UNIVERSITY OF Hull

Doctorate in Clinical Psychology

Supervisor Handbook

(February 2018)

Contents

INTRODUCTION

The Hull Doctorate in Clinical Psychology is a unique training course in the UK as the only university providing an integrated training route to the profession of Clinical Psychology. Trainees are selected from undergraduate Psychology courses at Hull and York Universities – these are referred to as year one to three of training. The trainees embarking on the Doctorate therefore begin as year 4 trainees and complete it as 6th years. This terminology will be used throughout the handbook.

The Supervisor Handbook contains extracts from the Course Handbook, which is given to all trainees and which can be sent to Supervisors on request. It also includes additional information of relevance to placement supervisors. The training partnership that exists between the course and those professionals who supervise trainees in their clinical practice is highly valued. We look forward to our continuing work together to train new clinical psychologists in a way that ensures high quality graduates for their role in today's NHS.

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Contacting the Clinical Tutor team

Clinical Tutors all have other commitments outside the university. To make it easier to contact us please see the timetable below. We can also be contacted by e-mail or by contacting Beverley Leak (Programme Team Leader) on 01482 464106.

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1. PLACEMENT STRUCTURE AND DURATION

1.1. Days on placement.

Placement experience constitutes the largest single component of the Course. All trainees should be on placement on Mondays, Tuesdays and Wednesdays with the exception of time spent on block teaching at the beginning of each academic year. They should not normally be engaged in clinical work on Thursdays or Fridays, without prior discussion with their Clinical Tutor. Final year trainees work for five days a week after the completion of their research (usually early June).

It is a requirement of the course that trainees spend at least 70% of allocated time on placement. Trainee absence from placement is reported under reserved business to the weekly Coordinators', and figures include the percentage attendance. The percentage attendance is reviewed on an annual basis for each trainee.

It is the trainee's responsibility to ensure that their clinical supervisor and placement administrative staff are informed as to their contact details on days when they are not on placement in case of clinical emergencies.

1.2. Support on placement

Fourth year trainees will be allocated a Clinical Tutor, a member of course staff, who should be their first contact point in relation to any placement related issues that arise. Clinical Tutors are also the first point of contact for supervisors with any issues relating to their trainees and can be contacted at any time. The Clinical Tutor will be present at initial, mid and end of placement review meetings during the fourth year and at mid and end of placement review meetings in the fifth and sixth years. Trainees' main relationship on placement is with their primary supervisor, a psychologist employed within the service where the trainee is on placement. Other staff, including non-psychologists, may supervise significant parts of the trainee's work, but the role of the primary supervisor is to ensure that the trainee is gaining sufficient experience overall to enable progress to be made towards the range of learning outcomes. Supervisors have a responsibility to ensure that trainees are safe to practice

but their main role is to facilitate trainee development. Trainees should feel able to raise a range of issues with supervisors, including personal issues that may be affecting work performance. Personal tutors and mentors also have a role to play in supporting the trainee.

1.3. Training Pathways

In conjunction with its NHS partners and a small number of private sector providers, the Course has developed a number of training placements that provide trainees with experience of working with service users and their carers/supporters across the age and ability range. The model of training across the UK is now competency based rather than population based and as such, training pathways for individual trainees can vary significantly. Table 1 lists the Core Competencies to develop and the range of experiences expected to be available to a trainee.

Table 1: Core Competencies and Range of Experiences

Core Competency		**Experiences**
Generalisable Meta-competencies		Age range
Psychological Assessment		Ability range
Psychological Formulation		Range of presentations
Psychological Intervention		Service delivery settings
Evaluation		Chronicity & severity
Research		Diversity
Personal and Professional Skills & Values		Modes of delivery
Communication & Teaching		Providers
Organisational & systemic influence and leadership		

To introduce Hull trainees to the importance of understanding a person's context and of reflecting upon their own value base, Placement 1 is a six-week Community Psychology block. This block incorporates teaching, placement experience in a non-NHS setting and formal Reflective Practice groups. Following the completion of the Community Psychology block and in line with the progressive learning model, placement experience in Placement 2 of the 4th year is oriented towards learning 1:1 clinical skills. In the 5th year the emphasis is on working as a member of a multidisciplinary service, working with family members and carers and consultation work. The recently published Standards for the Accreditation of Doctoral Programmes in Clinical Psychology Training (BPS, 2015) retains an emphasis on providing evidence that Trainee Clinical

Psychologists are competent in CBT and one other therapy by the end of training and as such 4th year placements should include significant opportunities for the development of CBT competencies which can be built upon in subsequent years. In the sixth year, trainees are able to select placements that provide experiences that have not been available to them previously. Trainees are strongly encouraged to select final year placements within Departments where they have not worked during the first two years of the Course, in order to obtain as broad an experience as possible. Table 2a lists the main organisations which currently provide placements.

Table 2a: Placement Locations & Organisations

Location	**Organisation**
Hull/Bridlington/ Beverley/Driffield	• Humber NHS Foundation Trust • Hull and East Yorkshire Hospitals NHS Trust
Grimsby/Scunthorpe/ Doncaster	• Care Trust Plus • NAViGO • Lincolnshire Partnership NHS Trust • North Lincolnshire and Goole Hospitals NHS Trust • Rotherham, Doncaster and South Humber NHS Trust
York	• York Teaching Hospital NHS Trust • Leeds & York Partnership NHS Trust • Tees, Esk and Wear Valleys NHS Trust • The Retreat
Harrogate/Northallerton	• Harrogate & District NHS Trust • Tees, Esk and Wear Valleys NHS Trust

Trainees may gain experience through a variety of placement arrangements, organised around the progressive learning model. Table 2b illustrates the essence of the clinical practice structure for Hull trainees. The first year of training incorporates a six week Community Psychology placement and a nine month Clinical Psychology placement. The second and third year of training incorporates two further placements in each year, which will either run consecutively (2x5 month placements) or concurrently (2 days in one specialty and a day in another over the year; or on occasion the two/one day split reversing after the first 5 months). The majority of pathways enable trainees to obtain experience over the age and ability range, so that trainees retain a wider choice of placements in the sixth year. Some pathways may not always include the full range of experiences and trainees will then have to ensure that any gaps are remedied in their choice of final placements.

Table 2b: Placement Pathways and associated coursework

Year of Training	**Year 4**		**Year 5**		**Year 6**	
Placement	**1 (Nov-Dec)**	**2 (Jan-Sept)**	**3 (Oct-Apr)**	**4 (Apr-Sept)**	**5 (Oct-Apr)**	**6 (Apr-Sept)**
Competency focus	Community and Critical Psychology	1-1 Assessment, Formulation & Intervention	Wider systemic thinking; Indirect working with families, carers and MDTs.		Supervision Consultation Leadership	
Model	Community and Critical Psychology	CBT	Systemic CBT Neuro Other Models		Psychodynamic/ISTDP CFT Schema Therapy DBT	
Client Group	Adults Young Adults Older Adults LD Forensic	***Adult*** Older Adult Psych Med LD	***CAMHS*** LD Older Adult Adult Health Neuro		Forensic Health Neuro Other specialist service	
Placement related coursework	Poster Presentation Clinical issues presentation (Apr) *Both formative*	Clinical Literature Review (Apr) Clinical Practice Evaluation 1 (1-1/Assessment) Individual Case Study	Small Scale Project (Jan)	Clinical Practice Evaluation 2 (MDT/systemic/ Intervention)	Psychometric Case Study	

During each placement the trainee will have a primary supervisor who is responsible for liaising with the Course. If the placement is split (two days/one day) then the main supervisor of the 'day a week' experience will also be involved in all review meetings to ensure that a balanced appraisal of trainee development occurs. Where more than one supervisor is involved in overseeing trainee work within a specialty it is the role of the primary or main supervisor to ensure that other staff from that specialty involved in the supervision of the trainee (secondary supervisors) input into discussions about progress towards learning outcomes prior to review meetings. A suggested supervision record can be found in Appendix 1 of this handbook to facilitate the recording of sessions in relation to the trainee competencies focussed on during supervision.

1.4 Placements outside Yorkshire and Humber

The majority of trainees select final year placements within the geographical areas described above. From time to time however, trainees may opt to explore the possibility of a final year placement in another part of the UK or abroad. This is usually only possible to arrange in the first half of the 6th year because of the demands posed by trainee's research in the run up to hand in June. Any trainee wishing a distant placement in the final year of training must have the support of their research supervisor. Placements in other parts of the UK can be organised in line with local final year placements. Liaison with local Courses is essential when discussing placements outside the area. Overseas placements need to begin to be thought about towards the end of the fourth year. They should be designed to meet specific learning needs that cannot be met locally and should be within nationally/internationally recognised services.

2. PLACEMENT ALLOCATION

2.1 Prior to coming on the Course

Candidates for clinical training are informed at selection that they need to be prepared to travel to placements outside the Hull and East Yorkshire area. Travel expenses are paid, which can be put towards the cost of overnight accommodation, if the trainee chooses not to commute. Whilst every effort will be made to arrange local placements for trainees with carer responsibilities, candidates are made aware that this cannot be guaranteed. Factors that are taken into account when determining allocation of a training pathway at the beginning of the fourth year include:

- Special needs relating to trainee disabilities
- Carer responsibilities
- Trainee preference for a particular set of clinical experiences
- Trainee preference for a particular geographical area

Trainees who feel that they have special needs relating to the allocation of a training pathway are strongly encouraged to make contact with the Clinical Practice Co-ordinator prior to the beginning of the Course (See section on trainees with disabilities below).

Although the Course endeavours to inform trainees as soon as possible about changes in allocated placements, trainees must be aware that sometimes changes can occur at short notice and that alternative options may be limited. Where there is a choice of alternative options the trainee will always be asked for their preferences.

Any queries or concerns about placements once allocated should be raised with the Clinical Practice Coordinator.

Fourth Years

Year 4 trainees begin their training with a six week teaching block, followed by a six-week Community Psychology placement and a nine month Clinical Psychology placement from January. During the early weeks of training, trainees are asked for any clinical or geographical preferences for the January Clinical placement. The Clinical Practice Coordinator then uses these preferences to help inform placement allocation.

In April of each year the Clinical Practice Coordinator and the Locality Coordinators (clinical psychologists employed in the Trusts who coordinate all placement provision in their areas) confirm placement availability for the second year of training. The Clinical Practice Coordinator then discusses trainee progress with fellow Clinical Tutors to plan the fifth year placements. These will normally include a placement focused on working with children and families.

Fifth Years

In January, following liaison with Locality Coordinators, trainees are circulated with information about the final year placements available and are asked to indicate in writing their placement preferences for Year 6. If competing preferences are identified decisions will be taken about allocation based on the following criteria:

- Special needs relating to trainee disability
- Log book gaps that require to be filled/other identified training needs
- Carer responsibilities
- Experience in different department/s to the ones in which they have previously worked.
- Trainee preference for a particular set of clinical experiences
- Trainee preference for a particular geographical area

Locality coordinators should confirm availability of the trainee preferences indicated by the end of March, with the aim of finalising placements by April. Trainees should be informed about the final allocation in writing by the end of April. Trainees should not approach individual supervisors to discuss possible placements prior to allocation in order to ensure both transparency and equity

in the allocation process. Trainees wanting additional information that cannot be provided by the Clinical Practice Coordinator should note that all communication with supervisors at the allocation stage should be through the Locality Coordinators.

2.2 Review Process for Allocation Procedures

There is always considerable variability in the ease with which placements are allocated from year to year and the need to retain flexibility in any process agreed for placement allocation is important. In some years very little discussion will be needed, and in other years the process may be protracted.

Feedback on the process each year is obtained through a variety of mechanisms:

- Individual feedback from trainees and supervisors to the Clinical Practice Coordinator
- Trainee and Locality Coordinator representation on the Placement Committee; placement allocation process is a standing agenda item.
- A formal review is held at the first Placement Committee of each academic year where feedback from all the above sources is discussed.

2.3. Trainees with Disabilities

Both the Course and placement providers are committed to implementing Part 2 of the Disability Discrimination Act (1995) which deals with employment. This relates to the requirement to make ‘reasonable adjustments’ and ensure that trainees are not subject to ‘less favourable treatment’ because of their disability. Part 4 of the DDA covers Higher Education, specifically in relation to placements. The Course aims to ensure that supervisors are aware of their obligations under the Act through teaching and discussions in initial supervisor training workshops and aspires to a culture within which difference and diversity are valued.

2.3.1. Needs Assessment

At the beginning of the first year of training, trainees with a disability will be offered an opportunity for a meeting with the Clinical Practice Co-ordinator to establish any special needs that require to be taken account of in placement planning. A written statement of need will be produced which will be taken into account when allocating placements. It is recognised that not all needs may be able to be identified in advance of the placement and that this needs assessment may need to be amended as training progresses or needs change. Trainees who are unsure of their needs in relation to carrying out clinical work or who need assistance in obtaining specialised equipment should contact the University Disabilities Office and the Clinical Practice Co-ordinator as soon as possible after selection to obtain advice, as experience suggests that obtaining equipment can take some time.

2.3.2. Pre-placement Planning

Once a placement is allocated, there should be a three way meeting between the trainee, the supervisor and the Clinical Practice Co-ordinator or Clinical Tutor at the base/s where the trainee will be working. This should occur at least one month in advance of the commencement of the placement. During this visit, any potential barriers to the smooth running of the placement should be identified. How these difficulties are responded to will be discussed at the meeting. The over-riding principle is that although not all difficulties can always be surmounted the trainee should feel confident that they have been offered the best placement experience available in line with their particular needs.

2.3.3. Confidentiality

At the pre-placement meeting supervisors need to agree with trainees what the limits of confidentiality are and how information should be communicated with others where relevant. Issues relating to meeting special needs should be discussed with Health and Safety representatives when required, not brought up at NHS team business meetings.

2.3.4. Placement Planning and Assessment Pack (PPAP)

Trainees should ensure that supervisors are provided with their written statement of needs, which should be attached to the Placement Planning and Assessment Pack (see below). Clinical Tutors should ensure that these needs are being met at the mid-placement visit and that any amendments that require to be made are notified to the supervisor in writing.

2.3.5. Trainee Placement Feedback Form

The feedback form that all trainees complete at the end of each placement includes a section commenting on the extent to which special needs were met on placement.

3. MANDATORY TRAINING FOR TRAINEES

The Course organises annual 'mandatory' NHS training courses for all trainees, covering Fire Training, Manual Handling, Display Screen Equipment, Child Protection 1 and 2, Violence and Aggression Awareness, which occurs during block teaching at the beginning of each term. Trainees should not be expected to undergo such training on placement and if asked to do so should contact the Clinical Practice Coordinator. Additional child protection training, training in CPR and breakaway training may be offered on some placements and trainees are encouraged to participate in this where relevant. Trainees are not expected to, and should not be expected to participate in, control and restraint training.

4. EXPERIENCES REQUIRED FROM PLACEMENTS

The British Psychological Society Membership and Qualifications Board through the Committee on Training in Clinical Psychology have outlined the experiences that trainees should have whilst on clinical placements in order to allow them to develop the competencies required by a Clinical Psychologist. These are specified in the Standards for the Accreditation of Doctoral Programmes in Clinical Psychology Training (BPS, 2015) and recorded in the Logbook of Clinical Experience.

