. November-May or May-September), are flexible with either or would prefer to have trainees on both first and second half placements.	
11 months only (often described as "long thin" placements and can be split with another setting)	
Either long / short placements	
If you can offer 5 to 6 month placements, would you prefer: Nov to May / May to Sept / Flexible with either / Both Nov to May and May to Sep	

LOG OF SUPERVISOR TRAINING			
Description of event	Attended (Y/N)	Date	Where (e.g. University of Exeter/ other)
New Supervisor Training			
Pre-placement Supervisor Workshop			
Anti-Racism Training			

Other (please describe)		

SUPERVISOR THERAPEUTIC MODALITIES					
Modality	**Accredited Practitioner (Y/N)**	**Accredited Supervisor (Y/N)**	**Supervisor working towards / interested in working towards accreditation (Y/N)**	**Offer placement in this modality (Y/N)**	**Use Model in Clinical Work (Y/N)**
CBT					
Systemic					
CAT					
Psychodynamic					
Other (please specify)					

Are you on the Specialist register of clinical neuropsychologists (SRCN) (Y/N/working towards)?	**Please provide us with any further relevant information on your accreditation status:**
Would you be willing to be approached as a mentor (providing informal mentoring to a trainee(s) independently of the programme)? (Y/N)	

PLACEMENT INFORMATION
Please give a short description of your Clinical Psychology Training Placement (key characteristics, opportunities presented):

COMPETENCIES AND EXPERIENCES AVAILABLE AT THIS PLACEMENT

	Experiences	Scale from Never -> Rarely -> Sometimes -> Often -> Always
Developmental period/age range	Infancy/Pre-school (0-4)	
	Children (4-11)	
	Adolescent (12-18)	
	Adult (18-65)	
	Older Adults (65+)	
Intellectual Functioning and Neurodiversity	Average	
	Mild/specific cognitive deficits	
	Moderate cognitive deficits	
	Severe and profound learning disabilities	
	Autism	
	ADHD	
	Acquired brain injury	
	Stroke	
	Dementia	
	Other degenerative neurological conditions (e.g. MS, ME/CFS, PD, HD)	
Breadth and diversity of presentations	Acute/Transient	
	Enduring/Long Term (Mental Health)	
	Enduring/Long Term (Medical)	
	Mild	
	Moderate	
	Severe	
	Organic	
	Social/Financial Considerations	
	Cultural/Diversity Related Trauma	
	Family/Domestic	
	Coping/Adaption	
	Challenging Behaviour	
	Disability	
	Communication difficulties	
	Sensory Impairments	
Specific Problems	Depression	

	Anxiety presentations (Phobia, Social Phobia, GAD, Panic)	
	Bipolar Disorder	
	Psychosis	
	OCD	
	PTSD	
	Health Related Presentations	
	Addictive Behaviours	
	Eating Disorders	
	Presentations of Childhood	
	Presentations in Young Adulthood	
	Developmental Transitions	
	Family Functioning	
	Relationship Difficulties	
	Complex Emotional, Interpersonal and Behavioural Difficulties (e.g. with clients who have been given a diagnosis of personality disorder)	
	Risk / Safeguarding Issues	
	Biopsychosocial Sequelae of Brain Injury	
	Biopsychosocial Sequelae of Degenerative Conditions	
	Perinatal Presentations	
	Developmental Trauma	
Service delivery systems	Outpatient	
	Inpatient	
	Residential/Supported	
	Primary Care	
	Secondary Care	
	Tertiary / Specialist Care	
	Education Settings	
	Digital / Online Services	
	Other	
Levels of intervention	Individual	
	Family	
	Couple	
	Group	
	Organisational	

	Via Carer	
Direct Clinical Work	Psychological Assessment	
	Psychological Formulation	
	Psychological Intervention	
	Psychological Evaluation	
	Neuropsychological Assessment	
	Neuropsychological Rehabilitation	
Indirect Clinical Work	Providing Supervision	
	Consultancy	
	Joint/ Team Working	
	Leadership	
	Expert by Experience Involvement or Co-production	
	Teaching	
	Inter-agency liaison and influence	
	Organisational initiatives and interventions/ developing services	
Work with Others	Multidisciplinary/ interprofessional work	
	Work with trainees from other disciplines/ professions	
	Specialist supervision from other qualified professionals	
Psychological model / Framework	Cognitive Behavioural	
	Systemic	
	Cognitive Analytic Therapy	
	Psychodynamic	
	“Integrative”	
	Positive Behaviour Support	
	Neuropsychological	
	Other (e.g. DBT, IPT, Community Psychology) and how often used (Never -> Always scale)	
Psychometrics	WAIS-IV	
	WISC-IV	
	WMS-IV	
	HADS	

	SDQ	
	Dementia Assessment	
	Other Neuropsychological Assessment	
Other psychometrics used in placement (please list):		
Other Specialist Psychological Assessment specific to population/ setting used in this placement (please list):		

TRAINEE SUITABILITY	
This placement is suitable for…	**Y/N/ Maybe**
A first year trainee	
A second year trainee	
A first or second year trainee with prior experience in this area (please specify type of experience)	
A third year trainee	
Please specify the type of experience needed:	

How we will use your data

The information that you provide will be stored in our database. Whilst on our database, we may contact you to invite you to meetings, training events, or provide information about upcoming supervisor's workshops.

In order to assist our trainees to choose a suitable placement, we will share with them information about the placements and provide your email address so they can contact you directly about your placement. Your data will not be shared beyond our programme and other supervisors within your Trust/organisation, and will be held on the University's UK-based servers, and the MS Form EU server only. Your data will be retained on our database unless you contact us and wish to be removed from it; you may contact us at any time via this email address to do this: DClinPsy@exeter.ac.uk

Appendix 3 Taunton and Somerset NHS Trust Policies and Procedures

(14)

TRUST POLICIES AND PROCEDURES

This is a list of documents setting out the Trust's Policy and Procedure in particular areas. These documents are readily available and may be inspected or copy obtained within the relevant functional area e.g. Health & Safety, Human Resources or within your own department or via the Trusts intranet. You should note that any Taunton & Somerset NHS Foundation Trust Policy/Procedure supersedes any document relating to predecessor organisations. In due course, any such policies/procedures will be replaced by those of Taunton & Somerset NHS Foundation Trust.

<table>
<tr><th colspan="2">Taunton & Somerset NHS Foundation Trust</th></tr>
<tr><td><u>Employment Policies & Procedures</u>

Standards of Business Conduct and Hospitality for Trust Employees
Declaration of Interest Policy
Standing Orders
Standing Financial Instructions
Identification Badges
Internet & E-mail Usage
Working Time
Recognition Agreement
Retirement Awards
Raising Concerns about Healthcare Services
Equality Diversity Policy
Trade Union Facilities Agreement
Procedure for the Management of Sickness Absence
Fraud Policy and Response Plan
Guidance for Managers on Periods of Notice
Annualised Hours
Disputes Procedure
Relocation Expenses
Employment Break
Grievance Procedure
Guidance on Home Working
Job Sharing
Professional Registration
Short Term Unpaid Leave</td><td>

Trust Board Appeals Procedure
Capability Policy and Procedure
Dealing with Harassment
Adoption Leave
Bereavement Leave
Domestic/Carer Leave
Paternity Leave
Parental Leave
Study Leave Guidance
Protection of Pay
Redeployment Procedure
Staff Development Strategy
Disciplinary Procedure
Guidance for Managers on the Recruitment & Selection Process
Grading Review Procedure
Appraisal Policy & Procedure
Procedure for Maternity Leave
Guidance on Flexible Working
Protocol on Staff Employment Records
Partnership Working
Procedure on Organisational Change/Redundancy
Fixed Term Contract Guidance
Code of Conduct for Employees in Respect of Confidentiality Freedom of Information Act 2000 Policy.</td></tr>
<tr><td>Health & Safety Policies & Procedures

Health & Safety Policy
Protecting Healthcare Workers and Patients against Infection with Blood Borne Viruses
Policy on Working Alone in Safety
Actions & Responsibilities Arising Out of Enforcement
Authority Visits
Contamination Incident Procedure</td><td></td></tr>
<tr><td colspan="2">Please note that the policies and procedures relating to predecessor organisations will become the appropriate source of reference, if necessary.</td></tr>
</table>

Appendix 4 Code of Good Practice for Psychological Testing

Code of Good Practice for Psychological Testing

People who use psychological tests in clinical settings are expected by the British Psychological Society to:

Responsibility for competence

1. Take steps to ensure that they are able to meet all the standards of competence defined by the Society and to endeavour, where possible, to develop and enhance their competence as test users.

2. Monitor the limits of their competence in psychometric testing and not to offer services which lie outside their competence nor encourage or cause others to do so.

Procedures and techniques

3. Use tests only in conjunction with other assessment methods and only when their use can be supported by the available technical information.

4. Administer, score and interpret tests in accordance with the instructions provided by the test distributor and to the standards defined by the Society.

5. Store test materials securely and to ensure that no unqualified person has access to them.

6. Keep test results securely, in a form suitable for developing norms, validation, and monitoring for bias.

Client welfare

7. Obtain the informed consent of potential test takers and/or relevant others, making sure that they understand why the tests will be used, what will be done with their results and who will be provided with access to them.

8. Ensure that all test takers are well informed and well prepared for the test session.

9. Give due consideration to factors such as gender, ethnicity, age, disability and special needs, educational background and level of ability in using and interpreting the results of tests.

10. Provide the test taker and other authorised persons with feedback about the results in a form which makes clear the implications of the results, is clear and in a style appropriate to their level of understanding.

11. Ensure test results are stored securely, are not accessible to unauthorised or unqualified persons and are not used for any purposes other than those agreed with the test taker.

****

A2.11 Using norm tables, find percentile equivalents of raw scores and then obtain both Z-scores and T-scores from normal distribution tables.

Unit 3- The Importance of Reliability and Validity
Can the Assessee:

A3.1 Explain the notion of correlation as a measure of the degree of relationship between two measures. A3.2 Define the conditions under which correlation is maximised

(both positively and negatively) and minimised.

A3.3 Provide reasonable rough estimates of correlation coefficients represented by various bivariate scatter grams.

A3.4 Describe the basic premises of classical test theory - that actual measures are 'fallible' scores which contain a 'true' score and a random error.

A3.5 Explain in outline the methods of estimating reliability (internal consistency, test retest— same on alternate form) and describe their relative pros and cons.

A3.6 Describe why test scores are unreliable (e.g. measurement error, scoring error, situational factors, item sampling. etc.).

A3.7 Describe how reliability is affected by changes in the length of a test.

A3.8 Describe how reliability is affected by range restriction and how to adjust for such effects.

A3.9 Compute limits for different levels of confidence from raw and standard scores using the standard error of measurement.

A3.10 Compute the standard error for the difference between two scale scores and for the sum of two scale scores.

A3.11 Describe how the degree of correlation between two scale scores affects the reliability of:
(a) their sum; (b) the difference between them.

A3.12 Express the basic notion of Generalisability Theory - that reliability concerns the degree to which one can generalise from results obtained under one set of conditions to those which would be obtained under another.

A3.13 Describe and illustrate the distinctions between face, content, construct and criterion-related validity.

A3.14 Describe the procedures used to assess concurrent and predictive criterion-related validities and explain the pros and cons of each procedure.

A3.15 Describe the relationship between reliability and validity.

A3.16 Describe the degree to which it may be reasonable to generalise from validity information obtained in one situation to the use of a test in some other situation.

Level Aq
(Questionnaire-based assessments)

Unit 4 - Administration
Does the Assessee:

Q4.1 Arrange for a quiet, private, well-lit environment with furniture and equipment appropriate for the questionnaires to be used which maximize comfort and concentration.

Q4.2 Brief candidates on the purpose of each questionnaire and put them at ease while maintaining an appropriately businesslike atmosphere.

Q4.3 Obtain informed consent for the assessment procedures, including how results are to be used, who will be given access to them and for how long they will be retained.

Q4.4 Plan the session taking account of the duration of individual questionnaires, their cognitive demands and the likely capacity of the client to tolerate these.

Q4.5 Check that the client is not unnecessarily hindered by remediable perceptual difficulties such as poor eyesight by ensuring the client has appropriate perceptual

aids (e.g. reading glasses).

Q4.6 Ensure that the client can read and comprehend individual items and the instructions given at the beginning of the questionnaire.

Q4.7 Check to ensure that the client has the necessary materials to complete the questionnaire (e.g. pencil and eraser).

Q4.8 Deal appropriately with any questions that arise without compromising the purpose of the questionnaire.

Q4.9 When the client has indicated she/he has finished the questionnaire(s), check that all items have been completed.

Q4.10 Lock all materials away in a secure place which is not accessible to people other than authorised questionnaire-users.

Q4.11 Thank the client for her/his participation when the final questionnaire has been completed, and explain the next stage *(if* any) in the assessment to them.

Q4.12 Make final entries in the assessment session log — including notes on any particular problems which arose during the session which might have affected the client's responses.

Q4.13 All questionnaire data are kept in a secure place and that access is not given to unauthorised personnel.

Q4.14 All mandatory requirements relating to the client's rights and obligations under data protection legislation are clearly explained to the client and adhered to.

Unit 5 - Scoring

Can the Assessee:

Q5.1 Accurately score the client's performance adhering to the questionnaire manual instructions and calculate raw scores.

Q5.2 Select appropriate norm tables from the questionnaire manual or supplementary material.

Q5.3 Use norm tables to obtain and record relevant percentile and/or standard scores.

Q5.4 Make appropriate use of information provided in the questionnaire manual about cut-off scores.
authorised test-users.

Unit 6 - Interpretation and Report

Does the Assessee:

Q6.1 Either attach suitable cautions to interpretation of the results, or not to use the questionnaire, where no relevant norms or cut-off tables are available.

Q6.2 Give due consideration, where necessary, to the comparability between the client and any reference groups, the standard error of the group mean and the standard error of measurement of the client's scores.

Q6.3 Present norm-based scores within a context which clearly describes the range of abilities or other relevant characteristics of the norm group they relate to.

Q6.4 Describe the meanings of scale scores in terms which are accurate and reflect the confidence limits associated with those scores.

Q6.5 Provide interpretations of scale scores paying due regard to the correlations which

exist between each pair of scales and for the standard error of their difference.

Q6.6 Provide feedback of information about results to the client which is matched to the client's ability and understanding.

Q6.7 Provide the client with opportunities to ask questions, clarify points and comment upon the questionnaire and the administration procedure.

Q6.8 Clearly inform the client about how the information will be presented and to whom.

Q6.9 Provide written reports for the referring agent which describe the purposes of the various questionnaires and scales in an accurate and meaningful way.

Q6.10 Provide written reports for the referring agent which carefully explain any use of normed scores in relation to the ability range of the norm group; carefully justify any predictions made about future behaviour in relation to the validity information about the questionnaire.

Q6.11 Provide written reports for the referring agent which give clear guidance as to the appropriate weight to be placed on the findings.

Level Ap
(Performance-based tests)

Unit 4 - Administration
Does the Assessee:

P4.1 Arrange for a quiet, private, well-lit testing environment with furniture and equipment appropriate for the tests to be used which maximise comfort and minimise opportunities for faking good or bad.

P4.2 Brief candidates on the purpose of each test and put them at ease while maintaining an appropriately businesslike atmosphere.

P4.3 Obtain informed consent for the testing procedures, including how results are to be used, who will be given access to them and for how long they will be retained.

P4.4 Plan the testing session taking account of the duration of individual tests and subtests, their cognitive demands, and the likely capacity of the client to tolerate testing.

P4.5 Check all test materials prior to testing, ensuring that all materials are complete and in the correct order for presentation to the client.

P4.6 Check that the client is not unnecessarily hindered by remediable perceptual difficulties such as poor eyesight or hearing by ensuring the client has appropriate perceptual aids (e.g. reading glasses).

P4.7 Use standard test instructions to the client as specified by the test manual for each subtest and test item.

P4.8 Where appropriate and as required by the test, time the client's performance in an unobtrusive and efficient manner; adhere strictly to test-specific instructions concerning pacing and timing.

P4.9 Carefully record all aspects of test performance as required by the individual tests, including the client's demeanour, behaviour, concentration and motivation, making particular note of test errors.

P4.10 Monitor the client's concentration and performance during testing and arrange breaks or deferment of testing as necessary.

P4.11 Deal appropriately with any questions that arise without compromising the purpose of the test.

P4.12 Collect all test materials when each test is completed.
P4.13 Carry out a careful check against the inventory of materials to ensure that everything has been returned.

P4.14 Lock all materials away in a secure place which is not accessible to people other than authorised test-users.
P4.15 Thank the client for her/his participation when the final test has been completed, and explain the next stage (if any) in the assessment to them.
P4.16 Make final entries in the test session log - including notes on any particular problems which arose during the session which might have affected the client's performance.
P4.17 All test data are kept in a secure place and that access is not given to unauthorised personnel.
P4.18 All mandatory requirements relating to the client's rights and obligations under data protection legislation are clearly explained to the client and adhered to.

Unit 5 - Scoring
Can the Assessee:

P5.1 Accurately score the client's performance adhering to the test manual instructions and calculate raw scores.
P5.2 Select appropriate norm tables from the test manual or supplementary material.
P5.3 Use norm tables to obtain and record relevant percentile and/or standard scores.
P5.4 Make appropriate use of information provided in the test manual about cut-off scores.

Unit 6- Interpretation and Report
Does the Assessee:

P6.1 Either attach suitable cautions to interpretation of the results, or not use the test, where no relevant norms or cut-off tables are available.
P6.2 Give due consideration, where necessary, to the comparability between the client and any reference groups, the standard error of the group mean and the standard error of measurement of the client's scores.
P6.3 Present norm-based scores within a context which clearly describes the range of abilities or other relevant characteristics of the norm group they relate to.
P6.4 Describe the meanings of scale scores in terms which are accurate and reflect the confidence limits associated with those scores.
P6.5 Provide interpretations of scale scores paying due regard to the correlations which exist between each pair of scales and for the standard error of their difference.
P6.6 Provide feedback of information about results to the client which is matched to the client's ability and understanding.
P6.7 Provide the client with opportunities to ask questions, clarify points and comment upon the test and the administration procedure.
P6.8 Clearly inform the client about how the information will be presented and to whom.
P6.9 Provide written reports for the referring agent which describe the purposes of the various tests/subtests in an accurate and meaningful way.
P6.10 Provide written reports for the referring agent which carefully explain any use of normed scores in relation to the ability range of the norm group; carefully justify any predictions made about future behaviour in relation to the validity information about

the test.

P6.11 Provide written reports for the referring agent which give clear guidance as to the appropriate weight to be placed on the findings.

Appendix 5 Guidelines on Confidentiality and Consent

Confidentiality, Consent and Academic Reporting of Clinical Activity

Guidelines for the University of Exeter Doctorate in Clinical Psychology programme

Background

These guidelines have been produced by a small working group from the Supervisors' Committee. They are based on consideration of the following: discussion within and feedback from Supervisors' and Course Policy Committee, discussion within the Exeter Lived Experience Group, the DoH reference guide to consent for examination or treatment (2009), an academic paper on consent and reports of clinical activity (Sperlinger and Callanan, 2002), the BPS

Code of Ethics and Conduct (2009) and HCPC Standards of Proficiency: Practitioner Psychologists (2010), the Mental Capacity Act (2005), the BPS DCP (2008) Record Keeping: Guidance of Good Practice and the Data Protection Act (1998).

Guidelines

Gaining consent and maintaining confidentiality when working with clients on placement

1. All health professionals, including clinical psychologists, must obtain clients' voluntary informed consent before treating or caring for them. This requires the professional to provide as much information (in a form that the person can understand) about the likely risks and benefits of the care, and about what it is likely to involve, as the client reasonably needs in order to make a decision (Department of Health 2009). Trainees should consult the Department of Health website on consent for guidance of issues of consent for particular client groups (children, people with learning disabilities, older people, people in prison). This would include Mental Capacity Act (2005) and Mental Health Act (1983).

2. Clients must be offered a choice as to whether or not to be seen by a trainee clinical psychologist. It should be made clear to clients that their treatment will not be compromised in any way if they decide they do not want to be seen by a trainee. The trainee must follow any policy and good practice guidelines on consent within the Trust in which they are working.

3. When clients are offered the option of seeing a trainee clinical psychologist, information should be provided to them about what seeing a trainee is likely to involve. This will usually include, for example, that the trainee will be regularly supervised, the nature of
the trainee's training and experience, the length of time that the trainee will be available, what may happen when the trainee's placement comes to an end, that the work may be written up for academic purposes, and that the client may be asked to comment on the trainee's performance.

4. With regard to confidentiality of personally identifiable material, the trainee must explain the limits of confidentiality with regard to supervision and team work (see below point 5). Various legal frameworks safeguard the interests of citizens in relation to disclosure of information. The Data Protection Act 1998 is the most recent of these. It sets out the conditions that must be met before personal data can be processed fairly and lawfully. It allows for the disclosure of "personal" or "sensitive" information only under certain circumstances, including the circumstance when information is needed to protect the vital interests of the person or another person. It also provides that personal data can be processed, if withholding it would be likely to prejudice the prevention or the detection of crime, or the apprehension or prosecution of offenders. The Crime and Disorder Act 1989 also gives power to disclose information to a relevant authority "for the preventing and detecting of crime". In relation to children, the Children Act 1989 sets out a range of duties in relation to statutory authorities to assist in the collection of information in relation to child protection cases. The "Safeguarding Children in Education" 2004 paper by the Department for Education and Skills state that in cases of child abuse, *"staff have a professional responsibility to share relevant information about the protection of children with other professionals, particularly investigative agencies. If a child confides in a member of staff and requests that the information is kept secret, it is important that the member of staff tells the child sensitively that he or she has a responsibility to refer cases of alleged abuse to the appropriate agencies for the child's own sake. Within that context, the child should, however, be assured that the matter will only be disclosed to people who need to know about it. Staff members who receive information about children and their families in the course of their work should share that information only within appropriate professional contexts. Child protection records should be kept securely locked."*

5. Trainees should therefore let clients know that there are limits to confidentiality and should indicate the sort of circumstances under which breaches might occur. The trainee should also say that if the need for a breach of confidentiality arose that they would usually try to discuss it with the client first. In addition, trainees should remember that they will be regularly breaching confidentiality when they discuss clients with their supervisor. In some settings they may also discuss clients with team members as a normal part of the assessment process. In most settings they will be writing to the referrer and will often include the client's GP in any communications. A good principle is to make sure that clients know about such discussions and communications, and the boundaries and safeguards that exist to safeguard the client's interests.

6. Under the Data Protection Act (1998), patients are entitled to see all information relating to their physical or mental health which has been

recorded by or on behalf of a health professional in connection with their care. If there is a possibility that the person may be seriously harmed by the record, then the health professional responsible for the record may need to be consulted. Trainees should write reports, letters and notes in the knowledge that they may be seen by clients.

7. With regard to case notes, trainees must follow the guidance of the BPS DCP - Clinical Psychology and Case Notes: Guidance on Good Practice (2008), and must follow policy and good practice guidelines from the Trust within which they are working.

8. The trainee clinical psychologist must explain what will be involved in the particular circumstances, and must check over time that the client remains content to be seen: giving consent is a process, not a one-off event. No one else can give consent on behalf of a person who lacks capacity to consent (i.e. if they are not competent to understand and weigh up the information needed to make the decision). Where there is doubt about the person's capacity to give consent the trainee must ask the advice of their supervisor (who may consult with another trained professional within the team), who should take into account the views of people close to the person such as carers, family and friends before making the decision as to whether being seen by a trainee, with all that this entails, would be in the client's best interests. The process of dealing with consent should be documented in the notes. Use of Mental Capacity Act should be considered.

Gaining consent and maintaining confidentially in academic reports

9. As part of the information given, client consent should be sought to write up clinical work in a suitably anonymised form, for training purposes, and the precautions discussed to protect clients' interests about this: the alteration of identifying features, the requirement that it be reported in a thoughtful and respectful way, limits on who will see it, and that it will be stored in a secure place. How this information is given will depend on particular circumstances, taking into account different client needs and abilities. Basic information may be given in a standardised form to all potential clients within a Trust or service (e.g. as part of a standard appointment letter).

10. Trainees will learn about obtaining client consent through preparatory workshops during academic teaching blocks; in addition, supervisors and trainees should discuss together the best forms of words to use within particular service contexts.

11. The trainee must seek consent from other professionals before their anonymised correspondence is included as an appendix for submitted course work.

12. The trainee must gain the signature from their supervisor on the consent form for CPR. This indicates that the supervisor confirms the consent has been granted for written reports and audio/video recordings. The completed consent form for CPR must be submitted with CPR. To ensure anonymity the admin team will remove this prior to sending the CPR for marking.

13. Trainees must ensure that client and carer confidentiality is protected in all work submitted for university requirements. The BPS Code of Ethics and Conduct requires that psychologists should "take care to prevent the identity

of individuals… being
revealed, deliberately or inadvertently without their express permission"(BPS 2009). All identifying features such as names, addresses, hospital numbers and any other

recognisable details must be changed or deleted. Trainees must not use the client's own initials when referring to him or her.

14. Trainees must ensure that they consider and respect clients' dignity in all written and spoken communications about their clinical work. A good rule of thumb is to consider
what would be the answer to the question; "Would I feel respected if I or my family were written or spoken about in this way?"

15. The question arises as to whether clients should have the right to read anonymised material that is written up about their work and submitted as part of training requirements. There is no clear consensus on this. Whenever a piece of work is written up, supervisors and trainees should consider carefully whether the client should be given the opportunity to read the report. If clients do request to see material that has been written about them, then they have the right to do so, under the Data Protection Act, unless it is considered that by doing so they would be seriously harmed. In such a case the trainee and supervisor should consider carefully the ethical, therapeutic and practical implications of the decision. The trainee may decide not to share the critical review section of the work in which they record their own response to the work undertaken. Where the client does read the report (or parts of it), his or her comments on it may form part of the content of the report itself.

16. Opinion and guidance about good practice in ethical matters develops over time and these guidelines will be subject to regular review.

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(16)

WHO ARE MY PEOPLE

Taking Clinical histories the culturally sensitive way

As clinicians and social workers employed by a mental health and learning disabilities Trust (or in any public service in Britain today,) we are required to be culturally aware, capable and sensitive. This is not always easy to achieve, if we feel that we work in an area where we do not meet many people from a range of ethnic minorities, or are unsure what to ask without seeming intrusive, or feel we do not have the time to become expert on every culture, in case we might meet a member of it. In fact the majority of our staff have some knowledge of many cultures through holiday travel, as well as experience at work and home, and via telecommunications.

A useful key to ensuring that we work in a culturally sensitive way is to make it a usual practice to take an holistic (or systemic) clinical history: this means that any individual's health or social care needs are always assessed within a wider family, socioeconomic and cultural context.(1)

Whether a potential client or service user seems to be part of an ethnic majority or minority then may not seem to matter so much, as holistic history taking becomes the norm, and the exploration of degrees and ranges of diversity become commonplace.

An ethnic group is "a community of people who share cultural and/or physical characteristics including one or more of the following: history, political system, religion, language, geographical origin, traditions, myths, behaviours, foods, genetic similarities and physical features."(2)

Historically the concept of ethnicity derives from the Greek 'ethnos' meaning people or 'my people' in the sense of my clan or tribe. In complex modern societies we tend to have a clan or clans of origin that we identify with, plus many more superimposed clans and layers of identification or belonging, that may be what we become- e.g. We may belong to familial, geographical, occupational, friendship, belief based, or special interest groups and they may become mainstays of our identity. Sometimes we are able to choose to retain membership of all; sometimes there are conflicts or tensions between the groups.

One way of reflecting on our own complex clans is to ask ourselves from what sections of society might we/did we choose our life partners, friends, colleagues.

The 2001 National Census tells us that in the South West, approximately 2% of our population are from a non white ethnic minority, but this statistic seems based on very broad essentially racial groupings.(3)
The Census tells us separately e.g. that there were 113,200 approx Welsh born people living in the South West, who regarded themselves as Welsh, British or English. It does not appear to report on the Scottish born.

It also tells us that the greatest growth is probably in the 'Mixed' ethnic groups. These are likely to be British born people with at least one parent from another ethnic group. People with mixed ethnicity overwhelmingly regard themselves as British, (9 out of 10) but are nearly twice as likely to be the victims of violent crime as anyone from an 'unmixed' group (3)

It is important to remember that there is much more variability within races than between them, both genetically speaking and in terms of experience, and that ethnicity is a separate concept- Ethnicity is about how a person perceives and feels their identity; we always need to ask them. They and their family may have come a few miles, or thousands of miles to live in Somerset, or have 'always' lived here, Wherever they originated, each person's ethnicity is important to them.

Often, initial impressions can be deceptive, if we don't enquire carefully, as many 'obviously English' people may, for example be the children of immigrants and view themselves as part of their family's cultural group, or have made a conscious choice to study and embrace the ideas and way of life of a different culture, e. g. someone who converts to a particular faith on marriage.

Most 'culturally insensitive' mistakes are made by simply not asking open questions- anyone who retains interest and curiosity in the varied doings of humankind will be valued for their sensitivity, providing they are reasonably diplomatic. Open questions do not stereotype, or assume anything.

Use of this guidance

The following sections are intended as a useful reminder as to what clinicians might wish to ask in an in-depth holistic or systemic clinical history, in addition to focussing on the referred problem. It is intended to be non pathologising, and to aid systemic formulation.

This is a gathering together of possible areas to touch on or explore, not a directive to ask all of these questions at any one time.

Typically, clinicians using any process based psychotherapy or creative therapy may find these useful. Many of the questions are appropriate whatever someone's cultural origins are, apparent majority or minority. Actual questions or actions are bullet pointed.

Contents

Section 1: Personal history

Ask-

- Date and place of birth, any significant details that the client can remember being told, or ask their parents if available/appropriate
- For person's view of their ethnicity
- Were there any rites of passage associated with birth-e.g. baptism, christening or naming ceremonies. Any identified religion or spiritual path.
- Early childhood milestones- e.g. when did they smile, sit up, crawl, walk, talk, use the toilet, play.
- Whether they learned one or more languages, and which is their first or preferred.

(*If English is not someone's preferred language, the clinician needs to find a translator. It is often inadvisable to use family members as translators, especially children.) Sign languages are not universal either*

- Whether there were any problems before 5 years
- What schools they went to, when and where. How it went and what levels achieved.

Ask about middle childhood-

- What hopes and aspirations did they have, what were their favourite stories, heroes and heroines
- What early friends and significant relationships
- Ask what was usual, for them as a child- it helps the clinician to formulate later what might be unusual.
- Whether there were any problems, before 11 years

What happened during adolescence

- Include- were there any rites of passage, e.g. confirmation, bar or bat mitzvah, 'sacred thread' (Hindu initiation for higher caste boys)
- Was there any dating, or sexual experience, or arrangements (or any taboos)

Section 2: Immediate Family History

Ask-

- For family member's names. If names are unfamiliar to you, take down the spelling, and also write down how they are pronounced- how they sound to you.
- About how first, second and third names are constructed, as different cultures do it differently.

E.g. the Chinese name Cheung Lan-Ying is a family name followed by a personal name. Traditional Hindu names have a first, middle then family name, and a polite form of address is to combine first and middle names, so Jyoti Devi Gupta may appreciate being addressed as Jyotidevi (4). Don't assume that women take their male partners family name in any culture- it's getting rarer.

- Who chose your name, or how was your name chosen
- Where does your name come from
- What do you know about your ancestors
- Who is your next of kin

A simple geneogram of important family members with places and dates of birth is very helpful, particularly if children have been in care, or there are remarriages and stepfamilies.

- What kind of beliefs are important to your family, could you describe them
- Would you say you have a faith, religion , spiritual path or practice (note all)
- What role does your faith have in everyday life
- Do you have any special traditions, practices or values
- Are you members of any groups/ organisations/churches/clubs that you wish to discuss
- Include informal groupings, sporting and fun ones
- Do you have good friends/extended family around who help when needed, or particular organisations who help

- Do you get involved in local/national/international politics, are you registered to vote
- What kinds of skills do family members have, what occupations. Any employment successes/problems
- Any financial issues.
- Any issues of safety or threat.
- What kind of issues does your family discuss, are there any issues that are difficult
- Do men and women have different or similar roles in your family
- Do older and younger people have different roles in your family
- Do you feel proud of your family, or do they sometimes embarrass you
- Are there any special challenges in this stage of your families' life cycle
- Have you experienced any major changes recently
- Are you expecting any changes soon
- What do you think/hope will happen in the future (re any expressed family issues)

Section 3: Ethnicity, acculturation and migration issues

Ask-

- About any wider family and group movements, diasporas and events
- If it is easy/hard to keep in touch with living relatives/friends/associates
- If the family has moved, there may be difficult situations they have escaped, and/or people/things they badly miss
- What differences/similarities do you notice between yourself/your family, and the people you live near now
- What differences/similarities are there between your previous town/village/environment, and where you live now.
- Have you felt welcomed
- Have you experienced any harassment /racism/exclusion
- Have you experienced any 'human rights' issues- expand if necessary

For migrant workers

Issues are very different if workers are from the E.U. or not. European workers may work anywhere in Europe; e.g. a number of eastern European workers have arrived in Britain since 2004, when 10 new countries joined the E.U. In Slovakia and Poland unemployment rates are highest, at 15.8% and17.2% respectively, and substantial migration has resulted.
There are reciprocal healthcare agreements, but the United Kingdom has applied some transitional restrictions on the movement of migrant workers from countries who joined in 2004 and 2007. (work permits)
Bulgaria and Romania joined the E.U. on 1st January 2007.

For travelling and gypsy groups

Repeated exclusion by the settled majority and the need to implement a specific welcome in healthcare

Are discussed e.g. at **www.equalitysouthwest.org.uk/about-us/**

For non Europeans, *entry to Britain to work may be complex. The Home office at www.homeoffice.gov.uk/ has all the details; Regulations may change without notice.*

For Asylum seekers

There may be unresolved trauma, injuries, and disease, then further harrowing uncertainties about whether Asylum will be granted or not.
Healthcare is free until the last stage of a failed application, when the asylum seeker is awaiting deportation, when 'non urgent' hospital treatment must be paid for. (7)

The 'Harp' websites (Health for Asylum seekers and Refugees Portal) contain a wealth of information.
http://www.harpweb.org.uk/index.php

- Ask what they would like to talk about

Section 4: Language and communication issues

Ask-

- Would you like an interpreter, if one seems needed, preferably one who has the required specialist vocabulary.

(*Either if English is not spoken, or not the preferred language, or if the person uses sign language, or total communication or any other form of communicating)*

Somerset Partnership uses a network of local translators, (see Interpreters policy on intranet) supplemented by Languageline

Somerset County Council have changed from using Languageline to using Prestigeline, 0870 770 5260 www.prestigenetwork.com as they found this service offered a greater range of eastern European languages.

- Offer leaflets and information translated into the person's preferred language

Useful sources www.ethnicityonline.net
National register of Public service interpreters at www.nrpsi.co.uk/database

Modern versions of Microsoft office have some free machine translation; select 'Tools' menu, 'Language' then 'Translate' (some of these functions need to be downloaded from www.worldlingo.com)

Free machine translation can also be accessed from www.babelfish.org or http://babelfish.yahoo.com/

Google free translation can be accessed easily from the Google homepage: click on language tools.
Be aware that any machine translation may not be fully accurate. Translating back into the original language can help spot errors.

If there are literacy issues, try and find a source of pictures or symbols to explain (Our Speech and Language service may be able to assist locally)

There are now a number of specific organisations offering helpful online picture leaflets- e.g. the Down's syndrome association at www.down-syndrome.org/DSA 1stliterature.aspx

All you need is a colour printer

Be aware of differences in the expression of emotion. Although some facial expressions are universal to the whole of humankind, the display rules vary from culture to culture; e.g. in Japanese culture it is unacceptable to express anger in public- it tends to be covered by a smile. In England it is frowned upon, but in many other cultures it is more acceptable to 'let it all out'

Paralinguistics i.e. the structure, emphasis and intonation of language can also cause problems. An excellent summary of issues to consider can be found at www.ethnicityonline.net

Body language, eye contact, gesture, personal space, and permitted touching all vary greatly from culture to culture: e.g. inadvertent gestures with the left hand can cause offence to people who regard the left hand as unclean, (because it is only used for washing after going to the toilet)

The British Red Cross has produced an Emergency Multilingual Phrasebook this year at £20 from 0800 7311663

Section 5: Health and Wellbeing Beliefs, and spiritual links.

