Supervised clinical placements account for over half of the three years in training. In line with the British Psychological Society’s (BPS) requirements for clinical psychology training and the Health Professions Council (HPC Standards of Education and Training Guidance - see reading list), we have a core competence model of training. Throughout the three years, three main areas are assessed: competence, experience and reflection.

COMPETENCE AND EXPERIENCE FRAMEWORKS

**Competence**: Core competencies in clinical psychology are those areas of activity that are considered by the BPS and our regulatory body, the Health Professions Council (HPC), to be central to our identity and role in the public services. “Competence” is defined as the ability to perform the activities of an occupation to the standards expected in employment. In the NHS National Plan and workforce planning this translates into “fit for purpose” and “fitness to practise” (HPC Standards of Conduct, Performance and Ethics, Guidance on Conduct and Ethics for Students, Standards of Proficiency, Practitioner Psychologists).

By the end of each placement year, trainees are expected to demonstrate they have met learning outcomes and they are progressing satisfactorily towards the competency level expected of a newly qualified clinical psychologist in that area of practice. The required professional (BPS) competencies are:

- **Relationships**
- **Psychological Assessment**
- **Psychological Formulation**
- **Psychological Intervention**
- **Psychological Evaluation**
- **Transferrable Skills**
- **Personal and Professional Skills and Values**
- **Communication and Teaching**
- **Service Delivery**

**Experience**: Trainees are expected to develop their competence through a balanced range of experiences across settings and client groups. The BPS and HPC specify the range of experience required to be covered in clinical psychology training:

- **Exposure to clients, carers and families with a range of presenting problems, resources and abilities across the life span, based in a range of service delivery systems or settings, working at a number of different levels (direct, indirect, and within multi-disciplinary teams) and using and integrating more than one psychological approach.**

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

PLACEMENT SEQUENCE

Supervised clinical experience is gained through three placements, each nearly one year in duration. The placement sequence is planned so that trainees can develop their
core competencies within a life-span, developmental and cultural contextual framework in which they can understand psychological well-being and distress. Attendance at placements is mandatory. If a trainee misses more than ten days of a placement the clinical tutor will form an action plan around this absence and the appraiser will be involved in this. An absenteeism form should be completed for any day of absence from placement.

**Year One** placement involves work with children/families and with people with learning disabilities, with an emphasis on community and systemic orientations. **Year Two** placement involves work in services with adults and with older adults. In both of these year-long placements each trainee will have one or two supervisors, who may come from a number of different specialisms. **Year Three** is a consolidation and specialisation, preparation for practice year in which trainees will gain more in-depth experience of applying and integrating psychological approaches, fill in any gaps and consolidate their acquisition of core competencies and experiences as they prepare for their first qualified post. This is also a year for further specialisation (such as CBT, family therapy and others).

**Year One: Children/Learning Disabilities**
Theory-practice introductory placement days: 13.10.11.-14.10.11
Placement start and end dates: 16.11.11 - 30.09.12
NHS mandatory Induction day: 17.11.11.
Submission dates: 07.05.12 and 3.09.12
Placement audit forms: 07.09.12.

**Year Two: Adults/Older Adults**
Theory-practice introductory placement days: 17.10.11-19.10.11.
Placement start and end dates: 28.11.12 -30.09.13.
Submission dates: 06.05.13. and 02.09.13.
Placement audit forms 13.09.13.

**Year Three: Consolidation, specialisation and preparation for qualified practice**
Placement start and end dates: October 2013 – September 2014
Placement audit forms: 12.09.14

**Planning placements for Year 3**
In Year 2 – March – Clinical tutor thinks with trainee about Year 3 and discussions with appraiser begin. Trainee can approaches supervisors informally about one or two possible placements bearing in mind that future Year 1 and 2 placements must take priority.
April/May – Appraisal leads to identification of learning gaps and suggestions of most appropriate supervisors.
May – August – Supervisors are agreed via Programme Team, Liaison Tutors and Clinical Tutors
August – Final confirmation of supervisor for Year 3.
In Year 3
October/November - Clinical tutors to send an email in to plan a contracting visit during the first six weeks of placement. To clarify with trainee and supervisors what will be required from the Year 3 placement.
ROLE OF TRAINEES

We aim to facilitate an open learning environment in which information is shared appropriately and respectfully between staff, trainees and other key stakeholders to enable trainees’ development and to ensure appropriate client care. Trainees should expect that information about day-to-day aspects of training will be shared as appropriate. For example, clinical tutors read notes made during trainees’ appraisal to facilitate the support of placements. Assessment reports on continuous assessment work are held on open files available to all team members.

In order to plan the placement, develop their strengths and meet their training needs, the trainee shares with the supervisors, at the start of the year one, relevant information about previous experiences. At the start of subsequent placement periods, the previous Clinical Competence Goals and Evaluation Form and Portfolio of Clinical Experience – or, at the beginning of training, relevant information about previous experiences and prior learning will also be shared.

Trainees must always use the term Trainee Clinical Psychologist when introducing themselves to clients (see section on informed consent in Programme handbook). Trainees must also ensure that all letters and reports are signed appropriately. The British Psychological Society requires the following: “Trainee Clinical Psychologist working under the supervision of… (name of supervisor)”. Exeter trainees may add: “studying Doctorate in Clinical Psychology”. Supervisors retain clinical responsibility for the work undertaken by trainees, but trainees should check with supervisors what is the expected practice within the Trust that they are working in.

Evaluation of Trainees’ Placement Performance – Guidance on Completion of Clinical Paperwork

Trainees are required to submit one hard copy of the Clinical Competence Goals and Evaluation Form (App 2), the Portfolio of Clinical Experience (App 2), the Supervisors Overall Evaluation form (App 3) and the observational tool (App 6), using the standard format in a one slide binder. These documents are completed by the trainee and signed and agreed by the supervisors as an accurate record. Trainees must ensure their submissions are complete and submitted by the deadline. If the date of submission does not fall on a day that you would be expected to attend the Uni, you may post your work. Your package must be postmarked on or before the submission deadline.

It is essential, as with all continuously assessed work that these evaluations are submitted by the required deadlines; if not, the trainee risks the paperwork being marked as late, not progressing through to the next year, or completing the course in time. Clinical work undertaken after the September deadline should be mostly finishing work, completing reports etc rather than taking on any new work. Any new work undertaken after the September deadline would not normally be included in the assessment. Should an incomplete or incorrect set of paperwork be submitted it is the trainees responsibility to make any amendments or additions and re-organise their paperwork accordingly. Trainees must also keep their own copies in a ring bound file to retain a cumulative record of all their placement reports to share with subsequent supervisors and at annual appraisal meetings. The Clinical Director moderates and agrees the ratings.

Appendix 5 summarises paperwork and signatures required from trainees and supervisors.
Supervision agreement
At the contracting visit the trainee, supervisors and clinical tutor finalise an overall supervision agreement, confirming arrangements for timing and frequency of supervision sessions and placement visits, with some consideration of how content and process issues will be addressed (see Appendix 7 for document on managing difficulties in supervision, a suggested format for the supervision agreement and BPS guidelines on supervision.)

The trainee should have a total of at least one and a half hour’s (pro-rata) direct supervision each week based on a four day week (BPS), and the trainee’s total “contact time” across supervisors should be at least three hours (the balance of how these are to be provided across supervisors will be individually negotiated). Some supervision may be group supervision. The trainee must keep supervision notes for their own use, to include:
- a record of the date, duration and name of supervisor for each session;
- brief notes on content and process issues attended to during supervision;
- a clear record of decisions reached and agreed actions;
- a summary of any reviews of supervision.

Trusts will have their own supervision policies and trainees should access these as they join Trusts.

ASSESSMENT

The supervisors evaluate the trainee’s competence twice in each of the first two years of training and once towards the middle of the final year of training, (with a final evaluation at the end of training if needed) using the Clinical Competence Goals and Evaluation Form and Observational Tool (see Appendices 2,3 and 6). The trainee’s appraiser reads this evaluation and it feeds into the annual appraisal meetings (outlined in more detail in Programme handbook) that generally functions as a gateway to the following year of training.

The supervisor(s) monitors and evaluates the trainee’s experience twice in each of the first two years of training (at the middle and end of each year-long placement) and once towards the middle of the final year of training (with a final evaluation at the end of training if needed) using the Portfolio of Clinical Activity, completed by the trainee and counter-signed by the supervisor (see Appendix 2 and 3).

Reflection is monitored through feedback on reflexivity from clinical supervisors which feeds trainees’ annual appraisals (further reflective feedback comes from the programme team generally, and more specifically from the academic and research team). The observational tool (observation of trainee with client) is completed twice in a year-long placement by supervisors and is submitted as part of the trainees’ assessment.

Paperwork to be submitted by supervisors/trainees – please follow grid for assessment completion guidance (C61).

PLACEMENT VISITS

By the time the clinical tutor makes the contracting visit, (usually about a month after the start of placement) a draft of the following must be available for discussion: 1) the general placement outline and the strengths, learning needs and specific goals for each competence area in the Clinical Competence Goals and Evaluation Form; 2) the early
entries into the Log of Clinical Activity from the Portfolio of Clinical Activity; and 3) and the Supervision Agreement. This would normally be forwarded to the clinical tutor prior to the first visit.
Additionally, for those trainees who were given a conditional pass or a referred rating for the previous placement period, by the end of the second week on placement the trainee must send the clinical tutor a first draft of the general placement outline from the Clinical Competence Goals and Evaluation Form, including initial consideration of how those issues identified as requiring particular attention from the previous placement will be addressed.
If there are concerns about the trainee’s performance, or about the adequacy of the placement, an action plan must be drawn up, indicating what needs to be done for the trainee’s Clinical Competence and Experience to be evaluated as reaching a pass level by the supervisor. Clear arrangements must be set up to monitor the action plan and the trainee’s progress, including, if necessary, a final placement visit.

SUPERVISOR ROLE

We run an introductory workshop for new supervisors in the spring of every year and a pre-placement workshop for those having a trainee. Supervisors are also invited to attend bi-annual supervisors’ committee meetings containing CPD. In addition, supervisors are invited to attend relevant academic Programme events in the teaching block prior to the placement or in integrated teaching days. Clinical Supervisors are required to complete a database form indicating when they have attended training or refresher training as well as a description of what their service/placement offers for trainees (pre-placement audit). This is updated by the clinical administrator every six months and is accessible for trainees when they come to plan their placements ahead of Year 3.

In years one and two (and possibly in year three), most trainees will have two supervisors from different specialisms in which the trainee will be gaining experience during the year. The balance of work across the two specialisms over three days a week (Weds-Friday) will be individually negotiated between the trainee and supervisors, assisted by the clinical tutor where necessary. The work balance as far as possible will depend on trainees’ previous strengths, prior experiences and current learning needs and service opportunities/needs. In most cases the trainee undertakes more work in one specialism than the other, but overall by the end of each year the trainee will need to meet learning outcomes in each specialism as specified in the competence and experience documentation.
It is expected that supervisors attend the pre-placement event offered to them prior to taking a trainee so they can prepare for the trainee joining their service. Supervisors will be inducting their trainees in the two/three theory-practice days preceding each placement year.

During these days, trainees would normally:

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

Supervisors evaluate trainees competencies, evaluate their portfolio of experiences and observe their trainees in Year 1, Year 2 and Year 3. They also sign off attendance at placement, sick leave and annual leave. (see Appendix 5 for paperwork grid).

**ASSESSMENT GRADING**

A conditional pass on either of the two placement evaluations (Clinical Competence Goals and Assessment Form and/or Portfolio of Clinical Activity) will be upgraded to a pass on confirmation from the Clinical Tutor that the issues identified have been attended to through the general placement outline for the next placement period. If the trainee receives a conditional pass at the mid-point of the final year placement, then the issue identified must be addressed in the planning for the next placement period and the trainee will be further evaluated at the end of the third year.

Placement referral or failure would ensue only after the procedures to address problems on placement had been exhausted without success. Any problems or concerns that could mean that the trainee may fail or be referred, should first be discussed by the trainee and supervisor together, and must be brought to the attention of the Clinical Tutor at the placement review visit (earlier if already identified, and later if they emerge subsequently). If a trainee is referred on clinical placement, the host employer will be informed so that services from HR can be utilized as necessary (e.g. occupational health, employment support). This will prompt a letter from the employer registering confirmation/receipt of a clinical referral and commenting on any action plan. Notification will be given by the employer that if a trainee received another referral clinically, the trainee would normally fail the programme.

A trainee may be referred due to unsatisfactory clinical competence and/or unsatisfactory clinical experience. Both supervisors make the judgement, after discussion, which is agreed. All cases where the trainee’s placement performance is evaluated as conditional pass or referred, or where there is disagreement between supervisors, are moderated by the Clinical Director who liaises with the clinical tutor, appraiser and supervisors as necessary. In any case where, following moderation by the Clinical Director, there is continuing disagreement between supervisors or between the supervisor and the trainee’s appraiser, all relevant paper work is sent to the external examiner. The external examiner will always be involved in all cases where the evaluation of the trainee’s placement performance is referred. The external examiner may take advice from the clinical tutor, the Clinical Director and, if necessary, the Head of Service in the Trust in which the placement was based. The decision of the external examiner, when ratified by the Board of Examiners, is final.

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

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

CLINICAL TUTOR ROLE

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

Clinical Tutors also liaise with placement providers before the trainee enters services through the self-assessment audit tool (Appendix 15) and follow up the completion of the audit tool. The Clinical Director then signs off the placement as meeting necessary and required standards. Normally the clinical tutor visits the placement three times in a year: a contracting visit (or more if required - contracting checklist Appendix 9) and two placement reviews (placement review checklist Appendix 10). At each visit the clinical tutor will meet the supervisors and trainee with individual time for each as well as some joint time. In addition, further visits can be triggered by issues/concerns/requests from supervisors/trainees/clinical tutors. Where two six monthly placements occur, a contracting visit and a placement review will be provided.

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

PLACEMENT PLANNING

Placements are jointly planned by Clinical Director, clinical tutors, heads of service and placement coordinators. Liaison or Placement coordinators are NHS clinical psychologists who take on their role in relation to Programmes in Clinical Psychology across most Trusts in the Southwest. Some Trusts do not have a named coordinator, and in these cases Heads of Service generally take on aspects of this role. The role of
the coordinator is to act as a communicator between their Trust and the Programmes. (See Appendix 8 for document summarising liaison between Trusts and Universities.) Each trainee is allocated to a geographical area and a Trust following selection. This Trust becomes the hosted Trust for this trainee. Placements cannot always be guaranteed in host Trust. Priorities for matching trainees with available placements would take disability as high priority. Reasonable adjustments to locality or host Trust area will be made for an individual and would take priority over preferred choice of another trainee for that placement.

NON-TRUST HOSTED TRAINEES

Rationale for placement outside of host Trust
- Learning needs cannot be met in host Trust, as evidenced by appraiser/and clinical tutor.
- Learning needs/performance would be impaired (through possible personal/coping/stress/difficulties) This needs evidencing from clinical tutor and appraiser if this is the case
- Services elsewhere can accommodate the request.
- We have an agreement with Liaison Tutors in the host trust (representing Service Heads’ views) that this is acceptable.
- This is cost neutral and Alan Taylor (HR) is in agreement.

These criteria are in no particular order and all need to be met for a case to be agreed.

PRE-AUDIT OF PLACEMENTS

Placements are audited prior to trainees arriving in placement setting. A database entry is recorded for every supervisor (Appendix 13) which gives a record of the training of each supervisor, and shows that each service has appropriate induction policies for trainees.

A self assessment tool is carried out with the placement provider/supervisor prior to the trainee going to the placement. This is reviewed by the clinical tutor in order to report on any difficulties to ensure that the trainees enter safe and supportive environments when in a placement setting (Appendix 15).

Minimum standards for supervisors/head of services in providing a placement:
- Confirmation in Trusts of the equality and diversity policies
- Health and safety policies
- Risk assessments
- Supervision contract – feasibility on hours that supervisors work
- Practical resources available for trainees
- Lone working policy
- Fitness to practice guidelines
- Supervisor training undertaken
Placements are accredited as follows:

a. Trust coordinators/ Service Heads identify supervisors whose qualifications meet
   the current criteria of the BPS Guidelines on Clinical Supervision (see Appendix 7).

b. Liaison Tutors/ Clinical Director/Clinical Tutor also ascertain through
   communication with the supervisor and Head of Service (and other service managers
   as required) that minimum resources are available: a desk in (at least) a shared office
   with access to telephone and secretarial support.

c. Individual supervisors are accredited through attendance at the pre-placement
   meeting or, when this is not possible, through receiving the relevant placement and
   supervision documentation, with, if necessary, a meeting or telephone contact with the
   Clinical Tutor or Clinical Director at which the placement procedures are outlined and
   documentation clarified.

Ongoing individual placement quality is monitored through clinical tutor observation
and trainee and supervisor feedback at placement visits.