The training pathways agreed between the Course and its NHS and other partners, described above, have been designed to enable trainees to obtain experience in working with people across the age and ability range, in a variety of clinical contexts and using a range of modes and models of working. In choosing final year placements trainees must ensure that they will have completed the range of required experiences before the end of the Course. Trainees develop a portfolio of experience over the course of training to record and demonstrate their development – the Clinical Practice Portfolio.

4.1 Clinical Practice Portfolio (CPP)

The Clinical Practice Portfolio is made up of a number of sources listed in Table B5.

Table 3: Clinical Practice Portfolio

Portfolio	**Purpose**	**Contains**
Core Net	To record demographic data on all clients seen	Basic information on all clients
Excel Logbook	To record the ***range*** of clients seen and models used	- Log of clients extracted from CORE-NET; - Log of non-therapy experiences; - Log of therapy skills used; - Log of tests used
Placement Planning and Assessment Pack	To provide ***evidence*** of progress towards each of the required core competencies. To ***evaluate*** trainee progress	Examples of work done to fulfil both core and therapy competencies. - Placement Contract - Evaluation of trainee - Evaluation of placement

The CPP serves several purposes:

- It lists the range of experiences that trainees are required to have
- It records the experiences obtained on placements
- It is an important means by which trainees, supervisors and Course staff are able to monitor gaps in experience in order to consider how these may be addressed
- It enables external assessors to evaluate the experiences that placements provide

The format and content of the CPP is reviewed periodically at the Board of Supervisors meeting, in order that it continues to reflect the realities of day-to-day NHS practice for clinical psychologists. The Hull, Leeds and Sheffield courses have worked in conjunction to develop an electronic portfolio of experience which incorporates the CORE-NET system and a locally written Excel logbook. The CORE-NET system provides a secure means to record all of the clients that the trainee will work with over the course of their training. The CORE-NET system also allows trainees to record clinical outcomes. The Excel logbook records both therapy and non-therapy experiences.

It is a trainees' responsibility to ensure that his/her CPP is updated regularly and is referred to when planning placements, setting placement contracts and in their own individual annual appraisals. **Trainees are required to bring their Portfolio to all placement review meetings.**

The experiences recorded in the CPP should enable the trainee to achieve the competencies specified in the Placement Planning and Assessment Pack (PPAP). At least **one week prior** to each placement review, the trainee must email their Excel Logbook to their Clinical Tutor in preparation for the Mid (MPR) or End of Placement Review (EPR). Trainees must submit their CPP to CANVAS (the university's VLE) no later than **two weeks following the MPR**; and no later than the **final day** of their placement following the EPR.

NB: The Pass/Fail form in the PPAP must be signed by the supervisor by hand to confirm that they are satisfied with the trainee's progress and the evidence that the trainee has presented. The trainee or supervisor can then scan this document to form part of the complete PPAP for submission to CANVAS.

Trainees will only be considered to have passed the placement once the completed Clinical Practice Portfolio for that placement has been submitted to the University. As with all other coursework, trainees will be required to submit an extension request should they believe they will not be able to submit the CPP by the deadline. The CPP from previous placements should be reviewed at the start of the next placement as part of the initial contracting process.

4.1.1 Placement Planning and Assessment Pack (PPAP)

This document allows for the joint planning, monitoring and documenting of specific learning outcomes that trainees should aim to achieve on placement.

Learning outcomes in the PPAP relate to the areas of core clinical competency outlined by the Committee for Training in Clinical Psychology (BPS CTCP, 2002) and updated in Standards for the Accreditation of Doctoral Programmes in Clinical Psychology Training (BPS, 2015). The British Psychological Society Membership and Qualifications Board, through the CTCP, has outlined the experiences that trainees should have whilst on clinical placements in order to allow them to develop those competencies required by a clinical psychologist.

In addition to the generic learning outcomes, trainees set individual goals/ learning outcomes with supervisors to address areas of skill on which they wish to focus. This is again a developmental process with goals being revised, and new goals identified at each placement review meeting. It is recognised that every trainee has areas of skill with which they are less confident, and which may not be specifically addressed by the generic learning outcomes, and therefore setting individual goals bridges this gap.

4.1.2. Using the PPAP

At the beginning of a placement (within the first 2 weeks), trainees and supervisors should;

1. Review the PPAP and Logbook from the previous placement;

2. Review the competencies relevant to the trainee's current stage of training. These competencies constitute goals toward which the trainee will be progressing on placement. The specific experiences and resources made available on placement should be geared towards the achievement of these competencies. Progress on previous placements should be reviewed at the beginning of each placement to ensure that areas requiring particular development are being focussed upon.

3. Review the trainee's individual goal plan. Note that trainees on their very first placement will not yet have a goal plan as this is developed at the first mid-placement review.

4. Complete sections A to G of the PPAP incorporating into the contracting process, specific placement experiences which allow each competency and individual goal to be demonstrated. Use statements that say which specific learning outcomes will be demonstrated by which placement experiences. Make statements clear and measurable where possible.

Trainees should then submit the PPAP to CANVAS by the end of the second week on placement.

Prior to any mid- and end of placement meetings the trainee should write a list of evidence of progression towards both the generic and individual learning outcomes in the PPAP. The trainee and their supervisor(s) should then rate the trainee's progress towards, and demonstration of, each of the nine Core Competencies using the Likert scale included in the PPAP. There should also be a discussion about trainee competence in specific therapy models, which

will be aided by the trainee completing a Therapy Self Evaluation form for one or more therapies used on placement.

For all trainees there will be two points of evaluation; one at mid-placement review and one at the end of placement review. Ten-month placements which previously required require two mid-placement reviews will now only require one with an end of placement review now being introduced to facilitate smoother trainee transition between 5th and 6th year placements.

Where a trainee is judged at the mid-placement review to be at risk of potentially failing a placement then they will be written to by their Clinical Tutor outlining the changes/developments that must be evidenced to pass the placement. Additional review meetings may be put in place to provide support to both trainee and supervisor by the Clinical Tutor.

The ratings made at mid and end of placements are intended to be 'formative' to the trainee, not 'summative', i.e. these ratings should contribute to the professional development of the trainee in all competency areas by highlighting areas for improvement and continued development. The ratings do not contribute to a trainee's final marks on the course.

If the supervisor and the trainee cannot agree on the same mark they may record both views and this will be discussed with the visiting Clinical Tutor. The Clinical Tutor will ensure that ratings recorded on the PPAP are also held on the Course trainee file. These ratings will be discussed with the trainee in the context of their annual appraisal meeting.

Progress in relation to specific learning outcomes is assessed on a scale of 0-5 with a score of 5 implying full achievement of the goal to an excellent standard. The scale is constructed around the competency concept in that it attempts to clearly describe the minimum standards needed to be achieved to signify progression in a particular goal area. A key way of assessing trainees' progress toward specific goals is assessing their ability to do so without excessive reliance on didactic instruction from supervisors. Trainees who are

performing well should be clearly demonstrating progress towards required learning outcomes and should be seen to do this on more than one occasion and without needing heavy instruction from their supervisor(s).

An essential part of this process is that supervisors ensure that they are regularly able to observe trainees outside of supervision in different settings so that valid assessments of progress in different competencies can be made. Supervisors are advised to make regular use of audio or video recordings, direct observation, process notes and competency based supervision records in order to ensure that they can validly evaluate their trainee's progression and development. Consistent with other training courses, it is required that trainees are observed directly on a minimum of one occasion per placement, though three is recommended (beginning, middle and end of placement). Direct observation may be done in a number of ways (see Table 3) and examples of a structure for feedback are provided in the **Appendix 3.**

Table 4: Method of Direct observation

Method of Direct Observation	
Direct in-session observation	Meetings
Audio recording	Staff groups (e.g. reflective practice)
Video recording	Teaching
Reflecting Team	Group work
Joint working	

The End of Placement Review EPR is also when the supervisor gives a summative mark. This is a simple pass/fail for the placement and does contribute to the trainee's marks for their training.

5. THE BEGINNING OF PLACEMENT: PREPARATION, INDUCTION AND CONTRACTING

5.1 Preparation *(Figure 1)*

Trainees should contact their primary supervisor/s at the department where they will be on placement at least two weeks prior to starting the placement to discuss joining arrangements. If more than one supervisor is involved with the trainee they should arrange to meet/contact each other prior to this so that they are clear about how roles/induction/workload/responsibilities are being divided.

If appropriate, trainees may want to meet with their new supervisor(s) in advance of placement commencement. Supervisors should already have negotiated with their line managers the presence of a trainee and checked that office space, clinical space, a phone, IT facilities (where possible) and secretarial support are available by that point. Trainees should make supervisors aware of particular experiences that are important for them to obtain on the placement to facilitate the early identification of suitable cases and other experiences by their supervisor/s.

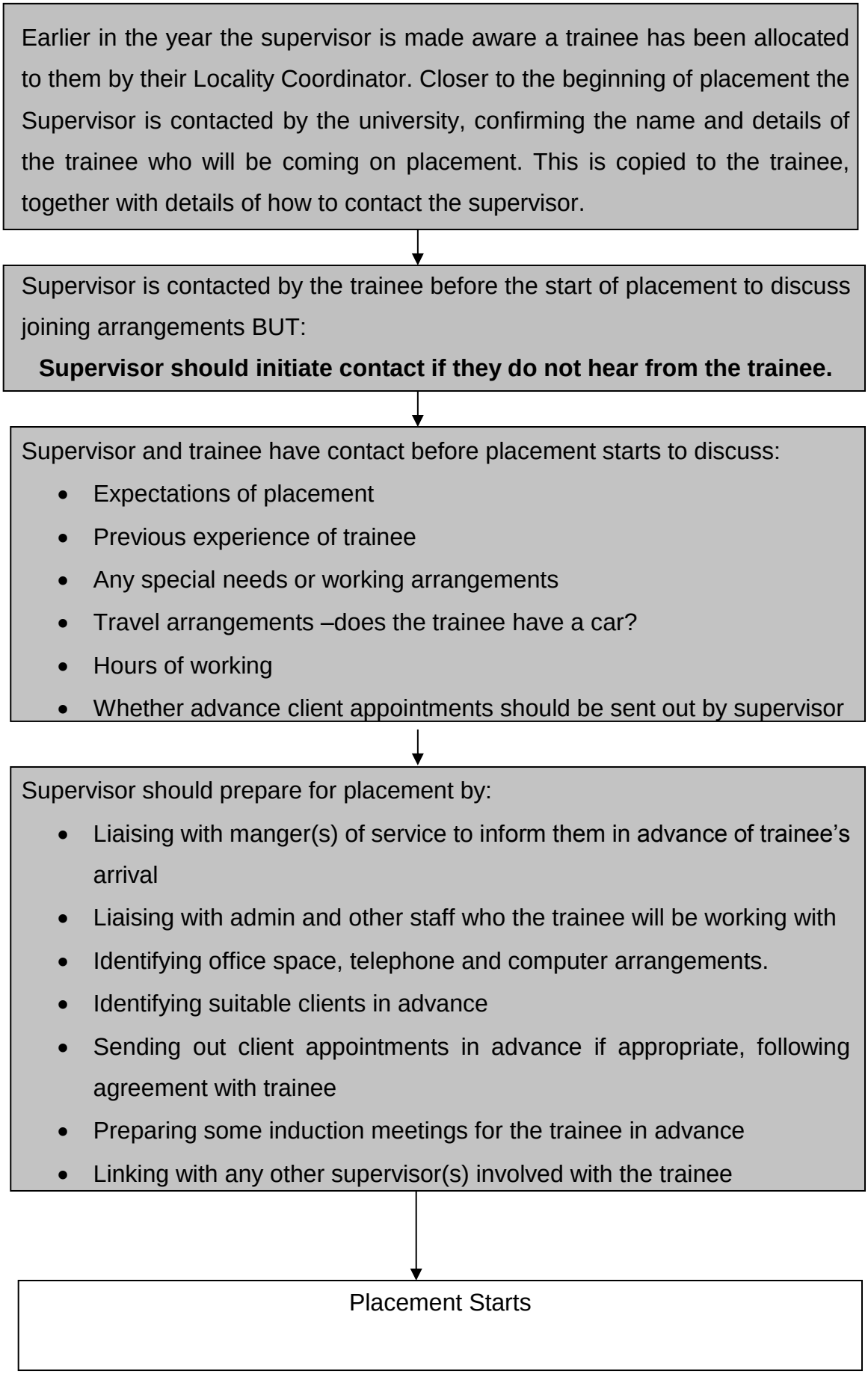
5.2 Induction

When starting on placement there will be an initial induction period, the length of which will vary depending on the placement and trainee's stage of training. It is likely to involve visits to a variety of services/bases of relevance, discussions with and observations of the work of a variety of professionals and substantial `supervisor shadowing', including sitting in on sessions with clients/patients, and accompanying the supervisor to clinical, organisational, research and teaching meetings.

Trainees and supervisors should discuss any clinical experience 4th year trainees have had as an undergraduate or graduate mental health worker, or previously if a mature student. Supervisors need to take this into account in deciding on learning experiences.

During this phase the supervisor should plan to be frequently and flexibly accessible to the trainee for the purpose of basic education and discussion. Meetings with administrative staff to learn about office and administration procedures should also occur as well as a familiarisation with available resources. Towards the end of such an induction phase, the supervisor should begin to involve the trainee in clinical situations in which there is potential for joint work. Sitting in with the trainee, or the use of session tapes are encouraged throughout the placement, but are of particular importance in the early and later stages in order to assess and evaluate trainee performance.

Figure 1. Preparation



5.3 Contracting *(Figure 2)*

In addition to discussing the experiences that the placement will provide, the learning outcomes to be achieved and practical/administrative issues, the early meetings between the trainee and supervisor/s should also focus on contracting in relation to issues relating to the development, aims and boundaries of the supervisory relationship. Mutual expectations should be explored and models of supervision discussed. Records of supervision sessions should be kept by both trainees and supervisors. (See Appendix 1)

5.3.1 Frequency/amount of supervision

Supervisors should plan regular supervision sessions with the trainee at the beginning of placement and include this in the placement contract. Trainees should have at least one hour of formal scheduled supervision a week and at least three hours of total contact time with their supervisor/s. Under the primary/secondary supervisor system this minimum standard applies to the whole “package” of supervisor contact. Primary supervisors should provide the majority of this. Where some supervision is delegated out to groups or other supervisors the primary supervisor should always coordinate and monitor how this is working. Back-up supervisors should be identified in the contract for situations where the regular supervisor is unavailable for any length of time (See Appendix 2. Guidelines on Clinical Supervision, BPS, 2010).

5.3.2 Safety Issues

Either before the placement begins, or during the first week of the placement, the trainee and supervisor should discuss personal safety issues associated with the particular placement concerned. The trainee should make a point of finding out about, and obtaining a copy of any local, hospital, Trust or team policies on personal safety, and acquaint themselves with these.

Basic guidelines for working in health and social care premises provided to trainees are given below:

- Try to use a room that has a telephone or emergency call system.