Lia Lee, a 3 year old child of Hmong parents (from Laos) living in California was diagnosed as having severe epilepsy. Lia's parents understood that epilepsy is serious, but also thought of it as a distinguished affliction, as Hmong epileptics sometimes grow up to be Shamans. The translation of epilepsy quag dab peg means 'the spirit catches you and you fall down' They believed the spirit steals the sufferer's soul, therefore the cure is to guide the soul's return, which involved finding a Shaman, clan leader, amulets and offering the sacrifice of animals . They did all they could. They did not understand the medication regime, and the child was taken into care. (5)

Ask-

- What do you think causes illness
- What have you tried already
- How do you usually stay well
- If you feel ill, do you usually see a doctor first, or try and sort it out another way
- Do you use any traditional remedies and/or Do you use any alternative therapies/healers
- Is your doctor OK with combining western medicine with alternatives.
- Do you have a faith (or spiritual path) that helps you with health issues

Alternative therapies can be very effective: scientific evidence, from randomised clinical trials, is strong for many uses of acupuncture, some herbal medicines and for some of the manual therapies. The global market for herbal medicines stands at US$60 billion annually and is rising steadily. In China, approx 40% of total medicinal consumption is of traditional herbal preparations. 25% of modern medicine is extracted from plants that were originally 'traditional medicine' (6)

Some cultures have traditions of use of herbs that may not be legal in England- for example for many Rastafari, smoking cannabis (ganga) is an important part of worship, and a ritual aid to meditation. Conversely, although alcohol is widely used in England, many followers of Islam find the use of alcohol unacceptable, and may feel uncomfortable just being somewhere that sells it.

Section 6: Formal spiritual or religious paths

NHS Trusts now have a clear duty to explore and respect our service users beliefs, drawn from all faiths and from secular systems. Definitions of spirituality can be wide: e.g. 'Spirituality concerns an ancient and primal search for meaning that is as old as humanity itself….our spiritual story as a human species is at least 70,000 years old; by comparison, the formal religions have existed for a mere 4,500 years….(9)

Ask about:

- Types of beliefs in deities, for example beliefs in one corporeal god/goddess, one incorporeal god/goddess, many gods or goddesses.
- Beliefs in Impersonal higher orders such as Ultimate truth, cosmic order or supreme life force.
- Beliefs in humans as being the supreme force around, or the total balance of life on earth being the main pattern in nature. About belief in intelligent life on other planets.
- Being undecided or uninterested
- Belief in human reincarnations of divine beings or Messiahs, one or many.
- What happens to people after death- for example, if souls are judged immediately death occurs, and sent to heaven hell or for purification; or souls are judged later at the final judgement, (and maybe only the good ones are resurrected); or souls continue their development after death, in some way, maybe by rebirth, towards ultimate bliss; or the people just return to compost. (8)
- Whether people think there is wrongdoing and sinfulness in the world and why- Are heinous crimes caused by e.g. original sin, Satan's temptations, personality disorder, selfishness, misguidedness, sociology, or a failure to listen to the good within or the god without, or too much listening to a false god.
- Whether people think there is great good in the world, and what they attribute that to.
- What (if any) rituals can tap the power of the divine.
- Any Taboos that are observed, including strong beliefs on abortion or homosexuality
- Deeply held secular ethics, or moral codes which may come from a whole system of experience, or more formally from e.g. professional ethical codes, or philanthropic societies.

Section 7: Personal care during inpatient/residential/supported living stays

Do have a look at detailed 'good practice' guidance at www.ethnicityonline.net

Ask-

- About dietary requirements and taboos and also about particular food preparation requirements e.g. Halal or Kosher preparation.
- About gender issues- it may be very important to be examined by a clinician of the same gender.

If physically examining, consider only asking people to remove hair coverings (shawls or wigs) jewellery, temporary body marks if absolutely necessary

1. About any chaperoning requirements for women or need for single sex accommodation
2. About any toilet requirements- a number of cultures regard toilet paper as less than satisfactory, and would wish for running water

- About any requirements for prayer/meditation/rites or rituals
- Consider Holy days and festivals when making outpatient appointments
- Would you like to speak to the Chaplain, a religious leader from your faith community, or a spiritual advisor?
- Consider any rites required around death and mourning.

For Diversity Group

16 January 2007

Placement Provider
Quality Self- Assessment Document

Please provide the following details:

Trust/Service:	
Contact Name:	
Job title	
Contact Address:	
Telephone no:	
Email address:	
Fax	
Clinical Tutor Name:	
Clinical Tutor contact details	College of Life and Environmental Sciences Washington Singer Laboratories University of Exeter Perry Road, Exeter, EX4 4QG
Contact Telephone no:	Tel: 01392 722 459
Date assessment	
Date of review	

For Exeter program staff to complete:

REVIEWERS RECOMMENDATION	Yes	No
Offers suitable placements for trainee clinical psychologists		
Currently unsuitable for trainee clinical psychologists *(see action plan – page 7)*		

The details on this form are used to inform
the allocation to placements of trainee clinical psychologists

SECTION 1: PLACEMENT OUTLINE

Please describe:

Type of Placement/Specialit y	
Client Patient Group/s	

SECTION 2: OTHER INFORMATION

The following sources have been used to determine the suitability of placements for trainee clinical psychologists.

- Standards of Proficiency HCPC
- Standards of Education and Training HCPC
- BPS Guidelines as on Supervision
- Guidance on conduct and Ethics for Students HCPC

Please answer the following questions by circling the relevant score. It would be helpful if you could provide any additional information in the space provided as to how your placement meets the needs raised in the question.

1. Placement resources.

1.	Do you have the relevant resources to provide a viable placement? *(Note: resources would include access to a work space, telephone, computer, clinic space etc.)*					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

2. Student support

2.1	Do you provide trainees with a named practice placement supervisor for the duration of that placement, who is appropriately qualified and experienced and meets relevant Regulatory body requirements (HCPC registered) *(Note: The Exeter Program provides the trainee with details of their supervisor(s) in advance of placement. A theory-practice day is time-tabled during which trainees meet their supervisors prior to starting the placement. The program would expect the placement provider to inform the program if a named supervisor is no longer available to supervise and the appropriate arrangements will be made to find an alternative supervisor.*					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

2.2	Are your placement supervisors aware of the trainee's placement outcomes, so that they can agree with the trainees a learning contract for the placement? *(Note: All supervisors are invited to a pre-placement workshop where the placement outcomes are discussed. Each supervisor is also given a 'Clinical Handbook' which outlines all the relevant information. The Exeter Program requires supervisors complete a 'Clinical Competence Goals and Evaluation Form' as a means of developing a learning contract.*					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

2.3	Do placement supervisors schedule regular supervision slots during which their progresses towards meeting their learning objectives are reviewed? *(Note: BPS guidance is that trainee should receive 1.5 hours per week of supervision, and should have a total contact time with supervisor(s) of 3 hours per week)*					
	N/A	Never	Rarely	Sometimes	Mostly	Always

Additional information:						
2.4	Do you have any process by which you gather feedback from trainees on their placement experience? Do you take action following feedback?					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

2.5	Do you provide trainees with an orientation or induction to the placement? (This might include non-discriminatory policy, health and safety, equality and diversity policies, child protection.)					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						
2.6	Do you make trainees aware of their responsibilities and rights with regard to any resources and support they could receive on placement? (This can include anything from admin support, to in-house training etc)					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

3. Learning and teaching

3.1	Does this placement ensure that provision is made for trainees to reflect on practice, and to link practice explicitly with their theoretical underpinning?					
	N/A	Never	Rarely	Sometimes	Mostly	Always

Additional information:						
3.2	Does the placements provide varied learning opportunities that enable trainees to achieve learning outcomes through: • observing skilled professionals deliver service and care • participating, under supervision, in the delivery of treatment and care • practising in an environment that respects users' rights, privacy & dignity					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						
3.3	Do placement supervisors demonstrate evidence-based teaching, assessment and practice?					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						
3.4	Does the placement provide learning opportunities in placements that are appropriate to the level and need of the trainee, and provide opportunities for inter-professional working?					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

3.5	Is there a strategy in place to ensure implementation and compliance with organisation polices in induction:

Improving working lives	☐
Health and Safety	☐
Equality and Diversity	☐
Complaints Procedures	☐
Anti-discriminatory practice	☐
Equal Opportunities	☐
Infection Control	☐
Vulnerable Adult	☐
Child Protection	☐
Risk Assessments	☐
Lone working policy	☐
Others (please state)	☐

Additional information:

4. Monitoring of trainee progression during placement.

4	Do you have processes in place for monitoring progress of trainees? Would this enable you to recognise early poor performance of trainees, and take appropriate and prompt action? *(Note: Relevant processes would include supervision, regular review of placement goal, and placement visits by the Clinical Tutor)*					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

5. Assessment

5.1	The Exeter Program seeks to work collaboratively with placement providers to agree the number of placement supervisors that are

	available to supervise. The program also offer regular opportunities, (in the form of placement workshops or individual meetings with clinical tutors), for supervisors to update their knowledge of how trainees are assessed on placement. To what degree does this reflect your experience?					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						
5.2	The Exeter Program seeks to work collaboratively with placement supervisor to ensure a fair and reliable process for rating practice assessments. To what degree does this reflect your experience? *(Note: Supervisors are invited to supervisor workshops during which the rating of practice assessments are discussed, each supervisor has a copy of the Clinical Handbook which outlines how practice assessments are rated and clinical tutors monitor placements and advise of supervisors rating. The Clinical Director will also moderate all placement assignments.)*					
	N/A	Never	Rarely	Sometimes	Mostly	Always
Additional information:						

6.	Are placement supervisors released to attend supervisor training?	**Yes/No**

7.	Do placement supervisors undertake individual Performance Review where education responsibilities are clearly defined and future education requirements are identified? Is Continuing professional development recorded?	**Yes/No**

9.	All staff are HCPC registered	**Yes/No**

I have examined evidence that all the above standards have been met

For Placement Provider:

Name:…… Signature……

Designation:

Date……

For Exeter Clinical Psychology Program representative:

Name: ……Signature……

Designation: Clinical Tutor

Date:

SUMMARY OF PROPOSED ACTIONS

For Exeter program staff to complete

Commendation of best practice (education practice that is positive, working well or commendable and areas where there have been demonstrable improvements).

For Exeter program staff to complete

Proposed Action Plan	Responsibility	Review **Date**

For Exeter program staff to complete:

REVIEWERS RECOMMENDATION	**Ye**	**No**
Offers suitable placements for trainee clinical psychologists		
Currently unsuitable for trainee clinical psychologists *(see above action plan)*		

Appendix 8 Supervision Contract (for supervisor and trainee)

Doctorate in Clinical Psychology

University of Exeter

THE WORLD UNIVERSITY RANKINGS 2022 TOP 150

SUPERVISION CONTRACT

Trainee:- **Clinical Tutor:-**

Purpose of this Contract:
To highlight a number of areas that the supervisor and trainee might like to consider when planning and reviewing supervision arrangements.

☐☐☐ **Year of Training:** Year 1 Year 2 Year 3 *(please tick)*

Placement number: 1 2 3 4 5 6 (please circle)

Placement Type:-_____

☐ Placement length:

☐ Sequential (6 month followed by 6 month placement)
Parallel (2 x 12 month parallel placements)
☐ Long full placement (12 months on one placement)
(please tick)

Trainee Annual Leave Dates:

_____

Study leave Dates: _____

Primary Supervisor:-

_____

Placement Address(es):-

_____

_____

Primary Supervisor Responsibilities:

- Hold an overview across both placements
- In placement paperwork; provide grade and written feedback on each area of competency as well as overall grade / evaluation of placement (taking into account grades / feedback provided by secondary supervisor on any parallel placement)

Time/place/freq of supervision agreed:_____

Other opportunities for contact with supervisor:

_____

Agreed supervision cover when supervisor is absent:

Secondary Supervisor:-

_____

Secondary Supervisor Responsibilities:

- Provide grade and written feedback on each area of competency in advance of paperwork submission date

Time/place/freq of supervision agreed:_____

Other opportunities for contact with supervisor:

_____

Agreed supervision cover when supervisor is absent:

Email addresses:
Primary Supervisor: _____

Secondary Supervisor: _____

Method and Frequency of communication agreed between Primary and Secondary Supervisors:

Professionalism and Confidentiality

- The informed consent of the service user, carer or professional must be obtained before video or audio recording any session.
- The full Supervision and Professional Guidelines as published by the BPS and HCPC will be adhered to at all times

Supervisor(s) Responsibilities

- Co-ordinate and liaise with each other (where relevant) and with clinical tutor
- Take responsibility for evaluation of trainee's performance
- Provide a minimum of one hour of supervision per week with a total contact time of at least three hours (pro rata, based on 4 days a week allowing for the placement being 2 days, 3 days and then 4 across both supervisors where relevant).
- Address issues of power implicit in supervisor/trainee relationship.
- Seek advice from clinical tutor if required.
- Share any concerns that may impact on placement/clinical work initially with the trainee and if not resolved with clinical tutor.
- Share supervision policy of Trust with trainee
- Consider how significant personal issues for trainee may be dealt with

Trainee Responsibilities

- Attend and prepare for supervision.
- Pass on information re strengths and learning needs and discuss implications for this placement – identifying what needs taking forward and what needs leaving behind.
- Show previous paperwork to any new supervisor to assist in the construction of goals. This applies whatever the grade, as learning needs would always apply from one placement to the next.
- Share any concerns that may impact on placement/clinical work initially with supervisors and if not resolved with clinical tutor.
- Ensure that supervisors are aware of clinical assessment deadline/s and allow enough time for them to review/sign off.

Trainee & Supervisor Joint Responsibilities:

- Create a space for honest constructive feedback both ways in supervision to ensure a positive placement
- Share responsibility for punctuality and ensuring that the dedicated supervision time is protected and free from distraction
- Agree who takes responsibility for record keeping of supervision sessions
- Share responsibility for ensuring that supervision is a helpful and useful space which includes appropriately preparing for each meeting.
- Share responsibility for agreeing confidentiality boundaries
- Address issues of power implicit in supervisor/trainee relationship.
- Consider how significant personal issues for trainee may be dealt with
- Share any concerns that may impact on placement/clinical work initially between supervisor and trainee and if not resolved, with clinical tutor.
- Raise any placement related issues with clinical tutor in advance of mid-placement visit.

What will be included in the content of Supervision?
(Please tick all to be included)

☐ Recommended reading- clinical and theoretical

☐ Development of assessment and treatment skills

☐ Development of conceptualisation/formulation skills

☐ Research

☐ Treatment planning and therapeutic skill development

☐ Communication skills (written and verbal)

☐ Discharge planning

☐ Discussion of self-care skills and home/work balance

☐ Discussion of issues around diversity & inclusion

☐ Psychological models/models of therapy

☐ Models of supervision

☐ Discussion of therapeutic relationship and engagement

☐ Discussion of supervision and supervisory relationship

☐ Review of risk and therapist/service user safety

☐ Review of clinical logs completed by trainee

☐ Personal issues that arise in the course of trainee's work

Any Others?
(Please list)

_____
_____
_____

<u>What methods will be used in Supervision?</u>
(Please tick all to be used)

☐ Case presentation

☐ Questioning and challenging

☐ Feedback and evaluation

☐ Informing/suggesting

☐ Instruction/Teaching

☐ Review of audio and videotapes

☐ Direct observation of practice-trainee

☐ Direct observation/modelling of practice by supervisor

☐ Review of clinical guidelines/manuals

☐ Experiential exercises (e.g. role play, simulation)

☐ Behavioural experiments

☐ Live supervision eg reflecting team

☐ Trainee reflection on thoughts, attitudes, beliefs and potential impact of these on therapeutic and professional behaviour

☐ Facilitating reflection

☐ Review of psycho-educational material

☐ Use of structured assessment eg Cognitive Therapy Rating Scale

☐ Reflection on Supervisor's cases to inform trainee cases

Any others?
(Please list)

_____

_____

_____

Steps in the event of a breakdown in the arrangements for clinical supervision
Should the Clinical Tutor be unavailable in the event of any type of placement breakdown, including breakdown in supervision arrangements, then other appropriate sources of support include Trainee's Appraiser and Clinical Practice Director.

1.	**Clinical Tutor**
2.	Appraiser
3. Tracy Rydin-Orwin	Clinical Practice Director

Have you discussed and agreed:-
(Please tick)

☐ Review date for this contract

☐ Regular weekly supervision date/time

☐ Additional contact time in addition to supervision

☐ All prior outstanding learning objectives

☐ Cover arrangements if supervisor absent

☐ Placement goals

☐ Induction checklist

☐ Facilities for trainee (desk, clinic space, computer etc)

☐ Additional opportunities within the placement

Changes to this contract and timescale

Changes to this contract can be negotiated at any time. The contract should be agreed at the beginning of placement and reviewed, at latest, before the Mid Placement Review.

This contract covers the period: _____

This contract will be reviewed on: _____

Trainee:-

Signature: Date:

Primary Supervisor:-

Signature: Date:

Secondary Supervisor (if applicable):-

Signature: Date:

A copy of this contract must be sent to the DClinPsy Admin and Clinical Tutor, **no later than two weeks after the start of placement**.

Appendix 9 Guidance around face to face and online placement visits

Guidance around face-to-face and online placement visits.

Placement visits can take place online, or face-to-face. Following consultation with trainees, supervisors and clinical tutors, the policy of the Exeter DClinPsy is now to offer an online placement visit as standard. This has been found to be acceptable to supervisors and trainees and has increased efficiency at a time when the programme has seen significant expansion.

Year one trainees should be offered a face-to-face visit during their first year. This may be at the first or second placement, depending on need and supervisor/Clinical Tutor availability.

Additional face to face visits may be considered more appropriate in the following circumstances:

- Where a trainee or supervisor has specific sensory needs or health conditions that significantly impact on the accessibility of online video platforms (for example, visual or hearing impairments).
- Where the trainee has received a referral or conditional pass from a preceding placement.
- Where the trainee (or supervisor) has requested a face-to-face visit to discuss sensitive or challenging topics (such as a potential conditional pass or supervision difficulties). Trainees can request this from their Clinical Tutor confidentially, given the power dynamics within supervisory relationships.
- Where the physical set up of the placement is integral in the clinical tutor's understanding of the placement and this is considered by all parties to be relevant to the placement review.
- Where there is a new supervisor or new service where a face-to-face meeting would provide an enhanced opportunity develop good course-supervisor links.

Whilst the course team will always try and accommodate requests for face-to-face meetings, please note that this might result in less flexibility in terms of day, timing or venue of the placement meeting.

Appendix 10 Placement Visit Checklist (for clinical tutor)

Placement Visit

Trainee: **Clinical Tutor:**
Supervisor 1:
Placement: Year 1, year 2 Year 3 **Date of Visit:**
Location **Appraiser:**

It is recommended that the following areas will be discussed during the placement visit.

Goals / Assessment

- Goals are appropriate, balanced, and manageable, and based on trainee strengths and learning needs
- Check that Portfolio of Clinical Experience (Log of Clinical Activity and Cumulative Record) are being completed by trainee
- How are diversity issues are being addressed on placement?
- Consideration of balance of work/ responsibilities across the two supervisors
- Supervisors aware of how to evaluate the trainee and deadlines for paperwork.
- Supervisors have seen trainee evaluations from previous placement(s)
- Issues from previous referred or conditional pass are being addressed.
- At this point, is the trainee on track to pass/conditional pass Clinical Competence Goals and Evaluation Form and Portfolio of Clinical Activity? (If 'no' following discussion and clarification, set up Action Plan)
- Trainee's annual & study leave has been negotiated?

Supervision

- Supervision is regular (fixed, if possible) supervision times (total 1.5 hours per week) & total contact time across supervisors 3 hours per week
- Consider how possible difficulties between trainee and supervisors may be dealt with.
- Is there evidence of good supervisory relationships developing?

Observation

- Are there opportunities for trainee to both observe, and be observed by, the Supervisor(s)
- Check which observational tool is going to be used *(NB CAPS in Year 1, CTS-R in Year 2)*
- Agree a time to fill in observational form

- Refer to audio/video taping as possible means of bringing material to supervision where direct observation will prove difficult
- Explore what kind of feedback the trainee might find helpful

Placement Resources

- Trust policies/induction (access to equality and diversity policies, health and safety policies, risk assessment, child protection/supervision policy)

- Discuss placement resource issues /use of tariff for placement and refer to placement audit form
- Trainee has access to desk, computer, phone and admin support

Academic/research requirements

Discuss role of supervisor and opportunities for: Problem- Based Learning task, Clinical Practice Report, Small Scale Service Related Project, and Major Research Project

- Check SSRP is not running on academic days, and that time to work on this has been negotiated.

Support for trainee

In separate time with trainee, check whether support is in place Yr. 1? (incl. Mentor); are any issues significantly affecting trainee's ability to get on with work, e.g. supervision relationships; transport; IT facilities; home; health /well-being; finances; workload.

Summary

Support for supervisors

In separate time with supervisor(s) check what, if any, further support/ information needed from programme; any other issues/ concerns? Any resource issues to take forward to service managers?

- Remind supervisors of the obligation to attend supervisors training. Has supervisor attended? If supervisor has not been able to attend what do they need to equip them to supervise?
- Talk to supervisor about placement planning (issues? Happy to supervise?)
- Check supervisor database completed/up to date

Summary

Actions

Please summaries any action that were agreed during the placement visit

(17)

ECC FORM - APPENDIX 1: SERVICE USER EVALUATION FORM

Name of Psychologist: ***Date:***

We would be grateful if you could answer the following questions to give us an impression as to how helpful you have found the psychological service you have received. For each question, please circle the answer which applies to you. Thank you.

1. How long on average did you have to wait before being seen after you had arrived for your appointment?

More than 15 minutes	**between 5 & 15 minutes**	**between0 & 5 minutes**
0	1	2

2. At your first appointment, were you received in a way that made you feel welcome and helped set you at ease?

Not at all	*somewhat*	*very much so*
0	1	2

3. Were you happy with the information that you were given about the work undertaken with you?

Not at all	*somewhat*	*very much so*
0	1	2

4. Did the psychologist understand your problem and how you felt about it?

Not at all	*somewhat*	*very much so*
0	1	2

5. Do you feel you were treated in a confidential and respectful way?

Not at all	*somewhat*	*very much so*
0	1	2

6. How satisfied were you with the help you received?

Not at all	*somewhat*	*very much so*
0	1	2

7. Have the psychological services you received helped you to deal more effectively with your problems?

Not at all	*somewhat*	*very much so*
0	1	2

8. If you needed help again, would you feel able to return to this service?

Definitely no	*not sure*	*definitely would*
0	1	2

9. If you had a friend who had similar problems, would you recommend that she/he seeks psychological help?

Definitely no	*not sure*	*definitely would*
0	1	2

Please add any further comments if you wish:

ECC FORM - APPENDIX 2: SERVICE USER EVALUATION FORM FOR PEOPLE WITH LEARNING DISABILITY

Name of Psychologist: ***Date:***

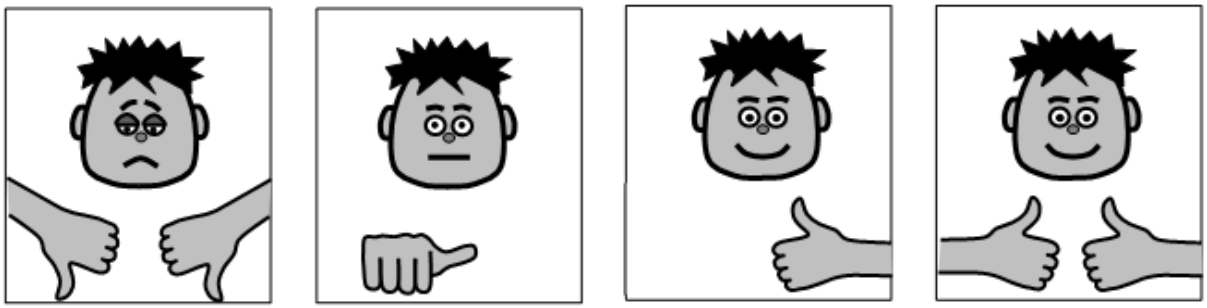
The service would like to know how helpful your psychologist was?

1. What was your problem?

_____

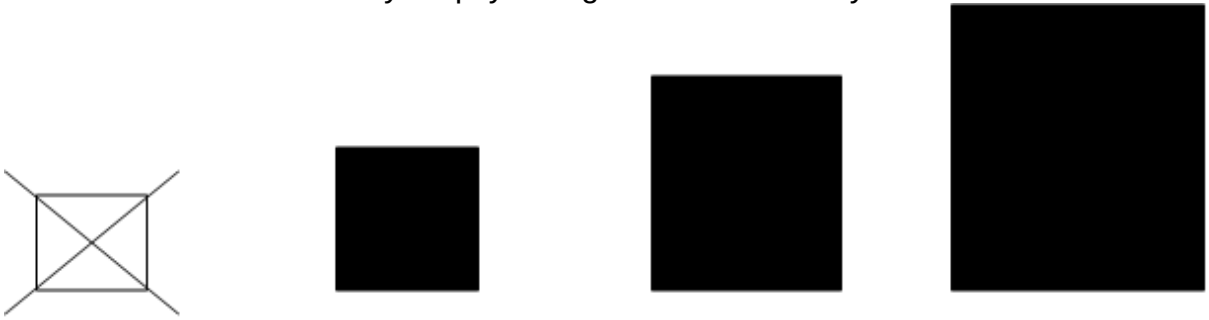
2. How is your problem now?

WORSE THE SAME A LITTLE A LOT



BETTER BETTER

3. How often was your psychologist on time to see you?



4. [GroupDrawing]How comfortable were you with your psychologist?

5. How happy were you with the information your psychologist gave you?
[GroupDrawing]

6. Did your psychologist understand your problem?
[GroupDrawing]

7. Did your psychologist listen to your feelings?
[GroupDrawing]

8. Did your psychologist keep what you said private?

YES SOMETIMES NO

9. How helpful was your psychologist?
[GroupDrawing]

10. If you need help in future, would you want a psychologist to help you again?

YES MAYBE NO

9. Would you tell a friend to see a psychologist?

YES MAYBE NO

Do you want to say anything else?

THE SUPERVISORY RELATIONSHIP QUESTIONNAIRE (SRQ)

Developed by Marina Palomo (supervised by Helen Beinart)

The following statements describe some of the ways a person may feel about his/her supervisor. **To what extent do you agree or disagree with each of the following statements about your relationship with your supervisor? Please tick the column which matches your opinion most closely.**	**Strongly Disagree**	**Disagree**	**Slightly Disagree**	**Neither Agree nor Disagree**	**Slightly Agree**	**Agree**	**Strongly Agree**
SAFE BASE SUBSCALE							
1. My Supervisor was respectful of my views and ideas							
2. My supervisor and I were equal partners in supervision							
3. My supervisor had a collaborative approach in supervision							
4. I felt safe in my supervision sessions							
5. My supervisor was non-judgemental in supervision							
6. My supervisor treated me with respect							
7. My supervisor was open-minded in supervision							
8. Feedback on my performance from my supervisor felt like criticism							
9.The advice I received from my supervisor was prescriptive rather than collaborative							
10. I felt able to discuss my concerns with my supervisor openly							
11. Supervision felt like an exchange of ideas							
12. My supervisor gave feedback in a way that felt safe							
13. My supervisor treated me like an adult							
14. I was able to be open with my supervisor							
15. I felt if I discussed my feelings openly with my supervisor, I would be negatively evaluated							
STRUCTURE SUBSCALE							
16. My supervision sessions took place regularly							
17. Supervision sessions were structured							
18. My supervisor made sure that our supervision sessions were kept free from interruptions							

19. Supervision sessions were regularly cut short by my supervisor							
20. Supervision sessions were focused							
21. My supervision sessions were disorganised							
22. My supervision sessions were arranged in advance							
23. My supervisor and I both drew up an agenda for supervision together							
COMMITMENT SUBSCALE							
24. My supervisor was enthusiastic about supervising me							

25. My supervisor appeared interested in supervising me							
26. My supervisor appeared uninterested in me							
27. My supervisor appeared interested in me as a person							
28. My supervisor appeared to like supervising							
29. I felt like a burden to my supervisor							
30. My supervisor was approachable							
31. My supervisor was available to me							
32. My supervisor paid attention to my spoken feelings and anxieties							
33. My supervisor appeared interested in my development as a professional							
REFLECTIVE EDUCATION SUBSCALE							
34. My supervisor drew from a number of theoretical models							
35.My supervisor drew from a number of theoretical models flexibly							
36. My supervisor gave me the opportunity to learn about a range of models							
37. My supervisor encouraged me to reflect on my practice							
38. My supervisor linked theory and clinical practice well							
39. My supervisor paid close attention to the process of supervision							
40. My supervisor acknowledged the power differential between supervisor and supervisee							
41. My relationship with my supervisor allowed me to learn by experimenting with different therapeutic techniques							
42. My supervisor paid attention to my unspoken feelings and anxieties							
43. My supervisor facilitated interesting and informative discussions in supervision							
44. I learnt a great deal from observing my supervisor							
ROLE MODEL SUBSCALE							
45. My supervisor was knowledgeable							
46. My supervisor was an experienced clinician							
47. I respected my supervisor's skills							
48. My supervisor was knowledgeable about the organisational system in which they worked							
49. Colleagues appeared to respect my supervisor's views							
50. I respected my supervisor as a professional							
51. My supervisor gave me practical support							
52. I respected my supervisor as a clinician							
53. My supervisor was respectful of clients							
54. I respected my supervisor as a person							
55. My supervisor appeared uninterested in his / her clients							

56. My supervisor treated his / her colleagues with respect							

FORMATIVE FEEDBACK SUBSCALE							
57. My supervisor gave me helpful negative feedback on my performance							
58. My supervisor was able to balance negative feedback on my performance with praise							
59. My supervisor gave me positive feedback on my performance							
60. My supervisor's feedback on my performance was constructive							
61. My supervisor paid attention to my level of competence							
62. My supervisor helped me identify my own learning needs							
63. My supervisor did not consider the impact of my previous skills and experience on my learning needs							
64. My supervisor thought about my training needs							
65. My supervisor gave me regular feedback on my performance							
66. As my skills and confidence grew, my supervisor adapted supervision to take this into account							
67. My supervisor tailored supervision to my level of competence							

Scoring Key

Scored 1 (Strongly Disagree) to 7 (Strongly Agree)

Reverse Scoring
Scored 7 (Strongly Disagree) to 1 (Strongly Agree)

References:

Palomo, M. (2004). Development and validation of a questionnaire measure of the supervisory relationship. Unpublished DClinPsych Thesis, Oxford University.

Palomo, M., Beinart, H. & Cooper, M. (in preparation), Development and validation of the Supervisory Relationship Questionnaire (SRQ) in a population of UK trainee clinical psychologists.

Contact details:

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uk

Appendix 13 Planning Your Third Year Placement (second years only)

Planning your Third Year Placement.

Name:
Date:

Do you have competency gaps at this stage in training? Review your Cumulative Record to try and identify these. Have you discussed with your appraiser and are they in agreement with you?	
What are you most interested in? (speciality/modality etc.)	
Do you have an idea as to what speciality(ies) or area/context you would like to work in post qualification? Which supervisors or specialities have you had preliminary conversations with and what were your reflections on these?	
Are you working towards secondary accreditation in a specific therapeutic approach? Consider how will you plan to meet these aims alongside other clinical, academic and research requirements.	
Are you considering one or two placements? If two, would you want to run them as long-thin placements or in blocks? Which days of the week will fit better for one or other placement?	

Are there personal circumstances which will affect this coming year?	

Please return this to your clinical tutor by 31st March. A meeting can be booked to discuss options further, if useful.

Appendix 14 Paperwork Summary Checklist

Paperwork Summary Checklist

You are advised to allow a month for filling in these documents, given that annual leave and sick leave can disrupt the process of signing and completion.

Procedures for a late submission are overtaken by University regulations and the Board of Examiners may need to be informed.

If you have any queries, please contact your clinical tutor.

1	**Electronic Front Page for Clinical Submission** (incorporating Placement Summary, providing basic information on placement including number of days and the **Supervisor Overall Evaluation Form**)	☐
2	**Portfolio of Clinical Experience**	
	Log Book - a running record of clinical work, completed by trainees on a weekly basis throughout placement.	☐
	Cumulative Record **-** a cumulative record completed prior to initial placement and then at each assessment period after that.	☐
3	**Clinical Competence Goals & Evaluation**	
	General Placement Outline -Trainee Identification of own Strengths & Learning Needs,	☐
	Competence Areas **-** based around core competences. Each section needs to be completed. Clearly, many goals will be ongoing or, indeed, maintained at this	☐

	point, but this will need to be stated explicitly	
	Supervisor Reflection	☐
	Trainee Reflection	☐
	Observation Tool	☐

Appendix 15 Clinical Assessment Frontsheet

Doctorate in Clinical Psychology Exeter

Front Sheet for Electronic Submission of Clinical Assessment

Trainee Name:

Assessment Date:

Placement Period: ***Please select as appropriate*** –

YEAR 1 PART 1 - days (including theory/practice days and annual leave)

YEAR 1 PART 2 - days (including theory/practice days and annual leave)

YEAR 2 PART 1 - days (including theory/practice days and annual leave)

YEAR 2 PART 2 - days (including theory/practice days and annual leave)

YEAR 3 - days minimum on placement at point of assessment

Annual Leave:

Sickness Leave:

Study Leave Taken:

Placement Provider:
(e.g Sompar/DHUFT)

Supervisor Overall Evaluation
To be completed at each of the assessment points

Portfolio of Clinical Experience

Pass ☐ Conditional Pass ☐ Fail ☐

Trainee's Competence

Pass ☐ Conditional Pass ☐ Fail ☐

If ***conditional*** *pass* please specify which learning needs require particular attention in the next placement period and must be identified in the next stage of placement planning:

Assessment: Clinical Goals, Portfolio and Observation; For work undertaken on placement:

"I certify that the work reported in this assessment took place as described and I have signed and contributed to the feedback within the document."

A copy has been sent to the clinical tutor by the trainee.

Supervisor name:

Supervisor Signature:

Trainee name:

Trainee signature:

To be sent through to Programme Administrators by e-mail at DClinPsy@exeter.ac.uk having been signed and scanned (or signed electronically), with the paperwork

Paperwork Summary Checklist

You are advised to allow a month for filling in these documents, given that annual leave and sick leave can disrupt the process of signing and completion.

Procedures for a late submission are overtaken by University regulations and the Board of Examiners may need to be informed. If work is submitted late this will normally lead to a Conditional Pass as this is a professional issue.

If you have any queries, please contact your clinical tutor.

1	**Electronic Front Page for Clinical Submission** (incorporating Placement Summary, providing basic information on placement including number of days and the **Supervisor Overall Evaluation Form**)	☐
2	**Portfolio of Clinical Experience**	
	Log Book - a running record of clinical work, completed by trainees on a weekly basis throughout placement.	☐
	Cumulative Record **-** a cumulative record completed prior to initial placement and then at each assessment period after that.	☐
3	**Clinical Competence Goals & Evaluation**	
	General Placement Outline	☐
	Competence Areas **-** based around core competences. Each section needs to be completed. Clearly, many goals will be ongoing or, indeed, maintained at this point, but this will need to be stated explicitly	☐
	Supervisor Reflection	☐
	Trainee Reflection	☐
	Observation Tool	☐

Cumulative Record of Experience

Purpose of the Record

Trainee experiences are gathered cumulatively across placements. No one placement can provide all the experiences that a trainee needs to gain through training. The record is divided into 3 broad areas of experience: clients, service settings and
modes of clinical work. The clinical work is expanded upon in three more psychological therapy logs to evidence your CBT, Systemic and CAT experiences. For further BPS accreditation and HCPC regulation, criteria require that trainees develop their competencies within a balanced range of these experiences across the three years of their training. The purpose of this record is to help the trainee and supervisors review progress so as to:

- give the supervisors a framework within which to evaluate the trainee's acquisition of experiences, and
- to enable planning of subsequent placement experiences.

It is important to recognise that a trainee should not expect to be an expert in everything, and that different trainees will be more practiced in some areas than others. Training will progress through Continuing Professional Development throughout the trainee's career. Nevertheless, we do expect that by the end of training trainees will normally have reached level 2 or 3 in all domains of experience and level 4 in most domains of experience.

Use of the Record

Before the first placement (pre-), and towards the end of each placement period (Year 1 Part 1; Year 1 Part 2; Year 2 Part 1; Year 2 Part 2; Year 3), the trainee should review their experience (with their appraiser before year 1 part 1) and subsequently with their supervisors and then appraiser. Following discussion, the trainee rates his or her own level of achievement in each area of experience using the rating criteria below. One column should be filled in for each placement. The supervisor confirms this as an accurate record.

Previous paperwork should be shown to any new supervisor to assist in the construction of the goals for that placement. This would apply whatever the grade, as learning needs would always apply from one placement to the next.

Rating Standards for Cumulative Record of Experience:

0 = No relevant experience or knowledge

1 = Early experience in one or more of: (please specify all that apply)

A) understanding client and carer perspectives; and/or
B) relevant theory and knowledge; and/or
C) relevant practice, skills and techniques

At this level, trainees will have limited (maybe indirect) experience, based for example: A) in own life experiences or observations made in relevant client or service settings; and/or B) some basic reading; and/or C) observation of supervisor's or others' work.

2 = Developing experience in one or more of: (please specify all that apply)

A) understanding client and perspectives; and/or
B) relevant theory and knowledge; and/or
C) relevant practice, skills and techniques

At this level, trainees will have had some experiences based, for example: A) in conversations with, or shadowing of, clients/carers, or reading relevant first person accounts, and/ or B) participation in relevant Problem Based Learning exercise and/or familiarity with some basic texts/references; and/or C) some direct practice or co-working over several sessions of work; and beginning to underpin own work with theory based formulations although will probably have had little or no experience yet of generalising skills/knowledge across situations or settings.