The trainee and each supervisor separately complete a placement audit form
(Appendix 11). Placement audit data across placements in the Southwest are collated
by the Programme annually. Relevant data are forwarded for action as appropriate to
individual supervisors and, where appropriate and with agreement, Heads of Service
or specialism. Collective anonymised data are circulated to Supervisors’ Committee
and to Trusts via Heads of Service and this information is also provided at Contract
Management meetings, as appropriate.
1. Module Descriptor

2. Trainee Clinical Paperwork
   - Clinical Competence Goals and Evaluation Form
   - Portfolio of Clinical Experience

3. Supervisor Overall Evaluation Form

4. KSF Dimensions for trainee clinical psychologists

5. Year long placement – paperwork summary

6. In vivo observation of trainees’ clinical work

7. Supervision Agreement

8. Responsibilities of programmes, Liaison Tutors and Heads of Service

9. Contracting visit checklist

10. Placement review checklist

11. Placement Audit forms for trainees and supervisors

12. Fitness to Practise Procedures

13. Clinical Database form

14. Trust policies and procedures

15. Self Assessment Document

16. Taking clinical histories the culturally sensitive way

17. Service user evaluation form

18. HPC Standards of Proficiency
MODULE CODE | PSY D042 | MODULE TITLE | Clinical Skills in Clinical Psychology
LECTURER(S) | Clinical Director with Academic and Clinical Tutors and NHS Supervisors
CREDIT VALUE | 270 credits | ECTS VALUE | 135
PRE-REQUISITES | PSY D043, PSY D044
DURATION OF MODULE | 36 months
TOTAL STUDENT STUDY TIME | 2700 hours of placement time
AIMS
This module comprises one of the three necessary modules for the taught Doctorate in Clinical Psychology (DClinPsy). Taken together these modules form the basis for the academic, clinical and research skills that trainees require to practice as clinical psychologists. Overall, the clinical module aims to enable trainees to apply in practice the
• theoretical and empirical knowledge
• critical, analytical and integrative skills
• professional, ethical and client-centred values
needed to work effectively to enhance and promote psychological well-being.

Specific aims are to develop trainees’
1. Core clinical competencies in working directly and indirectly with individuals, carers, services and community systems (TS, PA, PF, PI, E, PPS)
2. Direct and indirect application of clinical competencies within a range of experiences: in a range of service delivery settings with clients with a representative range of problems and abilities from across the life span (TS, PA, PF, PI, PPS)
3. Application of clinical competencies with clients from a range of backgrounds taking into account social inequalities and diversity (TS, PA, PF, PI, PPS)
4. Integration of psychological theory, evidence and experience (TS, PA, PF, PI, E, PPS)
5. Commitment to working collaboratively, compassionately and respectfully with clients and colleagues, sharing essential capabilities and working as part of multi-disciplinary teams (PA, PF, PI)
6. Competence to work within professional and regulatory codes of practice and ethics (TS, PA, PF, PI, CT, SD)
7. Ability to conceptualise and adapt their practice in the light of current service policies and priorities (TS, PA, PF, PI, PPS, CT, SD)
8. Readiness to approach their work with critical reflection and self-awareness (TS, PA, PF, PI, ER, PPS)
9. Capacity to nurture their own particular clinical strengths and interests so that they can make a contribution to the development of psychological skills, knowledge and the profession (TS, PA, PF, PI, E, PPS, CT, SD, R)

INTENDED LEARNING OUTCOMES
On completion of the programme, trainees will be expected to be able to:
Core academic skills
1. explicitly underpin clinical work with theory, evidence and techniques drawn from two or more psychological approaches from at least the following: community; systemic; psychodynamic;
2. critically and autonomously evaluate and integrate theories in light of new information so as to develop new clinical approaches appropriate to the context (i.e taking into account the complex and unpredictable nature of real world settings and recognising complexities/deficiencies and/or contradictions in knowledge; (TS,PA,PF,E,R,PPS,CT,SD)

3. search and appraise relevant evidence bases and literature when planning interventions; (TS,PA,PF,E,R,PPS,CT,SD)

4. use clinical judgement, reflection and awareness of clients’ views in applying evidence in practice; (TS,PA,PF,E,R,PPS,CT,SD)

5. justify, reflect on, evaluate, report and monitor own and others’ work, and implement changes or acquire further knowledge when appropriate through a process of supervision and personal reflection. (TS,PA,PF,E,R,PPS,CT,SD)

Subject specific skills

1. demonstrate the core competencies of a clinical psychologist: relationships, assessment, formulation, intervention, evaluation, communication, training and consultation, management and organisation, professional practice, supervision and personal development; (TS,PA,PF,E,R,PPS,CT,SD)

2. demonstrate the core competencies within a range of experiences: in a range of service delivery settings with clients (individuals, carers, groups, services and communities) with a representative range of problems and abilities from across the life span; (TS,PA,PF,E,R,PPS,CT,SD)

3. demonstrate the essential shared capabilities for mental health practice: working in partnership, respecting diversity, practising ethically, challenging inequality, promoting recovery, identifying peoples’ needs and strengths, providing service user centred care, making a difference, promoting safety and positive risk taking, personal development and learning; (TS,PA,PF,E,R,PPS,CT,SD)

4. work effectively in consultation or in team work with professional colleagues across disciplines and across agencies, showing respect for knowledge and theories held by other professional groups including medical model diagnostic systems; (TS,PA,PF,E,R,PPS,CT,SD)

5. disseminate psychological skills and knowledge to others through formal or informal teaching; information provision; consultancy; supervision; (TS,PA,PF,E,R,PPS,CT,SD)

6. document clinical work appropriately through notes, reports and letter writing for clients and referrers; (TS,PA,PF,PI,E,PPS,CT,SD,R)

Personal and key skills

1. recognise and work within the limits of own professional and personal competence; (TS,PA,PF,E,R,PPS,CT,SD)

2. accept high levels of responsibility for self and others; (TS,PA,PF,E,R,PPS,CT,SD)

3. recognise and analyse professional and ethical dilemmas and act in accordance with professional guidelines and clinical governance; (TS,PA,PF,E,R,PPS,CT,SD)

4. understand, work within and influence the wider political, legal, organisational and systemic frameworks within which clinical psychologists operate; (TS,PA,PF,E,R,PPS,CT,SD)

5. manage workload and deal pro-actively with stress and the impact of clinical work; (TS,PA,PF,E,R,PPS,CT,SD)

6. demonstrate critical reflection and self-awareness; (TS,PA,PF,E,R,PPS,CT,SD)

7. identify own professional development needs and implement learning in practice as part of a process of life-long learning. (TS,PA,PF,E,R,PPS,CT,SD)

LEARNING/TEACHING METHODS

Learning will be through supervised practice in health and social care settings; feedback based on supervision and direct observation of clinical practice; literature searches; tutorials; assigned reading.

ASSIGNMENTS /ASSESSMENT

Formative assessment:
1. Observation Tool x 2 (relates to Reflection 1,2,3 subject specific skills)
2. Preparatory reading and literature searches for clinical work (relates to core academic skills 1 and 3)
3. Presentations of clinical work in teaching, tutorials and supervision (relates to subject specific skills 5)
4. Self-evaluation of Clinical Competence x 5 (relates to personal and key skills 6)

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

Year 1
1. Supervisor Evaluation of Clinical Competence x 2: end of part one (mid-placement) and end of part two (end of placement) (assesses core academic skills 1-5; subject specific skills 1, 3 - 6; personal & key skills 1-7) (10 pages)
2. Portfolio of Clinical Experience x2: mid-placement and end of placement (assesses subject specific skills 2) (7 pages with appendices)

Year 2
1. Supervisor Evaluation of Clinical Competence x 2: end of part one (mid-placement) and end of part two (end of placement) (assesses core academic skills 1-5; subject specific skills 1, 3 - 6; personal & key skills 1-7) (10 pages)
2. Portfolio of Clinical Experience x 2: end of part one (mid-placement) and end of part two (end of placement) (assesses subject specific skills 2) (7 pages with appendices)

Year 3
1. Supervisor Evaluation of Clinical Competence x 1: end of part one (mid-placement) (assesses core academic skills 1-5; subject specific skills 1, 3 - 6; personal & key skills 1-7) (10 pages)
2. Portfolio of Clinical Experience x 1: end of part one (mid-placement) (assesses subject specific skills 2) (7 pages with appendices)

ASSESSMENT

SYLLABUS PLAN
Year 1
1. Clinical placement 1: Part one (75 days – including theory practice days and annual leave)
2. Clinical placement 1: Part two (73 days – including theory practice days and annual leave)

Year 2
1. Clinical placement 2: Part one (64 days – including theory practice days and annual leave)
2. Clinical placement 2: Part two (79 days – including theory practice days and annual leave)

Year 3
1. Clinical placement 3: (Minimum 113 – maximum 145 days – recommended minimum 40 placement days by clinical assessment)

INDICATIVE BASIC READING LIST

British Psychological Society;
Code of Ethics and Conduct (2009)
Clinical Psychology and Case Notes: Guidance on Good Practice (2000)
Working in Teams (2001)
Health Professions Council
Standards of Education and Training guidance (2009)
Practitioner psychologists (2009)
Standards of conduct, performance and Ethics (2009)
Guidance on conduct and ethics for students (2009)
Practitioner psychologists (2009)
Department of Health

**National Institute for Clinical Excellence: [www.nice.org.uk](http://www.nice.org.uk)**
Website providing up to date guidance regarding a range of treatment strategies and approaches

**National Mental Health Development Unit [http://www.nmhdu.org.uk/](http://www.nmhdu.org.uk/)**
NMHDU, launched in April 2009, consists of a small central team and a range of programmes funded by both the Department of Health and the NHS to provide national support for implementing mental health policy

University of Exeter Doctorate in Clinical Psychology: 2011-2014

CLINICAL COMPETENCE

GOALS AND EVALUATION FORM

Trainee: ..........................................................................................................................

Placement dates: from ................................ to ............................................................

Placement:
- year one (part one) ☐
- year one (part two) ☐
- year two (part one) ☐
- year two (part two) ☐
- year three ☐

Supervisor’s name ........................................................................................................

Supervisor’s specialism ..............................................................................................

Supervisor’s base .........................................................................................................

Supervisor’s name ........................................................................................................

Supervisor’s specialism ..............................................................................................

Supervisor’s base .........................................................................................................
GUIDANCE NOTES FOR COMPLETING THE
CLINICAL COMPETENCE GOALS AND EVALUATION FORM

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

The purpose of this form is to:

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

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

SECTIONS OF THE FORM

General placement outline

In this section the trainee and supervisors:

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

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

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

**Evidence of Attainment** - this is filled out by the supervisor(s) at times of review, and towards the end of the placement period, as particular goals are attained. Some of the evidence must be based on supervisors’ own direct observation of trainees’ work in practice, and from direct client feedback. **The observational tool is to be utilized twice in a placement year.**

Evidence may be coded as follows:

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

Supervisors may also wish to add comments.

**Supervisor rating**

At the end of each placement period the supervisors (after consultation with others, and taking into account direct observation of the trainee’s work, and feedback from colleagues and clients) rate the trainee’s performance in each core competence area as “good”, “satisfactory” or “significant concerns”. “Good” indicates that the trainee’s performance has generally exceeded the level expected of a trainee at that stage of training (and that learning needs are as expected at this stage of training); “satisfactory” indicates that the trainee’s performance is generally at the level expected of a trainee at this stage of training (although there may be some learning needs that require particular attention the next placement period); “significant concerns” indicates that, taking into account the stage of training, there are significant difficulties regarding this aspect of the trainee’s development, which, unless they are urgently and successfully attended to in subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist.

**Strengths and Future Learning Needs**

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

Supervisors reflect on their impressions of the trainee, their own experience of having him or her for the placement period, including their experience of offering supervision. Formal learning needs are identified here by the supervisor that the clinical tutor and trainee will carry forward to the next placement period.

**Trainee identification of own strengths/learning needs & reflections on placement**

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

**Supervisor evaluation of trainee’s overall competence**

At the end of each placement period the lead supervisor makes a recommendation as to whether the overall trainee’s competence has reached the level of pass, conditional pass, referred or fail.

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

*Conditional pass* indicates that the trainee has exceeded or reached the overall competence of a trainee at this stage of training, but there are some learning needs that require particular attention in the next placement period and must be identified in the next stage of goal setting. In other words, that the supervisor judges that the trainee’s performance is “good enough” for this stage of training provided that the learning needs identified are given particular attention in the next placement period.

**Referred** indicates that the trainee has not reached the overall level of competence expected for a trainee at this stage of training. There are significant concerns in one or more competence area(s), which, unless they are urgently and successfully attended to through an action plan for subsequent placement period(s), mean that the trainee will likely not reach the level of competence expected of a newly qualified clinical psychologist. (NB if the trainee is referred again on any subsequent placement period they would normally fail the programme.) In other words, that the supervisor judges that the trainee's performance is not "good-enough" for the stage of training and that unless the concerns are attended to and the trainee reaches a "good enough" level at all further stages of training that they should not qualify as a clinical psychologist.

*Fail* indicates that following due investigation the trainee has been found to have engaged in serious professional misconduct. (This normally means that the trainee fails the programme.)

*A conditional pass will be upgraded to a pass once the clinical tutor indicates that plans for addressing the identified learning needs have been put in place in the general placement outline for the next placement period.*

**The Clinical Tutor will need to be involved to make an action plan to be carried forward to the next placement period if trainee is referred on this evaluation.**
Trainees must be given sufficient warning and time, as well as supervisory support and advice, to improve their performance if supervisors feel that there may be significant concerns in any competence area. If concerns persist, such that the trainee may be at risk of being referred for their competence on placement, the supervisor must raise these concerns at a placement visit, with the clinical tutor and the trainee. An action plan to address concerns will be put in place: this will specify what the trainee needs to do, and what support will be needed.

If there is disagreement between supervisors about their ratings and evaluation of the trainee’s competence, the Clinical Tutor and if necessary the Clinical Director will broker discussions and assist in making recommendations and future plans. Where necessary, the external examiner’s opinion and judgement will be sought. The final decision rests with the Examination Board.

**CORE COMPETENCE AREAS**

These are based on the BPS Accreditation Criteria for Clinical Psychology Training Programmes (2007), HPC Standards of Education and Guidance, HPC Standards of Proficiency and HPC Standards of Conduct, Performance and Ethics and are informed by the Accreditation guidelines for integration of Knowledge and Skills Framework (KSF).

**Relationships**

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

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

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

**Psychological Assessment**

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

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

*addresses biological, psychological and social processes in assessment and formulation*

*assesses clients’ strengths, aspirations and values and takes these into account in the work*
can undertake appropriate risk assessment exploring safety and positive risk taking and
guide work accordingly. Can recognise and work through any tensions arising from this
assessment

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

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

**Psychological Formulation**

**formulation and reformulation** - flows from assessment, underpinned by theory, evidence
and clients’ perspectives, reformulates in the light of emerging evidence as intervention
progresses; uses formulation with clients to facilitate their understanding; uses
psychological formulation to assist communication with other professionals

**Psychological Intervention**

**intervention** - is based on formulation, is appropriate to the presenting problem and to
the psychological and social needs and circumstances of the client(s), is modified in the
light of ongoing evaluation and emerging evidence, and is aimed at promoting recovery
and utilising the client(s) strengths and aspirations

**range of intervention techniques** - competent to use a variety of techniques drawn from
more than one psychological orientation, uses judgement about whether and when to
intervene, recognises when further intervention is inappropriate and communicates this
sensitively, generalises from previous knowledge and experience in order to adapt and
integrate approaches creatively to suit particular needs and circumstances

**knowledge of specialism** - understands range and types of referrals, recognises role of
psychology in the particular service settings

**Psychological Evaluation**

**evaluation** - monitors and evaluates own work through a range of means including
client/carer/family feedback, observation, reflection and supervision, using standard
approaches and outcome measures where appropriate, implements changes or acquires
further knowledge as needed, identifies areas of inequality, and recognises and
communicates own and others roles

**Transferrable Skills**

A knowledge of the major psychological theories and models as applied to diverse clinical
problems across the age range of clients and in service delivery settings.

**Critical and reflective evaluation**

Exercising personal responsibility and largely autonomous initiative in complex and
unpredictable situations in professional practice
Capacity to make informed judgements in complex situations

Personal and Professional Skills and Values

*professional and ethical behaviour* - understands ethical and professional guidelines and applies in complex clinical contexts; ensures informed consent underpins all client and research work; appreciates power imbalances and how abuse of power can be minimised; understands issues of social inequalities and implications for working practice, aims to promote research based on needs and values that is collaborative

*reliability and contribution* - punctual, handles reasonable workload, available, follows service guidelines

*autonomy and accountability* - works effectively at appropriate level of autonomy, with awareness of limits of own competence and accepting accountability to relevant professional and service managers

Communication and Teaching

*disseminates psychological knowledge* - able to adapt written, visual and verbal information to a variety of audiences taking account of cognitive ability, sensory acuity, and mode of communication

*reports on own work* both verbally and in writing, accurately, clearly and at an appropriate level for the needs of the audience

*training* - can plan, present, and evaluate teaching and training events to suit the needs of the audience

Service Delivery

*collaboration* - works collaboratively with service users, carers, fellow psychologists, and other professionals, respecting diverse viewpoints

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

Please feel free to seek further guidance for the completion of the form from the relevant Clinical Tutor or the Clinical Director.
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<tr>
<th>General Placement Outline</th>
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<td><strong>Overview</strong></td>
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<td><strong>Work with lead supervisor</strong></td>
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<td><strong>Work with subsidiary supervisor</strong></td>
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<td><strong>How will outstanding referred/conditional pass issues be addressed? (if relevant)</strong></td>
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# Trainee Identification of Own Strengths and Learning Needs

This document is a chance for you as a trainee to rate your own strengths and learning needs. You can use this to form the basis for future placement planning.