- Make sure that other staff are in the immediate vicinity, i.e. adjacent rooms and are aware you are interviewing in that particular room.
- Arrange room furniture so that the service user does not obstruct the path from your chair to the door, and neither do you block the service user's exit.
- Never see people outside working hours unless other staff are also on the premises who know you are conducting clinical work.
- Domiciliary Visits – Allocate someone who knows the precise times of all home visits, including expected time of return, preferably at the beginning of the working day. You may need to fill in a visits book and should always follow service procedures.
- Some placements are associated with a higher probability of encountering potentially violent people than others, e.g. forensic, substance abuse, assertive outreach, etc. In these placements you should always be accompanied by either your supervisor or another member of staff when making visits, unless the visit has been discussed with your supervisor and both of you are happy for an unaccompanied visit to occur.
- Carrying a mobile phone is recommended.
- Personal Alarms - The University provides each trainee with a personal alarm. It is emphasised to trainees however that personal alarms should not be seen as a replacement for adequate risk assessment or for taking proactive precautions. They are only a small component of any overall risk reduction strategy.

5.3.3. Use of Sessional and outcome measures

The trainees have access to the CORE-Net system for recording and monitoring client progress both session by session and at the beginning and end of therapy. Many NHS and third sector services use such measures routinely and there is growing evidence that frequently and formally monitoring the therapeutic relationship leads to improved outcomes for clients. The Hull and Leeds training courses are currently collaborating in using CORE-Net to assist trainees in their development. It is essential that Supervisors welcome

this work and encourage trainees to use both sessional and outcome measures and to bring these measures into supervision.

It is mandatory for trainees to complete an ***Assessment Form*** and ***End Form*** for ***every*** client with whom they carry out independent work in order to maintain their logbook in accordance with the requirements of the BPS. At regular intervals, trainees must import the data from CORE NET into their Excel Logbook by following the guidelines available on Canvas. At the very minimum this should be done for each placement review but it is recommended that trainees also take this information into supervision regularly in order to facilitate their development.

5.3.4. Using the PPAP in contracting

A meeting between the trainee, primary supervisor/s and Clinical Tutor will occur within the first two weeks of placement for fourth year trainees on their first clinical placement, generally at the placement base. At this meeting sections **A to G** of the PPAP will be reviewed detailing administrative and practical issues, special requirements and needs and the specific experiences and resources available to the trainee on placement that will enable the achievement of the competency based learning outcomes.

Contracting in the use of specific models of therapy is also now included in the PPAP (Section G.). Therapy competencies which trainees are expected to demonstrate as listed in the Trainee logbook are illustrated in Appendix 5. Trainees are expected to administer some form of self-evaluation of their therapy competency development. This may be using a published tool, e.g. Cognitive Therapy Rating Scale or one of the Self-Evaluation tools available to them on Canvas and should be made explicit during the contracting process.

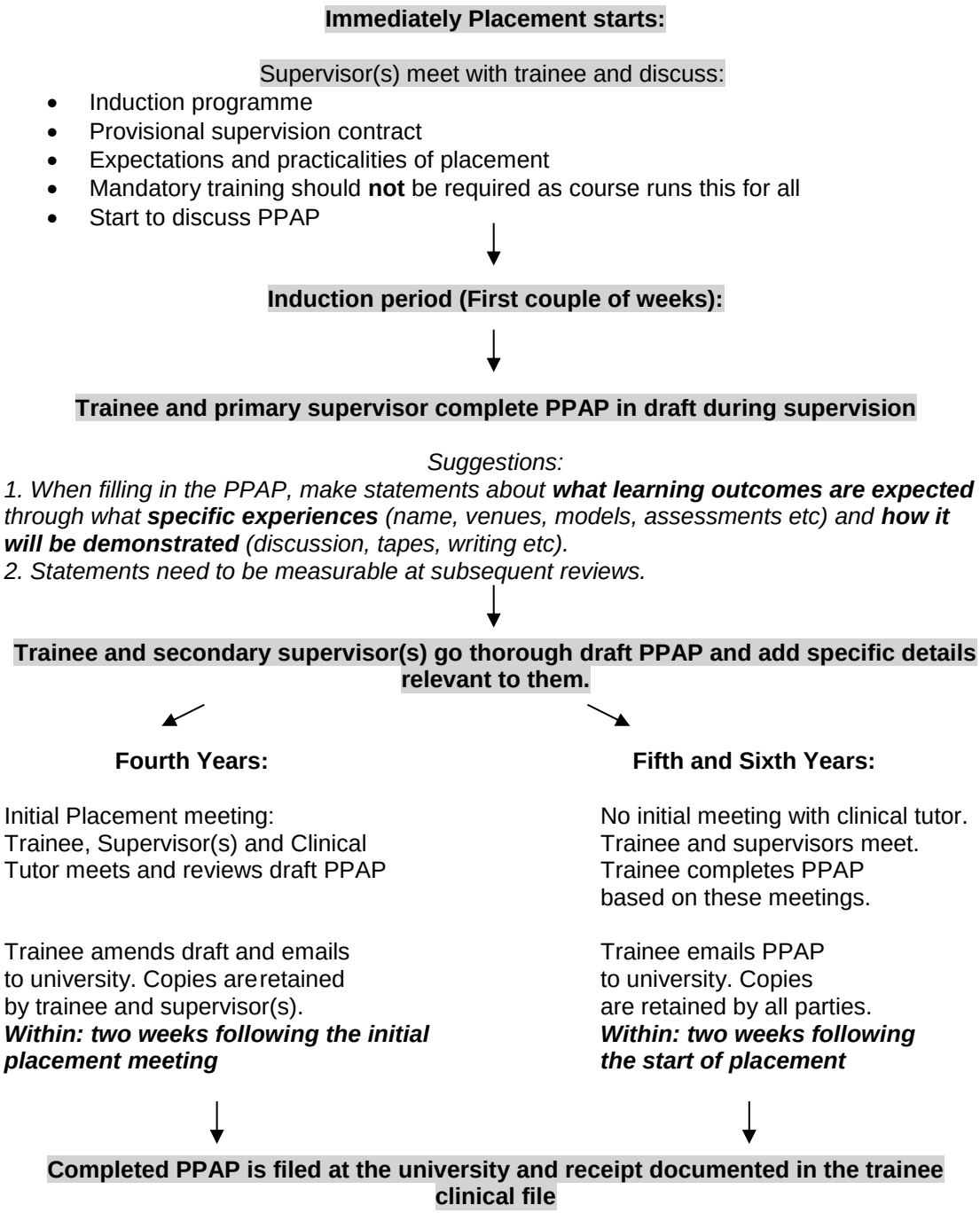
It is the trainee's responsibility to add any amendments to the PPAP and provide notice of this to the Clinical Tutor and Supervisor(s). As stated earlier, Trainees should then submit the PPAP to CANVAS by the end of the second week on placement.

For fifth and sixth years a routine initial meeting with the Clinical Tutor is considered unnecessary and the obligation is on the trainee to submit the PPAP to CANVAS by the end of the second week on placement. They should keep a copy for their records and provide a copy to the supervisor/s involved in the placement.

When there is more than one supervisor on a single placement. The PPAP contract document should be completed following discussions between the trainee and all placement supervisors. If these are separate meetings the trainee should take responsibility for completing a draft. The draft should then be checked with the supervisors and additions to the form made by trainee when necessary. An alternative is that trainee meets with both primary and secondary supervisor at the same time and completes the PPAP for the whole placement. Whichever method is used, trainee workload and experience should be balanced between the supervisors. Any differences in theoretical orientation of supervisors should be made explicit and the advantages of exploring different approaches highlighted for the trainee. The responsibility for ensuring that this process occurs on time belongs to both the trainee and supervisor(s). The responsibility of ensuring that the document is completed in writing and submitted to the university on time rests with the trainee.

Failure to submit up to date placement documentation may be subject to disciplinary action for the trainee and may result in delayed pay increment; delayed progression to the next stage of training; and the delay or non-completion of training. At the end of training this can cause delays in registering with the Health and Care Professions Council (HCPC) and therefore have implications for employment and practice as a Clinical Psychologist.

Figure 2. Induction and Contracting.



5.3.5. Some examples

Statements of placement experience in the PPAP should be written after considering the required competencies. The statements should be written in as objective or observable terms as possible so that the question *"has this experience occurred?"* can be answered at subsequent reviews. It is useful to write in terms of what specific objective is to be demonstrated through what specific placement experience. Figure 3 has an example.

Figure 3. Case illustration: What to write in the PPAP

Competency 1: Generalisable Meta-competencies

Opportunities on this placement

Helen will be able to demonstrate the application of psychological theory to practice in supervision, through detailed discussions of formulations and interventions; in a case presentation to the team; and in her reports to referrers.

Helen will be expected to reflect on and discuss in supervision the reasons for clinical decisions and emotional effects of her work. Clinical theory will be applied reflexively to this to aid understanding. We will monitor her workload and strategies for dealing with stress in supervision.

How the competence will be demonstrated/evaluated?

Helen will be observed with a client and presenting a case in MDT on at least one occasion;
Helen will bring written formulations to supervision for all of her clients;
Helen will produce assessment letters for each of her clients;
Helen will provide at least one example of how she used theory to understand a personal reaction in supervision.

Contrast the above with the more general statements sometimes used in placement contracts e.g.: *Self awareness and reflective practice will be encouraged throughout the placement.*

This is clearly harder to quantify and review and less helpful in giving explicit feedback.

6. PLACEMENT REVIEW MEETINGS

6.1. Mid Placement Review Meetings

At the beginning of the placement the Clinical Tutor will ensure that the **Mid-Placement Review (MPR) meeting** is arranged at a mutually convenient time for all three parties. See Table 5 for a summary of all review meetings. In general, the following agenda will be followed:

- Review of progress towards the learning outcomes and individual goals set at the beginning of the placement. ***Prior to the MPR*** the trainee and supervisor/s have the following tasks:
    - complete the likert scale ratings for each of the nine Core Competencies in section F of the PPAP;
    - Complete the section “Evidence of Progress at Mid-placement Review” for each of the nine Core Competencies (Section F.);
    - Complete the section “Progress at Mid-Placement Review” for each of the Therapies used on placement (Section G.)
    - Complete their comments on the overview of the trainee’s progress (Section H. – separate forms for Supervisor and trainee)
- Identification and documentation of any barriers preventing progress towards achieving learning outcomes
- Identification of areas of concern and remedial action to be taken.
- Identification and documentation of areas of strength
- Setting the date of the next MPR or End of Placement Review if appropriate and all completing the form “Actions Agreed”

The Mid-Placement Review begins with individual meetings between the Clinical Tutor and the trainee, and then the Tutor and the Supervisor, before all three parties meet together. If more than one supervisor is involved in the placement, the supervisors will meet together when the Clinical Tutor is meeting with the trainee.

Whenever concerns are raised at a MPR that might lead to placement failure, the trainee and Supervisor will receive in writing from the Clinical Tutor a

summary of the discussions held and the agreed action plan to be put in place over the remainder of the placement.

As with the documentation from the contracting meeting, Trainees should submit the Clinical Practice Portfolio to CANVAS by the end of the week following the MPR.

Table 5. Schedule of review meetings

Fourth Year	**Nine Month Placement**
Initial	February
Mid	May
End	September

Fifth & Sixth Year	**Six Month placements**		**11 Month placements**
Initial	October*	April*	October *
Mid	January	July	March
End	April	September	September

*meetings are held between the supervisor and the trainee without the Clinical Tutor, unless otherwise agreed.

6.2. End of Placement Review (EPR) meetings

The End of Placement Review (EPR) meeting takes place at some point during the last two weeks of the placement. Traditionally on the Hull course, Clinical Tutors only attended the EPR of the fourth years, however, it has been proposed that Clinical Tutors attend all trainee EPRs to allow for greater continuity of training. It has been proposed that the format will be different to the MPRs and will be a joint meeting between the trainee, supervisor and Clinical Tutor, unless otherwise arranged. This remains to be confirmed but will be discussed at the MPRs.

At the EPR, as in the MPR, there is a review of progress towards the learning outcomes set at the beginning of the placement. These should have been rated on the scales set out in the PPAP at the previous supervision session. These ratings represent formative feedback only - they do not count towards trainees marks. However, the EPR is also when the supervisor may indicate that the trainee has made so little progress that they consider the placement to be failed (see below for criteria). Placement supervisors thus provide summative feedback (whether the placement is passed or failed) and formative feedback (based on PPAP ratings and associated comments about development needs).

Comments about the trainee's overall progress, along with any agreed future goals, are noted on the Placement Continuation Form (H3) to be transferred to relevant sections of the next PPAP by the trainee. This is reviewed by the next supervisor as part of the initial contracting process.

As with the documentation from the Initial Contracting meeting and MPR, Trainees should submit the Clinical Practice Portfolio to CANVAS by the end of the final week on placement. ***Trainees will only be considered to have passed the placement once the completed Clinical Practice Portfolio for that placement has been submitted to the University***. As with all other coursework, trainees will be required to submit an extension request should they believe they will not be able to submit the CPP by the deadline.

The CPP from previous placements should be reviewed at the start of the next placement as part of the initial contracting process.

The trainee also provides feedback (recorded in the PPAP) to the supervisor/s about their placement experience. The central issue around which feedback is given is the trainee's judgement of the relative quality of the placement and supervision received in relation to enabling the development of the trainee's skills, knowledge and values under each competency area.

Throughout the duration of the placement, trainees should document their clinical experiences in the Logbook, which is examined at each review meeting.

If specific experiences/skills developed are not listed, they should be appended to the PPAP. Trainees should also keep a record on CORE NET of all the clients they have seen on placement (excluding cases where they have merely observed).

7. PLACEMENT FAILURE AND ASSOCIATED PROCEDURES

A trainee can fail a placement in one of two ways (see Figure 4):

(a) Because of a level of performance in conjunction with poor responsiveness to training that leads the supervisor to seriously question whether the trainee will be able/or should be allowed to qualify (PPAP Section J, Criteria 1-4).
(b) Because of serious professional misconduct (Criteria 5-7).

Failure on the grounds of (b), if upheld, will result in irreversible and outright failure of the Course, and termination of employment. If a trainee fails on the grounds of (a) they will be required to repeat an equivalent placement with a different supervisor.

Whatever the grounds, any case of placement failure is referred to the Board of Management, which, in turn, appoints a small enquiry committee comprising supervisor and academic representatives, along with an external assessor/examine. The recommendations of this committee are then referred back to the Board of Management for ratification. If upheld, the University's Board of Studies, and the Course's External Examiner are notified of the placement failure.