3= Satisfactory experience in one or more of: (please specify all that apply)

A) understanding client and carer perspectives; and/or
B) relevant theory and knowledge; and/or
C) relevant practice, skills and techniques

At this level, trainees will have had a significant amount of direct learning and exposure to relevant work based, for example, in A) having received direct client feedback on own work and/or having attended user or carer groups; and/or B) good knowledge of relevant literature; and/or C) direct

practice or co-working with others over a period of at least 5 months; and significant experience of underpinning own work with theory based formulations; and beginning to generalise skills/knowledge across situations or settings.

4= Thorough experience in: (at this level all three levels should apply)

A) understanding client and carer perspectives; and
B) relevant theory and knowledge; and
C) relevant practice, skills and techniques

At this level, trainees will be well able to integrate and generalise their understanding of clients' perspectives, theory and practice; capable of working independently and flexibly, adapting interventions to individual needs and changing circumstances, and ready to be innovative and creative in solving new problems.

Cumulative Record of Experience

Experience Domains	**Pre -**	**Yr1 Pt1**	**Yr1 Pt2**	**Yr2 Pt1**	**Yr2 Pt2**	**Yr3**
Age Range						
Children (0-11 yrs)						
Adolescents (12-18 yrs)						
Adults (18-65 yrs)						
Older Adults (65+ yrs)						
Conditions/Issues						
Acute/Transient Conditions (Mild)						
Acute/Transient Conditions (Mod-Severe)						
Long Term Conditions (Mental health)						
Long Term Conditions (Medical)						
Social/Financial Issues						
Cultural/Diversity Issues						
Family/Domestic Issues						

Other						
Presentations						
Challenging Behaviour						
Disability (learning/physical)						
Communication Difficulties						
Sensory Impairments						
Service Settings						
Outpatients						
Inpatients						
Residential						
Primary Care						
Secondary Care						
Direct Clinical Work						
Psychological Assessment						
Psychological Formulation						
Psychological Intervention						
Psychological Evaluation						
With Individuals						
With Couples						
With Families						
Indirect Clinical Work						
Providing Supervision						
Consultancy						

Joint/Team Working						
Leadership						
User Involvement						
Teaching						
Psychotherapy Models						
Cognitive Behavioural Therapy						
Systemic Therapy						
Cognitive Analytic Therapy						
Integrative Therapy						
Other (e.g. Psychodynamic approaches, IPT, DBT, ISTDP)						

Cumulative Cognitive Behaviour Therapy Log

Instances when therapy competencies have been demonstrated within placements should be indicated for each client or case (*i.e. not for each session)* in the following boxes and certified by the placement supervisor via a signature on the Clinical Assessment Frontsheet. A cumulative portfolio of CBT competencies should be kept across all placements.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Applied CBT in context of:																				
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Older Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child / Family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Applied CBT to specific problems:																				

Phobia / Social Phobia / GAD / Panic	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OCD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
PTSD	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Health related presentations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family functioning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Adjustment and coping	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Addictive behaviours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Demonstrated generic CBT skills:																				
Socialisation and rationale of CBT treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identified cognitive distortions and biases	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Agreed and collaboratively set agenda for session content and structure	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Developed collaborative hypotheses	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Developed intervention plans	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Planned and reviewed “homework”	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used measures and self-monitoring to guide and evaluate therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Demonstrated knowledge of safety behaviours and maintenance cycle and used to inform goals/targets	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used problem solving	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ended therapy appropriately and planned for the longer-term	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Selected and applied most appropriate CT and BT method	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Managed obstacles during therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Specific Behavioural and Cognitive Therapy skills:																				
Used Exposure techniques	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used Applied relaxation and/or applied tension	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used Activity monitoring and scheduling	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Implemented a Contingency programme	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Elicited key cognitions / images	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used thought records	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identified and worked with safety behaviours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Detected, examined and helped client/ family/system reality test automatic thoughts/images	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Elicited key cognitions/images	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identified and helped client's/ family's/system's modify assumptions, attitudes and rules	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Identified and helped client/family/system modify core beliefs	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Employed imagery techniques	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐
Planned and conducted behavioural experiments	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Promoted the development of consequential thinking	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used alternative solution generation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Parent training programme	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Able to develop formulation and treatment plan premised on a CBT model	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to understand client / family's inner world and response to therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Cumulative Systemic Therapy Log

Instances when therapy competencies have been demonstrated within placements should be indicated for each client or case (*i.e. not for each session)* in the following boxes and certified by the placement supervisor via a signature on the Clinical Assessment Frontsheet. A cumulative portfolio of systemic therapy competencies should be kept across all placements.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Applied systemic therapy in context of:																				
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Older Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child / Family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Applied systemic therapy to specific problems:																				
Anxiety presentations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relationship difficulties	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Presentations of childhood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☒	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Developmental transitions	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Family functioning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Health related presentations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Addictive behaviours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Competancy Benchmark for the Foundation in Family Therapy:																				
Use systemic ideas (e.g. circularity, multiple perspectives, repetitive patterns of interaction, trans-generational patterns) to think about, and contribute to, current practice.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Meet with more than one person within a client system or family, and interview in a way that pays attention to the therapeutic relationship with family members.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Apply a systemic perspective to an assessment of a problem.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Use systemic questions and techniques (such as hypothesising and circular questioning) to clarify goals and gather systemic information.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Work in a way that is ethical and takes account of difference and power.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Use basic interventions including verbal and non-verbal methods to improve communication and help families to achieve their goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Contruct a genogram with client(s), using this to identify patterns of relationship, historical infliences and stressors on the family, and consider how these may impact on the problem.	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Indeintify and consider how your own peronal family experiences, beliefs and assumptions influence the work undertaken	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Promote change through tasks between sessions, monitored and reviewed progress in therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Consider and manage ending appropriately	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER(please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Specific Systemic competencies:																				
Employed circular interviewing/questioning	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used reframing techniques to enable client(s) to understand the development and maintenance of the problem	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Enabled client(s) to identify individual and family strengths	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Used mapping techniques to identify current, historical and trans-generational patterns (e.g. ecomaps, lifelines, family circles)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Demonstrated ability to work with a systemic team (e.g. reflecting team, reflection on process in supervision)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Demonstrated self-reflexive practice/personal awareness	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Demonstrated awareness of cultural diversity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Cumulative Cognitive Analytic Therapy Log

Instances when therapy competencies have been demonstrated within placements should be indicated for each client or case (*i.e. not for each session)* in the following boxes and certified by the placement supervisor via a signature on the Clinical Assessment Frontsheet. A cumulative portfolio of psychodynamic competencies should be kept across all placements.

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
Applied Cognitive Analytic Therapy in context of:																				
Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Older Adult	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Child / Family	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Learning Disability	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other (specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Applied Cognitive Analytic Therapy to specific problems:																				
Anxiety presentations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Relationship difficulties	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Complex Emotional, Interpersonal and Behavioural Difficulties [e.g. with clients who	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

have been given a diagnosis of 'Personality Disorder']																				
Psychosis	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bipolar Disorder	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Presentations in young adulthood	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Health related presentations	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Addictive behaviours	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eating disorders	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Experience in core Cognitive Analytic Therapy competencies of:																				
Knowledge of the basic principles of CAT and rationale for therapy:																				
Knowledge of CAT theory of the self and developmental damage	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to draw on knowledge that CAT is integrative	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to draw on knowledge that CAT works within the client's 'zone of proximal development'	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to draw on knowledge that CAT is time-limited, and to understand the implications of this for therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Reformulation and Engagement Phase: Knowledge of Reformulation in CAT:																				
Knowledge of CAT's focus on Target Problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Knowledge of Reciprocal Roles (RRs) and their internalisation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Knowledge of problematic patterns (Procedural Sequences)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to draw on knowledge of the CAT 'Multiple Self States Model'	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Reformulation and Engagement Phase: Engaging the client to reach a shared reformulation:																				
Ability to set up the therapy, to plan and agree the contract for CAT	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to engage the client in the process of reformulation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to recognise and contain unmanageable feelings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to work with ethnic, social and cultural diversity	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability use CAT-specific tools	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to Reformulate and produce a CAT Reformulation: Target Problems & Target Problem Procedures list; Narrative ("Prose Letter"); Diagram ("Map")	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Agreeing target problems	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Constructing target problem procedures (TPPs or “key issues”)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Narrative Reformulation (‘Prose Letter’)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Constructing the Sequential Diagrammatic Reformulation (SDR) (or ‘Map’)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recognition and Revision phase: Knowledge of Working at Change in CAT:																				
Recognition and the observing self	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Revision	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to formulate Exits	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to use techniques and methods within the CAT reformulatory framework	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to use the therapeutic relationship to work with enactments	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to sustain and consolidate positive change	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to monitor positive change (recognition and revision)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Working with time limited nature of CAT in the Recognition and Revision phase:																				
Ability to use CAT skills to manage the ending of therapy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to produce and use goodbye letters and follow-up	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to work with other organisations and systems involved in the client’s care	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Ability to manage the risk of therapy causing harm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)																				
CAT specific Metacompetences																				
Ability to judge the suitability of CAT for a referred client	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to integrate task and process to maintain the therapeutic alliance	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to estimate the client's zone of proximal development (ZPD)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Ability to manage the risk of therapy causing harm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
OTHER (please specify)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Appendix 17 Goals and Evaluation Form (Six_Month) *

* this is a provisional copy of a document under review with an external examiner, it may change once reviewed

Clinical Competence Goals and Evaluation Form (Six Month Placement)

Guidance Notes

This is a working document, initiated at the start of placement, revised at review points and completed at the end of the placement. It is shared with subsequent supervisors after the placement is completed. The general placement outline should be sent to the relevant clinical tutor within two weeks of starting the placement and the goals should be ready for discussion at the contracting visit (about a month after the start of placement). The trainee's performance is evaluated at the end of part 1 and part 2 of each of the first two year-long placements, and at the middle of year three.

The purpose of this form is to:

- provide a broad overview of the placement plans (supervisors and trainee)
- develop placement goals based on the trainee's learning needs and the specific opportunities in that placement (supervisors and trainee)
- record evidence of achieved goals (supervisors after consultation with others who have been involved with the trainee's work, including other professionals and service users)
- give a rating for the trainee's performance in each of the nine core competence areas (supervisor responsibility) at each of the assessment periods.
- give an evaluation of the trainee's overall competence (supervisors)

- record strengths and future learning needs (supervisors and trainee)
- provide an opportunity to share reflections on the placement and supervision (supervisors and trainee).

The form is completed by trainee and both supervisors. Supervisors and trainees should exchange a draft version of the form to allow discussion and correction of any factual errors.

Sections of the Form

General Placement Outline

In this section the trainee and supervisors:

- specify broad aims for the placement linked to the type of placement and supervision opportunities available;
- outline how any issues requiring attention from previous placement evaluations (conditional pass/ fail) will be addressed;
- specify anticipated balance of time/work across the two main placement bases;
- record geographical locations, names of relevant teams/colleagues; note requirements and possibilities for any academic and research work linked with the placement;
- identify opportunities for inter-professional learning.

Goals and Evidence of Attainment

Within the first few weeks, trainee and supervisors discuss and identify, for each core competence area, the trainee's:

Specific Goals – clearly specified and flowing from the learning needs, taking into account the range of experiences available within the placement settings (these may be modified over time);

Evidence of Attainment – this is filled out by the supervisor(s) at times of review, and towards the end of the placement period, as particular goals are attained. Some of the evidence *must* be based on supervisors' own direct observation of trainees' work in practice, *and* from direct client feedback.

Evidence may be coded as follows:

DO	Direct Observation
IO	Indirect Observation
ST	Supervision with Trainee
D/W Cl.	Discussion with Client
D/W Col.	Discussion with Colleagues

Supervisors may also wish to add comments.

Previous paperwork should be shown to any new supervisor to assist in the construction of the goals. This would apply whatever the grade, as learning needs would always apply from one placement to the next.

Supervisor Rating of the Core Competencies

At the end of each placement period the supervisors (after consultation with others and taking into account direct observation of the trainee's work, and feedback from colleagues and clients) rate the trainee's performance in each core competence area as "*above expected level*", "*at expected level*", "*below expected level*" or "*not applicable"*.

- "***Above expected level****"* indicates that the trainee's performance has generally exceeded the level expected of a trainee at that stage of training (and that learning needs are as expected at that stage);
- "***At expected level****"* indicates that the trainee's performance is generally at the level expected of a trainee at this stage of training (although there may be some learning needs that require attention during the next placement period);
- "***Below expected level***" indicates that, taking into account the stage of training, there are significant difficulties regarding this aspect of the trainee's development, which, unless they are urgently and successfully attended to in subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist.

- ***"Not applicable"*** indicates that there was no opportunity to develop and evaluate this aspect during this placement.

Please note that where a placement is conducted on 'long-thin' lines i.e. over the course of a year trainees may well not have completed their goals at six months. However, supervisors should still make a judgment as to whether their work should be rated 'above expected level, at expected level, below expected level and not applicable' based on their performance in that first six months.

Strengths and Future Learning Needs

Supervisors' comments on the trainee's particular strengths and weaknesses will be used as guidance for planning future placements and continuing professional development.

Supervisor Reflection

Supervisors reflect on their impressions of the trainee, their own experience of having him or her for the placement period, including their experience of offering supervision.

The supervisor identifies formal learning needs, which the clinical tutor and trainee will carry forward to the next placement period.

Trainee Identification of Own Learning Needs & Reflections on Placement

Trainees record their own judgements about their strengths and leaning needs – which may be different or complementary to those of their supervisors. They also reflect on their own performance on the placement period, their experience of being on placement, including reflections on their experience of supervision.

Supervisor Evaluation of Trainee's Overall Competence

At the end of each placement period the lead supervisor makes a recommendation as to whether the overall trainee's competence has reached the level of pass, conditional pass, or fail. If *below expected level* are indicated on one or two competence levels, this would normally lead to a *conditional pass*. If *below expected level* are indicated on three or more competence levels, this would normally lead to *a fail.*

- *Pass* indicates that the trainee has exceeded or reached the overall competence of a trainee at this stage of training, and that learning needs are at the level expected. In other word, that the supervisor judges that trainee's performance is at least "good enough" for this stage of training.

- *Conditional Pass* indicates that the trainee has reached the overall competence of a trainee at this stage of training, but there are one or two competencies that require particular attention in the next placement period and must be identified in the next stage of goal setting. These competencies will be given particular attention in the subsequent placement and will have to be graded at the "expected level for training" to pass the placement. A late submission of paperwork will automatically be marked as a conditional pass as this is considered a professional issue.

- *Fail* indicates that the trainee has not reached the overall level of competence expected for a trainee at this stage of training. There are significant concerns in three or more competence area(s), which, unless they are urgently and successfully attended to through an action plan for subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist. (NB if the trainee is failed again on any subsequent placement period they would normally fail the programme.) In other words, that the supervisor judges that the trainee's performance is not "good-enough" for the stage of training and that unless the concerns are attended to and the trainee reaches a "good enough" level at all further stages of training that they should not qualify as a clinical psychologist. The clinical tutor will need to be involved to make an action plan to be carried forward to the next placement period if trainee is failed on this evaluation. *Fail* could also indicate that following due investigation the trainee has been found to have engaged in serious professional misconduct. (This normally means that the trainee fails the programme).

Two grades are given with a placement, one for the portfolio and one for the goals but this would make only one overall grade. Also, gaining one fail in either category of portfolio or goals, would give an overall Fail grading. A Fail for both goals and portfolio would still give one overall Fail on clinical placement, not two.

Trainees must be given sufficient warning and time, as well as supervisory support and advice, to improve their performance if supervisors feel that there may be significant concerns in any competence area. If concerns persist, such that the trainee may be at risk of being failed for their competencies on placement, the supervisor must raise these concerns at a placement visit, with the clinical tutor and the trainee. An action plan to address concerns will be put in place: this will specify what the trainee needs to do, and what support will be needed.

If there is disagreement between supervisors about their ratings and evaluation of the trainee's competence, the clinical tutor and if necessary the clinical director will facilitate discussions and assist in making recommendations and future plans. Where necessary and in the case of a fail, the external examiner's opinion and judgement will be sought. The final decision rests with the Examination Board.

Core Competence Areas

These are based on the BPS Standards for Doctoral programmes in Clinical Psychology (2014) HCPC Standards of Education and Guidance, HCPC Standards of Proficiency and the HCPC Standards of Conduct, Performance and Ethics.

1. Relationships

The competency focuses on developing and maintaining effective working alliances with clients, carers, supervisors, colleagues and other relevant stakeholders.

with clients and families – shows readiness to listen, empathy, compassion, sensitivity and respect; handles difficulties constructively; sensitive to clients' goals, values and aspirations; recognises and can work with any tensions created by conflicts of interest, prepares for endings in a thoughtful and timely way, with consideration of their on-going needs

with services – gets on well with other staff; communicates effectively; shows respect for, and understanding of, other professionals' knowledge and roles. Recognises the importance of a client(s) wider networks and resources and where appropriate forges necessary links

overall – can reflect on relationships, using supervision to do so as appropriate; works in a way that is empowering for others, respects diversity and challenges inequality

2. Psychological Assessment

Trainees must get informed consent to give treatment (HCPC). You must respect the confidentiality of service users (HCPC)

interview skills – establishes constructive atmosphere, clarifies purpose and collaboratively sets goals, communicates effectively taking into account client's communication needs, clarifies and communicates own and others roles

addresses biological, psychological and social processes in assessment and formulation

assesses clients' strengths, aspirations and values and takes these into account in the work

Ability to choose, *use and interpret a broad range of assessment methods* appropriate: to the client and service delivery system in which the assessment takes place; and to the type of intervention which is likely to be required.

Can *choose, use and interpret a broad range of assessment methods* relevant to the client and to the service delivery systems, to include systematic interviews, formal testing, structured methods e.g. observation or gathering information from others)

Formal assessment – chooses most appropriate tests or measures; collaboratively explores the rationale for and consequences of testing, willing to take into account and learn from any errors in administration; derives and evaluates results appropriately; understands psychometric properties of tests used and draws realistic conclusions; reports findings appropriately taking into account any cultural limitations of assessment

Assessment procedures in which competence is demonstrated will include: performance based psychometric measures (e.g. of cognition and development); self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours); systematic interviewing procedures; other structured methods of assessment (e.g. observation, or gathering information from others); and assessment of social context and organisations.

Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, limitations etc.) and utilising this knowledge to aid assessment practices and interpretations thereof.

Knowledge of *theory and evidence* – draws on and critically evaluates relevant psychological knowledge, takes into account limitation of knowledge in complex real world settings

Can undertake appropriate risk assessment exploring safety and positive risk taking and guide work accordingly. Can recognise and work through any tensions arising from this assessment

Ability *to refer to another practitioner* as necessary.

3. Psychological Formulation

Using assessment to develop *formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors*.

Can construct formulations of presentations which may be informed by, but which are not premised on, formal diagnostic classification systems; developing formulation in an emergent transdiagnostic context.

Ability to construct formulations utilising theoretical frameworks with an integrative, multi-model, perspective as appropriate and adapted to circumstance and context.

Can develop a formulation through a *shared understanding of its personal meaning* with the client(s) and / or team in a way which helps the client better understand their experience.

Capacity to *develop a formulation collaboratively* with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.

Can making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.

Ability to ensure that formulations are expressed in *accessible language*, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.

Can use *formulations to guide appropriate interventions* if appropriate.

Ability to *reflect on and revise formulations* in the light of on-going feedback and intervention.

Leading on the *implementation of formulation in services and utilizing formulation to enhance teamwork, multi-professional communication and psychological mindedness in services*.

4. Psychological Intervention

On the basis of a formulation, *implementing psychological therapy* or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with: individuals, couples, families or groups, services / organisations

Understanding therapeutic techniques and processes as applied when working with a *range of different individuals in distress*, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating difficulties, psychosis, misuse of substances, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.

Ability to implement therapeutic interventions based on knowledge and practice in at least *two evidence-based models of formal psychological interventions*, of which one must be cognitive-behaviour therapy. Model specific therapeutic skills must be evidenced against a competence framework as described below, though these may be adapted to account for specific ages and presentations etc.

In addition, however, the *ability to utilise multi-model interventions*, as appropriate to the complexity and / or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals.

Knowledge of, and capacity to conduct interventions related to, secondary prevention and the promotion of health and well-being.

Conducting interventions in a way which *promotes recovery of personal and social functioning* as informed by service user values and goals.

Having an *awareness of the impact and relevance of psychopharmacological and other multidisciplinary interventions.*

Understanding *social approaches* to intervention; for example, those informed by community, critical, and social constructionist perspectives.

Implementing interventions and care plans through, and with, *other professions* and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.

Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and *communicating this sensitively* to clients and carers.

5. Psychological Evaluation and Research

Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values and goals and as informed by service user experiences as well as clinical indicators (such as behaviour change and change on standardised psychometric instruments).

Devising innovate evaluative procedures where appropriate.

Capacity to *utilise supervision* effectively to reflect upon personal effectiveness, shape and change personal and organisational practice including that information offered by outcomes monitoring.

Appreciating outcomes frameworks in wider use within national healthcare systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and creating synergy with personal evaluative strategies.

Critical appreciation of the strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.

Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.

Being a *critical and effective consumer, interpreter and disseminator of the research* evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

The capacity to *conduct service evaluation* and other research which is consistent with the values of both evidence based practice and practice based evidence.

Conducting research in respectful collaboration with others (e.g. service users, supervisors, other disciplines and collaborators, funders, community groups etc.) and *within the ethical and governance frameworks* of the Society, the Division, HCPC, universities and other statutory regulators as appropriate.

6. Generalisable Meta-competencies

Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to *facilitate adaptability and change* in individuals, groups, families, organisations and communities.

Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to *work effectively whilst holding in mind alternative, competing explanations*.

Generalising and synthesising prior knowledge and experience in order to *apply them critically and creatively in different settings and novel situations*.

Being *familiar with theoretical frameworks, the evidence base and practice guidance frameworks* such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision making without being formulaic in application.

Complementing evidence based practice with an ethos of practice based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.

Ability to *collaborate* with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.

Making *informed judgments on complex issues in specialist fields*, often in the absence of complete information.

Ability to *communicate psychologically-informed ideas* and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision making.

Ability to work effectively in *multi-disciplinary teams*, and to communicate properly and effectively with service users and other practitioners.

Exercising *personal responsibility and largely autonomous initiative in complex and unpredictable situations* in professional practice. Demonstrating self-awareness and sensitivity , and working as a reflective practitioner within ethical and professional practice frameworks.

7. Personal and Professional Skills and Values

Understanding of *ethical issues and applying these in complex clinical contexts*, ensuring that *informed consent* underpins all contact with clients and research participants.

Appreciating the inherent *power imbalance* between practitioners and clients and how abuse of this can be minimised.

Understanding the impact of *differences, diversity and social inequalities* on people's lives, and their implications for working practices.

Understanding the *impact of one's own value base* upon clinical practice.

Working effectively at an *appropriate level of autonomy*, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.

Capacity to adapt to, and *comply with, the policies and practices* of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.

Managing own personal *learning needs* and developing strategies for meeting these. Using *supervision* to reflect on practice, and making appropriate use of feedback received.

Developing *strategies to handle the emotional and physical impact of practice* and seeking appropriate support when necessary, with good awareness of boundary issues.

Developing *resilience* but also the capacity to recognize when *own fitness to practice* is compromised and take steps to manage this risk as appropriate.

Demonstrate an appropriate level of professional practice in accordance with HCPC Guidance on Conduct and Ethics for Students and BPS Code of Practice

Working *collaboratively and constructively* with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.

8. Communication and Teaching

Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).

Ability to write *accurate records* of clinical activity in accordance with the host trust / organisation's policies.

Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.

Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).

Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.

Understanding the process of *communicating effectively through interpreters* and having an awareness of the limitations thereof.

Supporting others' learning in the application of psychological skills, knowledge, practices and procedures. Trainees must effectively supervise tasks that they have asked people to carry out.

9. Organisational and Systemic Influence and Leadership

Awareness of the *legislative and national planning contexts* for service delivery and clinical practice.

Capacity to *adapt practice to different organisational contexts* for service delivery. This should include a variety of settings such as in-patient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.

Providing supervision at an appropriate level within own sphere of competence. *Understanding of the supervision process* for both supervisee and supervisor roles.

Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Bringing psychological influence to bear in the service delivery of others.

Understanding of *leadership theories and models*, and their application to service development and delivery. *Demonstrating leadership qualities* such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.

Consultancy – understands constancy models and can work with others to enable the integration of psychological ideas into practice to promote well-being and to help to prevent psychological distress while reflecting an individual's aspirations and values.

Please feel free to seek further guidance for the completion of the form from your clinical tutor or the clinical director.

Overview

-

Work with lead supervisor

-

Work with subsidiary supervisor

-

How will outstanding conditional pass/fail issues be addressed? (if relevant)

-

General Placement Outline

Core Competence Areas

Specific Goals	Evidence of Attainment
	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues
	1.

Supervisor Comments

Supervisor rating:	☐ Above expected level	☐ At expected level	☐ Below expected level	☐ Not applicable

1. Relationships

2. Psychological Assessment

Specific Goals	**Evidence of Attainment**
	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

3. Psychological Formulation

Specific Goals	**Evidence of Attainment** ☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

4. Psychological Intervention

Specific Goals	**Evidence of Attainment**
	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

5. Psychological Evaluation and Research

Specific Goals	**Evidence of Attainment** ☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

6. Generalisable Meta-competencies

Specific Goals	**Evidence of Attainment** ☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

7. Personal and Professional Skills and Values

Specific Goals	**Evidence of Attainment**
	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

8. Communication and Teaching

Specific Goals	**Evidence of Attainment** ☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues
1.	

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

9. Organisational and Systemic Influence and Leadership

Specific Goals	**Evidence of Attainment** ☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

Supervisor Reflections on Overall Placement

(Should include impressions of the trainee, supervisors' own experience of having him or her on placement period, comments on limitations or contextual factors within the placement, and reflections on own experiences of offering supervision.)

Supervisors Name:

Date:

Trainee Reflections on Overall Placement

Please include reflections on own performance during the placement, any factors which may have affected performance, experience of being on placement, and reflections and feedback to supervisor on supervision received.

Please specify the **key learning needs** that you would like to focus on in future placement(s): *(e.g. working with groups, offering supervision / training, formulating from a specific model etc*.)

Please complete the following:

	Could be improved	About right	Good
Induction (*meeting people, understanding organisation and its context, room booking system, and where to access policies.)*	☐	☐	☐
Information *(organisation, referral procedures, clinical documentation procedures (e.g. electronic notes) and local procedures)*	☐	☐	☐
Supervision arrangements *(sufficient amount, regular, reliable)*	☐	☐	☐
Supervision style *(available, approachable, supportive, facilitative of reflection and learning)*	☐	☐	☐
Theory/practice links *(directed to references, models explicit)*	☐	☐	☐
Clinical advice *(appropriate to level, flexible, alternative approaches)*	☐	☐	☐
Observation of Supervisor	☐	☐	☐
Supervisor Observation of me *(Direct, review of audio and/ or video material)*	☐	☐	☐
Feedback *(balanced, constructive, concrete, & supportive)*	☐	☐	☐
Mutuality *(sharing ideas and feelings)*	☐	☐	☐
From dependence to autonomy *(style adapted to trainee's level)*	☐	☐	☐
Clinical work balance *(over / under demanding, range, depth)*	☐	☐	☐
Physical resources *(desk space, computer access, test materials, clinical rooms)*	☐	☐	☐

Further comments on any of the above (we would like to hear more about anything that 'could be improved'):

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The NHS is committed to providing a culture of compassionate care that is based on six key values – the 6c's: care, compassion, competence, communication, courage and commitment. (*For more information see:* http://www.england.nhs.uk/wp-content/uploads/2013/12/MH6Cs.pdf *.)* Please share any comments that you may have of your experience of these values during your placement.

Appendix 18 Goals and Evaluation Form (Year_Long) *

* this is a provisional copy of a document under review with an external examiner, it may change once reviewed

Clinical Competence Goals and Evaluation Form (Year Long)

Guidance Notes

This is a working document, initiated at the start of placement, revised at review points and completed at the end of the placement. It is shared with subsequent supervisors after the placement is completed. The general placement outline should be sent to the relevant clinical tutor within two weeks of starting the placement and the goals should be ready for discussion at the contracting visit (about a month after the start of placement). The trainee's performance is evaluated at the end of part 1 and part 2 of each of the first two year-long placements, and at the middle of year three.

The purpose of this form is to:

- provide a broad overview of the placement plans (supervisors and trainee)
- develop placement goals based on the trainee's learning needs and the specific opportunities in that placement (supervisors and trainee)
- record evidence of achieved goals (supervisors after consultation with others who have been involved with the trainee's work, including other professionals and service users)
- give a rating for the trainee's performance in each of the nine core competence areas (supervisor responsibility) at each of the assessment periods.
- give an evaluation of the trainee's overall competence (supervisors)

- record strengths and future learning needs (supervisors and trainee)

- provide an opportunity to share reflections on the placement and supervision (supervisors and trainee).

The form is to be completed by trainee and both supervisors, at both submission points. Where the trainee has worked on one placement more than the other, it may be appropriate for the supervisor from that placement to sign off the paperwork with the expectation that the other supervisor (s) will complete it, or at least provide substantive comment, at the end of the year. If that is the case, please advise DClinPsy@exeter.ac.uk on submission.
Supervisors and trainees should exchange a draft version of the form to allow discussion and correction of any factual errors.

Sections of the Form

General Placement Outline

In this section the trainee and supervisors:

- specify broad aims for the placement linked to the type of placement and supervision opportunities available;
- outline how any issues requiring attention from previous placement evaluations (conditional pass/fail) will be addressed;
- specify anticipated balance of time/work across the two main placement bases;
- record geographical locations, names of relevant teams/colleagues; note requirements and possibilities for any academic and research work linked with the placement;
- identify opportunities for inter-professional learning.

Goals and Evidence of Attainment

Within the first few weeks, trainee and supervisors discuss and identify, for each core competence area, the trainee's:

Specific Goals – clearly specified and flowing from the learning needs, taking into account the range of experiences available within the placement settings (these may be modified over time);

Evidence of Attainment – this is filled out by the supervisor(s) at times of review, and towards the end of the placement period, as particular goals are attained. Some of the evidence *must* be based on supervisors' own direct observation of trainees' work in practice, *and* from direct client feedback.

Evidence may be coded as follows:

DO	Direct Observation
IO	Indirect Observation
ST	Supervision with Trainee
D/W Cl.	Discussion with Client
D/W Col.	Discussion with Colleagues

Supervisors may also wish to add comments.

Previous paperwork should be shown to any new supervisor to assist in the construction of the goals. This would apply whatever the grade, as learning needs would always apply from one placement to the next.

Supervisor Rating of the Core Competencies

At the end of each placement period the supervisors (after consultation with others and taking into account direct observation of the trainee's work, and feedback from colleagues and clients) rate the trainee's performance in each core competence area as "*above expected level*", "*at expected level*", "*below expected level*" or "*not applicable"*.

- "***Above expected level****"* indicates that the trainee's performance has generally exceeded the level expected of a trainee at that stage of training (and that learning needs are as expected at that stage);
- "***At expected level****"* indicates that the trainee's performance is generally at the level expected of a trainee at this stage of training (although there may be some learning needs that require attention during the next placement period);
- "***Below expected level***" indicates that, taking into account the stage of training, there are significant difficulties regarding this aspect of the trainee's development, which, unless they are urgently and successfully attended to in subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist.

- ***"Not applicable"*** indicates that there was no opportunity to develop and evaluate this aspect during this placement.

Please note that where a placement is conducted on 'long-thin' lines i.e. over the course of a year trainees may well not have completed their goals at six months. However supervisors should still make a judgment as to whether their work should be rated 'good/satisfactory/significant concerns' based on their performance in that first six months

Strengths and Future Learning Needs

Supervisors' comments on the trainee's particular strengths and weaknesses will be used as guidance for planning future placements and continuing professional development.

Supervisor Reflection

Supervisors reflect on their impressions of the trainee, their own experience of having him or her for the placement period, including their experience of offering supervision.

The supervisor identifies formal learning needs, which the clinical tutor and trainee will carry forward to the next placement period.

Trainee Identification of Own Learning Needs & Reflections on Placement

Trainees record their own judgements about their strengths and leaning needs – which may be different or complementary to those of their supervisors. They also reflect on their own performance on the placement period, their experience of being on placement, including reflections on their experience of supervision.

Supervisor Evaluation of Trainee's Overall Competence

At the end of each placement period the lead supervisor makes a recommendation as to whether the overall trainee's competence has reached the level of pass, conditional pass, or fail. If *below expected level* are indicated on one or two competence levels, this would normally lead to a *conditional pass*. If *below expected level* are indicated on three or more competence levels, this would normally lead to *a fail.*

- *Pass* indicates that the trainee has exceeded or reached the overall competence of a trainee at this stage of training, and that learning needs are at the level expected. In other word, that the supervisor judges that trainee's performance is at least "good enough" for this stage of training.

- *Conditional Pass* indicates that the trainee has reached the overall competence of a trainee at this stage of training, but there are one or two competencies that require particular attention in the next placement period and must be identified in the next stage of goal setting. These competencies will be given particular attention in the subsequent placement and will have to be graded at the "expected level for training" to pass the placement. A late submission of paperwork will automatically be marked as a conditional pass as this is considered a professional issue.

- *Fail* indicates that the trainee has not reached the overall level of competence expected for a trainee at this stage of training. There are significant concerns in three or more competence area(s), which, unless they are urgently and successfully attended to through an action plan for subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist. (NB if the trainee is failed again on any subsequent placement period they would normally fail the programme.) In other words, that the supervisor judges that the trainee's performance is not "good-enough" for the stage of training and that unless the concerns are attended to and the trainee reaches a "good enough" level at all further stages of training that they should not qualify as a clinical psychologist. The clinical tutor will need to be involved to make an action plan to be carried forward to the next placement period if trainee is failed on this evaluation. *Fail* could also indicate that following due investigation the trainee has been found to have engaged in serious professional misconduct. (This normally means that the trainee fails the programme).

Two grades are given with a placement, one for the portfolio and one for the goals but this would make only one overall grade. Also, gaining one fail in either category of portfolio or goals, would give an overall Fail grading. A Fail for both goals and portfolio would still give one overall Fail on clinical placement, not two.

Trainees must be given sufficient warning and time, as well as supervisory support and advice, to improve their performance if supervisors feel that there may be significant concerns in any competence area. If concerns persist, such that the trainee may be at risk of being referred for their competence on placement, the supervisor must raise these concerns at a placement visit, with the clinical tutor and the trainee. An action plan to address concerns will be put in place: this will specify what the trainee needs to do, and what support will be needed.

If there is disagreement between supervisors about their ratings and evaluation of the trainee's competence, the clinical tutor and if necessary the clinical director will broker discussions and assist in making recommendations and future plans. Where necessary, the external examiner's opinion and judgement will be sought. The final decision rests with the Examination Board.

Core Competence Areas

These are based on the BPS Standards for Doctoral programmes in Clinical Psychology (2014) HCPC Standards of Education and Guidance, HCPC Standards of Proficiency and the HCPC Standards of Conduct, Performance and Ethics.

Relationships

The competency focuses on developing and maintaining effective working alliances with clients, carers, supervisors, colleagues and other relevant stakeholders.

with clients and families – shows readiness to listen, empathy, compassion, sensitivity and respect; handles difficulties constructively; sensitive to clients' goals, values and aspirations; recognises and can work with any tensions created by conflicts of interest, prepares for endings in a thoughtful and timely way, with consideration of their on-going needs

with services – gets on well with other staff; communicates effectively; shows respect for, and understanding of, other professionals' knowledge and roles. Recognises the importance of a client(s) wider networks and resources and where appropriate forges necessary links

overall – can reflect on relationships, using supervision to do so as appropriate; works in a way that is empowering for others, respects diversity and challenges inequality

Psychological Assessment

Trainees must get informed consent to give treatment (HCPC). You must respect the confidentiality of service users (HCPC)

interview skills – establishes constructive atmosphere, clarifies purpose and collaboratively sets goals, communicates effectively taking into account client's communication needs, clarifies and communicates own and others roles

addresses biological, psychological and social processes in assessment and formulation

assesses clients' strengths, aspirations and values and takes these into account in the work

Ability to choose, *use and interpret a broad range of assessment methods* appropriate: to the client and service delivery system in which the assessment takes place; and to the type of intervention which is likely to be required.

Can *choose, use and interpret a broad range of assessment methods* relevant to the client and to the service delivery systems, to include systematic interviews, formal testing, structured methods e.g. observation or gathering information from others)

Formal assessment – chooses most appropriate tests or measures; collaboratively explores the rationale for and consequences of testing, willing to take into account and learn from any errors in administration; derives and evaluates results appropriately; understands psychometric properties of tests used and draws realistic conclusions; reports findings appropriately taking into account any cultural limitations of assessment

Assessment procedures in which competence is demonstrated will include: performance based psychometric measures (e.g. of cognition and development); self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours); systematic interviewing procedures; other structured methods of assessment (e.g. observation, or gathering information from others); and assessment of social context and organisations.

Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, limitations etc.) and utilising this knowledge to aid assessment practices and interpretations thereof.

Knowledge of *theory and evidence* – draws on and critically evaluates relevant psychological knowledge, takes into account limitation of knowledge in complex real world settings

Can undertake appropriate risk assessment exploring safety and positive risk taking and guide work accordingly. Can recognise and work through any tensions arising from this assessment

Ability *to refer to another practitioner* as necessary.

Psychological Formulation

Using assessment to develop *formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors*.

Can construct formulations of presentations which may be informed by, but which are not premised on, formal diagnostic classification systems; developing formulation in an emergent transdiagnostic context.

Ability to construct formulations utilising theoretical frameworks with an integrative, multi-model, perspective as appropriate and adapted to circumstance and context.

Can develop a formulation through a *shared understanding of its personal meaning* with the client(s) and / or team in a way which helps the client better understand their experience.

Capacity to *develop a formulation collaboratively* with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.

Can making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.

Ability to ensure that formulations are expressed in *accessible language*, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.

Can use *formulations to guide appropriate interventions* if appropriate.

Ability to *reflect on and revise formulations* in the light of on-going feedback and intervention.

Leading on the *implementation of formulation in services and utilizing formulation to enhance teamwork, multi-professional communication and psychological mindedness in services*.

Psychological Intervention

On the basis of a formulation, *implementing psychological therapy* or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with: individuals, couples, families or groups, services / organisations

Understanding therapeutic techniques and processes as applied when working with a *range of different individuals in distress*, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating difficulties, psychosis, misuse of substances, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.

Ability to implement therapeutic interventions based on knowledge and practice in at least *two evidence-based models of formal psychological interventions*, of which one must be cognitive-behaviour therapy. Model specific therapeutic skills must be evidenced against a competence framework as described below, though these may be adapted to account for specific ages and presentations etc.

In addition, however, the *ability to utilise multi-model interventions*, as appropriate to the complexity and / or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals.

Knowledge of, and capacity to conduct interventions related to, secondary prevention and the promotion of health and well-being.

Conducting interventions in a way which *promotes recovery of personal and social functioning* as informed by service user values and goals.

Having an *awareness of the impact and relevance of psychopharmacological and other multidisciplinary interventions.*

Understanding *social approaches* to intervention; for example, those informed by community, critical, and social constructionist perspectives.

Implementing interventions and care plans through, and with, *other professions* and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.

Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and *communicating this sensitively* to clients and carers.

Psychological Evaluation and Research

Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values and goals and as informed by service user experiences as well as clinical indicators (such as behaviour change and change on standardised psychometric instruments).

Devising innovate evaluative procedures where appropriate.

Capacity to *utilise supervision* effectively to reflect upon personal effectiveness, shape and change personal and organisational practice including that information offered by outcomes monitoring.

Appreciating outcomes frameworks in wider use within national healthcare systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and creating synergy with personal evaluative strategies.

Critical appreciation of the strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.

Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.

Being a *critical and effective consumer, interpreter and disseminator of the research* evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

The capacity to *conduct service evaluation* and other research which is consistent with the values of both evidence based practice and practice based evidence.

Conducting research in respectful collaboration with others (e.g. service users, supervisors, other disciplines and collaborators, funders, community groups etc.) and *within the ethical and governance frameworks* of the Society, the Division, HCPC, universities and other statutory regulators as appropriate.

Generalisable Meta-competencies

Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to *facilitate adaptability and change* in individuals, groups, families, organisations and communities.

Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to *work effectively whilst holding in mind alternative, competing explanations*.

Generalising and synthesising prior knowledge and experience in order to *apply them critically and creatively in different settings and novel situations*.

Being *familiar with theoretical frameworks, the evidence base and practice guidance frameworks* such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision making without being formulaic in application.

Complementing evidence based practice with an ethos of practice based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.

Ability to *collaborate* with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.

Making *informed judgments on complex issues in specialist fields*, often in the absence of complete information.

Ability to *communicate psychologically-informed ideas* and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision making.

Ability to work effectively in *multi-disciplinary teams*, and to communicate properly and effectively with service users and other practitioners.

Exercising *personal responsibility and largely autonomous initiative in complex and unpredictable situations* in professional practice. Demonstrating self-awareness and sensitivity , and working as a reflective practitioner within ethical and professional practice frameworks.

Personal and Professional Skills and Values

Understanding of *ethical issues and applying these in complex clinical contexts*, ensuring that *informed consent* underpins all contact with clients and research participants.

Appreciating the inherent *power imbalance* between practitioners and clients and how abuse of this can be minimised.

Understanding the impact of *differences, diversity and social inequalities* on people's lives, and their implications for working practices.

Understanding the *impact of one's own value base* upon clinical practice.

Working effectively at an *appropriate level of autonomy*, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.

Capacity to adapt to, and *comply with, the policies and practices* of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.

Managing own personal *learning needs* and developing strategies for meeting these. Using *supervision* to reflect on practice, and making appropriate use of feedback received.

Developing *strategies to handle the emotional and physical impact of practice* and seeking appropriate support when necessary, with good awareness of boundary issues.

Developing *resilience* but also the capacity to recognize when *own fitness to practice* is compromised and take steps to manage this risk as appropriate.

Demonstrate an appropriate level of professional practice in accordance with HCPC Guidance on Conduct and Ethics for Students and BPS Code of Practice

Working *collaboratively and constructively* with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.

Communication and Teaching

Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).

Ability to write *accurate records* of clinical activity in accordance with the host trust / organisation's policies.

Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.

Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).

Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.

Understanding the process of *communicating effectively through interpreters* and having an awareness of the limitations thereof.

Supporting others' learning in the application of psychological skills, knowledge, practices and procedures. Trainees must effectively supervise tasks that they have asked people to carry out.

Organisational and Systemic Influence and Leadership

Awareness of the *legislative and national planning contexts* for service delivery and clinical practice.

Capacity to *adapt practice to different organisational contexts* for service delivery. This should include a variety of settings such as in-patient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.

Providing supervision at an appropriate level within own sphere of competence. *Understanding of the supervision process* for both supervisee and supervisor roles.

Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Bringing psychological influence to bear in the service delivery of others.

Understanding of *leadership theories and models*, and their application to service development and delivery. *Demonstrating leadership qualities* such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.

C*onsultancy* – understands constancy models and can work with others to enable the integration of psychological ideas into practice to promote well-being and to help to prevent psychological distress while reflecting an individual's aspirations and values

Please feel free to seek further guidance for the completion of the form from the relevant clinical tutor or the clinical director.

General Placement Outline

Overview

-

Work with lead supervisor

-

Work with subsidiary supervisor

-

How will outstanding conditional pass/ fail issues be addressed? (if relevant)

-

Core Competence Areas

1. Relationships

Specific Goals Placement 1	**Evidence of Attainment Placement 1**
2.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 3.

Specific Goals Placement 2	**Evidence of Attainment Placement 2**
4.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 5.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

2. Psychological Assessment

Specific Goals Placement 1	Evidence of Attainment Placement 1
6.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues
7.	

Specific Goals Placement 2	Evidence of Attainment Placement 2
8.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues
9.	

Supervisor Comments

Supervisor rating:				
	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

3. Psychological Formulation

Specific Goals Placement 1	**Evidence of Attainment Placement 1**
10.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Specific Goals Placement 2	**Evidence of Attainment Placement 2**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

4. Psychological Intervention

Specific Goals **Placement 1**	**Evidence of Attainment** **Placement 1**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Specific Goals **Placement 2**	**Evidence of Attainment** **Placement 2**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

5. Psychological Evaluation and Research

Specific Goals Placement 1	**Evidence of Attainment Placement 1**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Specific Goals Placement 2	**Evidence of Attainment Placement 2**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

6. Generalisable Meta-competencies

Specific Goals Placement 1	**Evidence of Attainment Placement 1**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Specific Goals Placement 2	**Evidence of Attainment Placement 2**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

7. Personal and Professional Skills and Values

Specific Goals Placement 1	**Evidence of Attainment Placement 1**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Specific Goals Placement 2	**Evidence of Attainment Placement 2**
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

8. Communication and Teaching

Specific Goals Placement 1	Evidence of Attainment Placement 1
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Specific Goals Placement 2	Evidence of Attainment Placement 2
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ Above expected level	☐ At expected level	☐ Below expected level	☐ Not applicable

9. Organisational and Systemic Influence and Leadership

Specific Goals Placement 1	Evidence of Attainment Placement 1
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Specific Goals Placement 2	Evidence of Attainment Placement 2
1.	☐ Direct observation ☐ Indirect observation ☐ Supervision with trainee ☐ Discussion with client ☐ Discussion with colleagues 1.

Supervisor Comments

Supervisor rating:	☐ Above expected level	☐ At expected level	☐ Below expected level	☐ Not applicable

Supervisor Reflections on Overall Placement

(Should include impressions of the trainee, supervisors' own experience of having him or her on placement period, comments on limitations or contextual factors within the placement, and reflections on own experiences of offering supervision.)

Supervisors Name:

Date:

Trainee Reflections on Overall Placement

Please include reflections on own performance during the placement, any factors which may have affected performance, experience of being on placement, and reflections and feedback to supervisor on supervision received.

Please specify the **key learning needs** that you would like to focus on in future placement(s): *(e.g. working with groups, offering supervision / training, formulating from a specific model etc*.)

Please complete the following:

	Could be improved	About right	Good
Induction (*meeting people, understanding organisation and its context, room booking system, and where to access policies.)*	☐	☐	☐
Information *(organisation, referral procedures, clinical documentation procedures (e.g. electronic notes) and local procedures)*	☐	☐	☐
Supervision arrangements *(sufficient amount, regular, reliable)*	☐	☐	☐
Supervision style *(available, approachable, supportive, facilitative of reflection and learning)*	☐	☐	☐
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Clinical work balance *(over / under demanding, range, depth)*	☐	☐	☐
Physical resources *(desk space, computer access, test materials, clinical rooms)*	☐	☐	☐

Further comments on any of the above (we would like to hear more about anything that 'could be improved'):

The NHS is committed to providing a culture of compassionate care that is based on six key values – the 6c's: care, compassion, competence, communication, courage and commitment. (*For more information see:* http://www.england.nhs.uk/wp-content/uploads/2013/12/MH6Cs.pdf *.)* Please share any comments that you may have of your experience of these values during your placement.

Appendix 19 Example- Goals and Evaluation Form *

* this is a provisional copy of a document under review with an external examiner, it may change once reviewed

Clinical Competence Goals and Evaluation Form (Six Month Placement)

Guidance Notes

This is a working document, initiated at the start of placement, revised at review points and completed at the end of the placement. It is shared with subsequent supervisors after the placement is completed. The general placement outline should be sent to the relevant clinical tutor within two weeks of starting the placement and the goals should be ready for discussion at the contracting visit (about a month after the start of placement). The trainee's performance is evaluated at the end of part 1 and part 2 of each of the first two year-long placements, and at the middle of year three.

The purpose of this form is to:

- provide a broad overview of the placement plans (supervisors and trainee)
- develop placement goals based on the trainee's learning needs and the specific opportunities in that placement (supervisors and trainee)
- record evidence of achieved goals (supervisors after consultation with others who have been involved with the trainee's work, including other professionals and service users)
- give a rating for the trainee's performance in each of the nine core competence areas (supervisor responsibility) at each of the assessment periods.
- give an evaluation of the trainee's overall competence (supervisors)

- record strengths and future learning needs (supervisors and trainee)
- provide an opportunity to share reflections on the placement and supervision (supervisors and trainee).

The form is completed by trainee and both supervisors. Supervisors and trainees should exchange a draft version of the form to allow discussion and correction of any factual errors.

Sections of the Form

General Placement Outline

In this section the trainee and supervisors:

- specify broad aims for the placement linked to the type of placement and supervision opportunities available;
- outline how any issues requiring attention from previous placement evaluations (conditional pass/ fail) will be addressed;
- specify anticipated balance of time/work across the two main placement bases;
- record geographical locations, names of relevant teams/colleagues; note requirements and possibilities for any academic and research work linked with the placement;
- identify opportunities for inter-professional learning.

Goals and Evidence of Attainment

Within the first few weeks, trainee and supervisors discuss and identify, for each core competence area, the trainee's:

Specific Goals – clearly specified and flowing from the learning needs, taking into account the range of experiences available within the placement settings (these may be modified over time);

Evidence of Attainment – this is filled out by the supervisor(s) at times of review, and towards the end of the placement period, as particular goals are attained. Some of the evidence *must* be based on supervisors' own direct observation of trainees' work in practice, *and* from direct client feedback.

Evidence may be coded as follows:

DO	Direct Observation
IO	Indirect Observation
ST	Supervision with Trainee
D/W Cl.	Discussion with Client
D/W Col.	Discussion with Colleagues

Supervisors may also wish to add comments.

Previous paperwork should be shown to any new supervisor to assist in the construction of the goals. This would apply whatever the grade, as learning needs would always apply from one placement to the next.

Supervisor Rating of the Core Competencies

At the end of each placement period the supervisors (after consultation with others and taking into account direct observation of the trainee's work, and feedback from colleagues and clients) rate the trainee's performance in each core competence area as "*above expected level*", "*at expected level*", "*below expected level*" or "*not applicable"*.

- "***Above expected level"*** indicates that the trainee's performance has generally exceeded the level expected of a trainee at that stage of training (and that learning needs are as expected at that stage);
- "***At expected level"*** indicates that the trainee's performance is generally at the level expected of a trainee at this stage of training (although there may be some learning needs that require attention during the next placement period);
- "***Below expected level***" indicates that, taking into account the stage of training, there are significant difficulties regarding this aspect of the trainee's development, which, unless they are urgently and successfully attended to in subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist.

- ***"Not applicable"*** indicates that there was no opportunity to develop and evaluate this aspect during this placement.

Please note that where a placement is conducted on 'long-thin' lines i.e. over the course of a year trainees may well not have completed their goals at six months. However, supervisors should still make a judgment as to whether their work should be rated 'above expected level, at expected level, below expected level and not applicable' based on their performance in that first six months.

Strengths and Future Learning Needs

Supervisors' comments on the trainee's particular strengths and weaknesses will be used as guidance for planning future placements and continuing professional development.

Supervisor Reflection

Supervisors reflect on their impressions of the trainee, their own experience of having him or her for the placement period, including their experience of offering supervision.

The supervisor identifies formal learning needs, which the clinical tutor and trainee will carry forward to the next placement period.

Trainee Identification of Own Learning Needs & Reflections on Placement

Trainees record their own judgements about their strengths and leaning needs – which may be different or complementary to those of their supervisors. They also reflect on their own performance on the placement period, their experience of being on placement, including reflections on their experience of supervision.

Supervisor Evaluation of Trainee's Overall Competence

At the end of each placement period the lead supervisor makes a recommendation as to whether the overall trainee's competence has reached the level of pass, conditional pass, or fail. If *below expected level* are indicated on one or two competence levels, this would normally lead to a *conditional pass*. If *below expected level* are indicated on three or more competence levels, this would normally lead to

a fail.

- *Pass* indicates that the trainee has exceeded or reached the overall competence of a trainee at this stage of training, and that learning needs are at the level expected. In other word, that the supervisor judges that trainee's performance is at least "good enough" for this stage of training.

- *Conditional Pass* indicates that the trainee has reached the overall competence of a trainee at this stage of training, but there are one or two competencies that require particular attention in the next placement period and must be identified in the next stage of goal setting. These competencies will be given particular attention in the subsequent placement and will have to be graded at the "expected level for training" to pass the placement. A late submission of paperwork will automatically be marked as a conditional pass as this is considered a professional issue.

- *Fail* indicates that the trainee has not reached the overall level of competence expected for a trainee at this stage of training. There are significant concerns in three or more competence area(s), which, unless they are urgently and successfully attended to through an action plan for subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist. (NB if the trainee is failed again on any subsequent placement period they would normally fail the programme.) In other words, that the supervisor judges that the trainee's performance is not "good-enough" for the stage of training and that unless the concerns are attended to and the trainee reaches a "good enough" level at all further stages of training that they should not qualify as a clinical psychologist. The clinical tutor will need to be involved to make an action plan to be carried forward to the next placement period if trainee is failed on this evaluation. *Fail* could also indicate that following due investigation the trainee has been found to have engaged in serious professional misconduct. (This normally means that the trainee fails the programme).

Two grades are given with a placement, one for the portfolio and one for the goals but this would make only one overall grade. Also, gaining one fail in either category of portfolio or goals, would give an overall Fail grading. A Fail for both goals and portfolio would still give one overall Fail on clinical placement, not two.

Trainees must be given sufficient warning and time, as well as supervisory support and advice, to improve their performance if supervisors feel that there may be significant concerns in any competence area. If concerns persist, such that the trainee may be at risk of being failed for their competencies on placement, the supervisor must raise these concerns at a placement visit, with the clinical tutor and the trainee. An action plan to address concerns will be put in place: this will specify what the trainee needs to do, and what support will be needed.

If there is disagreement between supervisors about their ratings and evaluation of the trainee's competence, the clinical tutor and if necessary the clinical director will facilitate discussions and assist in making recommendations and future plans. Where necessary and in the case of a fail, the external examiner's opinion and judgement will be sought. The final decision rests with the Examination Board.

Core Competence Areas

These are based on the BPS Standards for Doctoral programmes in Clinical Psychology (2014) HCPC Standards of Education and Guidance, HCPC Standards of Proficiency and the HCPC Standards of Conduct, Performance and Ethics.

Relationships

The competency focuses on developing and maintaining effective working alliances with clients, carers, supervisors, colleagues and other relevant stakeholders.

with clients and families – shows readiness to listen, empathy, compassion, sensitivity and respect; handles difficulties constructively; sensitive to clients' goals, values and aspirations; recognises and can work with any tensions created by conflicts of interest, prepares for endings in a thoughtful and timely way, with consideration of their on-going needs

with services – gets on well with other staff; communicates effectively; shows respect for, and understanding of, other professionals' knowledge and roles. Recognises the importance of a client(s) wider networks and resources and where appropriate forges necessary links

overall – can reflect on relationships, using supervision to do so as appropriate; works in a way that is empowering for others, respects diversity and challenges inequality

Psychological Assessment

Trainees must get informed consent to give treatment (HCPC). You must respect the confidentiality of service users (HCPC)

interview skills – establishes constructive atmosphere, clarifies purpose and collaboratively sets goals, communicates effectively taking into account client's communication needs, clarifies and communicates own and others roles

addresses biological, psychological and social processes in assessment and formulation

assesses clients' strengths, aspirations and values and takes these into account in the work

Ability to choose, *use and interpret a broad range of assessment methods* appropriate: to the client and service delivery system in which the assessment takes place; and to the type of intervention which is likely to be required.

Can *choose, use and interpret a broad range of assessment methods* relevant to the client and to the service delivery systems, to include systematic interviews, formal testing, structured methods e.g. observation or gathering information from others)

Formal assessment – chooses most appropriate tests or measures; collaboratively explores the rationale for and consequences of testing, willing to take into account and learn from any errors in administration; derives and evaluates results appropriately; understands psychometric properties of tests used and draws realistic conclusions; reports findings appropriately taking into account any cultural limitations of assessment

Assessment procedures in which competence is demonstrated will include: performance based psychometric measures (e.g. of cognition and development); self and other informant reported psychometrics (e.g. of symptoms, thoughts, feelings, beliefs, behaviours); systematic interviewing procedures; other structured methods of assessment (e.g. observation, or gathering information from others); and assessment of social context and organisations.

Understanding of key elements of psychometric theory which have relevance to psychological assessment (e.g. effect sizes, reliable change scores, sources of error and bias, base rates, limitations etc.) and utilising this knowledge to aid assessment practices and interpretations thereof.

Knowledge of *theory and evidence* – draws on and critically evaluates relevant psychological knowledge, takes into account limitation of knowledge in complex real world settings

Can undertake appropriate risk assessment exploring safety and positive risk taking and guide work accordingly. Can recognise and work through any tensions arising from this assessment

Ability *to refer to another practitioner* as necessary.

Psychological Formulation

Using assessment to develop *formulations which are informed by theory and evidence about relevant individual, systemic, cultural and biological factors*.

Can construct formulations of presentations which may be informed by, but which are not premised on, formal diagnostic classification systems; developing formulation in an emergent transdiagnostic context.

Ability to construct formulations utilising theoretical frameworks with an integrative, multi-model, perspective as appropriate and adapted to circumstance and context.

Can develop a formulation through a *shared understanding of its personal meaning* with the client(s) and / or team in a way which helps the client better understand their experience.

Capacity to *develop a formulation collaboratively* with service users, carers, teams and services and being respectful of the client or team's feedback about what is accurate and helpful.

Can making justifiable choices about the format and complexity of the formulation that is presented or utilised as appropriate to a given situation.

Ability to ensure that formulations are expressed in *accessible language*, culturally sensitive, and non-discriminatory in terms of, for example, age, gender, disability and sexuality.

Can use *formulations to guide appropriate interventions* if appropriate.

Ability to *reflect on and revise formulations* in the light of on-going feedback and intervention.

Leading on the *implementation of formulation in services and utilizing formulation to enhance teamwork, multi-professional communication and psychological mindedness in services*.

Psychological Intervention

On the basis of a formulation, *implementing psychological therapy* or other interventions appropriate to the presenting problem and to the psychological and social circumstances of the client(s), and to do this in a collaborative manner with: individuals, couples, families or groups, services / organisations

Understanding therapeutic techniques and processes as applied when working with a *range of different individuals in distress*, such as those who experience difficulties related to: anxiety, mood, adjustment to adverse circumstances or life events, eating difficulties, psychosis, misuse of substances, physical health presentations and those with somatoform, psychosexual, developmental, personality, cognitive and neurological presentations.

Ability to implement therapeutic interventions based on knowledge and practice in at least *two evidence-based models of formal psychological interventions*, of which one must be cognitive-behaviour therapy. Model specific therapeutic skills must be evidenced against a competence framework as described below, though these may be adapted to account for specific ages and presentations etc.

In addition, however, the *ability to utilise multi-model interventions*, as appropriate to the complexity and / or co-morbidity of the presentation, the clinical and social context and service user opinions, values and goals.

Knowledge of, and capacity to conduct interventions related to, secondary prevention and the promotion of health and well-being.

Conducting interventions in a way which *promotes recovery of personal and social functioning* as informed by service user values and goals.

Having an *awareness of the impact and relevance of psychopharmacological and other multidisciplinary interventions.*

Understanding *social approaches* to intervention; for example, those informed by community, critical, and social constructionist perspectives.

Implementing interventions and care plans through, and with, *other professions* and/or with individuals who are formal (professional) carers for a client, or who care for a client by virtue of family or partnership arrangements.

Recognising when (further) intervention is inappropriate, or unlikely to be helpful, and *communicating this sensitively* to clients and carers.

Psychological Evaluation and Research

Evaluating practice through the monitoring of processes and outcomes, across multiple dimensions of functioning, in relation to recovery, values and goals and as informed by service user experiences as well as clinical indicators (such as behaviour change and change on standardised psychometric instruments).

Devising innovate evaluative procedures where appropriate.

Capacity to *utilise supervision* effectively to reflect upon personal effectiveness, shape and change personal and organisational practice including that information offered by outcomes monitoring.

Appreciating outcomes frameworks in wider use within national healthcare systems, the evidence base and theories of outcomes monitoring (e.g. as related to dimensions of accessibility, acceptability, clinical effectiveness and efficacy) and creating synergy with personal evaluative strategies.

Critical appreciation of the strengths and limitations of different evaluative strategies, including psychometric theory and knowledge related to indices of change.

Capacity to evaluate processes and outcomes at the organisational and systemic levels as well as the individual level.

Being a *critical and effective consumer, interpreter and disseminator of the research* evidence base relevant to clinical psychology practice and that of psychological services and interventions more widely. Utilising such research to influence and inform the practice of self and others.

The capacity to *conduct service evaluation* and other research which is consistent with the values of both evidence based practice and practice based evidence.

Conducting research in respectful collaboration with others (e.g. service users, supervisors, other disciplines and collaborators, funders, community groups etc.) and *within the ethical and governance frameworks* of the Society, the Division, HCPC, universities and other statutory regulators as appropriate.

Generalisable Meta-competencies

Drawing on psychological knowledge of developmental, social and neuropsychological processes across the lifespan to *facilitate adaptability and change* in individuals, groups, families, organisations and communities.

Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems. Ability to *work effectively whilst holding in mind alternative, competing explanations*.

Generalising and synthesising prior knowledge and experience in order to *apply them critically and creatively in different settings and novel situations*.

Being *familiar with theoretical frameworks, the evidence base and practice guidance frameworks* such as NICE and SIGN, and having the capacity to critically utilise these in complex clinical decision making without being formulaic in application.

Complementing evidence based practice with an ethos of practice based evidence where processes, outcomes, progress and needs are critically and reflectively evaluated.

Ability to *collaborate* with service users and carers, and other relevant stakeholders, in advancing psychological initiatives such as interventions and research.

Making *informed judgments on complex issues in specialist fields*, often in the absence of complete information.

Ability to *communicate psychologically-informed ideas* and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision making.

Ability to work effectively in *multi-disciplinary teams*, and to communicate properly and effectively with service users and other practitioners.

Exercising *personal responsibility and largely autonomous initiative in complex and unpredictable situations* in professional practice. Demonstrating self-awareness and sensitivity , and working as a reflective practitioner within ethical and professional practice frameworks.

Personal and Professional Skills and Values

Understanding of *ethical issues and applying these in complex clinical contexts*, ensuring that *informed consent* underpins all contact with clients and research participants.

Appreciating the inherent *power imbalance* between practitioners and clients and how abuse of this can be minimised.

Understanding the impact of *differences, diversity and social inequalities* on people's lives, and their implications for working practices.

Understanding the *impact of one's own value base* upon clinical practice.

Working effectively at an *appropriate level of autonomy*, with awareness of the limits of own competence and accepting accountability to relevant professional and service managers.

Capacity to adapt to, and *comply with, the policies and practices* of a host organisation with respect to time-keeping, record keeping, meeting deadlines, managing leave, health and safety and good working relations.

Managing own personal *learning needs* and developing strategies for meeting these. Using *supervision* to reflect on practice, and making appropriate use of feedback received.

Developing *strategies to handle the emotional and physical impact of practice* and seeking appropriate support when necessary, with good awareness of boundary issues.

Developing *resilience* but also the capacity to recognize when *own fitness to practice* is compromised and take steps to manage this risk as appropriate.

Demonstrate an appropriate level of professional practice in accordance with HCPC Guidance on Conduct and Ethics for Students and BPS Code of Practice

Working *collaboratively and constructively* with fellow psychologists and other colleagues and users of services, respecting diverse viewpoints.

Communication and Teaching

Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).

Ability to write *accurate records* of clinical activity in accordance with the host trust / organisation's policies.

Adapting style of communication to people with a wide range of levels of cognitive ability, sensory acuity and modes of communication.

Preparing and delivering teaching and training which takes into account the needs and goals of the participants (for example, by appropriate adaptations to methods and content).

Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence in formal settings.

Understanding the process of *communicating effectively through interpreters* and having an awareness of the limitations thereof.

Supporting others' learning in the application of psychological skills, knowledge, practices and procedures. Trainees must effectively supervise tasks that they have asked people to carry out.

Organisational and Systemic Influence and Leadership

Awareness of the *legislative and national planning contexts* for service delivery and clinical practice.

Capacity to *adapt practice to different organisational contexts* for service delivery. This should include a variety of settings such as in-patient and community, primary, secondary and tertiary care and may include work with providers outside of the NHS.

Providing supervision at an appropriate level within own sphere of competence. *Understanding of the supervision process* for both supervisee and supervisor roles.

Indirect influence of service delivery including through consultancy, training and working effectively in multidisciplinary and cross-professional teams. Bringing psychological influence to bear in the service delivery of others.

Understanding of *leadership theories and models*, and their application to service development and delivery. *Demonstrating leadership qualities* such as being aware of and working with interpersonal processes, proactivity, influencing the psychological mindedness of teams and organisations, contributing to and fostering collaborative working practices within teams.

Consultancy – understands constancy models and can work with others to enable the integration of psychological ideas into practice to promote well-being and to help to prevent psychological distress while reflecting an individual's aspirations and values.

Please feel free to seek further guidance for the completion of the form from your clinical tutor or the clinical director.

General Placement Outline

Overview

- As a Paediatric Service I will have the opportunity to experience how Psychology Services are offered in a health setting. Within the Paediatric department I will experience how Psychologists work at a range of levels (direct, indirect, consultation, teaching) and with a range of stakeholders (children, families, teams, social care, school/education).
- As part of the placement I will have an opportunity to learn about the experience of living with chronic childhood experience (Diabetes, cancer, CF, chronic allergies) which carry a risk to life. I will have the opportunity to learn how this condition might affect childrne and their families and the support that is needed from the systems around them, as well as how it affects the teams delivering their care and how this influences their approach to treatment and team-working.
- Finally, I will have an opportunity to see how Psychological services are organised, structured and led within a health environment when very limited time is allocated to a range teams; the challenges that this poses in terms of stablishing successful partnerships with teams, while delivering services a range of levels; and the impact that this has on psychologist working in such settings when they are a minority within the system.

Work with lead supervisor

-

Work with subsidiary supervisor

-

How will outstanding conditional pass/ fail issues be addressed? (if relevant)

- Open discussion about concerns regarding trainees performance will be discussed in supervision and a clear action plan will be set up to ensure that goals can be achieved.

Core Competence Areas
1. Relationships

Specific Goals	Evidence of Attainment
2. Spends some time with children, young people (CYP) with health conditions and their families. 3. Has a relationship with MDT Diabetes, CF and oncology team. 4. Has a relationship with Psychology team (attends psychology meetings, away days,…) and wider health psychology structures. 5. Understands the different roles in the Pediatric Diabetes, Oncology and CF team and their contribution to holistic and integrated care. 6. Observes different professionals working with children and young people with chronic conditions (Psychology, Nurse, Sergent Clic, play specialist/therapist, doctors) 7. Co-works with members of the team. 8. Carries out pieces of work under the supervision and in consultation with key members of the MDT team. 9. Calls on others expertise and access consultation when needed. 10. Understands who are the external agencies/key stakeholders that interact with the service/team.	☒Direct observation ☒Indirect observation ☒Supervision with trainee ☒Discussion with client ☒Discussion with colleagues 11. Attended MDT clinics for diabetes, oncology and Cystic Fibrosis (CF), participated in group work with CYP which allowed me get to understand their situation in regards to their health conditions. 12. Attended MDT Diabetes meeting month and weekly and observe their MDT performance, reflecting about members contribution and role and found ways to contribute to clinics from a psychological perspective. 13. Attended and observed the MDT Diabetes clinics led by a range of Consultant Pediatrician and reflected on roles and responsibilities of different professionals. I also tried to contribute where possible with a psychological perspective. 14. Met individually with members of the diabetes team to understand their role and different aspects of the condition (consultants, nurse specialist, ward liaison diabetes nurse, dietitian). 15. Attend the MDT weekly oncology meeting and observe their MDT performance reflecting about each members contribution and role. 16. Attended the oncology clinic led by Consultant Pediatrician. 17. Met with Oncology team staff to understand their roles (play therapist, play specialist, Social worker, nurses,). 18. Attend the CF monthly clinic let by Consultant Pediatrician. 19. Met with the CF team staff to understand their role and different aspects of the condition (respiratory nurse, dietitian).

20. Attend the CF monthly clinic let by Consultant Pediatrician.
21. Spend time with children and families living with cancer, diabetes, CF while attending the clinic and gain insight into the challenges associated with living with this condition and the strategies that families and cyp activate to develop resilience.
22. Accessed consultation from Dietitian to inform clinical work about one case.
23. Contributed to diabetes/oncology clinics as appropriate providing psychological information and views.
24. Worked jointly with nurses in transition meetings with school for one of the clients I was offering individual therapy.
25. Increased my awareness of the relevant stakeholders in the life of the children and their families e.g. schools, ed psychology, charities, CAMHS, CEDS, and have taken action to discuss with them their role where possible e.g. Educational Psychology, with limited success.
26.

Supervisor Comments

XXX has consistently created excellent working relationships with colleagues across a number of teams with diverse and complex dynamics. Her thoughtful and considerate approach to building therapeutic relationships and skills in engagement have been evident across the board, and contributed to positive outcomes for her clients and teams. She has been sensitive to wider service dynamics and thoughtful about her responses to challenging situations. She has used the supervisory relationship appropriately for personal/professional issues as well as seeking support for clinical dilemmas. She has been a valued team member and used her considerable prior experience in working with children across multiple settings to contribute above and beyond her role of Trainee Clinical Psychologist - Thank you!

Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

2. Psychological Assessment

Specific Goals	Evidence of Attainment
27. Observes clinicians carry out assessments 28. Observes clinicians offering therapy 29. Gathers consent and explain confidentiality adapting to different age and stage 30. Experience of reporting assesssments 31. Assesses and records risk appropriately in clinical notes 32. Carries out risk assessments in a methodical way to ensure safety and safeguarding are adequately addressed. 33. Uses bespoke scaling measures to capture psycological estates or/and change. 34. Consider the use of ROM as part of the clinical assessment in Paediatric Psychology services. 35. Carries out observation/assessment of team functioning and MDT working and relationship with Psychology services.	☒Direct observation ☒Indirect observation ☒Supervision with trainee ☒Discussion with client ☒Discussion with colleagues 36. Observed assessments carried out by Clinical Supervisor - TG/MG 37. Experience of joint working with Clinical Psychologist at assessment phase - TG/GG/EM 38. Experience of leading on assesment - EM/GG 39. Experience of gathering consent and discuss confidentiality in an accessible way with cyp and their families in a verbal and written way. 40. Experience of assessing risk in a methodical way. Considers when to assess risk in the context of presentation, age/stage and condition. 41. Records risk on clinical notes and raises risk with supervisors as appropriately ad hoc/supervision depending on severity/immediacy of risk formulation. 42. Considered risk and safeguarding of clients at well as other vulnerable individuals living in their systems. 43. Considered the safeguarding implications of non-adherence to treatment about specific cases in consultation. 44. Considered the safeguarding and risk implications of cases discussed in MDT consultation and meetings. 45. Use ROMs specific to Paediatric setting as well as CAMHS to draw a baseline of difficulties to track overtime therapeutic progress and performance. 46. Engaged in team meetings, clinics and one to one discussion with members of the teams to assess understand their performance espcially in relation to accessing/understanding psychology.

47. Reflected with supervisor about the role of psychologist to promote and safeguard the wellbeing of the teams on going and specially during times of transition e.g. Diabetes.
48. Carried out observations of clinics observing specifically team dynamics and process and families reaction to these (Diabetes)

Supervisor Comments

XXX has shown skill in assessment with a range of clients with complex physical health conditions. She has been sensitive to the difference between CAMHS and Paediatric Settings and prioritised the assessment process accordingly, whilst drawing on her previous experiences appropriately. She has utilised appropriate standardised assessment tools and created shared and collaborative goals for therapeutic endeavours with clients. There has not been an opportunity for neuropsychological assessment as part of this placement.

Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

3. Psychological Formulation

Specific Goals	Evidence of Attainment
49. Formulates cases that she has observed being assessed or assessed herself 50. Formulates cases from a particular model 51. Carries collaborative formulation with clients, carers or staff. 52. Writes succinct formulation synthesis 53. Presents/communicates a formulation to other professionals (eg psychologist, MDT team) 54. Records formulations in clients paper records appropriately. 55. Formulates team functioning.	☒Direct observation ☒Indirect observation ☒Supervision with trainee ☒Discussion with client ☒Discussion with colleagues 56. Formulated cases in supervision and clinical notes. 57. Written succinct formulation of difficulties on clinical notes. 58. Discussed in supervision ways of introducing formulation in team meetings as a tool to increase holistic views of cyp living with chronic conditions. 59. Formulates difficulties with clients to gain a better undersntanding of their perpective and ground treatment. 60. Contributes to team meetings with a psychological formulation of how difficulties, clinicial presentations, or resistance in patients can be understood. 61. Formulates team functioning and dynamics in respect to psychology as a profession and psychological input.

Supervisor Comments

XXX has shown excellent skills in formulation, drawing upon multiple theoretical frameworks to build shared understandings of the multiple levels of impact that living with a chronic illness can have for the lives of young people and their families. She has been able to share complex formulations with the children and young people and families and teams in an accessible and comprehensive way, while holding in mind issues of difference, diversity and power. This has been especially relevant to the consultative role of paediatric psychology, where interventions may occur at service level, and must take into account existing hierachies and team dynamics.

Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

4. Psychological Intervention

Specific Goals	Evidence of Attainment
62. Participates in a number of pieces of work: individual and group work 63. Offers individual therapy 64. Builds an appropriate therapeutic relationship with clients 65. Develops personalised interventions and plans of care 66. Develops materials to support clients with their psychological intervention. 67. Carries out/contributes to a piece of narrative work e.g. Tree of Life 68. Co-facilitates group work/interventions with children and young people 69. Co-facilitates group work/interventions with families and carers. 70. Considers the role of 'patient participation and involvement' in supporting interventions with young people and their families. 71. Participates in a piece of systemic intervention 72. Reviews/reports on the progress of interventions 73. Gathers feedback on clients experiences of interventions 74. Reconsiders interventions when they are not working to understand barriers to progress. 75. Keeps clients at the centre of the psychological work. 76. Engages in peer consultation/supervision	☒Direct observation ☒Indirect observation ☒Supervision with trainee ☒Discussion with client ☒Discussion with colleagues 77. Carried out psychotherapy with 4 clients: 2 clients living with diabetes; 1 living with complex allergies; and 1 experiencing encopresis. 78. Reflected on the TR in supervision and process of recording clinical notes. Have reflected with clients on the therapeutic relationship. 79. Have built care plans for cases where multiple parallel pieces of work were necessary to ensure progress in all areas. 80. I have used techniques and resources that supported the therapeutic work of each case e.g. dilemmas, externalising techniques, use of metaphor, use of mythological tales, Winnicott's Squiggle. 81. Contributed to the overall programme for the year 6 to year 7 transition workshops for parents and families living with diabetes and also the programme/activities offered by the psychology team. 82. I co-facilitated group work with parents and parents and their children attending an information workshop on transition to secondary school and living with diabetes. 83. Accessed consultation from dietitian to support clinical intervention carried out with a yp. 84. I was not able to participate or contribute to Tree of Life work but was able to discuss in supervision and read about this work. 85. I have considered in supervision the potential role of buddies/mentoring for those young people living with diabetes that struggle with treatment fatigue and burnout. I have explored

	and considered where in the pathway this ideas could be explored with patients and how to build that network of support both for parents and young people. 86. I have used systemic thinking and techniques in all cases which it has been really interesting to practinsing systemically. 87. I have reviewed progress of cases in supervision and with clients. I have also used psychological scaling to assist clients see their progress and to track progress. Outcome measures have been used at points to illustrate this too. 88. I have collected feedback from patients about the interventions that have been more and least useful. 89. I have discussed in supervision when I have struggled to make progress with cases or when I have failed to put in practice an intervention or technique to explore the barriers to the work and in neccesary reconsider the intervention. 90. I have kept clients at the centre of the work by practicing from a relational approach where the relationship with the client is the principal aspect to influece change. To this end I have notice 'here and now' moments in therapy that have allowed me to explore the relatioship, defences, validate difficult expereinces and emotions. I have also taken opportutnity to get feedback from clients of what works for them to tailor interventions to their needs. 91. I have not managed to access/offer peers supervision with my DClinPsy fellow students. However I hope to be able to experience this on my next placement.

Supervisor Comments

XXX has drawn from multiple models during her work with the children and families referred to the paediatric psychology service. She has consistently established a strong therapeutic frame, and made informed choices in selecting approaptiate modes of intervention according to age and stage of developemnt and need of the clients. she has skillfully moved between modes in sessions according to her assessment of the clients needs (e.g. here and now vs agenda/plan for session) and has facilitated change in family systems through successfully engaging both child/YP and parents in her sessions. She has also reflected on the timing of interventions and recognised the need sometimes to phase therapeutic work, in order to reach the anticipated outcomes.

Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

5. Psychological Evaluation and Research

Specific Goals	Evidence of Attainment
92. Consider with clients, families and teams if intervention has helped. 93. Research, identify and tries out appropriate ROMs to track change. 94. Identify and explore areas of development in the service linked with research 95. Offer constructive feedback on resources developed by the team (eg systems, processes, leaflets…) 96. Considers processes to gather information about service in an efficient way to protect valuable psychology time. 97. Influence systems and processes in the service to improve the experience of professional and clients. 98. Reports monthly on clinical activity to inform service evaluation and development	☒Direct observation ☒Indirect observation ☒Supervision with trainee ☒Discussion with client ☒Discussion with colleagues 99. Collected feedback from supervisor and clients about interventions. 100. Compiled a database of ROMs suitable for Paediatric Psychology services. 101. Made suggestions about how to integrate ROMs in the care pathway to highlight the role and contribution of psychology, draw a baseline of difficulties for tirage and monitoring. 102. Tried out the use of ROMs that are also used in CAMHs to see how this could be made meaningful in this setting but also become useful if a referral to CAMHS was required in the future. 103. Investigated and developed systems to facilitate monthly monitoring of clinical activity. 104. Proposed the development of an SSRP project and developed a suitable proposal in collaboration with supervisor. Discussed with supervision areas that could be considered to be research to inform service planning and delivery. 105. Networked the service to research initiatives at the University of Exeter that could benefit the service strategy and patient care. 106. Provided data on clinical activity at the end of placement.

Supervisor Comments

XXX has been very helpful in developing opportunities for research/ and service evaluation. She has identified and accessed appropriate ROMS, helped to create a more robust database for recording clinical activity and proproased a number of possible SSRP/research projects which may benefit the service.

Supervisor rating:	**☒ Above expected level**	**☐ At expected level**	**☐ Below expected level**	**☐ Not applicable**

6. Generalisable Meta-competencies

Specific Goals	Evidence of Attainment
107. Practice from a person centred approach observing diversity from assessment. 108. Be reflective and critical in my practice 109. Be self aware in supervision 110. Reflect on the impact that the clinical work has on me. 111. Reflect on the impact that working relationships will have on me. 112. Openly discuss my areas for development and our relationship with my supervisor. 113. Develop autonomy by checking my plans with my supervisor and building confidence and skills.	☒Direct observation ☒Indirect observation ☒Supervision with trainee ☒Discussion with client ☒Discussion with colleagues 114. I have practiced from a person centred approach by developing insight into how clients understood their difficulties. I have also drawn on developmental psychology to understand clients understanding of difficulties from an age and stage perspective and to consider that other developmental tasks were clients facing in addition to their current treatment requirements e.g. moral development with teenagers that face the dilemma of making decisions about their health balancing quality of life and wellbeing and treatment adherence and burn out. 115. I have kept clients at the centre of the work by practicing from a relational approach where the relationship with the client is the principal aspect to influece change. To this end I have notice 'here and now' moments in therapy that have allowed me to explore the relatioship, defences, validate difficult expereinces and emotions. I have also taken opportutnity to get feedback from clients of what works for them to tailor interventions to their needs. 116. In terms of diversity, I have had to observe gender and age/stage differences. However, as a fluent speaker of french, a case where the family was french speaking, triggered some interested dillemmas regarding diversity, access to services, the function of the communicating in the mother tongue for families with more than one language and my standpoint as a multilingual clinician.

	117. I have reflectively extensively in supervision on my different roles as trainee clinical psychologist and previous roles to keep developing personally and professionally. I have brought to supervision elements of my practice that have prosed dilemmas. 118. I have had an oppportunity to reflect on the impact that working in this service has had in me due to my own experiences e.g. as a mother of younger children, my own struggles as a parent with potty training, my own process of bereavement. I have realised how essential is this aspect of the work to stay well and healthy to do the work. 119. I have discussed in supervision aspects of my practice that need further development e.g. being able to note and talk about process in supervision. 120. I have routinely shared my thoughts, plans an ideas in supervision with my supervisor.

Supervisor Comments

XXX has a wealth of generalisable skills and abilities which she has being honing in this setting. She has used supervision appropriately for clinical as well as personal/professional dilemmas. She has been reflective about issues of diversity and language with her clients and staff teams. She has been considerate in her approach to supporting staff teams and non-psychology colleagues and sensitively used her position as Trainee to reflect with curiosity anomalies of team functioning with a view to influencing the systems in a helpful direction. This has especially been in the context of team meetings where discussions are brief, time pressured and not all information is available, all the while remaining sensitive to complex team dynamics. She has worked hard to gain an appropriate level of understanding of relevant national guidance and impact of national networks on service structure and activities within paediatric diabetes.

Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

7. Personal and Professional Skills and Values

Specific Goals	Evidence of Attainment
121. Think holistically about clients' needs and is able to contemplate other systems when doing so. 122. Considers confidentiality when working clinically with clients/cases (triaging, discussing cases with other agencies, clinical notes, correspondence) 123. Consider consent to share information when working with clients and others in the client's networks (colleagues, family, other agencies) 124. Consider risks when working therapeutically or thinking about cases. 125. Consider capacity when working or thinking clinically about cases. 126. Show awareness and practices within the HCPC and BPS ethical guidelines. 127. Identify ethical dilemmas and activates strategies/resources to think through this.	☒Direct observation ☒Indirect observation ☒Supervision with trainee ☒Discussion with client ☒Discussion with colleagues 128. I have really enjoyed working from a person-centred perspective by also bringing in systemic thinking into our clinical thinking by reflecting not only on systems where clients are immersed (school, family, groups, CAMHS…) but also our service and teams as another system that has an impact on how we operate and relate with clients as well as how families and clients perceive us as professionals, disciplines, teams and services. 129. I have discussed in supervision issues about data governance and data protection in services as most information in on paper. Also, considered confidentiality when liaising with other agencies outside of health e.g. school. 130. I have discussed confidentiality and information sharing at the beginning of assessment meeting the needs of children and their families. I have used forms to collect consent from clients to write about their clinical work in CPRs. 131. Discussed in supervision the issue of capacity of children and young people e.g. choosing not to adhere to treatment, children too young to consent. 132. Discussed extensively in supervision and raised awaressnes about the ethical dilemmas bourne in indirect working with teams and leaders. 133. I have considered HCPC and BPS Ethical guidelines when faced with

	dilemmas about access to supervision and service delivery.

Supervisor Comments

XXX has been extremelly reflective and open to considering the personal/professional conflictwhich canarise when working in health care settings. She has recognised the need to priorities self care in order to sustain good working frames and the resilience to work in high pressure, fast paced environments when dealingwith potentially distressing clinical issues. She has sensitively considered how to negotiate boundaries of confidentiality between different stakeholders and how these may differ within a health setting compared to other therapeutic settings.

Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

8. Communication and Teaching

Specific Goals

134. Produces accessible information about diabetes for families and young people.
135. Reports findings from psychological assessment, formulation and intervention in clinical notes, reports, or letters.
136. Able to share verbally progress of clinical interventions in a sensitive way to clients, carer and other professionals
137. Communicates psychological information to other colleagues in a way that is useful and supportive.
138. Is able to produce reports and clinical notes that are appropriate for the intended audience
139. Able to report about reflective processes in therapy.
140. Is able to facilitate communication in groups
141. Offers training on specific topics to a supportive audience
142. Considers a range of teaching methods to facilitate the learning of the audience

Evidence of Attainment

☒ Direct observation

☒ Indirect observation

☒ Supervision with trainee

☐ Discussion with client

☒ Discussion with colleagues

143. I contributed to the production of an app (Handi app) that provides information about wellbeing and psychological impact of living with Type I Diabetes.
144. Produced detailed clinical progress notes and documented reflections on clinical process as part of routine clinical recording activity.
145. I reported weekly at clinical team meetings on clinical interventions and progress with clinical cases.
146. I have contributed to diabetes/oncology clinics with psychological information e.g. developmental trauma, attachment and mental health difficulties, learning and attachment, language, communication and relationship in yp with mild LD; challenging behaviour and parental anxiety; behavioural treatment of sleeping difficulties. Contributions were always well received and found to be useful/clarifying.
147. Contributed to the development of the programme for the 'year 6 to year 7 transition workshops' for parents and families living with diabetes and also the programme/activities offered by the psychology team. Contributed with ideas about activities and methodologies that facilitated the audience learning outcomes.
148. I co-facilitated group work with parents and parents and their children attending an information workshop on transition to secondary school and living with diabetes.
149. Contributed to training of Consultant Paeds and Junior doctors by offering personal

	reflections of my experience as a mother of a young child that required early surgery observing boundaries and with a clear teaching objective in mind. 150.

Supervisor Comments XXX has demonstrated highly developed skills in communication across a number of different domains. Her therapeutic communication skills have been born out in her relationships with clients of a range of ages and ability. Her session notes have been extremely clear and appropriately detailed. Her regular emails have helped to maintian good levels of coworking and service fluidity. She has been instrumental in developing and designing and delivering group work sessions, and has significantly contributed to the psychology section of an online application for supporting families living with diabetes in childhood . She has also contributed approapriately to clinical discussions - drawing from and articulating psychological understandings of behaviour and relationships for the benefit of the medical teams supporting the children. Her communications are clear and effective.				
Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

9. Organisational and Systemic Influence and Leadership

Specific Goals

151. Understands the leadership structure in the team/service
152. Understands how leadership is build through a range of activities
153. Contributes to thinking about the leadership of psychology within the MDT team through creative methodologies
154. Participates actively in meetings and is capable of holding a constructive attitude.
155. Reflects on dynamics that might be affecting relationships in the team or care offered to clients.
156. Observes team dynamics to identity relationship with psychology service.
157. Reflects about strategic systems and processes and service cutlure that can influence team performance in their understanding and delivery of psychological interventions.
158. Considers elements of referral pathway that can increase the team's awareness and value of psychology within the team.
159. Considers elements of intervention and evaluation that can increase the perceived value of psychology by team.
160. Considers other systems that are involved in the care of children living with chronic conditions.
161. Networks the service into other systems that can influence leadership and strategy.
162. Considers participation to inform service delivery.

Evidence of Attainment

☒ Direct observation

☒ Indirect observation

☒ Supervision with trainee

☐ Discussion with client

☒ Discussion with colleagues

163. I have spent some time with members of the team understanding their leadership structure and development plans.
164. Took part in service development strategic thinking.
165. Observed team meetings and clinics to understand their awareness, understanding and value of psychological services. I reflected with my supervisor in supervision about this experiences and suggested ways of influencing individuals and teams.
166. I participated in weekly meetings, observed and reflected where appropriate on the dynamics between the local team and other agencies that impacted team performance and patient care, always looking for proactive ways of working effective partnership working.
167. Reflected in supervision on how psychology/members of the psychology team are introduced to patients in clinic in a defensive fashion and the negative implication that accessing psychological services to patients; or when psychology trainee were requested to leave a clinic as there were 2 nurses and felt to have too many people in the room. We reflected about alternative ways of talking about psychology in clinics and ways of suggesting changes to the team; We also reflected about he hierarchies of professions in a medical team and the implications of asking the psychologist to leave (potentially perceived as the least relevant/necessary). Discussion were

interesting to reflect on teams' construction of psychological input in patient care and team work and the underlying culture of teams in relation to MDT working and psychology specifically.

168. Considered in supervision ideas for SSRPs investigating the contribution of psychology to teams to increase the positive outcomes of psychology to the team and influence team culture e.g. aspects of care pathway; wellbeing questionnaires routinely collected by diabetes…
169. I researched key charity organisation at national level (Diabetes uk; jfdr); educational psychology services in somerset; community psychology projects with families living with childhood diabetes (jets); local voluntary sector organisations that could support parents offering counselling (SCC).
170. As I trainee psychologist I networked the service to other teams and key individuals that could benefit the strategic leadership of the service e.g. CYP IAPT team, research collaborators, systemic peer group.
171. Discussed in supervision participation systems in place to allow young people with diabetes to influence the service. Discussed ways to set up particiation strategies as a driver for CYP IAPT. Researched funding streams to support this work without success.

Supervisor Comments

XXX has been extremely effective in supporting service development and in her observtions and reflections on the position and role of psychology across the different teams she has been working with. She has been proactive in sharing her knowledge and ideas regarding opportnities to influence and shape the service, whilst remaiing sensnitive to service constraints and resource limitations. She has been keen to share valuable service structure and process observations within supervision and has used her initiative to support these ideas practically day to day.

Supervisor rating:	☒ **Above expected level**	☐ **At expected level**	☐ **Below expected level**	☐ **Not applicable**

Supervisor Reflections on Overall Placement

(Should include impressions of the trainee, supervisors' own experience of having him or her on placement period, comments on limitations or contextual factors within the placement, and reflections on own experiences of offering supervision.)

XXX has more than fulfilled the core competency requirements in her training role within paediatrics. She has sensitively built good working relationships with colleagues across a number of teams with diverse dynamics and levels of complexity. She has worked clinically at a highly skilled level beyond the expectation that would be appropriate for someone at her stage of training. She has introduced appropriate standardised measures and service development strategies in a thoughtful and appropriate way. She has built excellent working relationships with her clients, and they have clearly benefitted from her support and reflective practice. She has used supervision appropriately, bringing clinical, personal/professional dilemmas when appropriate to do so. She has asked for direction when needed and used her own initiative at appropriate times and with good judgement.

Supervisors Name:

Date: 08/08/23

Trainee Reflections on Overall Placement

Please include reflections on own performance during the placement, any factors which may have affected performance, experience of being on placement, and reflections and feedback to supervisor on supervision received.

The Paediatric Psychology placement at Musgrove Park Hospital and Yeovil District Hospital has been a exceptional well-rounded experience. I have participated in the Diabetes, Oncology, Cystic Fibrosis and General Paediatric team. I feel incredibly privileged to have been able to be part of this service and to have been allowed to contribute in a diversity of roles and areas or work.

While I had previous extensive experience working with children and young people (CYP) in educational and mental health setting, this placement has allowed me to see how CYP experience the impact that living with chronic and life threatening conditions can have on their wellbeing and their families; as well as to consider the importance of engaging with other systems e.g. educational, mental health, social care, third sector… to offer a holistic response that can meet the needs of CYP and their families. This systemic approach is also essential when thinking about medical and psychological service delivery and MDT working within this health teams and this is often a challenging but crucial aspect of the role.

This placement has given me insight into the different roles that a clinical psychologist can take in a health setting but also the different levels at which they need to operate to make sure they can maximise their clinical impact. I have been able to carry out direct work with CYP and families on a one-to-one as well as a group setting; indirect working in team meetings offering consultation, or helping formulate difficulties affecting families; participation in MDT clinics where I have been able to offer some psychological consultation to professionals; I have been able to contribute to the develop of a training programme, participate in training delivery and produce psychoeducational materials to support families and young people living with diabetes; finally, I have been able to contribute to the strategic planning and leadership of the service by suggesting ways to introduce research, zone referrals to psychology, develop care pathways.

The relationship with my supervisor has been exceptional. She has supported me throughout the placement with high quality weekly supervision as well as ad hoc supervision when required. It has been always easy to access advice, resources and any support needed to fulfil my work. Her trust and value of my skills to undertake the tasks during placement has helped me develop confidence to perform in a health setting, where initially I felt out of my depth. She has offered consistently feedback about my performance in the placement making me belief I could achieve my goals. Also I have been able to work systemically and used some narrative and solution-focus approaches that I know will be valuable to my future clinical practice. My supervisor has offered me a range of opportunities to get involved and contribute to the service always checking if I

needed support or if the workload was appropriate with other university and life commitments. Her flexibility to accommodate my family commitments has also been very reassuring and helpful allowing me to speak up when things have been difficult at home. Being in Taunton for 2 days a week has contributed greatly to my wellbeing, too.

All teams have been wellcoming and I have had a good professional relationship with them. They have been very generous with their time and allowed me to observe their practice in clinic. In YDH I have been able to co-work more closely with nurses which has been a fantastic experience.

Finally, this experience in Paediatrics has helped me value how my previous experience and clinical skills are transferable to working in health settings and has motivated to consider this setting for my future professional activity.

Please specify the **key learning needs** that you would like to focus on in future placement(s): *(e.g. working with groups, offering supervision / training, formulating from a specific model etc*.)

In future placements I would benefit from:
- offering supervision and consultation
- carry out neuropsychological assessment and report writing
- working in specific therapeutic models such as CBT, psychodynamic, CAT (once we have received training)
- participate co-facilitating in group therapy or group work
- working with adults and older adults with moderate/severe and long-term mental health conditions - working in residential and inpatient.

Please complete the following:

	Could be improved	About right	Good
Induction (*meeting people, understanding organisation and its context, room booking system, and where to access policies.)*	☐	☒	☐
Information *(organisation, referral procedures, clinical documentation procedures (e.g. electronic notes) and local procedures)*	☐	☐	☒
Supervision arrangements *(sufficient amount, regular, reliable)*	☐	☐	☒
Supervision style *(available, approachable, supportive, facilitative of reflection and learning)*	☐	☐	☒
Theory/practice links *(directed to references, models explicit)*	☐	☐	☒
Clinical advice *(appropriate to level, flexible, alternative approaches)*	☐	☐	☒
Observation of Supervisor	☐	☐	☒
Supervisor Observation of me *(Direct, review of audio and/ or video material)*	☐	☐	☒
Feedback *(balanced, constructive, concrete, & supportive)*	☐	☐	☒
Mutuality *(sharing ideas and feelings)*	☐	☐	☒
From dependence to autonomy *(style adapted to trainee's level)*	☐	☐	☒
Clinical work balance *(over / under demanding, range, depth)*	☐	☐	☒
Physical resources *(desk space, computer access, test materials, clinical rooms)*	☐	☒	☐

Further comments on any of the above (we would like to hear more about anything that 'could be improved'):

.

The NHS is committed to providing a culture of compassionate care that is based on six key values – the 6c's: care, compassion, competence, communication, courage and commitment. (*For more information see:* http://www.england.nhs.uk/wp-content/uploads/2013/12/MH6Cs.pdf *.)* Please share any comments that you may have of your experience of these values during your placement.

Appendix 20 Developing Leadership Competencies on Placement *

* this is a provisional copy of a document under review with an external examiner, it may change once reviewed

Developing Leadership Competencies on Placement

During your clinical training, you will need to start describing your goals with leadership competencies in mind. In the new Goals and Evaluation form, there is a separate section on leadership competencies (e.g. see section 9: Organisational and Systemic Influence and Leadership), but you can consider including leadership competencies in many other goals and sections of the form as well. These goals should then be transferred into your Log of Clinical Activity and thus a comprehensive record of all your leadership experiences and competencies is established.

Here are just some non-exhaustive examples of how to apply a leadership approach to each section of the form. Some of these have been developed from my own clinical experience as a supervisor and tutor and others have been adapted from the BPS (2010) *Clinical Psychology Leadership Development Framewor*k and the Goals and Evaluation form.

Relationships

To gain knowledge and develop of other professional's ways of working and service users views and develop relationships.

To gain knowledge of important and influential local networks and develop

relationships (under supervision).

To regularly reflect on team dynamics during supervision and use this to develop and maintain effective working relationships with other team members as well as listening to other's perspectives.

To contribute to problem solving with colleagues by taking the lead on psychological aspects of care.

Helping and supporting both colleagues and clients to become more reflective.

Advocate a psychological stance in conjunction with or instead of other health care models even in difficult circumstances demonstrating values and ethics. Show strong engagement and conflict resolution skills.

Psychological Assessment:

To lead in supervision with identifying and selecting the appropriate assessment tools.

To identify in supervision when a specific assessment may not be appropriate and/or being mindful of the timeliness of the assessment.

To be observed by junior staff and/or non-psychologists when conducting interventions.

Psychological Formulation

To lead in developing the appropriate formulation and then choosing the appropriate method of sharing it with colleagues/clients/families.

To lead on the implementation of formulation in services and utilizing formulation to enhance teamwork, multi-professional communication and psychological mindedness in services.

To lead in developing integrative formulations using more than one therapeutic model.

To identify when it might be appropriate **not** to share specific issues within the formulation.

To lead on giving feedback on formulation to hostile teams/clients/familes.

Psychological Intervention

To lead on identifying an appropriate intervention based on the formulation.
To lead on identifying if, when and where the intervention should take place.
To be observed by junior staff and/or non-psychologists when conducting interventions.

Psychological Evaluation

To lead on deciding if, how and when to evaluate a clinical intervention.
To lead on deciding who should be made aware of the results and by which method.
To lead on deciding how the results might best be used to improve or influence service delivery.
To lead on the design, planning and marketing of a future potential small-scale research project for the service.

Generalisable Metacompetencies.

Generalising and synthesising prior knowledge and experience in order to lead on ways of applying it critically and creatively in different settings and novel situations.

Leading on the collaboration with, and identify who the relevant stakeholders are in order to advance psychological initiatives such as interventions and research.

Discuss with supervisor and lead on devising ways to facilitate access to psychological services.

Ability to communicate psychologically-informed ideas and conclusions to, and to work effectively with, other stakeholders, (specialist and non-specialist), in order to influence practice, facilitate problem solving and decision-making.

To design and write business plan with the aim of improving psychological services in your setting.

To co-present with supervisor the business plan to the local commissioners of services.

Personal and Professional Skills and Values

To lead on designing new ways of addressing diversity and cultural challenges within the service.

Encourage team reflection on current/innovative practice. Enhance the credibility of psychology in teams through engagement/conflict management and sharing stories of effective practice.

Communication and Teaching

To lead on the design, planning, marketing and delivery of a new or innovative educational initiative in collaboration with stakeholders and local training officers or commissioners.

To lead on the writing and submission of a relevant psychological paper to a journal.

Organisational and Systemic Influence and Leadership (These are self explanatory in the Goals form but some examples might include the following)

To collaborate with supervisor in any consultancy project that improves psychological well-being within the service or a wider setting and to lead on disseminating the findings/results.

To 'lone' supervise a junior or non-psychologist colleague/s using a contract and adopting an evaluative approach.

Appendix 21 Observation guidance

Observation guidance

Trainees benefit from observing their supervisors working with clients because of the obvious advantages they gain from seeing good clinical work being modelled by their supervisor. Trainees benefit from supervisor observation since structured debrief provides them with direct feedback on their clinical work. Members of the User Advisory Group have strongly recommended that all trainees must be regularly observed during training, with feedback in part based on observation of the personal and relationship factors that service users particularly value. It is therefore encourage that **observation by the trainee of the supervisor, and vice versa, is built in to all your placement goals.**

Strategies for observation and/or joint work should be negotiated by trainee and supervisor at the beginning of the placement and reviewed throughout.

Benefits of mutual observation

1. Supervisor present as a resource/knowledge base
2. Provides support while trainee gains confidence

3. Experience of working in co-therapy
4. Opportunity for supervisor to give direct feedback on trainee's clinical work - removes bias of self-report in supervision.
5. Supervisor can give positive feedback and constructive criticism on trainee's development.

Observation strategies

- Shared work with supervisor and trainee working as co-therapy team or within therapeutic team.
- Trainee as observer.
- Supervisor as observer (e.g. sitting in on a session, assessment or training)
- Observing through one-way monitor.
- Retrospective observation using video and/or audio recordings.
- Indirect access to supervisor's clinical work through case discussion of supervisor's own work. While this does not fall within the broad category of observation, it remains an important adjunct of it.

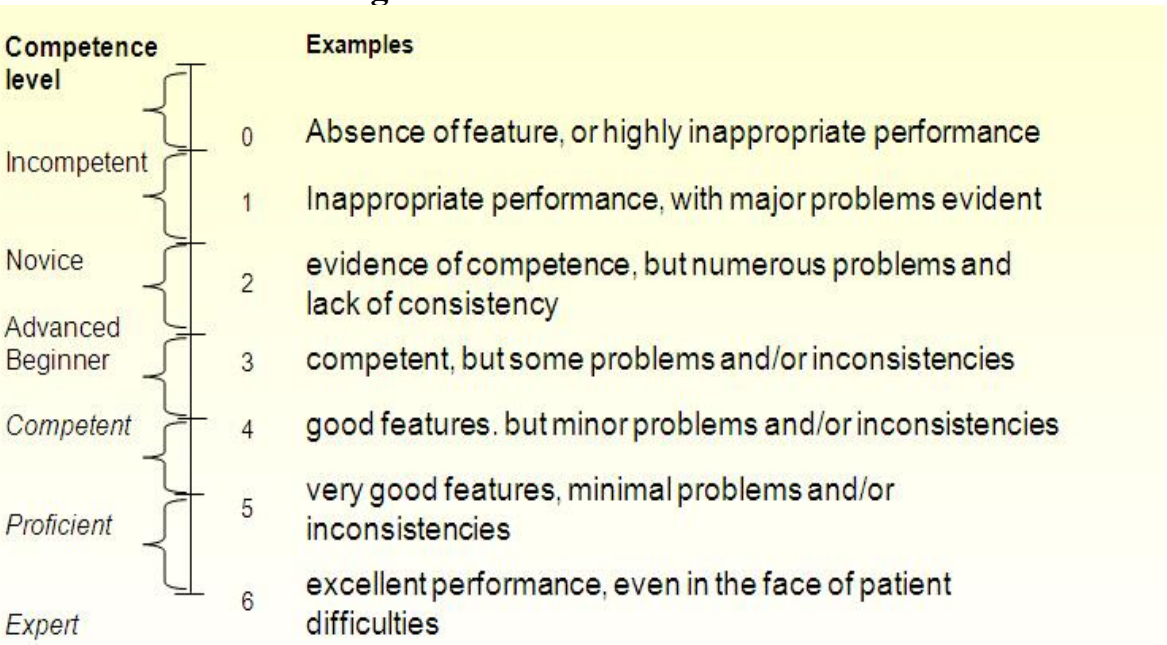
Top tips for getting the most out of observation (supervisor observing trainee)

- Plan the observation
- Gain consent from the client, and emphasize that the supervisor will be focusing on you as the trainee. Highlight the importance of observation as a way of ensuring good quality and transparent practice.
- Set up the room so that your supervisor is positioned outside of the client- therapist position (e.g. sitting more in the corner, or not in the direct eye- line of the client).
- Negotiate with your supervisor what particular areas of your practice you would like feedback on.
- Discuss with your supervisor how best to get feedback (good practice is to identify areas of good practice, and then to consider area for improvement). It could be helpful if you could agree with your supervisor what area you would particularly value feedback on (e.g. eliciting and sitting with distressing feelings, ending sessions on time etc).
- Just do it!

Consent

The service user should always have a full explanation about what is going on in order to decide whether to give informed consent to the observation. This should make reference to the learner status of the trainee and the nature of the observation. Any trusts will have policies around the recording of client activity. Trainees must work in accordance with the trust procedures.

CAPS 'PRECISE' – Scoring / Feedback Sheet



Item	Comments	
Overall comments		
Partnership Working Collaborative and respectful partnership		SCORE
Right Developmental Level Engages in a way, level and manner consistent with developmental level of young person		SCORE

Empathic Establishes a genuine, warm, respectful relationship		SCORE
Creative Adapts and tailors to level of understanding and interests		SCORE
InvestigativeAdopts a curious stance and facilitates discovery and reflection		SCORE
Self efficacy An empowering approach promoting self-efficacy		SCORE
Enjoyable Sessions appropriately engaging and interesting		SCORE
Overall Score **Competent / Incompetent**		
Overall Score (%)		

A Measure of Cognitive Analytic Therapy (CAT) Competence – CCAT

Dr Dawn Bennett & Professor Glenys Parry

INSTRUCTIONS

This scale contains 77 elements of therapist competence in Cognitive Analytic Therapy (CAT) across 10 domains of therapeutic practice. For two of the domains of competence (1 and 3), the section you rate depends on the stage of therapy, a) for early sessions, b) for later ones. For these two, please rate *either* section a *or* section b, but not both.

Some of the domains of competence are highly CAT specific (e.g. CAT specific tools & techniques) whilst others reflect generic competencies (e.g. common factors: basic supportive good practice).

The scale is designed for use with audiotapes of whole CAT therapy sessions in which the therapist's competence in each of the domains of practice is rated for **the session as a whole**. For each tape you will receive contextual information relevant to the current stage of the therapy.

PART A

Work through the 10 domains, look at each element of competence and decide if it was **present or absent** in the session.

If the competence was **present** you will be asked to rate how well it was demonstrated.

If the competence was **absent** you will be asked whether this constitutes a therapist error, in which case, consider the following points:

1. Sometimes it is *inappropriate* for a particular competence to be demonstrated. For example, if the therapeutic alliance were intact, the therapist would not need to identify and work with threats to the alliance (competence 9.4) or it may be too early in therapy to focus on change (competence 3.12). Code this **XI**.

2. An in-session event may make it *difficult* for the therapist to show the competence. For example, it is difficult to focus on specific formulation work when the client uses the session to discuss a current major life event. Code this **XD**.

3. The competence should have happened and didn't – the therapist failed to respond to a cue and there was a *missed opportunity*. Code this **XM**.

4. If the competence was absent for some other reason, please specify.

RATINGS

Rate each element of competence in the following way Present/observed: √**+** well demonstrated

√**-** observed but with missed opportunities and/or not good enough Absent/not observed: **XI** it was inappropriate to practice the competence

XD it was difficult to practice the competence

XM missed opportunity(ies) to practice the competence

XO absent for other reason, please specify

PART B

For each of the ten domains please make a general rating of competence on a scale of 0 - 4. Do this after you have scored the individual elements. This rating summarises competence in the whole domain and takes the individual items into account but is not derived directly on them. It is based on your overall judgement of the therapist's work in that particular session. A score of 4 represents highly competent practice and 0 represents completely incompetent practice. The scale is anchored and contains descriptions of competent and incompetent performance. For any session that you rate using the CCAT be aware of the whole range of possible competencies e.g. the worst session possible

versus an expert therapist working with a highly responsive client. Use X if you are unable to rate a cluster (e.g. if the competency domain was not observed in this session)

The research leading to this measure was funded by the Mental Health Foundation

Manual of the Revised Cognitive Therapy Scale (CTS-R)

I.A. James, I.-M. Blackburn & F.K. Reichelt

Collaborators
A. Garland, P. Armstrong

Dec. 2001

Manual of the Revised Cognitive Therapy Scale (CTS-R)

Introduction

This is a scale for measuring therapist competence in Cognitive Therapy and is based on the original Cognitive Therapy Scales (CTS, Young & Beck, 1980, 1988). The CTS-R was developed jointly by clinicians and researchers at the Newcastle Cognitive and Behavioural Therapies Centre and the University of Newcastle upon Tyne, UK.

The CTS-R contains 12 items, in contrast to earlier versions of the CTS which contained either 13 (Young & Beck, 1980) or 11 (Young & Beck, 1988). The development of the revised scale, together with the psychometric properties, is described in Appendix 28 - Systemic Family Practice Rating Scale.

Table 1: The CTS-R Items

General items	Cognitive therapy specific items
Item 1: Agenda Setting & Adherence* Item 2: Feedback Item 3: Collaboration Item 4: Pacing and Efficient Use of Time Item 5: Interpersonal Effectiveness	Item 1: Agenda Setting & Adherence* Item 6: Eliciting Appropriate Emotional Expression ** Item 7: Eliciting Key Cognitions Item 8: Eliciting Behaviours** Item 9: Guided Discovery Item 10: Conceptual Integration Item 11: Application of Change Methods Item 12: Homework Setting

* Item 1 can be regarded as both a general and CT item.

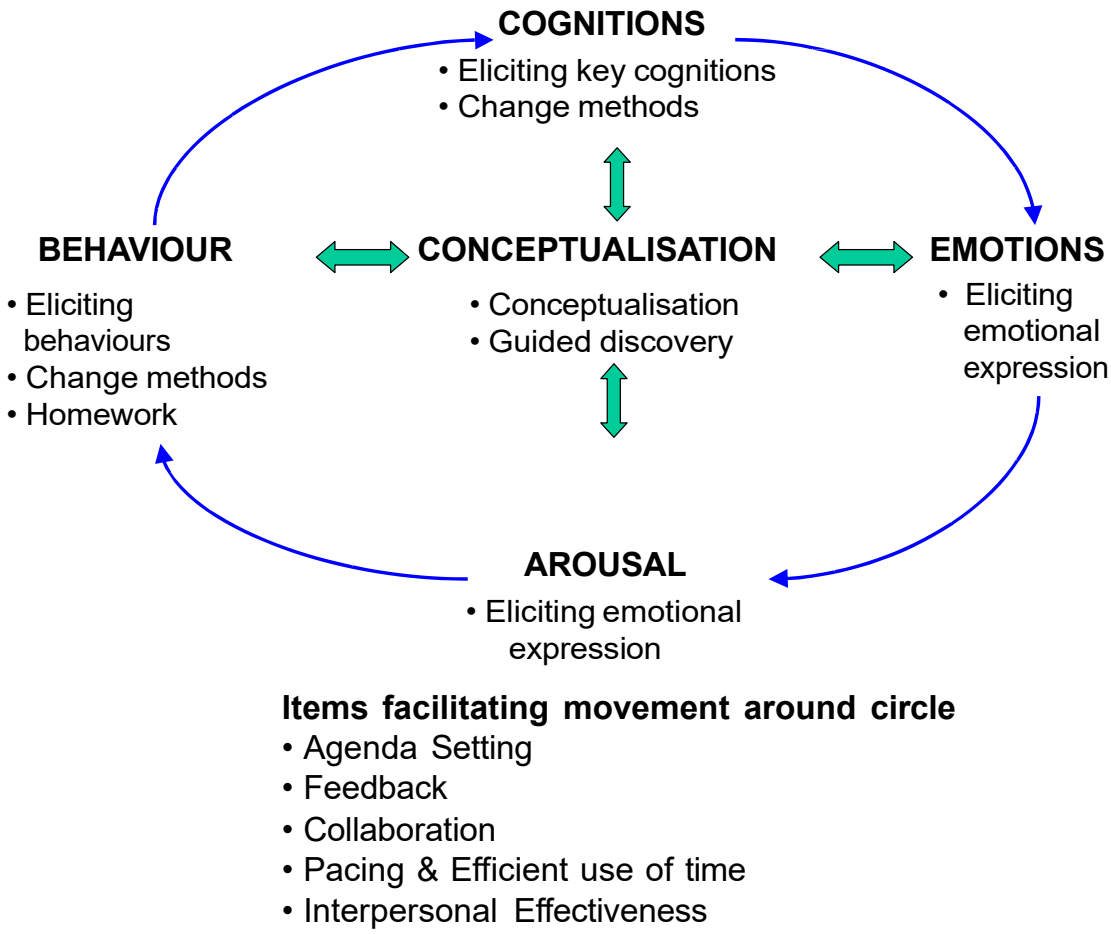
** Items 6 and 8 are new items developed for the scale.