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<tr>
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<th>Strengths</th>
<th>Learning Needs</th>
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<td><strong>Relationships</strong></td>
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<td><strong>Psychological Assessment</strong></td>
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<td><strong>Psychological Formulation</strong></td>
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<td><strong>Psychological Intervention</strong></td>
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<th>Psychological Evaluation</th>
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<th>Personal and Professional Skills and Values</th>
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<td><strong>Strengths</strong></td>
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<td><strong>Learning Needs</strong></td>
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<td>Service Delivery</td>
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<td><strong>Strengths</strong></td>
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### Relationships

**BPS:**
- Relationships/engagement with individuals, families, carers, services (assessing and working therapeutically with complex service systems)
- Evidence must include direct reports from clients
- Developing and maintaining effective working alliances with clients, including individuals, carers and services.

**HPC:**
- You must get informed consent to give treatment (HPC)
- You must respect the confidentiality of service users (HPC)

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<th>Specific Goals</th>
<th>Evidence of Attainment</th>
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### Supervisor Comments

- **Supervisor Rating:**
  - Good: □
  - Satisfactory: □
  - Significant Concerns: □
Psychological Assessment

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

Assessment procedures in which competence is demonstrated will include:
- formal procedures (use of standardised psychometric instruments)
- systematic interviewing procedures
- other structured methods of assessment (e.g. observation, or gathering information from others); *and*
- assessment of social context and organisations.
- Conducting appropriate risk assessment and using this to guide practice

**HPC**
- Ability to refer to another practitioner as necessary

**KSF**
- Able to assess health and well-being needs and develop, monitor and review care plans to meet specific needs (KSF)
- Able to assess psychological functioning, develop, monitor and review related treatment plans (KSF)

### Specific Goals

### Evidence of Attainment

<table>
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<th>Supervisor Comments</th>
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**Supervisor Rating:**
- Good
- Satisfactory
- Significant Concerns
## Psychological Formulation

### BPS
- Developing formulations of presenting problems or situations which integrate information from assessments within a coherent framework that draws upon psychological theory and evidence and which incorporates interpersonal, societal, cultural and biological factors.
- Using formulations with clients to facilitate their understanding of their experience.
- Using formulations to plan appropriate interventions that take the client’s perspective into account.
- Using formulations to assist multi-professional communication, and the understanding of clients and their care.
- Revising formulations in the light of ongoing intervention and when necessary reformulating the problem.

### KSF
- Able to gather, analyse, interpret and present extensive and/or complex data and information

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### Supervisor Comments

### Supervisor Rating: Good □ Satisfactory □ Significant Concerns □
### Psychological Intervention

**BPS**

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

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

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

**KSF**

- Able to plan, deliver and evaluate interventions and treatments
- Able to plan develop and implement approaches to promote health and wellbeing and prevent adverse effects on health and well being

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**Supervisor Comments**

**Supervisor Rating:**

- Good
- Satisfactory
- Significant Concerns

C - 29
### Psychological Evaluation

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<th>BPS</th>
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<td>• Selecting and implementing appropriate methods to evaluate the</td>
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<td>effectiveness, acceptability and broader impact of interventions</td>
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<td>(both individual and organisational), and using this information</td>
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<td>to inform and shape practice. Where appropriate this will also</td>
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<td>involve devising innovative procedures.</td>
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<td><strong>KSF</strong></td>
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<tr>
<td>• Able to contribute to protecting people at risk</td>
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<td>• Able to contribute to developing, testing and reviewing new</td>
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<td>concepts, models, methods and practices</td>
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## Transferrable skills

**BPS:**
- Deciding, using a broad evidence and knowledge base, how to assess, formulate and intervene psychologically, from a range of possible models and modes of intervention with clients, carers and service systems.
- Critical and Reflective evaluation
- Exercising personal responsibility and largely autonomous initiative in complex and unpredictable situations in professional practice.

**KSF:**
- Able to support equality and value diversity

**HPC:**
- Working effectively in multi-disciplinary teams. You must communicate properly and effectively with service users and other practitioners (HPC)

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### Supervisor Comments

Supervisor Rating: Good □ Satisfactory □ Significant Concerns □
## Personal and professional skills and values

### BPS
- Understanding of ethical issues and legally informed practice (Mental Health and Mental Capacity Acts)
- Appreciating the inherent power imbalance between practitioners and clients and how abuse of this can be minimised.
- Understanding the impact of differences, diversity and social inequalities on people’s lives, and their implications for working practices.
- Understanding the impact of one’s own value base upon clinical practice.
- Work organisation and Time management
- Using supervision to reflect on practice, and making appropriate use of feedback received.
- Good awareness of boundary issues.
- Understanding of quality assurance principles and processes. Demonstrate an appropriate level of professional practice in accordance with HPC Guidance on Conduct and Ethics for Students and BPS Code of Practice

### KSF
- Able to monitor and maintain health and safety and security of self and others
- Able to maintain quality in own work and encourage others to do so

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## Communication and Teaching

### BPS
- Communicating effectively clinical and non-clinical information from a psychological perspective in a style appropriate to a variety of different audiences (for example, to professional colleagues, and to users and their carers).
- Preparing and delivering teaching and training
- Understanding of the supervision process for both supervisee and supervisor roles.
- Understanding the process of providing expert psychological opinion and advice, including the preparation and presentation of evidence.
- Supporting others’ learning in the application of psychological skills, knowledge, practices and procedures.

### HPC
- Written communication (including records) You must keep accurate records
- You must effectively supervise tasks you have asked people to carry out

### KSF
- Able to develop and maintain communications with people about difficult matters and/or in difficult situations

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### Supervisor Comments

**Supervisor Rating:** Good

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### Service Delivery

**BPS**
- Adapting practice to a range of organisational contexts, on the basis of an understanding of pertinent organisational and cultural issues.
- Providing supervision at an appropriate level within own sphere of competence.
- Understanding of consultancy and leadership models and the contribution of consultancy and leadership to practice.
- Understanding of leadership theories and models, and their application to service development and delivery.
- Awareness of the legislative and national planning context of service delivery and clinical practice.
- Working effectively with formal service systems and procedures.
- Working with users and carers to facilitate their involvement in service planning and delivery.

**KSF**
- Able to make changes in a practice and offer suggestions for improving services.
- Able to contribute to developing, testing and reviewing new concepts, models and methods and practices.

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**Supervisor Comments**

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SUPERVISOR REFLECTION ON PLACEMENT OVERALL

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

Signed by supervisor ..........................................................
Date ..........................................................
<table>
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<tr>
<th>Signed by trainee:</th>
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<td>Date ..............................................</td>
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(Should include reflections on own performance during each placement period, any factors which may have affected performance, experience of being on placement period, and reflections and feedback to supervisor on supervision received.)
PORTFOLIO OF CLINICAL EXPERIENCE

Trainee: .......................................................... ...................................................

Placement dates: from ......................... to ......................................................

Placement:
- year one (part one) ☐
- year one (part two) ☐
- year two (part one) ☐
- year two (part two) ☐
- year three ☐

Supervisor’s name .......................................................... ..................................
Supervisor’s specialism .......................................................... ..................................
Supervisor’s base .......................................................... ..................................

Supervisor’s name .......................................................... ..................................
Supervisor’s specialism .......................................................... ..................................
Supervisor’s base .......................................................... ..................................


GUIDANCE NOTES FOR COMPLETING THE PORTFOLIO OF CLINICAL EXPERIENCE FORM

This document is intended as a record of the trainee's experience across their years of training. It has three components:

1. Log of Clinical and Professional Activity: provides summary information of all clinical and professional activities undertaken during each placement period. This is kept as a running record by the trainee throughout each placement period; ideally updated every week.

2. Cumulative Record of Experience: provides a cumulative record of the levels reached by the trainee across the three broad areas of experience domains required by the BPS accreditation criteria: client groups; service settings; and modes and types of work. This is updated at the end of each placement period.

3. Placement Summary and Supervisor Evaluation: provides basic information about the placement period, including number of days spent on each part of the placement, annual leave and sick leave; and gives supervisor's recommendation for evaluation of trainee's experience. This is completed at the end of each placement period.

All information in the Portfolio is entered by the trainee and signed off as an accurate record by the supervisor, who also makes a recommendation for the evaluation of the trainee's experiences as follows:

*Pass* indicates that the trainee has undertaken a satisfactory amount and range of experiences for this stage of training (taking into account limitations of time and opportunity) and that the trainee has reached a developing or satisfactory level of experience in all of the available and relevant experience domains in the particular placement specialisms; the trainee carries forward needs for further experience as expected for this stage of training.

*Conditional Pass* indicates that the trainee has undertaken a satisfactory amount and range of experience available at this stage of training (taking into account limitations of time and opportunity) and that the trainee has reached a developing or satisfactory level of experience in most of the available and relevant experience domains in the particular placement specialisms, but that some experiences require particular further attention, to be built into the placement planning for subsequent placement period(s).

*Referred* indicates that the trainee has not undertaken the amount and range of experience available at this stage of training (taking into account limitations of time and opportunity) and that there are significant concerns in one or more available and relevant experience area(s), which, unless they are urgently and successfully attended to through an action plan for subsequent placement period(s), mean that the trainee will likely not reach the level of experience expected of a newly qualified clinical psychologist. (NB if the trainee is referred again on any subsequent placement period they would normally fail the programme.)
Fail indicates that following due investigation the trainee has been found to have engaged in serious professional misconduct. (This normally means that the trainee fails the programme.)

*A conditional pass will be upgraded to a pass once the clinical tutor indicates that plans for attending to the experiences that require further attention been made in the general placement outline for the next placement period.

**The Clinical Tutor will need to be involved to make an action plan to be carried forward to the next placement period(s) if trainee is referred on this evaluation.

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

If there is disagreement between the supervisors about their ratings and evaluation of the trainee's experience, the Clinical Tutor and, if necessary, the Clinical Director will broker discussions and assist in making recommendations and future plans. Where necessary, the external examiner's opinion and judgement will be sought. The final decision rests with the Examination Board.

**Using the Portfolio for placement planning**

The Cumulative Record ratings should be discussed with the trainee's appraiser after each placement period, as well as with the clinical tutor and upcoming supervisor(s). Appraisal notes should identify areas of experience that need attention in the next placement period. Subsequent placement plans should be devised with the next supervisors so as to ensure a balanced portfolio by the end of training. The year three placement, in particular, should be planned so as to make good any significant gaps in experience by the end of year two. This will require discussion with the appraiser, clinical tutor and clinical director to make sure that the year three placement can supply the necessary experiences. By the end of training, the trainee should normally have acquired satisfactory experience (level 3C) in all experience domains, and thorough experience (level 4) in most of them.
1. Log of Clinical Activity

The log is a record of all clinical and professional activity undertaken on placement. The trainee should update the log at regular intervals, ideally weekly. The headings largely correspond to the core competence areas:

A) assessment and formulation
   I) psychometric assessment
   II) broader information gathering (interviews, observation, diaries etc)

B) intervention

C) evaluation

D) communication/training/consultation

E) management/organisational/staff work

F) professional practice: meetings, visits, observations and any other experiences

G) supervision
<table>
<thead>
<tr>
<th>Method of Assessment</th>
<th>Reason for Use</th>
<th>Hours expended</th>
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</table>
A (II) Broader information gathering (interviews, observations, diaries etc.)
(eg. CBT, IPT, CAT, IAPT)

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<th>Method of Assessment</th>
<th>Reason for Use</th>
<th>Hours expended</th>
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</table>
B) Intervention Summary

Guidance for completing intervention summary

Please complete the chart on the following page, summarising the information about clinical interventions that you have been involved with on placement as follows:

**Age:** give age or age range of client(s), group or community

**Gender:** for pieces of work with a referred client, use client’s preferred label for their gender

**Reason:** specify whether the reason for the intervention is prevention: (PREV) or problem-based: acute (A) or enduring (E); mild (M) or severe (S); mainly of biological (B) or psychosocial (PS) causation; involves coping with adverse conditions or circumstances (AC); or is

**Special needs:** specify whether the client(s) had any of the following special needs: challenging behaviour; learning disability (mild/moderate/severe); communication difficulties; physical disability; neurological problems; other

**Intervention:** summarise the type of intervention as follows:

- **level:** individual; couple/family/systemic; group; community; organisation
- **main theoretical orientation:** community/social inequalities; systemic; CBT; psychodynamic; integrated; other

**Role:** specify your role in the work: observer; co-worker; lead worker; other

**Co-workers:** specify professional background of any co-workers

**Time expended:** give number of hours worked – both direct (D) ie actual client contact, and indirect (I) ie preparation, liaison, report writing etc

**Socio-cultural factors:** specify ethnicity and any other relevant social inequality or cultural or diversity issues eg socio-economic factors; immigration issues; rural/urban; religious affiliation.
## B) Intervention summary

<table>
<thead>
<tr>
<th>Age</th>
<th>Gender</th>
<th>Prevention/Problem</th>
<th>Special Needs</th>
<th>CBT,IPT,CAT, IAPT specify intervention</th>
<th>Role</th>
<th>Co-workers</th>
<th>Time expended</th>
<th>Social/Diversity/Cultural factors</th>
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</table>
C) Evaluation
e.g., of a piece of work of clinical work, small-scale service oriented project, response to a request for feedback from a client

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<thead>
<tr>
<th>Work Evaluated</th>
<th>Method of Evaluation</th>
<th>Reason for Use</th>
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</table>
D) Communication/Training/Consultation  
(offering supervision, management/leadership examples)

<table>
<thead>
<tr>
<th>Work undertaken</th>
<th>Involving whom?</th>
<th>Extent of role</th>
<th>Time expended (hrs)</th>
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</table>
E) Management/organisational/staff work

eg, staff support group, developing systems, service development, involvement in audit, clinical governance, user involvement, small scale service related project, offers supervision to other professionals

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<thead>
<tr>
<th>Outline of the piece of work</th>
<th>Extent of role</th>
<th>Time expended (hrs)</th>
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</table>
F) Professional practice: observations, meetings, visits, conferences or training events attended (plus any other experiences not covered elsewhere)

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<tr>
<th>Outline of experience</th>
<th>Extent of role</th>
<th>Time expended (hrs)</th>
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</table>
G) Supervision given by supervisor or other professional (please specify)

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<thead>
<tr>
<th>Supervisor’s role</th>
<th>Time expended</th>
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</table>
2. CUMULATIVE RECORD OF EXPERIENCE

Purpose of the record:

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

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

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

Use of the record:

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

0. No relevant experience or knowledge

1. Early experience in one or more of: (please specify all that apply)
   A) understanding client and carer perspectives; and/or
   B) relevant theory and knowledge; and/or
   C) relevant practice, skills and techniques

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

2. Developing experience in one or more of: (please specify all that apply)
   A) understanding client and perspectives; and/or
   B) relevant theory and knowledge; and/or
   C) relevant practice, skills and techniques

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

3. Satisfactory experience in one or more of: (please specify all that apply)
   A) understanding client and carer perspectives; and/or
   B) relevant theory and knowledge; and/or
   C) relevant practice, skills and techniques

   At this level, trainees will have had a significant amount of direct learning and exposure to relevant work based, for example, in A) having received direct client feedback on own work and/or having attended user or carer groups; and/or B) good knowledge of relevant literature; and/or C) direct practice or co-working with others over a period of at least 5 months; and significant experience of underpinning own work with theory based formulations; and beginning to generalise skills/knowledge across situations or settings.