7.1 Professional/ Ethical Misconduct

In those rare cases when the supervisor believes a trainee on placement with them has committed professional misconduct (See BPS Code of Ethics and Conduct March, 2009) they should immediately contact the Clinical Practice Coordinator/Course Director for advice. Any complaint of this nature which the supervisor then wishes to take forward must be followed by a written statement which details the source of information, what the trainee did and why it constitutes professional misconduct. The supervisor should also provide this information to their Professional Head of Service. The Course Director and Head of Service will liaise to determine the appropriate course of action to be followed. If the trainee is on placement outside of the employing Trust (Humber Mental Health Trust) the Professional Head of Service of the employing Trust will be informed by the Course Director and participate in determining the

course of action to be followed. Both the Humber Mental Health Trust, as the trainees' employer, and the University have a responsibility to assess any risk to patients/staff or students associated with the behaviour of concern. Further details about action that may be taken can be found in the Regulations Governing the Investigation and Determination of Allegations of Professional Unsuitability and Professional Misconduct (University Quality Handbook). https://universityofhull.app.box.com/s/m66jsr37u3gbzrmzw1mx0mmz9kdexr4q

Figure 4. Placement Failure Criteria

Placement Failure Criteria:

1. Inadequate learning or progress over duration of placement

2. Failure to make use of supervision, because of:
   a. failure to attend supervision sessions
   b. failure to disclose important details of independent clinical work
   c. dogged adherence to a particular treatment orientation to the exclusion of all others
   d. consistently negative response to constructive criticism

3. Major interpersonal or social skills difficulties:
   a. with patients/clients
   b. with carers
   c. with staff

4. Poor reliability:
   a. significant absence from placement due to illness
   b. absences from placement without prior supervisor agreement or knowledge
   c. failure to attend agreed meetings, appointments, clinics, etc.
   d. extreme and persistent punctuality problems

5. Gross incompetence or negligence resulting in potential or actual harm to patients/clients or the public, including failure to inform supervisor of critical actions/situations when this could be reasonably expected.

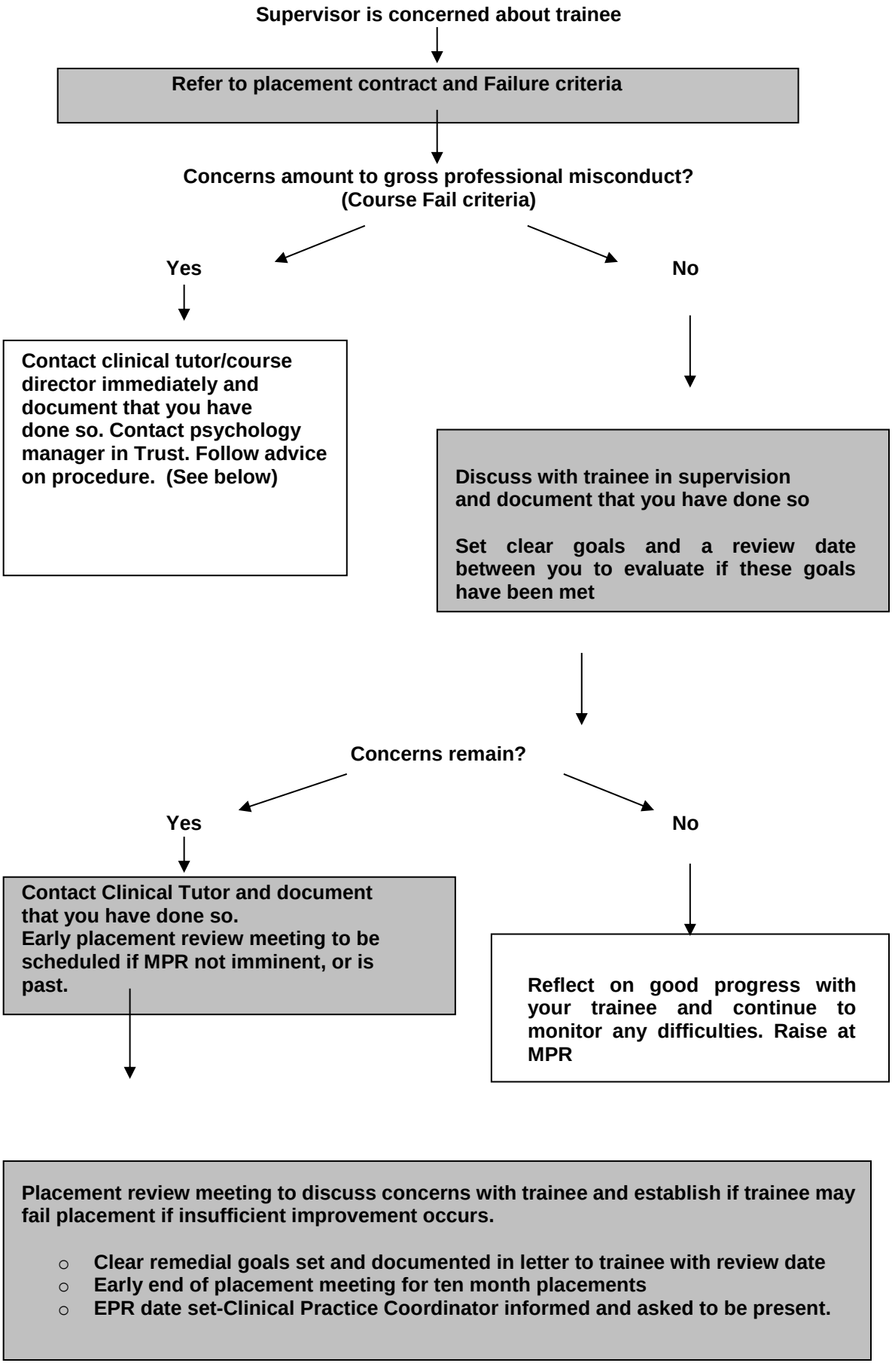
6. Abuse of patients/clients:
   a. physical violence
   b. verbal abuse or intimidation
   c. exploitation for financial or material gain
   d. entering into a sexual relationship

7. Other gross and/or persistent unprofessional conduct, including contravention of national or local health service policy or British Psychological Society ethical and professional guidelines.

(A trainee failing a placement on the grounds of criteria 1 to 4, or failing to achieve 50% or over on placement performance evaluation, may repeat the same or a similar placement. However, failure of (any) *two* placements implies failure of the Course. Failure on the grounds of criteria 5 to 7 may result in expulsion from the Course and termination of employment, subject to appeal.)

Please describe overleaf the conduct, deficit(s) or incident(s) giving rise to the failure.

Figure 5. Summary of process if concerns about failure arise



8. COMPLAINTS ABOUT TRAINEES.

Supervisors who have concerns about a trainee which cannot be resolved through the supervision process, but which do not amount to professional misconduct, should contact the Clinical Tutor (See Placement Failure and Associated Procedures).

Clinical Psychologists, or other staff, who have concerns about the behaviour of a trainee who is not on placement with them, which do not amount to professional misconduct, should in the first instance discuss these with the Placement Supervisor in order to determine whether any remedial action can be taken. These discussions must be documented by the supervisor as part of the supervision record relating to the placement and the Clinical Tutor consulted about the agreed course of action.

The trainee must be informed by the Supervisor that concerns have been raised about them, and by whom, and that the Clinical Tutor has been informed. The subsequent discussions with the trainee should also be documented as part of the supervision record and a copy sent to the Clinical Tutor to be placed on the trainee's placement file. The Placement Supervisor should discuss with the member of staff raising the concern whether there is any reason why they should not discuss their concerns directly with the trainee. Consideration should always be given to providing the trainee with the opportunity to talk the issues through with the person who has raised them, if the complainant is a member of staff. The emphasis in this process is ensuring that the trainee receives clear feedback that is owned by the staff member with concerns, which enables the trainee to reflect on aspects of their behaviour/ performance with a view to making changes where appropriate. Concerns dealt with in this manner are unlikely to be at a level where consideration is given to making a formal complaint.

In those circumstances were the person with concerns believes that the above course of action is insufficient, or in those cases where the allegation is of professional misconduct, they should utilise the University complaints procedure. In such circumstances the Course Director should be contacted for

advice and a written statement made which details what the trainee did and why it is a cause for complaint / constitutes professional misconduct. The Course Director and the Head of Clinical Psychology for the relevant Trust will liaise to determine the appropriate course of action to be followed. If the trainee is on placement outside the employing Trust (Humber Mental Health Trust) the Professional Head of Service of the employing Trust will be informed by the Course Director and participate in determining the course of action to be followed. Further details about action that may be taken can be found in the Regulations Governing the Investigation and Determination of Allegations of Professional Unsuitability and Professional Misconduct (University Quality Handbook).
https://universityofhull.app.box.com/s/m66jsr37u3gbzrmzw1mx0mmz9kdexr4q

Without a written statement of complaint the Course cannot take further action to resolve concerns expressed about trainees' professional/ethical conduct.

9. PLACEMENT RELATED SUMMATIVE EVALUATION *(Table 6)*

Whilst supervisors provide formative feedback to the trainees, summative evaluation of clinical competency is carried out through the marking of case studies submitted by the trainee and through the Clinical Practice Evaluations carried out in the 4th and 5th years. This section outlines these evaluations and two additional assessments which have been designed to provide feedback to placement supervisors about trainee performance from members of the multi-disciplinary team and from service users/carers. These additional assessments are not summative, but contribute to the supervisors' judgement about trainee progress, which results in their (summative) decision to pass or fail the placement. Trainees are also required to provide evidence from placement that they are competent in administering, scoring and interpreting the WAIS and WISC.

9.1 Year 4

Clinical Literature Review. Based on a clinical case, trainees are required to carry out a literature search on relevant clinical problems and demonstrate the ability to critically evaluate theory and evidence from literature in order to address clinically related questions. This piece of work is marked by the Research Tutors and not the Clinical Tutors.

Clinical Practice Evaluation. (CPE) Trainees are required to submit a 50 minute recorded assessment interview and present an initial formulation, intervention plan and a reflective piece on the recorded session. The CPEs are held in July and the trainee presents the material, and answers questions relating to it to two examiners, at least one of whom is a Clinical Tutor. The marking frame and procedure to be followed at the CPE can be found on CANVAS. The CPE can be based on the same case as the Clinical Literature Review, but not Case Studies.

Case Study: Trainees are required to produce a report on a one-to-one treatment case (3500 words) for submission in August/September.

Small Scale Project (SSP): The requirement is for a project of a clinical audit nature, usually undertaken on placement. It is assessed in terms of a number of the key competence areas. The project is conducted in year 4 and is submitted in January of Year 5.

9.2 Year 5

Clinical Practice Evaluation: Trainees are required to present a case referred to the MDT or service within which they are working. They present an ecomap of the system surrounding the client, a formulation of the client's presentation, an intervention plan and a 10 minute recording of a piece of work demonstrating some aspect of the psychology intervention which is part of the plan already outlined. The recording itself is not marked and the focus here is on a reflective piece where the trainee considers their work using the Approach, Method Technique framework proposed by John Burnham (1992). The recording can be of an intervention with a client, carer or staff. The CPEs are held in June and the trainee presents the material and answers questions relating to it to two examiners, at least one of whom is a Clinical Tutor. The marking frame and procedure to be followed at the CPE can be found on CANVAS.

Multi-Disciplinary Team Interaction Rating: As with the above evaluations, emphasis lies on the fifth year development of competences of working with teams, carers and other agencies. This rating scale is completed by two members of the MDT in which the trainee is working on their second 5th year placement. A single rating is agreed by both members where possible, or two separate ratings where not, and ***submitted to the supervisor*** at the MPR. The ratings are used by the supervisor in assessing trainee progress on the placement at the last MPR of the year.

9.3 Year 6

Psychometric Assessment Case Study Trainees are required to submit a psychometric assessment case study in February (5000 words). Trainees are encouraged to use material from placements from the fourth year onwards.

Service User Rating: This is a measure used in the sixth year together with the MDT rating to evaluate the trainee's progress in core clinical skills from the user perspective. As with the MDT rating, three service user ratings are considered at the MPR of the second placement in the year and will be taken account by the supervisor in assessing the trainee's progress on placement. Forms are sent out by the supervisor to randomly selected clients.

9.4 Remedial Supervision

All trainees are provided with detailed written feedback about summative assessments. If a trainee has failed a piece of work, or on occasion when major corrections are required, then they should discuss with their Clinical Tutor whether remedial supervision is required to assist them in improving their performance. This is provided by their Clinical Tutor and can range from a single session to a series of sessions, based on trainee need.

Table 6. Summary of summative evaluations,etc.

	4th year	**5th year**	**6th year**
October			
November		PPAP Contract (3)	PPAP Contract (5)
December			
January	PPAP Contract (2)	**Small Scale Project*** CPP (3)	**Psychometric Case Study** CPP (5)
February			
March			
April	**Clinical Lit Review**	CPP (3) PPAP Contract (4)	CPP (5) PPAP Contract (6)
May	CPP (2) **Exams**	**Exams**	
June		**CPE - systemic**	**Thesis Portfolio**
July	**CPE - Assessment**	CPP (4)	CPP (6)
August	**1-1 Case Study**		
September	CPP (2)	CPP (4)	CPP (6)

* Needs to be based on project occurring in the fourth year

Trainees often ask how much supervisors should help them with their clinical evaluation material. Supervisors are advised to give guidance on this only to the same extent that they would provide guidance on any clinical case; they should not give special help because the information is being used for

evaluation purposes. Supervisors should be aware that trainees are not expected to take placement time to write up case studies or small scale research for submission to the Course.

10. SUPERVISOR TRAINING

10.1 Introductory supervisor training

The Course has a commitment towards providing introductory supervisor training to uphold the basic quality of supervision for trainees. All supervisors are expected to complete this before supervising a trainee.

Introductory supervisor training is run in partnership with the Leeds and Sheffield Universities Doctorate in Clinical Psychology Training Courses. The programme is currently run over the course of four separate days (generally between February-November) at different venues in the catchment area. Supervisors are asked to form peer supervision groups over the course of this time in order to work on supervision issues between workshops. The programme at time of printing covers the following areas:

Day One:	*The professional context; What is supervision? Models of supervision; The supervisory relationship; Values, attitudes, ethics.*
Day Two:	*The structure of placements; Contracting; Difference and diversity; continuing development of supervisory skills; Peer supervision groups. Giving feedback; Evaluation of clinical competence; Failing trainees; Action planning.*
Day Three:	*Local course developments and documentation*
Day Four:	*Supervisory skills revisited; Peer supervision group presentations; Evaluating supervisory skills and CPD for supervisors. Action planning.*

This training is free to all supervisors. Although new supervisors are the target recipients of the training, experienced supervisors are welcome to attend to refresh their knowledge and skills.

10.2. CPD for all Supervisors

In addition to introductory supervisor training a programme of ongoing training is provided to further enhance the quality of supervision provided in the area,

and to provide CPD and support for local clinicians who contribute to the course. The following are examples of workshops which have been run in the past:

Supervising in Compassion Focused Therapy
Systemic approaches to Supervision
CAT Supervision

Every effort is made to provide pleasant venues and food and to give supervisors valuable time for reflection and networking as well as engaging in the timetabled tasks of the day.

Ideas for the content of future supervisor training are welcomed and any suggestions should be forwarded to a member of the clinical tutor team. All supervisor training workshops are advertised to supervisors by e-mail. They are all free to supervisors eligible to supervise on the Hull course. Further training not related to supervision is available within the region via the Post Qualification Training network (PQT), which is also free at the point of access and is advertised by e-mail to all PQT members.

11. SUPERVISOR MEETINGS (See Boards and Committees in Course Handbook for all course committees)

Annual Timetable:

Board of Management March, June, Sept, Dec.
Attended by Representative of Locality Coordinators.

Placement Committee April, October.
Committee members (Locality Coordinators/Clinical Practice Coordinator/ Clinical Tutors/Co-opted supervisors)

Trainee Research Conference September
All supervisors are invited.