Theoretical Bases of the Scale

Two frameworks underpin the revised scale, the Cognitive Cycle and the Dreyfus Scale of Competence (Dreyfus, 1989).

The Cognitive Cycle: The cognitive cycle represented in Figure 1 demonstrates how the CTS-R items address specific cognitive features. At the heart of the scale, as in therapy, is the conceptualisation. In order to move the patient from a dysfunctional cycle, dominated by a dysfunctional conceptualisation, the therapist must address the four features highlighted in the outer ring of the circle: thoughts, feelings, physiology and behaviour/planning. In terms of **therapeutic competence**, the therapist's must be skilled at encouraging the patient to move around the points of the cycle, using the Cognitive Specific items (Items 6-12) to address the features. To facilitate the smooth movement around the cycle, the therapist must also demonstrate competence in areas assessed by the remaining items 1-5 (agenda & adherence, feedback, collaboration, pacing, interpersonal effectiveness).

Figure 1: The relationship between the CTS-R items and the Cognitive Cycle*



* The cycle occurs within an Environmental context. Its relevance to the environment is explored mainly through Item 8 (Eliciting Behaviours) and Item 12 (Homework Setting).

Dreyfus Model of Competence: The Dreyfus Model has also been incorporated within the CTS-R. It is designed to assess the level of competence shown by the therapist (see Table 2). In the original Dreyfus scale there are five levels, to this we added a further level to denote 'incompetence', as outlined below.

Table 2: Adapted Dreyfus Level of Competence

Incompetent - The therapist commits errors and displays poor and unacceptable behaviour, leading to negative therapeutic consequences.

Novice - At this level the therapist displays a rigid adherence to taught rules and is unable to take account of situational factors. He/she is not yet showing any discretionary judgement.

Advanced Beginner - The therapist treats all aspects of the task separately and gives equal importance to them. There is evidence of situational perspective and discretionary judgement.

Competent - The therapist is able to see the tasks linked within a conceptual framework. He/she makes plans within this framework and uses standardised and routinised procedures.

Proficient - The therapist sees the patient's problems holistically, prioritises tasks and is able to make quick decisions. The therapist is clearly skilled and able.

Expert - The therapist no longer uses rules, guidelines or maxims. He/she has deep tacit understanding of the issues and is able to use novel problem-solving techniques. The skills are demonstrated even in the face of difficulties (e.g. excessive avoidance).

This model has been incorporated within the scoring system as demonstrated in the scoring layout below.

Scoring system

A detailed explanation of the scoring system is provided below. As you can see, each item is rated on a Likert scale, ranging from 0-6. Each level being defined in detail to conform to the levels of competence (see Table 2).

Example of the scoring layout:

Key features: this is an operationalised description of the item (see examples within the CTS-R).

Mark with an 'X' on the vertical line, using whole and half numbers, the level to which you think the therapist has fulfilled the key features. The descriptive features on the right are designed to guide your decision.

Competence level		Examples
Incompetent	0	Absence of feature, or highly inappropriate performance
	1	Inappropriate performance, with major problems evident
Novice	2	Evidence of competence, but numerous problems and lack of consistency
Advanced beginner	3	Competent, but some problems and/or inconsistencies
Competent	4	Good features, but minor problems and/or inconsistencies
Proficient	5	very good features, minimal problems and/or inconsistencies
Expe	6	excellent performance, or very good even in the face of patient

Please note that the top marks (i.e. near the 'expert' end of the continuum) are reserved for those therapists demonstrating highly effective skills, particularly in the face of difficulties (i.e. highly aggressive or avoidant patients; high levels of emotional discharge from the patients; and various situational factors).

Maximum score on the scale is 72 (12 x 6). At the Newcastle Cognitive Therapy Centre we set a minimum competence standard of 36, which would be an average of 3 marks per item.

Item 1 - Agenda Setting and Adherence

Introduction

The agenda helps ensure that the most important issues are addressed in an efficient manner. Therapist and patient must establish these issues jointly. The agenda should review items from the previous session(s), in particular the homework assignment, and include one or two items for the session. Once set, it should be appropriately adhered to. However, if changes are necessary, because of an important new issue arising, the deviation from the agenda should be made explicit.

The key features of the 'agenda' is outlined in the CTS-R Rating Scale as follows:

Key features: To address adequately topics that have been agreed and set in an appropriate way. This involves the setting of discrete and realistic targets collaboratively. The format for setting the agenda may vary according to the stage of therapy - see manual.

Three features need to be considered when scoring this item:

(i) presence/absence of an agenda which is explicit, agreed and prioritised, and feasible in the time available;
(ii) appropriateness of the contents of the agenda (to stage of therapy, current concerns etc.), a standing item being a review of the homework set previously;
(iii) appropriate adherence to the agenda.

Mark with an 'X' on the vertical line, the level to which you think the therapist has fulfilled the key features. The descriptive features on the right are designed to guide your decision.

NB: Agenda setting requires collaboration and credit for this should be given here, and here alone. Collaboration occurring at any other phase of the session should be scored under Item 3 (Collaboration).

Short-term cognitive therapy requires that the important issues are discussed sensitively but managed in a business-like way. In order to cover a lot of material adequately in a relatively short space of time, **specific and realistic** targets need to be set in a **collaborative** manner, and adhered to appropriately. Indeed, it is of limited use to set a good agenda and then not be guided by it.

On setting the agenda the therapist must ensure the items are **appropriate**. They should be suitable for the stage of therapy, amenable to a CT rationale, consistent with the formulation, and conceived to take the therapy forward. In addition, the items should be **clear and discrete**. If the items are too vague, this may lead to confusion and also result in divergent and tangential material being discussed. It is important to note, however, that the therapist must be aware not to let the patient go into too much detail about any one item at this stage, as this will disrupt the agenda setting process. The therapist must be careful not to include too many items, as this may lead to either important items being missed or the therapy being rushed.

The list of items should include material from both the patient and therapist. A discussion of the **homework** which was set previously should be a **'standing'** item. Even when no homework was set in the previous session (for whatever reason), the value of such assignments should be discussed in order to restate the importance of this aspect of therapy. Unless this is done the patient may come to think that there is no need to complete the assignment carefully.

Part of socialising the patient to CT is to establish an expectation that he/she will need to come to each session having thought through the key topics for that day's therapeutic work.

Following the setting of the agenda, the patient should be asked to **prioritise** his/her list of items. The prioritisation permits the therapist to plan the session and allot appropriate time for the material. Efficient prioritising facilitates the pacing of the therapy.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist set an agenda with clear, discrete, and realistic goals - and adhere to it?
2. Can you identify at least two specific agenda items?
3. Was the patient encouraged to participate in setting the agenda?
4. Do you think the patient clearly understood what the therapy was going to cover?
5. Did the agenda seem appropriate?
6. Were the items prioritised?
7. Was the session set sensitively?
8. Did you hear any of the following:
    - What would you like to get from today's session?
    - As usual at the beginning of the session, we need to set a plan.
    - What benefits do you think we get by setting the agenda?
    - Perhaps we need to put some time for X.
    - What is the most important thing to cover today? ... Are there any other things to include?
    - Is there anything that has been troubling you this week, which might help to illustrate your problems?
    - You have mentioned X, Y and Z. Which of these would you like to talk about first?
    - If we did discuss this item, how would it help take the therapy forward?
    - What would be most helpful to discuss today, keeping in mind the stage we're at in therapy?
    - By discussing X, how will this help us move forward?

Item 2 - Feedback

Introduction

The therapist should both provide and elicit feedback throughout each session. The therapist's feedback should occur at regular intervals and is particularly important at the end of the therapy session. This feedback helps to focus the patient on the main therapeutic issues, and assists in reducing vague or amorphous issues into manageable units. It also helps both the therapist and the patient to determine whether they have a shared understanding of the problems and concerns.

Eliciting feedback ensures that the patient understands the therapist's interventions, formulations and lines of reasoning. It also allows the individual to express positive and negative reactions regarding the therapy.

The key features of 'feedback' is outlined in the CTS-R Rating Scale as follows:

> **Key features**: The patient's and therapist's understanding of key issues should be helped through the use
>
> of two-way feedback. The two major forms of feeding back information are through general summary and chunking of important units of information. The use of appropriate feedback helps both the therapist to understand the patient's situation, and the patient to synthesise material enabling him/her to gain major insight and make therapeutic shifts. It also helps to keep the patient focused.
>
> Three features need to be considered when scoring this item:
>
> (i) Presence and frequency, or absence, of feedback. Feedback should be given/elicited throughout the therapy – with major summaries both at the beginning (review of week) and end (session summary), while topic reviews (i.e. chunking) should occur throughout the session;
> (ii) Appropriateness of the contents of the feedback;
> (iii) Manner of its delivery and elicitation (NB: can be written).

This item stresses the importance of **two-way feedback**. By 'summarising' and 'chunking' information at regular intervals, the therapist can emphasise the major features, **synthesise** new material and highlight issues that require further clarification. By eliciting the patient's feedback (thoughts and feelings) regarding the therapy, the therapist can check the patient's attitude, knowledge base and understanding.

Chunking information and eliciting feedback should **occur frequently**. On occasions, when either particularly important or confusing material is being discussed, the feedback should occur after each major point; this can also help 'contain' distressing issues. During normal short-term CT, the two-way feedback should occur at least every 10 minutes.

Major summaries should occur at the beginning and end of each session, to help reinforce and consolidate therapeutic material.

It is important that the feedback be **appropriate**. For example, when providing feedback the therapist must choose the salient material presented to him her, and then summarise these features in a way that both clarifies and highlights key issues. This form of summarising and feeding back is the foundation for many forms of cognitive techniques (e.g. Socratic questioning). When eliciting feedback, the therapist should be aware that patients (especially people suffering from depression) often indicate understanding simply out of compliance. Hence, it is vital that the therapist explores the patient's understanding and attitude towards the therapy carefully.

The **manner** in which the feedback is elicited and delivered is also important. For example, the therapist should be sensitive to negative and covert reactions expressed both verbally and non-verbally by the patient, and should also ask for the patient's thoughts when such clues are noticed. Whenever appropriate the therapist should ask the patient either for suggestions about how to proceed, or to choose among alternative courses of action.

When giving feedback the therapist should deliver it in a manner that is constructive and helps to move the therapy forward. This will involve anticipation of how the information may be received (e.g. perceived as criticism).

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Do you think the feedback was appropriate? ... Sufficiently frequent?
2. Did the therapist chunk the salient pieces of information to provide a platform for new insight?
3. Was the patient encouraged to provide feedback throughout the session?
4. Do you think that the feedback was used effectively in helping the patient's understanding?
5. Did you hear any of the following:
    - Could you tell me the three most important issues we've discussed today?
    - Just to summarise, at the beginning of the session we spoke about X and the effect it had on your feelings. Then we discussed Y, etc. etc.
    - I think I have understood what you just said, let me see if I can repeat back the main points.
    - Could you tell me whether I've got that right?
    - Is there anything that I've said, that didn't make sense?
    - What was the most/lease helpful thing that we discussed today?

Item 3 - Collaboration

Introduction

Good therapeutic teamwork is a fundamental feature of cognitive therapy. Collaboration should be consistent throughout the session, although at times didactic approaches may be necessary (e.g. educating the patient about the physical effects of anxiety).

The key features of 'collaboration' is outlined in the CTS-R Rating Scale as follows:

> **Key features:** The patient should be encouraged to be active in the session. There must be clear evidence of productive teamwork, with the therapist skilfully encouraging the patient to participate fully (e.g. through questioning techniques, shared problem solving and decision making) and take responsibility. However, the therapist must not allow the patient to ramble in an unstructured way.
>
> Three features need to be considered: the therapist style should encourage effective teamwork through his/her use of:
>
> (i) verbal skills (e.g. non-hectoring);
> (ii) non-verbal skills (e.g. attention and use of joint activities);
> (iii) sharing of written summaries.
>
> NB: Questioning is a central feature with regard to this item, but questions designed to facilitate reflections and self discovery should be scored under Item 9 (Guided Discovery).

As mentioned above, collaboration will be used during Agenda Setting (Item 1) and should be credited accordingly within this item. Hence, credit on this item should only be given for evidence of collaboration that occurs outwith Agenda Setting.

The therapist should adopt a style that promotes an egalitarian relationship, whereby he/she and the patient work **actively** towards shared goals. This is achieved by the development of a **'teamwork'** approach. Hence the therapist should avoid being overly directive, too intellectual, controlling or passive.

The therapist needs to strike a balance between being structured on the one hand and on the other allowing the patient to make choices and take responsibility. In order to achieve a good therapeutic alliance, the therapist must assess the patient's needs, and particularly his/her preferred modes of learning. For example, Beck (1983) suggests that individuals who display sociotropic traits respond better to a warm supportive therapeutic relationships, while those with autonomous traits prefer to take a high level of responsibility within the therapy and respond better to a more task-oriented approach.

Good Collaboration will also involve striking a balance between the **verbal** and **non-verbal** features. For example, deciding when to talk and when to listen; when to confront and when to back-off; when to offer suggestions and when to wait for the patient to devise his/her own.

Another important element of Collaboration is for the therapist to be open about the process and status of therapy. This will include the therapist explaining the rationale for interventions, admitting confusion; sharing **summaries both verbally and in writing**.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Was the patient encouraged to participate fully as a team member?
2. Was the therapist able to establish a collaborative relationship?
3. Did the therapist give the patient sufficient space and time to think?
4. Was the therapist overly directive or too controlling?
5. Did you hear any of the following:
    - How might we test that out?
    - Perhaps we could work out together an alternative way of looking at this issue.
    - Before setting this behavioural task, let's both examine the potential obstacles which might prevent us learning anything from it.
    - That's a difficult one, so let's put our heads together and try and think it through.
    - Could you help me make sense of this?
    - I'm sure that together we can work this one out.
    - Let's look at this together.
    - You're the expert with respect to your problem, so could you help me understand?
    - You've got your homework, so would you like me to do anything for next week?

Item 4 - Pacing and Efficient Use of Time

Introduction

The therapist should make optimal use of the time in accordance with items set in the agenda. He/she must maintain sufficient control, limit discussion of peripheral issues, interrupt unproductive discussion, and pace the session appropriately. Nevertheless, the therapist should avoid rushing crucial features of the session.

The key features of 'Pacing and efficient use of time' is outlined in the CTS-R Rating Scale as follows:

> **Key features:** The session should be well 'time managed' in relation to the agenda, with the session flowing smoothly through discrete start, middle, and concluding phases. The work must be paced well in relation to the patient's needs, and while important issues need to be followed, unproductive digressions should be dealt with smoothly. The session should not go over time, without good reason. Three features need to be considered:
>
> (i) The degree to which the session flows smoothly through the discrete
> (ii) phases; the appropriateness of the pacing throughout the session;
> (iii the degree of fit to the learning speed of the patient.

The session should be well **time managed**, such that it is neither too slow nor too quick. For example, the therapist may unwittingly belabour a point after the patient has already grasped the message, or may gather much more data than is necessary before formulating a strategy for change. In these cases, the sessions can seem painfully slow and inefficient. On the other hand, the therapist may switch from topic to topic too rapidly, thus not allowing the patient to integrate the new material sufficiently. The therapist may also intervene before having gathered enough data to conceptualise the problem. In summary, if the therapy is conducted too slowly or too quickly, it may impede therapeutic change and could de-motivate the patient.

The pacing of the material should always be accommodated to the **patient's needs and speed of learning**. For example, when there is evidence of difficulties (e.g. emotional or cognitive difficulties), more time and attention may need to be given. In such circumstances the agenda items may be shuffled or adapted accordingly. In some extreme circumstances (e.g. disclosure of suicidal thoughts), the structure and pacing of the session will need to change drastically in accordance with the needs of the situation.

The therapy should move through **discrete phases**. At the start, there should be a structured agenda. Then the agreed plan of the session should be handled efficiently during the main phase.

It is important that the therapist maintains an overview of the session to allow correct pacing **throughout**. This may involve the therapist politely interrupting peripheral discussion and directing the patient back to the agenda.

A well paced session should not need to exceed the time allocated for the period and should cover the items set in the agreed agenda. It will also allow sufficient time for the homework task to be set appropriately, and not be unduly rushed.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Was the therapist able to recognise the patient's need and adapt the session accordingly?
2. Was there any time during the session when the session moved too slowly/quickly (e.g. agenda setting phase)?
3. Do you think the session flowed well overall?
4. Was the therapist able to avoid unproductive digressions?
5. Was there sufficient time left for the homework assignment?
6. Was the pacing of the session adapted well to the needs of the patient?
7. Did the patient appear rushed?
8. Did you hear any of the following:
    - How much time should we spend on that item?
    - Do you mind stopping a second, you've given me lots of information already. Just to make sure I have understood completely, let's look at the major points you've made.
    - We may have strayed off the topic a little, shall we get back and focus on the chief issues you raised.
    - Now we have 20 minutes left before the end of the session. Is there anything you think we must cover before the end - keeping in mind that we will also need to set the homework assignment?
    - Do you think we should move off this topic now?

Item 5 - Interpersonal Effectiveness

Introduction

The ability of the therapist to form a good relationship with the patient is deemed crucial to the therapy. Indeed, in order for the patient to be able to disclose difficult material, there must be both trust and confidence in the therapist. Rogers suggests that the non-specific factors of 'empathy, genuineness and warmth' are key features of effective therapy.

The key features of 'Interpersonal Effectiveness' is outlined in the CTS-R Rating Scale as follows:

Key features: The patient is put at ease by the therapist's verbal and non-verbal (e.g. listening skills)

behaviour. The patient should feel that the core conditions (i.e. warmth, genuineness, empathy and understanding) are present. However, it is important to keep professional boundaries. In situations where the therapist is extremely interpersonally effective, he/she is creative, insightful and inspirational.

Three features need to be considered:

(i) empathy - the therapist is able to understand and enter the patient's feelings imaginatively and uses this understanding to promote change;
(ii) genuineness - the therapist has established a trusting working relationship;
(iii) warmth - the patient seems to feel liked and accepted by the therapist.

In order that the appropriate levels of the three features are conveyed, careful judgement is required from the therapist. Personal and contextual needs must be taken into account. For example, towards the end of therapy lower levels of warmth may be used, as compared to the beginning, in order to promote patient disengagement.

Empathy concerns the therapist's ability to make the patient aware that their difficulties are recognised and understood on both an emotional and cognitive level. The therapist needs to show that he/she shares the patient's feelings imaginatively. For example, the promotion of a shared-value system between therapist and patient will help to enhance this aspect of the relationship. The therapist should avoid appearing distant, aloof or critical.

A good therapist should adopt a **genuine** and straightforward therapeutic style. A sincere and open style will promote a trusting, collaborative working relationship. The therapist should avoid appearing condescending or patronising.

It is also important for the therapist to convey **warmth** and concern through both his/her verbal and non-verbal behaviour. The therapist should avoid being critical, disapproving, impatient or cold. He/she should convey an attitude of acceptance of the person, but not of course with respect to the style of thinking.

It is important to highlight that appropriate use of humour can often help to establish and maintain a good therapeutic relationship.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

I. Did you consider the relationship was positive?

2. Was the therapist displaying appropriate empathy, understanding, warmth and genuineness?
3. Did he/she appear appropriately genuine, helping to facilitate therapeutic trust?
4. Do you think he/she showed acceptance and liking of the individual, while remaining within professional boundaries?
5. Did the therapist appear confident?
6. Did the therapist empathise with the patient's distress?
7. Did the therapist acknowledge any difficulties?
8. Did you hear any of the following:
    - I understand that X was difficult for you to do
    - Shared laughter
    - This must have felt awful for you
    - You've made a great effort here. Thank you.
    - Despite the huge difficulties, you did really well.
    - Many people would feel that way, but you have decided to do something about it.

Item 6 - Eliciting Appropriate Emotional Expression

Introduction

The ability of the therapist to deal effectively with the emotional content of the therapy session is a crucial feature of therapy. The therapist should be able to increase or reduce the emotional ambience of a session through his her verbal and non-verbal behaviour. The therapist should then be able to use the patient's emotions to promote therapeutic change. The current item reflects the degree to which the therapist is able to create the circumstances through which emotional change and expression can be elicited and then used effectively.

Key features: The therapist facilitates the processing of appropriate levels of emotion by the patient.

Emotional levels that are too high or too low are likely to interfere with therapy. The therapist must also be able to deal effectively with emotional issues which interfere with effective change (e.g. hostility, anxiety, excessive anger). Effective facilitation will enable the patient to access and express his/her emotions in a way that facilitates change.

Three features have to be considered:

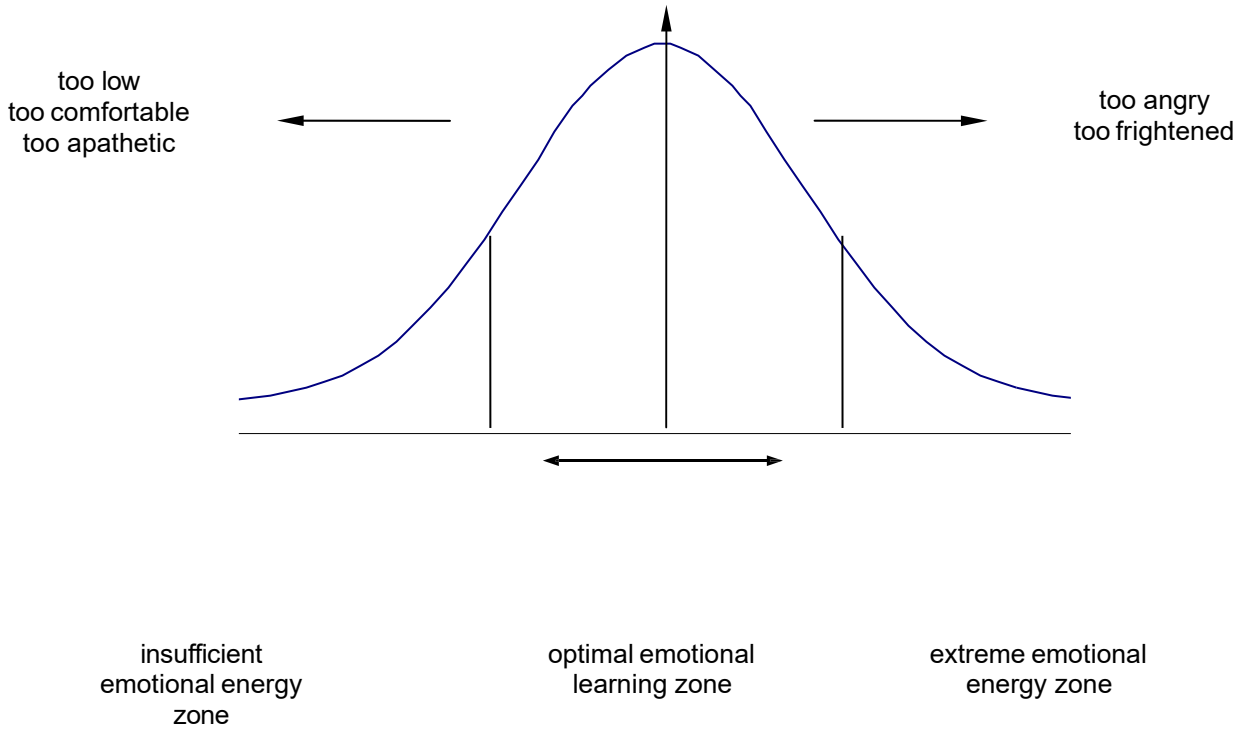
(i) facilitation of access to a range of emotions;
(ii) appropriate use and containment of emotional expression;
(iii) facilitation of emotional expression, encouraging appropriate access and differentiation of emotions.

Cognitive therapy requires both cognitive and **emotional** shift. In order to produce emotional change the therapist must first facilitate the patient to express himself/herself on an emotional level. The therapist should ensure that emotions associated with a particular situation or cognition are elicited and assessed for intensity. The therapist must also be able to assess the emotional shift within a session and work with it accordingly; increasing and decreasing the level of emotionality as appropriate (see Figure 6.1).

There is an optimal level of emotional affect required to motivate a person to change constructively. **Too little** emotional energy (i.e. apathy, lack of motivation, avoidance) will be insufficient to create change. In these cases the therapist must first be able to stimulate the patient (through verbal and non-verbal behaviour) to become an active participant in the therapeutic process.

On the other hand **too much** emotion (i.e. anger, despair, fear, etc.) will interfere with therapy. The therapist should be able to contain the energy, or use or dissipate it, in order that it no longer serves as an obstacle to effective change.

Figure 6.1: Curve of energy levels for optimal learning



A skilled therapist will also recognise inconsistency between the emotional and cognitive content, and explore such discrepancies accordingly. For example, if a patient expresses no distressful emotion when talking about some unpleasant event, careful questioning will help the patient access his/her associated emotions.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist pay sufficient attention to the person's emotions?
2. Did the therapist help the patient to differentiate between different emotions?
3. Did the therapist raise emotional topics in a sensitive manner?
4. Was there an optimal level of emotional arousal to promote change?
5. Did the therapist's activity serve to motivate the patient appropriately?
6. Did the therapist prepare the patient to work on his/her emotions?
7. Was the therapist able to contain any emotional outbursts?
8. Did you hear any of the following:
   - How did that make you feel?
   - On a scale of 1 to 100, how would rate your feelings?
   - You seem very distressed today? Am I right?
   - If you tried to do that, how would it make you feel?
   - How does it feel when your recalling that event?
   - You appear to be fearful of talking about that subject. I'm sorry, but I'd like to press you a little more.
   - Did you feel anything else than sadness?
   - You are relating very distressing events, and you are smiling. How do you understand this?

Item 7 - Eliciting Key Cognitions

Introduction

Cognitive therapy stresses the role of cognitions and the emotions associated with them in the genesis and maintenance of a range of psychiatric disorders. The current feature addresses the ability of the therapist to elicit important cognitions in an effective manner.

It is important to note that there are a number of techniques used frequently to elicit key cognitions, for example thought monitoring (e.g. thought eliciting diaries) and downward arrowing techniques. Such methods should be scored under this item rather than Item 11 (Application of Change Methods). The latter item is concerned with change techniques.

The key features of 'Eliciting Key Cognitions' is outlined in the CTS-R Rating Scale as follows:

Key features: To help the patient gain access to his/her cognitions (thoughts, assumptions and beliefs)

and to understand the relationship between these and their distressing emotions. This can be done though the use of questioning, diaries and monitoring procedures.

Three features need to be considered:

(i) eliciting cognitions that are associated with distressing emotions (i.e. selecting key cognitions or hot thoughts);
(ii) the skilfulness and breadth of the methods used (i.e. Socratic questioning; appropriate monitoring, downward arrowing, imagery, role-plays, etc.);
(iii) choosing the appropriate level of work for the stage of therapy (i.e. automatic thoughts, assumptions, or core beliefs).

NB: This item is concerned with the general work done with eliciting cognitions and emotions. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (Application of Change Methods).

A therapist should be able to **identify** and elicit those thoughts, images and beliefs which are fundamental to the patient's distress (i.e. the **key cognitions**). Key cognitions often take the form of negative automatic self-statements or beliefs relating to the self and the world that either drive or maintain negative emotions.

In the case of depression, such negative automatic thoughts (NATs) might be:

- *No one could ever love me, I'll always be rejected.*
- *My future is bleak, and it will always be this way.* } DEPRESSION

In panic with agoraphobia:

- *I'm having a heart attack*
- *Unless I'm very careful, I'll collapse.* } FEAR & ANXIETY

In PTSD:

- *The world is a hostile place, I'm never quite sure when the next thing will go wrong.*
- *I can't cope with things like I used to.* } ANXIETY

Other types of key cognitions are dysfunctional core beliefs (core schemata, Early Maladaptive Schemata). These are rigid, inflexible and dysfunctional self-beliefs which are not open to the 'normal' corrective processes of logical thinking. These can be expressed through basic assumptions and rules (If

... then; I should ...; people should...).

The negative automatic thoughts, basic assumptions, rules and core beliefs often exist in the face of overwhelming contradictory evidence (e.g. *The eminent professor who thinks she is worthless*). As part of the assessment, it is also important for the therapist to determine the different forms of cognitive biases being used to support the patient's thinking. For example, the patient may be engaging in **'minimising the positive'**: reducing the frequency or impact of good events, perhaps even focusing on the negative side of such events *(e.g. "Now that I've got a new job, I'll have to get up early")* OR**, 'catastrophising'**: exaggerating the potential negative impact of an occurrence out of all reasonable proportions *(e.g. "Mark didn't call last night, I don't think he likes me any more").* Other cognitive biases include: **overgeneralising, black and white (absolute) thinking, etc**.

On certain occasions the patient may display a great deal of emotion (cry, shake, etc.) while discussing issues. At such times, the patient's thinking needs to be checked-out as he/she may be experiencing dysfunctional thoughts at that moment (such thoughts are termed 'hot cognitions'). During such an episode, the therapist must exercise a great deal of empathy and skill when eliciting these cognitions.

The therapist should also be able to elicit the key cognitions, when they are not immediately apparent. The therapist needs to use his her professional judgement in determining which are the 'key' cognitions, taking into account both the needs of the patient and the stage of therapy. For example, during the first few sessions it is not usually appropriate to elicit and tackle core beliefs, because the patient will not be sufficiently socialised to the therapy for effective work to be done.

CHECKLIST: OUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Was the therapist able to identify and elicit the appropriate cognitions and biases?
2. Was the therapist able to access and work with key cognitions?
3. Was the therapist able to identify thinking biases and elicit hot cognitions?
4. Were the cognitions elicited well?
5. Does the therapist adequately demonstrate to the patient how to identify key cognitions and biases?
6. Did you hear any of the following:
    - What was going through your mind at the time?
    - Did you make anything of that?
    - What did you say to yourself when ...?
    - There seems to be a rule there that you apply to yourself. Do you see what it is?
    - A word that comes up often in these records is "weak". Is this how you see yourself in general?
    - If you didn't finish your work on time, what would this say about you?

Item 8 - Eliciting Behaviours

Introduction

Behavioural problems are observed frequently in psychiatric disorders. They take numerous forms, including withdrawal, avoidance, compulsions and various types of safety seeking behaviours. As such, it is important that the therapist elicits the roles these behavioural features play in the maintenance of the patient's problems.

Key features: To help the patient gain insight into the effect of his/her behaviours with respect to the problems. This can be done through the use of questioning, diaries and monitoring procedures..

Two features need to be considered:

(i) eliciting behaviours that are associated with distressing emotions (including, use of safety seeking behaviours);

(ii) the skilfulness and breadth of the methods used (i.e. socratic questioning; appropriate monitoring, imagery, role-plays, etc.).

NB: This item is concerned with the general work done with eliciting behaviours. If any specific cognitive or behavioural change methods are used, they should be scored under item 11 (Application of change methods).

It is important to examine the role that behaviours have in triggering and maintaining the patient's disorder. Behaviours often reinforce both negative thoughts and feelings. For example, the typical avoidance observed in social phobia prevents the person overcoming his/her fear, and obtaining the skills necessary to engage in social interactions.

Some activities can be termed "safety seeking behaviours" as patients employ them as a means of reducing their levels of distress (eg. self monitoring procedures, holding on tightly to objects). However, safety behaviours can often serve to unwittingly maintain a person's problems, ensuring that the dysfunctional cycles are preserved. On occasions the patient might react to difficulties by over- compensating in some manner (e.g. becoming aggressive when feeling vulnerable); such behavioural patterns clearly ought to be elicited and examined in relation to the relevant emotions associated with them.

The following table (Table 8.1) outlines some of the common forms of safety seeking behaviours associated with the different disorders. It is relevant to note that safety behaviours are often distinguished from avoidance and withdrawal strategies. The latter are escape strategies (eg. avoidance of situations/objects/people), while the former are active (ie. non-avoidant) behaviours that either (i) reduce a perceived risk, or (ii) are used by the person to cope in situations where negative feelings are being experienced.

Table 8.1: Safety seeking behaviours associated with the different mental health disorders

Panic

Monitoring of pulse and other physiological sensations; deep breathing, holding onto objects, inactivity, muscle tension.

Generalised anxiety disorder

Worrying, scanning for danger, mental control, distraction, thought suppression, ruminations in an attempt to anticipate threat.

Social phobia

Gripping objects tightly to avoid tremor, self-monitoring, reassurance seeking, attempting not to attract attention, perceptual scanning, self absorption, excessive self-reflection, over-rehearsing and excessive planning, post-morteming, perceptual avoidance (eye-contact, tactile).

Obsessive compulsive disorder

Neutralisations (mental and physical), control seeking, employment of rituals, checking, excessive deliberation, excessive taking of responsibility.

Health anxiety

Self monitoring, reassurance seeking, medical consultations, hyper-vigilance, avoidance of physical exertion, selective attention to illness-related information (media, TV), bodily checking, selective attention on body.

Post traumatic stress disorder

Thought suppression, imagery, distraction.

This table provides some of the characteristic safety behaviours identified by people experiencing different mental health problems. It is important to remember that there is a large degree of co- morbidity with respect to people's affective states and one is likely to find someone exhibiting a range of safety behaviours from each of the different categories. Thus it is essential that a thorough individual formulation is developed.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist examine adequately the role that behavioural features played in the triggering and maintenance of the patient's problems?
2. Did the therapist help the patient discover the impact of his/her behaviours in terms of relevant emtoinal features?
3. Did you hear any of the following:

- When you felt fearful, did you do anything that reduced your level of fear?
- If I had a camera and filmed you when you are feeling low, what would I see?
- Some people develop habits or rituals, have you noticed any patterns to your behaviour?
- When you check your heart rate, how do you feel?

Item 9 - Guided Discovery

Introduction

Guided discovery is a form of presentation and questioning which assists the patient to gain new perspectives for himself/herself without the use of debate or lecturing. It is used throughout the sessions in order to help promote the patient to gain understanding. It is based on the principles of socratic dialogue, whereby a questioning style is used to promote discovery, to explore concepts, synthesise ideas and develop hypotheses regarding the patient's problems and experiences.

The key features of 'Guided Discovery' is outlined in the CTS-R Rating Scale as follows:

> **Key features:** The patient should be helped to develop hypotheses regarding his/her current situation and
>
> to generate potential solutions for him/herself. The patient is helped to develop a range of perspectives regarding his/her experience. Effective guided discovery will create doubt where previously there was certainty, thus providing the opportunity for re-evaluation and new learning to occur.
>
> Two elements need to be considered:
>
> (i) the style of the therapist - this should be open and inquisitive;
>
> (ii) the effective use of questioning techniques (e.g. Socratic questions) should encourage the patient to discover useful information that can be used to help him/her to gain a better level of understanding.

It has been observed that patients are more likely to adopt new perspectives, if they perceive they have been able to come to such views and conclusions for themselves. Hence, rather than adopting a debating stance, the therapist should use a questioning **style** to engage the patient in a problem solving process.

Skilfully phrased questions, which are presented in a clear manner, can help to highlight either links or discrepancies in the patient's thinking. In order to accommodate the new information or learning, new insight is often achieved. Padesky (1993) emphasises that the aim of questioning is not to 'change minds' through logic, but to engage the patient in a socratic dialogue. Within this dialogue the patient can arrive at new perspectives and solutions for themselves.

> The therapist's **questioning technique** should reveal a constant flow of inquiry from concrete and specific ("*Does your mood drop every time you argue with your mother?*") to abstract ("*Do you always feel this way when someone is shouting at you?*") and back again ("*What thoughts were going through your head when it was your mother shouting?*"). Good questions are those asked in the spirit of inquiry, while bad ones are those which lead the patient to a predetermined conclusion.

The techniques may also permit the patient to make both lateral and vertical linkages. The lateral links are those day to day features of the patient's life which produce and maintain his/her difficulties (i.e. the NATs, dysfunctional behaviours, moods and physical sensations). The vertical links are the historical patterns and cycles, which manifestly relate to the patient's current problems (i.e. childhood issues, parenting, relationship difficulties, work issues, etc.).

The questions posed should not be way-beyond the patient's current level of understanding, as this is unlikely to promote effective change. Rather they should be phrased within, or just outside, the patient's current understanding in order that he/she can make realistic attempts to answer them. The product of attempting to deal with such intelligently phrased question is likely to be new discoveries.

The therapists should appear both inquisitive and sensitive without coming across as patronising.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Has the therapist used appropriate questions?
2. Does the manner in which the questions are asked facilitate the patient's understanding?
3. Did the questions lead to or promote change?
4. Did you hear any of the following:
    - I wonder whether there are any other times in your life when you felt the same way?
    - You have this dreadful image when you're with both John and Paul, but you never have it with Peter. Can you think of a reason for this?
    - If you were not depressed, how might you think differently about this situation?
    - How does this relate to what you told me earlier - that you never get anything right?
    - What is the common link between X and Y?