4. Thorough experience in: (at this level all three levels should apply)
   A) understanding client and carer perspectives; and
   B) relevant theory and knowledge; and
   C) relevant practice, skills and techniques

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

<table>
<thead>
<tr>
<th>Experience domains</th>
<th>Pre- Yr1 Pt1</th>
<th>Yr1 Pt2</th>
<th>Yr2 Pt1</th>
<th>Yr2 Pt2</th>
<th>Yr3</th>
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<tbody>
<tr>
<td><strong>CLIENTS</strong></td>
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<td>• Across the life cycle</td>
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<td>Children (0-11 yrs)</td>
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<td>Adolescents (12-18 yrs)</td>
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<td>Adults (18-65 yrs)</td>
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<td>Older Adults (65+ yrs)</td>
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<td>• Types of problem</td>
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<td>Acute problems</td>
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<td>Enduring/chronic problems</td>
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<td>Mild-moderate problems</td>
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<td>Severe problems</td>
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<td>Coping with adverse circumstances/conditions</td>
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<td>Significant biological component</td>
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<td>Significant psychosocial component</td>
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<td>From broad range of demographic backgrounds</td>
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<td>• Special needs</td>
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<td>Challenging behaviour</td>
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<td>Learning disability</td>
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<td>Communication difficulties</td>
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<td>Experience domain</td>
<td>Pre-Yr1</td>
<td>Yr1 Pt1</td>
<td>Yr1 Pt2</td>
<td>Yr2 Pt1</td>
<td>Yr2 Pt2</td>
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<td><strong>SERVICE SYSTEMS</strong></td>
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<td>In-patient/residential</td>
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<td>Out-patient/secondary care</td>
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<td>Primary care/IAPT services/Other primary care</td>
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<td>Organisational/service development</td>
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<td><strong>MODES AND TYPES OF WORK</strong></td>
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<td>• <strong>Direct clinical work</strong></td>
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<td>Therapeutic relationships</td>
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<td>Assessment</td>
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<td>Formulation</td>
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<td>Evaluation</td>
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<td>• <strong>Indirect work</strong></td>
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<td>Leadership</td>
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<td>Via staff/carers</td>
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<td>Multi-disciplinary teams</td>
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<td>User Involvement</td>
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<td>• <strong>Psychological orientations:</strong></td>
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<td>Community/Social Inequalities</td>
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<td>Systemic</td>
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<td>Other (Psychodynamic, CAT, IPT, DBT)</td>
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<td>Integrative</td>
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<td>Diversity Factors, cultural experience</td>
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3) Placement Period Summary

TRAINEE:

SUPERVISOR NAMES:

PLACEMENT PERIOD: YEAR 1 PART 1
74 days (including theory/practice days and annual leave)

ASSESSMENT DATE: 07.05.12

ANNUAL LEAVE:

SICKNESS LEAVE:

Trainee’s signature:

Supervisor’s signature:

Supervisor’s signature:

Dates:
TRAINEE:

SUPERVISOR NAMES:

PLACEMENT PERIOD: YEAR 1 PART 2
62 days (including theory/practice days and annual leave)

ASSESSMENT DATE: 03.09.12.

ANNUAL LEAVE:

SICKNESS LEAVE:

Trainee’s signature:

Supervisor’s signature:

Supervisor’s signature:

Dates:
TRAINEE:

SUPERVISOR NAMES:

PLACEMENT PERIOD: YEAR 2 PART 1
64 days (including theory/practice days and annual leave)

ASSESSMENT DATE: 06.05.13.

ANNUAL LEAVE:

SICKNESS LEAVE:

Trainee’s signature:

Supervisor’s signature:

Supervisor’s signature:

Dates:
TRAINEE:

SUPERVISOR NAMES:

PLACEMENT PERIOD: YEAR 2 PART 2
79 days (including theory/practice days and annual leave)

ASSESSMENT DATE: 02.09.13

ANNUAL LEAVE:

SICKNESS LEAVE:

Trainee’s signature:

Supervisor’s signature:

Supervisor’s signature:

Dates:
TRAINEE:

SUPERVISOR NAMES:

PLACEMENT PERIOD: YEAR 3
Up to a maximum of 91 days (40 recommended minimum days – not including annual leave)
(113 days minimum for whole year on placement – up to 145 days including annual leave)

ASSESSMENT DATE: 16.6.14
ANNUAL LEAVE:

SICKNESS LEAVE:

Trainee’s signature:

Supervisor’s signature:

Supervisor’s signature:

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

Portfolio of Clinical Experience

Pass  Conditional Pass  Referred  Fail

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

*If referred* please specify which significant concerns in one or more competence area(s) must be urgently addressed through an action plan for subsequent placement period(s):

Trainee’s Competence.

Pass ☐  Conditional pass ☐  Referred ☐  Fail ☐

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

*If referred* please specify which significant concerns in one or more competence area(s) must be urgently addressed through an action plan for subsequent placement period(s):

Signed and dated by supervisor(s):  .................................................................
<table>
<thead>
<tr>
<th>Dimension</th>
<th>End of Year 1</th>
<th>End of Year 2</th>
<th>By end of training</th>
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<tbody>
<tr>
<td>Communication</td>
<td></td>
<td></td>
<td>Develop and maintain communication with people about difficult matters and/or in difficult situations (3).</td>
</tr>
<tr>
<td>Personal and people development</td>
<td></td>
<td></td>
<td>Develop own skills and knowledge and provide information to others to help their development (2).</td>
</tr>
<tr>
<td>Health, safety and security</td>
<td></td>
<td></td>
<td>Monitor and maintain health, safety and security of self and others (2).</td>
</tr>
<tr>
<td>Service improvement</td>
<td></td>
<td></td>
<td>Make changes in own practice and offer suggestions for improving services (1).</td>
</tr>
<tr>
<td>Quality</td>
<td></td>
<td></td>
<td>Maintain quality in own work and encourage others to do so (2).</td>
</tr>
<tr>
<td>Equality and Diversity</td>
<td></td>
<td></td>
<td>Support equality and value diversity (2).</td>
</tr>
<tr>
<td>Health and Wellbeing</td>
<td>Contribute to promoting health and wellbeing and preventing adverse effects on health and wellbeing (1)</td>
<td>Plan, develop, and implement approaches to promote health and wellbeing and prevent adverse effects on health and wellbeing (2)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Assess health and wellbeing needs and develop, monitor and review care plans to meet specific needs (3).</td>
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<tr>
<td></td>
<td>Assess physiological and psychological functioning and develop, monitor and review related treatment plans (3).</td>
<td></td>
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<td></td>
<td>Plan, deliver and evaluate interventions and/or treatments (3).</td>
<td></td>
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<td></td>
<td>Contribute to protecting people at risk (2).</td>
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<tr>
<td>Information and Knowledge</td>
<td>Gather, analyse, interpret and present extensive and/or complex data and information (3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>General</td>
<td>Enable people to learn and develop (2).</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Contribute to developing, testing and reviewing new concepts, models, methods and practices in a setting (2).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
YEAR LONG PLACEMENT - Paperwork Summary

You are advised to allow a month for filling in these documents, given that annual leave and sick leave can disrupt the process of signing and completion. Procedures for a late submission are overtaken by University regulations and the Board of Examiners may need to be informed.

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

There are 2 documents for submission:

Front sheet, C37

Log Book, C44 – C49, a running record of clinical work, completed by trainees on a weekly basis throughout placement.

Cumulative Record, C52 - C53, a cumulative record completed prior to initial placement and then at each assessment period after that.

Placement Summary, C54–C58, provides basic information on placement including number of days.

Trainee and Supervisor agreement


Competence Areas, C26–C34, based around core competences. Each section needs to be completed. Clearly, many goals will be ongoing or, indeed, maintained at this point, but this will need to be stated explicitly.

Supervisor Reflection, C35

Trainee Reflection, C35

Observation Tool C62

Supervisor to complete Evidence of Attainment

Trainee with supervisor agreement
YEAR ONE
IN VIVO OBSERVATION OF TRAINEES’ CLINICAL WORK

The purpose of this document is to provide a framework for supervisors to directly observe and give feedback on trainees’ clinical work with clients (interventions and formal assessment). This document should be used on all placements as a tool for supervisors to inform their judgements about trainees’ competence as documented on the Clinical Competence Goals and Evaluation Form.

Observations should be done on several occasions (so this does not become a “one-off” assessment). On each occasion the trainee and the observing supervisor should decide in advance which aspect(s) of the session will be the subject of detailed observation and feedback. During the observation the supervisor notes examples of good practice and areas for improvement / development. Afterwards, time is set aside for mutual discussion. The trainee is then responsible for recording supervisor feedback and his or her own reflections.

The final document should be signed off by the trainee and supervisor and submitted as part of the Portfolio of Clinical Experience for each placement period in years one and two (i.e. four submissions over the first two years).

The document is divided into five sections:

1. Preparing for the session and setting the scene
2. Conducting the session
3. Ending the session
4. After the session
5. Observation of test competence (see also appended document BPS Checklist of Competence in Psychological Testing)

Direct observation may be live or though review of audio or video tape of the session. Consent for the observation must be negotiated with the client(s), with the educational purpose carefully explained.
1. Preparing for the session and setting the scene

a) Was the trainee sensitive to issues of capacity and consent?

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

b) Was the trainee sensitive to issues of culture, gender, power and diversity?

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

c) Was the trainee thoughtful about the location of the session (privacy, convenience, safety, familiarity, suitability for the therapeutic content)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Was the trainee thoughtful about the potential impact on the session of those participating/observing (supervisors presence/position, advocate? Family member? Carer?)

C - 63
Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

e) Did the trainee liaise appropriately with other professionals before the session, and share this with client(s) as necessary?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

f) Was a time period for the session established?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

g) Did the trainee explain the purpose of the meeting to those present?

Supervisor feedback (strengths and suggestions for improvement / development)
2. Conducting the session

a) Was the level of communication appropriate for the abilities of those present (simplified language/pictures/symbols if needed etc)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

b) Did the trainee engage with those present at the outset in order to “settle” them (small talk, introductions)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
c) Were the perspectives of all those present actively sought during the meeting (or were there legitimate reasons for not doing this)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Did the trainee take sufficient account of the likely emotional experience of those present (in terms of reflecting, further enquiring etc?)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

f) Did the trainee convey genuineness and positive regard in both verbal and non-verbal ways during the session?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
g) Did the trainee demonstrate an understanding of the information being conveyed via appropriate summarising/paraphrasing etc?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

h) Did the trainee use psychological ideas/formulation sensitively and appropriately?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

i) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
3 Ending the session

a) Was a “warning” prior to the end of the session given?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

b) Overall, did the trainee manage the balance of time available in the session effectively?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

c) Was a closing summary of the outcome of the session provided?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Was this checked with those present for their perspectives?

Supervisor feedback (strengths and suggestions for improvement / development)
Trainee reflection (strengths and intentions for improvement)

e) Were “next steps” discussed prior to finishing the meeting?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

f) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
4. After the session

a) Were notes appropriately written up and filed?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

b) Was consideration given to whether and how to inform relevant parties of the outcome of the meeting (including carers as well as other professionals)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

c) Was any feedback/comments from clients/carers reflected upon for future action?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
d) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

5. Observation of Test Competence (see attached Code of Good Practice for Psychological Testing)

a) Questionnaire based assessment: administration of test

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

b) Questionnaire based assessment: scoring

Supervisor feedback (strengths and suggestions for improvement/development)

Trainee reflection (strengths and intentions for improvement)

c) Performance based assessment: administration of test

Supervisor feedback (strengths and suggestions for improvement / development)
Trainee reflection (strengths and intentions for improvement)

d) Performance based assessment: scoring

Supervisor feedback (strengths and suggestions for improvement/development)

Trainee reflection (strengths and intentions for improvement)

e) Additional aspect(s) of testing as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
Overall suggestions for future development of trainee?

Supervisor comments

Trainee reflection

Name of trainee:  

Name of supervisor:  

Date of final completion:  


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

### Responsibility for competence

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

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

### Procedures and techniques

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

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

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

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

### Client welfare

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

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

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

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

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

*******************

A2.11 Using norm tables, find percentile equivalents of raw scores and then obtain both Z-scores and T-scores from normal distribution tables.
Unit 3 - The Importance of Reliability and Validity
Can the Assessee:

A3.1 Explain the notion of correlation as a measure of the degree of relationship between two measures.
A3.2 Define the conditions under which correlation is maximised (both positively and negatively) and minimised.
A3.3 Provide reasonable rough estimates of correlation coefficients represented by various bivariate scattergrams.
A3.4 Describe the basic premises of classical test theory - that actual measures are ‘fallible’ scores which contain a ‘true’ score and a random error.
A3.5 Explain in outline the methods of estimating reliability (internal consistency, test retest— same on alternate form) and describe their relative pros and cons.
A3.6 Describe why test scores are unreliable (e.g. measurement error, scoring error, situational factors, item sampling, etc.).
A3.7 Describe how reliability is affected by changes in the length of a test.
A3.8 Describe how reliability is affected by range restriction and how to adjust for such effects.
A3.9 Compute limits for different levels of confidence from raw and standard scores using the standard error of measurement.
A3.10 Compute the standard error for the difference between two scale scores and for the sum of two scale scores.
A3.11 Describe how the degree of correlation between two scale scores affects the reliability of:
   (a) their sum; (b) the difference between them.
A3.12 Express the basic notion of Generalisability Theory - that reliability concerns the degree to which one can generalise from results obtained under one set of conditions to those which would be obtained under another.
A3.13 Describe and illustrate the distinctions between face, content, construct and criterion-related validity.
A3.14 Describe the procedures used to assess concurrent and predictive criterion-related validities and explain the pros and cons of each procedure.
A3.15 Describe the relationship between reliability and validity.
A3.16 Describe the degree to which it may be reasonable to generalise from validity information obtained in one situation to the use of a test in some other situation.

Level Aq
(Questionnaire-based assessments)

Unit 4 - Administration
Does the Assessee:

Q4.1 Arrange for a quiet, private, well-lit environment with furniture and equipment appropriate for the questionnaires to be used which maximize comfort and concentration.
Q4.2 Brief candidates on the purpose of each questionnaire and put them at ease while maintaining an appropriately businesslike atmosphere.
Q4.3 Obtain informed consent for the assessment procedures, including how results are to be used, who will be given access to them and for how long they will be retained.
Q4.4 Plan the session taking account of the duration of individual questionnaires, their cognitive demands and the likely capacity of the client to tolerate these.
Q4.5 Check that the client is not unnecessarily hindered by remediable perceptual difficulties such as poor eyesight by ensuring the client has appropriate perceptual aids (e.g. reading glasses).
Q4.6 Ensure that the client can read and comprehend individual items and the instructions
given at the beginning of the questionnaire.

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

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

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

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

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

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

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

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

Unit 5 - Scoring
Can the Assessee:

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

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

Q5.3 Use norm tables to obtain and record relevant percentile and/or standard scores. Make appropriate use of information provided in the questionnaire manual about cut-off scores.

Unit 6 - Interpretation and Report
Does the Assessee:

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

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

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

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

Q6.5 Provide interpretations of scale scores paying due regard to the correlations which exist between each pair of scales and for the standard error of their difference.

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

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

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

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

Q6.10 Provide written reports for the referring agent which carefully explain any use of normed scores in relation to the ability range of the norm group; carefully justify any predictions made about future behaviour in relation to the validity information about
Q6.11 Provide written reports for the referring agent which give clear guidance as to the appropriate weight to be placed on the findings.

Level Ap
(Performance-based tests)

Unit 4 - Administration
Does the Assessee:

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

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

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

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

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

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

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

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

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

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

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

P4.12 Collect all test materials when each test is completed.

P4.13 Carry out a careful check against the inventory of materials to ensure that everything has been returned.

P4.14 Lock all materials away in a secure place which is not accessible to people other than authorised test-users.

P4.15 Thank the client for her/his participation when the final test has been completed, and explain the next stage (if any) in the assessment to them.

P4.16 Make final entries in the test session log - including notes on any particular problems which arose during the session which might have affected the client’s performance.

P4.17 All test data are kept in a secure place and that access is not given to unauthorised personnel.

P4.18 All mandatory requirements relating to the client’s rights and obligations under data protection legislation are clearly explained to the client and adhered to.

Unit 5 - Scoring
Can the Assessee:
P5.1 Accurately score the client’s performance adhering to the test manual instructions and calculate raw scores.
P5.2 Select appropriate norm tables from the test manual or supplementary material.
P5.3 Use norm tables to obtain and record relevant percentile and/or standard scores.
P5.4 Make appropriate use of information provided in the test manual about cut-off scores.

Unit 6- Interpretation and Report

Does the Assessee:

P6.1 Either attach suitable cautions to interpretation of the results, or not use the test, where no relevant norms or cut-off tables are available.
P6.2 Give due consideration, where necessary, to the comparability between the client and any reference groups, the standard error of the group mean and the standard error of measurement of the client’s scores.
P6.3 Present norm-based scores within a context which clearly describes the range of abilities or other relevant characteristics of the norm group they relate to.
P6.4 Describe the meanings of scale scores in terms which are accurate and reflect the confidence limits associated with those scores.
P6.5 Provide interpretations of scale scores paying due regard to the correlations which exist between each pair of scales and for the standard error of their difference.
P6.6 Provide feedback of information about results to the client which is matched to the client’s ability and understanding.
P6.7 Provide the client with opportunities to ask questions, clarify points and comment upon the test and the administration procedure.
P6.8 Clearly inform the client about how the information will be presented and to whom.
P6.9 Provide written reports for the referring agent which describe the purposes of the various tests/subtests in an accurate and meaningful way.
P6.10 Provide written reports for the referring agent which carefully explain any use of normed scores in relation to the ability range of the norm group; carefully justify any predictions made about future behaviour in relation to the validity information about the test.
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Observations should be done on several occasions (so this does not become a “one-off” assessment). On each occasion the trainee and the observing supervisor should decide in advance which aspect(s) of the session will be the subject of detailed observation and feedback. During the observation the supervisor notes examples of good practice and areas for improvement/development. Afterwards, time is set aside for mutual discussion. The trainee is then responsible for recording supervisor feedback and his or her own reflections.