Board of Supervisors November.
All supervisors are invited.

Any supervisor wishing to place an item on the agenda of the Board of Supervisors or Placement Committee should contact their Locality Coordinator or the Clinical Practice Coordinator and are welcome to attend the relevant meeting to present the item and participate in discussions.

APPENDIX 1

SUPERVISION RECORD

THE DEPARTMENT OF CLINICAL PSYCHOLOGY AND PSYCHOLOGICAL THERAPIES

UNIVERSITY of HULL

WEEKLY SUPERVISION Trainee …….

Supervisor ……..

Date:	Session notes
Action points	
Trainee	
Supervisor	

APPENDIX 2 – Supervision Guidelines

ACCREDITATION THROUGH PARTNERSHIP

The British Psychological Society
Partnership & Accreditation

Additional guidance for clinical psychology training programmes: Guidelines on clinical supervision

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Introduction

The following guidelines set out the minimum standards necessary to achieve good practice in the supervision of clinical trainees. In practice it is often helpful to adapt these guidelines and customise them to your specific programme. It is important that these guidelines are read in conjunction with the Society's standards for accredited programmes in clinical psychology, which are available at http://www.bps.org.uk/accreditationdownloads.

Revised September 2010

1. Qualifications of supervisors

1.1 Trainees must be supervised either by:

(i) A clinical psychologist who is registered with the Health Professions Council, and/or who holds Chartered Membership of the Society and full membership of the Division of Clinical Psychology, who has at least two years' post-qualification experience, and who has clinical responsibilities in the unit in which the work is carried out; *or*

(ii) Any other appropriately qualified and experienced psychologist who is registered with the Health Professions Council, and/or who holds Chartered Membership of the Society; *or*

(iii) An appropriately qualified and experienced member of another profession who is registered with a professional or statutory body which has a code of ethics, and accreditation and disciplinary/complaints procedures.

In case of (ii) or (iii) above, the quality and quantity of supervision that is received by the trainee must be monitored carefully by the Programme Director or Clinical Tutor.

1.2 Supervision should normally be provided by a supervisor who has clinical responsibilities in the unit or service in which the work is carried out.

2. Supervisors Workshops and Meetings

2.1 Programmes must organise regular supervision workshops to train supervisors in methods of supervision; these should be designed with the needs of new as well as experienced supervisors in mind. Supervisors are expected to attend workshops on supervision. There should also be regular meetings at which supervisors have an opportunity to share information and discuss problems. Where programmes make use of team supervision, viz. where the ratio of trainee to supervisor is other than 1:1, the programme must ensure that appropriate guidance is given to supervisors and trainees on the procedures that are necessary for good team supervision. It will probably be necessary to establish supervisor workshops related specifically to team supervision.

2.2 Suggested learning objectives for introductory supervisor training are provided at www.bps.org.uk/accreditation/downloads. Programmes that have developed supervisor training that reflects these objectives are able to seek approval for their training from the Society's Learning Centre (www.bps.org.uk/learningcentre), enabling supervisors who successfully complete the training to apply for entry to the Society's Register of Applied Psychology Practice Supervisors.

2.3 It is important that supervisors keep abreast of theoretical, research and professional developments in their fields of work and participate in continuing professional development.

3. Allocation to Clinical Placements

3.1 There should be an explicit procedure for allocating trainees to clinical placements. All trainees and supervisors involved should understand the procedure and know how to influence decisions about clinical placements. The person responsible for arranging placements should give primacy to general training requirements and competency development needs but should also take account of the needs of individual trainees. Information should be provided about the experience obtainable in the various placements to help trainees and programme staff to make placement decisions.

3.2 The Programme should try to ensure effective co-working for trainees who are sharing the same placement. This is especially important where there is team supervision, with two trainees allocated to one supervisor, or when two or more trainees receive supervision from a team of supervisors, within the same placement.

4. Setting up the Placement

4.1 Both trainee(s) and supervisor(s) must have an opportunity to meet either before, or at the very beginning of the placement to discuss the range of experience, which is to be provided, and the expectations (hours, days of work, etc) of the trainee(s). The general aims of the placement should normally be agreed within the first two weeks of the placement and a clinical contract should be written. Attention must be paid in the clinical contract to the range of opportunities available in the placement, and to the needs, interests and previous experience of the trainee. Particular efforts should be made to fill major gaps in the trainee's experience, and records of the trainee's previous experience should be available for this purpose. The Programme Director or Clinical Tutor will have played a major role in the assessment of the trainee's strengths and needs and in the sequence of placements.

4.2 In cases where there is more than one supervisor involved in a trainee's placement (team supervision) a primary supervisor must be identified for each trainee who will take responsibility for the planning and co-ordination of that trainee's placement, supervision and assessment, and for liaison with Programme staff.

4.3 The supervisor must plan an induction for the trainee, arrange for cover in the event of annual or other leave and should plan casework well in advance.

4.4 Care should be taken to ensure that the trainee has access to (at least) shared office space, telephone and a desk. There must be adequate arrangements for secretarial and IT support for placement work and trainees must be given guidance on the facilities available.

4.5 Supervisors must remember that they have clinical and legal responsibilities for their trainees throughout the training period. It is good practice for supervisors to be insured, for trainees to be aware of relevant legal boundaries (e.g. re. the Data Protection Act, the Children Act). It is essential that trainees have appropriate (substantive or honorary) contracts that allow them to work in their placement.

5. Placement Content

5.1 Programmes must develop, in consultation with the Division of Clinical Psychology's Faculties and Special Interest Groups and local supervisors, guidelines on the required experience in clinical placements, recommending an appropriate amount of clinical work.

5.2 The local guidelines on placement content should be taken into account in the provision of placement experience for the trainee. The level of his/her experience and expertise and the stage of training will determine the particular balance of work for each individual trainee.

5.3 Supervisors should ensure that trainees undertake an appropriate quantity of clinical work. There are dangers in both extremes: too little work reduces the opportunity for learning and too much may reduce trainees' capacity for planning or reflecting upon the work. Supervisors should monitor the balance of time spent by the trainee on work at different levels (direct client work, indirect and organisational work). This balance will vary according to the stage of training and the type of placement. Supervisors should be alert to the dangers of time being lost at the start of the placement through suitable work not being available and should take this into account in preparing for the arrival of the trainee.

5.4 A log must be kept of the work a trainee has done in a clinical placement. The programme must ensure that the Clinical Tutor appropriately uses these records in planning future placements and by future clinical supervisors in discussing what experience they should provide.

5.5 With team supervision, the programme should give clear guidelines about the experience to be acquired so that the placement may be planned to make optimal use of others involved in providing supervision.

6. Clinical Supervision

6.1 There must be a formal, scheduled supervision meeting each week that must be of at least an hour's duration. Longer supervision will sometimes be needed, especially where team or group supervision is used. In addition, supervisors should try to make themselves available for informal discussion of matters that arise between formal supervision sessions. The total contact between the trainee(s) and supervisor(s) must be at least three hours a week, and will need to be considerably longer than this time at the beginning of training.

6.2 In cases of team or group supervision, trainees must always receive, in addition, an appropriate amount of individual supervision. Individual supervision must provide opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as on-going casework.

6.3 Adequate time for clinically relevant reading must be made available to the trainee on placement. In addition, supervisors have a crucial role in contributing to the integration of the academic and practical aspects of the Programme. They should discuss literature relevant to the clinical work in hand and suggest suitable reading to the trainee. In general they should help trainees to develop a scholarly and critical approach to their clinical work.

6.4 In addition to discussing clinical work, it is essential that the trainees and supervisors have opportunities to observe each other at work: the trainee can learn much more from this and it is essential in order for the supervisor to give the trainee accurate and constructive feedback. Placements differ in the most appropriate opportunities for such direct contact: some may use joint clinical work of some kind; others may prefer audiotape, videotape or a one-way screen. Some form of mutual observation of clinical work is regarded as essential.

7. Quality of Clinical Supervision

7.1 The quality of the supervision that is provided for the trainee will depend upon many factors. The care taken in the early stages to build up a good relationship will enhance the quality of the clinical supervision.

7.2 Supervisors should be prepared to adapt their style of supervision to the stage of the programme a trainee has reached. It is necessary to be prepared to describe basic clinical procedures in detail and to ensure that trainees have an adequate grasp of techniques they are asked to use. Detailed training in techniques should also be available to more experienced trainees if required.

7.3 Trainees and supervisors may find that they have a different orientation and interests. Where this happens tolerance should be shown on both sides. Trainees should be helped to see that they might learn much that is valuable from a supervisor whose approach they may not ultimately wish to adopt. On the other hand, supervisors should see it as one of their functions to help trainees develop their own interests in an appropriate way. Where supervisors decide they must overrule the way the trainee wishes to work, they should explain their reasons with care, rather than simply asserting that this is how things should be done.

7.4 Supervisors should be prepared to discuss seriously and sympathetically any general issues of relationships with patients or staff that arise in the programme of clinical work. They should be sensitive to any personal issues that arise for the trainees in relation to clients and be prepared to discuss these in a supportive way when they are considered to affect the trainee's work. The range of personal issues that can be raised by clinical work is wide and includes, for example, over-involvement, dealing with anger and despair, workload and time management problems.

8. Clinical Reports and Communication

8.1 Communication with other members of clinical teams and networks involves both written and verbal reports. Verbal reporting and discussion are often more important than formal written reports in terms of their effects on clinical decisions and action. Since the relative importance of written and oral communication is likely to vary between settings, supervisors will need to identify the most important channels of communication in their placement and teach the trainee to use these channels effectively and efficiently. Training in effective communication will involve both observation of the supervisor's behaviour, and practice by the trainee with ample opportunity for feedback.

8.2 There is a wide variation within the profession in how clinical reports are written and presented, particularly with respect to the amount of detailed information provided. Trainees need to be acquainted with a variety of report and

letter writing styles. If there is agreement about minimal requirements of clarity and relevance in reports, exposure to individual differences between supervisors is more likely to be constructive than confusing. Trainees should be encouraged to write reports that are appropriate to the recipient (whether this is a professional colleague or a client), avoid jargon, distinguish clearly between fact and opinion, and provide consistent clarity of expression. Both supervisor and trainee should be aware of the potential conflict between communicating fully to professional colleagues and maintaining confidentiality.

9. Review Meetings and Feedback

9.1 There must be a formal process during each placement whereby the Programme team monitors the clinical experience of trainees and the supervision provided, and helps to resolve any problems that may have arisen. The aims of this are:

a) to review the progress of the clinical Contract

b) to give feedback to the trainee on his/her clinical performance

c) to allow the trainee to comment on the adequacy of the placement

d) to set targets based upon the above for the remainder of the placement

e) to give feedback to the supervisor on his/her performance.

9.2 When a trainee is involved with some form of team supervision, the programme must ensure that each trainee's experience is monitored on an individual basis. Other review or feedback of meetings that may be held at the beginning and end of a placement should also allow for individual time allocation for each trainee. If possible, all team supervisors involved with any single trainee should be involved in the monitoring process (and beginning and end of placement meetings). Where it is not possible for all a trainee's supervisors to be present at a key review meeting, one designated supervisor should seek views from other team supervisors prior to the meeting, and provide feedback after the meeting.

9.3 Matters such as the physical resources available to the trainee (room space, secretarial backup, etc) and theory-practice links may also be usefully discussed at this time. Supervisors and trainees may find it helpful in the review to go through the rating forms that will be used at the end of the placement.

In general, it is expected that the programme staff member conducting the monitoring will hold discussions with the trainee and supervisor separately and then hold a joint discussion. In this way more accurate feedback about the trainee's performance and about the quality of the supervision provided may be obtained. The timing of the monitoring is important if sufficient time is to be left for improvements to be made. A plan and timetable for the review should be agreed at the start of the placement.

9.4 Mid placement qualitative feedback is essential both for the supervisor and the trainee. Supervisors should try to set aside positive or negative

personal feelings about trainees when making evaluations. Feedback should be detailed and constructive and designed to help trainees develop a range of effective and appropriate skills; thus, feedback should be critical but not wholly negative.

9.5 If seriously dissatisfied about aspects of a trainee's performance, supervisors should regard themselves as under an obligation to the profession to indicate this to the programme staff.

9.6 The trainee also has a responsibility to the programme and to the profession to give feedback to the programme staff about the quality of the placement and the supervision.

9.7 At the end of the placement the supervisor must give the trainee full feedback on his/her clinical performance. The trainee must see the supervisor's written assessment. Any major points that the supervisor is concerned about should normally have been raised well beforehand, at least during the formal monitoring process, to allow the trainee time to improve. The trainee must also have ample opportunity to comment on the placement, for example, on the experience and the supervision received. The trainee's views should be recorded formally as part of the general evaluation of the placement. Feedback forms and forms for rating clinical competence should always be completed at the time of the end of placement review and returned promptly.

9.8 The points made in section 9.5 concerning the provision of balanced, constructive and detailed feedback to the trainee also apply to the end of placement review. The supervisor should, in addition, help the trainee to identify gaps in his/her experience to facilitate planning for subsequent placements. It is important for the supervisor and trainee to forward this information to the person responsible for co-ordinating placements.

10. Assessment of Clinical Competence

10.1 It is important that supervisors are familiar with the examination and continuous assessment requirements for trainees and the guidelines and regulations for these.

10.2 In cases of team supervision, all supervisors who have been involved with the trainee(s) must be familiar with the programme's assessment procedure and must give feedback on the trainee(s) clinical competence.

10.3 Supervisors must be familiar with the specific criteria for passing and failing in the assessment of clinical competence set by the programme. In addition, supervisors should be aware of appeals procedures. In cases where trainees have displayed unsatisfactory behaviour, such as regular and serious lateness for clinical appointments, professional misconduct, or failure to acquire an adequate level of clinical competence, trainees must be left in no doubt about the problem. The supervisors should discuss with the Clinical Tutor what action should be taken and it may be helpful to have a member of the programme staff present at the time of the end of placement review.