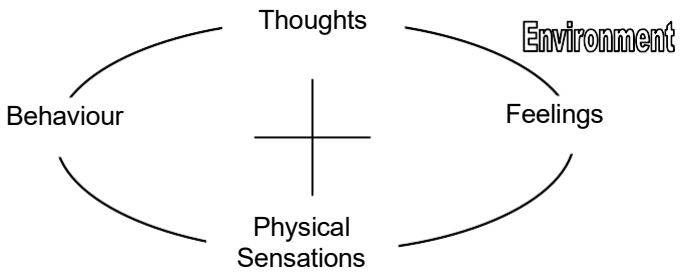
Item 10 - Conceptual Integration

Introduction

Conceptualisation concerns the provision of an appropriate knowledge base that promotes understanding and facilitates therapeutic change. It encompasses both the cognitive therapy rationale and the cognitive formulation. Through the conceptualisation the patient will gain an understanding of the cognitive rationale of his/her disorder, its underlying and maintaining features, and relevant triggers. Importantly, the patient should also gain an understanding of the relative efficacy of the coping strategies currently being used in order to deal with the problem.

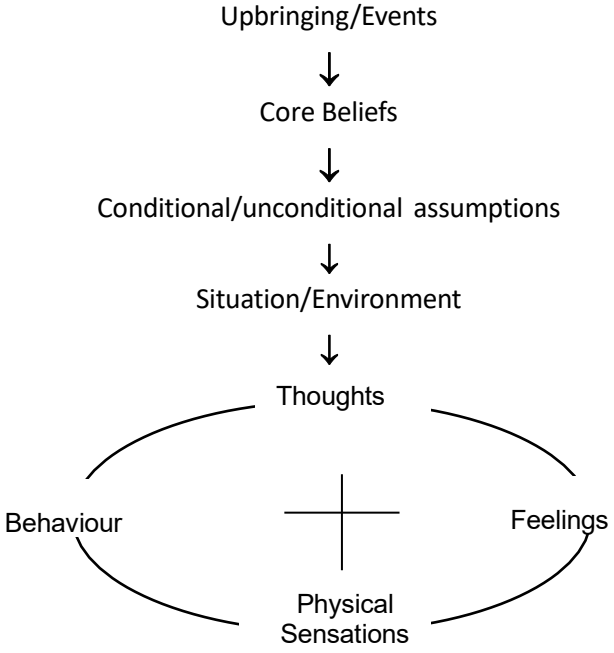
The conceptualisation process involves initially socialising the patient to the therapeutic rationale (i.e. establishing the links between "thoughts → feelings → behaviours"). This rationale (i.e. the generic CT model) is presented in Figure 10.1. Its specific format will vary with respect to the different disorders.

Figure 10.1: The generic CT model



After the initial assessment phase, the process involves the development of an appropriate understanding of the problem. This is termed formulation, and is a personalised account of the disorder in terms of both its genesis and maintaining features. The formulation involves establishing the lateral (i.e. situational and maintaining features) and vertical (i.e. historical) linkages underpinning the disorder. Figure 10.2 presents an integrated formulation, using both vertical and lateral linkages.

Figure 10.2: Integrated Formulation



Following the formulation, the patient must acknowledge of what needs to be changed and the most appropriate strategies for change (i.e. change mechanisms). When working effectively, both the therapist and patient will have a shared theoretical understanding of the aims, model and current status of the therapy with respect to the therapeutic goals.

The key features of 'conceptualisation' is outlined in the CTS-R Rating Scale as follows:

Key features: The patient should be helped to gain an appreciation of the history, triggers and maintaining features of his/her problem in order to bring about change in the present and future. The therapist should help the patient to gain an understanding of how his/her perceptions and interpretations, beliefs, attitudes and rules relate to his/her problem. A good conceptualisation will examine previous cognitions and coping strategies as well as current ones. This theory-based understanding should be well integrated and used to guide the therapy forward.

Two features need to be considered:

(i) the presence/absence of an appropriate conceptualisation which is in line with goals of therapy;

(ii) the manner in which the conceptualisation is used (e.g. used as the platform for interventions, homework etc.).

NB: This item is to do with therapeutic integration (using theory to link present, past and future). If the therapist deals specifically with cognitions and emotions, this should be scored under Items 6 (Facilitation of Emotional Expression) and 7 (Eliciting Key of Cognitions).

Conceptualising is one of the key processes of therapy through which change takes place. It provides the theoretical overview of the work. Its **absence** can lead to disjointed therapy, which might prevent major insight being gained by the patient. When it is not appropriately integrated within therapy, the work may lose its focus and only consist of a set of unrelated techniques.

In order for effective therapy to occur the conceptualisation must be **appropriate**. To arrive at an appropriate cognitive rationale a thorough assessment needs to take place, in which both therapist and patient collect information to increase their understanding of the problem. Through this data-gathering process the patient learns to monitor the important features of his/her disorder (NATs, feelings, behaviours, safety behaviours, cognitive biases, etc.), and thereby gain further insight. To instigate this process effectively, the therapist must have a good theoretical understanding of generic cognitive therapy and the specifics of the patient's disorder (i.e. the cognitive models of depression, panic, OCD, PTSD, etc.).

During this period, patients learn to break down situations using the rationale. In essence, they begin to become their own therapist. This process is often facilitated greatly through the use of suitable written material. Typically the therapist will illustrate relationships via diagrams or through the use of examples, stories and/or metaphors. If not performed adequately, the patient can feel misunderstood and alienated. He/she may become less active both in an out of sessions.

A good collaborative relationship is usually essential in developing a comprehensive formulation. The therapist must also be sensitive, particularly when working at the level of core beliefs. It is important to remember, however, that these features should be rated under the relevant items (e.g. Collaboration & Interpersonal Effectiveness respectively).

One of the main purposes of establishing the CT rationale is to socialise the patient to the model and generate evidence towards the formulation. The **appropriately** constructed formulation should be able to explain most of the features of the patient's disorders (historical and present, including: fears, vulnerabilities, avoidance, maintenance and compensation strategies, effective and dysfunctional coping strategies, etc.). The ultimate aim of the formulation is to arrive at an agreed set of key core beliefs which, based on empirical evidence, make a major contribution to the patient's understanding of his/her current difficulties. Thus the formulation provides the foundation for change. This shared 'frame of reference' then leads on to the choice of treatment techniques that help inform potential change mechanisms.

A good conceptualisation will provide an awareness of effective and dysfunctional cycles of thoughts ⇔ emotions ⇔ behaviour and thereby suggest potential mechanisms of change.

It is important to note that the patient's self-conceptualisation will not be entirely negative and dysfunctional. Therefore it is vital, when helping to define him/herself, that the therapist highlights the patient's strengths too. This more balanced conceptualisation, may also help clarify areas that could be used effectively in promoting change.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Has the therapist socialised the patient to the CT rationale?
2. Does the therapist demonstrate a good understanding of generic CT?
3. Does the therapist demonstrate a good understanding of the CT rationale for the specific disorder?
4. Does the patient have an adequate CT understanding of the problem?
5. If you asked the patient about his her problems, would he/she be able to produce a working conceptualisation that was broadly consistent with a CT perspective?
6. Has the conceptualisation been truly integrated (i.e. has it been used to guide the therapy)?
7. Did you hear any of the following:
    - Let's see how the various things we have talked about hold together.
    - What we have done so far is look at the way your thoughts affect the way you feel and what you do. It would be useful for us today to look at some general rules and attitudes that are contained in these thoughts. The reason for doing this is for us to try to understand where they come from. Is this OK with you?
    - Do you remember anybody saying this to you: "You are no good"?
    - Let's look at times in your life when you have been depressed before.
    - Are there times in your life when you have felt good about yourself?
    - Does this way of looking at your depression make sense to you?

Item 11 - Application of Change Methods

Introduction

Change methodologies are cognitive and behavioural strategies employed by the therapist which are consistent with the cognitive rationale and/or formulation and designed to promote therapeutic change. The potency of the techniques will depend upon whether they are applied at the appropriate stage in therapy, and the degree to which they are implemented skilfully. It is important to note that during some sessions it may not be appropriate to use a wide range of methods; a rater should take this into account when scoring this item.

The key features of 'Application of change methods' is outlined in the CTS-R Rating Scale as follows:

Key features: Therapist skilfully uses, and helps the patient to use, appropriate cognitive and behavioural techniques in line with the formulation. The therapist helps the patient devise appropriate cognitive methods to evaluate the key cognitions associated with distressing emotions, leading to major new perspectives and shifts in emotions. The therapist also helps the patient to apply behavioural techniques in line with the formulation. The therapist helps the patient to identify potential difficulties and think through the cognitive rationales for performing the tasks. The methods provide useful ways for the patient to test- out cognitions practically and gain experience in dealing with high levels of emotion. The methods also allow the therapist to obtain feedback regarding the patient's level of understanding of prospective practical assignments (i.e. by the patient performing the task in-session).

Two features need to be considered:

(i) the appropriateness and range of both cognitive methods (e.g. cognitive change diaries, continua, distancing, responsibility charts, evaluating alternatives, examining pros and cons, determining meanings, imagery restructuring, etc.) and behavioural methods (e.g. behavioural diaries, behavioural tests, role play, graded task assignments, response prevention, reinforcement of patient's work, modelling, applied relaxation, controlled breathing, etc.);

(ii) the skill in the application of the methods – however, skills such as feedback, interpersonal effectiveness, etc. should be rated separately under their appropriate items;

(iii) the suitability of the methods for the needs of the patient (i.e. neither too difficult nor complex).

NB: This item is not concerned with accessing or identifying thoughts, rather with their re-evaluation.

In deciding the **appropriateness** of a method it is important to determine whether the technique is a coherent strategy for change, following logically from the patient's formulation.

Clinical judgement is required in assessing the degree of **skill** with which a particular methodology is applied. This feature goes beyond mere adherence (i.e. the preciseness with which a technique is applied). Indeed, the rater should be concerned with the manner of application, i.e. the therapist must be articulate, comprehensible, sensitive and systematic when discussing and implementing the technique. The therapist should also be creative and resourceful in his/her selection of methods. He/she should be able to draw upon a wide **range** of suitable cognitive and behavioural methodologies.

It is important to remember that the same technique can have a different function depending on the stage of therapy. For example, a diary can act as an assessment tool early on in therapy, but later may serve as an effective way of promoting the re-evaluation of thought processes. The timing of the intervention is vital and must be **suited to the needs of the patient**. For example, if a therapist challenges basic assumptions or core beliefs too early in therapy, before he/she has a clear understanding of the patient's view of the world, the patient could feel misunderstood and alienated. Only after sufficient socialisation, should the therapist get the patient to start to reassess that level of cognition. The evaluation of automatic thoughts starts earlier, first as part of the socialisation into the cognitive model and then as a change method to improve mood and to improve on coping behaviour.

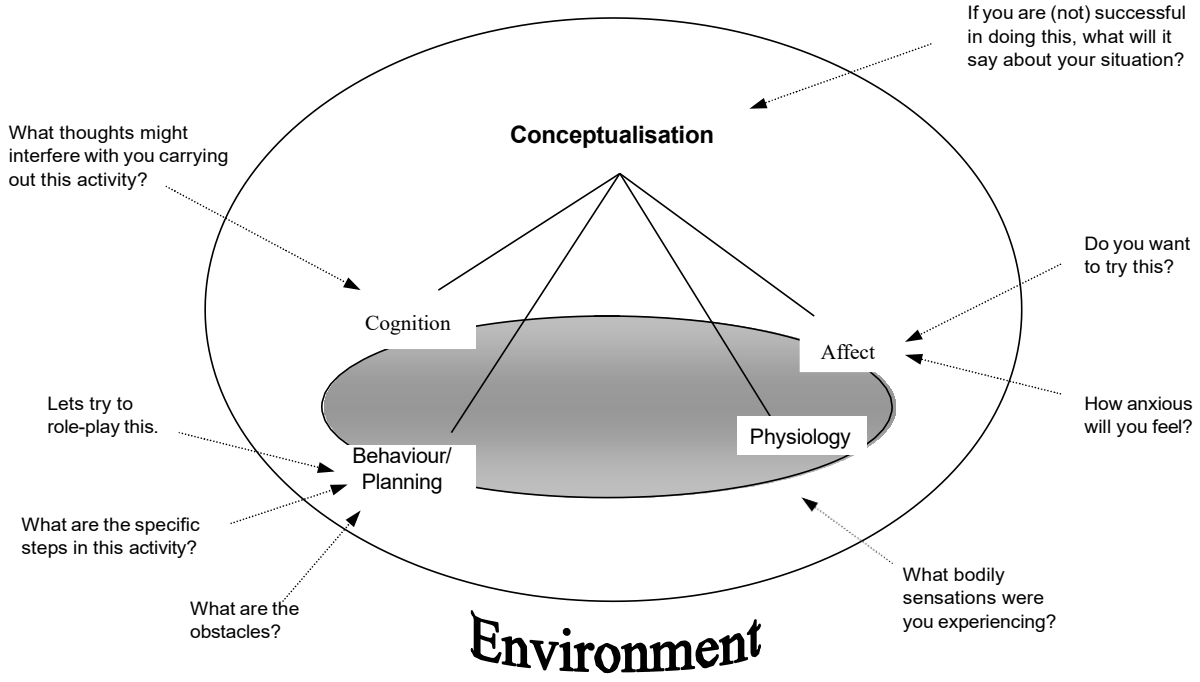
As with the application of cognitive techniques, the therapist must display skill in applying behavioural methodologies. The rationale for employing the tasks should be carefully explored, and clear learning goals established. It is important to remember that behavioural tasks play a key role with respect to the reinforcement of new learning. For example, by engaging a patient in a role-play, one can assess whether the theoretical information has been truly learned and integrated into his/her behavioural repertoire. The role-play will also allow the person to practice new skills. Behavioural tasks are also useful methodologies to employ prior to asking the patient to use the activity in a homework task. For example, it is useful to get the patient to complete monitoring sheets within the session in order to ensure the task is understood correctly. In this way the behavioural methodologies are important feedback and reinforcement activities.

In addition, the therapist needs to elicit and develop practical plans with the patient in order that effective change takes place (e.g. the where, what, when, and how of a desensitisation programme). Indeed, part of the process of producing effective behavioural change is the development of plans that help to test out hypotheses and break unhelpful patterns of behaviour. For example, when setting a behavioural task, the therapist should get the patient to:

- think through the relevance of the assignment
- be confident in his/her ability to perform it, and be sufficiently motivated
- check through anticipated level of arousal
- plan what needs to be done carefully, and be cognisant of potential obstacles
- practice the behaviour
- be able to relate either success or failure to a change in perspective.

In planning the task, relevant questions should be asked of the person's concepts, cognitions, affective and physiological states, and behavioural repertoire. See Figure 11.1 below.

Figure 11.1: Examples of questions used when planning a behavioural intervention



It is important to note that sometimes it is inappropriate to use many methodologies within a particular session. The therapist should not be penalised in such cases, when done for appropriate reasons.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Has the therapist ensured that the patient understands the rationale underpinning the method?
2. Was the method conducted skilfully?
3. Were the learning goals achieved?
4. Were too many/few techniques used in the session?
5. Were the techniques suitable and appropriate for the patient (i.e. neither too complicated nor too demanding)?
6. Was the technique consistent with the formulation?
7. Were the techniques administered with skill?
8. Prior to using the techniques were the learning goals clearly established?
9. Where necessary, was a competent explanation of the rationale of the technique given?
10. Were there valuable opportunities missed when appropriate techniques could have been administered?
11. Did you hear any of the following:
    - What are the benefits of thinking in this way . . . and are there any problems?

- How else could you have seen this situation? Are there alternative views?
- What would you say to your best friend?
- Have you ever had the same experience in the past and reacted differently?
- Would other people have the same opinion of you?
- What are the disadvantages of thinking that way? What are the advantages?
- Let's see whether there are events/situations/experiences that disconfirm this belief about yourself?
- Can we test this assumption in the next week? What might you try and do differently to see whether your predictions are right
- See questions outlined in Figure 11.1

Item 12 - Homework Setting

Introduction

Progress is more likely to occur when patients are able to apply the concepts learned in the therapy sessions to their lives outside; homework assignments are the bridges between therapy and the real world. The current item rates the therapist's competence in setting relevant homework tasks. The tasks should be 'custom-tailored' to the needs of the patient. They should ideally test hypotheses, incorporate new perspectives, and may encourage the patient to experiment with new behaviours outside of the session. The therapist should always explain the rationale for the prospective assignments, and elicit reactions to the homework. The homework rationale should follow on logically from the contents of the session and be consistent with the formulation.

Key features: This aspect concerns the setting of an appropriate homework task, one with clear and

precise goals. The aims should be to negotiate an appropriate task for the stage of therapy in line with the conceptualisation; to ensure the patient understands the rationale for undertaking the task; to test out ideas, try new experiences, predict and deal with potential obstacles, and experiment with new ways of responding. This item ensures that the content of the therapy session is both relevant to, and integrated with, the patient's environment.

There are three aspects to this item:

(i) presence/absence of a homework task in which clear and precise goals have been set;

(ii) the task should be derived from material discussed in the session, such that there is a clear understanding of what will be learnt from performing the task;

(iii) the homework task should be set jointly, and sufficient time should be allowed for it to be explained clearly (i.e. explain, discuss relevance, predict obstacles, etc.).

NB: Review of homework from the previous session should be rated in Item 1 (Agenda Setting).

Homework helps to transfer within-session learning to real-life settings. In other words, this item bridges the gap between in-session work and the patient's activity out of the therapy session. To facilitate the transfer, the homework material is usually based upon **material discussed in the session**.

Homework also provides a structure for helping patients gather data and test hypotheses. It also encourages autonomy rather than reliance on the therapist, and therefore plays an important role in relapse prevention. To help empower the patient, and encourage compliance, the assignments should be **negotiated**. It also is important to explore **possible difficulties**, and how these might be overcome. To mitigate against potential problems. It is often useful for the therapist to suggest that the patient visualise carrying out the assignment to identify future problems.

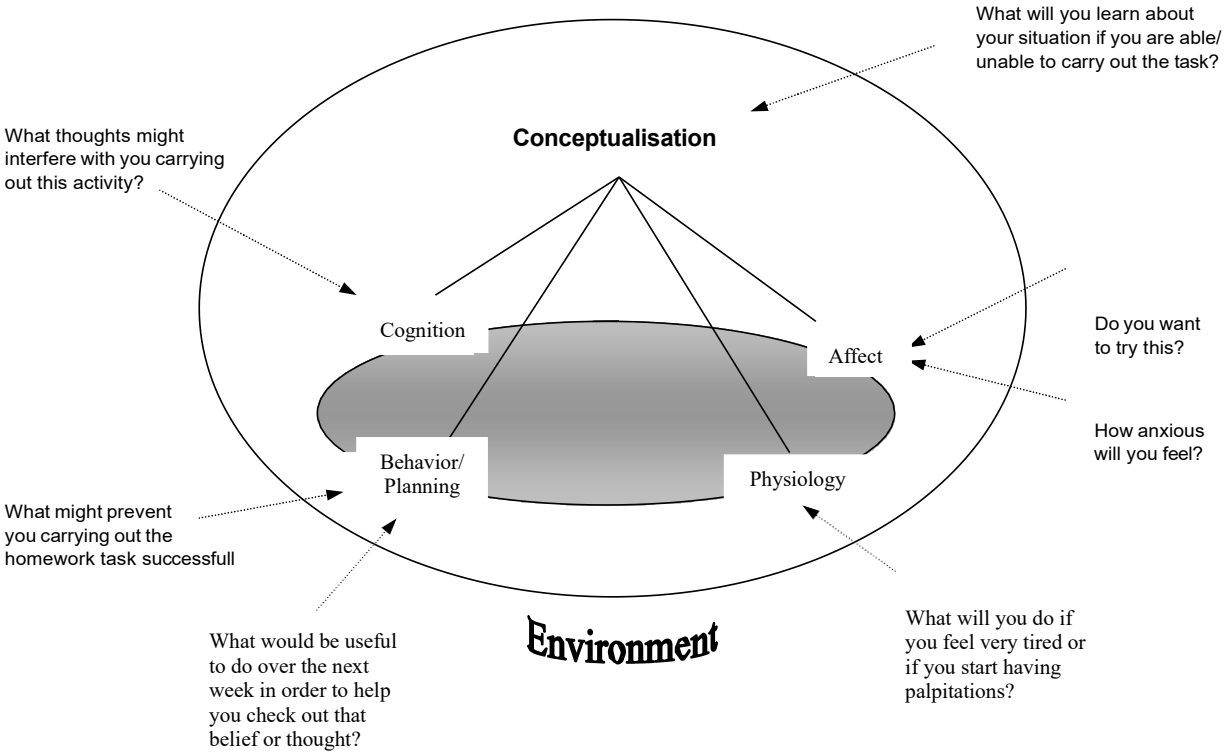
In addition, it is desirable to get patient's feedback regarding a specific assignment ("*Does it sound useful?" "Does it seem manageable?" "Is the assignment clear?" "What will be learned from the accomplishment/non-accomplishment of the task?*"). These questions will help to determine whether the patient is both **clear about the task,** and **understands the cognitive rationale** underpinning it. It is vital that the patient is aware of the cognitive aspects of the assignment and how the results will impact on his/her interpretations. Indeed, one of the important features of homework tasks is that they bring about cognitive shift, and so they must be seen as more than just isolated behavioural assignments.

Because the setting of homework tends to occur towards the end of the session, there is sometimes a tendency to rush the process. This tendency should be avoided, as it can lead to ill-prepared and unclear tasks being set. Hence it is good practice to leave **sufficient time** to set the homework appropriately.

CHECKLIST: QUESTIONS FOR RATERS TO ASK THEMSELVES:

1. Did the therapist adequately explain the rationale underpinning the assignment?
2. Did the therapist check that the patient was confident about conducting the task correctly?
3. Did the patient see the relevance of the assignment?
4. Was the assignment adequately planned within the session?
5. Were the obstacles to conducting the plan discussed?
6. Were the learning goals established sufficiently?
7. Did the therapist set the most appropriate homework task?
8. Was the homework material consistent with the themes from the session?
9. Was the task explained sufficiently?
10. Will the patient learn something useful from engaging in this task?
11. Did you hear any of the questions highlighted in Figure 12.1.

Figure 12.1: Examples of questions used when setting homework assignments



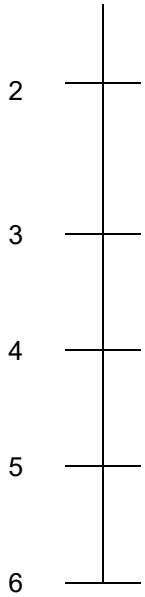
Appendix 25 CTS R form for rating 17 01 12

ITEM 1 – AGENDA SETTING AND ADHERENCE

Competence level	Examples NB: Score according to features, not examples!
0	No agenda set, highly inappropriate agenda set, or agenda not adhered to.
1	Inappropriate agenda set (eg. lack of focus, unrealistic, no account of patient's presentation, homework not reviewed.
2	An attempt at an agenda made, but major difficulties evidence (eg. Unilaterally set). Poor adherence.
3	Appropriate agenda, which was set well, but some difficulties evident (eg. poor collaboration). Some adherence.
4	Appropriate agenda, minor difficulties evident (eg. no prioritization), but appropriate features covered (eg. review of homework). Moderate adherence.
5	Appropriate agenda set with discrete and prioritized targets – review at the end. Agenda adhered to. Minimal problems.
6	Excellent agenda set, or highly effective agenda set in the face of difficulties.

ITEM 2 – FEEDBACK

Competence level	Examples NB: Score according to features, not examples!
0	Absence of feedback or highly inappropriate feedback.
1	Minimal appropriate feedback (verbal and/or written)



2 Appropriate feedback, but not given frequently enough by therapist, with insufficient attempts to elicit and give feedback, eg. feedback too vague to provide opportunities for understanding and change.

3 Appropriate feedback given and elicited frequently, although some difficulties evident in terms of content or method of delivery.

4 Appropriate feedback given and elicited frequently, facilitating moderate therapeutic gains. Minor problems evident (eg. inconsistent).

5 Highly appropriate feedback given and elicited regularly, facilitating shared understanding and enabling significant therapeutic gains. Minimal problems.

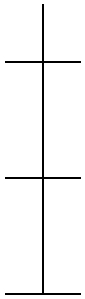
6 Excellent use of feedback, or highly effective feedback given and elicited regularly in the face of difficulties.

ITEM 3 – COLLABORATION

Competence level	Examples NB: Score according to features, not examples!
0	Patient is actively prevented or discouraged from being collaborative.
1	The therapist is too controlling, dominating, or passive.
2	Some occasional attempt at collaboration, but didactic style or passivity of therapist encourages passivity or other problems in the therapeutic relationship.
3	Teamwork evident, but some problems with collaborative set (eg. not enough time allowed for the patient to reflect and participate actively).
4	Effective teamwork is evident, but not consistent. Minor problems evident.
5	Effective teamwork evident throughout most of the session, both in terms of verbal content and use of written summaries. Minimal problems.
6	Excellent teamwork, or highly effective teamwork in the face of difficulties.

ITEM 4 – PACING AND EFFICIENT USE OF TIME

Competence level	Examples NB: Score according to features, not examples!
0	Poor time management leads either to an aimless or overly rigid session.
1	The session is too slow or too fast for the current needs and capacity of the patient.
2	Reasonable pacing, but digression or repetitions from therapist and/or patient lead to inefficient use of time; unbalanced allocation of time, over time.
3	Good pacing evident some of the time, but diffuse at times. Some problems evident.



4 Balanced allocation of time with discrete start, middle and concluding phases evident. Minor problems evident.

5 Good time management skills evident, session running smoothly. Therapist working effectively in controlling the flow within the session. Minimal problems.

6 Excellent time management, or highly effective management evident in the face of difficulties.

ITEM 5 – INTERPERSONAL EFFECTIVENESS

Competence level	Examples NB: Score according to features, not examples!
0	Therapist's manner and interventions make the patient disengage and become distrustful and/or hostile (absence of/or excessive I, ii, iii).
1	Difficulty in showing empathy, genuineness and warmth.
2	Therapist's style (eg. intellectualization) at times impedes his/her empathic understanding of the patient's communications.
3	The therapist is able to understand explicit meanings of patient's communications, resulting in some trust developing. Some evidence of inconsistencies in sustaining a relationship.
4	The therapist is able to understand the implicit, as well as the explicit meanings of the patient's communications and demonstrates it in his/her manner. Minor problems evident (eg. inconsistent).
5	The therapist demonstrates very good interpersonal effectiveness. Patient appears confident that he/she is being understood, which facilitates self-disclosure. Minimal problems.
6	Highly interpersonally effective, even in the face of difficulties.

ITEM 6 – ELICITING OF APPROPRIATE EMOTIONAL EXPRESSION

Competence level	Examples NB: Score according to features, not examples!
0	Patient is under- or over-stimulated (eg. his/her feelings are ignored or dismissed or allowed to reach an unmanaged pitch). Or the therapist's own mood or strategies (eg. intellectualization) adversely influences the session.
1	Failure to facilitate access to, and expression of, appropriate emotional expression.
2	Facilitation of appropriate emotional expression evident, but many relevant opportunities missed.
3	Some effective facilitation of appropriate emotional expression, created and/or maintained. Patient

enabled to become slightly more aware.

4 Effective facilitation of appropriate emotional expression leading to the patient becoming more aware of relevant emotions. Minor problems evident.

5 Very effective facilitation of emotional expression, optimally arousing the patient's motivation and awareness. Good expression of relevant emotions evident – done in an effective manner. Minimal problems.

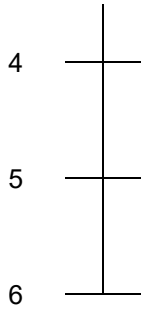
6 Excellent facilitation of appropriate emotional expression, or effective facilitation in the face of difficulties.

ITEM 7 – ELICITING KEY COGNITIONS

Competence level	Examples NB: Score according to features, not examples!
0	Therapist fails to elicit relevant cognitions.
1	Inappropriate cognitions and emotions selected, or key cognitions/emotions ignored.
2	Some cognitions/emotions (or one key cognition, eg. core belief) elicited, but links between cognitions and emotions not made clear to patient.
3	Some cognitions/emotions (or one key cognition) elicited in a competent way, although some problems evident.
4	A number of cognitions and emotions (or one key cognition) elicited in verbal or written form, leading to a new understanding of their relationship. Minor problems evident.
5	Effective eliciting and selection of a number of cognitions/emotions (or one key cognition), which are generally dealt with appropriately. Minimal problems.
6	Excellent work done on key cognition(s) and emotions(s), even in the face of difficulties.

ITEM 8 – ELICITING AND PLANNING BEHAVIOURS

Competence level	Examples NB: Score according to features, not examples!
0	Therapist fails to elicit relevant behaviours and plans.
1	Inappropriate behaviours focused on and/or plans generated.
2	Some behaviours and plans elicited, but links between behaviours, cognitions and emotions not made clear to patient.
3	Some behaviours and plans elicited in a competent way, although some problems evident.



4 A number of behaviours and plans elicited in verbal or written form, leading to a new understanding of their importance in maintaining problems. Minor difficulties evident.

5 Effective eliciting and selection of a number of behaviours and plans, which are generally dealt with appropriately. Minimal problems.

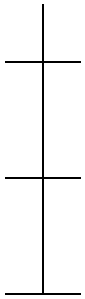
6 Excellent work done on behaviours and plans, even in the face of difficulties.

ITEM 9 – GUIDED DISCOVERY

Competence level	Examples NB: Score according to features, not examples!
0	No attempt at guided discovery (eg. hectoring and lecturing).
1	Little opportunity for discovery by patient. Persuasion and debate used excessively.
2	Minimal opportunity for discovery. Some use of questioning, but unhelpful in assisting the patient to gain access to his/her thoughts or emotions or to make connections between themes.
3	Some reflection evident. Therapist uses primarily a questioning style which is following a productive line of discovery.
4	Moderate degree of discovery evident. Therapist uses a questioning style with skill, and this leads to some synthesis. Minor problems evident.
5	Effective reflection evident. Therapist uses skilful questioning style leading to reflection, discovery and synthesis. Minimal problems.
6	Excellent guided discovery leading to a deep patient understanding. Highly effective discovery produced in the face of difficulties, with evidence of a deeper understanding having been developed.

ITEM 10 – CONCEPTUAL INTEGRATION

Competence level	Examples NB: Score according to features, not examples!
0	The absence of an appropriate conceptualization.
1	The lack, or inappropriateness or misapplication of a conceptualization leads to a neutral impact (eg. interferes with progress or leads to aimless application of procedures).
2	Some rudimentary conceptualization arrived at, but not well integrated with goals of therapy. Does not lead to a clear rationale for interventions.
3	Cognitive conceptualization partially developed with some integration, but some difficulties evident (eg. in synthesizing and in sharing it with the patient). Leads to coherent interventions.



4 Cognitive conceptualization is moderately developed and integrated within the therapy. Minor problems evident.

5 Cognitive conceptualization is very well developed and integrated within the therapy – there is a credible cognitive understanding leading to major therapeutic shifts. Minimal problems.

6 Excellent development and integration evident, or highly effective in the face of difficulties.

ITEM 11 – APPLICATION OF CHANGE METHODS

Competence level	Examples NB: Score according to features, not examples!
0	Therapist fails to use or misuses appropriate cognitive and behavioural methods.
1	Therapist applies either insufficient or inappropriate methods, and/or with limited skill or flexibility.
2	Therapist applies appropriate methods, but major difficulties evident.
3	Therapist applies a number of methods in competent ways, although some problems evident (eg. the interventions are incomplete).
4	Therapist applies a range of methods with skill and flexibility, enabling the patient to develop new perspectives. Minor problems evident.
5	Therapist systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.
6	Excellent range and application, or successful application in the face of difficulties.

ITEM 12 – HOMEWORK SETTING

Competence level	Examples NB: Score according to features, not examples!
0	Therapist fails to set homework, or sets inappropriate homework.
1	Therapist does not negotiate homework. Insufficient time allotted for adequate explanation, leading to ineffectual task being set.
2	Therapist negotiates homework unilaterally and in a routine fashion, without explaining the rationale for new homework.
3	Therapist has set an appropriate new homework task, but some problems evident (eg. not explained sufficiently and/or not developed jointly).
4	Appropriate new homework jointly negotiated with clear goals and rationales. However, minor

problems evident.

5 Appropriate homework negotiated jointly and explained well, including an exploration of potential obstacles. Minimal problems.

6 Excellent homework negotiated, or appropriate one set in the face of difficulties.

Appendix 26 Observation tool for indirect clinical work

(G)

OBSERVATION TOOL FOR INDIRECT CLINICAL WORK

The purpose of this document is to provide a framework for supervisors to directly observe and give feedback on trainees' clinical work with clients (interventions and formal assessment). This document **or parts thereof** should be used on all placements as a guide for supervisors to inform their judgements about trainees' competence as documented on the Clinical Competence Goals and Evaluation Form.

The final document should be signed off by the trainee and supervisor and submitted as part of the Portfolio of Clinical Experience for each placement period in years one and two (i.e. four submissions over the first two years).

The document is divided into four sections:

1. Pre-session
2. The session
3. Post-session
4. Observation of test competence (see also appended document BPS Checklist of Competence in Psychological Testing)

Direct observation may be live or though review of audio or video tape of the session. Consent for the observation must be negotiated with the client(s), with the educational purpose carefully explained. **Observations should be done on several occasions (so this does not become a "one-off" assessment). On each occasion the trainee and the observing supervisor should decide in advance which aspect(s) of the session will be the subject of detailed observation and feedback.**

During the observation the supervisor notes examples of good practice and areas for improvement / development.

Afterwards, time is set aside for mutual discussion. **The trainee is then responsible for recording supervisor feedback and his or her own reflections.**

Previous paperwork should be shown to any new supervisor to assist in the construction of the goals. This would apply whatever the grade, as learning needs would always apply from one placement to the next.

1. Pre-Consultation/Meeting/Training

A) Did the trainee take account of issues of confidentiality and risk?

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

B) Did the trainee take account of issues of culture, gender, power and diversity?

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

C) Was the trainee thoughtful about the location of the session (privacy, convenience, safety, familiarity, suitability for the content)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Was the trainee adequately prepared for the session?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

E) Did the trainee liaise appropriately with other professionals before the session?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

F) Was a time period for the session established?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

G) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

2. Conducting the Consultation/Meeting/Training

A) Did the trainee explain the purpose of the meeting to those present?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

B) Was the level of communication appropriate for the abilities of those present (simplified language/pictures/symbols if needed etc)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

C) Did the trainee make attempts to relax those present at the outset?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Were the perspectives and reasons for attending of all those present actively sought (or were there legitimate reasons for not doing this)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

E) Did the trainee take sufficient account of the likely experience of those present (in terms of reflecting, further enquiring etc?)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

Trainee reflection (strengths and intentions for improvement)

F) Did the trainee convey genuineness and positive regard in both verbal and non-verbal ways during the session?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

G) Did the trainee demonstrate an understanding of the information being conveyed via appropriate summarising/paraphrasing etc?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

H) Did the trainee use psychological ideas/formulation sensitively and appropriately?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

I) Did the trainee manage the timing of the session appropriately?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

J) Was a closing summary of the outcome of the session provided?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

K) Was this checked with those present for their perspectives?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

L) Were "next steps" discussed prior to finishing the meeting?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

M) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

3. Post-Consultation/Meeting/Training

A) Were any notes appropriately written up and filed?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

B) Was consideration given to whether and how to inform relevant parties of the outcome of the meeting?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

C) Was any feedback/comments from attendees reflected upon for future action?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

Name of trainee:

Name of supervisor:

---------- **Date of final completion:**

3. Post-Consultation/Meeting/Training

a) Were any notes appropriately written up and filed?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

b) Was consideration given to whether and how to inform relevant parties of the outcome of the meeting?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

c) Was any feedback/comments from attendees reflected upon for future action?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

4.

Name of trainee:

Name of supervisor:

- -

Date of final completion:

In Vivo Observation of Trainee Clinical Psychologists

The purpose of this document is to provide a framework for supervisors to directly observe and give feedback on trainees' clinical work with clients (interventions and formal assessment). This document should be used on all placements as a tool for supervisors to inform their judgments about trainees' competence as documented on the Clinical Competence Goals and Evaluation Form.

Observations should be done on several occasions (so this does not become a "one-off" assessment). On each occasion the trainee and the observing supervisor should decide in advance which aspect(s) of the session will be the subject of detailed observation and feedback. During the observation the supervisor notes examples of good practice and areas for improvement / development. Afterwards, time is set aside for mutual discussion. The trainee is then responsible for recording supervisor feedback and his or her own reflections.

The final document should be signed off by the trainee and supervisor and submitted as part of the Portfolio of Clinical Experience for each placement period in years one and two (i.e. four submissions over the first two years).

There are two versions of the document; either of these can be used according to which best fits the work being undertaken.