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10. Observation of test competence (see also appended document BPS Checklist of Competence in Psychological Testing)

Direct observation may be live or though review of audio or video tape of the session. Consent for the observation must be negotiated with the client(s), with the educational purpose carefully explained.
1. **Preparing for the session and setting the scene**

a) **Was the trainee sensitive to issues around confidentiality and risk?**

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

b) **Was the trainee sensitive to issues of culture, gender, power and diversity?**

Supervisor feedback (strengths and suggestions for improvement)

Trainee reflection (strengths and intentions for improvement)

c) **Was the trainee thoughtful about the location and the timing of the session (privacy, convenience, safety, familiarity, suitability for the therapeutic content)?**

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) **Was the trainee thoughtful about the potential impact on the session of those participating/observing (supervisors presence/position, advocate? Family member? Carer?)**
e) Did the trainee liaise appropriately with other professionals before the session, and share this with client(s) as necessary?

f) Was a time period for the session established?

g) Did the trainee explain the purpose of the meeting to those present?
Trainee reflection (strengths and intentions for improvement)

h) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

2. Conducting the session

a) Did the trainee communicate in ways that could be clearly understood by those present?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

b) Did the trainee engage with those present at the outset in order to make them feel more comfortable and help alleviate anxiety (small talk, introductions, asking how they felt about attending today)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
c) Were the perspectives and reasons for attending of all those present actively sought during the meeting (or were there legitimate reasons for not doing this)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Did the trainee take sufficient account of the likely emotional experience of those present (in terms of reflecting, further enquiring etc?)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

f) Did the trainee convey genuineness and positive regard in both verbal and non-verbal ways during the session?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
g) Did the trainee demonstrate an understanding of the information being conveyed via appropriate summarising/paraphrasing etc?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

h) Did the trainee use psychological ideas/formulation sensitively and appropriately?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

i) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

3 Ending the session

a) Was a “warning” prior to the end of the session given?

Supervisor feedback (strengths and suggestions for improvement / development)
Trainee reflection (strengths and intentions for improvement)

b) Overall, did the trainee manage the balance of time available in the session effectively?
Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

c) Was a closing summary of the outcome of the session provided?
Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Was this checked with those present for their perspectives?
Supervisor feedback (strengths and suggestions for improvement / development)
Trainee reflection (strengths and intentions for improvement)

e) Were “next steps” discussed prior to finishing the meeting?
Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

f) Additional aspects(s) as negotiated by trainee and supervisor (please specify)
Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

4. After the session

a) Were notes appropriately written up and filed?
Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
b) Was consideration given to whether and how to inform relevant parties of the outcome of the meeting (including carers as well as other professionals)?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

c) Was any feedback/comments from clients/carers reflected upon for future action?

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Additional aspects(s) as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)
5. Observation of Test Competence (see attached Code of Good Practice for Psychological Testing)

a) Questionnaire based assessment: administration of test

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

b) Questionnaire based assessment: scoring

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

c) Performance based assessment: administration of test

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

d) Performance based assessment: scoring

Supervisor feedback (strengths and suggestions for improvement / development)
Trainee reflection (strengths and intentions for improvement)

e) Additional aspect(s) of testing as negotiated by trainee and supervisor (please specify)

Supervisor feedback (strengths and suggestions for improvement / development)

Trainee reflection (strengths and intentions for improvement)

Overall suggestions for future development of trainee?

Supervisor comments

Trainee reflection

Name of trainee:  

Name of supervisor:  

Date of final completion:  

C - 89
**Code of Good Practice for Psychological Testing**

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

**Responsibility for competence**

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

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

**Procedures and techniques**

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

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

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

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

**Client welfare**

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

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

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

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

11. Ensure test results are stored securely, are not accessible to unauthorised or unqualified persons and are not used for any purposes other than those agreed with the test taker.
A2.11 Using norm tables, find percentile equivalents of raw scores and then obtain both Z-scores and T-scores from normal distribution tables.

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

A3.1 Explain the notion of correlation as a measure of the degree of relationship between two measures. A3.2 Define the conditions under which correlation is maximised (both positively and negatively) and minimised.
A3.3 Provide reasonable rough estimates of correlation coefficients represented by various bivariate scatter grams.
A3.4 Describe the basic premises of classical test theory - that actual measures are ‘fallible’ scores which contain a ‘true’ score and a random error.
A3.5 Explain in outline the methods of estimating reliability (internal consistency, test retest— same on alternate form) and describe their relative pros and cons.
A3.6 Describe why test scores are unreliable (e.g. measurement error, scoring error, situational factors, item sampling. etc.).
A3.7 Describe how reliability is affected by changes in the length of a test.
A3.8 Describe how reliability is affected by range restriction and how to adjust for such effects.
A3.9 Compute limits for different levels of confidence from raw and standard scores using the standard error of measurement.
A3.10 Compute the standard error for the difference between two scale scores and for the sum of two scale scores.
A3.11 Describe how the degree of correlation between two scale scores affects the reliability of:
   (a) their sum; (b) the difference between them.
A3.12 Express the basic notion of Generalisability Theory - that reliability concerns the degree to which one can generalise from results obtained under one set of conditions to those which would be obtained under another.
A3.13 Describe and illustrate the distinctions between face, content, construct and criterion-related validity.
A3.14 Describe the procedures used to assess concurrent and predictive criterion-related validities and explain the pros and cons of each procedure.
A3.15 Describe the relationship between reliability and validity.
A3.16 Describe the degree to which it may be reasonable to generalise from validity information obtained in one situation to the use of a test in some other situation.

Level Aq
(Questionnaire-based assessments)

Unit 4 - Administration
Does the Assessee:

Q4.1 Arrange for a quiet, private, well-lit environment with furniture and equipment appropriate for the questionnaires to be used which maximize comfort and concentration.
Q4.2 Brief candidates on the purpose of each questionnaire and put them at ease while maintaining an appropriately businesslike atmosphere.
Q4.3 Obtain informed consent for the assessment procedures, including how results are to be used, who will be given access to them and for how long they will be retained.
Q4.4 Plan the session taking account of the duration of individual questionnaires, their cognitive demands and the likely capacity of the client to tolerate these.
Q4.5 Check that the client is not unnecessarily hindered by remediable perceptual
difficulties such as poor eyesight by ensuring the client has appropriate perceptual aids (e.g. reading glasses).

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

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

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

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

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

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

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

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

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

Unit 5 - Scoring
Can the Assessee:

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

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

Q5.3 Use norm tables to obtain and record relevant percentile and/or standard scores. Q5.4 Make appropriate use of information provided in the questionnaire manual about cut-off scores.

Unit 6 - Interpretation and Report
Does the Assessee:

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

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

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

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

Q6.5 Provide interpretations of scale scores paying due regard to the correlations which exist between each pair of scales and for the standard error of their difference.

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

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

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

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

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

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

Level Ap
(Performance-based tests)

Unit 4 - Administration
Does the Assessee:

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

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

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

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

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

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

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

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

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

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

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

P4.12 Collect all test materials when each test is completed.

P4.13 Carry out a careful check against the inventory of materials to ensure that everything has been returned.

P4.14 Lock all materials away in a secure place which is not accessible to people other than authorised test-users.

P4.15 Thank the client for her/his participation when the final test has been completed, and explain the next stage (if any) in the assessment to them.

P4.16 Make final entries in the test session log - including notes on any particular problems which arose during the session which might have affected the client’s performance.

P4.17 All test data are kept in a secure place and that access is not given to unauthorised personnel.
P4.18 All mandatory requirements relating to the client’s rights and obligations under data protection legislation are clearly explained to the client and adhered to.

Unit 5 - Scoring
Can the Assessees:

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

Unit 6 - Interpretation and Report
Does the Assessees:

P6.1 Either attach suitable cautions to interpretation of the results, or not use the test, where no relevant norms or cut-off tables are available.
P6.2 Give due consideration, where necessary, to the comparability between the client and any reference groups, the standard error of the group mean and the standard error of measurement of the client’s scores.
P6.3 Present norm-based scores within a context which clearly describes the range of abilities or other relevant characteristics of the norm group they relate to.
P6.4 Describe the meanings of scale scores in terms which are accurate and reflect the confidence limits associated with those scores.
P6.5 Provide interpretations of scale scores paying due regard to the correlations which exist between each pair of scales and for the standard error of their difference.
P6.6 Provide feedback of information about results to the client which is matched to the client’s ability and understanding.
P6.7 Provide the client with opportunities to ask questions, clarify points and comment upon the test and the administration procedure.
P6.8 Clearly inform the client about how the information will be presented and to whom.
P6.9 Provide written reports for the referring agent which describe the purposes of the various tests/subtests in an accurate and meaningful way.
P6.10 Provide written reports for the referring agent which carefully explain any use of normed scores in relation to the ability range of the norm group; carefully justify any predictions made about future behaviour in relation to the validity information about the test.
P6.11 Provide written reports for the referring agent which give clear guidance as to the appropriate weight to be placed on the findings.
GUIDELINES FOR MUTUAL OBSERVATION

Trainees benefit from observing their supervisors working with clients because of the obvious advantages they gain from seeing good clinical work being modelled by their supervisor. Trainees benefit from supervisor observation since structured debrief provides them with direct feedback on their clinical work. Members of the User Advisory Group have strongly recommended that all trainees must be regularly observed during training, with feedback in part based on observation of the personal and relationship factors that service users particularly value.

Strategies for observation and/or joint work should be negotiated by trainee and supervisor at the beginning of the placement and reviewed throughout.

Benefits of mutual observation

1. Supervisor present as a resource/knowledge base
2. Provides support while trainee gains confidence
3. Experience of working in co-therapy
   1. Opportunity for supervisor to give direct feedback on trainee's clinical work - removes bias of self-report in supervision.
   2. Supervisor can give positive feedback and constructive criticism on trainee's development.

Observation strategies

(i) Shared work with supervisor and trainee working as co-therapy team or within therapeutic team.
(ii) Trainee as observer.
    a. Sitting in.
    b. Observing through one-way monitor.
(iii) Retrospective observation using video and/or audiotapes.
(iv) Indirect access to supervisor's clinical work through case discussion of supervisor's own work. While this does not fall within the broad category of observation, it remains an important adjunct of it.

Consent

The service user should always have a full explanation about what is going on in order to decide whether to give informed consent to the observation. This should make reference to the learner status of the trainee and the nature of the observation.
Supervision Agreement

Trainee: Clinical Tutor

Supervisor 1              Supervisor 2

Placement: Year 1; Year 2; year 3
(Please add any additional responsibilities that have been mutually agreed)

**Clinical Tutor Responsibilities**
- Alert trainee and supervisor to training issues that might impact on the placement.
- Attend at least one placement visit.
- Be available via ‘phone or email for problem solving/advice.
- Share any concerns that may impact on placement/clinical work with trainee and supervisor.

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

**Trainee Responsibilities**
- Attend and prepare for supervision.
- Share previous paperwork and pass on information re strengths and learning needs and discuss implications for this placement – identifying what needs taking forward and what needs leaving behind.
- Share any concerns that may impact on placement/clinical work initially with supervisors and if not resolved with clinical tutor.
- Ensure that supervisors are aware of clinical assessment deadline/s and allow enough time for them to review/sign off.

Signed:

 Supervisor 1 …………….       Supervisor 2 ……………………

Trainee………………………       Clinical tutor ……………………………..
Managing difficulties in supervision

Supervision works well when supervisor and trainee build an open relationship, with mutual respect and tolerance for difference in style, interests and orientation, and with appropriate support from the Programme team. A good supervision agreement should establish realistic expectations on all sides and should prevent difficulties from arising. It helps if supervisors and trainee acknowledge their strengths and weaknesses in the use of supervision, as well as their hopes and fears for the placement, so that these can be addressed in planning for the placement and for supervision. It is important to acknowledge the difference in power between supervisor and trainee. It can be hard for trainees to be fully open about difficulties with supervisors who hold the power of passing or failing trainees’ performance on placement. For their part, supervisors can feel vulnerable and exposed in opening up their practice to the scrutiny of trainees (and indirectly to the Programme team). It is therefore essential to try to build in safe ways to share feedback, and to address potential differences, difficulties, disappointments and disagreements. In most cases, supervision goes well – but inevitably problems sometimes develop; these guidelines are intended to help prevent difficulties and give guidance about how to manage difficulties should they arise.

- Supervisor and trainee discuss, as part of setting up the supervision agreement, how issues of power and difficulties in supervision will be addressed. They also specify how mutual feedback about trainee and supervisor performance will be shared.

- Supervisor and trainee build in regular time to reflect on how supervision is going – and to find ways to improve the supervision experience if necessary.

- The clinical tutor assists in reviewing supervision at the placement visits: and helps problem-solve if difficulties are expressed.

- If the trainee or supervisors experience difficulties they first discuss the problem with one another in supervision (referring back to the agreements set out in the supervision agreement).

- If difficulties persist, the trainee or supervisor contacts the clinical tutor, who explores the problem, helps in problem-solving, encourages further communication between trainee and supervisor and monitors the situation. The clinical tutor may request assistance from the clinical director.

- If difficulties still persist, the clinical tutor contacts the trainee and/or the supervisor to discuss the issues and problem solve.
• If necessary the clinical tutor arranges and facilitates a meeting between the supervisors and trainee to discuss how to improve the situation.

• In difficult circumstances, the clinical director may request the assistance of the supervisor’s clinical psychology manager and/or of the clinical director(s) of local Programmes who share the same supervisory resource.

• Possible solutions, if the supervisory relationship breaks down badly, include giving extra support to the trainee or supervisor(s) from the clinical tutor and/or psychology manager, finding a different co-supervision arrangement or, in extreme circumstances, withdrawing the trainee from the placement and finding an alternative supervisor/placement.

• When necessary, the clinical director holds a post-placement debrief (to include all those affected, as appropriate) to review what has taken place, identify lessons learnt, and plan any follow-up action.
9. Clinical supervision

9.1. The main supervisor of a trainee shall normally be a Clinical Psychologist who has at least two years’ experience after gaining the qualification and eligibility for Registration as a Chartered Clinical Psychologist, and who has clinical responsibilities in the unit in which the work is carried out. Alternatively it could be an experienced Clinical Psychologist with at least two years’ practice who has recently gained a Statement of Equivalence and eligibility for Chartered Status. In certain circumstances, the main supervision may, at the discretion of the Programme Director or Clinical Tutor, be carried out by a Clinical Psychologist who has at least one year’s experience after gaining the qualification and eligibility for Registration as a Chartered Clinical Psychologist. When this occurs, the quality and quantity of supervision that is received by the trainee must be monitored carefully by the Programme Director or Clinical Tutor.

9.2. At the discretion of the Programme Director or Clinical Tutor, the supervision of specific aspects of the trainee’s work can be formally delegated to an appropriately qualified and experienced Psychologist who is eligible for Registration as a Chartered Psychologist, or an appropriately qualified and experienced member of another profession, either in one-to-one supervision or as part of a supervisory team. When this occurs, the quality and quantity of supervision that is received by the trainee must be monitored carefully by the Programme Director or Clinical Tutor.

9.3. All clinical supervisors must be fully aware of their responsibilities. No placement should be arranged unless the supervisor has indicated his/her willingness to provide full supervision and take responsibility for the trainee. The programme must have written guidelines on clinical supervision, or, alternatively, utilise the guidelines prepared by the Committee on Training in Clinical Psychology (see Appendix 4). The guidelines on supervision must be circulated to all supervisors.

9.4. A variety of supervisory arrangements is acceptable. These include trainee to supervisor ratios of 1:1 and 2:1 and various forms of team supervision for groups of trainees. The programme must ensure that appropriate mechanisms are in place to safeguard the standards set out in the Committee on Training in Clinical Psychology’s Guidelines on Clinical Supervision. These guidelines include:

9.4.1. that each trainee must have a named supervisor who is responsible for the coordination of their supervision and who formally assesses the trainee in consultation with the other supervisor(s) involved; and

9.4.2. that individual supervision must provide opportunities to discuss personal issues, professional development, overall workload and organisational difficulties as well as on-going case work.

9.5. Supervision in all placements must meet the standards set out in the Committee on Training in Clinical Psychology’s Guidelines on Clinical Supervision. These guidelines include:
9.5.1. that the general aims of the placement be established prior to or at the very beginning of the placement;

9.5.2. that a written placement contract be drawn up within two weeks of the start of the placement;

9.5.3. that the trainee must have an appropriate amount of individual supervision in addition to any group supervision;

9.5.4. that total ‘contact’ time between supervisor(s) and trainee(s) must be at least three hours per week;

9.5.5. that there must be a formal, interim review of the trainee’s progress in the placement, and of the experience provided;

9.5.6. that full written feedback is given on the trainee’s performance on placements;

9.5.7. that the trainee must see and comment on the full report;

9.5.8. that trainees must have the opportunity to observe the work of their supervisors and that supervisors observe the work of trainees;

9.5.9. that supervisors be sensitive to, and prepared to discuss, personal issues that arise for trainees in the course of their work; and

9.5.10. that supervisors closely monitor and help develop trainees’ communications (oral and written).

Reference
South West Training Scheme in Clinical Psychology: Liaison between Trusts and Programmes

Responsibilities of Programmes, Liaison Tutors, Heads of Service

Training Programmes and Service Providers share responsibility for ensuring that sufficient training places are provided to meet the training place numbers commissioned by the Strategic Health Authorities. This document outlines how Programmes and Trusts liaise to ensure good communication and provision of placements, as agreed through the Service Level Agreements.