APPENDIX 3a – Observation feedback example (based upon year 4 CPE marking framework)

Observation of Clinical Practice

Trainee: **Date:**

1. Demonstrates the ability to structure the initial stages of the interview		
Prompt	**Strengths**	**Areas for Development**
□ Summarises how the person came to be seeing them (if contextually appropriate) □ Provides information about the purpose of the interview □ Provides information about how long the interview can last □ Checks out understanding of confidentiality □ Asks permission to take notes during the session		

2. Demonstrates the aim of engaging the service user in a collaborative working relationship		
Prompt	**Strengths**	**Areas for Development**
□ Allows initial ventilation about the problem □ Uses appropriate questioning styles □ Uses summarising throughout interview □ Reflective listening to facilitate disclosure □ Reflection of feelings to demonstrate empathy including appropriate acknowledgement of strong emotion □ Avoidance of jargon □ Use of the language and understandings that are shared by the client □ Generally acts in a warm encouraging manner □ Checking out that the client understands □ Managing and containing their own feelings in response to the material presented by the client □ Demonstrating an appropriate use of silence when necessary		

3. Obtains information which enables the beginning of the process of developing an initial formulation		
Prompt	**Strengths**	**Areas for Development**
□ Information about the problem: □ Explores the persons reasons for attending the interview □ Explores other problems the person may be currently experiencing □ Elicits information about strengths/positive coping/protective factors □ Exploration of factors relating to initiation of problem □ Exploration of severity, pervasiveness and/ or frequency and duration, now and previously. □ Exploration of the impact of problem on the person's life, now and previously. □ Exploration of coped strategies and what makes the problem better/worse □ Exploration of how other people react to it/contribute to the □ Exploration of whether there are there any specific triggers □ Exploration of persons own perception of the problem □ Exploration of previous attempts to tackle the problem (including previous contact with services) □ Exploration of risk to self/ others and risk of vulnerability to harm from others □ Information about current situation and personal context: □ Exploration of their current situation and relevant history (occupation/ family**/** social relationships and activities/ financial situation/housing/ substance use/ medication/contact with health and social care services and criminal justice system) with an emphasis on exploring sources of stress/ loss/ trauma/ physical illness or injury/ substance use problems □ Exploration of the person's childhood experiences		

4. Shows an ability to structure the interview, use time effectively and contain the service user		
Prompt	**Strengths**	**Areas for Development**

5. Demonstrates use of structured ending to the session		
Prompt	**Strengths**	**Areas for Development**
□ Lets the person know the interview will be ending shortly □ Summarises understanding so far □ Provides the opportunity for questions □ Asks how the person found the interview □ Arranges a further appointment or explains further contact arrangements		

6. Other/Summary		
Prompt	**Strengths**	**Areas for Development**

APPENDIX 3b – Observation feedback example (based upon year 4 CPE marking framework)

Clinical Skills Assessment Session

Feedback Summary

Trainee: Client: Date:

Clinical Tutor:

Service User:

1. Demonstrates the ability to structure the initial stages of the interview		
	Strengths	**Areas for Development**

2. Demonstrates the aim of engaging the service user in a collaborative working relationship		
	Strengths	**Areas for Development**

3. Obtains information which enables the beginning of the process of developing an initial formulation		
	Strengths	**Areas for Development**

4. Shows an ability to structure the interview, use time effectively and contain the service user		
	Strengths	**Areas for Development**

5. Demonstrates use of structured ending to the session		
	Strengths	**Areas for Development**

6. Other/Summary		
	Strengths	**Areas for Development**

Appendix 4: Client group placement guidelines:

a. Working Age Adults

b. Children and Families

c. Older Adults

d. People with a Learning Disability

e. Clinical Health Psychology

f. Forensic

g. Neuropsychology

a. Working Age Adults

Dimension	Year 4	Year 5	Year 6 and beyond
General competencies	• Interviewing Skills • Developing working alliances Assessment, Formulation and Intervention using psychological theories and evidence based practice • Theory – practice linking • Utilising practice based evidence (sessional and outcome measures)		
Focus of work	Working with service users and carers in 1-1 and group settings.	Working with service users and carers in 1-1 and group settings; Working with teams and systems.	Specific therapy competency development (e.g. CAT, CFT, ACT); Leadership, Supervision and training of others in Psychological aspects of mental health
Setting	Outpatient/community CMHT Primary Care IAPT	Inpatient/Secondary Care	Any setting/supervisor that provides supervision in specific models/competencies Therapeutic Communities Assertive Outreach
Presentations/ examples of appropriate work	Anxiety presentations Depression Eating Disorders Bereavement/loss Adjustment Trauma/Abuse Self-Esteem Interpersonal Relationships Service Evaluation	Facilitating Formulation groups; Working with personality problems; Significant risk presentations	Supervision & Consultation Complex Trauma Psychosis

Dimension	Year 4	Year 5	Year 6 and beyond
Therapeutic approaches/models	CBT, ACT, CFT, DBT		
Professionalism and Ethics	Power Language Difference & diversity Managing emotional impact of the work Boundaries		
Caseload	6-9 direct work with individuals, adjusted for other roles, e.g. running a group		
National Guidance documentation, Key reading etc.	Good practice guidelines on the use of psychological formulation (BPS); Understanding psychosis and schizophrenia (BPS); Care Package and pathways: Payment by Results for mental health services (BPS); The contribution of clinical psychologists to recovery oriented drug and alcohol treatment systems (BPS); Lindsey & Powell (2007) The Handbook of Clinical Adult Psychology; Wells (1997) Cognitive Therapy of Anxiety Disorders; Gilbert, P (2010) The Compassionate Mind; Hawton, Salkovskis, Kirk & Clark (1996) Cognitive Behaviour Therapy for Psychiatric Problems.		

b. Children and Families

Dimension	Year 4	Year 5	Year 6 and beyond
General competencies	• Ability to engage and work with children of all ages and adapt communication, etc. accordingly • Awareness of systems surrounding children and their families • Ability to manage the dynamics of the members of these systems within the same room • Ability to adapt a variety of psychological models to children • Carrying out observational assessments as part of developing formulations • Awareness of Attachment based models and creative therapies • Awareness of developmental psychological theories and ability to integrate into formulations • Cognitive and neurodevelopmental assessment		
Focus of work	Working with service users and carers in 1-1 and group settings.	Working with service users and carers in 1-1 and group settings. Working with teams and systems.	Specific therapy competency development (e.g. Family Therapy, play therapy, Psychodynamic therapy); Leadership, Supervision and training of others in Psychological aspects of child development, parenting, health and emotional wellbeing; Working with complex systems and individual presentations of complexity
Setting	Outpatient/community CYIAPT	Outpatient/community & Inpatient	Any setting/supervisor that provides supervision in specific models/competencies
Presentations/ examples of appropriate work	Anxiety Depression Autism/ADHD assessment	Group work Family interventions including Family Therapy	Supervision & Consultation to multidisciplinary staff groups; Life-limiting conditions;

Dimension	Year 4	Year 5	Year 6 and beyond
	Service evaluation	Paediatrics Eating Disorders Children/Young people at significant risk of self-harm or of harm from others	Peri-natal mental health; Looked After and Adopted Children (LAAC)
Therapeutic approaches/models	CBT, Family Therapy, Play Therapy, Narrative Therapy, Psychodynamic therapy		
Professionalism and Ethics	Managing safeguarding, risk and child protection issues; Understanding professional boundaries and limits and awareness of the limits of the role.		
Caseload	6-9 direct work with individuals, adjusted for other roles, e.g. running a group		
National Guidance documentation, Key reading etc.	• BPS (2016) Top tips for working with children, young people and their families; • Carr, A. (2006) The Handbook of child and adolescent clinical psychology: A contextual approach; • Gerhardt, S. (2004) Why love matters: How affection shapes a baby's brain; • Hedges, F. (2005) An introduction to systemic Therapy with individuals: A social constructionist approach; • Johnstone, L. & Dallas, R. (2013) Formulation in psychology and psychotherapy: Making sense of people's problems; • Schofield, G. & Beek, M. (2009) Attachment handbook for foster care and adoption • What good looks like in psychological services for children, young people and their families – special issue of the *Child and Family Clinical Psychology Review.*		

c. Older Adults

Dimension	Year 4	Year 5	Year 6 and beyond
General competencies	• Able to effectively communicate with older people. Able to overcome cognitive and sensory impairments to enable effective work to take place. Able to provide written information in the right format for an individual older person. • To develop an understanding of common problems of old age related to bereavement, different types of dementia, late-life depression, stroke, and physical health problems. This should include NSF target areas: for example falls and fear of falling, continence, pain, disability and quality of life, and end of life issues and palliative care. • To be able to recognise ageism and its influence on society and professionals. • Demonstrate knowledge of the dementias, including presenting symptoms, patterns of change in neuropsychological profiles, key assessment tools and effects on the individual and their family. • To understand the effects of ageing on cognitive function including 'normal' or successful ageing and dementia and related conditions. This should include the psychometric properties of assessments when used with older people (typically less norms available for older adults). • The social context of older people; retirement issues including loss of social role, diminishing social networks; isolation and geographically distributed families, current social policy, including benefits and pensions. • To have a good understanding of pre-assessment counselling for dementia assessments. • To develop an understanding of legal, moral and ethical issues. E.g. mental capacity, deprivation of liberty safeguards, mental health act, power of attorney (for finances, and health & wellbeing), advance directives, do not resuscitate orders, euthanasia, choice, and consent, and their relationships to duty of care.		
Focus of work	Working with service users and carers in 1-1 and group settings, e.g. • Differential dementia diagnosis	Working with service users and carers in 1-1 and group settings, e.g. • Differential dementia diagnosis • 1:1 therapeutic work • Family interventions	Focus on leadership skills, consultation work with carers and other professionals, training & supervising others. Perhaps a focus on particular aspects of older-adult work such as

Dimension	Year 4	Year 5	Year 6 and beyond
	• 1:1 therapeutic work • Family interventions • Challenging behaviour formulations/interventions	• Challenging behaviour formulations/interventions	differential dementia diagnosis, or models of therapy used with older adults.
Setting	Outpatient/community/care homes/inpatient health/dementia wards	Outpatient/community/care homes/inpatient health/dementia wards	Any setting/supervisor that provides older adult placements. Could focus on differential dementia diagnosis, consultation skills/systemic/MDT working, or specific models of therapy with older adults.
Presentations/ examples of appropriate work	Differential dementia diagnosis, cognitive stimulation groups, challenging behaviour formulations/interventions. Anxiety, depression, grief, adjustment, physical health issues. Working with carers.	As 4th year, but with the addition of completing mental capacity assessments, involvement in best interests meetings, risk assessments related to cognitive/physical and sensory problems, consultative work and indirect work, including sharing formulations related to challenging behaviour, staff training and support.	Supervision & Consultation, emotional distress related to receiving a dementia diagnosis and latter stages of life; coordinating interventions between different agencies; delivering difficult or unwelcome communications; supporting other health professionals in their own self-care.
Therapeutic approaches/models	Theories of life-span development; gerontological theories of adjustment in later life; neuropsychological profiles, and their associated functional/behavioural attributes of the different dementia types; neuropsychological, mood and physical attributes of stroke (including different types of locations of stroke, such as left middle cerebral artery, right middle cerebral artery, anterior communicating artery, etc). Psychotherapeutic models for older adults may include: CBT, psychodynamic approaches, CAT, narrative approaches, interpersonal therapy, solution-focussed approaches, family therapy for older people.		
Professionalism and Ethics	• Appreciating boundaries with other services and professional roles;		

Dimension	Year 4	Year 5	Year 6 and beyond
	• Establishing a structure of personal and professional support; • An understanding of legal frameworks and issues of risk/vulnerability that can occur with older adults		
Caseload	Work with around 8 people or more. This should preferably include contact with at least one person with stroke, dementia, depression, a late life event (e.g. bereavement, terminal illness, or retirement), poor physical health, substance abuse or drug dependency, and complex problems (the co-existence of at least 3 of the above). Experiences should reflect the age span within this group, i.e. people in their 6th, 7th, 8th and 9th decades of life. • A number of these cases should include neuropsychological and other psychometric assessments of intellectual function. • A number of these cases should include direct interventions using recognised psychological models; for example reminiscence therapy or cognitive, behavioural or psychodynamic therapies. • A number of these cases should involve indirect interventions. They should include at least one with joint working with a non-NHS agency. • At least one case should involve contact with family members. • At least one older person should be seen at home. • At least one older person should be seen in a long-term care setting; for example a nursing or residential home. • At least one person should be seen on a ward, day hospital, or other NHS setting.		
National Guidance documentation, Key reading etc.	• NSF for older people • DCP PSIGE – Psychology Specialists Working with OIder People (2006); Good Practice Guidleines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Older People • BPS DCP (2014) – Clinical Psychology in the Early Stage Dementia Care Pathway • BPS DCP (2014) – A Guide to Psychosocial Interventions in Early Stages of Dementia • DOH (2005) – 'Everybody's Business'		

d. People with a Learning Disability

Dimension	Year 4	Year 5	Year 6 and beyond
General competencies	• Understanding the history and current context of services for people with learning disabilities, including: historical constructions of 'learning disability', the marginalisation and stigmatisation of people with learning disabilities, institutionalisation, normalisation, the social model of disability, and the continued failure to safeguard adults with learning disabilities against abuse by those in whose care they have been placed. • Understanding of current policies, particularly Valuing People and Valuing People Now, and means of service delivery, including education, person centred planning, personalisation care and the Care Programme Approach as it applies to this client group. • Appreciation of the heterogeneity of people classified as having learning disabilities and an understanding of classification and epidemiological issues. • Understanding of the biopsychosocial model as it applies to this speciality, including an understanding of possible causes of learning disability, the interaction of biology and behaviour (including behaviour phenotypes), autistic spectrum disorders, and possible physical and mental health problems and disabilities co-occurring alongside learning disabilities (e.g. sensory impairments, dementia). • Understanding of the impact of having learning disabilities across the lifespan, which may include diagnosis and intervention during the childhood years, transition during late teenage and early adult years, adulthood and older age. Trainees should also develop some understanding of the potential impact on family and paid carers of caring for a person with learning disabilities. • Understanding of the different contexts of which people with learning disabilities may be part: i.e. the family, special and mainstream education in schools and colleges, day and leisure opportunities, supported living schemes and residential care, and specialist care settings, such as inpatient generic and mental health settings, and forensic settings. • Ability to communicate, both face-to-face and in written/pictorial form, with people from across the whole spectrum of communication abilities, including individuals who are non-verbal, together with an awareness of communication issues and mediums to facilitate accessible communication.		

Dimension	Year 4	Year 5	Year 6 and beyond
	• Ability to adapt psychological assessments and interventions to the cognitive, communication, sensory, social and physical needs of people with learning disabilities and their carers.		
Focus of work	Working with service users and carers in 1-1 and group settings	Working with service users and carers in 1-1 and group settings, further consultation work.	Focus on leadership skills, consultation work with carers and other professionals, training & supervising others.
Setting	Outpatient/community/care homes/inpatient wards	Outpatient/community/care homes/inpatient wards	Any setting/supervisor that provides LD placements.
Presentations/ examples of appropriate work	LD diagnosis assessment. Dementia assessments with LD populations. Individual therapy with LD service users. Functional analysis/challenging behaviour work with an indirect focus	As 4th year, but with the addition of completing mental capacity assessments, involvement in best interests meetings, risk assessments related to cognitive/physical and sensory problems, consultative work and indirect work, including sharing formulations related to challenging behaviour, staff training and support.	Supervision & Consultation, emotional distress related to receiving an LD diagnosis; coordinating interventions between different agencies; supporting other health professionals in their own self-care.
Therapeutic approaches/models	An awareness of the diagnostic criteria for LD, models of dementia applied to LD, therapeutic models could include CBT, behavioural approaches, psychodynamic therapy, third wave approaches (ACT/mindfulness/CFT), solution focused therapy, etc.		
Professionalism and Ethics	• Appreciating boundaries with other services and professional roles; • Establishing a structure of personal and professional support; • An understanding of legal frameworks and issues of risk/vulnerability that can occur with service users with learning disabilities.		