1. To be used for direct work e.g. an assessment or therapy session, or where undertaking testing; in the latter case the 'Observation of Test Competence' section is also to be completed. (See too, the appended document BPS Checklist of Competence in Psychological Testing);
2. To be used for indirect work for example, participation in a professionals meeting, or for training.

Both versions are divided into four sections:

1. Preparing for the session (meeting etc.) and setting the scene
2. Conducting the session
3. Ending the session
4. After the session.

It is possible to use other formalized tools at the discretion of the trainee and the supervisor. This may be particularly appropriate if the supervisor is an accredited practitioner in recognized psychotherapy training, as the completed tool may be used at a later stage to provide evidence for competence if the trainee choose to pursue accreditation in that model themselves (see for example, Hutchins, 2012). Examples of appropriate tools are the Cognitive Therapy Scale – Revised (CTS-R) for cognitive behaviour therapy and the Measure of Cognitive Analytic Therapy Competence (C-CAT) for cognitive analytic therapy. The Clinical Skills Assessment – Rating Form (CSA-RF) is a tool which was specifically developed for use by trainee psychologists and their supervisors and may also be useful for rating the observation of individual therapy work. If you are in any doubt about the appropriateness of an observational tool, please consult with your clinical tutor.

Direct observation may be live or though review of audio or video tape of the session. Consent for the observation must be negotiated with the client(s), with the educational purpose carefully explained.

References

Bennett, D. & Parry, G. (2004) A measure of psychotherapeutic competence derived from Cognitive Analytic Therapy, *Psychotherapy Research, 14,* 176-192.

Blackburn, I-M., James, I.A., Milne, D.L., Baker, C., Standart, S., Garland, A., & Reichelt, F.K. (2001) The revised cognitive therapy scale (CTS-R): psychometric properties. *Behavioural and Cognitive Psychotherapy, 29.* 431-446.

Hutchins, J. (2012) Getting CBT accreditation with the BABCP as a newly qualified clinical psychologist….and how we can retain our identity as clinical psychologists. *Clinical Psychology Forum, 235,* 11-15.

Tweed, A., Graber, R., Wang, M. (2010) Assessing Trainee Clinical Psychologists Clinical Competence, *Psychology Learning and Teaching, 9* (2), 50-60

1. <u>Preparing for the session and setting the scene</u>

A) Was the trainee sensitive to issues of capacity and consent?

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

B) Was the trainee sensitive to issues of culture, gender, power and diversity?

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

C) Was the trainee thoughtful about the location of the session (privacy, convenience, safety, familiarity, suitability for the therapeutic content)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Was the trainee thoughtful about the potential impact on the session of those participating/observing (supervisors presence/position, advocate? Family member? Carer?)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

E) Did the trainee liaise appropriately with other professionals before the session, and share this with client(s) as necessary?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

F) Was a time period for the session established?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

G) Did the trainee explain the purpose of the meeting to those present?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

H) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

2. Conducting the session

A) Was the level of communication appropriate for the abilities of those present (simplified language/pictures/symbols if needed etc)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

B) Did the trainee engage with those present at the outset in order to "settle" them (small talk, introductions)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

C) Were the perspectives of all those present actively sought during the meeting (or were there legitimate reasons for not doing this)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Did the trainee take sufficient account of the likely emotional experience of those present (in terms of reflecting, further enquiring etc?)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

E) Did the trainee convey genuineness and positive regard in both verbal and non-verbal ways during the session?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

F) Did the trainee demonstrate an understanding of the information being conveyed via appropriate summarising/paraphrasing etc?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

G) Did the trainee use psychological ideas/formulation sensitively and appropriately?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

H) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

3 Ending the session

A) Was a "warning" prior to the end of the session given?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

B) Overall, did the trainee mange the balance of time available in the session effectively?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

C) Was a closing summary of the outcome of the session provided?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Was this checked with those present for their perspectives?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

E) Were "next steps" discussed prior to finishing the meeting?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

F) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

4. <u>After the session</u>

A) Were notes appropriately written up and filed?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

B) Was consideration given to whether and how to inform relevant parties of the outcome of the meeting (including carers as well as other professionals)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

C) Was any feedback/comments from clients/carers reflected upon for future action?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

5. Observation of Test Competence (see attached Code of Good Practice for Psychological Testing)

A) Questionnaire based assessment: administration of test

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

B) Questionnaire based assessment: scoring

Supervisor feedback (strengths and suggestions for improvement/development)

Trainee reflection (strengths and intentions for improvement)

C) Performance based assessment: administration of test

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

D) Performance based assessment: scoring

Supervisor feedback (strengths and suggestions for improvement/development)

Trainee reflection (strengths and intentions for improvement)

E) Additional aspect(s) of testing as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

Overall suggestions for future development of trainee?

Supervisor comments

Trainee reflection

[Text Box]
Name of trainee:

[Text Box]
Name of supervisor:

[Text Box]
Date of final completion:

Code of Good Practice for Psychological Testing

People who use psychological tests in clinical settings are expected by the British Psychological Society to:

Responsibility for competence

1. Take steps to ensure that they are able to meet all the standards of competence defined by the Society and to endeavour, where possible, to develop and enhance their competence as test users.

2. Monitor the limits of their competence in psychometric testing and not to offer services which lie outside their competence nor encourage or cause others to do so.

Procedures and techniques

3. Use tests only in conjunction with other assessment methods and only when their use can be supported by the available technical information.

4. Administer, score and interpret tests in accordance with the instructions provided by the test distributor and to the standards defined by the Society.

5. Store test materials securely and to ensure that no unqualified person has access to them.

6. Keep test results securely, in a form suitable for developing norms, validation, and monitoring for bias.

Client welfare

7. Obtain the informed consent of potential test takers and/or relevant others, making

sure that they understand why the tests will be used, what will be done with their results and who will be provided with access to them.

8. Ensure that all test takers are well informed and well prepared for the test session.

9. Give due consideration to factors such as gender, ethnicity, age, disability and special needs, educational background and level of ability in using and interpreting the results of tests.

10. Provide the test taker and other authorised persons with feedback about the results in a form which makes clear the implications of the results, is clear and in a style appropriate to their level of understanding.

11. Ensure test results are stored securely, are not accessible to unauthorised or unqualified persons and are not used for any purposes other than those agreed with the test taker.

****

A2.11 Using norm tables, find percentile equivalents of raw scores and then obtain both Z-scores and T-scores from normal distribution tables.

Unit 3- The Importance of Reliability and Validity
Can the Assessee:

A3.1 Explain the notion of correlation as a measure of the degree of relationship between two measures. A3.2 Define the conditions under which correlation is maximised (both positively and negatively) and minimised.
A3.3 Provide reasonable rough estimates of correlation coefficients represented by various bivariate scatter grams.
A3.4 Describe the basic premises of classical test theory - that actual measures are 'fallible' scores which contain a 'true' score and a random error.
A3.5 Explain in outline the methods of estimating reliability (internal consistency, test retest— same on alternate form) and describe their relative pros and cons.
A3.6 Describe why test scores are unreliable (e.g. measurement error, scoring error, situational factors, item sampling. etc.).
A3.7 Describe how reliability is affected by changes in the length of a test.
A3.8 Describe how reliability is affected by range restriction and how to adjust for such effects.
A3.9 Compute limits for different levels of confidence from raw and standard scores using the standard error of measurement.
A3.10 Compute the standard error for the difference between two scale scores and for the sum of two scale scores.
A3.11 Describe how the degree of correlation between two scale scores affects the reliability of:
(a) their sum; (b) the difference between them.
A3.12 Express the basic notion of Generalisability Theory - that reliability concerns the

degree to which one can generalise from results obtained under one set of conditions to those which would be obtained under another.

A3.13 Describe and illustrate the distinctions between face, content, construct and criterion-related validity.

A3.14 Describe the procedures used to assess concurrent and predictive criterion-related validities and explain the pros and cons of each procedure.

A3.15 Describe the relationship between reliability and validity.

A3.16 Describe the degree to which it may be reasonable to generalise from validity information obtained in one situation to the use of a test in some other situation.

Level Aq
(Questionnaire-based assessments)

Unit 4 - Administration
Does the Assessee:

Q4.1 Arrange for a quiet, private, well-lit environment with furniture and equipment appropriate for the questionnaires to be used which maximize comfort and concentration.

Q4.2 Brief candidates on the purpose of each questionnaire and put them at ease while maintaining an appropriately businesslike atmosphere.

Q4.3 Obtain informed consent for the assessment procedures, including how results are to be used, who will be given access to them and for how long they will be retained.

Q4.4 Plan the session taking account of the duration of individual questionnaires, their cognitive demands and the likely capacity of the client to tolerate these.

Q4.5 Check that the client is not unnecessarily hindered by remediable perceptual difficulties such as poor eyesight by ensuring the client has appropriate perceptual aids (e.g. reading glasses).

Q4.6 Ensure that the client can read and comprehend individual items and the instructions given at the beginning of the questionnaire.

Q4.7 Check to ensure that the client has the necessary materials to complete the questionnaire (e.g. pencil and eraser).

Q4.8 Deal appropriately with any questions that arise without compromising the purpose of the questionnaire.

Q4.9 When the client has indicated she/he has finished the questionnaire(s), check that all items have been completed.

Q4.10 Lock all materials away in a secure place which is not accessible to people other than authorised questionnaire-users.

Q4.11 Thank the client for her/his participation when the final questionnaire has been completed, and explain the next stage *(if* any) in the assessment to them.

Q4.12 Make final entries in the assessment session log — including notes on any particular problems which arose during the session which might have affected the client's responses.

Q4.13 All questionnaire data are kept in a secure place and that access is not given to unauthorised personnel.

Q4.14 All mandatory requirements relating to the client's rights and obligations under data protection legislation are clearly explained to the client and adhered to.

Unit 5 - Scoring
Can the Assessee:

Q5.1 Accurately score the client's performance adhering to the questionnaire manual instructions and calculate raw scores.
Q5.2 Select appropriate norm tables from the questionnaire manual or supplementary material.
Q5.3 Use norm tables to obtain and record relevant percentile and/or standard scores. **Q5.4** Make appropriate use of information provided in the questionnaire manual about cut-off scores.

Unit 6 - Interpretation and Report
Does the Assessee:

Q6.1 Either attach suitable cautions to interpretation of the results, or not to use the questionnaire, where no relevant norms or cut-off tables are available.
Q6.2 Give due consideration, where necessary, to the comparability between the client and any reference groups, the standard error of the group mean and the standard error of measurement of the client's scores.
Q6.3 Present norm-based scores within a context which clearly describes the range of abilities or other relevant characteristics of the norm group they relate to.

Q6.4 Describe the meanings of scale scores in terms which are accurate and reflect the confidence limits associated with those scores.
Q6.5 Provide interpretations of scale scores paying due regard to the correlations which exist between each pair of scales and for the standard error of their difference.
Q6.6 Provide feedback of information about results to the client which is matched to the client's ability and understanding.
Q6.7 Provide the client with opportunities to ask questions, clarify points and comment upon the questionnaire and the administration procedure.
Q6.8 Clearly inform the client about how the information will be presented and to whom.
Q6.9 Provide written reports for the referring agent which describe the purposes of the various questionnaires and scales in an accurate and meaningful way.
Q6.10 Provide written reports for the referring agent which carefully explain any use of normed scores in relation to the ability range of the norm group; carefully justify any predictions made about future behaviour in relation to the validity information about the questionnaire.
Q6.11 Provide written reports for the referring agent which give clear guidance as to the appropriate weight to be placed on the findings.

Level Ap
(Performance-based tests)

Unit 4 - Administration
Does the Assessee:

P4.1 Arrange for a quiet, private, well-lit testing environment with furniture and equipment appropriate for the tests to be used which maximise comfort and minimise opportunities for faking good or bad.
P4.2 Brief candidates on the purpose of each test and put them at ease while maintaining an appropriately businesslike atmosphere.
P4.3 Obtain informed consent for the testing procedures, including how results are to be

used, who will be given access to them and for how long they will be retained.

P4.4 Plan the testing session taking account of the duration of individual tests and subtests, their cognitive demands, and the likely capacity of the client to tolerate testing.

P4.5 Check all test materials prior to testing, ensuring that all materials are complete and in the correct order for presentation to the client.

P4.6 Check that the client is not unnecessarily hindered by remediable perceptual difficulties such as poor eyesight or hearing by ensuring the client has appropriate perceptual aids (e.g. reading glasses).

P4.7 Use standard test instructions to the client as specified by the test manual for each subtest and test item.

P4.8 Where appropriate and as required by the test, time the client's performance in an unobtrusive and efficient manner; adhere strictly to test-specific instructions concerning pacing and timing.

P4.9 Carefully record all aspects of test performance as required by the individual tests, including the client's demeanour, behaviour, concentration and motivation, making particular note of test errors.

P4.10 Monitor the client's concentration and performance during testing and arrange breaks or deferment of testing as necessary.

P4.11 Deal appropriately with any questions that arise without compromising the purpose of the test.

P4.12 Collect all test materials when each test is completed.

P4.13 Carry out a careful check against the inventory of materials to ensure that everything has been returned.

P4.14 Lock all materials away in a secure place which is not accessible to. people other than authorised test-users.

P4.15 Thank the client for her/his participation when the final test has been completed, and explain the next stage (if any) in the assessment to them.

P4.16 Make final entries in the test session log - including notes on any particular problems which arose during the session which might have affected the client's performance.

P4.17 All test data are kept in a secure place and that access is not given to unauthorised personnel.

P4.18 All mandatory requirements relating to the client's rights and obligations under data protection legislation are clearly explained to the client and adhered to.

Unit 5 - Scoring

Can the Assessee:

P5.1 Accurately score the client's performance adhering to the test manual instructions and calculate raw scores.

P5.2 Select appropriate norm tables from the test manual or supplementary material.

P5.3 Use norm tables to obtain and record relevant percentile and/or standard scores.

P5.4 Make appropriate use of information provided in the test manual about cut-off scores.

Unit 6- Interpretation and Report

Does the Assessee:

P6.1 Either attach suitable cautions to interpretation of the results, or not use the test,

where no relevant norms or cut-off tables are available.

P6.2 Give due consideration, where necessary, to the comparability between the client and any reference groups, the standard error of the group mean and the standard error of measurement of the client's scores.

P6.3 Present norm-based scores within a context which clearly describes the range of abilities or other relevant characteristics of the norm group they relate to.

P6.4 Describe the meanings of scale scores in terms which are accurate and reflect the confidence limits associated with those scores.

P6.5 Provide interpretations of scale scores paying due regard to the correlations which exist between each pair of scales and for the standard error of their difference.

P6.6 Provide feedback of information about results to the client which is matched to the client's ability and understanding.

P6.7 Provide the client with opportunities to ask questions, clarify points and comment upon the test and the administration procedure.

P6.8 Clearly inform the client about how the information will be presented and to whom.

P6.9 Provide written reports for the referring agent which describe the purposes of the various tests/subtests in an accurate and meaningful way.

P6.10 Provide written reports for the referring agent which carefully explain any use of normed scores in relation to the ability range of the norm group; carefully justify any predictions made about future behaviour in relation to the validity information about the test.

P6.11 Provide written reports for the referring agent which give clear guidance as to the appropriate weight to be placed on the findings.

Appendix 28 Systemic Family Practice Rating Scale

Systemic Family Practice

Systemic Competency Scale

(SPS)[1]

Purpose

This scale has been devised to provide a structure for the assessment of Systemic Family Practice (SFP) skills. It is designed to evaluate a whole session but in addition can be used as a training and supervision tool and the focus may then be on particular areas of competence.

Rating the scale

The seven-point scale (i.e. a 0-6 Likert scale) extends from (0) where the practitioner does not demonstrate that skill to (6) where a high level of skill is demonstrated. Please refer to the competence level examples found below. These examples are intended to be used as useful guidelines only. They are not meant to be used as prescriptive scoring criteria, rather providing both illustrative anchor points and guides. There is inevitable overlap of the competencies so some aspects will be doubly rated. For example, circular questions may be rated as a change technique and as an aspect of systemic reframing.

Adjusting the scale to the challenges presented by families

The particular therapeutic challenges of the family, and the requirement for therapeutic intervention at a particular time, should be taken into account and individual items scored in relation to the therapeutic needs of the family. If the marker

[1] Updated November 2018

thinks it is appropriate that an item is not covered at all, then it should be rated at 3. If it is covered minimally, but appropriately, it can be scored higher. For example, it may be appropriate to hold back from exploring diversity until a later session. It would be expected that for most sessions all dimensions would be covered.

Interrelatedness of Items

All of the Items are of course related and, as with all assessment, there is a distinction being made that does not completely hold.

This scale has shown to have high internal reliability (Butler et al., 2018)- Measuring Competence in Systemic Practice: Development of the 'Systemic Family Practice – Systemic Competency Scale' (SPS). *Journal of Family Therapy,* doi 10.1111/1467-6427.12251)
It is based on the well-established Cognitive Therapy Scale – Revised (CTS-R) used in rating competence in Cognitive Behavioural Therapy training as well as being informed by well-established training practice within the field of Family Therapy and Systemic Practice. It is informed by the Competency map for Systemic Family Therapy (Roth and Pilling 2007). It is based on the Dreyfus system, which keeps the highest levels of attainment for very high levels of practice. Further validation of the scale is in progress.

Example of the scoring layout

Mark with an 'X' on the horizontal line, the level to which you think the practitioner has fulfilled the core function. Please use whole and half numbers. The descriptive features below are designed to guide your rating

N.B. When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy, perceived family difficulty and fit with the particular family being seen.

Competence Level Examples

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0 1 2 3 4 5 6

0.	Inappropriate absence of feature or highly inappropriate use
1.	Very little evidence that feature has been considered and addressed, or has been done in an inappropriate way
2.	Evidence of some competency but examples of unhelpful practice and general lack of consistency.
3.	Competent, but some problems and/or inconsistencies
4.	Competent with, minor problems and/or inconsistencies
5.	Very competent, minimal problems and/or inconsistencies
6.	Excellent performance, even in the face of high levels of complexity and challenge from family members

The benchmark for a 6 is a level of practice at the highest level expected from a successful Systemic Family Practitioner trained to intermediate level. It is expected that most practitioners will score a 3/4 with fewer scoring at the higher and lower ends of the scale. An average score of 3 should be considered the minimum for students reaching the level of clinical competence required to successfully complete a CYP-IAPT Systemic Family Practice course (Intermediate level). It follows that in the early stages practitioners may score at a low level as this scale is specifically for Systemic Practice Skills and these may be unfamiliar. It is important to explain this in order to avoid discouragement.

Please note this is a measure relating to one therapist's activity. It does not measure the involvement of a co-therapist, a reflecting team or an in-room supervisor. There is a free text box at the end of the scale if you wish to comment on the co-therapist, reflecting team or supervisor.

Item 1: Interpersonal Effectiveness and Development of Therapeutic Alliance

Key features: This dimension refers to some of the key elements in the creation of a sound therapeutic alliance- warmth, empathy, genuineness, understanding and a non-judgmental stance. It involves verbal and non-verbal skills such as 'joining', listening and creating a warm inviting atmosphere for all family members, taking account of developmental level, age and position in the family. It includes appropriate adherence to boundaries and use of self. A key element is the communication of these 'positions' to the family members.

0.	Practitioner's manner and interventions contribute to general disengagement or to an atmosphere of distrust or hostility.
1.	Difficulty in showing appropriate warmth, empathy and understanding in relation to family members, or lack of appropriate boundaries.
2.	Difficulty in demonstrating respect for the views of every family member although there is evidence of some warmth and empathy. Inconsistency in responding to the feedback from family members
3.	Good understanding of explicit meanings of communications from all family members, resulting in a good degree of trust developing, some evidence of inconsistencies in sustaining relationships with all family members. Good attention to different developmental stages of the children and young people.
4.	Ability to understand the implicit, as well as the explicit meanings of the communications and demonstrates it in his/her manner. Minor problems evident (e.g. inconsistencies or greater struggle to connect with particular family members).
5.	Demonstration of very good interpersonal effectiveness with all family members. Everything is done to help family members feel safe and confident and to engage in a sound therapeutic alliance. Minimal problems but generally therapeutic alliance issues are not due to ability of practitioner. Creativity in engaging younger children and

	adolescents
6.	Highly interpersonally effective, even in the face of difficulties. Shows creativity in responses to different family members.

Qualitative feedback from supervisor related to Item 1:

Item 2: Convening and managing the session

Key features: This includes five main elements and practitioners are expected-

1. To begin the session in a way that is inclusive of all family members, ensuring the involvement of all present including small children. This includes appropriate use of toys and drawing materials.
2. To collaboratively agree a clear focus and to hold onto that focus through the session allowing for useful diversions when necessary.
3. To manage the session so that it has a beginning, middle and end, within the time constraints set, and managing essential administrative tasks sensitively within the allotted time.
4. Ensure that discussions are appropriate for the stage of the work, client needs and point in the session. Where appropriate making good connections with past sessions and future sessions.
5. Pacing the session to fit the needs of family members.

0.	Poor beginning to the session and no attempt at engaging or agenda setting. Session pace does not fit the needs of family members.
1.	Little time given to convening, poor time management and lack of focus, or the application of an over rigid agenda. Problems with pacing.
2.	Time given to convening but may not include all family members. Lack of collaboration in agenda setting but some attempts to create focus in the session. Some problems with time management.
3.	Good beginning to session and appropriate agenda but may be a lack of consistency in focus and pacing of session. May include some problems with time management, the inclusion of all family members, or ending the session.
4.	Good convening, appropriate agenda, minor difficulties in focus and time management. Good pacing of the session.
5.	Good convening and appropriate agenda set with good collaboration and focus throughout the session. All administrative tasks covered and good sense of beginning, middle and end to the

	session. Focus and flexibility are used appropriately.
6.	Excellent collaborative agenda set, and reviewed despite challenges in the therapeutic relationship. Ability to hold to the shared goals whilst also addressing other issues that may arise and appropriately need to be addressed. All administrative tasks covered with sufficient time allowed for discussion. Session brought to an appropriate ending.

Qualitative feedback from supervisor related to Item 2:

Item 3:

Collaboration

Key features: Working collaboratively is central to a systemic approach. The aim is for all family members to be active in the session and involved in decisions about goals

and the development of the work. There must be clear evidence of productive teamwork, with the practitioner skilfully encouraging all family members to participate fully (e.g. through questioning techniques, shared problem solving and decision making). The expertise and knowledge of family members should be identified, acknowledged and used, and the practitioner should aim to use their own expertise without inflexibly maintaining an expert position. This will include sharing of information and inviting different kinds of feedback. Another element is the ability to use tentative language that invites a co-construction of ideas.

0.	Family members are actively prevented or discouraged from being collaborative.
1.	The practitioner is too controlling, dominating, or passive and does not actively invite different forms of collaboration.
2.	There are occasional attempts at collaboration, but with little consistency and some family members may be excluded from this process.
3.	Teamwork evident, but some problems with collaboration (e.g. not enough time allowed for the family member to reflect and participate actively). Some use of tentative language as a tool to invite discussion.
4.	Effective collaboration is evident, but not entirely consistent. The practitioner checks out the family members' experience of the session and is able to adapt the session in response to feedback. Consistent use of tentative language.
5.	Effective collaboration evident throughout most of the session, both in terms of verbal content and sharing of information. Good attention paid to style and culture of family and the impact of this on the collaborative process. Flexibility in ways of encouraging collaboration and regular use of 'checking out' with the family. (relational reflexivity)
6.	Effective collaboration throughout the session (all family members), and creativity and skill in responding to any challenges to this process.

Qualitative feedback from supervisor related to Item 3:

Item 4:

Conveying a systemic view of family life, wider context and relationship of family to the problem

Key features: A key element in SFP is to help family members understand difficulties relationally and in the context of family and other relationships. This includes ideas such as circularity, family beliefs, behaviour and relationship patterns, narratives and wider system involvement. This systemic reframing is an essential basis for SFP interventions. This is often achieved through good use of circular and other questions together with reframing techniques and the process of the inclusion of multiple family members.

0.	Practitioner conveys no evidence of systemic understanding during the session.
1.	Some attempts to introduce systemic understanding but clumsy, and with no attempt to take into account the beliefs of family members.
2	The conveying of an over rigid and narrow systemic explanation which may blame the family, Little attempt to take into account beliefs of family members. Limited attention to wider systems.
3	Ability to apply systemic reframes and descriptions but with limited time taken to obtain feedback from family members or explore different ideas. Ability to use questions and track a circular sequence of interaction but may be inconsistencies.
4.	Good ability to reframe systemically in a way that takes into account history over time, developmental issues and effect of problem on the family. Good use of questions to elicit systemic connections.
5.	Consistent use of systemic ideas throughout the session adapted for all family members with good time given for discussion and feedback. Excellent use of questions to elicit systemic connections.
6.	Creativity in conveying systemic ideas including the use of non-verbal techniques and questions. Ability to manage challenges to a systemic perspective in a way that maintains a good therapeutic alliance.

Qualitative feedback from supervisor related to Item 4:

Item 5:

Conceptual Integration

Key features: A flexible conceptual map or formulation is necessary to structure the

work and create coherence. This dimension refers both to the practitioner's own conceptualisation, which should manifest itself in a coherent approach within the session, and the ability to convey these ideas to family members. It is expected that these maps will increase in complexity as the practitioner gains experience of different models and approaches.

0.	No evidence of conceptual map or formulation.
1.	Occasional evidence of conceptual thinking but no coherence or consistency in the session.
2.	Some evidence of conceptual thinking but not carried through, or linked well enough to formulation.
3.	Use of conceptual thinking evident in the session and informs most interventions. Some communication of ideas with family members. However, there may be inconsistencies or lapses.
4.	Good conceptual thinking clearly informing interventions but limited to a narrow range of ideas with some lack of skill in involving all family members in the thinking.
5.	Complex conceptualisations informing the session and good skills in taking account of the thinking and positions of family members when introducing the ideas. Clear connections between interventions, formulation and systemic theories.
6.	Good conceptualisations, open to revision and review and communicated in a collaborative way to family members. Coherent session and may include sharing of research findings or using a range of verbal and non-verbal ways of communicating ideas.

Qualitative feedback from supervisor related to Item 5:

Item 6: Use of questioning

Key features: The use of questioning is a key element in systemic work and in most interventions. It requires a stance of openness and curiosity as well as an ability to use questions in a strategic way to enhance observation and change thinking. Hypothesising is important as a guide to questioning and it also involves the ability to hold a position of uncertainty.

0.	Very little evidence of purposeful questioning.
1.	Some questions but tend to be closed or focused on gathering specific information and have an interrogatory quality.
2.	Use of some circular and other types of questions but with no evidence of a guiding hypothesis. No clear use of family feedback to guide direction of questioning.
3.	Use of purposeful questions organised around an idea or hypothesis identified in the on-going formulation and evidence of working from feedback.
4.	Good circular and other questions used for interventions as well as information gathering. Good attention to feedback and style of questioning differentiated well to fit with needs of different family members and purpose.
5.	Excellent range of questioning organised to support a range of interventions and designed well to fit with different family members. Evidence that they are making a difference to family thinking and functioning.
6.	Good use of questioning carefully following feedback and contributing continuously to the therapeutic plan, maintained even when there are difficulties and fully involving all family members.

Qualitative feedback from supervisor related to Item 6:

Item 7:

Feedback

Key features: Feedback is used in a number of ways and includes reframing. It is the ability to provide a response to session content and process, that is helpful to family members. It is used to enhance interventions such as externalisation (unique outcomes) and solution focused approaches (exceptions) and to highlight and encourage more positive behaviour and relationships (scaffolding). It includes positive feedback and positive connotation. This is different from the feeding back to a family what has been said to the therapist. This latter intervention is a key part of demonstrating listening skills and empathy, especially evident in the initial stages of the work and is rated under interpersonal skills. It is also different from the important skill of working in response to feedback from the family. This is covered in a number of items including questioning interventions.

0.	Absence of feedback.
1.	Feedback only given if requested and is not purposeful. The effect on family members is not sufficiently considered.
2.	Some feedback but mostly when summing up or giving more formal feedback such as at the end of the session.
3.	Some evidence of taking opportunities to feed back and support positive aspects but not consistent and not always taking account of the way in which feedback may be experienced.
4.	Good use of feedback when associated with a particular intervention (e.g. supporting changes in behaviour or relationships) but less evident throughout the session. Good account taken of effect on all family members in the session.
5.	Good use of feedback to support a variety of interventions throughout the session and which may include practitioner's own reactions and experiences. Good pacing.
6.	Excellent use of feedback to all family members even in the face of difficulties. Good flexibility in adapting to family style.

Qualitative feedback from supervisor related to Item 7:

Item 8:

Intervening in process during the session

Key features: This requires an understanding of the process between family members (patterns of interaction), and also the ability to intervene directly in that process through active questioning, communication work, enactment, role play, coaching. It includes active interventions to help family members experience different positions in the family and therefore encouraging empathy. It requires a leadership approach that

engages and involves family members in the process. It needs to be based on a systemic understanding and a good therapeutic alliance.

0.	No evident awareness of process as a focus for intervention or comment.
1.	Some awareness of process but no connections made between content and process, or attempt to address process in the session.
2.	Some awareness of process but interventions are not followed through or connected well enough to the session in general.
3.	Evidence awareness of process and attempts in the session to help family make changes. Simple interventions, such as slowing the process and taking turns in communicating, and helping parental alliance will be achieved.
4.	Good use of process observations and skills in discussions and direct interventions. Good attention paid to level of engagement and “fit” for all family members.
5.	A range of ways of intervening in process including enactment, work to strengthen parent subsystem and different ways of working with communications. Will stay focused on the intervention.
6.	Creativity in working with process adapted to suit different family members even when particular challenges to carrying out the interventions. Maintenance of good therapeutic relationship with all family members and appropriate use of humour and self disclosure.

Qualitative feedback from supervisor related to Item 8:

Item 9: Working with power and difference

Key features: This includes five main elements.

1. Working to reveal differences between family members and appropriately working with that difference.
2. Ability to hold and respect different positions and perspectives within the

family.

3. Using an understanding of power differentials between family members, practitioner and the family, and within different wider contexts to inform interventions
4. Paying attention to differences such as ability, gender, race, sexuality, spiritual beliefs, age, etc. and the way in which these inform behaviour, relationships and beliefs; exploring and taking account of these in the work.
5. Taking an ethical stance to ensure protection of vulnerable family members. This includes attention to safeguarding.

0.	No attention to difference.
1.	Some awareness of difference but not explored.
2.	Some areas of difference noted but no effort made to appropriately explore these. No exploration of cultural and power differences in the wider community.
3.	Some attention to difference and exploration of the meaning of this for family members. Ability to raise concerns of safety and ask about power and difference issues such as class, economic status, culture, religion and ethnicity.
4.	Good exploration of difference and its meanings, and attention to more subtle power differentials within the family, therapy and wider contexts, including all family members. Appropriate exploration of any safeguarding issues in a way that optimises the possibility of collaboration and protects vulnerable members of the family.
5.	Taking account of difference throughout the session and making it an ongoing part of the understanding of the family. Use of curiosity to explore difference. Use of questioning to explore difference and power issues between therapy (team, agency) and the family. (relational reflexivity)
6.	Excellent attention to difference and good skills in talking about it

	even in difficult circumstances. Using creative ways to help family members explore their differences further in a positive and productive way.

Item 10:	**Qualitative feedback from supervisor related to Item 9:**

Exploring and managing emotions in sessions

Key features: Working with the connections between behaviour, relationships, beliefs and emotions is a key skill. Practitioners need to be able to talk about emotions but contain them safely in a family session. They also have to ensure that family members feel understood and can develop strategies to manage their own emotions

0.	No eliciting of emotions or ability to respond appropriately to emotional content of session.
1.	Occasional eliciting of emotion but limited to certain family members or responded to in an unhelpful way.
2.	Some questioning about emotions and appropriate reaction and some notice of emotional response in session but inconsistent or limited to particular emotions or family members.
3.	Ability to talk about emotions that arise in session discussions, connect them to relationships and behaviour. Ability to tolerate and contain emotions in a helpful way . The discussions are superficial or not carried through.
4.	Ability to rigorously explore emotions, even those which are more difficult for both practitioner and family members. Attends to responses of all family members in the room. Begins to work with strategies to manage emotions.
5.	Acknowledges and discusses a range of emotions including happiness, conflict, anger and sadness. Observes the atmosphere in the room and subtle signs of emotional atmosphere. Helps all family members understand and explore emotional aspects of relationship taking account of history and context.
6	Works positively with a range of emotions in a number of different ways even when the emotional atmosphere in the session is challenging and some family members may want to stifle the discussion. Maintaining a good therapeutic relationship.

Qualitative feedback from supervisor related to Item 10:

Item 11: Use of Change techniques

Key features: Practitioner skilfully uses appropriate interventions in line with the formulation. There is some overlap with a number of other items, and activities may be rated more than once. This item focuses on the ability of the practitioner to use a range of interventions to help initiate and support change.

Three features need to be considered:

1. Appropriateness of interventions in relation to the formulation and evidence base.

2. Skill in the application of the methods.

   3.The way the intervention fits for the family members – paying attention to pace, developmental level, language, therapeutic alliance and acceptability of intervention.

0.	Practitioner fails to use, appropriate interventions, or uses interventions that are not appropriate or connected to the needs of the family.
1.	Practitioner initiates interventions but they are poorly executed and/or lack sensitivity to needs of the family at that particular time.
2.	Practitioner uses some appropriate interventions but not followed through or not well enough connected to needs of family.
3.	Practitioner applies a number of methods in competent ways, although some problems may be evident (e.g. the interventions are incomplete or poorly presented to the family).
4.	Practitioner applies a range of methods with skill and flexibility, enabling family members to develop new perspectives and make changes Minor problems evident.
5.	Practitioner systematically applies an appropriate range of methods in a creative, resourceful and effective manner. Minimal problems.
6.	Excellent range of interventions, skilfully carried out even in the face of difficulties.

Qualitative feedback from supervisor related to Item 11:

Item 12: Incorporating the outside world

Key features: It is important for practitioners to bring wider systems and networks into their formulation and into interventions. This could include other family members, professional networks or important groups such as community, church, peer group and school. It also involves the identification of pressures and stresses such as poverty, unemployment or discrimination, which are important in understanding difficulties and planning ways of

helping.

0.	No inclusion of anyone outside immediate family members in session discussions.
1.	Occasional questions asked about external networks, context and wider family but no follow up or continued reference to these in the session.
2.	Some questioning about external world but little empathy with the experience of family members and little response to issues raised by family members.
3.	Good exploration of wider contexts and some attempts to explore the experience of different family members and to incorporate this into conceptualisation of the difficulties. Identification of important people who may be included in session or part of liaison work.
4.	Wider contexts clearly part of thinking throughout the session and good ability to follow up information brought in by family members. Ability to work collaboratively to bring together views of professionals and other networks and to take wider context into account when devising tasks.
5.	Ability to use relationships with wider contexts as a core part of the work. To give tasks that make use of external resources and help family members to identify and work with some of the constraints and opportunities available in the outside world.
6.	Ability to explore different levels of relationship with outside world and continuously monitor, and discuss how these affect family members even when this is difficult and to do so in a way that fits for family and family members.

Qualitative feedback from supervisor related to Item 12:

Where appropriate, please comment on practitioner's ability to effectively make use of supervisory comments and interventions from reflecting team and /or co-therapist

Scoring: If the measure is used to evaluate a whole session it is useful to map the scores on a graph and an average score computed. In order to achieve an intermediate level of competence, the average should be 3 or above, with no scores below 2. Please note that if the person rating considers that it is appropriate that an item is missing from a session it can be scored at 3. This is unlikely but may occur in initial sessions or if a particular issue has to be addressed (for example safeguarding).

The person rating should use their judgement, together with the benchmark examples, to rate particular items. The most important factors are that the therapist activity is carried out in a way that helps the family at a particular point, with the problems they bring.

(November 2016)

Systemic Family Practice/Systemic Skills Rating Scale

(SFP-SSRS)

Please see guidance notes

Mark with an 'X' on the horizontal line, using whole and half numbers, the level to which you think the practitioner has fulfilled the core function.

N.B. When rating, take into consideration the appropriateness of therapeutic interventions for stage of therapy, perceived family difficulty and fit with the particular family being seen.

SFP Practitioner: _____Family: _____

Date of Session: _____ Tape ID#: _____ Rater: _____

Date of Rating: _____

Session# _____ ( ) Video ( ) Audiotape ( ) Transcript ( ) Live Observation

1. Interpersonal Effectiveness and Development of Therapeutic Alliance

0 1 2 3 4 5 6

2: Convening and managing the session

0 1 2 3 4 5 6

3. Collaboration

0 1 2 3 4 5 6

4. Conveying a Systemic View

0 1 2 3 4 5 6

5. Conceptual Integration

0 1 2 3 4 5 6

6. Use of Questioning

0 1 2 3 4 5 6

7. Feedback

0 1 2 3 4 5 6

8. Intervening in Process

0 1 2 3 4 5 6

9. Working with Power and difference

0 1 2 3 4 5 6

10. Exploring and managing emotions in sessions

0 1 2 3 4 5 6

11. Use of change techniques

0 1 2 3 4 5 6

12. Incorporating the outside World

0 1 2 3 4 5 6

Final Comments (areas of strength/development)