Programmes

1. Agree training numbers for each intake as commissioned by the Strategic Health Authorities, in consultation with Service Heads.

2. Maintain an up to date list of Liaison Tutors’ names and contact details: a lead and a deputy Liaison Tutor from each significant Trust (Exeter Programme Administrator)

3. Give Liaison Tutor contact details to newly appointed trainees

4. Retain an up-to date Placement Directory (Exeter Programme Administrator)

5. Circulate Liaison Tutors with all relevant training and consultation documents in a timely and co-ordinated way (all Programmes’ Clinical Directors)

6. Communicate with Liaison Tutors to co-ordinate placement planning (all Programmes)

7. Maintain placement audit system, ensuring that outcomes of the audit process are fed back to inform Authorities, Universities and Service Providers of any actions needed in order to satisfy Service Level Agreements.

8. Meet annually with Head of Service/ Clinical Psychology Leads from the local Trusts to review training issues (Clinical Directors from all Programmes)

Heads of Service/Trust Psychology Leads

1. Appoint Liaison Tutor

2. Inform Liaison Tutor of staff changes (new appointments, inductions, and staff leaving)

3. Arrange for newly appointed staff to meet the Liaison Tutor as part of their induction process

4. Ensure that supervisors and Liaison Tutors are supported within the Trust for their training role
5. Ensure training issues are discussed between staff psychologists within the Trust at the appropriate forum (e.g. departmental meetings)

6. Meet regularly with the Liaison Tutor to maintain an overview of training issues

7. Meet annually with the Clinical Director from the nearest Training Programme to review training issues

8. Communicate with Trust Chief Executives and other senior managers regarding training issues (ensuring resources are available to provide sufficient placements to meet commissioned numbers)

9. Represent the Trust at Regional Training Committee via Regional Advisory Committee

10. Facilitate any actions needed within the Trust to satisfy Service Level Agreements and to provide sufficient placements for commissioned training numbers

**Liaison Tutors**

1. Ensure own name and contact details are entered onto Liaison Tutor list

2. Find a deputy Liaison Tutor

3. Meet new staff, during induction, to give information about the Training Programmes and to request their details to add to the Placement Directory

4. Ensure that supervisor details are kept up to date on the Placement Directory

5. Liaise between Programmes (Clinical Directors) and supervisors to find supervisors and placements as needed

6. Assist Programmes in communicating with any local Trusts not covered by a Liaison Tutor

7. Circulate training documents and requests from Programmes to all supervisors

8. Co-ordinate feedback from supervisors to Programmes

9. Be available to trainees as needed to give local information (e.g. accommodation, travel, resources)

10. Represent supervisors from the Trust at Supervisors’ Committee

**Deputy Liaison Tutor:** deputise for, and back up, Liaison Tutor as needed and attend Supervisors’ Committee
CONTRACTING VISIT CHECKLIST

Trainee:                   Clinical Tutor:       
Supervisor 1:             Supervisor 2:       
Placement:               Date of Visit:      Location
Year 1; Yr 2; Yr 3

General supervision and placement details

Discuss/Sign Supervision Agreement     
(Trainee/Clinical Tutor to submit to Becky Davies Rebecca.Davies@exeter.ac.uk)

Supervisors have system for liaising.                      
Supervisors have up-to-date copy of the Clinical Handbook     
Supervisors aware of how to evaluate the trainee and deadlines for paperwork
Supervisors have seen trainee evaluations from previous placement(s) (if relevant)
Issues from previous referred or conditional pass addressed
Discuss what can be left behind, and what to take forward, from previous evaluations
Regular (fixed, if possible) supervision times (total 1.5 hours per week)
Total contact time across supervisors 3 hours per week
Reference to the style/content of supervision (e.g. Hawkins and Shohet levels)
Consideration of balance of work/ responsibilities across the two supervisors
Consider how power issues/cultural differences and possible conflicts between
trainee and supervisors may be dealt with
Discuss the need for reflective evidence- and value- based practice
Reminder of supervisor’s clinical responsibility; trainee requirement to sign reports as
Trainee Clinical Psychologist, under supervision of …
Trainee’s annual leave has been negotiated?
Remind of events requiring the Trainee to attend (teaching, committee reps, etc)
Evidence of good supervisory relationships developing?
Study negotiated for placement-related academic work (SSRP, PBL, CPR, CR)
Check self-assessment document completed

Placement Resources

Explain placement audit form       
Trust policies/induction (access to equality and diversity policies, health and safety policies, 
risk assessment, child protection/supervision policy)
Discuss placement resource issues and refer to placement audit form
Trainee has access to desk, ‘phone and secretarial support (even if shared)

Check Competence Goals and Evaluation Form and discuss

General placement outline is in place/goals established
Appropriate, balanced, manageable goals being established across both parts of placement,
based on trainee strengths and learning needs; to be reviewed as placement progresses
Opportunities for Trainee to both observe [ ] and be observed by [ ] the Supervisor(s)
Agree a time to fill in observational form [ ]
Refer to audio/video taping as possible means of bringing material to supervision where direct observation will prove difficult [ ]
Discuss options for giving and receiving feedback from observation [ ]
Discuss opportunities for inter-professional learning [ ]

Check Portfolio of Clinical Activity and discuss
cumulative Record of Activity agreed? [ ]
Are planned placement experiences balanced and appropriate? [ ]

Academic/research requirements:
Discuss role of supervisor and opportunities for:
- Problem- Based Learning task [ ]
- Clinical Practice Report [ ]
- Small Scale Service Related Project (year 1) [ ]
- Major Research Project [ ]

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

Support for supervisors
- In separate time with supervisor(s) check what, if any, further support/ information needed from programme; any other issues/ concerns? Any resource issues to take forward to service managers? [ ]
- Check competency database completed/up to date [ ]

Comments

Note the following for attention at the review:

- 
- 
- 

Arrangements for Placement Review:
Date: ___/___/___ Time: _________ Venue: ___/___/___
## PLACEMENT REVIEW CHECKLIST

<table>
<thead>
<tr>
<th>Trainee:</th>
<th>Clinical Tutor:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supervisor 1:</td>
<td>Supervisor 2:</td>
</tr>
<tr>
<td>Placement: Year 1 (pt 1) (pt 2); Yr 2 (pt 1) (pt 2); Yr 3</td>
<td>Date of Visit: / /</td>
</tr>
<tr>
<td>Location</td>
<td></td>
</tr>
</tbody>
</table>

Ask: is the trainee on track to pass/conditional pass Clinical Competence Goals and Evaluation Form and Portfolio of Clinical Activity?

Yes/ No

(If ‘no’ following discussion and clarification, set up Action Plan)

### Review Supervision Agreement

[ ]

- Are good supervisory relationships are developing?
- Appropriate liaison across supervisors?
- Sufficient liaison with Programme and clarity re expectations?
- Check quality, frequency and dependability of supervision
- Were there opportunities for trainee to both observe [ ] and be observed by [ ] the supervisor(s)?
- Discuss use of observational tool.
- Are any difficult issues being appropriately addressed?
- Monitor stress levels of the trainee and supervisors(s)

### Review Clinical Competence Goals and Evaluation Form

[ ]

- Changes/ modifications in goals?
- Check that outstanding goals can be achieved by end of placement period
- Ask about work that has gone less well on placement
- Ask about how diversity issues are being addressed on placement
- Remind supervisors about their responsibility to complete

### Review Portfolio of Clinical Activity

[ ]

- Is there an appropriate range and amount of work?
- Check that required levels will be reached on Cumulative Record
- Check that deadline date for clinical submissions is clear

### Review Placement Resources

- Health & Safety policies
- Equality and diversity polices have been made available to the trainee
- Discuss placement resource issues and refer to placement audit form

### Check that academic/research opportunities have been discussed as necessary:

- Problem -Based Learning task
- Clinical Practice Report
- Small Scale Service Related Project (yr 1)
support for trainee

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

support for supervisors

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

comments

note the following for attention at next review (if relevant):

- 

arrangements for next placement review if relevant (ie only after a part 1 visit in yr 1 or 2) (or action plan review if needed)

| Date: __ / __ / __ | Time: ________ | Venue: |

C - 106
Thank you for taking the time to complete this audit form. The collection of this data serves three purposes:

- the identification of support required by supervisors in the field
- the monitoring of Service Level Agreements held with the NHS Trusts and
- the fulfilment of audit requirements set by the Purchasers of training in the region.

For the first two purposes, it is necessary for the Clinical Director to be able to identify the placement in order for action to be taken, with the supervisor’s consent, on any resource issues identified. For the third purpose, anonymous, cumulative data only are used.

The Placement Audit Form is a valuable tool for us to monitor the quality and consistency of placements across the region but also to improve the quality of support we provide to supervisors. We would encourage you, therefore, to take time to complete this form as fully as possible.

Please tick the appropriate rating and add comments if you wish to. Notionally, rating equivalents are as follows:

- mostly = 90% of the time or more
- sometimes = between 50% and 89% of the time
- rarely = less than 50% of the time.

Trainee name: ...........................................................................................

Placement: Year 1; Year 2; Year 3

Placement start and end dates: ..........................................

Supervisor name, specialism and base:

Trainee Signature: ......................................................... Date ..........................
PART A: SUPERVISION

A1 Did you receive the correct pro-rata share of supervision? (total across placement of 1.5 hours per week)

mostly ☐  sometimes ☐  rarely ☐
...............................................................................................................................................
...............................................................................................................................................

A2 Were supervision arrangements (eg time, location) planned well in advance and adhered to?

mostly ☐  sometimes ☐  rarely ☐
...............................................................................................................................................
...............................................................................................................................................

A3 Was there sufficient informal contact time (eg. shared work, observation, information discussion) between supervisor and trainee each week? (total across placement should be 3 hours per week)

mostly ☐  sometimes ☐  rarely ☐
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A4 Did appropriate liaison take place across the two parts of the placement?

mostly ☐  sometimes ☐  rarely ☐
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A5 Did the placement allow for joint working with members/trainees from other health professions? (Please specify)

Yes ☐  No ☐
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A6 Was supervision facilitative in helping you achieve course requirements (eg. developing formulation skills, gaining knowledge of relevant evidence and theory base, regular reference to placement goals, encouraging reflective practice)?

mostly ☐  sometimes ☐  rarely ☐
A7 Was the process of supervision routinely monitored (e.g. issues of power, gender and race, acknowledgement of emotional impact of clinical work, encouragement of reflection)?

mostly ☐ sometimes ☐ rarely ☐

A8 Was your workload monitored for breadth, depth and volume?

mostly ☐ sometimes ☐ rarely ☐

A9 Did you have opportunities to observe, and subsequently discuss, the clinical work of the supervisor?

Yes ☐ No ☐

A10a Did the supervisor directly observe your work? Yes ☐ No ☐

A10b Did the supervisor indirectly (e.g. video) observe your work? Yes ☐ No ☐

A12 Was the writing and presentation of the end of placement report handled sensitively and appropriately by the supervisor? Yes ☐ No ☐

A13 What changes, if any, would improve the supervisory experience of future trainees in this placement?
PART B: PLACEMENT RESOURCES

B1 Did the placement provide appropriate access to:

- a desk [ ]
- a phone [ ]
- secretarial support [ ]
- secure filing [ ]
- bookable therapy room [ ]
- a word processor [ ]
- the internet [ ]
- test resources [ ]
- library resources [ ]
- health and safety policies [ ]
- equality and diversity policies [ ]
- aids to observation of clinical work (video/audio recording, one-way screens) [Yes] [No] [ ]
- workshop/group resources (flipchart, OHP, pens, petty cash, etc) [Yes] [No] [ ]

B2 Were there any opportunities for joint learning with trainees from other health/social care professions? (please give details) [Yes] [No] [ ]

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B3 What actions, if any, are required to improve placement resources? Are any actions planned, or underway?

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B4 Are there any service developments that might negatively affect future placement resources?

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C - 111
PART C: COURSE TEAM LIAISON

C1 Taking into account the emphasis on the adult learner model, did the supervisor receive sufficient information about your future learning needs in order to plan the placement appropriately?

Yes [ ] No [ ]

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C2a Was the supervisor(s) able to attend the Pre-Placement Workshop?

Yes [ ] No [ ]

C2b If yes, then was the Pre-Placement Workshop useful in preparing for the placement?

Yes [ ] No [ ]

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C3 Did the documentation (eg course handbook or supervisor’s pack) sent from the programme to the supervisor appear to be useful?

Yes [ ] No [ ]

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C4 Were the clinical placement visits:

a) sufficient in number? [ ]

b) useful in content? [ ]

c) partly with supervisor and trainee alone? [ ]

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C5 Did the supervisor know whom to contact about various aspects of the placement (eg. research, academic support, trainee personal problems, placement issues)?

Yes ☐ No ☐

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C6 Was the supervisor clear about course expectations regarding supervisor role in relation to coursework completed by trainees whilst on placement?

Yes ☐ No ☐

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C7 Did the supervisor(s) appear to feel sufficiently supported by the Programme – including the clinical tutor

Yes ☐ No ☐

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C8 What changes, if any, would improve liaison between the course and the supervisor(s)?

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Thank you for taking the time to complete this audit form. The collection of this data serves three purposes:

- the identification of support required by supervisors in the field
- the monitoring of Service Level Agreements held with the NHS Trusts and
- the fulfilment of audit requirements set by the Purchasers of training in the region.

For the first two purposes, it is necessary for the Clinical Directors to be able to identify the placement in order for action to be taken, with the supervisor’s consent, on any resource issues identified. For the third purpose, anonymous, cumulative data only are used.

The Placement Audit Form is a valuable tool for us to monitor the quality and consistency of placements across the region but also to improve the quality of support we provide to supervisors. We would encourage you, therefore, to take time to complete this form as fully as possible.

Please tick the appropriate rating and add comments if you wish to. Notionally, rating equivalents are as follows:

- mostly = 90% of the time or more
- sometimes = between 50% and 89% of the time
- rarely = less than 50% of the time.

Trainee name: ..........................................................................................

Placement: Year 1; Year 2; Year 3

Placement start and end dates: ............................... 

Supervisor name, specialism and base:

Supervisor Signature:.................................................. Date ......................

Please return to Becky Davies, Programme Administrator, Doctorate in Clinical Psychology, School of Psychology, Washington Singer Building, University of Exeter, EX4 4QG
PART A: SUPERVISION

A1 Did you offer the correct pro-rata share of supervision? (total across placement of 1.5 hours per week)
   mostly □  sometimes □  rarely □
   ……………………………………………………………………………………………………………………………

A2 Were supervision arrangements (eg time, location) planned well in advance and adhered to?
   mostly □  sometimes □  rarely □
   ……………………………………………………………………………………………………………………………

A3 Was there sufficient informal contact time (eg. shared work, observation, information discussion) between supervisor and trainee each week? (total across placement should be 3 hours per week)
   mostly □  sometimes □  rarely □
   ……………………………………………………………………………………………………………………………

A4 Did appropriate liaison take place across the two parts of the placement?

   Yes: mostly □  sometimes □  rarely □
   ……………………………………………………………………………………………………………………………

A5 Did the placement allow for joint working with members/trainees from other health professions? (Please specify)
   Yes □  No □
   ……………………………………………………………………………………………………………………………

A6 Was supervision facilitative in helping the trainee achieve course requirements (eg. developing formulation skills, gaining knowledge of relevant evidence and theory base, regular reference to placement goals, encouraging reflective practice)?
   mostly □  sometimes □  rarely □
   ……………………………………………………………………………………………………………………………

A7 Was the process of supervision routinely monitored (eg issues of power, gender and race, acknowledgement of emotional impact of clinical work, encouragement of reflection)?

C - 115
A8 Was the trainee’s workload monitored for breadth, depth and volume?

mostly ☐  sometimes ☐  rarely ☐

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A9 Did the trainee have opportunities to observe, and subsequently discuss, your clinical work?

Yes ☐  No ☐

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A10a Did you directly observe the trainee’s work?  Yes ☐  No ☐

A10b Did you indirectly (eg video) observe the trainee’s work?  Yes ☐  No ☐

A12 Was the writing and presentation of the end of placement feedback handled sensitively and appropriately by the trainee?

Yes ☐  No ☐

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A13 What changes, if any, would improve the supervisory experience of future trainees in this placement?

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PART B: PLACEMENT RESOURCES

B1 Did the placement provide appropriate access to:

a desk ☐  a phone ☐
<table>
<thead>
<tr>
<th>Secretarial Support</th>
<th>Secure Filing</th>
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<tbody>
<tr>
<td>□</td>
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<table>
<thead>
<tr>
<th>Bookable Therapy Room</th>
<th>A Word Processor</th>
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<tbody>
<tr>
<td>□</td>
<td>□</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>The Internet</th>
<th>Test Resources</th>
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<tbody>
<tr>
<td>□</td>
<td>□</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Library Resources</th>
<th>Policy Documents</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
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</tbody>
</table>

Aids to Observation of Clinical Work (Video/Audio Recording, One-Way Screens)

Yes [ ] No [□]

Workshop/Group Resources (Flipchart, OHP, Pens, Petty Cash, Etc)

Yes [ ] No [□]

**B2** Were there any opportunities for joint learning with trainees from other health/social care professions? (please give details)

Yes [□] No [□]

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**B3** What actions, if any, are required to improve placement resources? Are any actions planned, or underway?