Dimension	Year 4	Year 5	Year 6 and beyond
Caseload	Work with around 6-8 people. Trainees should have substantive experience with people with learning disabilities with a mix of presenting problems in a variety of service settings and, across the lifespan, should be exposed to individuals from across the spectrum of learning disabilities, including individuals with severe and profound learning disabilities. The following placement experiences are recommended: • Work relating to someone whose behaviour is constructed as 'challenging', involving a comprehensive functional analysis • Working relating to someone with an autistic spectrum disorder • Work with a person with severe of profound learning disabilities • At least one detailed psychological assessment, which should include the use of formal measures (e.g. psychometric or functional assessment), and which should at least partly be completed directly with a person with learning disabilities • At least one direct assessment and intervention with family or paid carers; this could include indirect work with a staff team • Formal evaluation of the impact of a piece of psychological work, whether assessment (and feedback) or intervention.		
National Guidance documentation, Key reading etc.	• DOH (2001) Valuing People • DOH (2009) Valuing People Now • BPS DCP – Division of Clinical Psychology Faculty for Learning Disabilities (2012). Good Practice Guidelines for UK Clinical Psychology Training Providers for the Training and Consolidation of Clinical Practice in Relation to Adults with Learning Disabilities • BPS DCP – Dementia and people with Learning Disabilities, Executive Summary • BPS DCP (2015). Guidance on Neuropsychological Testing with Individuals who have Intellectual Disabilities • BPS DCP. Guidance on the Assessment and Diagnosis of Intellectual Disabilities in Adulthood • BPS DCP (edited by Nigel Beail). Psychological therapies and people who have intellectual disabilities		

e. Clinical Health Psychology

Dimension	Year 4	Year 5	Year 6 and beyond
General competencies	• Broad understanding of how people perceive and experience health and well-being as well as illness/injury. • Understanding the interactions between illness/injury and life/developmental stage. • Awareness of the social and political context in the development, expression and care of illness/injury. • Working knowledge of the pathophysiology and progression of injuries/diseases frequently encountered in the particular setting; the medical treatments and procedures usually carried out; and the psychological significance these may have.		
Focus of work	Working with service users and carers in 1-1 and group settings.	Working with service users and carers in 1-1 and group settings; Working with teams and systems.	Specific therapy competency development (e.g. CAT, CFT, ACT); Leadership, Supervision and training of others in Psychological aspects of illness/injury.
Setting	Outpatient/community	Outpatient/community & Inpatient	Any setting/supervisor that provides supervision in specific models/competencies
Presentations/ examples of appropriate work	Anxiety; Depression; Adjustment; Concordance; Promoting self-management; Service evaluation.	Surgery assessment; Life limiting conditions; Complex risk assessments in medical settings (concordance/concurrent mental illness/drug misuse).	Supervision & Consultation; Emotional distress in the terminal phases of an illness; Coordinating interventions between different agencies; Delivering difficult or unwelcome communications; Supporting other health professionals in their own self-care; Health promotion.

Dimension	Year 4	Year 5	Year 6 and beyond
Therapeutic approaches/models	Self-Regulation, Self-Efficacy, theory of Planned Behaviour, CBT, ACT, CFT, Motivational Interviewing, adjustment models		
Professionalism and Ethics	• Appreciating boundaries with other services and professional roles; • Establishing a structure of personal and professional support; • An understanding of medical ethics • An understanding of issues relating to confidentiality particular to a medical setting		
Caseload	6-9 direct work with individuals, adjusted for other roles, e.g. running a group		
National Guidance documentation, Key reading etc.	Bennet, P (2003) Introduction to Clinical Health Psychology; Moorey, S & Greer, S (2007) CBT for people with cancer; Nichols, K (2003) Psychological care for ill and injured people; Nikcevic, AV, Kuczmierczyk, AR & Bruch, M (2006) Formulation and Treatment in Clinical Health Psychology; Sage, N, Sowden, M, Chorlton, E & Edeleanu, A (2008) CBT for chronic illness and palliative care; White, CA (2001) CBT for chronic medical problems		

f. Forensic

Dimension	Year 4	Year 5	Year 6 and beyond
Generic Mental Health / Forensic Competencies	• To develop a good understanding of the peculiarities of working in 'secure' forensic rehabilitation and related settings where forensic/clinical psychologists practise (community; low-medium-high hospitals NHS & private hospitals; prisons A,B,C,D categories; independent sector, criminal legal roles – expert witness; social services, private consultancy, police). • To develop and demonstrate good working knowledge of consultation, leadership and supervision models and practice. • To develop and demonstrate good working knowledge of teaching and conveying complex information to a diverse audience (e.g. Home Office, other agencies, clients and their families; related staff groups). • To demonstrate good working knowledge of forensic psychology and related complex mental health issues (e.g. psychosis, schizophrenia, Personality Disorders, trauma and attachment related disorders), as well as related neuropsychological difficulties (e.g. traumatic brain injury, dementia, neurodevelopmental disorders – ADHD, ASD), substance use/abuse (e.g. drug and alcohol) problems, health and forensic psychotherapy, organizational psychology/systems theory, and their theoretical foundations and association with offending behaviours across the life-span. • Practical application of mental health forensic psychology/psychotherapy to deliver specialist assessments, formulations and interventions. • To develop a sound theoretical and practical knowledge of forensic mental health, risk and psychological assessment inventories (e.g. PCL-R, HCR-20, MCMI-III), their psychometric properties, strengths and weaknesses, and • To understand and associate neuropsychological test performance with functional abilities, activities or daily living and potential risks/vulnerabilities and support needs. • To develop formulations based upon test results and wider assessment with the client, and to be able to communicate this to both the client, families and a range of professionals (where appropriate), and to devise intervention strategies (cognitive rehabilitation, behavioural or adjustment focussed) as appropriate.		

Dimension	Year 4	Year 5	Year 6 and beyond
	• To develop good working knowledge of Mental Health Law • To assess and develop formulations in collaboration with systems (e.g. the multi-disciplinary team, other relevant agencies, such as, MAPPA, Social Services, The Police), clients, their families. • To devise and deliver effective treatment strategies/programmes addressing risk and offending behaviours (e.g. group programmes, such, as sex offender, anger management, psychoeducational, drug abuse; 1:1 behavioural interventions). • Demonstrate and develop good ability to work assertively and compassionately in a boundaried fashion. • Demonstrate and develop awareness of intra- and inter-personal risk and ability to manage frightening/threatening situations (e.g. verbal and physical abuse; de-escalation, restrain). • Demonstrate and develop resilience and self-care to be able to manage vicarious traumatisation. • Demonstrate and develop ability to work effectively with challenging/violent behaviours. • Demonstrate and develop sound knowledge of diversity (e.g. gender, race, class, cultural and socio-economic factors) associated with forensic mental health and offending behaviours, including gender difference in expression of violence. • Good awareness of the recovery approach and ability to engage with people in secure settings. • To develop some understanding of pharmacology/ECT and its effect on functioning in relation to assessment and treatment. • To develop and demonstrate good research skills to audit and analyse/present statistical information.		
Focus of work	*Specialist forensic psychology placements are typically considered to be 6th year/final year placements and/or special interest placements and therefore unlikely to be provided as a 4th year placement.*	Specialist Forensic Mental Health /Risk assessment and interventions aimed at improving mental health problems and addressing risk to reduce/eliminate offending behaviours. Working with service users, staff, services and systems related to the criminal justice and rehab system (Home Office,	Sound understanding of the 'secure' forensic mental health setting; Completing specialist assessments (e.g. structured risk, personality disorder and offending behaviour related; Capacity, neuropsychological assessments); Psychological/forensic psychotherapeutic interventions (e.g.

Dimension	Year 4	Year 5	Year 6 and beyond
	Aspects of Forensic work can be tailored for 5th year placements.	Crown Prosecution, Advocacy, Courts, Police, Prisons; Tribunals, MAPPA) and family members in 1:1 and group settings. Systemic working across professions and agencies. Offering specialist consultations and supervision. Evaluating and treating risk (e.g. suicidality, challenging/violent behaviours). Writing specialist, detailed reports tailored to specialist audience (e.g. Home Office).	CBT 1:1, behaviour therapy, specific structured group programmes, group analytic groups, CAT; TFT); Working with staff groups and systems (e.g. inter/intra-disciplinary working across systems and professions); training & supervising staff.
Setting		Mostly low-, medium-, high-secure forensic hospitals; Youth Offending Teams; Prison Service (A-D categories)	Child & Adolescent, Adult/Older Adult, Male/Female (ASD, ADHD, LD; TBI; PDs)
Presentations/ examples of appropriate work		Specialist Risk/Forensic Assessments (e.g. HRC-20; RSVP; FACE; SAM; PCL-R); Specialist Psychogical and Neuropsychological/Neurodevelopmental (screening) assessments (e.g. MMPI-III; WAIS-IV, WMS-IV).	• Personality Disorders (e.g. detailed psychological assessment, formulation and intervention) • Complex Mental Health Problems (e.g. detailed assessment and intervention for delusions and hallucinations) & Substance

Dimension	Year 4	Year 5	Year 6 and beyond
		Different types of assessments tailored to the population (e.g. female, male, child & adolescent, old age).	Abuse (e.g. 1:1 drug/alcohol work). • Capacity assessments. • Complex risk assessments. • Significant inter/intra disciplinary working. • Consultation work, leadership skills, family work, working with external agencies.
Therapeutic approaches/models	CBT, structured group programmes (e.g. sex offenders, anger management, fire setting; substance abuse), Behavioural Approaches, CAT, TFT, Group Analytic , EMDR, psychodynamic)		
Legislation / Frameworks	• Mental Health Act (1983, particularly sections 37, 41, 47, 48, 2, 3). • Mental Capacity Act 2004 particularly sections 4, 24-26). • Social Care Act, 2012). • Criminal Law (e.g. Sexual Offences Legislation). • Professional Practice Guidelines (e.g. HCPC, PBS), Ethical/Professional Guidelines • Relevant NHS and Department of Health related frameworks.		
Caseload	Caseload size should be proportional to assessment/intervention focussed work but should total approximately 4-6 cases, depending on complexity. Trainees should have substantive experience with complex cases (e.g. PDs, Psychosis, Trauma, TBI, LD; challenging behaviours) with a mix of presenting problems and should be highly resilient. The following placement experiences are recommended: • Work with at least six people 1:1 (e.g. clients, staff members from MDT) • Offer at least 1 session for staff members (e.g. consultation, teaching, supervision, staff support) • Work with at least three people with personality difficulties. • Work at least with three people with trauma/attachment related problems.		

Dimension	Year 4	Year 5	Year 6 and beyond
	• The completion of at least three comprehensive risk/forensic assessments (e.g. HCR-20, MMPI-III). • The completion of at least three intervention either 1:1 or in group setting (CBT, behavioural approaches, group programmes, CAT, psychodynamic, TFT). • The completion of at least one piece of work that involves the team (e.g. teaching, staff support group). • If possible, attendance at a tribunal meeting and/or observing Capacity/Mental Health Act assessment. • Using at least two different psychotherapeutic models (e.g. group work, CBT, psychodynamic, CAT).		
National Guidance documentation, Key reading etc.	This will depend on the placement. Good resources include the BPS DON website, texts such as The Cambridge Handbook Forensic Psychology (eds. Brown & Campbell), Handbook of Forensic Psychology (Gupta et al.), The Psychology of Criminal Conduct (Bonta), Forensic Psychotherapy: Crime, Psychodynamics and the Offender Patient: Crime, Pyschodynamics and the Offender Patient (Cox & Cordess).		

g. Neuropsychology

Dimension	Year 4	Year 5	Year 6 and beyond
General competencies	• To develop an awareness of the different settings where clinical neuropsychologists commonly practice, including acute hospitals working alongside neurologists and neurosurgeons, community or hospital based rehabilitation services (NHS or independent sector), and the independent sector (medical legal or other private practice roles). • To demonstrate an understanding of clinical neuropsychology and its theoretical foundations, clinical application and relationship with related aspects of clinical psychology, neuroscience and other related disciplines. • Utilise neuropsychological knowledge and experience in the delivery of assessment, formulation and intervention. • To develop a good understanding of the range of neuropsychological assessment measures, their normative properties and relatives strengths and weaknesses of each, including measures that assess: screening tests, estimates of premorbid intellectual function, general abilities/current intellectual functioning, memory, executive functioning, attention, visuo-spatial skills. • To understand and associate neuropsychological test performance with functional abilities, activities or daily living and potential risks/vulnerabilities and support needs. • To develop an understanding of some of the key neuroanatomical features, including hemispheric differences, cortical (the lobes of the cerebral cortex; including particularly the frontal lobes and temporal lobes and their associations with executive functions and memory) subcortical, and key language, visual/perceptual and movement areas of the brain. A trainee is not expected to have a full understanding of this from one or two placements but should gain an appreciation of how this applies in neuropsychology settings. • To develop an understanding of neurological conditions and injuries, including traumatic brain injuries, stroke, hypoxia, encephalitis, tumours, epilepsy and degenerative conditions (dementia, MS, Parkinson's, motor-neurone disease, Huntington's). To be aware of, and where to find further information about, the typical neuropathology, common cognitive, physical, behavioural and emotional components of each, and typical courses of recovery/progression.		

Dimension	Year 4	Year 5	Year 6 and beyond
	• To develop formulations based upon test results and wider assessment with the client, and to be able to communicate this to both the client, families and a range of professionals (where appropriate), and to devise intervention strategies (cognitive rehabilitation, behavioural or adjustment focussed) as appropriate. • To be aware of legislative frameworks relevant to this clinical speciality.		
Focus of work	Most likely to be related to aspects of psychometric assessments on older adult (differential dementia diagnosis) placements or LD placements	Working with service users, family members, and carers in 1-1 and group settings. Placements may include inpatient/outpatient/community, NHS/independent sector stroke/brain injury rehabilitation settings (inpatient or outpatient). The focus will also likely include more of an MDT, inter-disciplinary working approach.	Specialist neuropsychology placements are typically considered to be 6th year/final year placements – these may be inpatient/outpatient focussed or relate to specialised settings such as neuro-oncology. Focus is on completing a range of neuropsychological assessments/interventions; capacity assessments/risk assessments leadership skills, inter/intra-disciplinary working, consultation work and joint work with other MDT members including but not limited to speech and language therapists, occupational therapists, medical staff, nurses, physiotherpaists; training & supervising others.
Setting	Most likely LD/Older adult settings	Older adult/ LD / Child (ASD pathways, neuro-developmental), acute neurology/neuropsychology settings, inpatient neuro rehab settings (NHS or	Acute neurology/neuropsychology settings, inpatient neuro rehab settings (NHS or other), community

Dimension	Year 4	Year 5	Year 6 and beyond
		other), community neuro rehab settings.	neuro rehab settings, specialist services such as neuro-oncology.
Presentations/ examples of appropriate work	LD diagnostic assessments. Differential dementia diagnosis	ASD / ADHD types of psychometric assessments on child placements. Neurological condition and brain injuries (TBI, stroke, encephalitis, hypoxia, epilepsy tumours, and degenerative neurological conditions). • Detailed neuropsychological assessment, formulation and intervention. • Capacity assessments. • Complex risk assessments • Significant inter/intra disciplinary working	Neurological condition and brain injuries (TBI, stroke, encephalitis, hypoxia, epilepsy tumours, and degenerative neurological conditions). • Detailed neuropsychological assessment, formulation and intervention. • Capacity assessments. • Complex risk assessments • Significant inter/intra disciplinary working • Consultation work, leadership skills, family work, working with external agencies.
Therapeutic approaches/ models	Neuropsychological/cognitive/, biopsychosocial model, neurobehavioural model. Models of adjustment post brain injury (e.g. the Y-shaped model, denial/lack of insight)Psychotherapeutic models applied and adapted to cognitively/physically impaired clients, including CBT, third wave models (ACT, mindfulness, CFT), etc		
Legislation	• The Mental Capacity Act (MCA) and common reasons for completing capacity assessments (capacity to consent to treatment, choice of discharge destination, care package on discharge, the right to refuse treatment, advance directives, financial capacity, sexual capacity). • Power of Attorney / Court of Protection • Deprivation of Liberty Safeguards (DOLS) • NICE guidelines • The Mental Health Act (MHA)		

Dimension	Year 4	Year 5	Year 6 and beyond
Caseload	Caseload size should be proportional to assessment/rehabilitation focussed work and may differ considerably depending upon the setting and type of work, with an anticipated case load size of between 8-15. Trainees should have substantive experience with people with a range of neurological conditions, brain injuries and potentially functional neurological with a mix of presenting problems, across the adult age range (or for child neuropsychology setting, across the child age range), should be exposed to individuals varying in degree of physical and cognitive difficulties: The following placement experiences are recommended, but will depend on the placement base and focus: • Work with at least one person who has suffered a traumatic brain injury. • Work with at least one person who has had a stroke. • Work with at least one person with a degenerative condition. • The completion of at least one comprehensive neuropsychological assessment. • The completion of at least one piece of work with a substantive neurorehabilitation focus (cognitive, behaviour or adjustment related work) • The completion of at least one piece of work that involves family/systemic work. • The completion of a least one mental capacity assessment (under supervision), and attendance at a best interests meeting. • The completion of at least piece of 'joint work' (assessment and rehabilitation) with another member of the MDT. • Work relating to someone whose behaviour is constructed as 'challenging', involving a comprehensive functional analysis, and behavioural management approaches • To complete at least one piece of a psychotherapeutic work with someone with a neurological condition, or who have suffered a brain injury.		