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**B4** Are there any service developments that might negatively affect future placement resources?

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PART C: COURSE TEAM LIAISON

C1 Did you receive sufficient notice of the request to place the trainee?  
Yes ☐ No ☐

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C2 Taking into account the emphasis on the adult learner model, did you receive sufficient information about the trainee’s future learning needs in order to plan the placement appropriately?  
Yes ☐ No ☐

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C3b Were you able to attend the offered Pre-Placement Workshop? Yes ☐ No ☐

C3c If yes, was the Pre-Placement Workshop useful in preparing for the placement?  
Yes ☐ No ☐

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C3d If no, was there anything the course could have done to have enabled attendance?  
Yes ☐ No ☐
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C4 Was the documentation (eg course handbook or supervisor’s pack) sent to you from the course useful?  
Yes ☐ No ☐
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...........................................................................................................................................
C5 Were the clinical placement visits:

d) sufficient in number? ☐
e) useful in content? ☐

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C6 Did you know whom to contact about various aspects of the placement (eg. research, academic support, trainee personal problems, placement issues)?

Yes ☐  No ☐

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C7 Were you clear about course expectations regarding supervisor role in relation to coursework completed by trainees whilst on placement?

Yes ☐  No ☐

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C8 Did you feel sufficiently supported by the course – including the Liaison Clinical Tutor?

Yes ☐  No ☐

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C9 What changes, if any, would improve liaison between the course and the supervisor(s)?

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1 Introduction

1.1 The University recognises that in conferring appropriate academic qualifications, where these lead to a professional qualification, admission to a professional body and/or statutory registration, it must be satisfied that the student will be a safe and suitable entrant to the given profession.

1.2 Students themselves on programmes leading to professional qualifications should also acknowledge that it is in their interests not to proceed into a career for which they may not be well suited or for which a professional body may not register them.

1.3 In order to discharge these responsibilities, the University has adopted the following procedures specific to registered students following a programme of study that leads to such a professional qualification and admission to a professional body. In the case of students registered with the Peninsula College of Medicine and Dentistry, other procedures apply.

1.4 These procedures will be taken into account in the admission of students to such programmes and in the design and approval of new programmes leading to professional qualifications.

2 Programmes within the Procedures

2.1 The programmes subject to these procedures are listed in Annex 1.

2.2 Notification of programmes subject to these procedures should be clearly indicated within School publications (both paper and web-based) relating to those programmes, including:
   - Prospectus information
   - Programme specifications
   - Programme handbooks

3 Principles relating to Student Behaviour

3.1 In the context of these procedures, students should understand that the successful completion of a programme leading to admission to a professional body requires adherence to both the requirements of that body and of these procedures.

3.2 Students shall behave in a manner appropriate to the Regulations and procedures of the University and to the code of conduct (or equivalent) of the relevant professional body.

3.3 Students shall at all times act in the best interests of their patients, service
users, staff and other students, and conduct themselves in a professional manner.

3.4 Students shall report to the appropriate authority and to the School actions by others that may put students, staff, patients and other service users at risk. Failure so to report could lead to disciplinary action against such a student. Persons making disclosures must identify themselves.

3.5 Where not subject to a Criminal Records Bureau check by the University prior to admission, students whose programmes fall under these procedures must disclose any criminal convictions (including spent convictions) to the University before entering the programme. Subsequently, any student within these procedures must disclose such a conviction if it occurs while the student remains registered. Students will be provided with guidance about the consequences for registration within the profession concerned. If a student fails to disclose such information and it subsequently comes to light, the student will be referred to a Fitness to Practise Board (see below). Enquiries to the Criminal Records Bureau, both before and after admission, will be managed through the University's Student Recruitment and Admissions Office except where student contract arrangements already place responsibility for such enquiries on a students employing trust.

4 Principles relating to Student Health

4.1 Students should understand that physical or mental health reasons may be a cause for their being deemed to be unfit to practise, a consequence of which could be that it would not be possible for them to complete a programme listed in Annex 1.

4.2 Students may be required as a condition of admission to a programme to complete a declaration of health questionnaire, to demonstrate that at the time they meet the health requirements of the profession for which successful completion of the programme could lead to registration. It is required that they inform the University about any condition for which reasonable additional provision may have to be made in programme arrangements.

4.3 A student whose health deteriorates during their studies should consult one of the University's Medical Officers and/or the relevant professional body for advice about any implications for continuing training or for pursuing their intended professional career. Students should inform their School of any changes in their health which could affect their fitness to practise, and subsequent discussions between student and School will determine if in the view of the latter consideration may have to be given to a termination of studies.

4.4 Except in cases where students acknowledge and accept that their health problems mean that their programmes should be terminated and have provided medical evidence from their general practitioner, and have had the opportunity to discuss their health problems with one of the University Medical Officers if they wish to do so, any registered student for whom termination of studies as being unfit to practise is being considered by the School on health grounds shall be referred by the School to a specialist occupational health physician or other medical adviser selected by the School but having no permanent contractual connection with the University. Any consultation fee shall be met by the School. The student will be required to attend any consultation considered necessary by the occupational health physician or medical adviser.
Should the student wish to consult an adviser other than the one selected by the School, any fees incurred shall be borne by the student. The School shall use the subsequent report as the basis for a discussion with the student ahead of any recommendation relating to termination of studies.

4.5 In the case of behaviour associated with diagnosed or suspected mental illness, or from addiction, these procedures shall only be invoked if medical and counselling interventions have not successfully addressed the behaviour or if the student has refused such interventions.

4.6 Failure by a student to disclose relevant medical information and providing false information will normally lead to the termination by the University of the students studies.

5 Academic Failure

5.1 Students should understand that academic failure during their programmes, including placements, may lead to the termination of their registration on a programme for a professional qualification normally allowing admission to a professional body and/or statutory registration.

6 Information for Students

6.1 In the case of any programme that requires staff to make a judgement on fitness to practise, students must be made aware by a School that the University will be required to make such a judgement. In addition, students must be informed by their School of the standards of academic performance, health, behaviour, attitude and attendance expected of them for such a declaration of fitness to practise to be made. In this context, a School must inform students of a profession's own fitness to practise standards which will contribute to the declaration by the University. Such information should normally be contained within a programme handbook.

6.2 Students registered for programmes subject to these procedures may be treated differently to other students of the University if their actions call into question their professional competence.

6.3 In formally registering on programmes subject to these procedures, students are expected to accept the force of the procedures. It is therefore important that as part of the induction process, Schools should notify new students on a programme leading to a professional qualification of the existence of these procedures. (See also 2.2. above.) Returning students should be so reminded annually.

7 Breaches of the Procedures

7.1 School Stage

7.1.1 Where, following a report by staff or students, a Head of School believes that a case has arisen that warrants the application of these procedures, the student concerned will be interviewed by the Head to advise the student of the concerns raised and how they fall below the professional expectations of those taking a particular programme. The student should be provided with evidence of the issues of concern before or during the meeting. The evidence should be verifiable and not based on hearsay.
7.1.2 A student attending such a meeting may be accompanied by a person who should normally be a member of the University.

7.1.3 The outcome of the meeting should be such that the student is clear on the nature of the concerns, why they have been raised and what the University expects as a result. There should be an action plan, to include follow-up meetings and monitoring if appropriate.

7.1.4 The meeting should be minuted by the School and the student sent in writing details of the full outcome.

7.1.5 Should the case involve an allegation of a case of abuse or other misdemeanour that, in the opinion of the Head of School, is so serious as to threaten the safety of others, the Head may seek the approval of the Vice-Chancellor for an immediate temporary suspension of the students studies.

7.2 University Stage

7.2.1 If the Head of School concludes that a breach of procedure is so serious that the consequences could potentially lead to a termination of studies or other penalty beyond the School’s powers, the case shall be referred to the Director of Academic Services for the attention of a University Fitness to Practise Board. If a student does not accept the outcome of the School stage of this process, then the case shall likewise be referred.

7.2.2 A University Fitness to Practise Board shall comprise the following members:

A present or past Deputy Vice-Chancellor of the University, who shall act as Chair;
A member of the Senate of the University;
An academic member of staff teaching a discipline (other than that of the student before the Board) leading to an award of the University and to a professional qualification;
A senior representative of the profession to which the programme for which the student is registered may lead to admission, who has had no previous connection with the student (including his or her placements of study);
A representative nominated by the Students' Guild.

No member shall have previously been associated with the case or be a member of the School(s) concerned.

7.2.3 The Fitness to Practise Board may impose one or more of the following penalties:

- to permit a student to continue with the programme but under additional supervision and within an additional reporting procedure;
- to impose disciplinary sanctions on the student consistent with penalties allowed under the University's Disciplinary Procedure;
- to suspend the studies of a student for a specified time or until the occurrence of a specified event to be decided by the Board;
- to refer a case to a relevant Board of Examiners for consideration whether or not a re-sit of a specified part or parts of the programme is
required;

- to terminate the student's studies that might otherwise lead to a professional qualification, but with permission to register on an alternative academic programme;
- to recommend to the Vice-Chancellor permanent exclusion from the University.

8 Appeal

8.1 A student incurring a penalty imposed or recommended by a Fitness to Practise Board who considers it to be unfair or excessive has the right to appeal against it. Appeals against such penalties must be submitted in writing to the Registrar and Secretary within seven working days, and will be heard by a Fitness to Practise Appeal Board.

8.2 The membership of a Fitness to Practise Appeal Board shall comprise:

A member of the University Council, not a member of the University's staff, who shall act as Chair;
A member of the Senate of the University;
An academic member of staff teaching a discipline leading to an award of the University and to a professional qualification;
A senior representative of the profession to which the programme for which the student is registered may lead to admission, who has had no previous connection with the student (including his or her placements of study);
One representative nominated by the Guild of Students.

No member shall have previously been associated with the case or be a member of the School(s) concerned.

8.3 The Appeal Board shall have powers to confirm, increase, reduce or quash the penalty or penalties originally imposed, or to recommend to the Vice-Chancellor permanent exclusion from the University.

8.4 The decision of the Fitness to Practise Appeal Board shall be final and there shall be no further right of appeal.

9 Reports on Proceedings

9.1 All penalties imposed under these procedures shall be reported to the Registrar and Secretary.

9.2 The proceedings of all Fitness to Practise Boards and Appeal Boards shall be reported to the Senate. A copy of any such report will be made available to the student involved and to the School concerned.

9.3 Records of penalties imposed on students will be included on their personal files held by the University.

10 Hearings of Boards

10.1 Hearings of Fitness to Practise Boards and Appeal Boards will be governed by procedures approved by the Senate (see Annex 2).
Confidentiality, Consent and Academic Reporting of Clinical Activity

Guidelines for the University of Exeter Doctorate in Clinical Psychology programme

Background

These guidelines have been produced by a small working group from the Supervisors’ Committee. They are based on consideration of the following: discussion within and feedback from Supervisors’ and Course Policy Committee, discussion within the Exeter service users, Department of Health guidelines on informed consent, the Good Practice in Consent Implementation Guide (2001), consent and reports of clinical activity (Sperlinger and Callanan, 2002), the BPS Code of Conduct (2006) and HPC Code of Conduct and Ethics for students (2009).

Guidelines

1. All health professionals, including clinical psychologists, must obtain clients’ voluntary consent before treating or caring for them. This requires the professional to provide as much information (in a form that the person can understand) about the likely risks and benefits of the care, and about what it is likely to involve, as the client reasonably needs in order to make a decision (Department of Health 2001). Trainees should consult the Department of Health website on consent (see above) for guidance of issues of consent for particular client groups (children, people with learning disabilities, older people, people in prison). This would include Mental Capacity Act (2005) and Mental Health Act.

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

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

4. With regard to confidentiality of personally identifiable material, the trainee must explain to the client the limits to confidentiality with regard to supervision and team work (see below point 5). Various legal frameworks safeguard the interests of citizens in relation to disclosure of information. The Data Protection Act 1998 is the most recent of these. It sets out the conditions that must be met before personal data can be processed fairly and lawfully. It allows for the disclosure of “personal” or “sensitive” information only under certain circumstances, including the circumstance when information is needed to protect the vital interests of the person or another person. It also provides that personal data can be processed, if
withholding it would be likely to prejudice the prevention or the detection of crime, or the apprehension or prosecution of offenders. The Crime and Disorder Act 1989 also gives power to disclose information to a relevant authority “for the preventing and detecting of crime”. In relation to children, the Children Act 1989 sets out a range of duties in relation to statutory authorities to assist in the collection of information in relation to child protection cases. DfES Circular 10/95 for schools makes clear that in cases of child abuse: “Staff have a professional responsibility to share relevant information about the protection of children with other professionals, particularly investigative agencies. If a child confides in a member of staff and requests that the information is kept secret, it is important that the member of staff tells the child sensitively that he or she has a responsibility to refer cases of alleged abuse to the appropriate agencies for the child’s own sake. Within that context, the child should, however, be assured that the matter will only be disclosed to people who need to know about it. Staff who receive information about children and their families in the course of their work should share that information only within appropriate professional contexts. Child protection records should be kept securely locked.”

5. Trainees should therefore let clients know that there are potential limits to complete confidentiality, and indicate the sort of circumstances under which breaches might occur. The trainee should also say that if the need for a breach of confidentiality arose that they would usually try to discuss it with the client first. This need not be a difficult or lengthy discussion - most clients will be happy to talk about this, and the more open the trainee is the more reassured they are likely to be. In addition, trainees should remember that they will be regularly breaching confidentiality when they discuss clients with their supervisor. In some settings they may also discuss clients with team members as a normal part of the assessment process. In most settings they will be writing to the referrer and will often include the client's GP in any communications. A good principle is to make sure that clients know about these sort of discussions and communications, and the boundaries and safeguards that exist to safeguard the client's interests.

6. Under the Data Protection Act (1998), patients are entitled to see all information relating to their physical or mental health which has been recorded by or on behalf of a health professional in connection with their care. If there is a possibility that the person may be seriously harmed by the record, then the health professional responsible for the record may need to be consulted. Trainees should write reports, letters and notes in the knowledge that they may be seen by clients.

7. With regard to case notes, trainees must follow the guidance of the BPS DCP - Clinical Psychology and Case Notes: Guidance on Good Practice (2000), and must follow policy and good practice guidelines from the Trust within which they are working.

8. As part of the information given, clients consent should be sought to write up their work in a suitably anonymised form, for training purposes, and the precautions discussed to protect clients’ interests about this: the alteration of identifying features, the requirement that it be reported in a thoughtful and respectful way, limits on who will see it, and that it will be stored in a secure place. How this information is given will depend on particular circumstances, taking into account different client needs and abilities. Basic information may be given in a standardised form to all potential clients within a Trust or service (eg as part of a standard appointment letter).
9. The trainee clinical psychologist must explain what will be involved in the particular circumstances, and must check over time that the client remains content to be seen: giving consent is a process, not a one-off event. No one else can give consent on behalf of a person who lacks capacity to consent (ie if they are not competent to understand and weigh up the information needed to make the decision). Where there is doubt about the person’s capacity to give consent the trainee must ask the advice of their supervisor (who may consult with another trained professional within the team), who should take into account the views of people close to the person such as carers, family and friends before making the decision as to whether being seen by a trainee, with all that this entails, would be in the client’s best interests. The process of dealing with consent should be documented in the notes. Use of Mental Capacity Act should be considered.

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

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

12. The trainee must report, on the front sheet of all work submitted for academic purposes, how the process of consent was addressed.

13. Trainees must ensure that client and carer confidentiality is protected in all work submitted for university requirements. The BPS Code of Ethics and Conduct requires that psychologists should “take care to prevent the identity of individuals… being revealed, deliberately or inadvertently without their express permission” (BPS 2000). All identifying features such as names, addresses, hospital numbers and any other recognisable details must be changed or deleted. Trainees must not use the client’s own initials when referring to him or her.

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

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

16. Opinion and guidance about good practice in ethical matters develops over time. The Department of Health is currently developing a new strategic framework for information management in the NHS which aims to bring together all the requirements, limits and best practice that apply to the processing of confidential
patient information about individuals and integrating these within a unified framework. Therefore these guidelines will be subject to review, taking into account Department of Health strategic developments and BPS recommendations, through discussion and consultation under the Supervisors’ Committee. Health Professions Council requirements.

References


Health Professions Council (2009) *Standards of conduct, performance and Ethics*.

Health Professions Council (2009) *Guidance on conduct and ethics for students*.

Health Professions Council (2009) *Practitioner psychologists*.