Dimension	Year 4	Year 5	Year 6 and beyond
National Guidance documentation, Key reading etc.	This will depend on the placement. Good resources include the BPS DON website, and core texts such as Lezak, and Spreen, Sherman & Straus. NICE guidelines: such as those for head injury, stroke, Parkinson's disease ,motor neurone disease, MS		

Appendix 5: Therapy Competencies

a. Generic Skills

b. CBT

c. CFT

d. ACT

e. CAT

f. Psychodynamic

g. Systemic

h. Narrative

i. Neuropsychology

j. DBT

k. Play Therapy

a. Generic Therapy Competencies

Assessment/Formulation	Intervention/Evaluation
Case note review	Managing a therapeutic relationship that is difficult at the point of engagement
Assessment interview with parent or carer	Initial formulation
Assessment interview with key worker	Communicating formulation OR collaborative development of structured ideas in vivo
Assessment of risk to self	Planning intervention/future work together
Assessment of risk to others	Re-formulation OR collaborative redevelopment of structured ideas previously shared
Client self-monitoring	Recognising when intervention may not be appropriate
Carer/worker monitoring (indirect working)	Use of therapeutic letters during therapy
Formal Carer Assessment	Use of therapeutic letters at the end of therapy
	Ending therapy

b. CBT Competencies

Basic CBT Competencies	Specific behavioural and cognitive therapy techniques
Knowledge of basic principles of CBT and capacity to implement it in a manner consistent with philosophy	Specific techniques (exposure, relaxation/tension, activity monitoring/scheduling)
Knowledge of common cognitive biases relevant to CBT	Ability to use thought records
Knowledge of the role of safety seeking behaviours	Ability to identify and work with safety behaviours
Ability to explain and demonstrate rationale for CBT to client	Ability to detect, examine and help client reality test automatic thoughts/images
Ability to agree goals for the intervention	Ability to elicit key cognitions/images
Ability to structure sessions (agenda setting, homework, summaries, pacing)	Ability to identify and help client modify core beliefs
Ability to use measures & self-monitoring to guide therapy	Ability to employ imagery techniques
Ability to devise a maintenance cycle and use this to set targets	Ability to plan and conduct behavioural experiments
Problem solving	Ability to develop formulation and use this to develop treatment plan/case
Ability to end therapy in a planned manner & plan long term maintenance	Ability to understand client's inner world and response to therapy
Problem specific competencies (Depression, OCD, GAD, Panic, Phobias, etc.)	Capacity to formulate and apply CBT models to the individual client

c. Compassion Focused Therapy Competencies

Basic CFT competencies	Specific CFT techniques
Collaboratively develops understanding of client's key early emotional experiences	Attention training, Mindfulness, Soothing Rhythm Breathing
Explores self to self, self to other and other to self-relationships	Compassionate Imagery (safe place, self, other)
Links to core motives, self-identities and goals	Reliability of Self-critic (self-attacking vs compassionate self-correction)
Exploration of threat system activation	Compassionate letter writing
Help client to understand development of protective strategies, their function & unintended consequences	Chair work
Help client to reflect on concept of 'not your fault'	Compassionate engagement to re-evaluate experiences
Explains evolutionary model & three systems	Working with safety beliefs, behaviours & emotions
Clarification of definitions of compassion	Assertiveness and courage
Exploration of client's & common blocks to compassion	Distinction between shame and guilt
Discussion of development, forms and functions of self-criticism	Understanding conditioning in relation to fear of warmth & compassion
Collaborating on goal setting and contracting for therapy	Rescripting

d. Acceptance & Commitment Therapy Competencies

General Therapy Skills	Helps the client get into contact with direct experience and does not attempt to rescue the client from painful psychological content.
	Introduces experiential exercises, paradoxes and/or metaphors as appropriate and de-emphasises literal “sense-making”.
	Avoids the use of “canned” ACT interventions, instead fitting interventions to the particular needs of particular clients.
Be Present	Therapist can defuse from client content and direct attention to the moment.
	Helps clients to make contact with the life that is happening now, whether it be filled with sorrow or happiness, using mindfulness and exercises where appropriate.
	Can detect when the client is drifting into the past or future and teaches the client how to come back to now.
	Help clients to make contact with a sense of self that is continuous, safe and consistent; and from which they can observe and accept all changing experience.
Open Up	Helps client make direct contact with paradoxical effect of emotional control strategies: helping them become aware of ways in which they attempt to avoid and control.
	Helps clients see experiential willingness as an alternative to experiential control.
	Helps clients make experiential contact with the cost of being unwilling relative to valued life ends
	Can use exercises, metaphors to demonstrate willingness and action in the presence of difficult internal experiences.
	Helps clients to understand willingness as an active process, not an outcome.
	Helps clients see thoughts as what they are – thoughts – so those thoughts can be responded to in terms of their workability given the client’s values.
	Therapist uses language, metaphors and experiential exercises to create a separation between the client’s direct experience and his/her conceptualisation of this.
	Therapist detects “mindiness” (fusion) in session and teaches the client to detect it as well.

e. Cognitive Analytic Therapy Competencies

Collaboratively identifies Target Problems.
Facilitates client awareness of their thoughts, feelings and behaviour by collaboratively formulating reciprocal role and target problem procedures.
Assessment ensures the client's goals have been addressed and suggests the possibility of change.
Uses a range of tools (e.g. Rep Grid, Self-States Procedure, etc.) to contribute to the assessment, but must include the Psychotherapy File.
Collaboratively draws a diagrammatic reformulation of difficulties.
Writes a prose reformulation that that conveys an understanding of the links between early experiences, current experience and the therapy experience.
Sensitively shares the CAT tools (e.g. reformulation letter), demonstrating the capacity to alter understanding where they are inaccurate, and identifies where further work is needed
The therapist explores and expands the initial formulation collaboratively with the client by reflecting on all the material the client brings to the session.
The therapist encourages/facilitates the client's capacity to use the jointly created tools both within and outside sessions (so promoting self-observation and reflective capacities).
The therapist helps the client to explore alternatives or exits to current TPPs and RRPs, and suggests and describes relevant work between sessions in recognising and revising TPPs.
The therapist shows that they have an awareness of the possibility of invitations by the client to enact their anticipated reciprocal role, and the desirability of avoiding this.
Threats to and breaches in the therapeutic alliance are named as TPP and RRP enactments within the session, are identified and responded to in a non-collusive manner and are linked to/located on the SDR/SSSD.
Progress, change and maintenance is assessed against statements of change within the CAT model (for example, using rating sheets, TP/TPP lists, exits on SDR/SSSD).

f. Psychodynamic Therapy Competencies

Basic analytic/dynamic competencies	**Specific analytic/dynamic techniques**
Knowledge of basic principles and rationale of analytic/dynamic approaches	Ability to make dynamic interpretations
Ability to assess likely suitability of an analytic/dynamic approach	Ability to work in the transference
Ability to engage the client in analytic/dynamic therapy	Ability to work in the counter-transference
Ability to derive an analytic/dynamic formulation	Ability to recognise and work with defences
Ability to establish and manage the therapeutic frame and boundaries	Ability to work through the termination phase of therapy
Ability to facilitate exploration of influence of unconscious dynamics on relationships	**Metacompetencies**
Ability to help client become aware of unexpressed emotions/feelings	Ability to make use of the therapeutic relationship as a vehicle for change
Ability to maintain an analytic/dynamic focus	Ability to apply the model flexibly in response to the client's individual need and context
Ability to identify and respond to difficulties in the therapeutic relationship	Ability to establish appropriate balance between interpretive and supportive work
Ability to work with both the client's internal and external reality	Ability to identify and skilfully apply the most appropriate analytic/dynamic approach
Problem-specific competencies (BPD, Panic, bereavement, etc.)	

g. Systemic Therapy Competencies

Basic Systemic competencies	Specific Systemic techniques
Knowledge of systemic principles that inform the therapeutic approach	Ability to use systemic hypotheses
Knowledge of systemic theories of psychological problems, resilience and change	Ability to use circular interviewing
Knowledge of systemic approaches that enable therapeutic change	Ability to use systemic techniques to promote change
Ability to initiate contact and undertake a systemic assessment	Ability to work towards resolving problems
Ability to develop and maintain engagement	Ability to map systems
Ability to develop systemic formulations and help clients to identify appropriate goals	Ability to make use of enactments
Ability to establish the context for a systemic intervention	Ability to work with a systemic team
Ability to work in a reflective manner	**Metacompetencies**
Ability to use monitoring to promote change	Ability to make use of the interpersonal perspective
Ability to facilitate communication across the system	Ability to hold an non-pathologising view of the system
Ability to manage endings	Ability to maintain a relational approach
Problem specific (couples therapy for depression, eating disorders, conduct disorder)	

h. Narrative Therapy Competencies

Naming the problem.
Separating the person from the problem (e.g. use of externalisation).
Tracing the history of the problem and its effects upon the person and others.
Storying the impact of the person and others on the problem.
Naming Unique Outcomes (exceptions – examples of when the person is not visited by the problem).
Use of landscape of action questions.
Use of landscape of consciousness questions.
Thickening subjugated stories (e.g. via re-membering, rituals or outsider witness use).
Use of therapeutic documents e.g. letters, artwork, certificates.

i. Neuropsychology Competencies

Working knowledge of impact of neurological conditions on symptoms including, hypoxia, encephalitis, CVA, metabolic disorders, etc.
Knowledge of issues associated with neurobehavioural rehabilitation, e.g. procedural learning, implicit memory, recovery of function, behavioural theory, and social learning theory.
General knowledge of frontal and executive systems commonly compromised in those receiving rehab following ABI and ability to effectively communicate these issue to others.
Demonstrates knowledge of the roles, demands and conflicts of stakeholders including: commissioners, solicitors, social workers, GP's, referring professional, parents, spouses, etc.
Up to date basic knowledge legislative issues (Mental Capacity Act and Bournewoods).
Ability to direct treatment efforts to work within Professional Guidelines.
Knowledge of neuropsychology and its neurochemical, neurophysiological and neuroanatomical bases.
Knowledge of approaches to, and theoretical and empirical bases of, brain injury rehabilitation.
Aiding a service user to contribute to his/her own rehabilitation plan.
The administration, scoring and basic interpretation of psychometric tests.
Oversee and coordinate all behavioural measures and intervention.
Integrate complex multi-factorial clinical information into a formulation, utilising a variety of psychological perspectives.
Coordinates the delivery of care plans, and feeds back relevant information to support the strategic efforts of the service.

j. Dialectical Behaviour Therapy Competencies

Basic DBT competencies	Specific DBT competencies
Knowledge of core theories and concepts	Ability to conduct a behavioural analysis
Knowledge of the structure and key assumptions of DBT	Ability to conduct a solution analysis
Knowledge of the use of agreements in DBT	Ability to utilise contingency management procedures
Knowledge of the principles underpinning the structure of DBT interventions	Ability to conduct exposure procedures
Knowledge of "target hierarchies" within each modality of DBT	Ability to conduct cognitive modification procedures
Knowledge of the stages of treatment in DBT	Ability to help the client to acquire, strengthen and generalise their skills
Knowledge of the goals of skills training in DBT	Shaping and strengthening commitment
Ability to convey didactic information about the DBT approach	Selecting communication styles
Ability to develop and maintain a DBT-congruent relationship with the client	Competencies for consulting to the client and for intervening in the client's environment
Establishing a target hierarchy	Ability to terminate the intervention
Ability to maintain a dialectical focus	Crisis-handling competencies
Ability to validate the client's experience	

k. Play Therapy Competencies

Knowledge & Understanding	Practice Skills
Understand the theory and practice of play therapy, including the humanistic child-centred approach. Understand models of the change process in a play therapy intervention	Formulate clear, meaningful and appropriate therapeutic contracts, including therapeutic aims, objectives, boundaries and rules.
Understand and integrate different models of play therapy including directive, non-directive and developmental approaches.	Intervene and provide play therapy to achieve identified therapeutic objectives; monitor and evaluate the effectiveness of play therapy interventions and adapt skills and techniques to a diverse range of children, young people and families
Understand theories of normal and abnormal play development, the role of play and the use of play as a therapeutic metaphor	Provide planned and coherent opportunities to enable work with clients to end in a therapeutic manner
To have the ability to articulate /translate Play Therapy practice /process and if appropriate to engage with the child's parents /carers in the therapeutic process.	Maintenance of rules and boundaries within play therapy practice
Demonstrate knowledge and understanding of contemporary practice and research in play therapy. Understand evidence-based practice principles	Accurately record play therapy interventions, working within the requirements of Data Protection legislation;
	Work in an effective anti-discriminatory way with a diverse range of children, young people and families, considering the individual's identity and cultural needs
	Communicate effectively, through non-verbal and verbal expression, with clients and significant others.
	Demonstrate and facilitate a range of verbal, non-verbal and symbolic communication using a variety of play and creative media with children, young people and families
	Collaborate and communicate with other professionals; demonstrate effective inter-professional working for the benefit of children, young people and families.
	Identify and critically evaluate relevant current research evidence and integrate into play therapy practice.