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<thead>
<tr>
<th>NAME:</th>
<th>SERVICE GROUP:</th>
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<td>ADDRESS:</td>
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<td>GEOGRAPHICAL AREA COVERED:</td>
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<td>TELEPHONE:</td>
<td>TRUST:</td>
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**COMPETENCIES AND EXPERIENCE AVAILABLE AT THIS PLACEMENT**

<table>
<thead>
<tr>
<th>SUPERVISOR HPC REGISTERED</th>
<th>YES</th>
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**LOG OF SUPERVISOR TRAINING**

<table>
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TRUST POLICIES AND PROCEDURES

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

<table>
<thead>
<tr>
<th>Taunton &amp; Somerset NHS Foundation Trust</th>
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<tbody>
<tr>
<td><strong>Employment Policies &amp; Procedures</strong></td>
</tr>
<tr>
<td>Standards of Business Conduct and Hospitality for Trust Employees</td>
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<tr>
<td>Declaration of Interest Policy</td>
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<tr>
<td>Standing Orders</td>
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<td>Standing Financial Instructions</td>
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<td>Identification Badges</td>
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<td>Internet &amp; E-mail Usage</td>
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<td>Working Time</td>
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<td>Recognition Agreement</td>
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<td>Retirement Awards</td>
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<tr>
<td>Raising Concerns about Healthcare Services</td>
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<tr>
<td>Equality Diversity Policy</td>
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<tr>
<td>Trade Union Facilities Agreement</td>
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<tr>
<td>Procedure for the Management of Sickness</td>
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<td>Absence</td>
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<td>Fraud Policy and Response Plan</td>
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<tr>
<td>Guidance for Managers on Periods of Notice</td>
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<tr>
<td>Annualised Hours</td>
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<tr>
<td>Disputes Procedure</td>
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<td>Relocation Expenses</td>
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<tr>
<td>Employment Break</td>
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<td>Grievance Procedure</td>
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<td>Guidance on Home Working</td>
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<td>Job Sharing</td>
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<td>Professional Registration</td>
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<td>Short Term Unpaid Leave</td>
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<td>Trust Board Appeals Procedure</td>
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<td>Capability Policy and Procedure</td>
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<td>Dealing with Harassment</td>
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<td>Adoption Leave</td>
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<td>Bereavement Leave</td>
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<td>Domestic/Carer Leave</td>
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<td>Paternity Leave</td>
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<td>Parental Leave</td>
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<td>Study Leave Guidance</td>
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<td>Protection of Pay</td>
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<td>Redeployment Procedure</td>
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<tr>
<td>Staff Development Strategy</td>
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<tr>
<td>Disciplinary Procedure</td>
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<tr>
<td>Guidance for Managers on the Recruitment &amp; Selection Process</td>
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<tr>
<td>Grading Review Procedure</td>
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<tr>
<td>Appraisal Policy &amp; Procedure</td>
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<tr>
<td>Procedure for Maternity Leave</td>
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<tr>
<td>Guidance on Flexible Working</td>
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<tr>
<td>Protocol on Staff Employment Records</td>
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<tr>
<td>Partnership Working</td>
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<tr>
<td>Procedure on Organisational Change/Redundancy</td>
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<tr>
<td>Fixed Term Contract Guidance</td>
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</table>

| **Health & Safety Policies & Procedures** |
| Health & Safety Policy                   |
| Protecting Healthcare Workers and Patients against Infection with Blood Borne Viruses |
| Policy on Working Alone in Safety        |
| Actions & Responsibilities Arising Out of Enforcement |
| Authority Visits                         |
| Contamination Incident Procedure         |

Please note that the policies and procedures relating to predecessor organisations will become the appropriate source of reference, if necessary.
SELF ASSESSMENT DOCUMENT

| Trust/Service: |  |
| Division |  |
| Unit |  |
| Contact Address: |  |

| Contact Name/Designation: |  |
| Telephone no: |  |
| Email address: |  |
| Fax |  |
| HEI/Clinical Tutor: |  |
| Designation: |  |
| Contact Telephone no: |  |
| Signatures at visit: |  |
| Participant 1: |  |
| Participant 2: |  |
| Participant 3: |  |
| Participant 4: |  |
| Date of review |  |

**COLLABORATIVE REVIEWERS RECOMMENDATION**

| Offers suitable placements for healthcare learners | Yes | No |
| Currently unsuitable for healthcare learners *(see action plan – page 8)* | | |

Doctorate in Clinical Psychology, Exeter  
2010-2011
The details on this form are used to inform the allocation to placements of healthcare learners

**SECTION 1:** (please mark the appropriate sections)

<table>
<thead>
<tr>
<th>Type of Placement/ Speciality</th>
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</thead>
<tbody>
<tr>
<td>Client Patient Group/s</td>
<td></td>
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</tbody>
</table>

**SECTION 2: OTHER INFORMATION**

Do your staff require mentor/clinical supervision preparation or updates? YES / NO (If yes, locate Action on p8)

Relevant Evidence for Staff offering placement:

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

### 1. Student selection, progression and achievement

The following standard is related to the **student selection, progression and achievement** that the PLACEMENT PROVIDERS are responsible for signing off.

<table>
<thead>
<tr>
<th>1.1</th>
<th>We have mechanisms in place in placement areas to recognise early poor performance of students and for taking appropriate and prompt action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self Assessment:</td>
<td>N/A Not Met At Risk Making Progress Fully Met Excelling</td>
</tr>
</tbody>
</table>

Rationale/Evidence

### 2. Student support

The following standards are related to the **student support** that the PLACEMENT PROVIDERS are responsible for signing off.

| 2.1 | We provide all students with a named practice placement supervisor for the duration of that placement, who is appropriately qualified and experienced |
and meets relevant Regulatory body requirements (HPC registered)

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
<th>Not Met</th>
<th>At Risk</th>
<th>Making Progress</th>
<th>Fully Met</th>
<th>Excelling</th>
</tr>
</thead>
</table>

Rationale/Evidence

Learners are provided with placement details in advance. Learners are expected to contact their placement and identify/introduce themselves to their named placement mentor/supervisor.

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
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</thead>
</table>

Rationale/Evidence

2.2

Our practice placement supervisors are aware of the students placement outcomes so that they are able to agree with students an individual learning contract for the placement experience.

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
<th>Not Met</th>
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<th>Fully Met</th>
<th>Excelling</th>
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</table>

Rationale/Evidence

2.3

We provide students with scheduled appointments with their practice placement supervisors at regular intervals to discuss their progress towards meeting their learning contract.

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
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</table>

Rationale/Evidence

2.4

We take action on evaluation/feedback information that students give us on the quality of their placements and practice placement supervision received.

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
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</table>

Rationale/Evidence
2.5 We provide students with an orientation/induction to each practice placement (non-discriminatory policy, health and safety, equality and diversity policies, child protection)

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
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<th>Fully Met</th>
<th>Excelling</th>
</tr>
</thead>
</table>

Rationale/Evidence

The following standard is related to the student support that the HEI and placement providers have joint responsibility for signing off.

2.6 We make students aware of their responsibilities and rights with regard to student support on-site and in practice placements

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
<th>Not Met</th>
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<th>Fully Met</th>
<th>Excelling</th>
</tr>
</thead>
</table>

Rationale/Evidence

3. Learning and teaching

The following standards are related to the learning and teaching that the PLACEMENT PROVIDERS are responsible for signing off.

3.1 Our placement areas ensure that provision is made for students to reflect in/on practice and link practice explicitly with their theoretical underpinning

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
<th>Not Met</th>
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<th>Fully Met</th>
<th>Excelling</th>
</tr>
</thead>
</table>

Rationale/Evidence
Our practice placements provide varied learning opportunities that enable students to achieve learning outcomes through:

- observing skilled professionals deliver service and care
- participating, under supervision, in the delivery of treatment and care
- practising in an environment that respects users' rights, privacy and dignity

<table>
<thead>
<tr>
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<th>N/A</th>
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<tr>
<td><strong>Rationale/Evidence</strong></td>
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</table>

Our staff, who act as practice placement supervisors of students, demonstrate evidence-based teaching, assessment and practice

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
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<tr>
<td><strong>Rationale/Evidence</strong></td>
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</table>

We provide learning opportunities in placements that are appropriate to the level and need of the student and provide opportunities for inter-professional working

<table>
<thead>
<tr>
<th>Self Assessment:</th>
<th>N/A</th>
<th>Not Met</th>
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<th>Making Progress</th>
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<tr>
<td><strong>Rationale/Evidence</strong></td>
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</tbody>
</table>
3.5 There is a strategy in place to ensure implementation and compliance with organisation policies in induction:

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

4. Assessment

The following standards are related to the assessment that the HEI and PLACEMENT PROVIDERS have joint responsibility for signing off.

4.1 We work collaboratively to agree the number of placement assessors in each practice placement and ensure that these assessors are periodically updated.

<table>
<thead>
<tr>
<th>Self Assessment: (please circle appropriate score)</th>
<th>N/A</th>
<th>Not Met</th>
<th>At Risk</th>
<th>Making Progress</th>
<th>Fully Met</th>
<th>Excelling</th>
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</table>

| Rationale/Evidence |
4.2 We work collaboratively to ensure that there is inter-assessor reliability in practice assessments

<table>
<thead>
<tr>
<th>Self Assessment: (please circle appropriate score)</th>
<th>N/A</th>
<th>Not Met</th>
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<th>Excelling</th>
</tr>
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</table>

Rationale/Evidence

5. Staff are released to attend supervisor training | Yes/No

6. All staff undertake individual Performance Review where education responsibilities are clearly defined and future education requirements are identified. Continuing professional development is recorded. | Yes/No

7. Each placement unit maintains a live database of clinical supervisors that is collated and maintained at organisation level | Yes/No

8. All staff are HPC registered | Yes/No
I have examined evidence that all the above standards have been met

For Placement Provider:
Signature,........................................................................................................................................
Designation:
Date...........................................................................................................................................

For HEI:
Signature,........................................................................................................................................
Designation: Clinical Tutor
Date:

<table>
<thead>
<tr>
<th>Proposed Action Plan</th>
<th>Responsibility</th>
<th>Review Date</th>
<th>Comments</th>
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**Commendation of best practice** (education practice that is positive, working well or commendable and areas where there have been demonstrable improvements).

Date and time of the next Annual Review Meeting:
WHO ARE MY PEOPLE

Taking Clinical histories the culturally sensitive way

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

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

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

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

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

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

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

It also tells us that the greatest growth is probably in the ‘Mixed’ ethnic groups. These are likely to be British born people with at least one parent from another ethnic group. People with mixed ethnicity overwhelmingly regard themselves as British, (9 out of 10) but are nearly twice as likely to be the victims of violent crime as anyone from an ‘unmixed’ group (3)
It is important to remember that there is much more variability within races than between them, both genetically speaking and in terms of experience, and that ethnicity is a separate concept. Ethnicity is about how a person perceives and feels their identity; we always need to ask them. They and their family may have come a few miles, or thousands of miles to live in Somerset, or have ‘always’ lived here, Wherever they originated, each person’s ethnicity is important to them.

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

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

Use of this guidance

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

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

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

Contents

1 Personal history
2 Family history
3 Ethnicity, acculturation and migration issues
4 Language and communication issues
5 Health and wellbeing beliefs, Spirituality
6 Formal religious/spiritual paths
7 Personal care, during inpatient/residential/supported living stays

Section 1: Personal history

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

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

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

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

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

Section 2: Immediate Family History
Ask-
• For family member’s names. If names are unfamiliar to you, take down the spelling, and also write down how they are pronounced- how they sound to you.
• About how first, second and third names are constructed, as different cultures do it differently.

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

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

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

• What kind of beliefs are important to your family, could you describe them
• Would you say you have a faith, religion, spiritual path or practice (note all)
• What role does your faith have in everyday life
• Do you have any special traditions, practices or values
• Are you members of any groups/ organisations/churches/clubs that you wish to discuss
• Include informal groupings, sporting and fun ones
• Do you have good friends/extended family around who help when needed, or particular organisations who help
• Do you get involved in local/national/international politics, are you registered to vote
• What kinds of skills do family members have, what occupations. Any employment successes/problems
• Any financial issues.
• Any issues of safety or threat.
• What kind of issues does your family discuss, are there any issues that are difficult
• Do men and women have different or similar roles in your family
• Do older and younger people have different roles in your family
• Do you feel proud of your family, or do they sometimes embarrass you
• Are there any special challenges in this stage of your families’ life cycle
• Have you experienced any major changes recently
• Are you expecting any changes soon
• What do you think/hope will happen in the future (re any expressed family issues)

Section 3: Ethnicity, acculturation and migration issues
Ask-
• About any wider family and group movements, diasporas and events
• If it is easy/hard to keep in touch with living relatives/friends/associates
• If the family has moved, there may be difficult situations they have escaped, and/or people/things they badly miss
• What differences/similarities do you notice between yourself/your family, and the people you live near now
• What differences/similarities are there between your previous town/village/environment, and where you live now.
• Have you felt welcomed
• Have you experienced any harassment /racism/exclusion
• Have you experienced any ‘human rights’ issues- expand if necessary

For migrant workers
Issues are very different if workers are from the E.U. or not. European workers may work anywhere in Europe; e.g. a number of eastern European workers have arrived in Britain since 2004, when 10 new countries joined the E.U. In Slovakia and Poland unemployment rates are highest, at 15.8% and 17.2% respectively, and substantial migration has resulted. There are reciprocal healthcare agreements, but the United Kingdom has applied some transitional restrictions on the movement of migrant workers from countries who joined in 2004 and 2007. (work permits)
Bulgaria and Romania joined the E.U. on 1st January 2007.

For travelling and gypsy groups
Repeated exclusion by the settled majority and the need to implement a specific welcome in healthcare
Are discussed e.g. at www.equalitysouthwest.org.uk/about-us/

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

For Asylum seekers
There may be unresolved trauma, injuries, and disease, then further harrowing uncertainties about whether Asylum will be granted or not.
Healthcare is free until the last stage of a failed application, when the asylum seeker is awaiting deportation, when ‘non urgent’ hospital treatment must be paid for. (7) The ‘Harp’ websites (Health for Asylum seekers and Refugees Portal) contain a wealth of information.

http://www.harpweb.org.uk/index.php

- Ask what they would like to talk about

Section 4: Language and communication issues

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

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

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

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

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

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

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

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

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

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

There are now a number of specific organisations offering helpful online picture leaflets- e.g. the Down’s syndrome association at www.down-syndrome.org/DSA1stliterature.aspx

All you need is a colour printer

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

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

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

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

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

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

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

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

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

Section 6: Formal spiritual or religious paths
NHS Trusts now have a clear duty to explore and respect our service users beliefs, drawn from all faiths and from secular systems. Definitions of spirituality can be wide: e.g. 'Spirituality concerns an ancient and primal search for meaning that is as old as humanity itself….our spiritual story as a human species is at least 70,000 years old; by comparison, the formal religions have existed for a mere 4,500 years….(9)

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

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

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

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

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

- About any chaperoning requirements for women or need for single sex accommodation
- About any toilet requirements- a number of cultures regard toilet paper as less than satisfactory, and would wish for running water
- About any requirements for prayer/meditation/rites or rituals
- Consider Holy days and festivals when making outpatient appointments
• Would you like to speak to the Chaplain, a religious leader from your faith community, or a spiritual advisor?
• Consider any rites required around death and mourning.

Terry Roth
For Diversity Group
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   www.who.int/mediacentre/factsheets/fs134/en/print.html

7. The Refugee Council
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8. Beliefnet:
   www.beliefnet.com

9. O’Murchu D ‘Reclaiming Spirituality’
   Gateway Publishing Dublin, Gill & Macmillan 2000
**ECC FORM - APPENDIX 1: SERVICE USER EVALUATION FORM**

*Name of Psychologist:*  
*Date:* 

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

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

<table>
<thead>
<tr>
<th>More than 15 minutes</th>
<th>between 5 &amp; 15 minutes</th>
<th>between 0 &amp; 5 minutes</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Not at all</th>
<th>somewhat</th>
<th>very much so</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Not at all</th>
<th>somewhat</th>
<th>very much so</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Not at all</th>
<th>somewhat</th>
<th>very much so</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Not at all</th>
<th>somewhat</th>
<th>very much so</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Not at all</th>
<th>somewhat</th>
<th>very much so</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Not at all</th>
<th>somewhat</th>
<th>very much so</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Definitely no</th>
<th>not sure</th>
<th>definitely would</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Definitely no</th>
<th>not sure</th>
<th>definitely would</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

Please add any further comments if you wish:
The service would like to know how helpful your psychologist was?

1. What was your problem?

2. How is your problem now?

   WORSE  |  THE SAME  |  A LITTLE BETTER  |  A LOT BETTER
   ![Images](Worse)  |  ![Images](Same)  |  ![Images](Better)  |  ![Images](Lot Better)

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

   NEVER  |  NOW AND THEN  |  MOST OF THE TIME  |  ALWAYS
   ![Images](Never)  |  ![Images](Now and Then)  |  ![Images](Most of the Time)  |  ![Images](Always)
4. How comfortable were you with your psychologist?

- NOT AT ALL
- A LITTLE
- QUITE A LOT
- VERY MUCH

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

- NOT AT ALL
- A LITTLE
- QUITE A LOT
- VERY MUCH
6. Did your psychologist understand your problem?

- NOT AT ALL
- A LITTLE
- QUITE A LOT
- VERY MUCH

7. Did your psychologist listen to your feelings?

- NOT AT ALL
- A LITTLE
- QUITE A LOT
- VERY MUCH
8. Did your psychologist keep what you said private?

YES

SOMETIMES

NO

9. How helpful was your psychologist?

NOT AT ALL

A LITTLE

QUITE A LOT

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

YES  MAYBE  NO

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

YES  MAYBE  NO

Do you want to say anything else?

